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Whole Person Care Los Angeles Impact Report

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WHOLE PERSON CARE LOS ANGELES

Medicaid Waiver 1115
January 1, 2016–December 31, 2021

Impact Report
June 2022

Los Angeles County
Department of Health Services



Health Services
LOS ANGELES COUNTY

Forward

Whole Person Care-Los Angeles (WPC-LA), administered by the Los Angeles County Department of Health Services (LAC-DHS) and funded for six years until 2021, by the Medicaid Waiver 1115, was an unprecedented opportunity to improve care for the sickest and most marginalized Los Angeles County Medi-Cal recipients. WPC-LA expanded care coordination services, built critical care delivery infrastructure, strengthened collaboration, and improved data sharing between health delivery entities. Programming focused on Medi-Cal eligible community members who were homeless, justice-involved, or pregnant, and those with serious mental illnesses, substance use disorders, or complex health conditions. By far the most extensive California program, WPC-LA brought over \$760 million in federal funding to these efforts.

This report summarizes the far-reaching impacts and outcomes of WPC-LA. WPC-LA strengthened our health delivery system in many ways, including breaking down silos in physical health, behavioral health, justice, and social services systems, and addressing health equity through holistic, person-centered programming.

Many WPC-LA programs have a sustainable funding path in CalAIM, the new Medicaid waiver program. This opportunity demonstrates the incredible value generated by WPC-LA and is a testament to the tireless efforts of cross-agency County staff and community-based partners who worked together to make WPC-LA successful. This funding continuity demonstrates the incredible value generated by WPC-LA and the tireless efforts of cross-agency County staff working together and with community-based partners. We want to thank everyone for their deep commitment to contributing experience, expertise, and endless hours to improve the health and wellbeing of our most impacted Angelenos.

WPC-LA was a leap forward in the County's safety-net services to our most marginalized community members; however, we have much more to accomplish to meet their needs. We look forward to continuing to bring the health delivery community together to collectively build towards a future where all Angelenos have the resources and support they need to thrive.

With Warmest Regards,

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Executive Summary:

WPC-LA Mission and Vision



From January 1, 2017, to December 31, 2021, WPC-LA leaders engaged county departments, health plans, clinics, social service agencies, and community-based organizations in expanding and developing care delivery infrastructure and care coordination programs for the most marginalized Medi-Cal beneficiaries. WPC-LA helped bridge cross-sector systems of care and spurred stronger community partnerships, capacity building, and data integration.

As detailed in this report, by connecting participants to primary care, housing, and social services many WPC-LA programs improved continuity of care and reduced costly acute care utilization, including medical and psychiatric hospitalizations and emergency department visits.

Cal-AIM, the new Medicaid waiver, will build on WPC-LA, continue to drive greater health and social services system integration, and promote improved health and well-being for the most Marginalized Medi-Cal beneficiaries.

Mission



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

Vision



Ensure the sickest, most vulnerable Medi-Cal beneficiaries in LA County have the resources and support they need to thrive

Executive Summary:

Key Takeaways

.....

WPC-LA improved the health of Medi-Cal beneficiaries and strengthened Los Angeles County's health system by:

- Building **new pathways for care coordination** across county departments and community-based organizations;
- Implementing **personalized health services** and social support for individuals with complex needs, including housing insecure and reentry populations;
- Creating a **robust and diverse workforce** of CHWs, case managers, doulas, community violence intervention workers, and other peer support services;
- Addressing **health disparities and promoting equitable care** through novel services in care continuity and care transitions;
- Using **regional multi-disciplinary care management teams** addressing participants' physical health, behavioral health, and social needs;
- Expanding **housing infrastructure and services** for housing insecure populations.

WPC-LA Highlights

150,619

PERSONS ENROLLED

From 1/1/2017-12/31/2021. As participants may have been enrolled in more than one program over time, WPC-LA served 101,704 unique participants overall. Of these, 77,370 were Medi-Cal eligible and billable to the State.

1,494,856

MONTHS OF SERVICE

Provided to WPC-LA participants from January 1, 2017, to December 31, 2021.

7-24%

PROGRAM-BASED ER VISIT REDUCTIONS

Reductions in medical and psychiatric ED visits across programs when comparing utilization 12 months pre- and post-enrollment. Other outcomes of note include increased primary care utilization [8-21%] and reduced hospitalizations [4-30%].

2,589

BEDS ADDED

Including 1443 interim housing beds, 1045 recuperative housing beds, and 101 enriched residential care beds.

187

PARTNER COMMUNITY ORGANIZATIONS

Provided services to WPC-LA participants.

200+

COMMUNITY HEALTH WORKERS

Supported through WPC-LA funding, both County and non-County, to support connections to health, social services, and community resources.

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Overview of Whole Person Care-Los Angeles

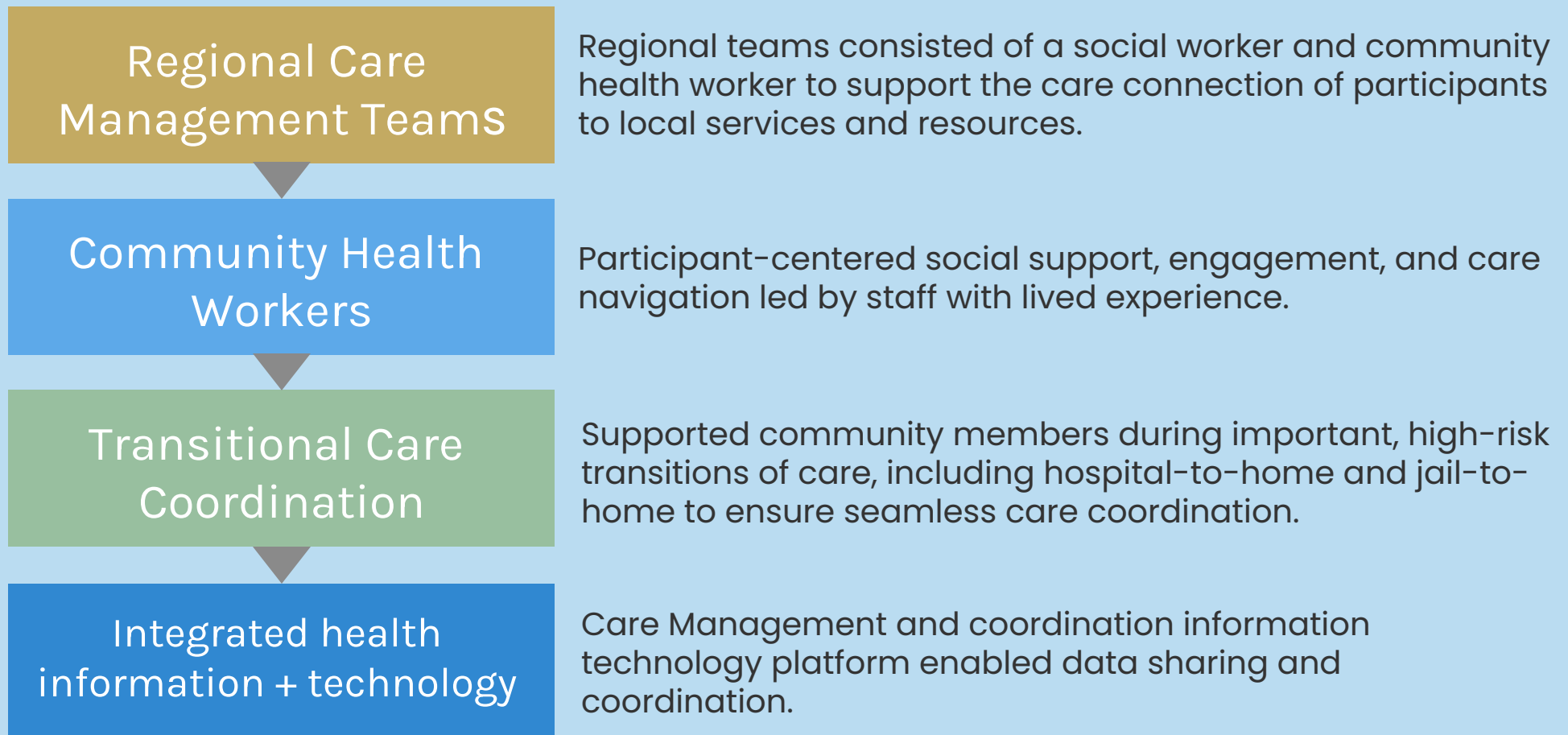
Introduction to the Whole Person Care-Los Angeles Care Model

Multi-disciplinary care management teams, including community health workers, addressed participants' physical health, behavioral health, and social needs. These teams worked across specific geographic areas of Los Angeles County, accepting referrals from many sources, and comprehensively meeting the specific health and social service needs of participants. These teams tailored services to the specific health needs of participants through locally-based enrollment, referrals, and service connections.



Care Coordination System

WPC-LA used an intensive care management model helping coordinate person-centered physical health, behavioral health, and social services while building health system infrastructure to improve integration.



High-Risk Populations Served

WPC-LA provided tailored care coordination services to individuals experiencing high-rates of healthcare discontinuity due to co-occurring social and health conditions. General description of populations of focus are described below.



Homeless High-Risk

Individuals experiencing homelessness who have chronic health needs, social needs, and/or disabilities.



Justice Involved High-Risk

Individuals returning to the community from the justice system face gaps in care, leading to emergency room visits due to multiple and/or complex chronic physical or behavioral health conditions.



Complex Mental Health

Individuals with serious mental illness frequently use mental health acute care services or those with potential for placement into community residential facilities.



Substance Use Disorder (SUD)

Individuals with a substance use disorder who lack continuity in care and frequently visit hospitals and emergency departments.



Medically Complex

Individuals with complex care needs and recurrent general acute hospital admissions.



Perinatal High-Risk

Individuals who are pregnant face high-risk maternal health outcomes due to a lack of social support, social needs, or behavioral health complexities.

Using a Community Health Worker Model

The key change agents in WPC-LA were Community Health Workers (CHWs). CHWs worked with vulnerable Medi-Cal beneficiaries to ensure support and access to the resources they needed to thrive. To achieve this, CHWs built trusting relationships through their community and care systems expertise, meeting participants "where they are at" in their journey. WPC-LA funded over 200 CHWs.

The CHW Role:

Meeting the needs of medically and socially complex participants

- Participant advocacy
- Navigation, coordination, accompaniment, and connection to health and social services
- Social support
- Culturally appropriate health education
- Linguistically and literacy appropriate communication
- Caseload of ~24-30 participants



*"They feel ashamed. I try to reduce that by treating them like human beings, normalizing the experience, and letting them know they're not alone... asking them what their interests are, how we can best support them in any way possible. If that's simply by listening or going for a walk, that's something that we're able to do that the clinician can't do. **To be able to be in the community, meet them where they're at, and actually engage with them on different activities, makes it a lot more enjoyable for them, and for us in building that rapport, in helping them to trust us...**"* -Kin Through Peer Community Health Worker

Community Partnership

WPC-LA partnered with over 187 community-based organizations (CBOs) that were embedded in the Los Angeles County communities WPC-LA served. Partners CBOs and WPC-LA provided bilateral referrals and supported the care continuum to provide services for reentry, housing, substance abuse treatment, and other social services. Partnerships supported local referrals for longitudinal community connections and to meet participants where they were at. These partnerships are funded to provide community-based services and to help build partner infrastructure including staff training, referral, and care coordination platform (CHAMP).

