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

San Joaquin County Whole Person Care
Annual Report, Program Year 2
4/2/2018

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.)* ☐ 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.
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.

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.

II. 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.*

The two primary goals for San Joaquin County Whole Person Care in PY2-PY5 is to increase integration, coordination, and access to care an among County agencies, health plans, providers, and other entities as well as improve health outcomes for the WPC Population. San Joaquin County has a traditional structure of providing services with minimal data sharing and coordination among community entities. Whole Person Care has allowed a new, more collaborative approach for clients who are accessing multiple community services but often not receiving many benefits.

The most significant step taken in PY2 was to identify and bring together a core team, including both San Joaquin County staff and community entities, at various staffing levels to create trust, develop an understanding of programs, reduce duplication of services, and utilize expertise to provide a higher level of service across the board. The Core team took several steps toward more effective collaboration and engagement to support our target population.

One of the primary areas of focus was on reducing inappropriate emergency and inpatient utilization. Local hospitals incur considerable cost on patients inappropriately utilizing their ED and inpatient facilities. SJC WPC spent a significant amount of time focusing on this area and created several practical steps to reduce the over-utilization. While there is still a lot of work to be done, the team found some small successes over the first six months of client enrollment.

Data Collection and sharing was a definite barrier for SJC WPC Pilot in PY2. Initially, there was very different understanding of what could and could not be shared, with whom, and when. It took a concentrated effort to find ways that allowed the WPC team to efficiently share information in a secure way that would enable frontline staff to provide the enrollees the care and support they need. This is another area that will require continued monitoring, education, and updates but the team that is in place is working well to find solutions and respect limitations.

Collecting data and reporting on metrics is a vital part of the pilot. PY2, as a ramp-up year for SJC, was challenged with achieving some benchmarks. Hiring staff, developing an understanding of the pilot, establishing workflows, policies, and procedures, housing, identifying supportive services, nature of the work, and complexity of the population barriers for WPC Administrative staff and other WPC team members. We anticipate PY3 providing us an opportunity to spend more time focusing on the benchmarks.

III. 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	Unduplicated Total
Unduplicated Enrollees	0	0	0	0	0	0	*

Item	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12	Annual Unduplicated Total
Unduplicated Enrollees	*	18	*	23	63	20	145

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.

FFS	Costs and Aggregate Utilization for Quarters 1 and 2						
	Month 1	Month 2	Month 3	Month 4	Month 5	Month 6	Total
Recuperative Care	$0	$0	$0	$0	$0	$0	$0
Utilization 1	0	0	0	0	0	0	0
Care Coordination	$0	$0	$0	$0	$0	$0	$0
Utilization 2	0	0	0	0	0	0	0
BHS Integration Team	$0	$0	$0	$0	$0	$0	$0
Utilization 3	0	0	0	0	0	0	0

Whole Person Care

San Joaquin County Whole Person Care

Annual Report, Program Year 2

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FFS	Costs and Aggregate Utilization for Quarters 3 and 4						
	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12	Total
Recuperative Care	$17,850	$26,265	$24,480	$22,355	$20,145	$20,655	$131,750
Utilization 1	210	309	288	263	237	243	1,550
Care Coordination	$*	$*	$*	$*	$*	$*	$898.40
Utilization 2	*	*	*	*	*	*	16
BHS Integration Team	$	$	$	$	$	$	$34,284.25
Utilization 3	21	80	68	77	83	58	387 encounters (250.25 hrs)

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.

PMPM		Amount Claimed						
	Rate	Month 1	Month 2	Month 3	Month 4	Month 5	Month 6	Total
Bundle #1 -Pop Health	$	$0	$0	$0	$0	$0	$0	$0
MM Counts 1		0	0	0	0	0	0	0
Bundle #1 - CMC	$	$0	$0	$0	$0	$0	$0	$0
MM Counts 2		0	0	0	0	0	0	0

PMPM		Amount Claimed						
	Rate	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12	Total
Bundle #1 -Pop Health	$	$*	$*	$*	$*	$2,093.91	$2,738.19	$6,120.66
MM Counts 1		*	*	*	*	13	17	39
Bundle #1 - CMC						$*	$*	$2,093.91
MM Counts 2		*	*	*	*	*	*	13

Please provide additional detail, if any, about your enrollment and utilization for this reporting period. (Optional)

We utilized two separate teams to provide PMPM bundle services, Population Health and Community Medical Centers.

