State of California - Health and Human Services Agency **Department of Health Care Services**

Whole Person Care

Lead Entity Mid-Year or Annual Narrative Report

Reporting Checklist

Monterey County
Annual PY3 Narrative Report
May 7, 2019

The following items are the required components of the Mid-Year and Annual Reports:

Component	Attachments
1. Narrative Report **Submit to:** Whole Person Care Mailbox	✔ Completed Narrative report ✔ List of participant entity and/or stakeholder meetings *(if not written in section VIII of the narrative report template)*
2. Invoice **Submit to:** Whole Person Care Mailbox	✔ Customized invoice
3. Variant and Universal Metrics Report **Submit to:** SFTP Portal	✔ Completed Variant and Universal metrics report
4. Administrative Metrics Reporting (This section is for those administrative metrics not reported in #3 above - the Variant and Universal Metrics Report.) **Note: If a Policy and Procedures document has been previously submitted and accepted, you do not need to resubmit unless it has been modified.** **Submit to:** Whole Person Care Mailbox	✔ Care coordination, case management, and referral policies and procedures, which may include *protocols and workflows.)* **PREVIOUSLY SUBMITTED AND ACCEPTED** ✔ Data and information sharing policies and procedures, which may include *MOUs, data sharing agreements, data workflows, and patient consent forms.* One administrative metric in addition to the Universal care coordination and data sharing metrics. Describe the metric including the purpose, methodology, and results. **PREVIOUSLY SUBMITTED AND ACCEPTED**
5. PDSA Report **Submit to:** Whole Person Care Mailbox	✔ Completed WPC PDSA report ✔ Completed PDSA Summary Report
6. Certification of Lead Entity Deliverables **Submit with associated documents to:** Whole Person Care Mailbox and SFTP Portal	✔ Certification form

NOTE: The WPC Quarterly Enrollment and Utilization Report is submitted on a quarterly basis to the DHCS SFTP site.

Whole Person Care

Monterey County

Annual PY3 Report

May 7, 2019

I. REPORTING INSTRUCTIONS

Pursuant to the Whole Person Care Agreement and the Special Terms and Conditions of California's Medi-Cal 2020 §1115 Medicaid Demonstration waiver, each WPC Program Lead Entity ("Lead Entity") shall submit Mid-Year and Annual reports for the duration of the WPC Program. The WPC Reporting and Evaluation guidelines, Attachment GG, provide the requirements for the Mid-year and Annual report.

The Mid-Year Report narrative contains data January-June 30, and is due August 31 for Program Years (PYs) 3-5.

The Annual Report narrative contains data from January 1 through December 31, and is due April 2 each program year. The Annual Report is not meant to be duplicative of narratives provided in the Mid-Year Report but aims to capture a complete picture of accomplishments and challenges during the Program year.

The Lead Entity is required to submit these reports to the Whole Person Care inbox at: 1115wholepersoncare@dhcs.ca.gov.

PROGRAM STATUS OVERVIEW

Please provide a brief overview of your program's successes and challenges and any lessons learned during the reporting period. Structure your responses in alignment with the WPC program's goals using the following as headers (from STC 112): *increasing integration among county agencies, health plans, providers, and other entities; increasing coordination and appropriate access to care; reducing inappropriate emergency and inpatient utilization; improving data collecting and sharing; achieving quality and administrative improvement benchmarks; increasing access to housing and supportive services; and improving health outcomes for the WPC population.*

1. **Increasing integration among county agencies, health plans, providers, and other entities – Social and Clinical collaborations**

   Challenges: Our partnering agency integration challenges for data sharing and direct services are mostly resolved; partners are fully engaged and coordinating well.

   Successes: Our network of partners now consists of 69 members meeting monthly to discuss coordination, emerging challenges, and sustainability. Members represent public health, behavioral health, clinic services, hospital discharge planners, hospital emergency department discharge planners, transitional and supportive care housing operators, our Medi-Cal provider, housing placement partner, Community Foundation, Social Services, our

Continuum of Care, shelter & day service operator, CSU Monterey Bay, sheriff and police departments, a variety of specialized homeless services providers, HIV/Hep C testing agency, nonprofit housing developers, county emergency medical services, sobering center operator, and Housing Authority.

Lessons Learned: Monthly coordination meetings have resulted in direct benefits for our enrollees; it's not uncommon that four agencies coordinate together to achieve housing placement for one of our enrollees.

2. **Increasing coordination and appropriate access to care**

Challenges: It came to our attention this year that some enrollees were caught in a push-pull situation between homeless services providers who were acting in a competitive, rather than collaborative manner. There is some, but not a lot of overlap between our funded provider scopes of work, and we feel there is enough variety in provider specialties for an enrollee to benefit from receiving services for more than one homeless services provider.