WPC-LA Partnered Community Organizations providing local services that "meet participants where they're at" include homeless shelters, substance abuse treatment, and many other social services.



Community Engagement: A Dedicated Cross-County Collaboration Team

The **WPC-LA Regional Collaboration Team** facilitated cross-country collaboration and community partnerships within WPC-LA. The team built community connections to expand the social service referral network and elevated community-identified priorities to impact changes in county policies and programs. From January 2018 to December 2019, the team organized over 2,500 outreach and collaboration events reaching over 65,000 people to increase awareness of WPC-LA services.

The team co-founded the **African American Infant and Maternal Mortality (AAIMM) Community Action Team**, a community-partnered collaborative to reduce service gaps affecting pregnancy and birth outcomes. As of 2020, AAIMM led over 65 meetings with over 500 stakeholders. Outcomes include establishing five workgroups, developing the "Birthing People's Bill of Rights," and instituting advocacy for the SB 464 *Pregnancy and Dignity in Childbirth Act*, signed in 2019.

A collaboration team member co-facilitated the **Alternatives to Incarceration (ATI) workgroup**, with the mission of providing the LA County Board of Supervisors a road map to scale strategies for alternatives to incarceration and diversion, prioritizing health and social care first, with jail as a last resort. ATI organized a cross-discipline of government stakeholders and community members to serve as voting members, developed six different ad hoc committees, and engaged hundreds of people in over 70 consensus-building meetings.

.....
Community Outreach Events: >2,500



The **California Birth Equity Summit 2019** was hosted by March of Dimes, LAC DHS, LAC DPH, community organizations, and the WPC-LA co-led AAIMM Community Action Team (see AAIMM description, left).



The **Care First, Jails Last** report is a product of the WPC-LA co-facilitated ATI Work Group (see ATI description, left). This report identifies community priorities and strategies for diversion and re-entry and was distributed widely to county policymakers.

Investing in Care Coordination Staff: Centralized Capacity Building

A centralized capacity-building infrastructure conducted and organized initial and ongoing high-quality training for CHWs and MCWs to strengthen person-centered care protocols and expectations. Curriculum development used popular (people's) education methodology, core competencies outlined in the Core Consensus (C3) Project, and the latest WPC-LA programmatic needs. The base curriculum included:

- The Power of the CHW Profession
- Health Inequities and Public Health
- Health and Social Service System Navigation
- Outreach, Engagement, & Person-Centered Care Planning
- Communication Skills
- Cross-Cultural Skills and Understanding Biases
- Motivational interviewing
- Advocacy
- Safety skills
- Trauma-informed self-care

The CB Team evaluated the required areas for ongoing training by engaging stakeholders, including CHWs, supervisors, program managers, and the leadership team. The CB team also provided cross-departmental recommendations and sample materials for CHW recruitment, hiring, retention, and training. The team has supported creating and managing online learning collaborative for County CHWs, "The CHW Connect."



CHWs and trainers celebrate the successful completion of a **Mental Health First Aid** Training. The CHWs learned risk factors and warning signs for mental health and substance use concerns, strategies for helping, and resources. CHWs were trained across the eight Service Planning Areas.

Building Infrastructure for Integrating Health and Social Service Data



Accessible data platforms were imperative to sharing participant data across health, mental health, justice, and social service systems. To this end, WPC-LA created the **Comprehensive Health Accompaniment and Management Platform (CHAMP)**, for data sharing and participant tracking. This novel system allowed multiple medical, behavioral, and social service providers to enter, access, and collaborate on participant demographic, enrollment, health, and care plan data.

The Comprehensive Health Accompaniment and Management Platform (CHAMP) platform:

- Allowed multiple CHWs, case managers, and providers to document, view, and share participants' health information across multiple care settings
- Facilitated collaboration and care continuity between these stakeholders by allowing them to develop a participant's care plan in one platform and track the participant's progress as they move through various care settings.
- Helped to inform health care decision-making by documenting participants' social determinants of health

WPC-LA Enrollment & Participant Characteristics

January 2017–December 2021

Persons Enrolled*

150,619

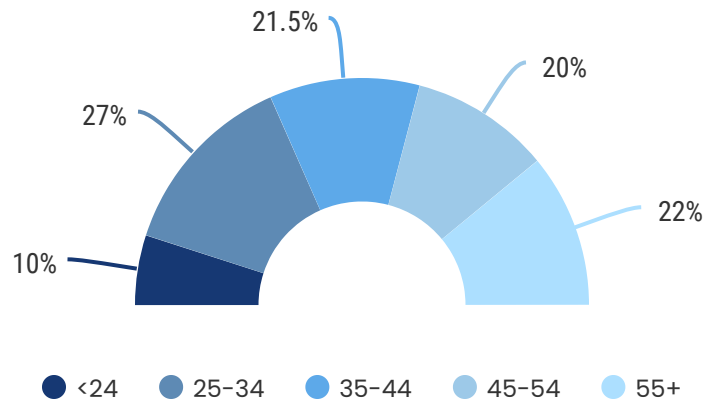


Member Months of Service

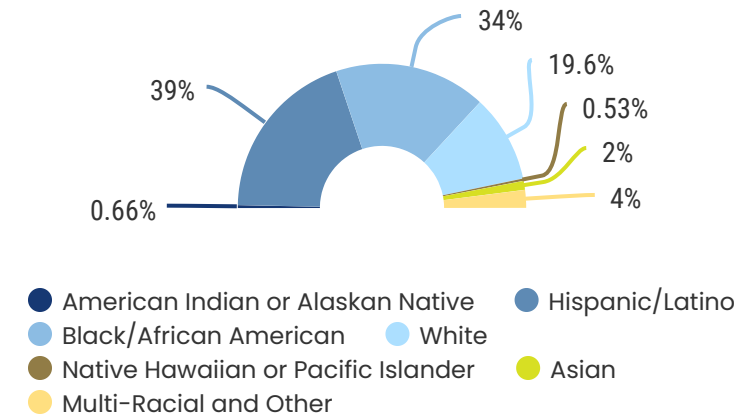
1,494,856



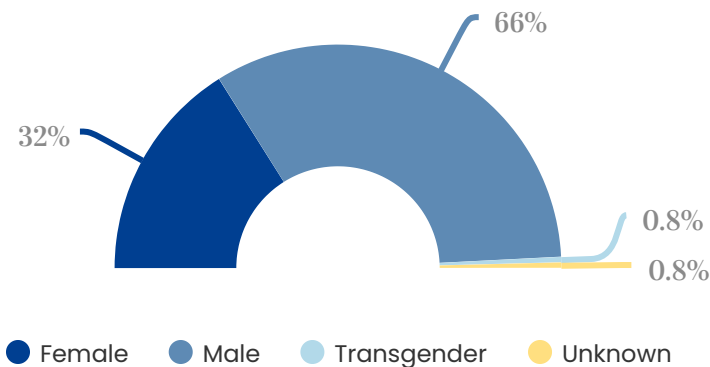
Age



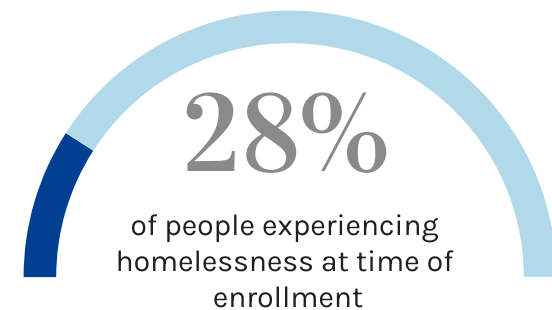
Race/Ethnicity



Gender



Homeless Status



*Unique program enrollments. As participants may have been enrolled in more than one program over time, WPC-LA served 101,704 unique participants overall.

Innovative Care Programs in WPC-LA



WPC-LA Programs for Participants Experiencing Homelessness

“I’m so grateful to have a place that my kids can come to, that I can be able to cook for them and be here after school... Without this program, we’d still be homeless, and that’s a scary thing.”

-Jahnmaika Normil, Housing for Health Participant



Photo: Mayra Beltran Vasquez, County of Los Angeles

Housing for Health Programs

Description: The Housing for Health (HFH) Program at the Los Angeles County Department of Health Services expanded housing services to people experiencing homelessness who have complex medical and behavioral histories. Through HFH, WPC-LA identified eligible participants and connected them with housing, medical and behavioral health care, social services, and psychosocial support. To facilitate housing transitions, WPC-LA added 2,589 beds at interim housing facilities (until permanent supportive housing can be secured), including 1443 interim housing beds, 1045 recuperative housing beds, and 101 enriched residential care beds.

Goals: The Housing for Health Programs strived to place participants experiencing homelessness into temporary and/or permanent housing tailored to their needs and connect them to long-term medical, behavioral, and psychosocial support. Through these intensive services, the housing programs reduced acute medical care usage and increased primary care and preventive services for participants experiencing homelessness.

Homeless Care Support Services–Tenancy Support Services (HCSS–TSS)

Description: The Homeless Care Support Services-Tenancy Support Services (HCSS-TSS) program provided intensive case management services in obtaining supportive housing. Once housing was obtained, additional support for housing retention was also provided. Navigational support enabled participants to achieve healthy outcomes, access mental health and substance use disorder services, and secure and maintain housing.

Eligibility: Participants experiencing homelessness who have complex medical and behavioral histories.

Average Length of Stay: Indefinite. Participants may stay in the program for as long as they need.

HCSS case managers, TSS workers, and other HCSS-TSS staff:

- Assisted participants with finding housing and moving in
- Facilitated discussions with landlords and lease signings
- Connected participants to primary care, behavioral health care, substance use disorder services, housing navigation, move-in assistance, and establishment of benefits
- Assisted participants with life and job skills, educational and vocational opportunities, and crisis intervention



Persons Enrolled

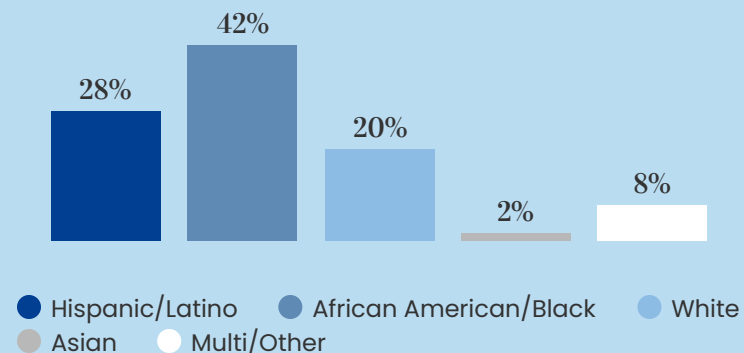
28,935



Member Months
of Service

580,749

Ethnicity (%)



HCSS-TSS Program: Health Outcomes



34%

Of participants experiencing homelessness were **connected to housing services** within 12 months of enrollment



53%

Of HCSS-TSS participants connected to housing **retained their housing** for at least 12 months



↓ 7%

In **emergency room visits** from 12 months before HCSS-TSS Program enrollment to 12 months after enrollment



↑ 8%

In **primary care visits** from 12 months before HCSS-TSS Program enrollment to 12 months after enrollment



↓ 11%

In **hospitalization stays** from 12 months before HCSS-TSS Program enrollment to 12 months after enrollment

Stories from the Field: Achieving Hope, Health, and Housing



Photo: Mayra Beltran Vasquez, County of Los Angeles

Joan*, a 56-year-old woman, was referred to HFH after spending several years experiencing homelessness in Los Angeles. Joan had schizophrenia, post-traumatic stress disorder, and a history of anxiety attacks and depression. She was often overwhelmed and felt that her mental illnesses were “hindering her ability to function in society.” HFH connected Joan to Liset Escobar, a permanent supportive housing case manager who connected her to a psychiatrist and therapist. The program also helped Joan secure permanent supportive housing.

