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

City of Sacramento
Annual PY2
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.

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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.*

PY2 was an important year for Pathways to Health + Home (Pathways), Sacramento's WPC pilot. In a short period of time and without existing infrastructure to administer Medicaid programming, the City engaged more than 20 partners in program planning and implementation and contracted with several service providers to provide outreach, enrollment, case management, and housing services. Success, challenges and lessons learned from our efforts by WPC goals are:

Increasing integration and improving data collection and sharing. In PY2, partners across all sectors moved beyond passively monitoring program progress to committing to an integrated service delivery model supported by data sharing. We learned that some partners require extensive legal review before they are able to execute key agreements that support integration, e.g. Data Sharing Agreements (DSAs). Building in the time and processes for this review is critical. The program's limited partnership with the County posed a challenge for integration and behavioral health data collection, but through proactive engagement with County officials in PY2, there has been some progress towards minimal sharing of data.

Increasing coordination, access to appropriate care, and housing services. In PY2, Pathways coordinated efforts with the Police Impact Team and the City's Winter Triage Shelter to leverage new and existing resources. Connection with the shelter helped stabilize enrollees, allowing for the co-location of providers and increasing coordination to help enrollees access to health and housing services. Pathways also developed tools, policies, and procedures to support care coordination, including a universal screening tool, consent form, referral form and process, and an early version of the Shared Care Plan. Care coordination and housing services included transportation to medical appointments, connection to FQHCs and health plan care teams, linking to behavioral health services, scheduling housing appointments, and assistance with housing applications. One key lesson learned was the need to assess provider readiness and care coordination capacity early on and secure "expedited access" to services, including priority appointments within 72 hours.

Reducing inappropriate emergency and inpatient utilization and improving health outcomes. Pathways refined the eligibility criteria for the target population in

PY2 to ensure enrollment of homeless individuals with high ED and inpatient utilization. The IT approach developed in PY2 included the future implementation of hospital alert systems to provide notifications when Pathways enrollees present. A key challenge in identifying homeless frequent users and enrolling them in the program was the need to initiate execution of Business Associate Agreements (BAAs) and DSAs with partners to facilitate referrals from hospitals and collect data to verify eligibility and track utilization. Despite this challenge, the program connected enrollees to primary care providers, behavioral health care, and stabilizing social supports and housing services that we anticipate will result in reductions of avoidable hospitalizations and improved overall health.

Achieving quality and administrative improvement benchmarks. Activities noted above document the program's progress in achieving administrative improvement benchmarks in PY2. In terms of achieving quality benchmarks, the program initiated critical steps necessary to secure BAAs and DSAs between partners to be able to establish baseline data on quality measures and track outcomes.

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							

Item	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12	Annual Unduplicated Total
Unduplicated Enrollees					144	92	236

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
ICP+ Bed Days Cost							
ICP+ Bed Days Util							
Outreach & Referral FFS Cost							
Outreach & Referral FFS Util							

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FFS	Costs and Aggregate Utilization for Quarters 3 and 4						
	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12	Total
ICP+ Bed Days Cost					$0	$0	$0
ICP+ Bed Days Util					0	0	0
Outreach & Referral FFS Cost					$90,000	$90,000	$180,000
Outreach & Referral FFS Util					572	601	1,173

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
Housing Bundle #1 Rate	$							
Housing Bundle MM Counts 1								
Enhanced Case Management & Navigation Services Bundle #2 Rate	$							
Enhanced Case Management & Navigation Services MM Counts 2								
Lower Level Case Management & Navigation Services Bundle #3 Rate	$							
Lower Level Case Management & Navigation Services MM Counts 3								

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PMPM		Amount Claimed						
	Rate	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12	Total
Housing Bundle #1 Rate	$375					$21,000	$25,875	$46,875
Housing Bundle MM Counts 1						56	79	135
Enhanced Case Management & Navigation Services Bundle #2 Rate	$537					$39,201	$27,924	$67,125
Enhanced Case Management & Navigation Services MM Counts 2						73	97	170
Lower Level Case Management & Navigation Services Bundle #3 Rate	$282					$20,022	$15,228	$35,250
Lower Level Case Management & Navigation Services MM Counts 3						71	55	126

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.

During PY2, the City of Sacramento made significant investments in administrative governance and the staffing required to run everyday activities for Pathways. While the City retains responsibility for overall fiscal and program management, we have contracted a team of consultants, who are subject matter experts, to manage the day-to-day operations of the program. Because the City does not operate health programs in the community, use of consultants as the project management team has allowed for quick implementation without the many constraints imposed by creating in-house capacity.