Successes: With the initiation of WPC, Monterey County began assembling a network of focused medical, behavioral health, AOD treatment, social services, housing, life skills education, transportation, and legal resolution strategies to address a wide variety of homeless services. Our network is growing more and more solid as we have added Nurse Family Partnership, Targeted Case Management, and Maternal Child Adolescent Health providers to our multidisciplinary efforts.

Lessons Learned: Rather than allowing a few of our funded providers to ill-advisedly suggest to enrollees that they "sign up" to receive services from just one provider, our WPC Supervising Public Health Nurse and Nurse Case Managers have advocated for our enrollees by coaching our partners to focus on collaborative coordination. We stress in our monthly social-clinical meetings our mutual client successes made possible through the strength of our cooperation.

3. **Reducing inappropriate emergency and inpatient utilization**

Challenges: In 2017, our rate of ED visits was 120 per 1,000 member months (9 visits per 75 total member months). In 2018, the rate climbed nearly four-fold, to 435 visits per 1,000 member months (124 visits/285 total member months). We know that the increase in ED visit rates were due to the high acuity of our enrollees as we deliberately sought and enrolled the very highest cost, highest utilizers identified by our safety net hospital.

Successes: In 2017 and 2018, our impatient discharges were 0 per total member months (2017 was 6 discharges per 75 member months; 2018 was 16 discharges per 285 member months).

Lessons Learned: We learned that along with very highest cost, highest use enrollees came the challenges of severe comorbidity coupled with addiction and noncompliant use of medications and medical care. The 2018 enrollees were ethically served with the best standards of care, and some enrollees were dropped from WPC for their combative and/or threatening behaviors or exploitation of our services. We realized there is a "sweet spot" of high cost, high use enrollees who are willing to accept and use supports to get into housing more stable living conditions. These are the enrollees who kept primary care and behavioral health appointments, while higher cost, higher use enrollees refused or couldn't accept structured environments such as clinics, housing appointments, learning sessions, shelter admittance, etc.

4. **Improving data collecting and sharing**

Challenges: Monterey County does not have a case management system thus we do not have a user-friendly reporting system for Whole Person Care data reporting. We invested a good deal of our epidemiologist's time to set up the processes for data collection, merging, and analysis needed to produce WPC summary data reports. We faced a steep learning curve for WPC data collection and reporting. Our first WPC epidemiologist developed a variety of methods for collecting, cleaning, and summarizing data using statistical analysis programs and programming algorithms. The large variety of metrics and processes for each report representing different IT systems was therefore complicated. Nevertheless, our Epi developed a system to report on over two dozen metrics generated by a dozen different sources. While our Epi provided general instructions when he left us for another job, there was limited time for cross-training with our interim epidemiologist to thoroughly learn all data collection, cleaning, and analysis steps necessary to produce all the reports. This has resulted in delays in timely reporting and resubmissions of revised reports.

Successes: Our challenges stem from a lack of a case management system that can import data from EPIC, AVATAR, and MEDITECH, and accept input data from our vendors. While this success did not occur in 2018, we are pleased that we will have Persimmony in place by the end of 2019.

Lessons Learned: We don't know if we were one of the few or one of the many who did not have an integrated EHR or CM system in place when we began our pilot, but we can point to the WPC Pilot for making possible our system-wide improvements. We would have liked to get our new systems in place earlier, but our RFP and other procurement processes were limiting factors for us. Still, by

the end of 2020, we will have a legacy of IT, case management, and partner data exchanges that will support our desire to continue our WPC programs.

5. Achieving quality and administrative improvement benchmarks - Enrollment and Enrollee Profile Data Management

Challenges: We are still using a time-consuming low-tech Excel sorting routine to drill down on enrollees with particular health conditions and cross tabulate that with the types of agencies the enrollee has consented us to share data. For example, we recently had to determine the current enrollees who have a depression diagnosis but not a SUD diagnosis, and of those, the enrollees who permitted us to share their PII with the county social services department.

Successes: After a year of issuing and reissuing RFPs for a case management, plus process delays, we are now sole sourcing a case management solution that will efficiently report enrollee utilization and profile cross tabulations.

Lessons Learned: Contributing to the difficulty Monterey WPC had with obtaining a case management system was that our safety-net hospital insisted on securing an EHR system that would also track their PRIME data and the Health Department's WPC case management data. Monterey did not find a single, integrated system that would meet these three distinct needs. In retrospect, the Health Department should have separately pursued the case management system.

6. Increasing access to housing and supportive services

Challenges: Rents in Salinas have increased by more than 50 percent in the past five years, about five times the national average. The average rent for an apartment in Salinas is $1,647, a 7% increase compared to the previous year, when the average rent was $1,540. The affordable housing inventory is very limited because housing developers are not incentivized to build low income units. Our housing placement partner estimates that with a Housing Choice Voucher, about $4,000 is needed for application fees, first and last month's rent, security and utility deposits, and if required, pet deposits.