Over the last year, Liset and Joan’s therapist worked together as a care team to create a robust support system for Joan. Liset helped Joan keep her mental health appointments, which enabled her to re-establish healthy relationships and boundaries with friends and family. Achieving her mental health goals facilitated Joan’s stability, and she has successfully maintained her permanent housing. With improved health and stable housing, Joan craved a way to give back to her community and applied to volunteer at a food bank. Liset assisted with the application, and Joan’s therapist accompanied her to the food bank to provide emotional and social support. Joan now volunteers at the food bank every other Saturday.

Joan’s progress and her growing sense of self-worth convinced Liset that Joan was ready to connect with the California Department of Rehabilitation for employment. Joan is currently enrolled in a training program at Home Depot and looks forward to submitting an employment application after program completion. She is looking forward to a fulfilling future where she maintains healthy boundaries, builds relationships, and achieves future employment goals.

**Name changed to protect identity*

Psychiatric & Medical Recuperative Care Programs

Description: The Psychiatric Recuperative Care and the Medical Recuperative Care Program provided housing placement options for health stabilization and recovery for homeless populations. Recuperative care provided semi-private or congregate living facilities, including onsite medical and supportive services.

Eligibility: People experiencing homelessness and discharged from an inpatient hospital setting without a place to live and recover from medical complexities. To be placed at these unlicensed facilities, participants must be independent of Assistance with Activities of Daily Living (ADLs), such as bathing, grooming, or other daily living support.

Average Length of Stay: 3-6 months

Case managers and other Recuperative Care staff provided:

- 24/7 health monitoring (general oversight of medical condition, vital signs, wound care, medication monitoring, etc.)
- Development of a comprehensive homeless care support services plan and coordination with permanent housing providers to support the transition of participants to permanent housing
- Connection to primary care, behavioral health care, substance use disorder services, the establishment of benefits, transportation, and social activities



Persons Enrolled

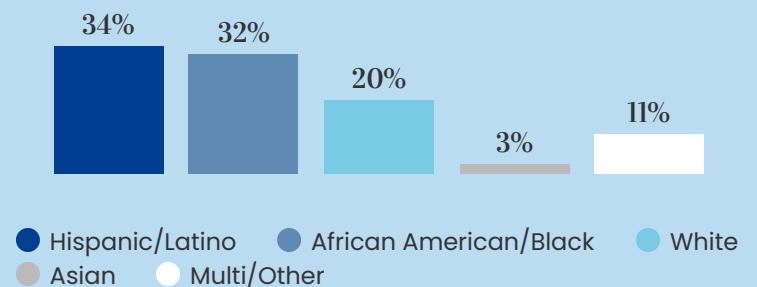
5,949



Member Months
of Service

45,696

Ethnicity (%)



Psychiatric Recuperative Care Program: Health Outcomes



↓ 16%
In **medical emergency room visits** from 12 months before program enrollment to 12 months after enrollment



↑ 24%
In **medical primary care visits** from 12 months before program enrollment to 12 months after enrollment



↓ 7%
In **medical hospitalization stays** from 12 months before program enrollment to 12 months after enrollment



↓ 10%
In **psychiatric emergency room visits** from 12 months before program enrollment to 12 months after enrollment



↑ 8%
In **psychiatric primary care visits** from 12 months before program enrollment to 12 months after enrollment



↓ 8%
In **psychiatric hospitalization stays** from 12 months before program enrollment to 12 months after enrollment

Medical Recuperative Care Program: Health Outcomes



↓ 14%
In **medical emergency room visits** from 12 months before program enrollment to 12 months after enrollment



↑ 22%
In **medical primary care visits** from 12 months before program enrollment to 12 months after enrollment



↓ 29%
In **medical hospitalization stays** from 12 months before program enrollment to 12 months after enrollment



↑ 9%
In **medical specialty care visits** from 12 months before program enrollment to 12 months after enrollment



↑ 10%
In **psychiatric primary care visits** from 12 months before program enrollment to 12 months after enrollment

Enriched Residential Care (ERC)

Description: Enriched Residential Care (ERC) aimed to transition people experiencing homelessness from inpatient hospitalization to permanent housing options with appropriate medical and behavioral health oversight. ERC facilitated participant access to licensed residential care services.

Eligibility: People experiencing homelessness with complex physical and mental health problems who need support in managing daily activities and recovery, particularly where interim housing and permanent supportive housing are inappropriate due to a lack of on-site residential assistance. Assistance with activities of daily living (ADLs) including bathing, grooming, dressing, personal hygiene, wheelchair transfers, or additional health support such as reminders/prompting, provision of equipment and supplies (including incontinence supplies), health education, etc.

Average Length of Stay: 17.5 months

ERC services included:

- A clean, comfortable sleeping environment
- Three nutritious meals per day
- On-site daily assistance with activities of daily living, medication administration, and medication adherence
- Case management to facilitate the transition to a residential care facility
- Connection to primary care, mental health services, substance abuse services, and transportation
- Group activities, socialization, and life skills development



Persons Enrolled

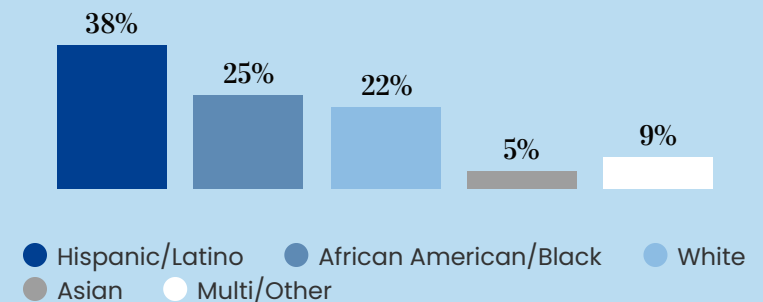
1,091



Member Months
of Service

24,919

Ethnicity (%)



ERC Program: Health Outcomes



↓ 8%

In **psychiatric emergency room visits** from the 12 months before program enrollment to the 12 months after enrollment



↑ 11%

In **psychiatric primary care visits** from the 12 months before program enrollment to the 12 months after enrollment



↓ 6%

In **psychiatric hospitalization stays** from the 12 months before program enrollment to the 12 months after enrollment



↓ 13%

In **medical emergency room visits** from the 12 months before program enrollment to the 12 months after enrollment



↑ 19%

In **medical primary care visits** from the 12 months before program enrollment to the 12 months after enrollment



↓ 21%

In **medical hospitalization stays** from the 12 months before program enrollment to the 12 months after enrollment

In-Home Care Giving (IHCG) Program

Description: The In-Home Care Giving (IHCG) Program provided temporary caregiving services to participants who are eligible for In-Home Supportive Services (IHSS) and awaiting approval, but require immediate in-home care services. The program coverage allowed those who need Activities of Daily Living (ADL) support such as meal prep, housekeeping, bathing, medication, and incontinence care to remain stably housed while their IHSS application is under review. Since September 2020, the program was also implemented in Project Room Key Sites (hotel and motel rooms for people experiencing homelessness to prevent the spread of COVID-19) to offer caregiving services.



Photo: Mayra Beltran Vasquez, County of Los Angeles

Eligibility: Participants with intensive in-home support needs. In-home services support living independently in permanent supportive housing.

Length of Stay: Ranges from 1 to 5+ years, depending on the needs of the participant

IHCG services include:

- Light housekeeping: cleaning and laundry assistance
- Errands and transportation: meal preparation, grocery and clothes shopping, prescription pick-up
- Hygiene assistance: bathing, dressing and grooming assistance, continence care
- Health assistance: accompaniment to doctor's appointments, medication assistance, assistance with physical therapy exercises
- Social activities: companionship activities such as cooking together

|  **350** Persons Enrolled* |

Countywide Benefits Entitlement Services Team (CBEST)

Description: CBEST assisted participants in applying and maintaining public benefits, such as Social Security Income (SSI) or Social Security Disability Insurance (SSDI). CBEST provided targeted navigation, connection, advisory support, and advocacy for application assistance.

Eligibility: Participants who are experiencing homelessness or at risk of homelessness, and eligible for public benefits.

Average Length of Stay: Dependent on participant needs, application, and approval

CBEST services included:

- Screening and assessment to ensure participants meet requirements for SSI/SSDI or other benefits, including addressing barriers to applying, such as case management around resolving immigration status, procuring ID documents, clarifying and understanding financial eligibility, establishing a treatment history, and other services
- Coordination of medical and behavioral health records to support the SSI/SSDI application
- Legal consultation and representation for complex claims, appeals, and hearings and reconsideration filings for denials
- Liaising with the Social Security Administration and State of California Department of Social Services Disability Determination Services
- Coordination with primary care, behavioral health, and PSH-ICMS providers



Persons Enrolled

24,595



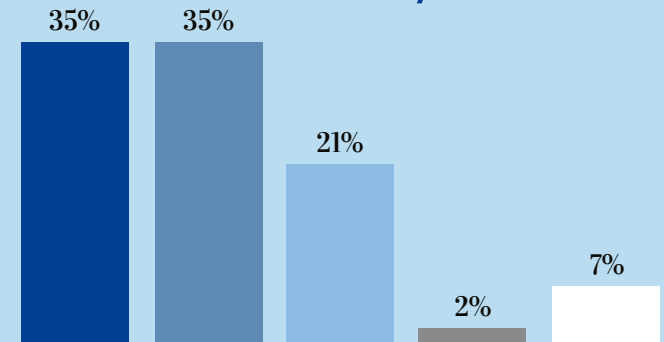
Member Months
of Service*

413,135



Photo: Mayra Beltran Vasquez, County of Los Angeles

Ethnicity (%)



● Hispanic/Latino ● African American/Black ● White
● Asian ● Multi/Other

*CBEST member months include the time until participants receive initial benefit payment (SSI, SSDI, or CAPI) or until payment for the highest rate CBEST can secure (CBEST may appeal further to increase pay rate).

Sobering Center

Description: The Sobering Center provided immediate resources for participants experiencing active, chronic, and serial inebriation living on and around Skid Row. The mission of the Sobering Center was to reduce incarcerations, minimize hospitalizations, and provide temporary, safe shelter. Local emergency departments identified individuals experiencing inebriation. Sobering Center staff assessed the participant, offered resources, and provided connections with sober coaches. Participants received the specific care and social services they need while freeing up paramedic resources.

Eligibility: Participants experience homelessness and inebriation.

