State of California - Health and Human Services Agency **Department of Health Care Services**

Whole Person Care

Lead Entity Mid-Year or Annual Narrative Report

Reporting Checklist

San Joaquin County Whole Person Care
Annual PY3 (2018)
Updated July 24, 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.

I. REPORTING INSTRUCTIONS

Pursuant to the Whole Person Care Agreement and the Special Terms and Conditions of California's Medi-Cal 2020 §1115 Medicaid Demonstration waiver, each WPC Program Lead Entity ("Lead Entity") shall submit Mid-Year and Annual reports for the duration of the WPC Program. The WPC Reporting and Evaluation guidelines, Attachment GG, provide the requirements for the Mid-year and Annual report.

The Mid-Year Report narrative contains data January-June 30, and is due August 31 for Program Years (PYs) 3-5.

The Annual Report narrative contains data from January 1 through December 31, and is due April 2 each program year. The Annual Report is not meant to be duplicative of narratives provided in the Mid-Year Report, but aims to capture a complete picture of accomplishments and challenges during the Program year.

The Lead Entity is required to submit these reports to the Whole Person Care inbox at: 1115wholepersoncare@dhcs.ca.gov.

II. PROGRAM STATUS OVERVIEW

Please provide a brief overview of your program's successes and challenges and any lessons learned during the reporting period. Structure your responses in alignment with the WPC program's goals using the following as headers (from STC 112): *increasing integration among county agencies, health plans, providers, and other entities; increasing coordination and appropriate access to care; reducing inappropriate emergency and inpatient utilization; improving data collecting and sharing; achieving quality and administrative improvement benchmarks; increasing access to housing and supportive services; and improving health outcomes for the WPC population.*

The primary goals for San Joaquin County Whole Person Care are to increase integration, coordination, and access to care throughout the County and to provide positive health outcomes for a very complex and vulnerable population. To achieve these goals, SJC Healthcare Services Agency, as the Lead Entity, is focusing on creating a strong infrastructure which allows data sharing and coordination among a variety of community entities.

During PY3, San Joaquin County faced several challenges and successes.

1. Improved communication, collaboration, and integration between organizations – Teams from San Joaquin General Hospital, St. Joseph's Medical Centers, Community Medical Centers, Behavioral Health Services, Correctional Health, Public Health, shelters, and health plans met and worked to develop workflows and strategies to develop further understanding of programs, reduce duplication of services, improve and increase care coordination, improve access to care, and reduce inappropriate utilization of services.

2. Improve data sharing – The same teams mentioned above, with support from County Council, also focused on methods to improve data sharing. Steps were taken to find new ways to obtain consents, expand available staff in the field to reach the enrollees, improve outreach efforts, and meet legal standards. Data sharing has probably been the most challenging part of the Pilot to date. Finding the enrollees and building enough trust to get them to sign the document is a complex and timely process. The team pushed forward and worked together to find enrollees and utilize relationships established to increase obtaining the consents.

3. Comprehensive Care Plan – In PY3, the Administrative team with the help and support of the SJCHIE identified and obtained a Care Management Platform, Act.md, to help support the Pilot with care coordination, data sharing, and reporting. A comprehensive care plan is a critical component in the work of case managers and others with the WPC enrollees. While the teams had a care plan in place that they were able to use and share, it was not the robust living document a comprehensive care plan needs to be. We have high hopes that Act.md will serve to fill that gap in PY4.

4. Focus on metrics and improving health outcomes – The big challenge in PY3 was balancing meeting our enrollment number requirements while ensuring teams were providing the best care to the highly complex WPC population. We continued to hire throughout PY3 which helped us support the quantity of individuals we enrolled, while also identifying new opportunities for referrals. Ultimately, our goal is to make sure we are providing the most appropriate level of care of enrollees and this is more about quality versus quantity.

Overall, SJC WPC's primary goals are to build a sustainable program that can live on beyond the Pilot while providing the highest level of services and support to an extremely vulnerable, complex population.