Successes: Our proposal to redirect unused funds into housing placement and tenancy preparedness was approved during the PY3 Mid-Year Budget Reallocation. The $120,960 in redirected funds equates to providing 78 potential tenants with $1,550 to support housing occupancy.

Lessons Learned: Monterey County has agreements in place with two nonprofit place-based low/very low income developers that have reserved between them 60 units specifically for WPC enrollees.

These units will be ready for occupancy in late summer/early fall, 2019. Our place-based Housing Choice Voucher programs provide developers with long-term occupants who receive WPC supportive services for at least 12 months after occupancy.

7. Improving health outcomes for the WPC population

Successes: Improvements were seen in the percentage of

- Enrollees with controlled blood pressure among those ages 60-85 with and without a diabetes diagnosis.
- Enrollees who accessed AOD treatment within 14 and 30 days.
- Enrollees who experienced depression remission within 12 months of diagnosis.
- Enrollees having a hospital readmission within 30 days of hospital discharge.
- Enrollees who initiated AOD treatment within 14 and 30 days of referral.

Challenges: A slight decrease was seen in controlled blood pressure among enrollees age 18-59.

Lessons Learned: Even with enrollment challenges we faced in 2018, we ultimately saw improvements in nearly all our measured enrollee health outcomes.

Monterey WPC Enrollee Health Outcomes, 2017 and 2018

Measure	2017	2018
Enrollees with BP<140/90 age 18-59	60%	56%
Enrollees with BP<140/90 age 60-85 with diabetes diagnosis	60%	75%
Enrollees with BP<150/90 age 60-85	67%	71%
Enrollees with HbA1c <8.0%	45%	40%
Enrollees with depression remission at 12 months	14%	0%
Enrollee All-Cause Readmissions at 30 days	21%	22%
Enrollees with AOD treatment within 14 days	37%	55%
Enrollees with AOD treatment within 30 days	21%	51%

II. ENROLLMENT AND UTILIZATION DATA

For the Mid-Year report, provide data for January-June 30 of the Program Year and for the Annual Report, provide data for January-December 31 of the Program Year.

The tables below should reflect enrollment and utilization numbers, consistent with your invoice and quarterly enrollment and utilization reports.

For revisions of enrollment and utilization data submitted during the Mid-Year Report (Months 1-6), changes should be made in bold. Additionally, note explicitly in the additional box at the end of this section if no changes were made to the Mid-Year reported data.

Item	Month 1	Month 2	Month 3	Month 4	Month 5	Month 6	Month 1-6 Unduplicated Total
Unduplicated Enrollees	11	13	9	7	7	2	49

Item	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12	Annual Unduplicated Total
Unduplicated Enrollees	0	0	2	1	0	0	52

For **Fee for Service (FFS),** please report your total costs and utilization for each service. These reports should tie to your budget, invoice, and utilization report. Add rows as needed.

Costs and Aggregate Utilization for Quarters 1 and 2							
FFS	Month 1	Month 2	Month 3	Month 4	Month 5	Month 6	Total
$ Service 1 531.92	0	0	0	0	0	0	0
Utilization 1	0	0	0	0	0	0	0
$ Service 2 164.89	0	0	0	0	0	0	0
Utilization 2	0	0	0	0	0	0	0
$ Service 3 77.28	0	0	0	0	0	0	0
Utilization 3	0	0	0	0	0	0	0

Costs and Aggregate Utilization for Quarters 1 and 2							
FFS	Month 1	Month 2	Month 3	Month 4	Month 5	Month 6	Total
$ Service 4 288.23	2017.61	5476.37	11240.97	80416.17	66004.67	0	165155.8
Utilization 4	7	19	39	279	229	0	573
$ Service 5480.00	0	0	0	0	0	0	0
Utilization 5	0	0	0	0	0	0	0
$ Service 6 216.65	1733.2	4116.35	6282.85	6282.85	7582.75	4116.35	30114.35
Utilization 6	8	19	29	29	35	19	139
$ Service 7 40.00	0	0	0	0	0	0	0
Utilization 7	0	0	0	0	0	0	0
$ Service 8 2,575.00	0	0	0	0	20600	20600	41200
Utilization 8	0	0	0	0	8	8	16
$ Service 9 2,574.09	0	0	0	0	23166.81	25740.9	48907.71
Utilization 9	0	0	0	0	9	10	19
$ Service 10 308.33	0	0	0	18808.33	17575	24050	60433.33
Utilization 10	0	0	0	61	57	78	196
$ Service 11 1,550.00	0	0	0	0	0	0	0
Utilization 11	0	0	0	0	0	0	0
$ Service 12 750.00	0	0	0	0	0	0	0
Utilization 12	0	0	0	0	0	0	0

