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

Napa County Whole Person Care
Annual Report (PY3: January – December 2018)
April 1, 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.)* ☐ 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
Napa County WPC
Annual Report, PY3 (January – December 2018)
April 1, 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.

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.*

In 2018, Napa's WPC pilot continued to build operational systems and infrastructure, as the pilot operations started in the second half of 2017. In the latter half of 2018, Napa brought PMPM services to smooth operations, developed and implemented a client Release of Information, launched respite care services and launched SOAR benefits advocacy services. In 2018, Napa's pilot served 293 homeless clients and was able to house 55 households. Key accomplishments and operational challenges are outlined below.

Increased access to housing and supportive services:
As a housing-focused pilot, access to housing is essential for the success of Napa's program. The pilot realized significant gains in securing housing resources, though high-volume housing placement continues to be a challenge, particularly after Napa's fire disaster in October of 2017.
Key successes include:

- Coordinated Entry System launched on mid-2017. By the end of calendar year 2018, CES had 293 households enrolled and 65 households housed in 18 months. Of the 65 households housed, 45 were WPC households.
- Successful application for new capital and subsidy dollars from California Homeless Emergency Aid Program (HEAP) and California Emergency Solutions and Housing (CESH) Program .
- Successful application for Mainstream Vouchers to serve chronically homeless clients, resulting in the award of 11 vouchers for Napa residents.
- Successful negotiation of five set-aside housing units in two housing projects, with MOU's in place.

Operational Challenges
The implementation of WPC in Napa coincided with a comprehensive redesign of Napa's Homeless and Supportive Housing Services system. Homeless system redesign included bringing in a new provider, development of a flexible housing subsidy pool, transitioning to a low barrier shelter, development of a Coordinated Entry System, developing stronger working relationships with local health and behavioral health providers, recruitment and engagement of landlords. These and

other efforts were designed to make the homeless services and supportive housing system more effective in finding, meeting the needs of and housing homeless households. Implementation of that work supported the goals of the Napa WPC Pilot and, at the same time, created strain on the administrative and delivery infrastructure of the homeless system in general and the WPC Pilot specifically.

In PY3, Napa was a year and a half into the implementation of the Napa WPC Pilot. Although the Pilot expected to be further along in systems implementation, Napa continued in some aspects of the Pilot to work on building the infrastructure necessary to deliver services to WPC eligible clients and to collect and track data from those encounters.

Chief among the areas in which the Pilot did not make the progress hoped for are:

- Tracking and reporting on Alcohol and Drug Services (ADS). Napa County Health and Human Services Agency (HHSA) provided services to Medi-Cal clients that were not billed to Medi-Cal. However, the pilot's supporting documentation in PY3 does not establish that those delivered services were necessarily provided to WPC enrolled clients. Therefore, the pilot did not develop the systems that would allow billing this on a Fee For Service basis. Napa billed $85,362 in our mid-year invoice for these services. The year-end invoice includes a charge for negative $85,362 for these services resulting in a zero balance for these services.
- Tracking and reporting on Mental Health (MH) Support Services. HHSA provided services to Medi-Cal clients that were not billed to Medi-Cal because they were services not eligible for Medi-Cal reimbursement. However, supporting documentation in PY3 establishes that only a very small percentage, less than 4%, were provided to WPC enrolled clients (those costs will be claimed through new Delivery Infrastructure lines proposed in this annual report narrative and related template). Therefore, the pilot did not provide the amount of MH support services to WPC enrolled client it had originally intended. Napa billed $182,676 in our mid-year invoice for these services. The year-end invoice includes a charge for negative $182,676 for these services resulting in a zero balance for these services.
- Tracking and reporting on Multi-Disciplinary Care Unit Support Services. HHSA staff provided services to Medi-Cal eligible clients that were not billed to Medi-Cal. The Pilot made strides in developing a documentation system in HMIS to track services provided to Medi-Cal eligible clients in the first half of PY3. However, later in the program year the County experienced a significant staffing shortage in this workgroup/unit, and subsequently redesigned the service offering. At this time, it is unlikely the MDCU service group will be re-constituted. In addition, grant funding has provided for a full-time staff person at the Shelter to conduct screenings and refer all clients – including WPC enrollees – to needed services. Napa billed $122,603 in our mid-year invoice for these services. The year-end invoice includes a charge for negative $65,012 for these services resulting in a balance of $57,591 billed for these services.

