The Los Angeles County Coverage Initiative Proposal

Healthy Way LA: Providing Health Care Coverage for Low-Income Uninsured Adults

Executive Summary

The Los Angeles County Department of Health Services (LACDHS) proposes to expand health care coverage to an estimated 94,000 low-income (at or below 133⅓ % of the Federal Poverty Level) uninsured adult residents of LAC. The target population includes those with chronic conditions such as diabetes and hypertension, as well as patients nearing Medicare-eligible age and those who have been using LACDHS services in a chronic but uncoordinated manner. The population to be enrolled in Healthy Way LA (HWLA) represents 14% of the total LACDHS patient population and 20% of the uninsured LACDHS population.

HWLA is a new health care coverage program that will facilitate a system shift from episodic to continuity care. Members will have a medical home with a named primary care provider or care team; expanded access to primary, preventive and specialty services; urgent appointment access; after-hours nurse advice line; member services; and care coordination services customized to each patient based on severity of illness. Enrolled members will continue to have access to the full array of County hospital-based inpatient and outpatient services.

Services will be available through a non-hospital based network of public and private clinics throughout LAC. This network includes a multi-service ambulatory care center, 6 Comprehensive Health Centers, 10 LACDHS Health Clinics, and 80 private health clinics that contract with LACDHS for indigent care through the Public Private Partner (PPP) Program.

LACDHS' efforts to expand access to outpatient services and integrate the system of care began in 1995 with the 1115 Waiver-Medicaid Demonstration Project. The Waiver expanded access to primary care and continues its commitment towards optimizing the care delivery system to meet the specific needs of the population. HWLA will build upon the successes of the Waiver to provide a redesigned approach to management of existing patients with chronic illness. HWLA seeks to maintain or improve the patient's current level of health and reduce morbidity, while enhancing objective, measurable quality of care outcomes. This fundamental shift from episodic care to care that endeavors to maximize the health of the covered population by enhancing access and continuity of services will serve as a model to transform LACDHS.

Required Elements

1. Enrollment processes, with an identification card system to demonstrate enrollment of eligible persons into the proposed health care coverage program.

(a) A description of the uninsured target population in the proposed service area; the rationale for selecting the proposed target population; and an estimated number of eligible persons to be served annually.

Based on HWLA's eligibility criteria (1c below), approximately 94,000 uninsured LAC residents will be enrolled as members and receive services annually. The target population will include those with chronic conditions such as diabetes and

hypertension, as well as patients nearing Medicare-eligible age and those who have been using LACDHS services in a chronic but uncoordinated manner.

The rationale for selecting this target population is to provide benefits and service enhancements to the populations that will benefit the most from focused, coordinated health care and to reduce unnecessary burden on the LACDHS system through elimination of duplication of services and reductions in emergency department use.

All enrolled patients will be at or below 133⅓ % of the Federal Poverty Level) and will reside in Los Angeles County, per HWLA eligibility criteria. Based on the analysis of historical utilization data for LACDHS-operated and PPP contracted clinics, about two-thirds (67%) of the eligible persons will likely be female and over half (51%) will be Latino, 9% African-American, 8% White, 7% Asian, 3% Native American and 24% other/unknown race/ethnicity. It is also estimated that almost one-third (29%) will be between the ages of 55 to 64 years old, about one-third (29%) 45 to 54 years old, one-fifth (20%) 35 to 44 years old, and 15% 18 to 34 years old among this population. The eligible individuals reside in all areas of LAC, and are concentrated in those areas of highest population density and greatest numbers of people living in poverty (see Attachment 1). Statewide, among the uninsured adults, there are about 46% female, 55% Latino, 8% between the ages of 55 and 64 years old, 14% ages 45 to 54, 20% ages 35 to 44, while 45% fall between 18 and 34 years old (Source: 2003 California Health Interview Survey).

The goal of the initiative is to provide benefits and service enhancements that are specifically designed to meet the needs of uninsured adults with chronic illness, older adults at risk for developing chronic conditions, and those who are chronic users of DHS services with no medical home.

(b) A description of the process and/or source of data for identifying the estimated number of eligible persons to be served, and the methods to be used to inform the target population of the availability of the services to be provided.

The LACDHS Enterprise Data Repository (EDR) maintains clinical and administrative data (including utilization, patient demographics, payer source, diagnoses) from all the LACDHS hospitals, LACDHS health centers, and PPP providers. This system was used to estimate number of patients who meet the eligibility criteria as defined in 1 (c) below.

Potentially eligible patients will be contacted by mail prior to September 1, 2007 to notify them that they may be eligible for enrollment into the HWLA coverage initiative. This communication will include a summary of the benefits and service enhancements that will be available once they are enrolled, as well as a listing of required documents to verify citizenship/legal immigrant status. Each outpatient clinic site will also post informational posters and brochures that explain services offered to enrolled members. Subsequent to meeting the requirements and verifications, potentially eligible individuals will receive an enrollment packet with details of HWLA benefits and services shortly after September 1, 2007. For those who cannot be contacted by mail due to inaccurate or unavailable mailing addresses, enrollment packets will be sent to their assigned

medical home where staff will orient patients to HWLA services and benefits at their next scheduled visit. Orientations to HWLA benefits and program features will be provided in scheduled group sessions.

(c) A description of the eligibility criteria, such as household income and other criteria as established by the program.

Eligibility under this coverage will be determined by income, insurance status, age, and diagnosis. All eligible persons must meet the following criteria: Resident of LA County, U.S. Citizen or legal resident for 5 or more years, age 18 or older, uninsured, at or below 133⅓ % of Federal Poverty Level, not qualified for the Medi-Cal program, Healthy Families program, or Access for Infants and Mothers, and at least one visit to a LACDHS or PPP facility during the past year. Three groups will be targeted for enrollment: 1) those who have been diagnosed with hypertension, diabetes, congestive heart failure (CHF), asthma or chronic obstructive pulmonary disorder (COPD), or dyslipidemia; 2) individuals who are not part of the first group and are pre-Medicare (ages 63 to 64); and 3) individuals who are chronic users of DHS services and do not have a medical home.

(d) A description of the population currently served by the applicant and how the program expands coverage beyond health care service programs currently in effect in the applicant's county or counties, including those programs set forth at WIC sections 16809 and 17000 et seq.

LACDHS operates a network of hospitals and clinics that serve approximately 700,000 patients annually, of which 67% (473,000) do not have health insurance and 26% are Medi-Cal patients. Among this population, 57% are female, 61% are Latino, 15% African-Americans, 9% White, and 5% Asian. 14% of our population is between 55-64, 18% is 45-54, another 18% is between 35-44, and 24% falls between 18-34. Available services include inpatient and outpatient hospital services as well as clinic, physician and certain ancillary services. Financially needy County residents can obtain these services at reduced cost or at no cost. (The existing financial screening mechanism will be utilized in the eligibility process. See response to No. 8.)