Costs and Aggregate Utilization for Quarters 3 and 4							
FFS	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12	Annual Total
$ Service 1 531.92	0	0	0	0	0	0	0
Utilization 1	0	0	0	0	0	0	0
$ Service 2 164.89	0	0	0	0	0	0	0
Utilization 2	0	0	0	0	0	0	0
$ Service 3 77.28	0	0	0	1159.2	1159.2	1159.2	3477.6
Utilization 3	0	0	0	15	15	15	45
$ Service 4 288.23	15852.65	29111.23	23923.09	44099.19	36605.21	30264.15	179855.5
Utilization 4	55	101	83	153	127	105	624
$ Service 5 480.00	0	0	0	0	0	0	0
Utilization 5	0	0	0	0	0	0	0
$ Service 6 216.65	3683.05	3033.1	2599.8	4333	2816.45	2166.5	18631.9
Utilization 6	17	14	12	20	13	10	86
$ Service 7	40.00	40.00	40.00	40.00	40.00	40.00	40.00
Utilization 7	0	0	0	0	0	0	0
$ Service 8 2,575.00	0	2,575.00	5150	61800	64375	59225	193125
Utilization 8	0	1	2	24	25	23	75
$ Service 9 2,574.09	33463.17	30889.08	38611.35	61778.16	64352.25	59204.07	288298.1
Utilization 9	13	12	15	24	25	23	112
$ Service 10 308.33	215833.3	215833.3	209975	250675	243891.6	177908.3	1314117

Costs and Aggregate Utilization for Quarters 3 and 4							
FFS	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12	Annual Total
Utilization 10	700	700	681	813	791	577	4262
$ Service 11 1,550.00	17050	20150	3100	38750	37200	4650	120900
Utilization 11	11	13	2	25	24	3	78
$ Service 12 750.00	0	0	0	0	0	0	0
Utilization 12	0	0	0	0	0	0	0

For ***Per Member Per Month (PMPM),*** please report your rate, amount claimed and member months by PMPM type. These reports should tie to your budget, invoice, and utilization reports. For “Bundle #” below, use the category number as reported in your submitted Quarterly Enrollment and Utilization Report. Add rows as needed

Amount Claimed								
PMPM	Rate	Month 1	Month 2	Month 3	Month 4	Month 5	Month 6	Total
Bundle #1	$1800	82800	93600	108000	118800	124200	115200	642600
MM Counts 1		46	52	60	66	69	64	357
Bundle #2	$308.33	14183.33	16033.33	18500	20350	21275	19733.33	110075
MM Counts 2		46	52	60	66	69	64	357

Whole Person Care

Monterey County

Annual PY3 Report

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Amount Claimed								
PMPM	Rate	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12	Total
Bundle #1	$1800	111600	111600	115200	108000	108000	93600	648000
MM Counts 1		62	62	64	60	60	52	360
Bundle #2	$308.33	0	0	0	0	0	0	0
MM Counts 2		0	0	0	0	0	0	0

III. NARRATIVE – Administrative Infrastructure

Please describe the administrative infrastructure that has been developed specifically for the WPC program and how it relates to achievement of program goals. Reimbursement will be based on actual costs expended and employees hired/employed for the WPC pilot, and only up to the limit of the funding request in the approved budget.

Please note the narrative submitted during the Mid-Year report will be considered part of the Annual report and will not need to be resubmitted. Include updates, notable trends, and highlights of achievements/progress as well as any changes since the report.

Administrative Infrastructure updates since June 30, 2018 are these:

- Submitted and received approval for our proposed PY3-to-PY4 budget rollover and narrative.
- Submitted and received approval for our proposed PY3 Mid-Year Budget Adjustment.
- A convening of 48 homeless service provider organization directors and supervisors from across the county was held in October 2018 to facilitate cooperative collaboration. Presentations included a discussion of WPC collaboration, goals, and vision; a housing availability update; a facilitated discussion of the complexity of homelessness; enrollee success stories, a rapid quality improvement instruction and exercise; and reflection on “what works.”
- Three Monterey County WPC staff attended the DHCS April 29-30 in-person convening in Sacramento.
- Recruitment continued to replace three (75%) of our public health nurse positions (each head up a case management team) that were vacated.

The WPC Operations Committee met monthly to discuss the overall operations of the program. The participants include Monterey County Health Department executive leaders who oversee WPC budgeting and invoicing, enrollment and utilization, contracts and partner performance, and sustainability. Meetings include updates provided by DHCS, updates on the progress of committee members’ action items which range from data management software tool and agreements, staffing challenges, finances, quality improvement efforts, and sustainability planning.