To ensure that the project management team is accessible to the local providers and vice-versa, we have rapidly engaged our consulting team and they have become deeply connected with the on-the-ground needs and opportunities in Sacramento.

Pathways is led by the City's WPC Program Director, with day-to-day operations conducted by the project management team who reports to the City's Senior Program Manager and Program Director. Working closely with the Program Director, the Senior Program Manager has been responsible for leading development of program policies and procedures, evaluating and monitoring services and programs, formulating administrative controls and quality assurance procedures, and developing a community communication plan.

The Senior Program Analyst works in close coordination with the Senior Program Manager and leads communication with community partners and ensures that program design and policies adhere to the overall project design and City goals. Our Program Analyst and Quality Control Analyst support the Senior Program Manager. The Program Analyst is responsible for overseeing provider contracts, program deadlines and milestones, preparing communication to the providers and community and ensuring operational fidelity to program policies. The Quality Control Analyst is responsible for regular tracking of outcome metrics and PDSA and reporting back to the Senior Program Manager on any data quality or data reporting/analysis issues.

The project management team is supported by a data manager and data analyst, who have responsibility to collect and analyze program data on an on-going basis and provide technical assistance to providers to ensure that all outcomes are met. The data

manager and data analyst also support development of appropriate data sharing infrastructure in collaboration with provider partners.

Finally, the team includes a financial analyst responsible for tracking expenditures in the program, payments for reporting and outcomes and tracking IGT payments, and subject matter experts. We have drawn on our clinical and IT subject matter experts working alongside our Pathway partners to support and align clinical process redesign, IT, ROI assessment, and other critical functions. For PY2, we had budgeted for a higher level of staffing than in subsequent years, intended to support establishing and launching the Pathways program. This staffing level has allowed us to rapidly retain project management staff and bring partners together to develop a comprehensive coordinated approach, from planning to initiating the first phase of the program.

In addition to the above staffing infrastructure, we have drawn on Administrative Infrastructure funds to procure needed IT for program staff.

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.

The goal of Pathways is to increase Sacramento's capacity to serve homeless individuals with complex health care needs through a more responsive, coordinated system of care. The care delivery model provides new services and coordination of existing services to stabilize and connect enrollees to the right care in the most appropriate settings. The centerpiece of the model is Community-Based Care Coordination, which facilitates expedited access across health, behavioral health, social services, and housing sectors.

The Community-Based Care Coordination infrastructure leverages, integrates, and aligns clinical and service delivery expertise and capacities from the following types of contracted entities:

1) **Pathways Hubs:** Serve as the "health home" and Pathways Care Team backbone, integrating Community Health Workers (CHWs) and housing navigators from the Assertive Outreach and Housing entities (described below) under the supervision of a Hub employed licensed Care Coordinator (e.g., RN, LCSW, LMFT, or PA). Each Care Team is responsible for a panel of 125 enrollees.

2) **Pathways Assertive Outreach and Referral Entity**: Organization(s) that employ CHWs, many with lived experience, with expertise working with the target population who provide outreach and referral services in close collaboration with the Pathways Eligibility and Enrollment Entity.

3) **Pathways Eligibility and Enrollment Entity:** Receives all referrals to Pathways, engages potential enrollees to determine eligibility and interest, enrolls them into Pathways or refers them to other services.

4**) Pathways Housing Services Entity:** Organization(s) that provide housing coordination and services to Pathways enrollees.

The infrastructure developed to support the Pathways Care Teams includes:

a) **Assessment and care planning tools**, including a multi-dimensional acuity and need rating scale and Shared Care Plan that documents enrollee goals and health, behavioral health, housing, and social service needs;

b) **Data collection and sharing platform and protocols**, including a shared care platform that allows Care Team members from the Hubs and Assertive Outreach and Housing entities to enter and access Shared Care Plan information. The fully functional platform, allowing coordination with hospitals and health plans, will be available in the fourth quarter 2018.

c). **Protocols and Workflows** to support communication and coordination within the Pathways Care Teams, as well as with key community partners including: the Complex Care Management programs implemented by the six GMC managed care plans; River City Medical Group IPA, emergency department and inpatient discharge planners and social workers in the four hospital systems; City and County housing and social services programs; the crisis response system, and the IMPACT teams fielded by the City's Police Department to work with individuals experiencing homelessness.

The Care Coordination infrastructure facilitates provider-to-provider activities to create seamless transitions, care continuity, and coordination between settings through cross-system work flows, routine case conferencing, and use of a Shared Care Plan on behalf of enrollees to optimize service delivery, reduce access and treatment barriers, and improve health, behavioral health, and housing outcomes.