- Tracking and reporting on Ole Health Coordinated Clinic Services. OLE Health operates clinics at the Health and Human Services Agency Campus, the adult shelter and, when it was a stand-alone site, the day use center. However, the pilot's supporting documentation in PY3 does not establish that those delivered services were necessarily provided to WPC eligible clients. Therefore, the pilot did not develop the systems that would allow billing this as on a Fee For Services basis. Napa billed $78,026 in our mid-year invoice for these services. The year-end invoice includes a charge for negative $78,026 for these services resulting in a zero balance for these services.
- Tracking and reporting on Sobering beds – HHSA believes that our contractor provided sobering services to Medi-Cal eligible clients that were not billed to Medi-Cal. However, the pilot's supporting documentation in PY3 does not establish that those delivered services were necessarily provided to WPC enrolled clients. Therefore, the pilot did not develop the systems that would allow billing this as on a Fee For Services basis. Napa did not bill for these services in our in our mid-year or annual invoices.

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	**23**	**1**	**12**	**13**	**50**	**14**	**113**

Item	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12	Annual Unduplicated Total
Unduplicated Enrollees	24	17	7	16	23	14	214

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
Respite Care $115	$0	$0	$0	$0	$0	$0	
Utilization	0	0	0	0	0	0	0
Detox/Sobering	$0	$0	$0	$0	$0	$0	$0
Utilization	0	0	0	0	0	0	0
Multi-Disciplinary Care Unit $729	$ 5,832	$ 4,374	$ 5,832	$ 9,477	$ 5,103	$ 12,393	$ 43,011
Utilization	8	6	8	13	7	17	59
Respite Care $115	$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
Respite Care $115	0	0	0	$1,265	$20,355	$30,130	$51,750
Utilization				11	177	262	450
Detox/Sobering	0	0	0	0	0	0	0
Utilization							
Multi-Disciplinary Care Unit $729	$ 9,477	$ 5,103	$ -	$ -	$ -	$ -	$ 57,591
Utilization	13	7	0	0	0	0	79

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
Mobile Engagement	$650	$ 32,500	$ 31,850	$ 33,800	$ 42,250	$ 53,950	$ 48,100	$ 242,450
MM Counts		50	49	52	65	83	74	**373**
Coordinated Entry	$776	$ 46,560	$ 47,336	$ 48,112	$ 56,648	$ 59,752	$ 58,200	316,608
MM Counts		60	61	62	73	77	75	**408**
Tenancy Care	$191	$ 1,146	$ 1,337	$ 1,719	$ 1,719	$ 2,865	$ 4,584	$13,370
MM Counts		6	7	9	9	15	24	**70**
SOAR	$510	$0	$0	$0	$0	$0	$0	$0
MM Counts		0	0	0	0	0	0	**0**

MM Counts								
PMPM	Rate	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12	**Total**
Mobile Engagement	**$650**	$50,050	$49,400	$47,450	$42,250	$50,700	$55,900	**$538,850**
MM Counts		77	77	73	65	78	86	**829**
Coordinated Entry	**$776**	$ 67,512	$ 69,840	$ 62,080	$ 55,872	$ 65,960	$ 67,512	**$705,384**
MM Counts		87	90	80	72	85	87	**909**
Tenancy Care	**$191**	$ 5,539	$ 6,494	$ 7,067	$ 6,303	$ 8,404	$ 8,213	**$55,390**
MM Counts		29	34	37	33	44	43	**290**
SOAR	**$510**	$1,020	2,550	$3,060	$$5,610	$4,080	$1,020	**$17,340**
MM Counts		2	5	6	7	7	7	**34**

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

The Napa pilot has been focused on steadily increasing enrollment during this reporting period and getting the program up to full capacity. Since July of 2017, when the program launched, the pilot has done well with identifying, engaging and enrolling clients, but a number of clients are subsequently dis-enrolled for a number of different reasons, which include Medi-Cal eligibility issues, refusal of services and moving out of county. The pilot has taken steps to address each of these issues, though we still anticipate enrollment fluctuations throughout the duration of this pilot, and therefore fluctuations in service bundle enrollment and services utilization.

