

# Whole Person Care – Los Angeles

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# Vision.

To ensure the most vulnerable individuals living in Los Angeles County have the resources and support they need to thrive

# Mission.

Build an integrated health system that delivers seamless, coordinated services to the highest risk LA County residents

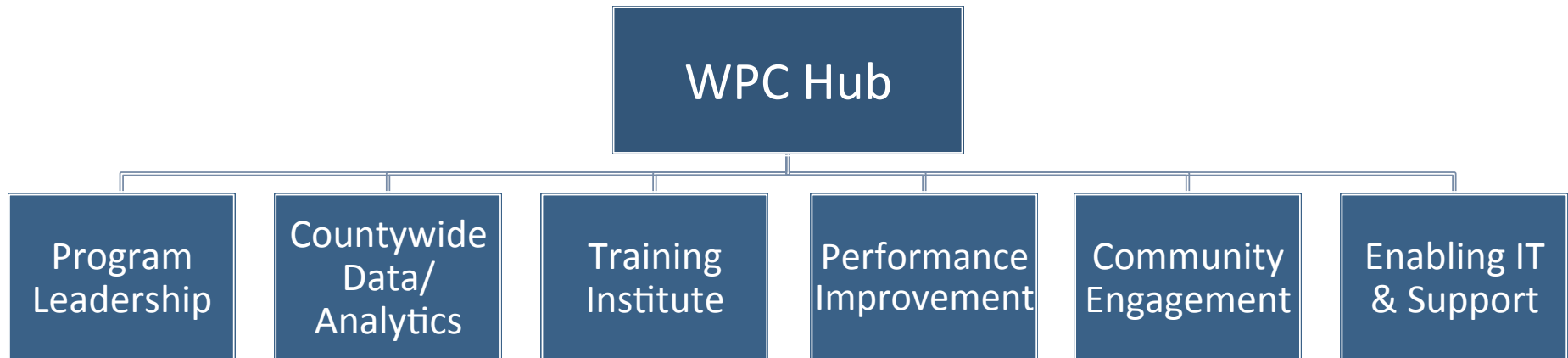
# WPC Overview.

- Part of the 1115 Medicaid Waiver
- \$900m (\$450m Federal funding) between 2016-2020
- Builds countywide infrastructure to improve care to high-risk, high-need Medi-Cal beneficiaries that are “high-users” of multiple public systems
- Focus on:
  - Creating an integrated delivery system
  - Care coordination during high-risk times
  - Addressing social needs

# Program Overview

- WPC Program Administration – housed at DHS
- Regional Coordinating Centers in each SPA
- 5 target populations & 11 programs
- Funding
  - Per member per month funding for most programs
  - Incentives for start-up, reporting and performance
- Helps support efforts such as the Homelessness Initiative, Housing for Health, Office of Diversion and Reentry, High Utilizer Programs, many MHSA programs & Health Homes

# Central Program Structure



## WPC Leadership

- Management Team
- Committees & Workgroups

## County Inputs

- Finance
- Contracts & Grants
- Human Resources
- Information Technology
- Data/Analytics
- Facilities