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.

In PY2 Pathways had 21 partners earn incentive payments by participating and being engaged in the various incentive types (numbered items below) and thresholds (lettered items below). Milestones of note include the development and adoption of a Universal Screening tool as well as Data Sharing plan.

1. Governance Participation
    a. 50% attendance of Steering Committee Meetings
    b. 75% attendance of Steering Committee Meetings
2. Universal Screening Tool Development and Adoption
    a. 75% attendance of Service Delivery Committee Meetings
    b. Executive Committee adoption of tool
3. Universal Consent Form Development and Adoption
    a. 75% attendance of IT Committee Meetings
    b. Executive Committee adoption of form
4. WPC Clinical Protocols, Policies & Procedures
    a. 75% attendance of Service Delivery Committee Meetings
    b. Executive Committee adoption
5. Referral Support - Target List Development
    a. Participate in at least 75% of target list workgroup meeting (i.e. Key Informant interview or planning meeting with Support Team)
    b. Provide referrals to pilot, minimum 5 per month (upon establishment of referral pathway)
6. Data Sharing (Planning & Adoption)
    a. 75% Attendance of IT Committee Meetings
    b. Support design, as evidenced by committee recommendations to Executive Committee for adoption
    c. Executive Committee adoption of data sharing solution

Partners receiving incentives for PY2 included one hospital, six managed care plans, and sixteen community-based organizations. Each partner met different thresholds and earned the amounts as outlined below.

Hospitals

- Dignity Hospital: 1a, 1b, 2a, 2b, 3a, 3b, 4a, 4b, 5a, 5b, 6a, 6b and 6c for a total of $100,000.00

Managed Care Plans

- Access Dental Plan: 2b, 3b, 4b, 5b, 6b and 6c for a total of $50,000.00
- LIBERTY Dental: 1a, 2b, 4b, 5a, 6b and 6c for a total of $50,000.00
- Anthem, Health Net, Molina Healthcare and UnitedHealthcare all meet the following thresholds: 1a, 1b, 2a, 2b, 3a, 3b, 4a, 4b, 5a, 5b, 6a, 6b and 6c for a total of $100,000.00 each.

Community-Based Organizations

- Care Community Health (dba One Community Health): 2b and 5a for a total of $30,000.00.
- Community Link Capital Region (211 Sacramento): 1a, 1b, 3a and 6a for a total of $30,000.00.
- HALO Inc.: 2b and 6a for a total of $30,000.00.
- Peach Tree Health: 2b and 5a for a total of $30,000.00.
- Volunteers of America: 1a, 1b and 2b for a total of $30,000.00.
- River City Medical Group, Sacramento Native American Health Center, Salvation Army, and TLCS: 1a, 1b, 2a and 4b for a total of $30,000.00 each.
- Elica Health Centers, Sacramento Covered, and Sacramento Steps Forward: 1a, 1b, 2a, 2b, 3a, 3b and 4a for a total of $80,000.00 each.
- Sacramento Self-Help Housing and WellSpace Health: 1a, 1b, 2a, 2b, 4a, 4b and 5a for a total of $80,000.00 each.

Sacramento Police Department and Sacramento Fire Department: 1a, 1b, 2a, 2b, 3a, 3b, 4a, 4b, 5a, 5b, 6a, 6b, and 6c for a total of $250,000.00 each.

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.

Pathways' two pay-for-outcomes metrics are Housing Services and 30-Day All Cause Readmissions, discussed below.

Housing Services: Pathways benchmarks to increase the percent of enrollees referred for housing services within the measurement year who actually receive those services are as follows: maintain baseline in PY2, 5% over baseline in PY3, 10% over baseline in PY4, and 15% over baseline in PY5. We do not have a baseline percentage established yet given DHCS' extension of the deadline for the Baseline Report. However, we know that for PY2 (November and December, 2017), the percentage of enrollees referred for housing services who actually received those services was 49%. With only two months of PY2 in which Pathways was an active program, there was very limited time to enroll individuals, assess their needs, refer them to housing services, and provide housing services. We anticipate Pathways' performance on this metric will improve significantly in 2018 and beyond. Once all participating partners begin providing services, and as referral relationships, data sharing and workflows between Outreach and Enrollment, Housing, and the Pathways Hub Teams get developed and strengthened, considerable progress will be accomplished.