Please note: in the unduplicated enrollee chart above, January includes the total number of new enrollments plus continuing enrollees from 2017, as January started a new program year. Thereafter, the numbers represent new enrollees only. The total represents unduplicated people enrolled in the program by month and across months from January-June and then July-Dec of 2018.

For PMPM services, the SOAR contract has finally been executed with CARE Network, after extended delays, so we initiated enrollment in the second half of 2018. Tenancy Care was lower than anticipated due to some difficulty placing clients into housing, but significant progress was made toward getting this bundle up to projected

enrollment levels in the second half of the reporting period. Enrollment in the Mobile Engagement and Coordinated Entry bundles were equal to or higher than projections.

In FFS, the contract for respite care is complete and utilization under WPC began in October 2018. Due to the Drug Medi-Cal waiver and the structure of the sobering services, we will no longer offer FFS sobering services under WPC, as Medi-Cal now covers the cost of those services. We therefore have eliminated this FFS item from our budget via budget adjustment.

Finally, FFS that are services paid with county match are those non-Medi-Cal billable services used by the Medi-Cal eligible population, per the pilot's original program budget. Those expenses are reflected in our program invoice.

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.

Although the program was projected to be fully operational by the first January 2018, delays meant some launch activities and program improvement took place during the latter half of this program year, and continue in PY4.
Successes from the year include:

- Added data from Behavioral Health and Medi-Cal to provide comprehensive and linked data for baseline reporting. This was achieved with WPC budget support for additional resources.
- Worked with HHSA Self Sufficiency to design a system to monitor Medi-Cal enrollment.
- The pilot's evaluator launched evaluation activities, hosting Community meetings to review data with community partners and stakeholders.
- Worked closely with Napa's MCO to trouble-shoot data sharing, including making revisions to the Release of Information (ROI) and to initiate the process of coordinating care.
- Spent considerable time in 2018 identifying and vetting care coordination/case management platforms.
- County IT supported the development of a "data warehouse," which serves as a repository and data-matching tool that supports care management and produces data for WPC metrics reporting.
- Napa continued to explore implementation of a care coordination platform, including the possibility of subcontracting with Queen of the Valley. Napa hopes to complete implementation in the first half of 2019.
- Created dashboards to display program metrics to help monitor and identify issues with enrollments and service delivery.

Challenges:

- A primary infrastructure challenge involved data sharing with the Pilot's MCO, Partnership Health Plan (PHP). New data sharing policies at PHP led to them to decline to accept the original ROI used by the Outreach and Engagement Team. This required the team to develop and vet a new ROI, then have all clients re-sign the ROI. The time involved in this work resulted in a significant delay in getting data from PHP and in submitting that data to DHCS. By year-end, Napa had still not secured new ROIs from all WPC participants.

- Two Napa WPC staff members resigned in 2018. One was the data lead and had done a considerable amount of work organizing data acquisition, reporting and evaluation. Losing that staff created significant holes in Napa's Pilot. The WPC Project Manager also resigned in 2018, leaving behind a significant amount of unfinished work for year-end invoicing and reporting.

- Napa has experienced delays in a few key elements of the program, including acquisition of a care coordination/case management software, executing a contract with our care coordination partner, and contracting with our SOAR services provider. The SOAR contract is in place and services launched, the other two remain delayed. The delays are due to the complexity of data sharing and needing to establish a PMPM for complex care management to support the contract.

V. NARRATIVE – Delivery Infrastructure

Napa's WPC program delivery infrastructure provides staffing support for and with the goal of full program enrollment. It also supports the development of a care coordination technology infrastructure and program evaluation.

The primary PMPM services contractor, Abode Services, began program enrollment on July 1, 2017. During and since that time, the pilot has worked with Abode to ensure hiring of necessary service staff; provide policies, procedures and training; enroll clients into WPC Bundles and Fee-For-Services. In addition, lead entity delivery infrastructure staff have provided operating oversight for other major initiatives in Napa's homeless system that support WPC, including the operationalizing of Napa's Flex Pool, Shelter and Coordinated Entry System (CES) access points, and administering housing resources within CES. During this reporting period, Abode focused on bringing PMPM enrollments up to capacity, ironing out referral pathways, and connecting WPC clients to housing and services.

