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

Orange County Whole Person Care
Annual and 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.*

Increase Integration:

Successes: The WPC Pilot contributed to increased communication and collaboration between County programs and departments, between CalOptima and various County programs, between the County and community providers, and between community providers and CalOptima. Attributable in large part to bi-weekly meetings of the WPC Collaborative and implementation of a WPC mailbox and website to address issues as they arise and provide guidance. There has not been a central coordination point in the past to deal with common issues across programs and organizations, so the WPC meets this need.

Challenges: Managing expectations and communications as the number of individuals needing to be involved and/or informed of WPC activities, guidance and policies expand.

Lessons Learned: Insufficient administrative resources allocated to implementation needs. Did not foresee how much involvement in a central communication/coordination hub was needed to successfully integrate the services. Certain deliverables delegated to WPC Subcommittees to report back to the WPC Collaborative for feedback and final approval. WPC mailbox is a result of lessons learned, as well as holding target audience WPC meetings (i.e., just hospitals). Orange County has also agreed to allocate additional resources not funded with WPC funds to help administer the program.

Increase Coordination/Access to Care:

Successes: Due to increase in communication and collaboration, there has been a noticeable increase in accessing care for some of our more vulnerable beneficiaries. Each participating entity is learning they need not know everything to effectively link a client to care, and are now armed with the resources to contact to effectively link clients to care.

Challenges: Overcoming and eliminating misinformation that is treated as fact.

Lessons Learned: It is impossible to get ahead of misinformation because it will come up on a case-by-case basis and some of it is so ingrained in the community that is accepted as fact without question. Instead, we advise all persons working with the WPC to submit "challenges" to the WPC mailbox so we can work to pilot solutions (oftentimes, getting accurate information is the solution).

Reduce inappropriate ER/Inpatient Utilization:

Successes: TBD - anticipate seeing results following submission of the baseline data in August, 2018.

Challenges: Need to establish baseline data.

Lessons Learned: TBD.

Improved Data Collection/Sharing:

Successes: TBD – implementation of automated data sharing in process. All WPC Participating providers still following respective program rules for client consents on sharing information for care coordination.

Challenges: Anticipate BHS rules for data sharing to be an issue.

Lessons Learned: TBD.

Achieve Quality/Administrative improvement benchmarks:

Successes: TBD - anticipate seeing results following submission of the baseline data in August, 2018.

Challenges: Timely implementation of automated systems; administrative resources for on-going quality/administrative review against benchmarks.

Lessons Learned: Did not allocate sufficient administrative resources; evaluating how to effectively address.

Increase Access to Housing & Supportive Services:

Successes: Anecdotal successes.

Challenges: Capturing data across WPC program components, specifically for programs that are not housing focused, but may result in someone being placed in housing.

Lessons Learned: TBD.

Improve Health Outcomes:

Successes: Anecdotal successes for individuals; however, overall TBD - anticipate seeing results following submission of the baseline data in August, 2018.

Challenges: Need to establish baseline data.

Lessons Learned: TBD.

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	*	*	118	160	215	340	*

Item	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12	Annual Unduplicated Total
Unduplicated Enrollees	477	386	284	301	385	255	3154

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	$0	$0	$0	$0	$0	$0	$0
Utilization 1	0	0	0	0	0	0	0
Service 2							
Utilization 2							

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							
Utilization 1	171	427	1019	1049	864	1464	4994
Service 2							
Utilization 2							

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	$	$0	$0	$0	$0	$0	$0	$0
MM Counts 1		127	233	347	496	705	1024	2932
Bundle #2	$	$0	$0	$0	$0	$0	$0	$0
MM Counts 2		0	0	0	0	0	0	0
Bundle #3		$0	$0	$0	$0	$0	$0	$0
MM Counts 3		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	$121	$153428	$174482	$186219	$199892	$214654	$220704	$1149379
MM Counts 1		1268	1442	1539	1652	1774	1824	12431
Bundle #2	$216	$21600	$28728	$35208	$43848	$50328	$55080	$234792
MM Counts 2		100	133	163	203	233	255	1087
Bundle # 3	$249	$27390	$57021	$72708	$78186	$87399	$90885	$413589
MM Counts 3								

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

Unduplicated Enrollees: The hospital and clinic outreach and navigation services began on January 1, 2017, so all unduplicated enrollees identified in this report are through the efforts of these providers for that period. Effective July 1, 2017, other providers/services were added.