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	88	13	30	14	16	9	170

Item	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12	Annual Unduplicated Total
Unduplicated Enrollees	13	27	15	374	44	45	518

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
Recuperative Care	$23,035	$27,455	$23,885	$20,315	$23,120	$24,225	$142,035
Utilization 1 $85.00	271	323	281	239	272	285	1,671
Care Coordination	$449.20	$224.60	$168.45	$224.60	$280.75	$168.45	$1,516.05
Utilization 2 $56.15	8	4	3	4	5	3	27

Whole Person Care

Error! Reference source not found. County

Annual PY3 2018

July 24, 2019

Costs and Aggregate Utilization for Quarters 1 and 2							
FFS	Month 1	Month 2	Month 3	Month 4	Month 5	Month 6	Total
BHS Integration Team	-	-	-	-	-	-	$60,214.24
Utilization 3 $137.00 per hour	58	98	107	132	142	102	639 (439.52 hrs)
Field Based Engagement of Homeless Individuals	$0	$0	$0	$0	$0	$0	$0
Utilization 4 $56.15	0	0	0	0	0	0	0
Re-Entry	$0	$0	$0	$0	$0	$0	$0
Utilization 5 $250.00	0	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
Recuperative Care	$37,910	$45,900	$41,055	$36,040	$38,930	$39,610	$381,480.00
Utilization 1 $85.00	446	540	483	424	458	466	4,488
Care Coordination	$224.60	$56.15	$224.60	$505.35	$224.60	$0	$2,751.35
Utilization 2 $56.15	4	1	4	9	4	0	
BHS Integration Team							$115,622.52 (404.44 hrs)
Utilization 3 $137.00 per hour	57	73	102	96	102	85	1,154 encounters (843.96 hrs)

Whole Person Care

Error! Reference source not found. County

Annual PY3 2018

July 24, 2019

Costs and Aggregate Utilization for Quarters 3 and 4							
FFS	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12	Annual Total
Field Based Engagement of Homeless Individuals	$0	$0	$0	$0	$0	$0	$0
Utilization 4 $56.15	0	0	0	0	0	0	0
Re-Entry	$0	$0	$0	$0	$0	$0	$0
Utilization 5 $250.00	0	0	0	0	0	0	0

For ***Per Member Per Month (PMPM),*** please report your rate, amount claimed and member months by PMPM type. These reports should tie to your budget, invoice and utilization reports. For "Bundle #" below, use the category number as reported in your submitted Quarterly Enrollment and Utilization Report. Add rows as needed

Amount Claimed								
PMPM	Rate	Month 1	Month 2	Month 3	Month 4	Month 5	Month 6	Total
Population Health	$161.07	$7,248.15	$1,610.70	$4,832.10	$1,288.56	$161.07	$322.14	$15,462.72
MM Counts 1		45	10	30	8	1	2	96
CMC	$161.07	$4,832.10	$4,026.75	$5,476.38	$6,764.94	$6,120.66	$7,731.36	$34,952.19
MM Counts 2		30	25	34	42	38	48	217

Amount Counts								
PMPM	Rate	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12	Total
Population Health	$161.07	$1,288.56	$805.35	$11,919.18	$66,199.77	$40,106.43	$28,187.25	$163,969.26
MM Counts 1		8	5	74	411	249	175	1,018
CMC	$161.07	$7,248.15	$11,113.83	$10,147.41	$14,174.16	$18,845.19	$12,724.53	$109,205.46
MM Counts 2		45	69	63	88	117	79	678

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

One challenge we ran into in late 2018 was when an enrollee who started out the month with one organization who was claiming a PMPM, but then transferred to a different agency who also provided a service. We are not able to claim two PMPM's for one person which meant one agency provided service but was not able to claim it.

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.