Also in July 2017, Napa officially launched its CES system after the homeless Continuum of Care approved updated CES policies and procedures developed during the first half of the year. These efforts were led by Napa's WPC Coordinated Entry Manager with support from WPC and system-wide technical assistance consultants. During 2018, 178 clients were enrolled in the CES bundle and 47 CES-enrolled clients were assisted into permanent housing.

Last year, HHSA's plan to contract with our FQHC for the Nurse Case Manager position unfortunately fell through due to the FQHC experiencing considerable staff turnover. To resolve that issue, the pilot negotiated with Queen of the Valley's CARE Network, the care coordination arm of Napa's primary hospital, to access an team of clinical and social work care coordination and complex care coordination staff capable of fulfilling the functions of the nurse case manager. This adaptive response ultimately gained access to a higher level of support for WPC clients with respect to care coordination. These negotiations took considerable time but, by late 2018, the pilot and QOTV were reviewing final-draft contract language. The pilot intends to have a signed contract in place by mid-2019.

The HMIS Workgroup and Data continued to work on securing a new care coordination technology platform while, in the meantime, relying upon HMIS for care planning activities, monitor WPC enrollment, and track new service programs. The team also is responsible for PDSA cycles around data and care plans.

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.

During the reporting period, Napa partially or completely attained eleven of its incentive goals, as described below.

- **Community Outreach Integration (complete attainment):**
  The pilot held 8 coordination meetings with key stakeholders, including Abode Services, Napa PD Homeless Outreach, and the Multi-Disciplinary Care Unit (MDCU), one per month. **Payment Trigger:** These meetings are documented in the attached agendas/meeting materials.
- **Multidisciplinary Care Unit Migration to HMIS Database (complete attainment):**
  The Pilot successfully migrated key homeless intake information and MDCU data into the Homeless Management Information System (HMIS), allowing for closer collaboration with respect to shared clients and electronic referrals. **Payment Trigger:** Documentation of HMIS Migration.
- **Community Networking Meetings (complete attainment):**
  The Pilot held three community networking meetings, one each in April, June and October. Each meeting focused on one element of PY2 data, and was attended by a broad group of stakeholders, community providers and team members. **Payment Trigger:** These meetings are documented in the attached meeting materials.
- **Medi-Cal Referral and Monitoring System (complete attainment):**
  At any given time, roughly 5-10% of Napa's WPC clients risk disenrollment and their services are unbillable because of an issue with their Medi-Cal enrollment. The Medi-Cal Referral and Monitoring System is designed to prevent WPC participants from being dis-enrolled from Medi-Cal while in WPC, and to ensure any Medi-Cal eligible clients not yet enrolled are supported with Medi-Cal enrollment so they can participate in WPC. **Payment Trigger:** Documented referral and monitoring system process and procedures, outlining steps, staff, timing and evaluation metrics.
- **Creation of WPC Release of Information (complete attainment):**
  Significant work was required to negotiate-draft-attain approval from the diverse range of partners needed to approve a new WPC ROI supporting data-sharing between the MCO, Lead Entity, Partner Organizations and Evaluation entities. **Payment Trigger:** Copy of final ROI.

- **Finalize and execute Data Sharing Agreements with FFS Partners (partial attainment):**
  Contract execution incentive for each of two FFS Partners (detox and respite care entities) at $25,000 each. **Payment Trigger:** Executed data sharing agreement with one of two FFS partners, followed by successful submission of data to Lead Entity.
- **Finalize and execute Data Sharing Agreements with PMPM Partners (complete attainment):**
  Contract execution incentive for each of two PMPM Partners (SOAR and Tenancy Care) at $20,000 each. **Payment Trigger:** Executed data sharing agreement with two PMPM partners, followed by successful submissions of data to Lead Entity.
- **Respite Care Fee-for-Service Contract executed (complete attainment):**
  At the start of PY3, the respite care contract was delayed due to changes in scope negotiated by both parties, as well as the addition of data sharing parameters. The $20,000 incentive was created to ensure barriers to execution were overcome. **Payment Trigger:** Executed FFS Respite Care Contract, followed by successful submission of data to Lead Entity.
- **Whole Person Care Program Monitoring Dashboard (complete attainment):**
  Napa's pilot developed a comprehensive data dashboard, providing a key program monitoring tool to facilitate planning and operations work, using Tableau. **Payment Trigger:** Screenshot of Tableau dashboard (see attached).
- **Housing Case Management (partial attainment):**
  Incentive of $500 for each client who stays in permanent housing for at least six consecutive months. **Payment Trigger:** Report demonstrating housing tenure for 28 clients who retained housing for six months or longer in 2018.
- **Active Involvement in Barrier Identification and Resolution (partial attainment):**
  During the WPC Pilot Program, it is expected participating stakeholder entities identify, capture, and propose solutions to encountered barriers. This allows for process improvement via PDSA cycles. Meetings will be held to review barriers, plan strategies for addressing identified barriers, implement corrective actions to address each barrier, monitor the applied corrective action for efficacy, and adjust each action according to observed results. **Payment Trigger:** Attendance at meetings for 184 units as documented in agendas/meeting materials.