However, the County does not currently operate a coverage program for its indigent population, as that term is used in the Request for Applications, and there are no current eligibility standards and no individuals are currently eligible. Rather, the entire hospital-based health care delivery system in the County functions to meet the needs of the indigent and uninsured and to fulfill the County's Section 17000 obligation.

Funding for health care services is currently budgeted as part of the County's annual overall budgeting process. Funding for current services comes from various sources, including revenues for services provided, federal grants, realignment and Vehicle License Fee funds, as well as County general tax revenue. Federal Coverage Initiative dollars will not supplant local funds that otherwise would be used for health care services.

While most potential enrollees will have already received some services in the County system, enrollment in HWLA will fundamentally change the way enrollees obtain health services from the County. It will provide members with the means to better utilize existing County services, through their medical homes and as a result of new care and

case management services, enhanced primary care and preventive care services. Thus, the entire program represents new coverage for approximately 94,000 newly eligible County residents, which will be accompanied by service expansions designed to improve access, outcomes and efficiencies. Enhancements will be implemented for the enrolled population totaling approximately $19.5 million, which includes $3.5 million of new case/care management that the State proposes to treat as administrative costs for federal claiming purposes. In addition, LACDHS will incur $12 million in other administrative expenses related to the program.

One goal of providing this coverage in the outpatient setting is to reduce the strain on the County's inpatient facilities, whose core function is the care and treatment of the indigent and uninsured population under Section 17000. Health care coverage in the outpatient setting will complement the County's hospital-based services that will continue to be available to these individuals when needed.

(e) An explanation of how the applicant will ensure target enrollment levels will be reached and maintained.

The pool of potentially eligible patients is significantly larger than the target enrollment number, which will facilitate reaching and maintaining target enrollment. The assumption is that some patients will be unwilling or unable to produce the necessary documentation of citizenship or legal immigrant status.

Utilization of services by the enrolled population will be tracked on a monthly basis by analyzing member utilization data in the LACDHS EDR. Estimated costs associated with utilization will allow for enrollment to be adjusted to meet the target. Enrollment will be closed to new members when cost estimates exceed the target and opened when cost estimates are short of target levels.

2. Use of a medical records system, which may include electronic medical records.

(a) A description of the reliable medical record system to be used that may include, but need not be limited to, existing electronic medical records, including a description of the safeguards utilized to comply with HIPAA.

The medical records systems used by the HWLA clinics are a combination of electronic and paper based systems. Each clinic utilizes a unique medical record numbering system to identify their patient medical records. All sites have written policies and procedures in place that comply with HIPAA requirements to ensure that protected health information, including oral communications, are safeguarded from intentional and unintentional use or disclosure. These policies include, but are not limited to, written consent for release of patient information, disclosures allowable with or without authorization, de-identification of patient information, and procedures for handling medical records. Physical safeguards are also utilized to protect medical records, including locked file rooms and controlled access to medical record storage areas.

All LACDHS clinics utilize QuadraMed's Affinity system as their primary health information system. This system contains components of an electronic medical record and allows for communication of limited clinical, utilization and demographic data between hospitals, specialty and primary care sites within 6 networks. Most PPP sites

have paper based medical records systems. HWLA will implement the patient Encounter Summary Sheet (see 3 (e) below for detailed description), which will provide access to select historical clinical activity across venues of care in LACDHS and PPPs. In addition, the Referral Processing System (also see 3 (e)) will be used by HWLA providers to track referrals and results of specialty care.

(b) A description of the unique identifiers that are assigned to each eligible person receiving health care services.

In addition to a medical record number assigned to patients at the point of care, a unique identifier will be assigned to each HWLA member at the time of the enrollment process. This identifier is a 16-digit number assigned to each unique patient that receives services at LACDHS or PPP sites. The process of ensuring the validity of this identifier involves assessing data elements such as name, date of birth, and other personal identifiers (e.g., SSN, Medical Records Numbers, address). A retrospective, probabilistic matching algorithm will be applied to each patient record in the data repository to assign a unique patient identifier. Thus, individuals with multiple identifiers at different facilities may have their clinical and administrative information aggregated. This is the first critical step in reducing duplicate services and coordinating care.

(c) A description of the methods used to track and record services provided to eligible persons.

The 16-digit unique identifier number along with a special HWLA code will be used to track and record utilization and services for each enrolled members and the aggregate HWLA population. The medical record at each clinical site (medical home) will serve as the master record of services rendered. In addition, the web-based Referral Processing System (see 3 (e)) will be used by HWLA providers to track referrals and results of specialty care. The Encounter Summary Sheet (see 3(e)) will provide a summary of key clinical information from multiple venues of care.

(d) A description of medical records management processes and controls to identify and reduce medical errors and eliminate duplicate services.

The basis for the expected reduction of medical errors and duplicate services is ensuring that appropriate care is delivered to the appropriate patient. Processes and controls in the network of HWLA providers that contribute to this reduction include:

- Assignment of unique identifiers at the clinic (medical record number) and the system level (16-digit unique identifier) will allow medical record information to be stored and utilized appropriately for more informed clinical decisions. Personal identifiers will allow providers to verify enrollment across venues of care by contacting Member Services.
- The Encounter Summary Sheet (see 3 (e)) will provide a summary of key clinical and administrative information from multiple venues of care. This will contribute to reducing duplication of services.
- All providers have adopted National Patient Safety Goals appropriate to their venue of care. These include: improve the accuracy of patient identification, improve the effectiveness of communication among caregivers, improve the

safety of using high-alert medications, implementation of policies to eliminate inappropriate abbreviations.
- Routine medical records audits are conducted to ensure compliance with medical record standards.
- The utilization of government-issued picture identification at the point of clinical care for member verification will be used by all clinics participating in HWLA.
- All providers will be able to verify enrollment in HWLA through Member Services. This will allow clinics to verify assignment of the medical home and to redirect patients to their medical home to minimize duplication of services.
- Care/case management services will monitor and facilitate clinical care and reduce duplication.
- The Referral Processing System (see 3 (e)) will allow providers to track and receive results of most specialty care referrals throughout the LACDHS ambulatory care network.

3. Designation of a medical home and assignment of eligible persons to a primary care provider, which is a provider from which the eligible person can access primary and preventive care.

(a) A description of the organized health care delivery system(s) to be used for the health care coverage program, including designation of a medical home and processes used to assign eligible persons to a primary care provider.

LACDHS serves approximately 700,000 individuals annually through 4 general acute care hospitals, one specialized hospital offering rehabilitation services, a multi-service ambulatory care center, 6 comprehensive health centers (CHC), 10 personal health centers (HC), and more than 100 private community-based ambulatory care sites.