The San Joaquin County WPC PY3 WPC Administrative Budget includes a Department Applications Analyst, Management Analyst, Accountant, Public Health Nurse, Registered Nurse, Outreach Events, Learning Collaborative, Office Specialist, and Office Supplies. In 2018, we spent $210,643.67, or 26%, of the Administrative budget to support the Pilot. We believe there are two primary reasons for the low amount spent – difficulty with hiring and onboarding staff and lower utilization of some staff than originally expected.

- Department Applications Analyst III – This position was hired in October 2017 but did not join the WPC team until early 2018. Due to the significant delay in getting this position hired and onboard, others on the WPC team were completing tasks initially planned for the Applications Analyst.
- Management Analyst II – This position was fully staffed all of 2018 and is responsible for overseeing, creating, and implementing all aspects of the pilot.
- Accountant II – This position is tasked with monitoring, tracking and providing financial reporting and invoicing for the Mid-Year and Annual invoices as well as supporting the Budget Adjustment and Rollover process. This position has not been filled but has utilized staff within the department to fulfill the tasks and fiscal needs of the pilot.
- Public Health Nurse – We divided this position between two organizations, CMC and SJC Public Health. The CMC team struggled to hire and place an individual in the position and maximize their role once in place. The other organization, SJC Public Health, was not able to hire and put a team in place for most of 2018, resulting in no billing for this position. They now have a team and completed MOU for WPC.
- Registered Nurse (Community Health Education Outreach) – This entire line item was allocated to the SJGH Population Health team. They were not able to fill the positions for most of 2018. Reasons include approval from Human Resources, interview process, and onboarding. The Population Health team was still supporting the pilot by providing services, but we were not able to bill for a nurse position. The Population Health WPC team is now in place.

- Office Specialist – This position was hired in April 2018 and is responsible for supporting the WPC pilot with daily operations.
- Community Health Education and Outreach Events – There were no Education or outreach events in PY3.

As a Lead Entity, SJC Healthcare Services Agency worked extremely hard to engage partners and support the hiring process. Most of PY3 was spent developing the relationships, working to fill positions, and creating an infrastructure that can be sustainable. Since one of our primary focuses is the sustainability of the program, we want to ensure that we are hiring the best teams and providing the best training. Based on those reasons, and the overall hiring process of the County, it was impossible to maximize the Administrative budget.

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.

Through the rollover funding we were approved for, we were able to create two line items for PY3 – Hardware/Software items for WPC team and Health Information Exchange. These new line items are necessary for the infrastructure and sustainability of the program. SJC WPC did not claim any reimbursement on the mid-year invoice for Delivery Infrastructure.

In the second half of PY3, we maximized all funding available in the Hardware/Software line item and overspent by $33,480.11. We also spent most of the funding on the Health Information Exchange line item. In total, we spend 92% of the funds in this category.

Our most significant costs were incurred in obtaining a care management platform, Accountable Care Transactions Inc (Act.md), which will allow our partners to share data, coordinate care, and have a shareable comprehensive care plan available to them at all times. Act.md provides a collaboration software that will be utilized to connect various services working together toward caring for the enrollees of the WPC program. The goal of the software is to provide a single location where multiple agencies can collectively share information that is beneficial for the entire group's combined care of the individual client. Phase one, expected to go live on April 1, 2019, will include multiple phases of development and integrations to establish the ability to capture data, more easily share data, workflow automation, reporting, and consent management. Additional highlights of using Act.md include:

1) Increased and ease of referrals
2) Tool for screenings and assessments
3) Secure method of having conversations with others regarding client
4) Commitment to address interagency data sharing
5) Reduce duplication of services, efforts, and costs
6) Reduce silos throughout San Joaquin County
7) One secure method of sharing data
8) Improve reporting

In addition to Act.md, Delivery funds allowed us to provide the Behavioral Health WPC team with cell phones. The cell phones allowed team members a method for clients to reach them, access information as needed while in the field, and make linkages and referrals while in the field. Although we originally planned to provide laptops or tablets, we ultimately decided that we should wait for the care management platform to be implemented. We will revisit laptops and tablets in PY4.