Average Length of Stay: Less than 24 hours

Sobering Center services included:

- Medical triage
- Wound and dressing changes
- Oral rehydration and food service
- Bed, shower, and laundry facilities
- Connection to primary care, behavioral health care, substance use disorder counseling and treatment, and PSH-ICMS as needed



Persons Enrolled

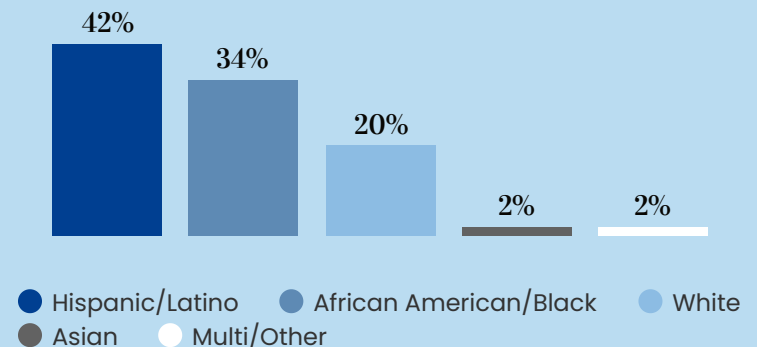
10,530



Encounters

57,767

Ethnicity (%)





WPC-LA Programs for Justice-Involved Participants

"One time, one of my clients had just done 22 years in prison. And he was a warm handoff [in-person transfer of care] from the medical provider at the clinic. And when he came in my office for his initial intake, and I was helping him—and I'm always, when I know they're coming straight out of prison doing a hard time, I try to be as gentle as possible with them. Because I know they're most vulnerable because this is new for them. And I was helping him, and tears just started rolling down his eyes."

-Community Health Worker, Post-Release Reentry

Reentry Programs

Description: The Reentry Programs served adults recently released from incarceration and provided health, social service, and community connections. The program offered pre-release planning services for adults incarcerated in Los Angeles County jails and post-release services, facilitating community reentry. Community Health Workers who have lived experience in the justice system were embedded in jails and community-based organizations and offered vital peer navigation, social support, and accompaniment to health, mental health, substance use disorder, and social service systems. In addition to WPC-LA funding, reentry programs were also funded by Prop 47 and SB 678.

Goals: By offering transition services before and after release, reentry programs aimed to facilitate successful reentry into the community and reduce recidivism through facilitating connection to health and social services. With connections to the appropriate services, WPC-LA hopes to lessen the utilization of costly acute care while also increasing primary care utilization, thereby improving health outcomes.

Average Length of Stay: 3 months, with a subset of participants receiving 9 months of service

Reentry Staff, CHWs (at partner community organizations), and Clients



Photos: Video Screenshots, Oceans and Mountains for LAC DHS ODR

Pre-Release Reentry Program

Description: The Pre-Release Reentry Program engaged incarcerated individuals before release to provide services for community reentry planning. Staff provided connection to healthcare, housing, and social services.

Program Duration: Typically 2-4 months, but can be as short as a few days before release

Eligibility: Individuals in Los Angeles County jails preparing for reentry who are eligible for Medi-Cal, are high utilizers of health or behavioral health services, and are experiencing chronic medical conditions, mental illness, substance use disorders, or homelessness.

CHWs and case workers, embedded in jail, supported:

- Psychosocial assessment and development of a reentry care plan with a CHW
- Initiation of Medi-Cal application while in custody, for activation upon release
- Connection to community-based services post-release, including substance use treatment, medical and mental health treatment coverage, interim housing, SSI advocacy, and employment assistance
- Facilitated eligibility for a 30-day supply of essential prescription medications at release and continuation of care documents of participants community health care providers
- Point-of-release services at the release desk, including arranging transportation, shelter, or other services
- Connection to a CHW in the community for support post-release



Persons Enrolled

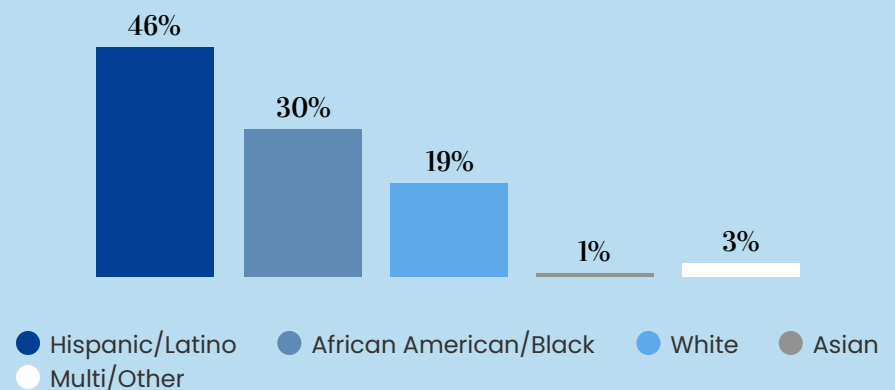
24,172



Member Months
of Service

117,688

Ethnicity (%)



Post-Release Reentry Program

Description: Once released from jail, the Post-Release Reentry Program connected participants to a community-based CHW who provided social support and connection to healthcare, housing, employment, and social services.

Program Duration: 4-6 months with option to extend to 12 months

Eligibility: Participants recently released from jail and reintegrating into society. High utilizers of health or behavioral health services, and have chronic medical conditions, mental illness, substance use disorders, or experiencing homelessness.

Community-based CHWs provided:

- Connection to housing, employment, education, legal assistance, and social support for community integration and support in recidivism, including public benefits, identification, substance use disorder treatment, employment, housing, benefits, transportation vouchers, domestic violence, and anger management classes, family reunification, and assistance with obtaining IDs and other documentation
- Accompaniment to crucial health and behavioral health appointments
- Mentoring and empowerment
- Health and social service navigation
- Assistance with adherence to appointments, treatments and medications, and connection to transportation.



Persons Enrolled

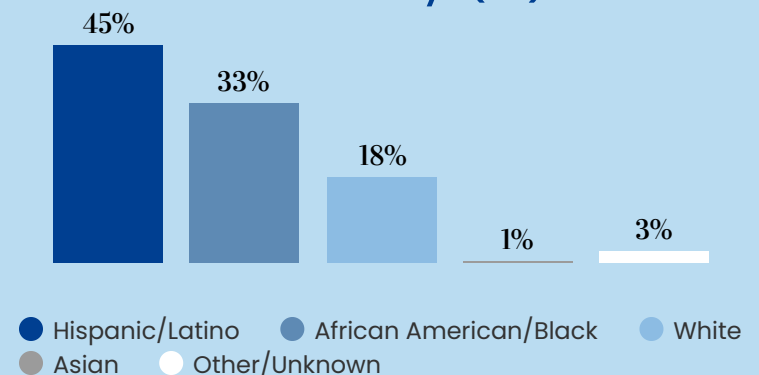
25,745



Member Months
of Service

128,089

Ethnicity (%)



Reentry Programs: Health Outcomes



99%, 97%

Of participants had a **care plan** created within 6 months of **Pre-Release Reentry program** enrollment and **Post-Release Reentry program enrollment**, respectively



↑ 12%

In **primary care visits** from 12 months before Post-Release Program enrollment to 12 months after enrollment*



↓ 4%

In **emergency room visits** from 12 months before Post-Release Program enrollment to 12 months after enrollment*

Health utilization analyses were completed using visit information from 2016-2019 (prior to COVID-19) and conducted using generalized linear mixed modeling. Data shown had significant differences ($p < 0.05$). No differences were observed for specialty care visits or hospitalization stays. Additionally, health utilization analysis are estimated using available 12 month data which may not account for medical care during the incarceration time period.

Stories from the Field:

Building Optimism for the Future



The LAC Sheriff's Department referred Ben* to the WPC-LA Reentry Programs in May 2019 while he was in custody at Men's Central Jail. Ben disclosed his struggles with addiction to cope with his post-traumatic stress disorder and depression. He had a history of physical and sexual abuse as a child, and he had lost two siblings in traumatic ways. As a result, he began using substances to cope with his trauma. In addition to substance use disorder and mental health struggles, Ben lived with lower back pain from an accident and uncontrolled hypertension. At 42 years old, Ben had served multiple prison sentences and jail stints.

Before his release from jail, Ben was matched with Kim Hobbs, a Reentry CHW. Kim met with him consistently to build rapport and to set goals while Ben was in jail. Following his incarceration in the Summer of 2019, Ben was court-ordered to an inpatient substance use disorder treatment program. Kim worked with his public defender to ensure a smooth care transition. However, Ben left the program after only one day as the program ordered Ben to cut his hair, styled in dreadlocks, and due to his refusal, they asked him to leave. This refusal registered him as absent from the court-ordered program, and an automatic warrant was issued for Ben's arrest.

Kim accompanied Ben to the court clerk's office to explain the situation and advocate for him. Due to Kim's advocacy, the court granted the program change, and Kim worked with Ben to find a new placement. However, in the days before a new placement was secured, Ben was washing his shirt using an alley faucet when police arrived, ran his name, and arrested him again. Kim then worked with a WPC-LA Substance Abuse Counselor to secure Ben's placement in a substance use disorder treatment center so he could be transported directly from jail. Ben entered inpatient treatment in October 2019 and has been thriving. He is forward-thinking, positive, and focused on his recovery. Ben recently met his goal of having phone contact with his five-year-old daughter and is working toward regular visitation with her.

**Name changed to protect participant identity*

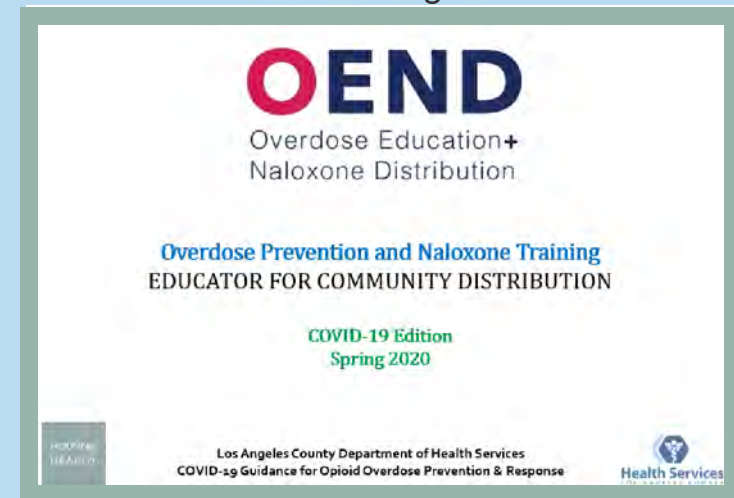
Overdose Education and Naloxone Distribution Program (OEND)

Description: The Overdose Education and Naloxone Distribution (OEND) Program, initiated in 2020, targeted reentry and other vulnerable populations at risk for opioid overdose for prevention education and distribution of Naloxone, a life-saving overdose reversal medication. People released from prisons and jails are at high risk for fatal opioid overdose.* Overdose prevention and response education, along with free naloxone, were provided to everyone leaving the jails through the Inmate Reception Center and Century Regional Detention Facility. The program also provided training on how to prevent, recognize, and respond to an opioid overdose, and Naloxone use to county service providers, community-based organizations, and community members. Naloxone distribution occurred in high-risk community settings (including vending machines).