FFS: Orange County only has Recuperative Care identified under the FFS category. Recuperative Care services, following a solicitation process, began on July 1, 2017. The FFS amount identified in the report and the invoice reflects the County's actual cost of providing these services. We understand we are limited to the PY 2 budgeted amount of $602,509 for this these services.

PMPM: All hospital and clinic providers in the first six months of our WPC application were given incentive payments to hire staff and start providing services; therefore, there are no associated PMPM costs on our invoice for this period. Effective July 1, 2017 –

member months are reported for all categories as approved in the extension application.

PMPM #1 – Hospital & Clinic Homeless Navigation Services: Orange County's PY 2 target member months for this service is 3,552. As noted in the above actuals, our utilization for this service exceeded this target by 5,947 member months. Our invoice reflects the budgeted amount of 3,552.

PMPM #2 – Drop-In Center Supportive & Linkage Services: Orange County's PY 2 target member months for this service is 900. As noted in the above actuals, our utilization for this service exceeded this target by 187 member months. Our invoice reflects the budgeted amount of 900.

PMPM #3 –SMI Supportive & Linkage Services: Orange County's PY 2 target member months for this service is 300. As noted in the above actuals, our utilization for this service exceeded this target by 1,661 member months. Our invoice reflects the budgeted amount of 300.

Revised quarterly report for Quarter 1 through Quarter 4 of 2017 has been submitted to correspond with the above numbers.

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.

County Administrative Support to Implement and Administer the WPC:
Both staff were hired to help implement and administer the WPC. Due to delays in recruitment, one staff member was brought on in a non-benefit position resulting in some savings that were requested to be rolled over to PY 3 and placed under Incentives per direction from DHCS.

CalOptima Administrative Support:
CalOptima hired the Personal Care Coordinator to aid in coordinating Medi-Cal benefits for WPC beneficiaries being served by hospitals, community clinics, recuperative care, County Behavioral Health Services, and the drop-in centers.

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.

Homeless Navigator Positions (Hospitals and Clinics):
All FTEs proposed by the hospitals and community clinics have been hired and all payments made, with the final $137,000 reflected on the annual invoice for PY 2.

WPC Connect:

Program and Test System
Load Eligibility Data
Connect 2 Hospital

While Safety Net Connect (SNC), the participating entity that will be implementing WPC Connect, is an active participant in the WPC, a contract was not executed until July 1, 2017. The timeframe to bring individual hospital IT departments on board with the WPC Connect plan have also been challenging, so SNC was not able to meet the deadlines to receive the required delivery infrastructure payments. Orange County has submitted rolling over the deliverables and corresponding funding to PY 3, so there are no payments that correspond to this Annual reporting period.

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.

Training of WPC Clinics and Hospitals on the Coordinated Entry Process by 211 OC:

A contract was executed with 2-1-1- Orange County (211 OC) effective July 1, 2017, 211 OC has provided all 5 of the coordinated entry trainings required to receive their incentive payments for 2017 and this is reflected in the invoice.

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.

For Orange County, there are two Universal Health Metrics (UHM) and three Universal Administrative Metrics (UAM) that need to be reported on at this time.

Universal Health Metrics:
UHM 1: Ambulatory Care- Emergency Department (AMB-ED)
UHM 2: Inpatient Utilization – General Hospital/Acute Care (IPU)

Achieved: Orange County will be reporting NR for each of these metrics at this time, but expects to have the data by the May 31st deadline provided by DHCS.

Challenges: Timely implementation of automated systems and adequate administrative resources to focus on implementation of electronic data sharing systems. All data reported to the WPC is currently done manually and processes to share data with CalOptima so they can run the required HEDIS measurements is in process until automated processes can come on board.

Lessons Learned: Did not allocate sufficient administrative resources; evaluating how to effectively address.

Universal Administrative Metrics:
UAM 1: Beneficiaries with a comprehensive Care Plan, Accessible by the Entire Care Team, Within 30-Days of Enrollment and Annually
UAM 2: Care Coordination, Case Management, and Referral Infrastructure
UAM 3: Data and Information Sharing Infrastructure

Achieved: Orange County will be reporting NR for UAM 1 as the automated WPC Care Plan is being prepared to go live; however, policies and procedures have been drafted for UAM 2 and UAM 3 drafted and will continue to be reviewed/update as automated processes are rolled out. This group assigned to this area will meet monthly for 6 months following go-live and then quarterly to monitor issues and address any needed modifications, including any updates to the P&Ps as needed.