The HWLA network of providers will consist of the 17 LACDHS non-hospital-based clinics and the 80 contracted private clinics that are Strategic Partners in the PPP program. Strategic Partners are agencies that are Federally Qualified Health Centers (FQHCs), FQHC Look-alikes, or meet all the requirements of a FQHC Look-alike excluding the governance requirement. These agencies provide a full range of services, including primary health care, some low-level specialty care services, diagnostic x-ray and laboratory services, pharmacy services and case management. Additionally, they have core full-time primary care provider staff, and staff physicians with admitting privileges at their referral hospital. These agencies were selected because they have the necessary infrastructure in place needed to be able to participate fully in the HWLA. They have also demonstrated to LACDHS a long term-commitment to the indigent, as well as the ability to provide certain "value added services" to meet the needs of the indigent and underserved population in LAC.

Eligible persons will be assigned a medical home at one of the 97 LACDHS or PPP clinic sites during the enrollment process. The medical home is the consistent site where primary and preventive services are provided by the assigned primary care provider or medical team. The medical home will also serve to house and maintain the medical record. Initial assignments will be based on location of previously utilized services and location of residence. Primary care providers (PCPs) or care teams will be assigned by the designated medical home at the point a new member seeks care. This

assignment will take into consideration patient preference and provider capacity for additional patients. Provider panel capacity will be monitored and managed locally by each clinic. Members will have the ability to request a change in assigned PCP or medical home through HWLA Member Services. Member Services staff will coordinate changes with the affected providers.

(b) Identification of the designated medical home and its relationship with the health care coverage program.

Approximately 97 sites will serve as HWLA medical homes. Each medical home will serve as the consistent care location for enrolled members. Each medical home will deliver primary care and preventive services, and will coordinate referrals to specialty care. The medical home will also ensure that timely access is provided to patients referred by the Nurse Advice Line. Educational sessions and orientation to HWLA services will be coordinated through the medical homes. In order to ensure that established treatment plans and courses of care are accurately followed, patients will be encouraged and redirected to seek care at their assigned medical home.

Medical homes throughout the ambulatory care network will employ consistent clinical practice guidelines for hypertension and lipid disorders to ensure that best clinical practices are utilized to meet the needs of the target population.

(c) A discussion of how the designated medical home was selected and to what extent primary care and preventive service will be located at the medical home.

The initial assignments of medical home will be based on location of previously utilized services and location of residence. Members will be able to request a change of medical home location at any time through HWLA Member Services. The medical home is the consistent site where primary and preventive services are provided by the assigned primary care provider or medical team. The medical home will also serve to house and maintain the medical record.

PPP partners that are designated FQHCs or FQHC Look-alikes were selected to serve as designated medical homes for patients enrolled in HWLA, as they have the infrastructure needed to provide HWLA services to enrollees. They represent 33 of our 51 partners and include 80 clinic sites. Primary and preventive services will be provided at all of these selected PPP clinic sites.

All directly owned and operated LACDHS comprehensive health centers (CHC), health centers (HC) and the multiservice ambulatory care center (MACC) were also selected to serve as medical homes for HWLA enrollees. All 17 of these facilities provide primary care and preventive services.

(d) A description of processes to ensure that health care services match the needs of the target population.

New enrollees will receive an initial risk assessment by a trained health educator to determine need for preventive services such as tobacco cessation counseling, mammography, etc.

HWLA benefits and service enhancements are specifically designed to meet the needs of adults with chronic illness and older adults at risk for developing chronic

conditions, as well as those who are chronic users of DHS services with no medical home. The assignment of a medical home and primary care provider will be the basis for management and prevention of chronic conditions. The stratification of the covered population by burden of illness and resource utilization will facilitate matching resources and intensity of interventions with patient needs (see section 4).

Case/care management services, an after-hours Nurse Advice Line and Member Services will facilitate access to appropriate and timely care. Targeted education of the population will seek to influence health behaviors and promote self-management. HWLA will also expand specialty care access to meet the needs of the target population (see section 4). The monitoring of key clinical and service outcomes will allow HWLA to evaluate and adjust services to meet the needs of the target population.

(e) A description of how medical information that is necessary to effectively coordinate all medical care including immunizations, labs, specialty care, as well as follow up from any inpatient or specialist care will be maintained.

Coordination of care and avoidance of duplicative services are a challenge in any healthcare environment. Truly interoperable electronic medical records are the gold standard for the instantaneous transfer of information across providers. LACDHS has been working towards this goal and currently is able to share key clinical information electronically through LACDHS' Affinity health information system within a network of hospital and clinics.

As part of the coverage initiative, a web-accessible *Encounter Summary Sheet (ESS)* that aggregates key demographic, administrative and clinical information from the EDR with data feeds from all LACDHS owned and operated sites and PPPs will be developed and implemented. This ESS is designed to supplement the traditional medical record. The key advantage is that for the first time, LACDHS providers will have access to information about clinical activity that occurred outside of their venue of care. While not the entire medical record, the ESS provides important key components that bring value to the point-of-care.

Phase 1 of the ESS implementation will include patients receiving intensive case management for chronic illness and will be implemented by September 2007. Phase 1 will inform the scope and timeline for expansion to other groups. The features of this intelligently aggregated and summarized information include the following:

- Clinical problem list, including visit frequency by problem
- Dispensed outpatient medications from LACDHS pharmacies
- Visit count and venue grid including use of emergency and inpatient care
- Procedures (both inpatient and outpatient) done with date performed
- Laboratory and imaging tests ordered (results of these tests will not be available initially, but will be added during the 3-year program)

Overall, these highly organized encounter information sheets provide a snapshot of information that we believe will both enhance care and reduce waste by avoiding duplicative services.

The Referral Processing System (RPS) will be another vehicle to distribute medical information across venues of care. RPS is a Web-based application that allows approximately 80% of specialty care referrals to be submitted electronically to the County's five Specialty Care Referral Centers. The referral centers facilitate and

coordinate communications between the referring providers and specialty clinics by using the RPS to screen specialty referrals for completeness and appropriateness and by notifying patients and providers of scheduled appointments. Each step of the RPS process is date-stamped. The date the referral was submitted, reviewed, approved/ denied, the appointment date, whether the patient kept the appointment, and the outcome of the appointment, including progress notes resulting from the specialty care appointment, can be viewed in real time in the RPS system by the referring provider and/or designated users of the system. Treating providers can also review a patient's referral record for any recent or future appointments the patient may have scheduled to eliminate potential duplicate care or referrals. Currently, one RPS is fully operational and the other four will be functional by July 2007.

4. A description of health care services to be included in a benefit package, particularly preventive and primary care services, as well as care management services designed to treat individuals with chronic health care conditions, mental illness, or who have high costs associated with their medical conditions in order to improve their health and decrease future costs.

Seven categories of patients have been identified for enrollment in HWLA:

1) Patients with CHF – approximately 995
2) Patients with asthma or chronic obstructive pulmonary disease (COPD) – approximately 5,345
3) Patients with diabetes – approximately 26,310
4) Patients with hypertension – approximately 22,510
5) Patients with dyslipidemia – approximately 9,410
6) Pre-Medicare patients (ages 63-64) not included above – approximately 1,350
7) Chronic users of LACDHS services who do not have a medical home – approximately 28,080

Note that each enrolled patient is listed under a single category; however in practice patients may overlap two or more of the above categories.