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.

Baseline-related metrics were shifted into PY3 per guidance from DHCS. The pilot achieved four of five possible measures/outcomes in PY3. The outcomes are listed below, with explanation of the status of program performance for each.

Pay for Outcome: **75% of those placed in housing maintain housing for 6 months**
Achievement Reached: **Attained**
Attestation of Achievement: **Universal and Variant Metric #7**

Pay for Outcome: **Improve self-reported health status by 5% for all clients enrolled in**
Achievement Reached: **Not attained**
Explanation of non-achievement: It was revealed during data collection for the annual report the partner organization currently responsible for tracking this data is only doing so at the point of intake. A PDSA cycle will be initiated for PY4 to determine a process of regular client engagement to track the change in this outcome over time during WPC enrollment.

Pay for Outcome: **Place 50 WPC homeless clients into housing**
Achievement Reached: **Attained**
Attestation of Achievement: **Abode Housing Report (attached)**
Pay for Outcome: **Reduce ED admissions by 5% from baseline**
Achievement Reached: **Attained**
Attestation of Achievement: **Universal and Variant Metric #11**

Pay for Outcome: **Reduce hospital admissions by 5% from baseline**
Achievement Reached: **Attained**
Attestation of Achievement: **Universal and Variant Metric #12**

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.

During PY3, Napa maintained the policy and program planning meeting structure established in PY2. Attached please find a list of all policy and program meetings held with participating entities and stakeholders in 2018. This document includes a description of each meeting, the regularly scheduled dates (or in the case of ad-hoc meetings, a note if it was a single/stand-alone meeting or one called multiple times during the year), a summary of the meeting content and decisions, and list of attendees. Included with this summary document are a sample of agendas for each of the meetings listed.

IX. PROGRAM ACTIVITIES

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

Napa's pilot does not have *distinct* care coordination services under a unique services bundles, but rather has included care coordination as an aspect of everyone one of its four core PMPM Bundles. Developing a care coordination system for the pilot has been a key focus throughout PY2 and PY3. In PY2 the pilot began to leverage its health coordination collaborative to accommodate basic care coordination activities. These activities intensified in the first half of PY3, with an emphasis on codifying care coordination functions into existing case conferencing activities, finalizing the care coordination contract with Queen of the Valley, and making progress toward implementing a care coordination software platform. Successes included:

- **Capacity building**. Our primary service provider, Abode Services, came to this program with a track record of excellent housing and supportive services. However, their team had not historically conducted care coordination activities in direct partnership with medical providers. By working closely with CARE Network and HHSA, Abode Services program staff have made tremendous strides to bring care coordination to the center of their work and to design their care plans accordingly.
- **Universal Care Coordination.** Through extensive community outreach, collaboration, and enrichment of partnerships, the Napa pilot has ensured every WPC client receives care coordination services. This is accomplished through CARE Network and Abode Services key case conferencing sessions for all WPC clients.
- **Integrated assessment and care plans**. CARE Network is the lead designing integrated assessment and care planning tools that allow Abode and CARE Network to identify clients with complex needs whose care planning should be the primary responsibility of CARE Network, and identify the appropriate referral pathways for all WPC Clients.

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

Please refer to Napa's PDSA cycles for detailed care coordination and care planning challenges and how the pilot is dealing with these challenges each quarter. Here are some highlights of the challenges the pilot faced in the first half of PY3, some of which carried over from PY2:

- **Care Coordination Technology Platform**. At the end of PY2, the Napa pilot made the decision to move away from implementing Pre-Manage and instead to proceed with ActMD. Since the pilot would be contracting with the Queen of the Valley for care coordination and care planning, and they are moving forward with Act MD,

ActMD would be the best option for long-term data sharing and care coordination abilities for vulnerable clients. However, the vetting and contracting processes have been quite slow and, despite our hopes of implementing ActMD 2018, that did not happen.