Challenges: Timely implementation of automated systems and adequate administrative resources to focus on implementation of electronic data sharing systems and development/finalization of procedures related to the above metrics.

Lessons Learned: Did not allocate sufficient administrative resources; evaluating how to effectively address.

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.

**Please limit responses to 500 words*

Date	Activity
July 14, 2017	Welcome new providers funded via WPC Round 2 dollars. Discussed the formation of subcommittees to move some of the WPC goals along faster, such as data sharing and care coordination. Share interim Recuperative Care referral process
July 28, 2017	Updates –challenges and successes with the implementation of Recuperative Care – 8 referrals to date. BHS Outreach & Engagement is meeting with each WPC Hospital and Community Clinic to talk about accessing the BHS team for WPC clients that need to be linked to BHS Services Clarified services that can be provided to Medi-Medi and out of county clients
August 11, 2017	BHS reported out on meetings with WPC Hospitals and community clinics to date- everything is being well received and referrals to BHS are happening. WPC Subcommittees have been established: *Data Sharing/Care Coordination – Lead is Keith Matsutsuyu *Shared BAA/Consent – Lead is Melissa Tober-Beers *Recuperative Care – Lead is Steve Thronson Others to be set up as needed. WPC has enrolled 680 clients to date
August 25, 2017	WPC 101 and Meet & Greet Overview of WPC Program Components and opportunity for all line level WPC staff (care coordinators, outreach and navigation staff, recuperative care) to meet each other.
October 6, 2017	Check in all Subcommittees Introduced new Recuperative Care Provider BHS is working on Depression and Suicide assessments to implement in the WPC – Can they be incorporated into the automated care plan?

October 20, 2017	Check in all subcommittees *DATA – the platform is ready and we have connectivity for WPC Connect – ER Notification system. Working out final details with initial hospitals. Reviewed automated enrollment form and took feedback
November 3, 2017	Check in all subcommittees Vision for automated care plan being finalized

IX. PROGRAM ACTIVITIES

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

Despite not having the automated processes in place at this time, the increase in communication and collaboration has resulted a noticeable increase in accessing care for some of our more vulnerable beneficiaries.

(1) Hospital and community clinic Homeless Navigation staff are a new concept for a number of our providers (we based the model in our WPC application on two current programs). As a result, many are learning how to help beneficiaries navigate services "on the job." Through the WPC, we have provided a WPC 101 course that included an opportunity to meet and hear from representatives from each of the WPC Participating Entities (Lestonnac for the Community Referral Network, Recuperative Care, the model hospital and community clinic, County Behavioral Health Services (BHS), Public Health Targeted Care Management Nurses working with the homeless) and provided an number of take away resources. One-on-one more intensive "trainings" with BHS are also occurring which share not only the additional services and coordination with BHS that is available due to WPC, but also educates on ALL services available through BHS. BHS is also excited to finally have contacts at these facilities to reach out to as well and to follow up with regarding care for the beneficiaries. Over 500 of our WPC enrollees are also linked to BHS.

(2) CalOptima has hired a Personal Care Coordinator who is specifically dedicated to helping WPC beneficiaries and WPC Participating Entities on their behalf, navigate the Manage Care Plan networks and more effectively accessing services. There was some initial resistance to changing how care was accessed, but through the WPC 101 Training and learning more about the challenges this segment of their beneficiary population faces, there have already been some great efforts to accommodate WPC clients needing access to certain Medi-Cal benefits and other care other than referring them to their PCP who may be someone they have not met, or no longer geographically logical. This is a connection/resource that has not been easily available to community agencies in the past. One new great example is:

(a) A client referred from an ER to recuperative care was really in need of hospice services. Recuperative care really did not want to refer the patient back to the ER; however, they were not contracted to handle this level of care through the WPC. A phone call to the CalOptima by the WPC team to assistance allowed the patient to access hospice service in another facility.

