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 Health Department
PY2 Annual Report
7/11/2018

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.

Whole Person Care

Monterey County Health Department

PY2 Annual Report

7/11/2018

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.*

Monterey County's program status over is presented below according to WPC STC 112 guidelines:

Increasing integration among county agencies, health plans, providers, and other entities; Hospital Discharge Planners' understanding of WPC

Challenges: Hospitals and emergency departments are overwhelmed with patients who are unsheltered. Discharging staff are enthusiastic about WPC but perceive WPC case managers to have abilities to immediately house unsheltered patients. When WPC was initially launched, case managers and their supervisors conducted a series of face-to-face calls to explain WPC activities, and left a 1-page description of the Pilot with each discharge planner and supervisor they met. Regardless, the perception of WPC as a "housing program" persisted, with discharge staff expecting WPC case managers to come to EDs/hospitals to "pick up" homeless patients.

Successes: While this challenge continues to exist, our relationships with ED staff and discharge planners has grown and deepened. Our safety-net discharge planners now attend our monthly coordination meetings with partners, and we are seeing more collaboration around discharge and housing solutions that ever before. We firmly believe that the WPC pilot has expanded and strengthened the network of health and homeless services providers in our county.

Lessons Learned: Our work to inform ED/hospital staff of our role and abilities will likely be ongoing, as care providers are desperate to get patients into housing while housing inventory is at a historic low. This problem will continue until housing inventory is increased and the types of housing products (such as housing for violent or formerly felony enrollees) is developed. We gratefully have two large section 8-based housing projects under construction that will provide a total of 128 apartments: more than half of these apartments are promised to WPC enrollees.

Increasing coordination and appropriate access to care – Hiring Public Health Nurses and LVNs

Challenges: The County's hiring process cannot be circumvented when staffing is urgently required. Our process included creating new positions, gaining Board of

Supervisor approval, creating new job descriptions, recruitment in a manner to assure diversity, a multi-step hiring process (scan for eligibility, panel interviews to assess qualifications, LiveScan background checks, interviews for selection, and offer/hire).

Successes: Despite hiring delays, our Nurse Case Management Teams are fully staffed with four, 2-person teams, headed by a supervising public health nurse. Teams consist of a public health nurse and an LVN or Behavioral Health Aide.

Lessons Learned: To help resolve the lengthy start-up staffing time, we attempted to cross-train our existing public health nurses in WPC services. We quickly learned that some nurses do not have the skill set to administer to the focus population or are adverse to working in the WPC in-situ environment. This realization underscored the need to make appropriate hires in spite of the lengthy process.

Reducing inappropriate emergency and inpatient utilization – Revised Enrollment Criteria

Challenges: We were finding it difficult to enrollee people in WPC: from January 1 through March 21 2017, we had only enrolled 5 individuals. We concluded that our enrollment criteria was too limited in scope. We also heard from our Continuum of Care agency that they could only house people who were truly homeless – and not those who are at risk for homelessness.

Successes: In the WPC Round 2 application process we discussed our enrollment difficulties with Rachel Hightower, and with her approval, we expanded our enrollment criteria as follows:

> *The initial WPC focus population (high utilizers) will be exclusively homeless and chronically homeless Medi-Cal recipients or Medi-Cal eligible persons (including those released from jail) and having two or more of the following characteristics: diagnosed mental illness, two or more MHU admissions in the prior year, diagnosed substance use disorder, two or more chronic health diagnoses, two or more ED visits within the prior 12 months, one or more hospital admissions within the prior 12 months, or two or more prescribed medications.*

Lessons Learned: Prior to making the above revisions to our enrollment criteria, we had only 5 consented WPC enrollees. With permission from DHCS, using the revised criteria, we were able to enroll 26 individuals by between March 21 and June 30, 2017. The PDSA team decided to permanently adopt the revised enrollment criteria. Our operations team continues to examine enrollment and enrollment criteria to assure that our case management staff is operating at full capacity. Should we find that our enrollment is constricted, we will once again review ways to broaden our enrollment criteria, within the requirements of the WPC program.