Goals: The program aimed to reduce opioid overdose deaths in Los Angeles County by expanding the provision of naloxone and overdose prevention and response education to providers, community partners, community members, and anyone in a position to respond to an overdose.



Naloxone Vending Machine



Overdose Prevention and Naloxone Training

 **134,634** Naloxone Doses Distributed in 2020–2021
8,960 Reports of Naloxone Use in Overdose Events

*Merrall, E. L., et al. (2010). Meta-analysis of drug-related deaths soon after release from prison. *Addiction*, 105(9), 1545-1554.



WPC-LA Programs for Participants with Mental Health Risks

"A client tells me, "They stopped my Social Security and I don't know why." I said, "Well, let's go down there, and let's go find out," right? So we get down there and the manager of the Social Security Office calls explained the client had had an outburst in the Social Security Office, and this is why he was banned. Okay, so that's understandable. I said to the official, "Behaviorally, the client has schizophrenia. The client has been unmedicated for about the last eight years." I said, "But what I'm not understanding is how can somebody be on Social Security for ten years, no employment history at all, at all, miss an appointment, and his benefits be terminated?" The lady looked at me and she goes, 'I don't know.' I said, 'Me neither.' She goes, 'Well, we start the application over.' I said, 'No worries. We start the application over.' **We're willing [as CHWs]—whatever it takes. Whatever it takes.**"

-Community Health Worker, WPC-LA, Department of Mental Health



Photo: Mayra Beltran Vasquez, County of Los Angeles

Mental Health Programs

Description: Vulnerable participants with serious mental illness face compounding physical and behavioral health conditions in addition to socioeconomic barriers that contribute to destabilization, poor health outcomes, and high utilization of inpatient visits. WPC-LA collaborated with the Los Angeles County Department of Mental Health to connect participants with serious mental illness with medical and psychosocial services, facilitating immediate and long-term stabilization.

Goals: Through intensive social support and connection with community-based medical and psychosocial services, the WPC-LA Mental Health Programs facilitated participants' transition back to their communities following discharge from inpatient facilities. These services helped to reduce admissions and readmissions to the emergency department and inpatient psychiatric hospitals.

Residential and Bridging Care Program (RBC)

Description: The Residential and Bridging Care (RBC) Program provided transition services from psychiatric hospital care to lower levels of care. The program ensured participants had what they needed to thrive in a lower level of care and when possible, to facilitate reintegration into the community.

Eligibility: Participants in locked or clinically enriched psychiatric facilities who would benefit from transitioning to community-based placement.

Average Length of Stay: 2 months

RBC staff:

- Provided peer support
- Augmented existing after-care plans to cover a broader range of service needs
- Coordinated between institutional teams and community-based providers
- Assisted with connection to residential treatment, primary care, substance use disorder providers, housing, legal services, benefits establishment, and other community-based resources
- Assisted with life skills, educational support, and vocational support



Persons Enrolled

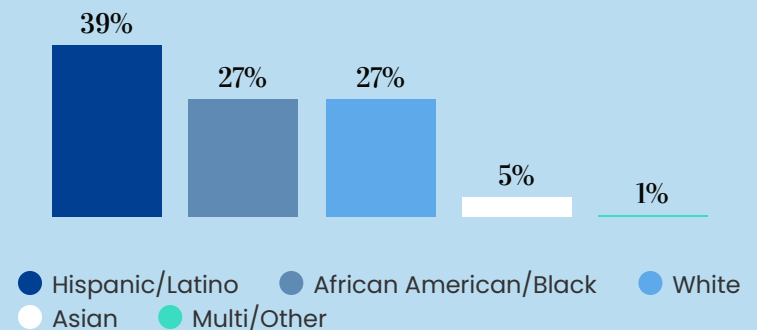
7,715



Member Months
of Service

36,074

Ethnicity (%)



RBC Program: Health Outcomes



↓ 21%

In **psychiatric emergency room visits** from the 12 months before RBC Program enrollment to the 12 months after enrollment



↓ 13%

In **psychiatric hospitalization stays** from the the 12 months before RBC Program enrollment to the 12 months after enrollment



↑ 16%

In **psychiatric primary care visits** from the 12 months before RBC Program enrollment to the 12 months after enrollment



↓ 16%

In **medical emergency room visits** from the 12 months before RBC Program enrollment to the 12 months after enrollment



↑ 11%

In **medical primary care visits** from the 12 months before RBC Program enrollment to the 12 months after enrollment



↓ 13%

In **medical hospitalization stays** from the the 12 months before RBC Program enrollment to the 12 months after enrollment



↑ 7%

In **medical specialty care visits** from the 12 months before RBC Program enrollment to the 12 months after enrollment

Intensive Service Recipient Program (ISR)

Description: The Intensive Service Recipient (ISR) Program assisted post-discharge participants with intensive after-care transition planning and navigation to transportation, housing, and other medical/psychosocial services.

Eligibility: Participants who access mental health services when in crisis and, as a result, are frequently admitted to inpatient psychiatric hospitals. The program promotes continuous mental health care and support services to reduce inpatient stays and improve care continuity.

Average Length of Stay: 3 months

ISR Community Health Workers and other staff members:

- Oversee ongoing medical and behavioral health monitoring and follow-up, including home visitation, assistance with crisis support services, and accompaniment to appointments
- Connect participants to primary care, behavioral health care, substance use disorder providers, housing, food, clothing, transportation, legal services, and benefits establishment
- Provide social support and assist with participant goals, life skills, educational support, and vocational support



Photo: Mayra Beltran Vasquez, County of Los Angeles



Persons Enrolled

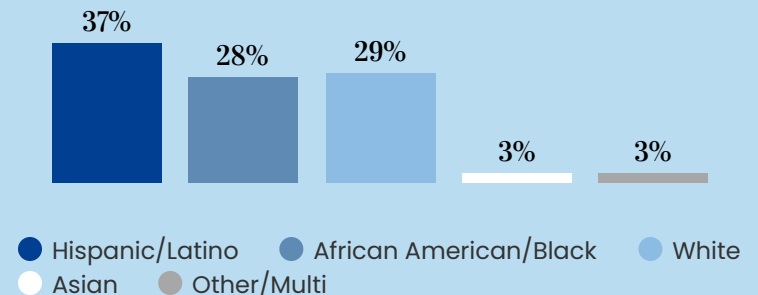
4,490



Member Months
of Service

19,009

Ethnicity (%)



ISR Program: Health Outcomes



97%

Of participants had a **care plan** created within 3 months of ISR Program enrollment



↓ 19%

In **psychiatric hospitalization stays** from the 12 months before ISR Program enrollment to the 12 months after enrollment



↓ 4%

In **medical emergency department visits** from the 12 months before ISR Program enrollment to the 12 months after enrollment



↑ 8%

In **medical primary care** visits from the 12 months before ISR Program enrollment to the 12 months after enrollment



↑ 15%

In **medical specialty care visits** from the 12 months before ISR Program enrollment to the 12 months after enrollment

Kin Through Peer Program (KTP)

Description: The KTP Program utilized community health workers to serve as surrogate kin to participants and provide intense, long-term psychosocial support. KTP staff worked with mental health service providers to promote the participant's recovery, facilitate case conferencing, and conduct home visits. Care services were provided by CHWs, who have lived experience with mental health care and can provide person-centered peer support.

Eligibility: WPC-LA ISR and RBC participants with serious mental illness who lack healthy social support systems, such as family.

Average Length of Stay: Up to 12 months

KTP Community Health Workers and staff:

- Fulfilled a kin role through social support activities ranging from participating in recreational activities together to assisting with applications
- Accompanied participants to appointments
- Assisted with connection to basic needs (housing, food, clothing, transportation), legal services, and benefits establishment
- Assisted with participant goals, life skills, educational support, and vocational support



Persons Enrolled

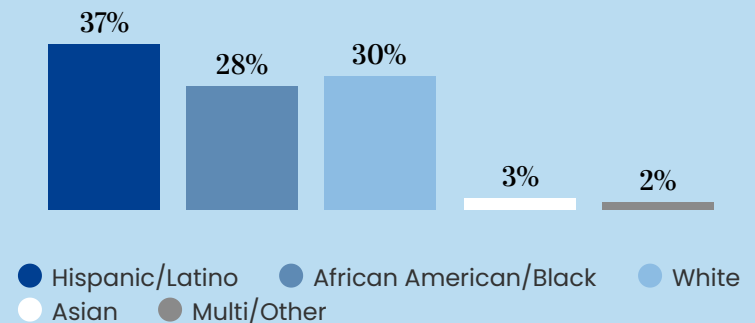
1,727



Member Months
of Service

14,407

Ethnicity (%)



KTP Program: Health Outcomes



↓ 11%

In **psychiatric emergency room visits** from the 12 months before KTP enrollment to the 12 months after enrollment



↓ 26%

In **psychiatric hospitalizations** from the 12 months before KTP enrollment to the 12 months after enrollment



↑ 18%

In **psychiatric primary care visits** from the 12 months before KTP enrollment to the 12 months after enrollment



↓ 11%

In **medical emergency room visits** from the 12 months before KTP enrollment to the 12 months after enrollment



↑ 12%

In **medical primary care visits** from the 12 months before KTP enrollment to the 12 months after enrollment



↓ 16%

In **medical hospitalization stays** from the 12 months before KTP enrollment to the 12 months after enrollment



↑ 23%

In **medical specialty care visits** from the 12 months before KTP enrollment to the 12 months after enrollment

Stories from the Field:

A Veteran's Mental Health Journey

Marcus*, a veteran experiencing homelessness, enrolled in the Intensive Services Recipient (ISR) Program while in the hospital. An ISR CHW connected Marcus with housing services and coordinated his mental illness appointments. Lacking a healthy support system, Marcus was then enrolled in the Kin Through Peer (KTP) Program to receive more intensive, long-term assistance.

Marcus's KTP CHW, who had lived experience with psychiatric illness, related to Marcus on a personal level. Their relationship supported care planning and coordination for all of Marcus's medical and psychiatric needs. The CHW helped Marcus apply for housing benefits with the LA Housing Services authority and to begin the matching process for an apartment. The CHW also accompanied Marcus to his appointment with the Department of Public Social Services to reinstate his public benefits.



Marcus had trouble keeping his appointments for the next four months, and his untreated medical conditions worsened. Not uncommon for participants struggling with multiple complexities and unstable housing, the KTP CHW continued their contact with Marcus to support him through his recovery process. When his CHW could not find Marcus, she would show up at the shelter. When he wanted to give up, she shared personal challenges she overcame to instill hope and motivation.

A month later, Marcus was provided with permanent housing and on-site supportive services. He was overwhelmed with gratitude for his CHW's steadfast commitment to helping him. In each care transition, team members went above and beyond to provide warm handoffs to care and service connections, including transportation and social support. KTP's peer support is essential to the recovery process of participants.

**Name changed to protect identity.*



WPC-LA Programs for Participants with Substance Use Disorder

"We can see the seeds sprout. We can see the lightbulb go off, where they're thinking about it, where they're ready to do it. And we may get a call later saying, 'Hey, I just graduated treatment.' And we get to see that, and I think the point at which they do that is when they know that they have a future. Hope, hope is the starting point for all of that."