30-Day All Cause Readmissions: Pathways benchmarks to decrease 30-Day All Cause Readmissions are as follows: maintain baseline in PY2, 5% over baseline in PY3, 10% over baseline in PY4, and 15% over baseline in PY5. Given DHCS' extension of the deadline for the Baseline Report, we do not have a baseline percentage established at this point. We also do not have the actual Readmission rate for PY2 because two hospital systems have not submitted their data thus far, as it is dependent on the execution of DSAs in mid-April. The Pathways team and partners look forward to reviewing our actual Readmission rate in late April, once all data has been submitted and comparing that to national data. We anticipate the rate will be fairly high since, with only two program months in PY2, there was not much time in which to enroll individuals, provide housing and care coordination services, and connect them to primary care. Likewise, the partners had inadequate time to initiate collaborative PDSAs that also engage hospitals to test specific interventions directly intended to prevent hospital readmissions. We expect by May, Pathways will be well positioned to facilitate creative idea generation and small-scale testing of change to reduce readmissions.

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 PY2, Pathways launched four governance committees: Executive, Steering, Service Delivery, and IT, and convened a total of fourteen meetings. The Executive Committee is comprised solely of leadership from the City of Sacramento and provides program oversight and direction. The Steering Committee is an advisory body of partner organizational leadership that makes strategic recommendations to program management and the Executive Committee. The Service Delivery and IT Committees, whose members include partner organization line staff, subject matter experts, and leadership, support the development and implementation of the program policies and procedures on the ground. In PY2, the Steering Committee convened every month from August through December. The Executive, Service Delivery, and IT Committees were launched in October and met monthly through December. In addition, through an extensive series of key informant interviews, surveys, and a Community Listening session, external stakeholders were engaged to provide critical input and feedback that informed program design and development.

Pathways committee meetings focused on the development and approval of policies and procedures needed to stand up the program and meet enrollment and service delivery targets for PY2 and beyond. Key topics included review and refinement of the program's service delivery model; 2017 service contracts and solicitation of additional providers for the program in 2018 to meet service delivery goals; and development and approval of the program's approach for data-sharing, shared care planning, assessment and screening, and enrollee consent. Committees also discussed program alignment with City and partner organization programs to implement referral pathways and better coordinate and leverage resources for the Pathways target population. As a result, the program was closely aligned with City of Sacramento's Winter Triage Shelter and Sacramento Police Department Impact Team, which works to engage chronically homeless individuals and connect them to services. The shelter provides stability for enrollees and opportunities for frequent contact with service providers that was leveraged by the program, making it easier to actively address enrollees' health and housing needs.

Key decisions made by the committees in PY2 included: 1) development and approval of the Pathways mission and vision; 2) addition of new partners critical to the success of the program (River City Medical Group, The Salvation Army, TLCS, and Volunteers of

America of Northern CA and Northern NV); 3) sign-off on initial service provider contracts for City Council vote; 4) endorsement of the Pathways enrollee screening/assessment tool, consent form, and initial Shared Care Plan data elements developed with input from the Service Delivery and IT Committees; 5) approval of a hybrid IT approach developed by the IT Committee that builds on existing partner data systems to facilitate data-sharing through a shared tool for care management and requires all partner to sign DSAs with the City; 6) approval of the Incentive Agreement template and approach to maximize partner engagement; and 7) approval of rolling over respite care bed funds to 2018 due to challenges in securing a suitable location.

IX. PROGRAM ACTIVITIES

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

(1) **Coordination between Assertive Outreach and Housing Entities:** A workflow was created between the Assertive Outreach entity (Sacramento Covered) and the Housing Service Provider (Sacramento Self-Help Housing) to facilitate collaboration between Pathways CHWs and housing navigators to better align health and housing assessments and initiate care planning. As part of this process, housing navigators and CHWs coordinated contacts with Pathways enrollees staying at the Winter Triage Shelter to get them document ready for securing more stable housing.

(2) **Field-based Collaboration between the Assertive Outreach entity (Sacramento Covered) and the Hub's (Elica) street medicine team:** Early in the implementation process CHWs from Sacramento Covered and the Physician Assistant/Nurse team from Elica Health Centers began coordinating and aligning outreach and care two days a week at the homeless encampments along the river. Together they would assess needs, enroll individuals into the Pathways program, conduct medical checks, transport individuals to the clinic if more attention was needed, and initiate the process of engaging them in social service and housing services.

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

(1) **Length of time it takes organizations to review, agree to and sign on DSAs and BAAs created challenges with care coordination.** In order to share enrollee rosters and information with service partners, organizational agreements need to be in place. This is a common challenge in cross-sector collaboration work that involves communication about populations with complex health and behavioral health conditions. Finalizing required agreements at the organizational level prior to program implementation is an ideal scenario.