- Data Sharing/Integration
- Health Plans, LANES, Health Intent

- Analytic support for performance feedback & reporting

- Countywide Collaborative of Trainers
- DMH/DHS, WERC

- Develop curriculum & tools to support WPC

- Central Improvement Advisors to support PI activities

- Central & regional analytic support

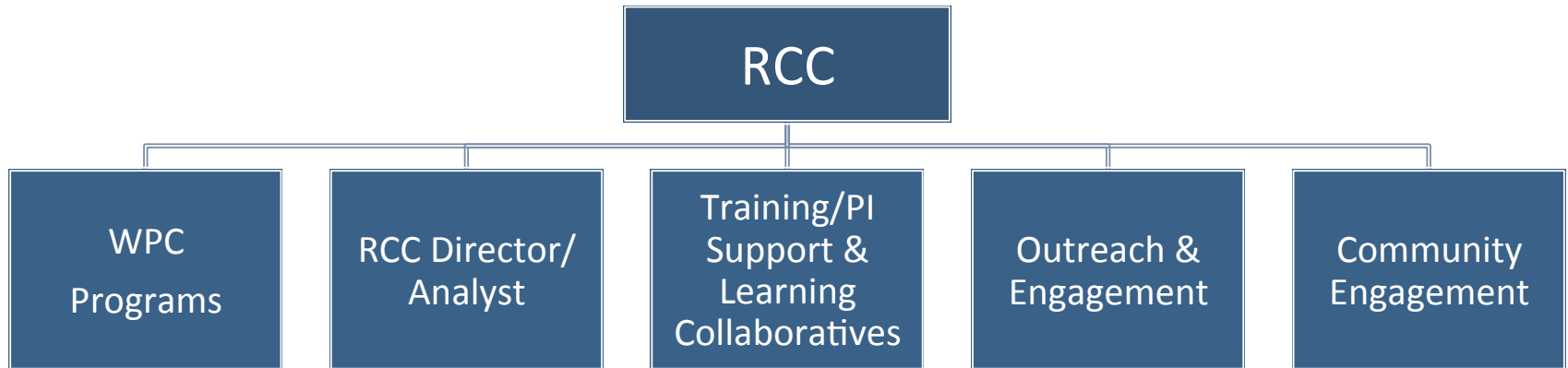
- Community engagement activities through Area Health Officers

- Community Table to discuss WPC issues/gaps & problem solve

- Care Management Platform - Shared Care Plan

- Community Resource Platform – searchable, online platform with case management & referral tracking functionality

# Structure – Regional Coordinating Centers



- Regional Home & Staging Center for each WPC program
- Regional Leadership and Analytic support
- Training & Performance Improvement activities, including Case Conferences and Learning Collaboratives
- Regional outreach & engagement – real-time engagement at the point of care
- Community engagement to support growth of regional resources/capacity to fill gaps & strengthen local delivery system

# Programs

WPC

Homeless  
High-Risk

Homeless Care  
Support Service

Tenancy Support  
Services

Recuperative Care

Sobering Center

Benefits Advocacy

Justice-  
Involved

Re-entry Enhanced  
Care Coordination

Community-based  
Re-entry

Mental Health  
High-Risk

Intensive Service  
Recipients

Residential and  
Bridging Care

SUD High-Risk

SUD Engagement,  
Navigation and  
Support

Medical High-  
Risk

Transitions of Care

Target Population	Program	Estimated Average Enrollees/Year	Budget/Year	% of total Budget
Homeless High Risk	Homeless Care Support Services	~2K	\$30.1m	23%
	Tenancy Support	~2K	\$9.7m	7%
	Recuperative Care	~1K	\$21.2	16%
	Sobering Center	~30K	\$8.2m	6%
	Benefits Advocacy	~10K	\$8.0m	6%
Justice Involved High Risk	Re-entry	~9K	\$39.7m	30%
Mental Health High Risk	Intensive Service Recipient	~1K	\$3.6m	3%
	Residential & Bridging Care	~1K	\$4.1m	3%
Substance Use Disorder High Risk	SUD-Engagement, Navigation, & Support	~4K	\$4.2m	3%
Medical High Risk	Transitions of Care	~3K	\$1.4m	1%



# Overarching Impacts

- ~50,000 served annually
- ~9000 housed
- Support at times of highest risk
- Improved experience

Patient  
Impact

- ~600 new jobs
- Largest Reentry effort
- Support County priorities
- Training & PI Institute
- Transportation

County  
Impact

- Collaborative governance structure
- New cross-county collaboration platform
- Increased community partner engagement

Collaboration

- Leverage WPC infrastructure
- Improve value (CQI)
- Partnerships & integration
- Policy Advocacy

Sustainability