All enrolled patients will be eligible for the following benefits (if applicable):

Summary of Non-Hospital Based Outpatient Services (detailed descriptions follow):

- Medical home for each enrollee
- Primary care, including named primary care provider or assigned care team
- Preventive health services
- Specialty care and web-based specialty care referral
- Nurse advice/triage line
- Member services
- Urgent care access and next-day appointments when necessary
- Chronic illness program for patients with diabetes, CHF, asthma/COPD, hypertension, and dyslipidemia
    - Care/Case management based on burden of illness and utilization

    - Standardized clinical guidelines for patients with uncomplicated hypertension and dyslipidemia
- Case management for homeless patients
- Diagnostic laboratory services
- Radiology services
- Dispensed outpatient medications from LACDHS pharmacies

While not included in the HWLA benefits package, all other medically necessary inpatient and hospital-based outpatient services will continue to be available at LACDHS facilities.

Medical Home

Each enrolled patient will be assigned to a facility that will serve as their medical home. The medical home will either be the facility that has provided the majority of the patient's care during the past 12 months, or one located closest to the patient's residence. There are 97 facilities in the HWLA network, providing broad geographic coverage with accessible locations throughout LAC (see Attachment 1).

Primary Care Services and Primary Care Provider (PCP)

The medical home will assign a specific PCP or care team to each patient, to enhance quality and continuity of care. This PCP or care team will serve as the focal point for addressing the patient's health care needs. Patients will have access to their PCP or care team via scheduled appointments for routine care. Same-day/next-day appointments to address urgent health issues will be made with the patient's PCP if at all possible. Another member of the health care team will care for the patient if the PCP is not available.

The PCP, along with the health care team at the facility, will diagnose and treat illness, provide education and counseling, health maintenance and preventive services, and coordinate referrals and follow-up of necessary specialty care and diagnostic services.

Additional primary care visit capacity will be added to the system to accommodate members who did not previously have a medical home.

The web-based RPS will enhance the PCP's ability to track referrals and referral outcomes. This system will contribute to care coordination, continuity and reduce duplication of services.

Preventive Health Services

Member benefits will include the following preventive services, to be provided at the patient's medical home: initial risk assessment by a trained health educator; annual hypertension screening for all adults; annual Pap smear for women; annual mammograms for women age 50 and older; daily aspirin for men over age 40 and women over age 50; annual influenza vaccination for adults over age 50 and those with chronic illness; pneumococcal vaccination for adults over age 65; tobacco use screening and intervention (including referral to counseling hotline and free nicotine replacement therapy for those completing counseling); and cholesterol screening for men over age 35 and women over age 45. Additional preventive and early intervention services will be provided for those with specific chronic conditions.

Specialty Care

Primary care providers and their identified medical home will be responsible for the vast majority of medical care delivery for patients enrolled in HWLA. However, specialty services are an integral part of care for patients with chronic disease. Adequate specialty services must be available to diagnose, treat, and consult with the primary care providers on various aspects of the patients' care. Specialists will also participate in the development of multi-disciplinary care plans for HWLA patients, as well as serving as the principal care providers for patients with the highest burden of illness.

All specialty services are currently available in the LACDHS system. However, there are sometimes long waiting times for specialty care appointments. The greatest need for specialty care expansion is for patients with diabetes, who represent over 28% of the eligible HWLA population. Core specialty services for patients with diabetes will include optometry for retinal screening (100% of diabetic patients), ophthalmology to treat specific problems identified during the retinal screening process (estimated at 20% of those screened) and podiatry to assist in the management of foot problems common among diabetic patients (conservatively estimated at 50% of diabetic patients). HWLA will expand access by adding 23,600 optometry visits, 9,400 ophthalmology consults, and 23,000 podiatry visits to the non hospital-based ambulatory care network.

Nurse Advice/Triage Line

An after-hours multilingual Nurse Advice Line will provide patients with timely clinical direction that contributes to member health and appropriate utilization of clinical services.

Member Services

New enrollees will be scheduled for a group orientation on the benefits available through HWLA. In addition, a Member Services hotline will provide culturally and linguistically competent phone assistance with benefit questions, direction to appropriate venue of care, and basic member services. This service will be available 24/7 and will transfer all clinically related questions to the Nurse Advice Line.

Urgent Appointment Access

Access to same or next day primary care visits through the Nurse Advice Line will ensure that the most appropriate level of care is accessible and reduce ED visits.

- All participating primary care sites will provide an adequate number of same day/next day appointments to provide urgent appointment access for HWLA members.
- The after-hours and weekend Nurse Advice Line will be able to provide patients with urgent health problems an appointment for same day or next business day care at their medical home.
- HWLA patients will also be able to call or walk-in to their medical home and get same-day/next business day primary care appointments if their medical condition requires it.
- Patients who have urgent specialty care needs will be seen within 21 days, for services offered at the community- based specialty locations.

- A physician-to-physician referral must be made for patients who need urgent appointments at hospital-based specialty clinics. These clinic appointments must be authorized by the hospital specialist or approved by protocol.

Standardized Clinical Services/Guidelines for Hypertension and Dyslipidemia

Implementation of standardized clinical guidelines throughout the non- hospital based ambulatory care delivery network. This will enhance the quality and efficiency of services and allow for non-physician clinical professionals to deliver care.

Case/Care Management Services

Intensive case management service will be provided to the patients with chronic illness who are the most severely ill. In addition, care management, compliance monitoring and health education will maximize the health of the covered population as detailed below.

Chronic Illness Program for patients with diabetes, CHF, asthma/COPD, hypertension, and dyslipidemia

This program will proactively identify and stratify the covered population into 4 groups according to severity of illness and resource utilization. A chronic care management program will be customized for each group to effectively match the intensity of services to patient needs. This program will emphasize the treatment of patients in comprehensive outpatient and home care environments rather than responding reactively and emergently to clinical crises in Emergency Department (ED) and Inpatient (IP) care venues.

Most patients eligible for HWLA will have at least one chronic illness; some will have several co-morbidities. As such, the redesign of chronic care delivery must apply program resources and interventions appropriate for patient need. Conceptually, based on burden of illness (objective, electronically available markers of disease severity) and resource use (focused on emergent, rescue care, ED, Inpatient, etc.), four groups of patients emerge:

		Burden of Illness	
		Low	High
Resource Use	High	**III**	**IV**
	Low	**I**	**II**

HWLA will build on our successful disease management programs by expanding our three existing programs (CHF, Asthma/COPD and Diabetes) for those with high burden of illness and developing new and innovative approaches for the large population with hypertension and lipid disorders. The interventions available for each group are detailed below. Each higher level group includes the processes, interventions, services and goals included in the lower level groups.