- **Expanding the Culture of Care Coordination**. The Napa homeless service system moved to a Housing First service model nearly concurrent with implementation of its Whole Person Care Pilot. This presented a unique challenge to care coordination: The overall system redesign to a Housing First model meant "the system" was focused primarily on connecting vulnerable clients to housing as foundation for receiving better health care and attaining better health outcomes. The Whole Person Care pilot was designed to introduce robust care coordination for a subset of that population to improve health outcomes. The pilot has struggled to seamlessly integrate care coordination activities into the housing-first service model because it was presumed that those activities would align more naturally with standard service coordination. In other words, we presumed resources to enhance existing case management focused on housing housing placement would be a welcome and natural extension of services. That has not been the case. Rather, we have realized that the role of and need for care coordination needs to be a defined and specific function for which all staff received supervision, training, and support, AND overseen by a medical entity with more experience in this area. In PY3, the pilot worked with CARE Network and Abode Services to codify policies and practices supporting this understanding.

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

In PY3, Napa achieved success with data and information sharing relative to enrollment, housing and utilization data, though data sharing for care coordination remained a challenge. In PY3, the pilot gained access to most reporting data, developed legal pathways for sharing that data, and tailored the HMIS database to work as WPC's centralized database for enrollment and PMPM services tracking. However, we encountered a setback with respect to sharing data with Partnership Health, explained in the following section. Successes included:

- **Dashboard Development:** Napa County WPC developed a WPC dashboard in Tableau, a visualization software, which will be used for tracking PDSA progress and outcomes over time. The dashboard is reviewed in monthly meetings and serves as a blueprint for program tracking and success measurement. Additional work is underway to improve the functionality and interoperability with HHSA's Data Mart, with a long-term vision of a public-facing dashboard showing key program metrics for the entire homeless and housing program.

- **Release of Information.** After encountering a series of barriers to data sharing with Partnership Health (described more fully below), the Pilot successfully finalized an ROI allowing access to health care utilization data for WPC clients.

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

Though the pilot achieved targeted successes with data sharing in 2018, challenges remain. More specifically:

- **Fee for Service Data Sharing Agreements and Formal Referral Pathways.** In PY3, Napa was effectively a year and a half into the implementation of the Napa WPC Pilot. Although the Pilot expected to be further along in systems implementation, Napa, as Lead Entity continued, in some aspects of the Pilot, to work on building the infrastructure necessary to deliver fee-based services to WPC and WPC eligible clients and to collect and track data from those encounters.

- **Technology Platform:** As described earlier, contracting with an appropriate technological solution to use in system-wide care coordination has taken time. We are eagerly awaiting the green light to move forward with ActMD, but the contracting and vetting process has been quite slow.

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

The pilot had notable achievements with data collection in PY3. Although there continue to be some challenges in accessing external reporting data (see above), the pilot has ongoing access to reporting data that is located within HHSA and is making progress on other fronts. Data collection/reporting successes:

- **Data Map**: After identifying all needed data sources for reporting purposes, negotiating access to these data, and successfully reporting our first year of data, pilot staff developed and finalized a comprehensive and detailed data collection map. The map describes all variables, identifies data sources, and details sharing protocols and access methods to allow for any authorized staff person to perform key data functions. When a key pilot data collection and reporting staff member resigned early in the year, the Data Map ensured that these processes would carry out without interruption.

- **Data Quality**: Considerable effort was made to improve HMIS data quality in PY3, resulting in notable increases to the number of clients with care plans, housing retention data, and other key program information. The HMIS Workgroup played a central role in overseeing and executing these activities.

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

Some of the data collection challenges that the pilot experiences this quarter include:

- **ROI challenges:** As described earlier, Partnership Health Plan's request for a new Release of Information made individual utilization data for key metrics functionally inaccessible to the pilot in 2018. Progress was made on a new ROI, and access has been re-instated in early 2019. However, this challenge created significant reporting challenges and delays, and made it impossible to monitor client medical outcomes as part of program oversight in 2018.