Improving data collecting and sharing – Hospital High Utilizer Lists

Challenges: Our safety-net hospital is owned by the county but is separate from the Health Department. We approached our county counsel for guidance on sharing data, and found they were unfamiliar with the WPC approach and the State Health Information Guidelines for data sharing. We met many times discuss what we considered "internal" data sharing, and eventually, our counsel determined that as two entities under the same umbrella, the hospital and health department could share PII and PHI prior to WPC patient consent.

Successes: Toward the end of 2017, WPC and our safety-net hospital were successful establishing a monthly transmission of high utilizers in the ED and hospital, from which we could determine and approach persons eligible for WPC enrollment.

Lessons Learned: We had hoped that DHCS could provider better guidance that would assuage our counsels' concerns, but their primary concern was to avoid risk, and therefore the process took nearly 5 months before the internal data sharing problem was resolved. Our appeals to DHCS for guidance were largely unaddressed.

Achieving quality and administrative improvement benchmarks – Case Management & Case Review

Challenges: We began working in partnerships before fully understanding the strengths and limitations of our partnering organizations. For example, we realized that all our organizations had staff they referred to as "case managers," but the job duties were fundamentally different, one from another. Our solution was to create a master spreadsheet that identified partner agencies and their case manager functions that we shared with all partners to help assure that the most appropriate referrals were being made.

Successes: We implemented monthly meetings with core partners that have helped to build understanding between our various scopes of work, enhance communications, and streamline the ways we work together as a network. We also implemented bi-monthly case review meetings in which our nurse case mangers work with partner agency case managers to confer over our most challenging enrollees to develop specific, individual strategies for care.

Lessons Learned: It took some time in working together in this new WPC capacity before we realized our misunderstandings caused by identical terminology for different functions. All of us now, more frequently, take time to describe functions, processes, and procedures to each other. Additionally, in early 2018, we initiated a quarterly partnership forum through which all partners share their capabilities and limitations, which has allowed us to identify opportunities for greater linkages.

Increasing access to housing and supportive services – Housing Placement through CCCIL

Challenges: The inventory of housing is further impacted in Monterey County as farmworker families (many times multiple families) occupy motel rooms that are used elsewhere for emergency shelters. We have just one emergency shelter in Monterey County (adult women) and a seasonal shelter (men, women, families). The resources to find appropriate housing through our homeless resource day shelter, coalition of care agency, and housing authority overwhelmed their capacities.

Successes: Toward the end of 2017 we began working with the Central Coast Center for Independent Living (CCCIL). CCCIL works with landlords to explain the housing choice voucher process, and assures landlords that through 12-months of supportive services to the tenant, they are less likely to experience turnover and property damage. CCCIL's supportive services include regular check-ins, counseling, and financial and life skills. By early 2018 we had in motion a budget adjustment proposal to contract with CCCIL using WPC funding.

Lessons Learned: We have successfully placed many clients in housing, but the need greatly outweighs the solutions. We are being as creative as we can imagine. If anyone had answers to California's housing affordability, the entire state would be rejoicing. We gratefully have two section 8-based housing project developments coming available in 2019.

Improving health outcomes for the WPC population – Timely Clinic Appointments
Challenges: Monterey County operates 7 primary and specialty care clinics throughout county that treat patients regardless of their ability to pay. The clinics always operate at full capacity and are backlogged; thus, WPC case managers have difficulty obtaining same-day or next-day primary care appointments for WPC-enrollees. Appointments at the county-operated clinics in the City of Salinas, where most of our homeless people reside, are backlogged. A new patient can typical wait months for an appointment. Whole Person Care enrollees have sometimes been lost to follow up by the Salinas clinics where appoints were made. This is especially problematic in that WPC enrollees may be medically vulnerable, may have transportation issues, and when new to WPC, may not yet have had opportunities to build trusting relationships with case managers. Without more immediate actions, our WPC enrollees continued to access the ED.

Successes: By working directly with the Seaside Clinic manager, we were successful in getting our enrollees prioritized for primary care appointments at this clinic which is located 15 miles from Salinas. We provide either direct transportation or bus passes to provide enrollees with timely care. This clinic also has the capacity to accommodate walk-in patients.