We have designed the program to maximize the investment value of patient communication and care coordination. Thus, patients in group III and IV will have a personally identified case and care manager. Those in groups I and II will have access to a nurse advice line. We performed capacity planning by utilizing standard commercial and, when available, Medi-Cal data. Caution must be exercised with the degree of certainty associated with these estimates. There is little experience with behavior change of individuals from episodic rescue care to coordinated, proactive care in a previously uninsured population.

Group I – Single, straightforward chronic illness (Estimated size of population – 20,000)

Interventions – Membership card, assignment to a Medical Home, nurse-delivered structured care delivery for hypertension and dyslipidemia, after-hours demand management, focus on select preventive measures, same-day/next-day urgent scheduled appointment availability.
Typical patient – Healthy-feeling and appearing individual who rarely seeks medical care. Their episodic, symptom driven healthcare resource use often excludes proactive control of their blood pressure or lipids.
Goals – Transform episodic symptom-driven episodes of care to scheduled, structured nurse delivered protocol-driven care delivery for hypertension and dyslipidemia. Reduce inappropriate variability in care; get to treatment goal faster.
Description – Although labeled as "low resource / low illness burden", patients in this population are nearly all chronically ill, and thus represent the largest component of patients who use our health care system. Unlike commercial health plans, where nearly half the "members" never seek care, each individual is a patient with a chronic illness.

The episodic nature of care for the chronically ill population requires change. Today's patients often seek care only when they have bothersome symptoms. Hypertension and dyslipidemia have no symptoms, until the preventable complications of these primary risk factors cause a devastating event, such as heart attack or stroke. We must continue to provide rescue care for those with these emergent, acute conditions; however, our goal is to provide a coordinated, preventive, evidence and expert panel based system-wide approach to risk reduction for these conditions. This approach includes developing a continuity relationship between the patient and a specific care team, replacing uncoordinated, episodic care.

LACDHS' successful track record of clinical transformation and standardization in its Disease Management programs (Group IV patients) has laid the foundation for structured care delivery. The coverage initiative will allow expansion of these evidence-based care programs to include isolated hypertension and lipid disorders. While Group IV is focused on secondary and tertiary prevention, Group I is focused on primary and secondary prevention.

Group II – Complex or multiple chronic illnesses (Estimated size of population – 37,000)

Intervention – Those included in Group I plus a shift from nurse –delivered care to MD or Nurse Practitioner (NP) management of chronic condition(s).

Typical patient – Middle aged diabetic with several visits to the ED for skin infections, but no scheduled visits or regular medication use for diabetic control. Feels "well" most of the time, "tired" a lot, and is unaware that their blood glucose levels is twice normal and is slowly ravaging their cardiovascular system. Although low-cost now, this patient is almost guaranteed to be a very high cost patient in the future as we care for their heart-attack, renal failure and blindness.
Goals – Transform episodic symptom-driven episodes of care to scheduled primary care. Reduce inappropriate variability in care; get to treatment goal faster.
Description - This patient population will contain those who are receiving appropriate care and those who may be underutilizing proactive preventive services.

Group III – High resource use disproportionate to illness burden (Estimated size of population – 4,000)

Intervention – Group II plus identified case manager and same-day, next-day urgent scheduled appointment availability.
Typical Patient – Multiple chronic illnesses, with multiple visits to the Emergency Department and Inpatient unit. They know they should take their medicines and keep their scheduled clinic appointments, but somehow can't seem to accomplish this goal. Often their chronic disease is "out of control". They are frustrated with the health care system, and their rescue care givers are often frustrated with them.
Goals – Reduce unscheduled rescue care events (ED and IP) by providing identified, easy-to-access case managers.
Description - Group III patients have lower burden of illness than Group IV patients, but may use resources, including duplication of services, that approach group IV patient levels. Group III may have the greatest opportunity for short-term resource reduction with case management. The key differentiation between Group III and Groups I and II are a pre-established relationship with a specific case manager. During normal business hours Group III patients will have direct access to their named case manager. After hours, they will have access to the general demand management line.

Group IV – High burden of illness, multiple co-morbid patients with Heart Failure, Diabetes and Asthma/COPD (Estimated size of population – 4,000)

Interventions – Comprehensive Disease Management Program (see 4(c) below)
Typical patient – Patient who has multiple chronic illnesses and knows it. They live with the limitations of their disease 24/7/365 and have many scheduled and unscheduled encounters with the health care system. Their medication regimens are confusing and they are frustrated when one of their doctors doesn't seem to know what the other is doing with their medication regimen. They want to take an active role in their disease management, but may not feel they are capable or knowledgeable enough to do so.
Goals – Transform care delivery from episodic rescue care to scheduled, planned visits to a coordinated, comprehensive care team. Reduce ED and IP care for exacerbations of chronic illness.
Description - The premise behind disease management programs is simple: provide comprehensive outpatient and home care management to improve quality of care, decrease disease morbidity, and lower the total cost of care by reducing the need

for ED and IP visits. In addition to traditional face-to-face encounters, our program will include care and case management, remote monitoring, patient self-management and integrated clinical decision support systems. These combined strategies reduce the number of times that patients with stable chronic disease decompensate, which avert clinical crises and expensive ED visits and/or IP stays.

- Key to the program is an identified, licensed healthcare professional who functions as the care coordinator, key contact and care delivery provider for most clinical and social interactions. These nursing care specialists are staffed at a ratio of 1:125 in recognition of the time requirements to provide comprehensive management to this challenging population.

Homeless Care Management Pilot

To assist with bridging the challenge of HWLA eligible homeless patients not having an address, phone or access to resources to keep them engaged in HWLA activities, a Homeless Health Advocacy model will be piloted within the HWLA infrastructure and will include adaptive service delivery practices to accommodate the needs and limitations of this special population. Homeless Health Advocates (HHAs), who would mostly be formerly homeless individuals, will provide homeless HWLA patients with care management to assist with follow-through with HWLA services. Their services will include semi-regular street outreach for contact with patients and when possible, review of adherence to established chronic illness specifications and facilitation of communication between HWLA provider and patient. The HHAs will also attempt to link patients to other services, including shelter, housing and nutrition. The highest utilizers of services will be selected for the pilot.

Homeless adults are currently served at LACDHS and PPP clinics including the Northeast Valley Health Corporation Cooperative Health Care for the Homeless Network, one of the largest federal Health Care for the Homeless grants nationally. Managing homeless adults in primary care clinics will reduce emergency room use and costs while strengthening existing outpatient care infrastructure and delivery by reducing fragmentation.

(a) A description of the care management services to be provided and the providers of those services, including primary and specialty care providers.

This program's case management system as described in section 4(c) is vital to optimal outcomes and program success. Additionally, this will help guide the patient through the health care delivery system; provide assessment, plans and advice on available treatment options and services; and direct patients to those resources best able to aid in their disease treatment. Both case and care management services will be mindful of balancing patient needs with cost efficiency with the paramount goal of optimizing each. Most care and case management services will be provided by licensed health care personnel, while system navigation services will be provided by non-licensed staff. Blood pressure cuffs and scales will be provided to patients as necessary based on disease acuity.