VI. NARRATIVE – Incentive Payments

Please provide a detailed explanation of incentive payments earned during the Reporting Period. Elaborate on what milestones were achieved to allow the payment, the amount of each payment, and to whom the payment was made. The lead entity will only be permitted to invoice for actual incentive payments made.

Please note the narrative submitted during the Mid-Year Report will be considered part of the Annual Report and will not need to be resubmitted. Include updates, notable trends, and highlights of achievements/progress as well as any changes since the prior report.

In an effort to provide support to the community and the WPC population, there are several areas we included as incentives for PY3: Homeless Management Information System (HMIS), Care Plans, Re-Entry from Incarceration, Health Information Exchange, Patient Advocate, and Clinic Patient Services.
Details are as follows:

- HMIS – Originally planned to use to coordinate care, manage housing opportunities, and track enrollees. The SJC HMIS platform is not as robust as needed for the above. We do have a few licenses to access and enter data. The data that is in the system allows us a very brief overview of the individual, but more importantly, does allow us to enter WPC enrollees under WPC programs which allows others throughout the community to identify WPC enrollees and contact us. The incentive allowed us to provide incentive opportunities to partners for entering data into HMIS. Partners include Behavioral Health Services (BHS), Public Health Services (PHS), and Community Medical Centers (CMC) in addition to the Whole Person Care Admin team. The only teams that utilized the HMIS system were BHS, PHS, and WPC Admin team. Annual payment made to these partners was $2,687.50. Unfortunately, some partners did not see enough value.
- Care Plan – One area that became more challenging than expected was having one care plan that all partners would share for WPC enrollees. The two primary challenges are data sharing without consent and most organizations already have their own required care plan, so completing a second was a large ask. The incentive allowed us to provide funding if partners completed the care plans within the timeframe for the metric. Partners asked to complete care plans included Behavioral Health, SJGH Population Health, and Community Medical Centers. Of the three agencies, only Behavioral Health and Community Medical Centers reported completing care plans in PY3. Behavioral Health accounted for 25% and Community Medical Centers accounted for 75%, and were paid a total of $1400 for the second half of the period. Unfortunately, the incentive was not sufficient to have a large impact on the outcome as most organizations are already completing their own care plans and sharing without a consent was a barrier.

- Re-Entry – We made an effort to increase our focus on those transitioning from incarceration into the community. We had an opportunity to provide incentive funds for re-entry referrals from the County Jail on individuals who were not already enrolled in WPC. We accepted five referrals from San Joaquin County Correctional Health for re-entry. Each referral has a unit value of $250 so we paid a total of $1,250.00 to SJC Correctional Health for the five individuals. Two identified barriers that contributed to the low number of referrals included some referrals made, individuals were already enrolled in WPC, and the Jail was in the process of hiring staff to fill rolls to better identify those eligible for WPC and make referrals.
- Health Information Exchange – We were successful with significant engagement with San Joaquin Community Health Information Exchange (SJCHIE). The SJCHIE met incentive requirements by providing HIE Infrastructure Development, Case Management Infrastructure, Population Health Analytics/Reporting Infrastructure, Data Management and Integration. The staff from SJCHIE spent close to 500 hours supporting Whole Person Care for a total billable amount of $78,142.94. The HIE continues to evolve and support WPC.
- Patient Advocate – We continued to utilize funding in this line item for a housing specialist through Central Valley Low Income Housing. Understanding the various housing programs and their criteria is challenging, so having an expert available is vital to the pilot when we identify enrollees who might be ready housing. We paid Central Valley Low Income Housing $11,099.82 to support this incentive.

Clinic Patient Services – This line item was from the original application and was not utilized for the second year in a row. We have removed from our budget.

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.