Lessons Learned: Monterey County Clinic Services operate on an appointment first-scheduled, first-seen basis as a measure of health equity, and therefore our proposals to prioritize WPC patients across all clinics was not accepted. Our less-impacted clinic approach was more feasible.

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	*	*	*	14	*

Item	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12	Annual Unduplicated Total
Unduplicated Enrollees	*	*	0	*	0	*	44

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
Service 1: Mobile Outreach Team	0	0	0	0	0	0	0
Utilization 1: $532.79	0	0	0	0	0	0	0
Service 2: Housing Placement Services	0	0	0	0	0	0	0
Utilization 2: $77.28	0	0	0	0	0	0	0
Service 3: Targeted Outreach	0	0	0	0	0	0	0

Utilization 3: $287.58	0	0	0	0	0	0	0
Service 4: Sobering Center	0	0	0	0	0	0	0
Utilization 4: $216.65	0	0	0	0	0	0	0
Service 5: Homeless Persons Peer Nav	0	0	0	0	0	0	0
Utilization5: $40.00	0	0	0	0	0	0	0

FFS	**Costs and Aggregate Utilization for Quarters 3 and 4**						
	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12	Total
Service 1: Mobile Outreach Team	0	0	0	0	0	0	0
Utilization 1: $532.79	0	0	0	0	0	0	0
Service 2: Housing Placement Services	0	0	0	0	0	0	0
Utilization 2: $77.28	0	0	0	0	0	0	0
Service 3: Targeted Outreach	0	0	0	0	0	0	0
Utilization 3: $287.58	0	0	0	0	0	0	0
Service 4: Sobering Center	0	0	0	0	0	$433.30	$433.30
Utilization 4: $216.65	0	0	0	0	0	2	2
Service 5: Homeless Persons Peer Nav	0	0	0	0	0	0	0
Utilization5: $40.00	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.

PMPM		**Amount Claimed**						
	Rate	Month 1	Month 2	Month 3	Month 4	Month 5	Month 6	Total
Bundle #1: Community	$333.33	$*	$*	$*	$4,999.95	$5,666.61	$9,999.90	$24,999.75

Based Case Mgmt Svcs								
MM Counts 1	600	*	*	*	15	17	30	75
Bundle #2: Complex Care Mgmt Team	$988.75	$*	$*	$*	$14,831.25	$16,808.75	$29,662.50	$74,156.25
MM Counts 2	600	*	*	*	15	17	30	75
Bundle #3: Hot Spotting Team	$413.00	0	0	0	0	0	0	0
MM Counts 3	480	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: Community Based Case Mgmt Svcs	$333.33	$11,999.88	$12,666.54	$12,666.54	$11,333.22	$10,333.23	$10,999.89	$69,999.30
MM Counts 1	600	36	38	38	34	31	33	210
Bundle #2: Complex Care Mgmt Team	$988.75	$35,595.00	$37,572.50	$37,572.50	$33,617.50	$30,651.25	$32,628.75	$207,637.50
MM Counts 2	600	36	38	38	34	31	33	210
Bundle #3: Hot Spotting Team	$413.00	0	0	0	0	0	0	0
MM Counts 3	480	0	0	0	0	0	0	0

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

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.

Administrative Infrastructure updates since June 30, 2017 are these:

- All administrative infrastructure staff are hired and trained.
- The budgeted vehicle for transporting enrollees to health and social services appointments has been purchased. A van capable of loading up and transporting enrollees in an electric wheelchair is available to WPC staff as needed.
- WPC Nurse Case Managers now have access to AVATAR, EPIC, and Meditech data systems.
- Laptops for Nurse Case Managers have been purchased.
- Four WPC staff traveled to the October in-person convening: Project Director, Project Manager, Supervising Nurse Case Manager, and Epidemiologist.
- Of the $100,000 budgeted in PY2 for Legal Services, $90,000 was rolled over to PY3. This line item is for legal services relating to data sharing and software agreements that will be needed to facilitate comprehensive case management, and therefore, the expenditure of these funds are linked to the purchase of IT solutions. An RFP for an electronic Master Person Index was issued in October 2017 and responses are currently under review. When a vendor is selected, legal services will be needed to assure that the processes and procedures for data exchange between all parties (hospitals, clinics, public health, behavioral health, and our Medi-Cal provider) are done in compliance with federal law.