Participants are:

- Carr, Kacy, Services Manager II, Behavioral Health Bureau
- Chombo, Fabricio, Finance Manager, Administration Bureau
- Corpus, Carol, Deputy Public Health Bureau Chief, Public Health Bureau
- Hernandez, Miriam, Finance Manager II, Behavioral Health Bureau
- House, Sarah, Departmental Information Systems Manager, Health IT
- Kim, Nan, Clinic Services Management Analyst, Clinic Services Bureau

- Lewis, Moira, Director of Nursing, Public Health Bureau
- Miller, Amie, Behavioral Health Director, Behavioral Health Bureau
- Moreno, Rose, Management Analyst II, Behavioral Health Bureau
- Pantoja, Elena, Whole Person Care Program Coordinator, Administration Bureau
- Sumeshwar, Shibaanee, Privacy Compliance Officer, Administration Bureau
- Vega, Ezequiel, Assistant Director of Health, Administration Bureau
- Voss, Robert, Epidemiologist, Administration Bureau
- Zerounian, Patricia, Whole Person Care Program Manager, Administration Bureau

IV. NARRATIVE – Delivery Infrastructure

Please describe the delivery infrastructure that has been developed as a result of these funds and how it relates to achievement of pilot goals. Reimbursement will be based on actual pilot expenditure for the final deliverable or outcomes, up to the limit projected or estimated costs in the approved budget.

Please note the narrative submitted during the Mid-Year Report will be considered part of the Annual Report and will not need to be resubmitted. Include updates, notable trends, and highlights of achievements/progress as well as any changes since the prior report.

Delivery Infrastructure updates since July 1 2018 are these:

- An agreement is pending with a nonprofit medical and oral health services provider to take overflow WPC primary care referrals
- An agreement is pending with Monterey County Probation Department to work collaboratively with WPC to facilitate jail-released persons deemed to meet WPC enrollment criteria.
- An agreement is pending to fund a medical-legal partnership that will work with Monterey County clinic patients, including WPC enrollees.
- A contract amendment is pending to augment our housing placement partner contract to provide funds for WPC housing application fees, first/last rent, security deposit, and utility deposit, and to prepare potential WPC enrollees for tenancy.
- An RFP was drafted to provide enrollee transportation to/from medical and behavioral health appointments.

V. NARRATIVE – Incentive Payments

Please provide a detailed explanation of incentive payments earned during the Reporting Period. Elaborate on what milestones were achieved to allow the payment, the amount of each payment, and to whom the payment was made. The lead entity will only be permitted to invoice for actual incentive payments made.

Please note the narrative submitted during the Mid-Year Report will be considered part of the Annual Report and will not need to be resubmitted. Include updates, notable trends, and highlights of achievements/progress as well as any changes since the prior report.

Incentive	Payment Trigger	Attainment	Achievement	Total $	Comment:
Primary Care Clinics	Clinics will receive $20,000 per WPC enrollee scheduled for and successful participation in follow-up appointment within 30 days post discharge or release.	28	Achieved	560,000	Monterey County Health Department, Clinic Services Bureau
Hospital Incentive	Natividad Medical Center (NMC) will be eligible for $20,000 per WPC enrollee successfully linked to care coordination without a readmission within 30 days. Biannual payments will be made.	29	Achieved	580,000	Natividad (formerly known as Natividad Medical Center)

Incentive	Payment Trigger	Attainment	Achievement	Total $	Comment:
Enrollment/re-enrollment of individuals transitioning from Jail (Round 2)	Behavioral Health Clinics will receive $2,000 per enrollment/re-enrollment upon completion of an initial assessment. Limited to one payment per enrollee every 12 months.	0	0	0	We will probably exchange this incentive to a different incentive in the PY4 mid-year budget adjustment as we don't have a way to successfully track enrollee incarceration.
Population Health IT System Business User Plan Completed	We will develop the business user plans once our vendor negotiations are complete.	0	0	0	We are negotiating with Persimmony now for the provision of a case management system.
Population Health IT System Vendor Selection & Negotiation	We are currently in the process of identifying a vendor for the population health / case management system.	0	0	0	We are negotiating with Persimmony now for the provision of a case management system.
Sustainability Planning Sessions	Incentive earnings will be $10,000 per session, for up to 12 sessions in each program year.	0	0	0	This was created in the PY3 Mid-Year Budget Adjustment approved on March 19, 2019.

Incentive	Payment Trigger	Attainment	Achievement	Total $	Comment:
Permanent Housing Placement	Incentive earnings will be $10,000 per placement for up to 40 placements that are in effect beyond 30 days of occupancy.	0	0	0	This incentive was created in the PY3 Mid-Year Budget Adjustment that was approved on March 19, 2019.
Telehealth Kiosk Placement	Incentive earnings will be $80,000 each for three Telehealth Kiosk installations.	0	0	0	This incentive was created in the PY3 Mid-Year Budget Adjustment that was approved on March 19, 2019.

VI. NARRATIVE – Pay for Outcome

Referencing the Whole Person Care Universal and Variant Metrics Technical Specifications, please provide a detailed explanation of the status of your program's performance on the pay-for-outcome metric(s). For the Mid-year report, only report those measures that are reported semi-annually; for the Annual report, please report all. Provide details that demonstrate what was achieved for each outcome, any challenges, and any lessons learned. Reimbursement will occur for achieved outcomes based on proposed annual target and methodology.