San Joaquin County WPC had one Pay for Outcome in PY3 – Reporting individuals with a follow-up after hospitalization. While our teams worked hard to engage and follow up with enrollees upon discharge from a hospital, we did not achieve the outcome for a few reasons.

1. We understood the metric to only include individuals released from a mental health hospitalization so we did not implement a system to capture follow-ups after other types of hospitalization.
2. Available technology in PY3 did not provide us alerts/notifications if an enrollee was in the hospitalized. Without an alert system, staff would not know to follow up on the hospitalization.
3. We only have a contract with San Joaquin General Hospital, not other local hospitals, so data collection is difficult.

We are considering removing this outcome and adding a new one that is more trackable on the PY4 budget adjustment or rollover.

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.

****Detailed list of meeting attached**

San Joaquin County Whole Person Care participated in many community meetings and facilitated several as well. Meetings included:

- WPC Lead Entity – Key stakeholders and Executive Leadership meet quarterly regarding ongoing initiatives, pilot overview, feedback, and direction for SJC WPC.
- WPC Care Coordination for Core Team – Leadership from Behavioral Health, Public Health, General Hospital, Correctional Health Services, ST. Joseph's Medical Center, Gospel Center Rescue Mission, Health Plan of San Joaquin for planning of processes and workflows, barriers, and successes.
- Housing – Various types of meetings regarding housing with the Housing Authority, Behavioral Health Services, and Gospel Center Rescue Mission.
- Care Management Platform – Includes staff from SJCHIE, WPC Admin team, Act.md, and WPC partners regarding identification of a platform, contracting, and implementation.
- St. Joseph's Medical Centers – Includes Director of Community Health, Social Workers, Director of SJMC Behavioral Health, and Coordinator of Community Health.
- County Jail/Correctional Health – Includes Chief Mental Health Clinician, Jail Case Manager Supervisor, Jail Case Manager, Population Health team, and Behavioral Health Services.
- Health Plan of San Joaquin – Includes Director of Utilization and Case Management and Manager of Social Workers, and more.

IX. PROGRAM ACTIVITIES

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

1. One of our successes with care coordination in PY3 was our engagement with the Social Work team at Health Plan of San Joaquin (HPSJ). We created a workflow where HPSJ refers members to WPC who meet minimum criteria including 5 or more ED visits and a mental health and/or substance use diagnosis. Our team verifies Medi-Cal eligibility and enrolls the member into WPC. On a weekly basis, the Administrative Team sends a list to HPSJ that includes all newly enrolled WPC individuals who are assigned to HPSJ whether those individuals were referred directly from HPSJ or a different partner organization. We also include a list of HPSJ members who were disenrolled from WPC during that week. This workflow allows HPSJ to keep their system current with WPC enrollees and improve services they are offering should they engage the person and allows HPSJ to let the WPC team know if they receive a notification for ED, inpatient, or any other encounters that might benefit the member.
2. A second success with care coordination was our engagement with Dignity Health St. Joseph's Medical Centers (SJMC). They are one of the big local hospitals who encounter many WPC enrollees through their ED department, inpatient, and Behavioral Health. The WPC Admin team met with the SJMC Community Health team and Social Workers to develop more understanding of processes, challenges, and gaps. We also met to strategize improved relationships, gained access to SJMC HIE, and reporting. By the end of PY3, the SJMC team was referring to WPC on a regular basis, providing reports, attending meetings, and working to be part of the Care Management Platform Act.md.

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

1. One of the most critical challenges we faced in PY3 with care coordination, as well as almost every other part of WPC, is data sharing. Although we have a consent in place that allows us to share data and have BAA's with several partners, obtaining a signed consent is very difficult. Enrollees are hard to find and often hard to engage. We continuously engage with our County Council to identify ways to share information while ensuring we are in compliance with all laws and work with partners to make sure policies we put into place work for their organizations as well.
2. Another challenging area we faced in PY3 was effectively capturing care coordination. The services and supports under care coordination can be very complex. Finding ways to document the various forms of encounters, especially with the different data systems and work for each partner organization.