The WPC Operations Committee meets monthly to discuss the overall operations of the program. The participants include Monterey County Health Department executive leaders many of who oversee staff that are part of our WPC Social and Clinical Committee. 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, and quality improvement efforts.

Participants are:

Chombo, Fabricio, Finance Manager, Administration Bureau
Corpus, Carol, Deputy Public Health Bureau Chief, Public Health Bureau
House, Sarah, Departmental Information Systems Manager, Health IT
Kim, Nan, Clinic Services Management Analyst, Clinic Services Bureau
Lewis, Moira, Supervising Public Health Nurse, Public Health Bureau

Leyva-Reyna, Ana, Whole Person Care Program Coordinator, Administration Bureau
Miller, Amie, Behavioral Health Director, Behavioral Health 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

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.

Delivery Infrastructure updates since June 30, 2017 are these:

- The entire allocated budget of $193,500 for case management software purchase was rolled over into PY3. An RFP to develop a master person index was issued.
- WPC is now funding the CARS/HMIS for staffing, operations, software licensing, training, and hardware costs.
- Our 8-bed, 24/7 Sobering Center opened in December 2017. We rolled over to PY3 the approved budgeted amount of $117,833 for facility modification as our vendor leased space rather than purchase space that needed renovation, as planned. The vendor expects to purchase and renovate a building in PY3 or PY4.
- Our approved Mobile Outreach Team budget was split in PY2 with 50% in **Delivery Infrastructure** (startup costs) and 50% in FFS. These amounts were fully rolled over into PY3 because the vendor we believed would provide this service was uninterested. In PY3 we hope to find another provider or issue an RFP for the service or will request a reallocation of these funds in PY4.

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.

Incentive	Payment Trigger	Attainment	Achievement	Total $	Entity Paid
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.	Partial	12 WPC enrollees had primary care clinic appointments within 30 days of their hospital discharge	$240,000.00	Monterey County Health Department Clinic Services Bureau
Primary Care Clinics Incentive comments: As this is the first report, there are no updates or trends to report. At the time of our application we anticipated claiming as many as 20 enrollees, therefore, we achieved 12/20 (60%) of our anticipated goal. We have a much more robust enrollment in 2018 and expect greater achievements to be reflected in our 2018 mid-year and annual reports.					
Hospital Incentive	Natividad Medical Center (NMC) will be eligible for $20,000 per WPC enrollee successfully linked to	Partial	11 WPC enrollees were not readmitted to NMC within 30 days of their hospital discharge	$220,000.00	Monterey County Health Department Public Health Bureau (as reassigned by NMC)

	care coordination without a readmission within 30 days. Biannual payments will be made.				
Hospital Incentive comments: As this is the first report, there are no updates or trends to report. At the time of our application we anticipated claiming as many as 20 enrollees, therefore, we achieved 11/20 (55%) of our anticipated goal. We have a much more robust enrollment in 2018 and expect greater achievements to be reflected in our 2018 mid-year and annual reports.					
Behavioral Health Incentive	Behavioral Health Clinics will receive $20,000 per WPC enrollee scheduled for and successful participation in follow-up appointment within 30 days post discharge or release.	Partial	* WPC enrollees had behavioral health appointments within 30 days of their hospital discharge	$*	Monterey County Health Department Behavioral Health Bureau
Behavioral Health Incentive comments: As this is the first report, there are no updates or trends to report. At the time of our application we anticipated claiming as many as 20 enrollees, therefore, we achieved * of our anticipated goal. We have a much more robust enrollment in 2018 and expect greater achievements to be reflected in our 2018 mid-year and annual reports.					
Enrollment/re-enrollment of individuals transitioning from Jail (Round 2)	Behavioral Health Clinics will receive $2,000 per	Not Attained	0 (no WPC enrollees were discharged	$0.00	Monterey County Health Department Behavioral

	enrollment/re-enrollment upon completion of an initial assessment. Limited to one payment per enrollee per 12-month period.		from jail in PY2)		Health Bureau