IV. 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.

Health Care Services (HCS) is the Lead Entity for the Whole Person Care Pilot in San Joaquin County. Establishing a robust Administrative Infrastructure has been a vital part of the SJC Pilot in 2017 as administrative functions are essential to providing support to enrollees and eventually having a program that is sustainable to the County.

Upon completion of the application, the management team determined that SJC HCS WPC required particular positions to support the Pilot's planning, implementation, and operations. The original application stated we would hire in following:

- Department Applications Analyst (1FTE)
- Management Analyst II (1 FTE)
- Accountant I/II (.32 FTE)
- Public Health Nurse (1 FTE)
- Registered Nurse (1 FTE)

As indicated in the mid-year report, onboarding new staff was challenging due to delays in Board of Supervisor approval, budget adjustments, and the County hiring process. In 2017, SJC HCS completed hiring two positions, Management Analyst II and Department Applications Analyst III.

The Management Analyst II was onboard in May 2017. The MA II position is ultimately responsible for providing coordination and support of the SJC WPC Pilot including data analysis, reporting, engaging partners, creating and implementing contracts and MOU's, coordinating and facilitating meetings, and other Administrative tasks. The hiring of the MA II allowed the Pilot to begin enrollment as of July 1, 2017.

The Department Applications Analyst III was an internal hire brought onboard in October 2017. Due to challenges in refilling her position she was not entirely onboard as of the end of 2017. The Application Analyst will ultimately be responsible for supporting and implementing information technology interfacing and data for WPC.

The Accountant I/II position is tasked with monitoring, tracking and providing accurate and timely financial reporting, invoicing within County system, supporting Mid-Year and Annual invoices, and supporting the Budget Adjustment and Rollover.

Full-time nurses were not hired in 2017 and funds from those positions were requested to roll over and adjust in PY3. Although the Pilot did have significant engagement and support from several nurses in PY2, we did not ultimately hire specifically for WPC. The nurses we engaged with did provide necessary support and coordination of care to enrollees. The plan is to utilize the adjustment and rollover funds to fractionalize and contract with several participating entities to provide the listed scope of services.

V. 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.

San Joaquin County Whole Person Care does not have any Delivery Infrastructure approved for PY2.

VI. 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.

Health Information Exchange

An essential part of the SJC WPC Pilot is an ability to share information, analyze data, and compile reports. SJC is working with partners through the San Joaquin Community Health Information Exchange to implement HIE technology.

In the second half of 2017, planning commenced for the inclusion of analytics and reporting initiative that will assist WPC reporting requirements and metrics tracking. Due diligence was performed to determine if a solution incorporated via the HIE or an entirely separate solution would be optimal. The team concluded that an HIE based analytics tool would be optimal and plan to activate in late March 2018. Multiple planning discussions, requirements sharing and analysis and vendor engagement occurred during the final two Quarters of 2017 to get to this point. Vendor activity continued into early 2018 in anticipation of the March activation.

While a separate care management platform is being explored for WPC, the HIE will also track and provide the ability to identify WPC patients for specific purposes. During 2017, the team examined approaches to the HIE vendor being able to identify patients via updated data files shared with the HIE on a frequent basis. This process may serve various benefits for WPC, including the ability to provide notifications to PCPs, EDs and Care Managers when a WPC patient visits the ED or admitted for an inpatient visit at a participating facility. This offers the ability for rapid and distinct follow up with the patient who may otherwise be difficult to reach. Buy-in discussions with HIE participants and requirements gathering commenced in preparation for implementation.