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

1. Although getting consents signed is difficult, we do feel we were successful in collecting consents for WPC enrollees we were able to engage with face-to-face. Our teams did an excellent job of building relationships and trust with enrollees and explaining the benefits of a signed consent. The signed consents allow our teams to share information and provide increased services and supports appropriate for the WPC enrollee.
2. Using Box to share documents and information was a success in PY3. Most of our partners utilized the Box platform to upload referrals, consents, and other patient documentation. Box was also used to message team members securely.

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

1. One effort we worked on in PY3 was to engage our Human Services Agency who has the ability to help us with Medi-Cal. We had hoped to have HSA help us check Medi-Cal eligibility on a monthly basis, but unfortunately, they do not have the manpower to do so. While that is a challenge, we were happy to implement an agreement that if we discovered an enrollee's Medi-Cal became ineligible, the HSA team would help us figure out why if we had a signed consent. We learned that even though we might not be able to utilize an entire system, we can often utilize at least parts of a system to help.
2. A second challenge we had in PY3 is data sharing in general. Without a signed consent, we are unable to share data with others or even connect multiple teams who are working with the same individual. The inability to share limits services and supports and creates inefficiencies. We have learned it is vital to obtain a consent.

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

1. We were able to increase the data we collected for reporting with more contracts and MOU's as well as relationships throughout the County with various partners. We also gained access to the systems both San Joaquin General Hospital and St. Joseph's Medical Centers.
2. In regards to data collection from enrollees, our teams worked to continuously refine our intake document and assessments. These revisions allowed us to get necessary information to help provide services.

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

1. A crucial challenge we had in PY3 was the inability to collect data from more partners. Although we increased the amount of data and the partners we were able to collect from, without contracts in place or signed consents, we were not able to get data from several organizations who are likely working with WPC enrollees and have important information. It is a work in progress to expand our partnerships and enter into agreements that will allow increased data sharing, but it is a challenge we face.
2. Another vital challenge has been the lack of a centralized system that allows us to collect the needed data for reporting. Data collection and reporting has continued to be a manual and laborious process which requires a significant amount of time and dependency on others to provide the data.

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

San Joaquin County Whole Person Care is proving itself to be a much needed missing part of the work needed to support the complex individuals who are part of the target population. There are a few areas that present concern to our team as we look forward to the sustainability of the Pilot.

1. Lack of housing: The lack of ability to house individuals is one of the top concerns in San Joaquin. Without an ability to house people, we wonder if all of the efforts put into place will allow for success. We are looking at a variety of models throughout the County in an effort to be creative with housing opportunities.

2. Data Sharing: While many efforts are being made to allow for data sharing, it is still a critical challenge and one that will possibly limit success. Every organization has their own understandings and comfort with sharing information. Once a consent is in place, it becomes easier, but overall, especially when it comes to mental health and substance use, it is extremely difficult to share information.

3. Pilot period not sufficient: The delay of Pilot approvals and lengthy process of hiring within the County meant most counties did not begin enrolling into WPC until mid PY2. Five years is not sufficient to hire, create new workflows, implement changes, analyze data, make adjustments, and make positive outcomes for the complex population of WPC. Without enough time to properly run the Pilot, we believe it will be difficult to show success.

X. PLAN-DO-STUDY-ACT

PDSA is a required component of the WPC program. The WPC PDSA Report template will be used for each PDSA that the LE is conducting. Summary and status reports are required components of your Mid-Year and Annual reports. Please attach all required PDSA documents and completed template demonstrating your progress in relation to the infrastructure, services, and other strategies as described in the approved WPC LE application and WPC STCs. Note: For the Mid-Year Report, submit information from January – June 30. For the Annual Report, submit information inclusive of all PDSAs that started, are ongoing, or were completed during the Program Year.

See attached PDSAs