Jail Transition Incentive comments: As this is the first report, there are no updates or trends to report. At the time of our application we anticipated claiming as many as 56 enrollees – this was obviously an overestimation, at least for 2017. We did not have any enrollees become incarcerated and transitioned out of jail in 2017, but with a more robust enrollment, we may see this occurrence in 2018. We have a communication pathway between our Director of Nursing and the Sheriff jail staff.

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.

Successes:

- Of the 5 health outcomes included in the Pay for Outcomes section our agency met four of those that could be billed in PY2. They include:
  - **Suicide Risk Assessment** for WPC enrollees. Target: 60%. Achievement: 80%
    - **Achieved: 11/13** enrollees were assessed by a behavioral health clinician for suicide risk to identify appropriate care coordination for therapy, social supports, and other suicide preventative services.
    - **Challenges:** By mid 2017 we realized that clinician data being logged into AVATAR was not being extracted by our data analysts, mostly because we did not have a standard way of recording the suicide risk assessments as they are part of a larger, comprehensive set of assessments. We suspect that all 13 enrollees had suicide risk assessments – we just didn't have the data to prove that.
    - **Lessons Learned:** Our Behavioral Health IT staff conferred with the behavioral health clinicians to determine a means of recording the suicide risk assessment in a way that is retrievable by IT.
  - **Coordinated Case Management** of those enrolled. Target 25-40%. Achievement: 66%
    - **Achieved: *** 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:** Because of the length of time needed to hire nurse case management staff, MCHD was not able to rapidly enroll in 2017, and therefore had only * enrollees who were eligible for 12 months of case management in 2017. We were fully staffed later in 2017. We also applied for and were approved for a broader interpretation of our original eligibility criteria, thereby making enrollment easier to achieve.
  - **Comprehensive Care Plan for Enrollees**. Target: 50%. Achievement: 86%.
    - **Achieved**: **38/44** 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.
- **Tobacco assessment and counseling for those enrolled**. Target: 90%. Achievement: 100%.
    - **Achieved: 31/31** enrollees who used tobacco products received an assessment from public health nurse case managers for tobacco use and counseling from public health nurse case managers for tobacco cessation.
    - **Challenges:** none.

- **Mental/medical/SUD appointment.** Target: 80%. Achievement: 80%.
    - **Achieved: *** 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 sometimes difficult to get a client to agree to a behavioral health and/or SUD appointment within 30 day of hospital discharge.
    - **Lessons Learned:** Our nurse case managers understand that building trust is imperative to providing WPC enrollees with services, and with more interaction with WPC enrollees, have further developed trust-building skills with our enrollees.

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.

WPC Social and Clinical Committee meets bi-weekly 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:

Allen, Jill, Executive Director, Dorothy's Place, homeless services provider
Anderson, Patrick, Epidemiologist, MCHD Emergency Medical Services Bureau
Fenton, Jennifer, Behavioral Health Unit Specialist, MCHD Behavioral Health Bureau
Hanni, Krista, Planning Evaluation Policy Unit Program Manager, MCHD Administration Bureau
Lewis, Moira, Supervising Public Health Nurse, MCHD Public Health Bureau
Leyva-Reyna, Ana, Whole Person Care Program Coordinator, MCHD Administration Bureau
Martinez, Solomon, Behavioral Health Aid, 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
Petrie, Michael, EMS Bureau Chief, MCHD Emergency Medical Services
Rager, Melanie, Care Management Director, Central Coast Alliance for Health, managed care plan
Romero, Begonia, Outpatient Services Manager II, Natividad Medical Center
Romero, Maria, Clinic Operations Supervisor, Natividad Medical Center
Rubalcava, Ahkahuil, Public Health Nurse, MCHD Public Health Bureau
Thoeni, Katherine, Executive Officer, Coalition of Homeless Services Providers
Voss, Robert, Epidemiologist, MCHD Administration Bureau