-Community Health Worker, WPC-LA, Substance Use Disorder Program

Substance Use Disorder Engagement, Navigation, and Support Program (SUD-ENS)

Description: The Substance Use Disorder Engagement, Navigation, and Support (SUD-ENS) Program supported those with substance use disorder in treatment and recovery. CHWs helped participants with an active substance use disorder navigate substance use resources and social services. CHWs supported participants in finding an appropriate treatment option at the appropriate level of care and helped navigate barriers to initiation of treatment. The program worked to address other social or medical needs and worked with participants on accomplishing shared goals.

Goals: The SUD-ENS Program aimed to reduce frequent emergency room and hospital utilization by engaging individuals who are ready for substance use disorder services and assisting them in navigating barriers to treatment options. It also aimed to sustain participant support by connecting participants to longer-term services.

Story from the Field:

A SUD participant in need connected to multiple points of care



Stephanie, a WPC-LA Substance Use Disorder CHW was conducting outreach at a homeless shelter and met with John,* a 51-year-old Latino man. John was facing food insecurity and homelessness while coping with substance use, family estrangement, and concern over his girlfriend living in a nursing home. Stephanie worked to gain John's trust, who shared he was feeling overwhelmed, depressed and also expressed suicidal thoughts and plans. Witnessing John's cry for help, Stephanie connected John to critical mental health care at a County ED. Once released from the hospital 5150 psychiatric hold, John was swiftly connected to substance abuse treatment and the WPC-LA Intensive Service Recipient Program, which offers comprehensive services for participants following a psychiatric admission. John credits Stephanie for saving his life and called her after hospitalization. By building a supportive relationship, Stephanie created a trusting environment and aided his recovery.

**Name was changed to protect privacy*

SUD-ENS Program

Eligibility: Participants with an active substance use disorder.

Average Length of Stay: 2-3 months

SUD-ENS Community Health Workers:

- Conducted outreach, engagement, and motivational interviewing
- Connected participants with and accompany them to primary care, behavioral health care, SUD providers, withdrawal management services, community residential treatment, and outpatient services
- Provided referrals for social services, including transportation, childcare, the establishment of benefits, permanent housing, and legal support
- Assisted with life skills



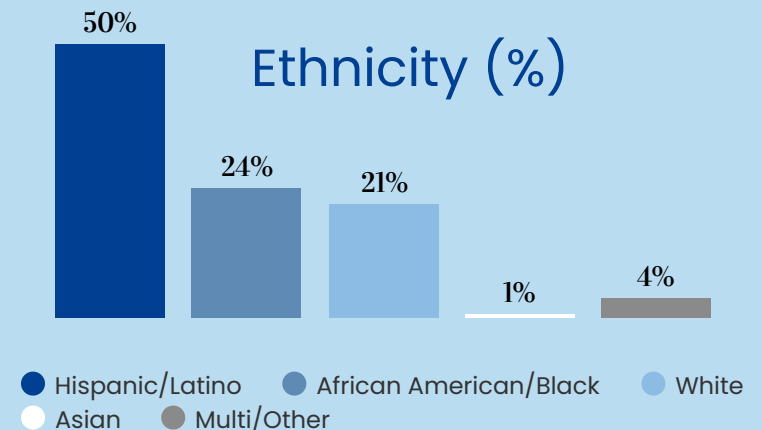
Persons Enrolled

2,664



Member Months
of Service

7,294



SUD-ENS Program: Health Outcomes



↑ 10%

In **primary care visits** from 12 months before SUD-ENS Program enrollment to 12 months after enrollment



↓ 4%

In **medical hospitalization stays** from 12 months before SUD-ENS Program enrollment to 12 months after enrollment



↓ 8%

In **psychiatric emergency room visits** from 12 months before SUD-ENS Program enrollment to 12 months after enrollment



↑ 9%

In **psychiatric primary care visits** from 12 months before SUD-ENS Program enrollment to 12 months after enrollment



WPC-LA Programs for Medically High-Risk Participants

"Why do I have to go to my PCP? I just got out of the hospital." And then you convince them to go and now we have a pharmacist who can work with them on their meds and that's really helpful, so they can understand why they're taking certain things. But then there's the factor of a lot of their conditions are kind of lifestyle diseases and they're due to their eating habits or their lack of exercise or just past drug use or alcohol, whatever, catching up with them. And there's the part where we need to motivate them to make some changes and educate them and take classes... I like classes for my patients or support groups. Because it shows them that there are other people like them and have the same issues and it could be fun and you know, all of that. And so, I like to motivate them."

-Community Health Worker, WPC-LA Transitions of Care Program

Transitions of Care Program (TOC)

Description: The Transitions of Care (TOC) Program provided comprehensive services in the hospital and 30-days post-discharge for medically high-risk participants with multiple hospital admissions. TOC supported participants from hospital to home, from when they were discharged from the hospital. TOC facilitated engagement with a primary care team and connection to social service needs and other community-based services.

Goals: Through a Community Health Worker model that supported participants' transition from the hospital to their homes, TOC provided person-centered care and bridged clinical teams and community-based organizations. TOC aimed to engage participants early in primary and specialty care and reduce emergency department and inpatient admissions.

Transitions of Care Pharmacy: Starting in 2020, the TOC Pharmacy Program supported high-risk, medically-complex LA County residents with medication-related needs as they transitioned from an inpatient hospital stay to their homes and communities. This is an innovative program that has delivered a high-value pharmacy intervention to vulnerable participants during the hospital-to-home transition period when medication-related problems are common and can result in safety complications and readmissions.



Photo: Mayra Beltran Vasquez, County of Los Angeles

TOC Program

Eligibility: Medically high-risk participants with multiple hospital admissions

Average Length of Stay: 1 month

TOC Community Health Workers:

- Assessed the participant's high need priorities and developed a care plan to prevent future readmissions
- Performed a home visit within 72 hours of discharge to assist with medication review, helped fill prescriptions, scheduled future appointments to primary care and specialty providers, and arranged transportation as necessary
- Connected the participant to primary care and accompany them to their follow-up visit(s)
- Provided referrals and warm handoffs to behavioral health (e.g., substance use/mental health treatment) and social service organizations



Persons Enrolled

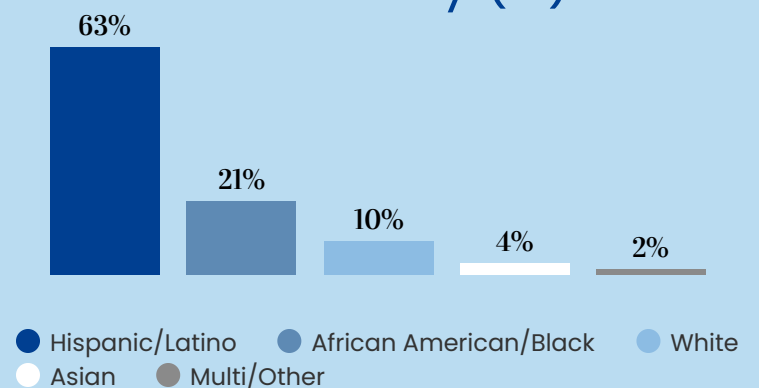
3,078



Member Months
of Service

8,022

Ethnicity (%)



TOC Program Health Outcomes



37%

Of participants were connected to and had a **primary care appointment** within 90 days of discharge



97%

Of participants had a **care plan** created within 1 month of TOC Program enrollment



↓ 16%

In **emergency room visits** from 6 months before TOC Program enrollment to 6 months after enrollment



↓ 30%

In **hospitalization stays** from 6 months before TOC Program enrollment to 6 months after enrollment



↑ 17%

In **primary care visits** from 6 months before TOC Program enrollment to 6 months after enrollment

Stories from the Field: Support with Life After Hospital Discharge

George*, a 47-year-old man experiencing homelessness, was suffering from acute and ongoing health issues, mental illness, and substance use disorder. Sheryl, a WPC-LA CHW, met with George while he was in the hospital and set goals to promote a healthy and independent lifestyle. Once discharged, Sheryl assisted George with primary care appointments and referrals to a mental health center. George received treatment and participated in dual diagnosis support groups. With the help of a psychiatrist, George was able to comply with his psychiatric medications and medication-assisted treatment for his substance use disorder. Sheryl often accompanied George to appointments to provide support and reinforcement in his care.



As Sheryl continued to work with George, they both recognized how his father's drug abuse posed a threat to George's sobriety. Sheryl helped him apply for General Relief Housing, and he soon moved into a sober living home. Sheryl also connected George with the Countywide Benefits Entitlement Services Team Program, which helped him obtain Supplemental Security Income and Social Security Disability Insurance benefits. Today, George consistently attends Narcotics Anonymous meetings, meets with a sponsor, and is proud of attaining his first year of sobriety. He is working well with his new primary care provider and is learning how to manage his health day by day.

**Name changed to protect identity.*



WPC-LA for Perinatal High-Risk Participants

.....

"When I build a rapport with the patients and they open up and kind of like build trust with them, sometimes they'll let me know that they've been struggling with things like breastfeeding. And then it helps me link them back to their provider or the nurse. So they feel more comfortable sharing some of the medical concerns that they have with me, and then I help connect them back to the doctors or the nurses or if it's mental health, with the mental health provider. If it's housing, then help them with applications and resources in the community. And I think because we're community health workers, we kind of can devote that time to them. So we can ask them, how you're doing? How are things going? How's your family? What are you struggling with? From there, link them and connect them to whatever it is that they need the additional support for."

-Community Health Worker, WPC-LA MAMA's Visits



Photos: Mayra Beltran Vasquez, County of Los Angeles

MAMA's Visits Program

Description: As an extension of the Maternity Assessment Management Access and Service (MAMA's) program, which provides maternal and parenting support, MAMA's Visits used a mobile care team to offer coordinated, compassionate home or community-based care management. MAMA's visits provided personalized services to support Medi-Cal eligible pregnant and parenting individuals experiencing complex, stressful life issues. The mobile care team promoted regular doctors visits and worked with participants to support healthy pregnancies and delivery. Over 90% of MAMA's Visits participants received prenatal support from MAMA's Neighborhood, a clinic-based program providing comprehensive prenatal care. Participants were also offered comprehensive care during the baby's first years of life.

Goals: MAMA's Visits aimed to improve parent and baby physical and psychosocial health. By extending maternal and infant health care from the clinic to the community, MAMA's Visits supported healthy birth outcomes, including full-term births and at a healthy weight. MAMAs helped to reduce disparities, systemic barriers, and sets the foundation for lifelong healthy growth.

MAMA'S Visits Program

Eligibility: Low-income pregnant and parenting individuals experiencing complex, stressful life issues. In addition to being high-risk perinatal, this population was characterized by chronic physical conditions (41%) and high utilization of urgent care and emergency departments (32%). Some participants were engaged in additional support for substance use (18%), homelessness (17%), and justice involvement (17%) during the perinatal period.