- **Data collection for care coordination**: Care coordination data is shared primarily through HMIS when it can be, but care coordination data with external health partners requires individual release of information forms with data shared in care coordination meetings. The pilot is anxious to contract with ActMD, where data can be shared easily across internal and external partners supporting a streamlined way for partners to create, access and managing WPC client care plans.

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

The biggest barriers to success overall are the following:

- **Data sharing:** This is described at length elsewhere in the report but, until the is able to establish all necessary FFS referral pathways and seamlessly exchange data with Partnership Health, measurement the impact of this pilot remains elusive. In addition, in many cases, it also results in missed opportunities to target specific potential clients based upon utilization. The pilot looks forward to resolving these issues in PY4.

- **Housing resources and opportunities:** Napa's WPC pilot is housing focused and success depends in large part on the availability of housing resources and opportunities for vulnerable populations, so they can realize better health outcomes. In the last year, HHSA was able to attract housing resource contributions from health partners: Queen of the Valley and Partnership Health each provided contributions to Napa's Flexible Housing Funding Pool operated by Abode Services. These grants provide needed flexible resources to secure housing for vulnerable clients in the community. Additional State housing resources from HCD bring additional, badly needed flexibility for housing placement. Each of these investments is vital. However, even with increased housing subsidies, there remains a dire shortage of *housing that is affordable* throughout Napa County, resulting in extreme challenging placing individuals who qualify for subsidy into housing units meeting Federal and State funding requirements, in particular Fair Market Rent (FMR). The 2017 Wildfire Disaster further exacerbated this challenge, eliminating 5000+ units of housing in Napa and Sonoma Counties and causing rents to rise by 10-20% region-wide.

  Continued success replenishing the Flex Pool will help, but investment in re-examining the fair market rent standard is critical to Napa's ability to utilize existing State and Federal funding sources in the existing rental market. Napa's CoC is considering investing in the survey required by HUD to alter the Fair Market Rent (FMR) calculation considerations to reflect market conditions and open up more affordable units in the community. To date, this decision has been held up by the cost of the survey and the risk that a review could potentially result in a lower FMR. In the meantime, Abode Services has engaged in active landlord recruitment and works to pay deposits quickly to ensure that clients can secure housing, and Napa County has aggressively pursued new funding opportunities such as HEAP, CESH and No Place Like Home Funds to address housing issues. Moving forward, Napa will have WPC FFS's supporting move-in funds, landlord recruitment funds and landlord risk mitigation funds, intended to further incent property renters to make units available for WPC clients. Lastly, there are several housing projects in the community's development pipeline; however, not all of the projects are approved for construction and even when approved, units are at least two years away from occupancy.

  Despite these housing market challenges, the pilot exceeded the year-end target of housing 50 WPC households. It will require persistence and creativity to unlock the number of housing opportunities needed throughout the course of this pilot. Abode Services is evaluating shared housing as a possible solution and HHSA is aggressively pursuing set aside units in affordable and market rate housing projects currently under construction in the community.

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.

The Napa County Whole Person Care Pilot aims to reduce chronic homelessness and high levels of unnecessary service use among vulnerable homeless people by providing services that are better coordinated, housing focused, client centered, and supported by a culture of continuous learning and improvement. By the end of WPC, vulnerable homeless people in Napa County will have improved access to housing, will stay housed, and will experience improved wellbeing.

In PY3, Napa County WPC focused on building the foundations needed to support successful PDSA cycles, including:

1. Developing a common agenda. The pilot realized a need to "take a step back" and re-set its target list of key stakeholders as a result of data-issues which emerged in 2018. This further required re-establishing a common agenda amongst 'new' and 'old' stakeholders, ensuring all are working toward a common goal and focused on the target group.

2. Building a culture of continuous learning. PDSA cycles are effective when data is used to facilitate learning, growth and change, rather than penalizing underperformance. Building a learning culture through PDSA cycles includes promoting curiosity and approaching the Whole Person Care pilot as a problem-solving process rather than an unchanging solution to assisting vulnerable homeless in the community.

3. Establishing shared measurement systems. The scope and scale of the Napa population and pilot limit the overall resources available toward investment in robust data-sharing systems. As a result, the team must creatively approach data sharing and measurement tools/systems that support timely review of performance metrics to support PDSA cycles.

Please refer to the attached PDSA report for Napa's PDSA summary and PDSA cycle reports for the third and fourth quarters of 2018.