Zerounian, Patricia, Whole Person Care Program Manager, MCHD Administration Bureau

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

Meeting Date	# of Attendees	Primary Discussion Topics
1/31/17	15	Sharing descriptions of partner agencies and services
3/20/17	12	Review committee role and functions; establish a meeting schedule. Review draft enrollment form and workflow for nurse case management processes
4/24/17	13	Review health metrics. review Participant eligibility and referral form. Continue discussing work flow for nurse case management processes. Discuss creation of logo, business cards, and materials for website
5/8/17	11	Revised referral form, updated workflow, WPC participant enrollment numbers, discussion on capacity to enroll participants.
5/22/17	10	Data Sharing, MOUs, WPC enrollment numbers, common vulnerability assessment tool, consent to share data forms
6/12/17	13	Data sharing agreements, priority for WPC enrollees at MCHD clinics, WPC enrollment numbers, Success Stories and challenges.
7/17/17	14	Success stories and barriers, WPC enrollment numbers, further discussion about appointment priority for WPC enrollees at MCHD clinics, priority for WPC enrollees at behavioral health clinics and on housing lists, update on consent, referral, and referral response forms, difficulties getting county counsel approval on data sharing agreements.
8/14/17	10	Success stories and challenges, WPC enrollment numbers, request to Housing Authority to prioritize WPC enrollees, WPC case management staffing difficulties, discussion on issuance of population health software RFP and estimated “go live” dates.
8/28/17	9	Success stories and challenges, WPC enrollment numbers, prescreening for eligibility prior to making a WPC referral, potential collaboration and data

			sharing with EMS, WPC enrollee referrals to new housing project.
	9/25/17	12	Success stories and challenges, WPC enrollment numbers, new case review format and potential attendees to case review meetings, continued work with hospital discharge planners who see WPC as a housing program, development of a case management database tool for the day center, discussion of pending RFP for case management software, newly filled staff positions, website document translations into Spanish.
	10/9/17	11	Success stories and challenges, WPC enrollment numbers, housing placement challenges, the use of WPC peer visitors at hospitals, CCAH funding for intensive case management at MCHD primary care clinics.
	10/23/17	9	Success stories and challenges, WPC enrollment numbers, positions yet to be filled, expanded referral sources, quality improvement at the system and operational levels, discussion of a case manager forum in the spring.
	11/13/17	10	Success stories and challenges, WPC enrollment numbers, new staff introductions, positions pending to be filled, housing placement challenges and barriers, case manager use of wheelchair van, cars, and phones, use of new case review tool, update on peer navigator program development, protocols on nurse case manager safety, work on updating WPC network contact list, input on PDSA topics.
	12/11/17	16	Success stories and challenges, WPC enrollment numbers, new staff introductions, positions pending to be filled, EMS high utilizer data presentation, progress on the development of a homeless resource matrix and nurse case manager field guide, update on peer navigator scope of work.

IX. PROGRAM ACTIVITIES

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

(1)The list of our service collaborators in both the governmental and nongovernmental sectors continues to grow. We have conscientiously outreached to more and more collaborative partners and as the word has gotten spread, the result has had a positive impact on the pilot. Through this successful collaboration, Whole Person Care (WPC) enrollees are becoming prioritized in various medical and behavioral health clinics. One hundred percent (100%) of our clients are medically complex, sixty eight percent (68%) have mental health or substance use disorders or both, and seventy six percent (76%) have been connected to housing at least once.

(2) Raising the standards of care in case management within WPC and across the county network has been a goal. Training for the WPC Nurse Case Management Teams and our community partners includes Crisis Prevention Institute training for Verbal Intervention, de-escalation and safety in the community, administering VI-SPDAT assessments, understanding Adverse Childhood Experiences (ACEs), Motivational Interviewing, training for Adult Protective Services, Depression Screening (PHQ9), Domestic Violence, Medi-Cal *C 4 Yourself*, and Mandated Reporter Training. Nurse Case managers are visiting community partners to continue to build a sustainable collaboration.