Length of Stay:

- 67% of participants who delivered were enrolled in the program for 8-18 months
- 45% of participants who delivered were enrolled in the program for 12-18 months

MAMA's Visits nurses, counselors, care coordinators, and other staff members:

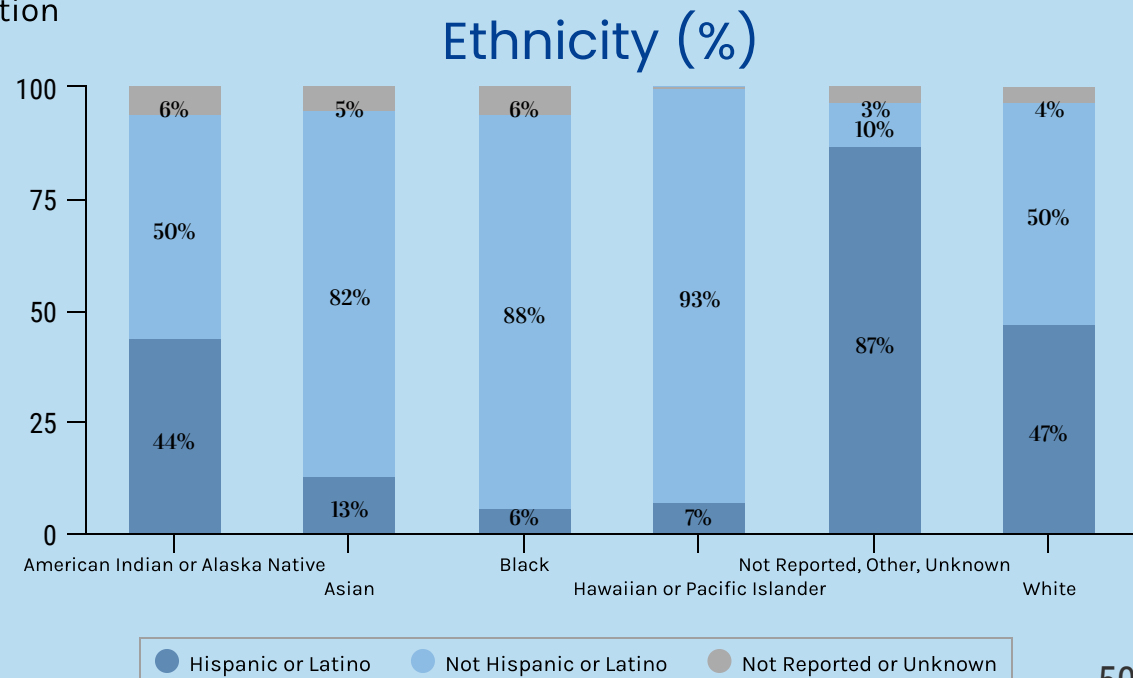
- Provided home or community-based care conducted by a Mobile Care Team (MCT)
- Connected the participant with a provider and birth planning at a MAMA'S Clinic
- Assisted with connection to advanced health services like behavioral health care, substance use support, violence counseling, and specialists for participants with chronic diseases such as diabetes and high blood pressure
- Offered education on healthy pregnancy, stress reduction, breastfeeding, recovery after birth, attachment, parenting, and infant development
- Provided referrals for WIC, transportation, housing, jobs, training, school, childcare, preschool, legal support, etc.
- Offered family planning education and contraception



Persons
Enrolled
3,753



Member Months
of Service
37,780



MAMA'S Visits: Health Outcomes



2,697

Total **pregnancies** supported with CHW support



83%

Of MAMA's participants who **delivered term births** (37 weeks or later)



80%

Of MAMA's **justice-involved participants** had term births (37 weeks or later)



85%

Of babies born with **normal birth weights**



80%

Of MAMA's **homeless participants** had term births (37 weeks or later)



70%

Of MAMA's **participants managing chronic illness** had term births (37 weeks or later)

Stories from the Field: **Supporting Mothers facing Adversity**

"When I found out I was pregnant, I was sleeping in the car. The only help that we really had was my mother-in-law, but she can only do so much. So, I made an appointment to go have my checkup. I had missed my appointment due to my homelessness. I didn't have a ride, and the nurse transferred me to [a MAMA's Visits Care Coordinator]. After we talked, our lives completely changed. She was so kind, so wonderful, so outgoing, and so much information she had given us that we didn't even know about. MAMA's is a really good thing. They help me out with clothes, pampers, anything I need. I would not be afraid, or [I would] tell anybody not to be afraid, to call for help because it is out there. We thought help wasn't out there, and I completely changed my mind about that."

-MAMA's Visits Participant



Other WPC-LA Programs

Medical-Legal Community Partnership (MLCP)

Description: The Medical-Legal Community Partnership (MLCP) program was launched in 2018 at the Los Angeles County Department of Health Services (LAC-DHS) to provide free civil legal assistance. Legal issues can negatively affect health and well-being, resulting in higher acute care utilization, morbidity, and mortality. MLCP attorneys helped low-income individuals avoid evictions, apply for immigration visas, access public benefits, obtain restraining orders, and more. MLCP was a partnership with four community-based legal aid organizations: *Neighborhood Legal Services of Los Angeles County* functions as the lead with *Legal Aid Foundation of Los Angeles*, *Mental Health Advocacy Services*, and *Bet Tzedek Legal Services*. MLCP services include legal advocacy, legal representation, education, and training for health providers.

Goals: MLCP aimed to achieve better health and well-being by addressing legal needs, addressing social determinants of health, and improving adherence to primary care.

MLCP attorneys and staff help participants with obtaining health coverage (e.g., Medi-Cal), addressing medical debt, obtaining child support or custody, evictions, and rectifying poor housing conditions, record expungements, reducing employment barriers, guardianships and conservatorships, immigration and legal status, income and employment, personal and family safety, public benefits (food, SSI and cash aid), special education, resource referral, and personal and family security.



Participant
Intakes*

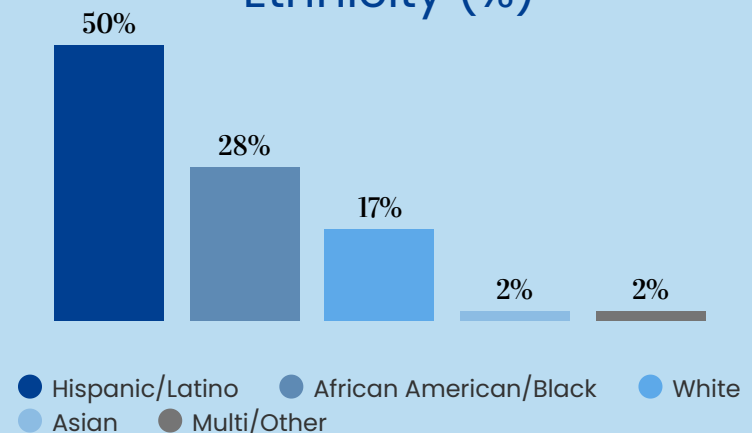
2,254



Cases*

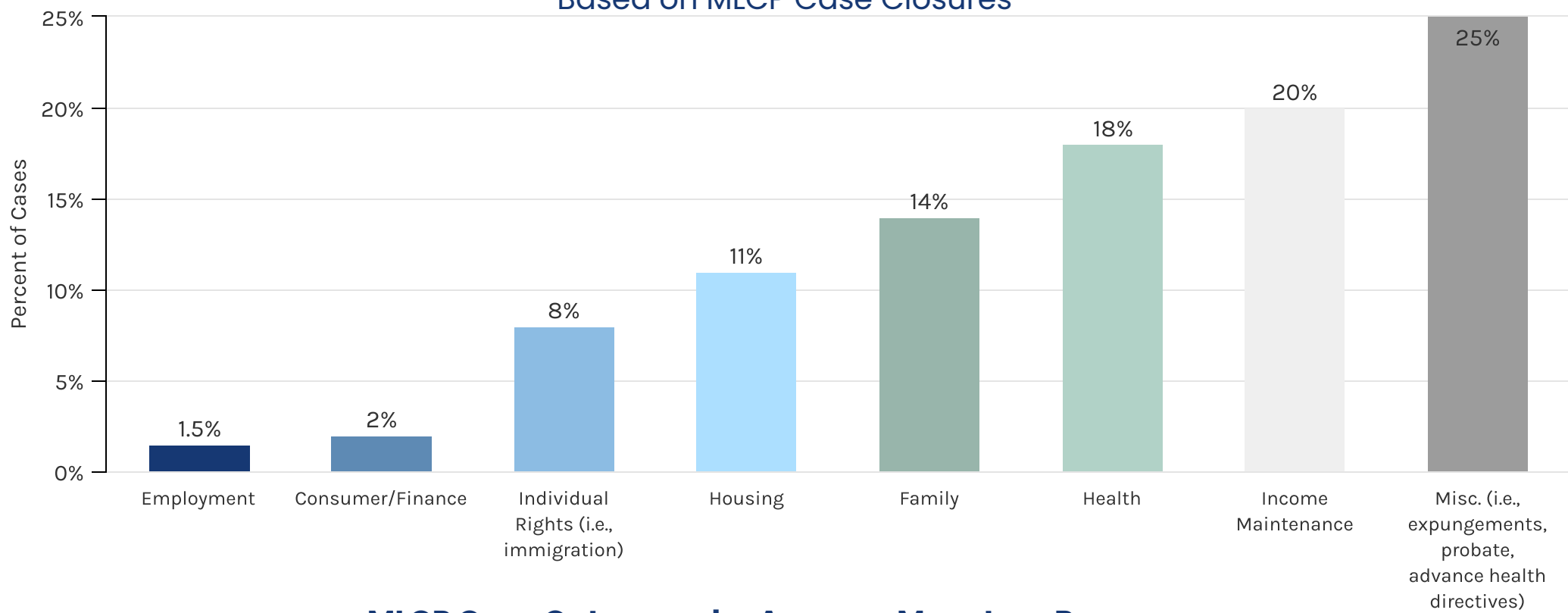
2,697

Ethnicity (%)

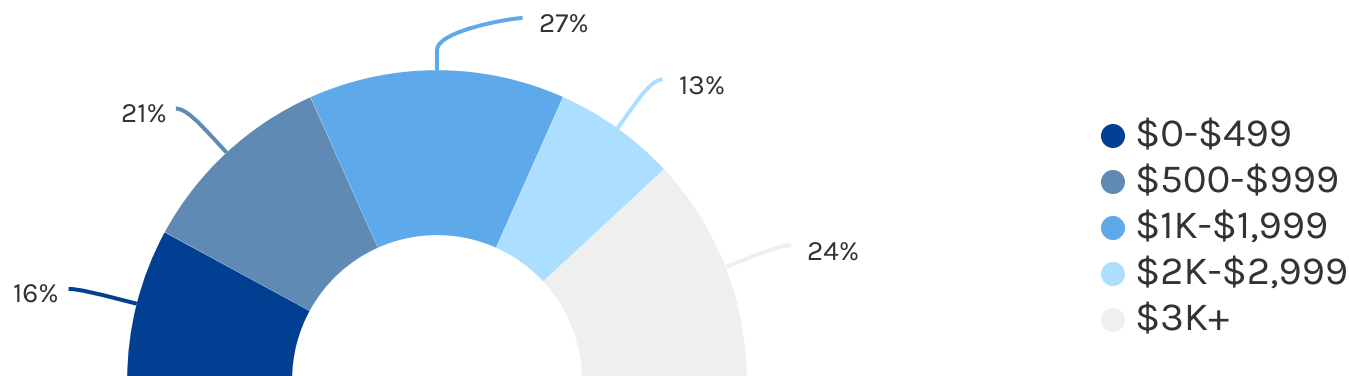


MLCP Case Overview & Outcomes

Most Common Legal Issues Faced by WPC-LA Participants (%)
Based on MLCP Case Closures



MLCP Case Outcomes by Average Monetary Recovery
(Employment, Housing, Immigration, Dismissed DMV Charges, etc.)