(b) A list of the health benefits to be provided, including, but not limited to, primary care and preventive care services; and a description of how the health care services will be promoted in the community.

See list of health benefits above (4). Because HWLA will provide coverage to a defined population of adults with chronic illness who already access the LACDHS ambulatory care network, promotion of services will focus on eligible and enrolled persons. Prior to September 2007, eligible persons will be contacted via mail and will be provided a summary of benefits, services and program goals, as well as eligibility criteria. Once enrolled, members will receive a member services package, membership card, and will be provided an orientation to benefits and services at their assigned medical home. Patients identified as eligible without a valid address will receive their enrollment packets and orientation to HWLA benefits and services at their next clinical visit. Enrollment will continue on an ongoing basis after September 2007 and patients will be contacted using the procedures listed above.

(c) A description of the system(s) and/or procedure(s) for case management or care management that demonstrates that there is capacity to ensure access and utilization.

Our system for case and care management is multi-factorial. First, patients will be risk-stratified into one of four groups based on a combination of their illness burden and "unscheduled rescue care" resource use. This initial retrospective utilization review will ensure that program design balances intervention efforts and cost with clinical and fiscal improvement. The initial part of this process will rely on electronic data aggregated from healthcare information systems in each of the geographic regions of LACDHS and e claims data from the PPPs.

Patients who are high resource users disproportionate to their burden of illness will have classic case management focused on removing barriers to scheduled primary care. At a minimum this will include communication of the advantages of routine over episodic care and an analysis of barriers to transform patient behaviors. Among other interventions, this may include selection of a medical home that has after-hours or weekend primary care availability, a specific cultural or linguistic competency or simply reminders and confirmation of appointments; and a medical care delivery structure previously foreign to the patient.

Comprehensive case and care management will be provided to those patients for whom intensive intervention will yield dramatic clinical and fiscal benefit. This approach will target both disease-specific and disease-independent factors. The care management structure will include the patient as a critical component of the health care team. Disease-independent interventions include assurance that each patient has a self-efficacy evaluation and interventions to improve such. In addition, important co-morbid conditions that cross specific diseases will be addressed and treated in a standardized manner. For example, since chronically ill patients are at high risk for depression, patients in Group IV will undergo formal evaluation of depression (via a standardized screening instrument), and care approaches will be standardized, including protocols and tools for selection of antidepressants based on patient characteristics.

Disease-specific interventions will be guideline-driven and delivered by staff with specialized training in both self-efficacy management and the specific targeted disease. The specific interventions are detailed in the section labeled “Group IV”. Key to this approach is application of resources appropriate for the patient’s condition. Thus, Group I and II patient services focus on assignment of a medical home and system navigation. Communication to patients will emphasize that care should be obtained in a scheduled primary care environment. Those patients who continue to seek care from the ED will receive mail or phone calls reinforcing the more appropriate approach.

Group III and IV patients will require far more intensive resource interventions to have an impact on their health care utilization and outcomes. As such, they will be assigned a named, specific care and/or case manager. These care managers will have access to next business day urgent appointment primary care slots at the patient’s medical home.

The project plan includes funding for contract and County staff, who will provide the case and care management services to all patients based on their disease specific needs. Capacity will be adjusted based on actual experience to ensure appropriate utilization of case and care management, as well as timely access to these services.

(d) A description of the applicant’s processes for conducting periodic utilization reviews for case management or care management to evaluate whether the services provided are consistent with program utilization projections (on a concurrent and retrospective basis) and meet the needs of the target population.

One of the major indicators of success will be the demonstrated shift of patients from unscheduled (emergent, walk-in, inpatient) visits to scheduled primary care and specialty visits. In order to appropriately evaluate our progress toward this goal, program management will conduct regular retrospective utilization reviews to evaluate effectiveness of program projections. Data supporting care patterns will be evaluated quarterly from EDR described above. A care/case manager will contact outliers from expected or desired care patterns as appropriate. Periodic reviews of utilization patterns will inform the re-stratification of the enrolled population to ensure that intervention intensity matches patient needs.

In addition, administrative staff will conduct concurrent reviews using encounter form data. Data will be analyzed quarterly to determine if patient utilization of care and case management services is consistent with the program projections. Also, staff will utilize RPS (see 3 (e)) to identify and track specialty care referrals and services provided to each patient in real time. Our concurrent and retrospective utilization reviews will enable us to ensure program objectives and projections are on target and working correctly. Adjustments will be made as necessary to ensure accomplishment of program goals.

(e) An estimate of the average cost per eligible person to be served, including a description of expected efficiencies in the delivery of health care services that could lead to savings in health care costs.

$108,000,000 in costs for 94,000 members results in an average of $1,149 per enrolled person for direct non-hospital care (not including case and care management costs, which are included in the Administrative budget). Cost estimates exceed the

$108 million in expenditures that will be necessary to receive the maximum allotment – see Budget Estimate (attached).

Comprehensive care management (including case management) will be provided to those patients for whom intensive intervention will yield dramatic clinical and fiscal benefit. One of the major indicators of success will be the demonstrated shift of patients from more expensive ED and urgent care visits to scheduled primary care and specialty visits.

8) **5. Quality monitoring processes to assess the health care outcomes of the eligible person enrolled in the health care coverage program.**

(a) A description of the quality monitoring system to evaluate whether the system is technically sound with sufficient capacity to be implemented with the health care coverage program.

HWLA's quality monitoring will use multiple data sources, namely the EDR, clinical laboratory databases, and an external data source for PPP data. The EDR contains LACDHS patient-level utilization and demographic information, as well as some clinical data. The laboratory databases contain patient-level laboratory test results. These two data sources have been used for a few years to create technically-sound clinical performance measures for LACDHS. Both consist of data collected at the hospital and clinic sites and are electronically sent to LACDHS Administration for analysis. They are also both high-capacity since they already contain data from all LACDHS patients. Data from the PPPs will come from an external data source created specifically for the PPP programs to use for HWLA. This web-based front-end program will be installed at all participating PPP sites and will feed a relational database that will be managed by HWLA administrative staff.

(b) A description of system processes to effectively coordinate, manage, and monitor services to ensure the quality of care.

LACDHS has developed a robust set of system wide performance measures designed to monitor and report on performance in four key areas: quality of care, access to care, operational efficiency, and quality of work life. These measures have been reported quarterly since 2003. In addition, key service volume metrics are tracked on a monthly basis. Under HWLA, a database will be developed so that PPP clinics can collect and enter data that will feed into LACDHS performance measures. This will allow for measures to be selectively monitored and reported on HWLA patients and services. Regular and frequent feedback on performance will be provided to clinic staff, administration, and executive management. The LACDHS Quality Improvement team will review these results and make recommendations for improvement.

