Outline

1. WPC-LA Overview & Highlights
2. Regional Care Management Teams
3. Populations of Focus
4. Implementation Update
5. Health Homes
6. Questions & Answer
Overview

**Mission**
Build an integrated health system that delivers seamless, coordinated services

**Goal: Collaboration**
Increase integration and collaboration among county agencies, health plans, providers, and other entities

**Whole Person Care**
A 5-year (2016-2020) pilot program designed to improve access and quality of care for the most marginalized Medi-Cal beneficiaries

**Goal: Coordination**
Increase coordination and appropriate access to care

**Goal: Data Integration**
Improve data collection and sharing to support case management, monitoring, and program improvement
Program Highlights

Integrated Health Delivery
Participant engagement & care coordination enabled by care teams, IT, and data integration

Regional Care Management Teams
Regional teams consisting of a social worker and CHW apply a “no wrong door” approach

Community Health Workers (CHWs)
Social service teams driven by CHWs with shared lived experience

Transitional Care Coordination
Accompaniment & linkage to and integration with long term providers during high-risk times
Regional Care Management Teams

- Consists of supervising social worker and CHWs
- Work closely with hospital case management and/or CBOs
- Work closely with participant’s primary care team
- Tools:
  - CHAMP – case management platform
  - One Degree – web-based community resource portal
Populations of Focus

WPC-LA

Homeless High-Risk
- Permanent Supportive Housing
- Interim Supportive Housing
- Sobering Center
- Benefits Advocacy

Justice-Involved High-Risk
- Re-entry Pre-Release
- Re-entry Post-Release

Mental Health High-Risk
- Intensive Service Recipients
- Residential and Bridging Care
- *Kin Through Peer

Perinatal High-Risk
- Mama’s Neighborhood

SUD High-Risk
- Engagement, Navigation & Support
- Other Services
- *Medical Legal Partnership

Medical High-Risk
- Transitions of Care

Whole Person Care – Los Angeles
Implementation Update

Number of L.A. County residents served since January 2017: **30,034**

Number of WPC—LA participants as of June 2017: **21,801**

Enrolled **1721** new WPC-LA participants in June of 2017

**16** WPC-LA programs operating throughout LA County

3rd cohort of CHWs to be hired and trained in Fall 2018
Health Homes

What we know

• Coming to LA County July 2019
• In LA County, Health Homes and WPC will provide same set of services except for 2 programs
• Across WPC programs, majority of participants will meet Health Homes criteria (32%-92%)
• Some WPC programs capture higher acuity population
• Health homes provides longer-term care management
Health Homes

What we don’t know

• How to align programs within continuum of care
• Alignment of network
• Operational workflows around enrollment, billing, and reporting
• Rate parity
• Actual supply of housing
For More Information

• For program related information, refer to the WPC-LA website at [www.wpc.dhs.lacounty.gov](http://www.wpc.dhs.lacounty.gov)

• For questions on status of enrollment for a specific patient, care coordination, or identifying who the patient’s CHW is, please email [WPCProviderInquiry@dhs.lacounty.gov](mailto:WPCProviderInquiry@dhs.lacounty.gov)

• For all other questions, contact:

  Belinda Waltman  
  [bwaltman@dhs.lacounty.gov](mailto:bwaltman@dhs.lacounty.gov)
Questions & Answers