The total amount of incentives paid to SJCHIE in PY2 was $37,868.73. Payment details include:

- July 2017 - $1,687.50 – Scope of Work development, crosswalk, Enrollees in HIE
- August 2017 – $1,108.75 – Metrics, crosswalk, contract, Enrollees in HIE
- September 2017 – $6,066.25 – Onboarding organizations, ED alerts, Enrollees in HIE, policies and procedures
- October 2017 – $11,186.25 – Care Plans, ED alerts, DSA's, content development, Enrollees in HIE, P&P's

- November 2017 – $10,207.50 – Care Plans, ED alerts, DSA's, content development, Enrollees in HIE, P&P's
- December 2017 – $7,612.50 – Care Plans, ED alerts, DSA's, content development, Enrollees in HIE, P&P's

Below is a table that represents the various activities associated with HIE/WPC:

	Date Joined HIE	Patient Volume	Users Trained in 2017	Users Accessing System	2017 Interface Development	2017 Interfaces Live and Managed	Additional Effort
Community Medical Centers	2/24/15	351,008	2	3	None.	Maintained: ADT, ORU, RDE	None.
Health Plan of San Joaquin (HPSJ)	3/3/15	456,126	0	0	Re-built Medical Claims and Prescription Claims file feeds. Implemented Notifications to HPSJ for Emergency Department visits	Maintained: Eligibility file feed.	None.
San Joaquin Behavioral Health Services	3/26/15	6,722	2	2	None.	Maintained: ADT, RDE	None.
San Joaquin General Hospital (SJGH) and **San Joaquin Communi**	3/31/15	144,560	4	2	Complete re-build of ADT and RDE interfaces, new builds of ORU and VXU	Maintained: ADT, ORU (outpatient), RDE	Planning commenced for inclusion of analytics and reporting initiative that will assist WPC reporting

ty Clinics (SJCC)					interfaces. Work expected to complete by April 2018 upon EHR transition at SJGH.		requirements and metrics tracking
Stanislaus County Human Services Agency (HSA)	12/19/16	15,917	0	0	Built out new ADT and ORU feeds, User Acceptance Testing completed in January 2018.	Live: ADT, ORU	Testing.
Stanislaus County Behavioral Health and Recovery Services (BHRS)	12/19/16	0	2	4	Developing notifications pilot between Stanislaus HSA and BHRS, currently on hold pending BHRS system upgrades.	N/A	Test and implement notifications between HSA and BHRS for patients seen by both entities.
Golden Valley Health Centers (GVHC)	1/1/17	48,370	4	0	Completed new build of ADT, ORU, and RDE feeds in 2017.	Live: ADT, ORU, RDE	Troubleshooting RDE data import into HIE system
Livingston Community Health	4/13/17	0	0	0	None.	N/A	Build out ADT, ORU, and RDE feeds.

County of Merced	8/15/17	0	0	0	None.	N/A	County in process of procuring/implementing new EHR and ePCR systems.

Patient Advocate/Navigator
Part of the original vision of the SJC WPC Pilot included an incentive to be issued to a provider in successfully facilitating with assisting monolingual patients through necessary administrative processes (i.e., applications, linkage, documentation, etc.). Although our Pilot does have several enrollees who speak multiple languages, we have not encountered a situation in which an enrollee is monolingual requiring us to access these services. We will likely request an Adjustment for PY4 if there is an opportunity to do so as we do not anticipate utilizing these funds or services in a significant way in PY3.

Clinic Patient Services for Patient Navigation
Another part of the original SJC WPC Pilot vision upon completion of the initial application included incentive payments to a provider upon successfully reporting the enrollment of eligible Medi-Cal beneficiaries. Due to ramp up and need to identify appropriate staff at San Joaquin General Hospital for front-line staff to interact with patients, assess, and refer to WPC, there was minimal opportunity to utilize these funds fully. Through PDSA process we identified new opportunities and staff which will allow us to claim funds in PY3.

VII. 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.

Pay for Outcomes: Reporting individuals with a follow-up after hospitalization

One of the most significant challenges facing San Joaquin County is high-risk individuals who are hesitant or resistant to engaging in mental health, substance abuse or regular medical care associated with a primary care physician. These individuals inappropriately over utilize a variety of services throughout the community resulting in significant costs. San Joaquin General Hospital's Emergency Department serves approximately 50,000 patients each year with an average of 500 of the patients with more than five visits. Of those 500 over-utilizers, about 20% utilize the ED more than ten times per year.