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

(1) Timely implementation of automated systems and adequate administrative resources to focus on implementation of electronic data sharing systems and development/finalization of procedures.
Lessons Learned: Did not allocate sufficient administrative resources. We expect that the development and rollout is more time involved than on-going evaluation and modifications, so once the processes are in place, administrative resources should be sufficient.

(2) Overcoming and eliminating misinformation that is treated as fact.

Lessons Learned: It is impossible to get ahead of misinformation because it will come up on a case-by-case basis and some of it is so ingrained in the community that is accepted as fact without question. Instead, we advise all persons working with the WPC to submit "challenges" to the WPC mailbox so we can work to pilot solutions (oftentimes, getting accurate information is the solution). We have also implemented a secure WPC Website that has key contact/referral information for members of the WPC Collaborative.

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

At the end of PY 2, other that the increased care coordination and communication reference above, there is no electronic or coordinated sharing of data at this time.

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

(1) Timely implementation of automated systems and adequate administrative resources to focus on implementation of electronic data sharing systems and development/finalization of procedures.
Lessons Learned: Did not allocate sufficient administrative resources. We expect that the development and rollout is more time involved than on-going evaluation and modifications, so once the processes are in place, administrative resources should be sufficient.

(2) On-going discussions with Behavioral Health that they do not believe they will be able to participate in data sharing within the WPC.

Lessons Learned: TBD as we continue to work towards this goal, we believe we now have consensus on limited data sets to be shared, but are working out the details and hope to report this as a success in PY 3.

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

(1) Currently all providers, including County's Behavioral Health Services are submitting enrollment data on a regular basis to the WPC team, although manually. We are targeting PY 3 for the electronic coordinated system to come on line.

(2) On-going discussions with Behavioral Health has them submitting manual information to the WPC Team. They are open to this data being in the electronic system, but we continue to work on the details

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

Timely implementation of automated systems and adequate administrative resources to focus on implementation of electronic data sharing systems and development/finalization of procedures.

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

(1) Timely rollout of automated systems to all providers after implementation with the test providers.

(2) Being able to financially sustain some of our more successful components to date, such as the level of recuperative care services needed.

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.

PDSA 1 – UHM: Ambulatory Care (AMB) – Emergency Department Visits
PDSA 2 – UHM: Inpatient Utilization – General Hospital/Acute Care (IPU)
PDSA 3 – UHM: Follow-up After Hospitalization for Mental Illness (FUH)
PDSA 4 – UHM: Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET)
PDSA 5 – UAM: Beneficiaries with Comprehensive care plan, accessible by the entire care team, within 30 days of enrollment and annually
PDSA 6 – UAM: Care Coordination, Case Management, and Referral Infrastructure
PDSA 7 – UAM: Data and Information Sharing Infrastructure
PDSA 8 – VAM: Members in Recuperative Care linked to CalOptima Case Management
PDSA 9 – VHM: 30-Day All Cause Readmissions
PDSA 10 – VHM: Comprehensive Diabetes Care
PDSA 11 – VHM: Suicide Risk Assessment
PDSA 12 – VHM: Housing Supportive Services
PDSA 13 – Deleted – Duplicate of PDSA5
PDSA 14 – OHM: Increase in Primary Care Physician (PCP) Office Visits
PDSA 15 – OHM: Increase in Appropriate Medication Utilization
PDSA 16 – OHM: Increase in Recuperative Care Beneficiaries Completing Assessments for Coordinated Entry Process
PDSA 17 – OAM: Percent of Referrals from WPC Participating Entities Linked to Behavioral Health Services
PDSA 18 – OHM: For WPC SMI Population, Decrease in Number of Days for Psychiatric Hospitalization
PDSA 19 – OHM: For WPC SMI Population, Reduction in Depressive Symptoms as Measured by the Symptom Distress Subscale for Beneficiaries Scoring in the Clinic Range
PDSA 20 – OHM: For WPC SMI Population, Decrease in the Number of Mental Health Emergencies Experienced
PDSA 21 – OHM: For WPC SMI Population, Decrease in Number of Days Homeless
PDSA 22 – OHM: For WPC SMI Population, Increase in Number of Days in Independent Living or Permanent Supportive Housing

UHM = Universal Health Metric

UAM = Universal Administrative Metric
VHM = Variant Health Metric
VAM = Variant Administrative Metric
OHM = Outcome Health Metric
OAM = Outcome Administrative Metric