Achievements beyond our goals:

Monterey County reached or exceeded all five it's health outcome targets, per the following achievements:

Tobacco assessment for those enrolled (Universal and Variant Item #24A). Target: 90%. Achievement: 100%.

- **Achieved:** 87/87 enrollees received an assessment from public health nurse case managers for tobacco use, and 43/43 tobacco-using enrollees received counseling from public health nurse case managers for tobacco cessation.
- **Challenges:** none. Because tobacco use is common in our population, we made tobacco assessment an element of our intake protocol for all enrollees.

Coordinated Case Management of those enrolled for 12 months (Universal and Variant Item #16). Target 25%. Achievement: 25%

- **Achieved:** 22/87 enrollees were enrolled in 12 months of coordinated case management headed by public health nurse case managers with connections to behavioral health, social services, and housing case managers.
- **Challenges:** Of the 87 individuals who were enrolled by January 2018, 22 of those enrollees are still receiving WPC services. Reasons for ceasing enrollment have been death, moving out of the area, and being dismissed from the program due to non-compliance or aggressive behaviors.

Comprehensive Care Plan for Enrollees (Universal and Variant Item #17). Target: 50%. Achievement: 90%

- **Achieved**: 47/53 enrollees were recipients of a comprehensive care plan within 30 days of enrollment that was coordinated by public health nurse case managers with connections to behavioral health, social services, and housing case managers.
- **Challenges:** It is sometimes difficult to get enrollees to agree to a comprehensive care planning appointment within 30 days of enrollment.
- **Lessons Learned:** Whenever possible, we try to conduct the care planning session at the same time as enrollment.

Alcohol & Other Drug Screening/Assessment for WPC enrollees (Universal and Variant Item #27). Target: 90%. Achievement: 100%

- **Achieved:** 87/87 enrollees received an assessment from public health nurse case managers for alcohol and other drug use and were offered behavioral health services and treatment.
- **Challenges:** none. Alcohol and Other Drug screening/assessment is part of our enrollee intake protocol.
- **Lessons Learned:** Because AOD use is common in our population, we made AOD screening/assessment an element of our intake protocol for all enrollees.

Mental/medical/SUD appointment follow up within 30 days of hospital discharge (Universal and Variant Item #25)**.** Target: 80%. Achievement: 80%.

- **Achieved:** 21 out of 24 enrollees had a medical, mental health, or SUD appointment within 30 days of hospital discharge as coordinated by public health nurse case managers.
- **Challenges:** It is many times difficult to get a client to agree to a behavioral health and/or SUD appointment within 30 day of hospital discharge.
- **Lessons Learned:** We continue to coordinate hospital notification of release for our enrollees so public health nurse case managers can respond to this need in a timely manner

VII. STAKEHOLDER ENGAGEMENT

Stakeholder Engagement - In the text below or as an attachment to this report, please provide a complete list of all program policy meetings you have held with participating entity/ies and/or stakeholders during the reporting period, and a brief summary, with topics and decisions, of the proceedings. The list of meetings will not count against your word limit. Please Note: Do not include meetings held as part of providing WPC services (e.g. care planning, MDT meetings). Meeting information provided in the Mid-Year Report does not need to be resubmitted.

WPC Social and Clinical Committee meets monthly to discuss and determine the most efficient way to provide wrap around services for our clients. This includes establishing data sharing agreements between agencies, developing case management tools, sharing successes, and addressing barriers. Some of our successes to date include: developing a referral form, referral response form and participant consent form to facilitate enrollment. We also have been working on increasing prioritization efforts for our WPC enrolled participants by discussing the best way to identify and process clients faster. Since we don't have an established population health software platform to share information quickly and efficiently; we are meeting with agencies one on one to develop data sharing and assessment tools that can be utilized while we wait for the software to be purchased and developed. Looking forward to the end of the program year we are planning to continue working together to determine best practices and address barriers as they arise.

Our participants include:

- Allard, Cara, Salinas Valley Community Hospital
- Allen, Janice, Natividad Medical Center, Emergency Department
- Allen, Jill, Executive Director, Dorothy's Place, homeless services provider
- Anzaldo, Alicia, LVN, MCHD Public Health Bureau
- Arrizon, Haydee, Case Manager, Central Coast Center for Independent Living
- Bass, James MCSD
- Beye, Travis, Adult Protective Services, Monterey County Department of Social Services
- Brunson, Bob. Program Manager, Sun Street
- Camarena, Marco – DSS AS
- Carr, Kacy, Deputy Director, MCHD Behavioral Health Bureau
- Castillo, Alyssa, Salinas Valley Community Hospital
- Ceralde, Marisa, Salinas Valley Community Hospital
- Cohen, Dominique, MidPen Housing
- Corpus, Carol, Deputy Director, MCHD Public Health Bureau
- Fenton, Jennifer, Behavioral Health clinician, MCHD BH
- Friedrich, Karen, Natividad Medical Center, Emergency Department
- Gonzalez, Rosi, Case Manager, CCCIL
- Gustus, Mary, WPC Case Manager, MCHD