SJC's WPC Pilot program proposes to provide timely follow-up with individuals discharged from hospitalization as a Pay for Outcome metric in PY2. In 2017, SJC enrolled 144 beneficiaries. Of the 144 enrollees, SJGH provided the following:

- Inpatient – 34 unique enrollees with 68 inpatient admissions
- Outpatient – 76 unique enrollees with 497 outpatient visits
- Emergency Department – 87 unique enrollees with 741 ED visits

Of the 34 enrollees who had an inpatient status during PY2 (2017), WPC staff made an attempt to follow-up in a timely way, within seven days, with 91% of the enrollees. Those who went to Recuperative Care (19 of the 34) and stayed more than three days were the most abundant group the WPC team was able to follow-up with. Attempts to follow-up via phone were made to those who did not go to recuperative care with some success. Teams assigned the task of following up with enrollees coming from an inpatient status included BHS Outreach Team (BHS), Community Medical Centers (CMC) staff, and SJGH Population Health staff.

Follow-up by the BHS Outreach Team includes staff going to Recuperative Care as well as known locations where the enrollee spends time (i.e., shelters, encampments, etc.) to meet the enrollee face to face to provide WPC information, obtain consent, and assess enrollee needs. If the enrollee is no longer at Recuperative Care or cannot be located, the BHS team attempts to contact the member via phone. Typically, the BHS team will take the lead with the enrollee who has primarily mental health and/or

substance use issues to provide necessary supports and linkage to services. Similarly, Community Medical Centers Case Managers and Behavioral Health staff also attempt to reach enrollees through Recuperative Care, clinic appointments through CMC, other known locations, or phone. CMC typically takes the lead with members assigned to CMC. Population Health faces the challenge of engaging enrollees face to face because they do not currently have staff that goes into the field. They must rely on engaging enrollees via follow-up clinic visits, over the phone, and more often than not asking BHS and CMC colleagues to make engagements and introductions.

During PY2, the WPC team learned that one of our most significant barriers is the inability of SJGH Population health staff in the field. This barrier is critical because the complex population enrolled in WPC requires the ability to build trust and relationships if we hope to be successful. We also learned that through continuous communication among the WPC Core team we were able to reach more individuals than we initially thought possible based on the lack of trust and transient nature of the population.

VIII. 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.

San Joaquin County Whole Person Care includes several participating entities and/or stakeholders including:

- San Joaquin County Behavioral Health Services (BHS)
- San Joaquin County Public Health Services (PHS)
- San Joaquin County Substance Abuse Services (SAS)
- San Joaquin County Clinics (SJCC)
- San Joaquin General Hospital (SJGH)
- San Joaquin County Correctional Health Services (CHS)
- San Joaquin Community Health Information Exchange (SJCHIE)
- Central Valley Low Income Housing (CVLIH)
- Community Medical Centers (CMC)
- Dignity Heath St. Joseph's Medical Center (SJMC)
- Gospel Center Rescue Mission (GCRM)
- Health Net
- Health Plan of San Joaquin (HPSJ)
- Housing Authority of the County of San Joaquin

In Quarters 3 and 4 San Joaquin County Whole Person Care Pilot facilitated many meetings. The purpose of the sessions included staffing, metrics, PDSA's, reporting, contracts, MOU's, policies and procedures, enrollment, Homeless Management Information System, and a variety of other topics. By year-end, we implemented three standing meetings, the Lead Entity meeting, Operations meeting, and HUDL team meeting.

The Lead Entity meetings consisted of Executive and Upper Management from Health Net, Health Plan San Joaquin (HPSJ), Behavioral Health Services (BHS), Central Valley Low Income Housing (CVLIH), Community Medical Centers (CMC), Correctional Health Services (CHS), San Joaquin General Hospital (SJGH), San Joaquin Community Health Information Exchange (SJCHIE), Housing Authority, Public Health Services (PHS), St. Joseph's Medical Center (SJMC), and Gospel Center Rescue Mission (GCRM). The purpose of these meetings is to update participating entities regarding

WPC, discuss upcoming changes, engage in discussion regarding operations, concerns, needs, resources, metrics, and sharing of other requested topics.