(c) An explanation of what standards will be used to quantify, measure, and report on the quality of care.

The following indicators will be tracked throughout the duration of the program:

- <u>Disease-independent measures (will apply to all enrolled patients)</u>
  - Number of unique patients served
  - Percent of encounters that were face-to-face

- Change in number of hospital admissions per patient from current year to prior year
- Change in number of ED visits per patient from current year to prior year
- Percent of women over age 50 who received a mammogram in the past year
- Percent of women who received a Pap smear in the past year
- Percent of enrollees who received an influenza vaccine in the past year
- Percent of enrollees over age 65 who have received a pneumococcal vaccine
- Average speed of phone call answer (care manager, nurse advice line)
- Phone call drop rate (care manager, nurse advice line)

➢ Disease-specific measures

- **Diabetes**
  - Change in % of patients who had hemoglobin A1c (HbA1c) measured
  - Change in % of patients who had LDL-cholesterol measured
  - Change in average systolic blood pressure (SBP) during the year among patients who had at least one SBP >= 130 and at least one subsequent SBP measurement during the year
  - Change in average diastolic blood pressure (DBP) during the year among patients who had at least one DBP >= 80 and at least one subsequent DBP measurement during the year
- **CHF and Hypertension**
  - Change in average SBP during the year among patients who had at least one SBP >= 140 and at least one subsequent SBP measurement during the year
  - Change in average DBP during the year among patients who had at least one DBP >= 90 and at least one subsequent DBP measurement during the year.
- **Dyslipidemia**
  - Change in average LDL-cholesterol during the year among patients who had at least one LDL >= 130 and at least one subsequent LDL measurement during the year
  - Change in average LDL-cholesterol during the year among patients who had at least one LDL >= 100 and at least one subsequent LDL measurement during the year
- **Asthma/COPD**
  - Percent of enrolled asthmatic adults with at least one visit and a subsequent LACDHS hospital admission for asthma during the past year
  - Percent of enrolled asthmatic adults with at least one visit and a subsequent LACDHS ED visit for asthma during the past year

(d) A description of the method by which the applicant will ensure that subcontractors have the capability to effectively establish, coordinate, manage, monitor, and maintain quality efforts.

The County has been contracting for primary care services under its PPP program since 1996, and has considerable experience monitoring and coordinating the medical services provided by its partners. Programmatic and medical record audits are conducted annually to ensure patients receive high-quality and cost-effective care. The following areas are audited in compliance with the PPP contract requirements: a) staff knowledge on operational, and health and safety procedures; b) health education programs; c) medical record storage, legibility, organization and completeness of the record; d) agency's emergency plan; e) Americans with Disabilities Act requirements; f) Title 22 safety requirements; g) pharmaceutical services; h) infection control and; i) laboratory and radiology services. Quarterly meetings, in addition to ad hoc meetings, are also held with our PPP partners to manage, coordinate, and advance the delivery of quality care for the medically indigent who rely on the LAC safety net system for their medical needs. In order to ensure that the PPPs have the resources necessary to support quality management of the HWLA program, they will be provided with a web-based data collection tool and staff for data entry.

6. Promotion of the use of preventive services and early intervention.

(a) Enrolled persons will be educated about the importance of preventive services.

At the time of the patient's initial introduction to the benefit package, they will also be given a brief risk assessment screening by a trained Health Educator. The Health Educator will identify needed preventive services and educate the patient about the importance of prevention in promoting a healthy lifestyle. Clinically appropriate* preventive services offered to enrollees will include: mammograms, cervical cancer screening (Pap smears), influenza immunizations, pneumococcal immunizations, hypertension screening, cholesterol screening, prophylactic aspirin use, and tobacco use screening and intervention (including Nicotine Replacement Therapy for smokers who undergo counseling).

Additional preventive services will be encouraged for those with specific chronic illnesses. For example, diabetic patients will receive annual retinal exams, hemoglobin A1c testing, LDL-cholesterol testing, foot exams, and diet counseling.

*Clinical appropriateness based on national clinical prevention guidelines.

(b) Providers will be encouraged to provide preventive services and early intervention.

Providers will receive an orientation about HWLA benefits, services and goals where providers will be encouraged to focus on preventive services as the system moves toward a chronic care delivery model. Performance measures will be tracked to monitor the provision of preventive services. Providers will be notified of their performance on these measures and we will work with them to improve performance, if necessary. In addition, a bi-annual HWLA newsletter for providers will provide updates in program enhancements and will promote the provision of preventive services and early intervention.

7. The provision of care to Medi-Cal beneficiaries by the applicant, the degree to which the applicant already serves these beneficiaries, and how the proposed health care coverage program will broaden existing services to these beneficiaries.

In LAC, health care is available to low-income adults and children through government sponsored health coverage and the County's services for the indigent. The assortment of payment options for patients and/or providers includes the various Medi-Cal fee-for-service programs, Medi-Cal managed care, Healthy Families, CaliforniaKids, or the County's ORSA/Ability to-Pay (ATP) programs. LACDHS is a disproportionate share provider, and during Fiscal Year 2004-05 it provided 51,722 admissions; 495,126 hospital outpatient visits; 124,358 hospital ER visits; and 187,917 non-hospital-based outpatient visits to Medi-Cal beneficiaries. Although HWLA is designed for the uninsured, the foundation that it lays permits us to continue our enhanced disease management services to the Medi-Cal population. Specifically, those patients with both the highest burden of illness and highest resource use will be enrolled in the LACDHS Clinical Resource Management Disease Management Program. This program, which assures coordination of care through a multitude of interventions, including case and care management, electronic sharing of clinical information within and across LACDHS clusters, as well as electronic clinical documentation, will be offered not only to HWLA participants but also to those who meet the clinical criteria and are covered by Medi-Cal.

8. A description of the screening and enrollment processes for individuals who may qualify for enrollment into the Medi-Cal, Healthy Families, or the Access for Infants and Mothers programs prior to determining eligibility and enrollment into the health care coverage program.

Subsequent to the financial screening process patients will be evaluated for enrollment in HWLA. The financial screening processes are detailed below. In addition to these established financial screening procedures, the enrollment process will include an electronic verification for Medi-Cal and Healthy Families coverage, and citizenship and eligible legal resident verification immediately before enrollment. If appropriate citizenship and eligible legal residents verification cannot be obtained electronically, the patient will be contacted to provide the necessary documentation prior to enrollment into HWLA.

<u>LACHDS Outpatient Facilities</u>

LACDHS has an established and extensive screening program that will be utilized for HWLA enrollment. Registration/financial screening and/or Patient Financial Services (PFS) staff financially screen patients presenting for medical care at the LACDHS outpatient facilities. These staff identify established third-party payer coverage and potential eligibility for programs which would reduce the patient's personal liability for charges (e.g., Medi-Cal, Healthy Families, AIM), and/or take program applications for Medi-Cal and Healthy Families. In addition, post LACDHS efforts, LACDHS employs several contingent-fee vendors to identify established third party coverage.