- Hanni, Krista, Program Manager, MCHD Administration Bureau
- Hathcock, Eddie, Project Manager, Sun Street Center
- Kaupp, Christina, California Forensics Management Group
- Juarez, Trini, Salinas Valley Community Hospital
- Knight, Katherine - SVMH
- Lee, Ronald – DSS AS
- Lewis, Moira, Director of Nursing, MCHD Public Health Bureau
- Mahon, Eleanor, Public Health Nurse, MCHD Public Health Bureau
- Martinez, Angelica, Salinas Valley Community Hospital
- Martinez, Solomon, Behavioral Health Aid, MCHD Public Health Bureau
- McCrae, Robin – CHS
- Medearis, Peggy – DSS AA
- Medera, Maria – HA
- Mendoza, Ana, LVN, MCHD Public Health Bureau
- Mendoza, Jose, LVN, MCHD Public Health Bureau
- Mitchell, Barbara, Executive Director, Interim, Inc, housing services
- Moreno, Edward, Health Officer and Director of Public Health, MCHD Public Health Bureau
- Muir, Thomas, Community Hospital of the Monterey Peninsula
- Nahas Wilson, Elisabeth, MidPen Housing
- Ortiz, Leticia - MCHD PH
- Pantoja, Elena, Whole Person Care Program Coordinator, MCHD Administration Bureau
- Rager, Melanie, Care Management Director, Central Coast Alliance for Health
- Rhoads, Gina – Central Coast Alliance for Health, managed care plan
- Rogers, Infanta – Natividad Medical Center, Emergency Department
- Romero, Begonia, Outpatient Services Manager II, Natividad Medical Center
- Romero, Maria, Clinic Operations Supervisor, Natividad Medical Center
- Rowland, Glorietta, Management Analyst, Monterey County Department of Social Services
- Ruiz, Jorge, Central Coast Center for Independent Living
- Sana, Camille, Management Analyst, MCHD Clinic Services
- Sanchez, Lorena, Salinas Valley Community Hospital
- Sinnhuber, Vickie, Clinica de Salud de Valle de Salinas
- Smith, Youlonda, California Forensics Management Group
- Sumensupa, Lauren, Monterey County Department of Social Services
- Thoeni, Katherine, Executive Officer, Coalition of Homeless Services Providers
- Tomaselli, Sarafina, Monterey County Department of Social Services
- Torres, Rodrigo, Community Human Services
- Tuazon, Joy – MCHD PH
- Voss, Robert, Epidemiologist, MCHD Administration Bureau
- Yant, Allison – DSS AS
- Zerounian, Patricia, Whole Person Care Program Manager, MCHD Administration Bureau

Stakeholder Meetings since July 1, 2018

Please note: Meeting agenda and notes are available for all Stakeholder Meetings listed below.

Meeting Date	# of Attendees	Primary Discussion Topics
7/9/18	22	Success stories; WPC PHN Staff shortage; current enrollment; Enrollee health outcomes; Confidential Case Management Review Meetings; Partner performance updates; meeting schedule; Autumn Forum planning.
8/13/18	22	Success stories; current enrollment; staff updates; case management roles and information sharing; housing availability; funding for low/very low income housing; Autumn Forum planning.
9/10/18	23	Success stories; current enrollment; hiring update; Medi-Cal Managed Care report; ED navigators update; housing subcommittee update; financial literacy training; HEAP funding opportunity.
10/8/18	16	Success stories; current enrollment; staffing update; housing update; challenges and barriers of Housing Choice Vouchers; Sobering Center report; Housing and Disability Advocacy Program.
12/10/18	21	Success stories; current enrollment; staffing update; housing update; state of Chinatown services area; multidisciplinary Community Action Team Meetings in Monterey; Section 8 Landlord Recognition event; Chinatown flu shots and Hep A vaccine; availability of public showers and lockers; upcoming homeless census and survey.

VIII. PROGRAM ACTIVITIES

a.) Briefly describe 1-2 successes you have had with care coordination.

(1) In 2018, 29 housing placements were made, representing 33% of our active caseload for the year. Because of PY3 Mid-Year Budget Adjustment approval, we expect this number and percentage to substantially increase as our housing placement provider is now funded to provide for application fees, first/last month rent, security deposits, and utility fees.

(2) An enrollee who was a dishonorably discharged veteran could not get housing through the regular pathways available through the VA. Through our network of homeless services providers, we contacted a nonprofit, nongovernmental veteran's association that was able to place the enrollee in a nongovernmental program that provides housing and an array of mental/emotional therapies and peer supports.

b.) Briefly describe 1-2 challenges you have faced with care coordination, and lessons learned from those challenges.