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

(1) The diplomatic dismantling of siloes has been our greatest challenge. What we have learned is that there are people within each clinical/ field, non-clinical, governmental, and nongovernmental agency who have long identified siloes as a problem. Consequently, across sectors, we have partners who are working hard to have a unified approach to WPC enrollees that not only eliminates the siloes, but the duplication of services.

(2) Housing remains a challenge, not only the paucity of it, but the nature of how clients qualify for that housing. Many of the program's Highest Use/Highest Cost clients have conditions of Substance Use Disorder that do not respond to treatment and Severe Mental Health conditions that stand in the way of getting and keeping continuous housing. Efforts on the part of the county and its partners to find and built more available units is strong and concerted. However, the concept of *Housing First*, an approach to quickly connecting clients to permanent housing without preconditions such as sobriety could be considered if plausible.

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

(1) The WPC need for sharing enrollee SUD treatment data between behavioral health clinicians and WPC nurse case managers conflicts with the DHCS WPC data collection requirements. We are actively meeting to trying to and understand the State's needs.

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

(1) Our work-around for gaining SUD information is time consuming. We hope the 5/22 data sharing meeting will help our county counsel better understand the State's needs for sharing WPC-enrolled SUD treatment episodes with WPC case managers. We hope the state will provide clear direction to counsel to resolve the SUD data sharing privacy conflicts. UPDATE: the 5/22 data sharing meeting with our county counsel was difficult and no resolution was found. We had already presented the State Health Information Guidance and data sharing agreements that we obtained from other counties, but our arguments did not prevail. We again appealed to our DCHS team for guidance, and we were told the problem was ours to solve. Lesson Learned: quite a letdown from DHCS: we know we signed an agreement with the state, but the state is asking us to find a way to share SUD which our county counsel finds illegal. This matter remains unresolved and SUD information is not available to our nurse case management teams and our coordinated partners.

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

(1) Our vendor for PMPM Community-based Case Management Services did not have a computer-based system for tracking clients and their related services. All records were kept on paper and in files. We created a web-based database case management system for this vendor that was launched at the end of 2017.

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

(1) Our vendor for PMPM Community-based Case Management Services did not have a computer-based system for tracking clients and their related services. All records were kept on paper and in files. We created a web-based database case management system for this vendor that was launched at the end of 2017.

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

The single greatest barrier to success for the WPC program is the lack of shelter beds and every type of transitional, supportive, and permanent housing product. California has the highest rents and real estate prices in the nation and one-quarter of the nation's homeless population live here. Local, state, and federal governments need to incentivize the construction of housing for people who are homeless and those who additionally have mental illness diagnoses. We are having some success with project-based Section 8 housing strategies that are being built by nonprofit organizations with a variety of tax credit plans, but the gamut – from city to county to counties to states is very difficult to navigate in a productive manner, hence, adequate shelter, transitional, supportive, and permanent housing is severely lacking.

We can't do Housing First if there is no housing.

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.

1. Boarden WPC Criteria
2. Prioritizing WPC at Seaside Clinic
3. Who does PHQ-9?
4. Match WPC Enrollment Criteria of CofC Housing Requirements
5. Reassess Boarden WPC Enrollment Criteria
6. Define WPC for Hospitals
7. Comprehensive Care Plan format
8. Reassess Match WPC Enrollment Criteria of CofC Housing Requirements
9. Reassess Prioritizing WPC at Seaside Clinic
10. Reassess Define WPC of Hospital
11. Reassess Comprehensive Care Plan format
12. Reassess Who does PHQ-9?
13. Soliciting EMS Frequent User Data
14. Examining EMS Frequent User Data
15. Obtain a high cost/high user list
16. Work-around to obtain high cost/high user list
17. How to transport wheel chair-bound enrollees to clinic appointments?
18. Solution for transporting wheel chair-bound enrollees to clinic appointments
19. Making Housing Stick
20. How to expand prioritization for clinic
21. Solution for expanding prioritization for clinic appointments