LAC residents with no existing or potential third party resource are provided an opportunity to apply for one of the LAC No-Cost or Low-Cost programs, e.g., Outpatient

Reduced-Cost Simplified Application (ORSA), Ability-To-Pay (ATP), or to take advantage of the Pre-Payment Plan. No-Cost or Low-Cost program coverage requires the patient to identify established third-party coverage, and if determined eligible for Medi-Cal, requires the patient to apply for Medi-Cal coverage.

Public Private Partners (PPP)

Similar to the above LACDHS process, PPP registration/financial screening staff at each clinic site financially screen patients presenting for medical care. Under the County/PPP contract, LACDHS pays for services to patients of all ages who reside in LAC and whose net family income is at or below 133⅓ % of the FPL (or are General Relief recipients), and who are not covered by Medi-Cal, Healthy Families, AIM or any other government or third-party assistance programs.

A Certificate of Indigence (COI) must be completed by individuals whose services are covered by the County. COIs must be completed annually and patients are asked to declare any changes in family income at each clinic visit. Income verification is not required. Documentation of county residency is mandatory and random audits are conducted annually.

PPP patients, who will be evaluated for eligibility enrollment into HWLA, will also be screened for citizenship and eligible legal status. If appropriate citizenship verification cannot be obtained electronically, patients will be contacted to provide the necessary documentation prior to enrollment into HWLA. Also, prior to LACDHS payment to PPPs for services rendered, billing records are cross-referenced against Medi-Cal records to verify ineligibility.

9. The ability to demonstrate how the health care coverage program will promote the viability of the existing safety net health care system.

The County's participation in the State's Coverage Initiative will promote the viability of our existing system by establishing this County as a key partner with the State and Federal governments in the effort to reduce the ranks of the medically uninsured in California. Further, the investment of new federal Medi-Cal matching funds will enable this County to improve patient care by being able to:

- Better address the health care needs of those with chronic illnesses by expanding the availability of primary care, providing nurse advice lines, implementing care management programs and better integrating clinical resource management programs.
- Expand specialty care in the optometry, ophthalmology and podiatry services
- Augment preventive services by adding a nursing care specialist and health educators and expanding tobacco intervention, influenza vaccination and cholesterol testing programs.
- Initiate a homeless care management pilot program.

The PPP Program represents a collaborative network of 51 community partner agencies that contract with LACDHS to provide quality health services in a culturally and linguistically appropriate environment to the uninsured and medically indigent. The mission of the PPP Program is to provide primary, specialty, and dental care services to the medically indigent that are complementary to the LACDHS safety net system of care

as the safety net currently exists and as it evolves in the future. The guiding principles are fairness in the system, quality of care, and efficiency. Through this innovative partnership, health care is now being provided at over 100 clinic sites that are geographically dispersed throughout LAC. As the partnership has grown and strengthened, the Program has become a vital component of the County's health care delivery system since its inception in 1996.

LACDHS conducts annual programmatic, fiscal and medical record audits of its PPP partners to ensure the effective and efficient delivery of services, including the use of best practices and the provision of quality care. We will rely on our extensive and successful PPP contract monitoring experience, in conjunction with our established auditing procedures, to coordinate, manage and monitor the effective and efficient delivery of services provided by our PPP partners under the proposed health care coverage initiative.

Sustainability of programs after funding ends is always a challenge. However, substantial parts of this program involve changes in system design that should be sustainable beyond the funding period. In addition, LACDHS will work with the State to integrate HWLA with the governor's proposed health care reform plan.

We have developed a robust evaluation component that should allow us to track and report on improvements in quality of care and associated health outcomes, reductions in duplication of services, and reductions in inappropriate or unnecessary ED use as a result of the HWLA initiative. We plan to prepare reports highlighting the data that point to these successes, and request external funders (such as foundations) to support those portions of the program that are not sustainable with existing funds.

10. Documentation to support the applicant's ability to implement the health care coverage program by September 1, 2007, and to fully use its allocation for each program year.

LACDHS certifies implementation of HWLA by September 1, 2007 and its ability to use its allocation for each program year. The program was designed with the short implementation timeline in mind and it builds on the existing infrastructure of its ambulatory care network and Office of Managed Care (OMC). It will also contract for many of its service enhancements (e.g., specialty care expansion, nurse advice line, care management services) to be able support the implementation timeline.

LACDHS currently has procedures in place to ensure fiscal accountability at each facility, including corporate oversight and review of budgeting and spending on a monthly basis. Existing LACDHS financial systems will be used to track program spending and are used by facility management to prepare monthly forecasts for their respective facilities. Facility performance is monitored by comparing established budgets to full-year estimates, and will include the program components. Facility management will report monthly financial forecasts to corporate fiscal personnel and budgetary variances will be explained and action will be taken when necessary to ensure LACDHS meets its financial goals. These forecasts are shared with corporate management and used to prepare the LACDHS 5-year fiscal outlook that is regularly presented to the LAC Board of Supervisors. One additional corporate fiscal officer will be hired to perform the above functions for HWLA and ensure full utilization of the funding allocation for each program year.

11. An explanation of how the health care coverage program will offer consumer assistance to individuals applying to, participating in, or accessing services in the program.

HWLA will offer consumer assistance to individuals by providing eligible individuals and providers with a HWLA Member Services Department. The existing LAC Office of Managed Care Community Health Plan (LACDHS' managed care plan) member services infrastructure will be expanded to provide member services functions for HWLA. The Member Services Division has 3 departments: Call Center, Member Relations, and Member Data Center. All product lines have distinct service staff and all services are provided in the Medi-Cal threshold languages. All other languages are immediately available through a telephone interpreter service.

The Call Center employs well-trained employees who receive a variety of calls. They have a computer-prompted menu and scripts so that all members are given consistent, accurate information. Depending on the inquiry, Call Center staff will:

- Triage member calls and forward all clinically related calls to Nurse Advice Line or assigned medical home
- Offer explanations of program benefits
- Provide verification of eligibility
- Provide provider demographic information (e.g., provider address, phone number)
- Direct callers to appropriate entities regarding enrollment assistance, address changes, and assist in system navigation
- Assist eligible individuals in understanding their rights and responsibilities
- Assist with provider transfers
- Assist eligible individuals in obtaining and understanding all information related to accessing health care services.

The Member Relations department provides support to members who have concerns, complaints or grievances about services provided to them or their family members.

The Member Data Center Department will provide the following functions:

- Prepare management reports and distribute reports to external agencies (e.g., Status of Members, member inquiries, PCP/medical home transfer report)
- Complete and updates all changes of information on members (e.g., member notification of PCP/medical home transfer change)
- Provide oversight and distribution of informational materials (i.e., development, approval, translation, printing of handbook, ID cards, notification letters)