Stories From the Field:

A Participant Finally Receives Disability Insurance

Maria*, a recent widow and single mom was referred to the MLCP after being denied disability insurance. Maria had suffered multiple heart attacks at the beginning of 2020, and was unable to work due to health issues. After she applied for State Disability insurance in 2020, Maria was erroneously denied benefits, due to the influx of COVID-19 benefit applications. This influx meant that Maria could not get through to reaching California's Employment Development Department (EDD) to self-advocate for her application. In June 2020, an MLCP attorney took on the case and represented her at her EDD hearing. The MLCP attorney recovered \$15,000 in State Disability Insurance back pay and secured ongoing benefits in light of her continued inability to work. With her improved economic stability, Maria can now focus on her health and care of her children.

Financial Relief and Peace of Mind for Medical Expenses

When Denise* didn't have Medi-Cal, her medical bills were astronomical at \$88,278. MLCP advocated on her behalf to secure retroactive Medi-Cal benefits. Denise now has retroactive Medi-Cal coverage for December 2019, and the bills amounting to \$88,278.11 have been billed to Medi-Cal. In addition to providing enormous relief for Denise and facilitating her well-being, the health care system received reimbursement for the services it administered.



**Names changed to protect identity.*

Photo: MLCP-LA Legal Team

Hospital-Based Violence Intervention Prevention Program (HBVIP)

Description: The County's Hospital-Based Violence Intervention Programs (HBVIPs) addressed community violence recovery at LAC DHS trauma centers (LAC-USC Medical Center, LAC Harbor-UCLA Medical Center, and LAC Rancho Los Amigos Rehabilitation Hospital). HBVIP provided case management and comprehensive wraparound services to victims of interpersonal violence. Culturally competent case managers, trained Community Intervention Workers, provided counseling, career development and job placement, gang prevention and intervention services, victim services, tattoo removal, and other resources. Many participants were gang-involved and face high-risk social and behavioral health conditions (e.g., substance use, re-entry status, homelessness, mental health needs).

Eligibility: Anyone impacted by violence, including victims of gang violence, physical assault, gunshot wound, stabbing, or any other form of violence, families of victims.

Goals: Interrupt the cycle of community violence through a trauma-informed care plan that mitigates risk factors associated with interpersonal injury.

Average length of case management: 6–8 months for low-risk participants; 8–12 for high-risk participants.

HBVIP Case managers/Community Intervention Workers:

- Offered psychosocial support and introduced the idea of services at the bedside
- Conduct risk and needs assessments to determine service eligibility and needs. Work closely with participants to develop an individual service plan (ISP) that identifies key risk factors and social determinants of health.
- Provided mentored longitudinal case management that focuses on facilitating connections to risk reduction resources, including safe housing, food assistance, skills training/job placement, education, court advocacy, tattoo removal, substance use/abuse treatment, individual and group counseling, and mental health care.



|  362 Persons Enrolled* |

Stories from the Field:

Healing Through Mentorship

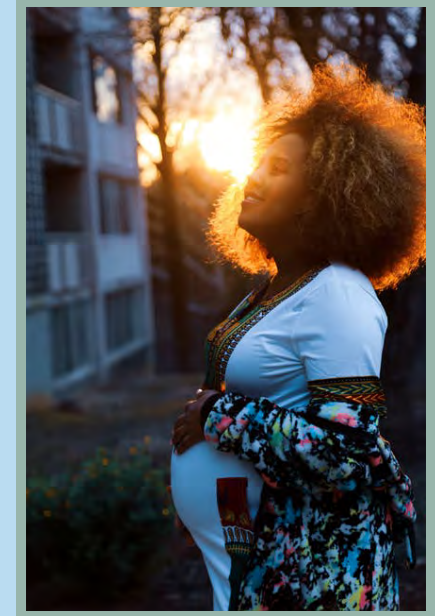
After suffering a gunshot wound, Jaime, a 16-year-old gang-involved youth, was brought to Harbor UCLA Medical Center. Immediately after Jaime's surgery, Javier, a Safe Harbor HBVIP Case Manager, offered support and assessed Jaime's immediate needs. When Jaime was discharged, the two developed an individual service plan that identified a schedule of needs and a long-term plan for promoting resilience and an independent healthy lifestyle. Javier checked in regularly with Jaime's father, a former gang member, to ensure that Jaime was showing up for his medical checkups and physical therapy. Javier also encouraged discussions of peace and healing to divert Jaime away from thoughts of retaliation and provided an important referral to a tattoo removal service to remove gang-related tattoos.

For almost eight months, Javier checked in with Jaime and his family every other week to make sure he was adhering to the plan they developed together, and that he had the emotional support he needed as he coped with his injuries and stressful life events. With Javier's help, Jaime was able to cope with the separation of his parents and put in place a plan to leave behind the gang connections that had contributed to his injuries.

With support, Jaime enrolled in a recovery credit high school program and transitioned back into full time school. Javier also connected Jaime with Jobs Corps, which helped him to identify several trade schools and internships he plans to attend after graduation. Today, Jaime is enrolled in a summer employment fellowship program Javier recommended, where he is learning about health care systems and medical care workers. Although Jaime completed the program several months ago, Javier continues to mentor him and alert him to new job and education opportunities. Jaime looks forward to what most 17-year-olds do: a summer of work and hanging out with friends and family.

African American Infant Morbidity and Mortality (AAIMM) Doula Program

Description: In partnership with First 5 LA, the LAC Department of Public Health launched the African American Infant and Maternal Mortality Prevention (AAIMM) Doula Program to address the severe inequities in maternal and infant outcomes among Black pregnant people and infants. AAIMM funded 14 African American/Black doulas who provided free, comprehensive support. While the program is a DPH-led initiative, WPC-LA allocated funding to support doula services. According to First 5 LA, doulas are *"trained professionals who provide physical, emotional, and informational support to a laboring person and family before, continuously during, and after childbirth to help them achieve the healthiest, most satisfying experience possible."* AAIMM doulas were uniquely empowered to engage with pregnant parents through culturally congruent, non-judgmental, and trauma-informed ways.



Goal: The goal is to combat disproportionately high rates of Black/African American infant and maternal deaths countywide.

Doulas provide:

- Prenatal and postpartum visits, with labor, birth, lactation, and other postpartum support to Black/African-American pregnant women
- Outreach and education, including free breastfeeding, trauma-informed care, and additional perinatal support training.



314 Persons Enrolled*



Looking Ahead: Sustainability for WPC-LA Programs

Looking Ahead: From WPC-LA to CalAIM

The work summarized in this Impact Report represents the tireless effort of County staff and community partners working collaboratively to change the lives of LA County's most marginalized residents. Through WPC-LA, we made much progress. We strengthened partnerships and infrastructure, developed effective programs, and laid a strong foundation for the future. Fortunately, we have the opportunity to sustain and build upon this work in the coming years. Billions of dollars in state and local investments, including CalAIM, the Home and Community Based Services Spending Plan, Homeless Housing, Assistance and Prevention Grants, CalHHS Infrastructure investments, Measure H, Care First Community Investments, AB-109, among others, will help sustain and extend this work.

In particular, CalAIM will bring funding to support numerous Whole Person Care Programs for Medi-Cal beneficiaries through managed care health plans. CalAIM's new Enhanced Care Management benefit will support intensive care management of the sickest, most marginalized Medi-Cal beneficiaries, including WPC-LA participants, with a particular focus on the justice-involved population starting prior to release. CalAIM's new Community Supports program will bring funding to housing support services, medically tailored meals, asthma remediation services, and services and supports to help keep individuals at risk for institutionalization in community-based settings. Community Supports programs are voluntary programs for Managed Care Health Plans that have the opportunity to become Medi-Cal benefit programs in the coming years.

Unfortunately, some programs will not be sustained in CalAIM. We are working to find sustainable funding sources for these programs. The table on the following page summarizes funding sources to help sustain the WPC-LA programs described in this report. The County is working closely with the State and local Medicaid Managed Care plans to maximize ongoing investments in whole-person care initiatives with the hope of expanding eligible populations and Medicaid benefits.

WPC-LA helped LA County make considerable progress towards the goal of ensuring the sickest and most marginalized Angelenos have the resources and support they need to thrive. Yet, we have so much more work to do. The LA County Department of Health Services and the County of Los Angeles look forward to building on the success of WPC-LA and the relationships we have built across County agencies and with community partners to continue to build an integrated health system that delivers seamless, coordinated services and ultimately, health and wellbeing to all LA County residents.

Population	WPC-LA Program	Cal-AIM Funded*	Sustained by Other Funding Sources
 Homeless High-Risk	Tenancy Support Services Sobering Centers Homeless Care Support Services Medical/Psychiatric Recuperative Care	✓ ✓ ✓ ✓	
 Complex Mental Health	Intensive Services Recipient (DMH) Residential and Bridging Care (DMH) Kin Through Peer (DMH)	✓ ✓ ✓	
 Medically Complex	Transitions of Care	✓	
 Justice Involved High-Risk	Reentry Pre-release Reentry Post-release	✓** ✓	
 Substance Use Disorder	Substance Use Disorder	✓	
 Perinatal High-Risk	MAMAS	✓	
 Additional Programs	Countywide Benefits Entitlement Services Team Housing for Health Outreach and Engagement Hospital-Based Violence Intervention Program Overdose Education and Naloxone Distribution African American Infant & Maternal Mortality Doula Project (DPH) Medical-Legal Community Partnership		✓ ✓ ✓ ✓ TBD TBD

* Cal-AIM does not fund all program components

** Delay in Cal-AIM funding (begins 2023)

Data Sources and Statistical Methods

Program enrollment dates, client demographics, and client actions (care plan and linkage to housing) for WPC-LA participants enrolled from January 1, 2017, to December 31, 2021, were abstracted from CHAMP, the database used to document track WPC-LA participants across health and social service agencies. Housing retention data are from Housing for Health programmatic data and cover all HFH participants dating back to November 2012. Health care utilization was collected from administrative files from Los Angeles County Departments of Health Services and Mental Health, LA Care, and Health Net. Health care utilization rates for emergency department, inpatient, primary care, specialty care and mental health services from January 1, 2017, to December 31, 2018, were adjusted for gender, age, race/ethnicity, and comorbidity score.

Participants included in analyses: For the analyses, 101,704 unique WPC-LA patients had 150,619 unique program enrollments. Programs not included in these numbers include WPC-LA participants from the following programs: In-Home Care Giving Program, Overdose Education and Naloxone Distribution Program, and the Hospital-Based Violence Intervention Prevention Program. Program enrollments for these programs included in this report were compiled from programmatic files.

MAMA's Program's health utilization outcomes are for participants enrolled from January 1, 2017 through December 31, 2021 and are not adjusted as described above.

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