(2) **Distinguishing Pathways from other outreach and navigation programs in Sacramento.** When Pathways began enrolling enrollees in early November through referrals and street outreach with the City Police Department's Impact Team, there was some confusion among the homeless individuals receiving outreach regarding what the Pathways program offers compared to other types of navigation programs offered by City and County housing providers, hospitals, and community clinics (FQHCs). There was a need to quickly create a distinct, visible identity for the Pathways CHWs to distinguish them from other programs, so the CHWs began wearing tee shirts with the Pathways logo when doing their outreach and enrollment work. Additionally, the Pathways Program Director at Sacramento Covered, who supervises the CHWs,

initiated outreach efforts to a range of stakeholder organizations (e.g., the county primary care clinic, behavioral health clinics, CBOs, among others) to provide clear information regarding the goals and scope of the Pathways model and answer questions or concerns regarding the program's specific requirements, including eligibility criteria, enrollment processes, the actual service delivery approach, and other operational topics.

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

(1) The City of Sacramento successfully developed and signed a DSA for Pathways with 25 Partners, including community clinics, hospital systems, health plans, and community-based organizations. We expect to execute the DSA with three additional Partners in April 2018, and are simultaneously entering into productive discussions with Sacramento County about data sharing.

(2) The City identified an established and trusted non-profit in the community, Sacramento Covered, to serve as the Data Management Entity for Pathways. The City successfully contracted with Sacramento Covered for these services, and Sacramento Covered is actively using its Salesforce platform to manage Pathways enrollees in collaboration with other Pathways Partners.

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

(1) Securing hospital agreement for an approach to hospital event notifications was initially challenging, but we have made significant progress in defining an approach that hospitals will support at a conceptual level. We plan to pilot this approach with one hospital system in Q2-Q3 2018 and spread to the other hospitals from there.

(2) In order to rapidly develop a care plan in the early phase of the program, Pathways developed a streamlined Participant Profile in Sacramento Covered's Salesforce platform. A more comprehensive patient Care Plan was also developed with additional data elements. Developing both in parallel resulted in additional data entry work for partner organizations in populating both the Participant Profile and Care Plan. After discussions with partner organizations, we have made the determination to harmonize and combine the Participant Profile and Care Plan into a singular Shared Care Plan, which is expected to be complete in Q2 of 2018.

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

(1) Sacramento's first Variant and Universal Report (PY2, 2017) includes data on all relevant metrics, despite the Pathways team only having started working with partners in September 2017. That required clear communication with partners regarding reporting requirements, prompt responses to their questions, creation of data reporting templates, and quick development and execution of BAAs and DSAs.

(2) The Pathways team appreciates DHCS' WPC Unit working closely with us to provide answers to our multiple questions about the reporting requirements, which enabled our team to get back to the participant partners in time for them to submit data for the 2017 reports.

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

(1) The biggest challenge was securing signed DSAs from hospitals and health plans in time for them to submit data for the Variant and Universal Metrics report. This effort ultimately was very successful, although Pathways will need to resubmit the 2017 report, after execution of their DSAs enables the two remaining hospital systems to submit their data.

(2) While DHCS was very responsive to Sacramento's reporting questions, it would be very helpful if the answers to reporting questions that DHCS receives from all of the LEs were made available through an FAQ document. The document could be periodically updated and kept accessible online. That way DHCS doesn't have to answer the same question twice, and LEs could get answers to most their questions within seconds rather than a period of days or weeks.

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

There are some significant barriers that have potential to impact the success of the pilot. First and foremost is the lack of affordable housing and housing services for our target population. Sacramento is in the midst of a housing crisis and the availability affordable housing, shelter beds, transitional housing, and permanent supportive housing is limited. Moreover, there is simultaneously a shortage of providers with the capacity to support connecting homeless individuals to non-subsidized housing options through housing search assistance and landlord relationship building. While Pathways can provide the

assertive outreach and wraparound services (health, social services, and housing supports) that can increase connection to housing opportunities, this alone will not address Sacramento's housing shortage. An additional major barrier is the accessibility of mental health and substance use disorder services for this population, particularly for enrollees with severe mental illness.

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 Care Coordination.docx
- PDSA Comprehensive Care Plan.docx
- PDSA Data Sharing.docx
- PDSA Hospital Notifications.docx
- PDSA Enrollee Consent.docx
- WPC Pilot PDSA Summary.xlsx