The Operations meetings include Clinician(s), Staff Nurse(s), Deputy Director(s), LVN (s), RN(s), and other staff from CMC, BHS, GCRM, CHS, HPSJ, SJGH, SJCHIE, SJMC, and PHS. The purpose of the Operations meeting is to provide a platform for those working with enrollees to discuss barriers, successes, policies, procedures, and workflows. It also allows the team to give a real perspective of what is happening with the program and enrollees, help identify and gain diverse views on how to best help the population, identify opportunities to increase capabilities, and support each other.

The HUDL Team meetings included the Director of Behavioral Health at CMC, the Mental Health Clinician Supervisor at BHS, the Deputy Director of BHS, a Clinical Social Worker from SJGH, an RN from SJGH, an LVN from SJGH, a Staff Nurse Supervisor from SJGH and a Mental Health Clinician Supervisor from CHS. The purpose of the HUDL Team meetings was to bring a small team together to discuss policies and procedures at a deeper level, create appropriate documentation for all staff, discuss challenges and successes both with the Pilot and with enrollees.

(See attached for a list of meetings and topics – "PY2 WPC Meeting Summary for Reporting")

IX. PROGRAM ACTIVITIES

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

1) We began establishing the workflow between Gospel Center Rescue Mission Recuperative Care and WPC enrollees. We executed a contract allowing WPC to pay GCRM Recuperative Care for beds and services. Having an ability to enroll people referred from an in-patient status who need recuperative care and meet the WPC criteria allowed enrollees an opportunity to recover, receive support, and often avoid readmission and ED visits.

2) WPC Admin staff worked with BHS WPC staff to create workflows to engage the target population, complete assessments, and identify enrollee needs. The workflow included care coordination between WPC Admin, BHS, and other Community Partners to support enrollees. Additionally, the BHS team implemented a Care Plan as part of the workflow to address enrollee strengths, needs, challenges, interventions, and outcomes.

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

1) One of the biggest challenges we faced was that even though there was a concentrated effort to coordinate and collaborate, once enrollees were “assigned” to a Lead organization everyone continued to continue working in silos. We believe part of this challenge stems from a lack of shared technology and hesitation to share data without a Data Sharing Agreement. We learned that we need to be creative with our efforts to coordinate care and share information. We executed a Data Sharing Agreement and created folders in Box as the primary method of sharing documents.

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

1) A data sharing agreement was executed between the Core WPC partners. It was a lengthy and relatively complicated process to determine language that provided the team with the confidence to share information primarily regarding substance use. The sharing allowed team members to share information through secure email and Box.

2) A WPC Consent was executed and implemented. It was often difficult to get consent from enrollees because they are often hard to locate. The team identified strategies to increase opportunities to collect the consent by utilizing each other to collect consent

even if the enrollee wasn't assigned to a particular agency. For example, if an enrollee was in Recuperative Care and Population Health was the primary team working with enrollee, the Population Health staff worked with the Recuperative Care staff to obtain the consent on their behalf.

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

1) The biggest challenge with data sharing were the limitations under Federal laws especially in regards to mental health and substance use. We learned that the team wanted a Data Sharing Agreement (DSA) specific to the partners involved in Operations meetings allowing for discussion about enrollees. Primary agencies worked with Counsel, both at the County and within their organizations, to establish a DSA that included CFR part 2.

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

1) The WPC team developed an understanding of the importance of data collection and reporting. A lot of manual work went into data collection and reporting, but WPC team members worked hard to make it happen.

2) The SJCHIE was actively engaged in working toward a system to report on data. We were able to identify an organization to help with the process and begin work with the company for 2018.

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

1) We did not have a robust system in place to allow us to collect information, share data, or create reports. This challenge led to manual data collection and an inefficient system requiring a large number of staff at multiple entities which was labor and time intensive.

g.) Looking ahead, what do you foresee as the biggest barriers to success for the WPC Program overall?
The most prominent barrier determined for the overall success of WPC Program is sustainability. Each County may find they will encounter varying degrees of this, but for San Joaquin County we see this a significant challenge. Concerns come from the financial perspective, infrastructure, staff turnover, community partner engagement, data sharing, and housing. Creating the infrastructure is critical throughout the Pilot as is engagement. The big concern is that once the Pilot is over, will San Joaquin County be able to find the financial support and continued commitment to continue the efforts.

X. 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 attached PDSA's