(1) We learned through our enrollees that a small number of services providers were telling enrollees that they needed to select them as a service provider and drop out of programs provided by other service providers. Our network of partners has traditionally been cooperative, so we were surprised to hear of the competitiveness between 2-3 partners. We discussed the situation with partners and brought them to the understanding that enrollees must have access to a wide variety of services and should be free to access services whenever, wherever, and from whoever they wish.

(2) One of our transitional housing programs unexpectedly shut down, leaving enrollees and others abruptly unsheltered. Our Public Health Nurse Case Managers quickly responded and in partnership with others, made shelter arrangements. We requested the provider give us notice prior to taking similar action in the future.

c.) Briefly describe 1-2 successes you have had with data and information sharing.

(1) We continued obtaining data from community partners and improved the formats of data provided to us, and we developed reporting methods with four new FFS category vendors. This required vendor meetings to learn about their system abilities and limitations, and methods, and developing appropriate data reporting tools.

(2) We refined metric data collection methods with several partners, including MCHD's Behavioral Health Bureau, Clinic Services, and our county hospital. Three different data systems were involved, which was complicated in that this involved three different data systems. WPC constituted the first opportunity MCHD had to share data across several county systems, and it provided us with important frameworks for future efforts. We also, for the first time, worked closely with our Medi-Cal Managed Care Provider to share data in both directions.

d.) Briefly describe 1-2 challenges you have faced with data sharing, and lessons learned from those challenges.

(1) Because we needed to access data from multiple systems, we first needed to establish memorandum of understanding and personal relationships with entities that were not accustomed to sharing PHI or PII. This was a time-consuming process requiring several meetings and consultation with contracted special council. A lesson learned is that staff in different disciplines do not always use the same language for describing similar components of a data sharing process. Ensuring that data sharing language was clearly defined was very important to our risk-adverse counsel.

(2) Data definitions need to be mutually understood prior to data sharing, which is challenging as each system had different definitions, different field names, and different ways of collecting data. Considerable time was needed to understand these data dictionaries to ensure we had created appropriate data merging for analyses and reporting.

(3) Our Public Health Nurse Case Managers were not accustomed to analyzing aggregated patient data as their normal practice was not to compare patient data housed in EPIC patient records. We introduced them to Excel for recording monthly activities and our Epidemiologist used Excel for data aggregation.

e.) Briefly describe 1-2 successes you have had with data collection and/or reporting.

1) Monterey County does not have a case management system thus we do not have a user-friendly reporting system for Whole Person Care data reporting. We invested a good deal of our epidemiologist's time to set up the processes for data collection, merging, and analysis needed to produce WPC summary data reports.

f.) Briefly describe 1-2 challenges you have faced with data collection and/or reporting.

1) We faced a steep learning curve for WPC data collection and reporting. Our first WPC first epidemiologist developed a variety of methods for collecting, cleaning, and summarizing data using statistical analysis programs and programming algorithms. The large variety of metrics and processes for each report representing different IT systems the therefore complicated. Nevertheless, our Epi developed a system to report on over two dozen metrics generated by a dozen different sources. While our Epi provided general instructions when he left us for another job, there was limited time for cross-training with our interim epidemiologist to thoroughly learn all data collection, cleaning, and analysis steps necessary to produce all the reports. This has resulted in delays in timely reporting and resubmissions of revised reports.

g.) Looking ahead, what do you foresee as the biggest barriers to success for the WPC Program overall?

(1) We are thrilled that between two place-based voucher housing developments we will have 60, 1-bedroom apartments available to WPC enrollees by the end of this year. We are also hopeful that our federal grant applications (HEAP, NPLH) will be successful in helping us create a 100-bed year-round emergency shelter for families and another shelter for single adults. Currently, only a small winter shelter exists in Monterey County.

(2) Monterey County Health Department has created a plan to extend WPC medical, mental health, and oral health services beyond December 2020 by transitioning enrollees to Targeted Case Management and continuing Public Health Nurse outreach. We are very concerned for some of our community homeless services partners that will lose WPC funding for their operations. Nearly all of these receive financial support from the county, but the WPC funds allowed them to expand their capacities, and we would hate to see a retraction of services due to lack of funds.

IX. PLAN-DO-STUDY-ACT

PDSA is a required component of the WPC program. The WPC PDSA Report template will be used for each PDSA that the LE is conducting. Summary and status reports are required components of your Mid-Year and Annual reports. Please attach all required PDSA documents and completed template demonstrating your progress in relation to the infrastructure, services, and other strategies as described in the approved WPC LE application and WPC STCs. Note: For the Mid-Year Report, submit information from January – June 30. For the Annual Report, submit information inclusive of all PDSAs that started, are ongoing, or were completed during the Program Year.

See attachment “PDSA Summary Reports”