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

Shasta County Health and Human Services Agency

Annual Report PY3

April 2, 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.*

Increasing integration among county agencies, health plans, providers, and other entities;

- The WPC Pilot Team consists of staff from the Lead Entity, two Federally Qualified Health Centers, HHSA Regional Services Housing, and Partnership HealthPlan of California (PHC). The Pilot Team convenes semimonthly on the second and fourth Tuesdays.
- Continued success of integrated collaboration has been boosted by the addition of hospital staff and other community providers in WPC care coordination meetings with the pilot team.
- One continued challenge includes renewed misconceptions related to the challenges of WPC participants. Following a depletion of housing stock, due to the CARR and CAMP fires in 2018, community focus has doubled down on the need for affordable housing options. The weight of this conversation has taken much of the local focus away from the critical nature of care coordination and seamless service delivery in the WPC pilot.

Increasing coordination and appropriate access to care;

- WPC participants often face significant challenges in navigating a complex system of supportive services. Coordinated case management has been the key to helping WPC participants understand and interact with a variety of community services and care providers in order to meet their personal goals.
- Challenges include determining the priority levels of care and which organization takes precedence. Additionally, many of the case managers lost their homes in the fires in August creating staffing shortages which contributed to staff burnout and hiring challenges that teamlets are still recovering from.

Reducing inappropriate emergency and inpatient utilization;

- Health Literacy education remains a top priority for RNs and case managers working with WPC participants. Education around the maintenance of chronic conditions, local non-emergency resources, and the need for regular medical visits has proven effective for many WPC participants.
- Challenges still remain for participants who have lost medications and who otherwise need to access prescribers and physicians during non-business hours.

Improving data collecting and sharing;

- Our multiparty, bi-directional release of information allows us to confidently share information amongst the Pilot Team.
- We continue to experience challenges between multiple software encryption systems for sharing data and information.
- There remain varied interpretations of HIPAA laws and data sharing agreements, which hamper data collection during critical reporting timeframes.
- We believe that the limited metrics related to chronic medical conditions are obscuring the prevalence of multiple chronic conditions and limiting our ability to share successes in improving these conditions for WPC participants.
- We also feel that building in a mechanism by which to explore the circumstances and prevalence of death among WPC participants would provide rich data to aid understanding of the gaps in the pilot's resources, structure, and systems of care.

Achieving quality and administrative improvement benchmarks;

- Having built our pilot with the administrative measures as milestones, we successfully established policies and procedures from our system model. Policies and procedures include comprehensive care plans, care coordination, referral infrastructure, data and information sharing. These policies and procedures were updated and revised to accommodate the growth and advancement of the pilot in the previous reporting year and have not needed adjusting in this period.
- Data collection from alcohol and drug resources and for those participants with Medicare are significant challenges.

Increasing access to housing and supportive services;

- Housing remains the most significant reason for people to engage with WPC. Our housing case management works quickly to help unsheltered participants obtain shelter and work towards more permanent housing.
- The housing case managers work extensively with participants to teach skills for obtaining and maintaining a home (not just temporary shelter)
- Shasta County is challenged with a significantly limited housing stock, especially appropriate affordable housing (room and board, board and care, shared housing, etc.). The housing case managers are resourceful, skilled in the housing first approach and work diligently to help our participants connect with the services, supports and resources necessary for becoming homed.
- There is a dearth of housing options to accommodate emergency shelter needs in the area, which was only made worse by the fire disasters in 2018. The limited emergency housing fund that had been available was consumed quickly by Carr and Camp Fire refugees and created a larger gap in care for the WPC population. In addition, the only shelter in town was filled and many WPC participants were forced to remain on the streets for much longer, or relocate out of the area in order to find housing.

Improving health outcomes for the WPC population;

- WPC Participants have a medical case manager, housing case manager and an RN working collaboratively with them to address their priority health and housing goals. This team has assisted participants in increasing health literacy about health care, health systems and healthy choices. Teams have assisted participants in obtaining shelter and housing which has been a significant step towards improving health outcomes and overall quality of life. Teams have also assisted participants repair relationships, learn skills for daily living, connect with resources such as benefits, foods, dental care, substance use treatment, credit repair and other daily supports. Improvement in health outcomes reported here pertains more to the Participant's goals and objectives instead of as reported in the metrics.
- Challenges arise when service provider perceptions of appropriate choices differ from the Participants'. The differing views of needs and appropriate treatment, services or interventions may happen between providers or between a participant and the care team. Harm reduction strategies are a frequent discussion item at our Pilot Team meetings.
- As much of our work in improving health behaviors is a harm reduction approach, it is difficult to utilize standard markers of improved health outcomes in many instances. We are looking to find ways to document health behavior change as a supplemental measure and how this can be applied to indicating improvements in a population health measurement.
- One additional challenge that is becoming increasingly problematic is the lack of medical and behavioral respite facilities in the area. The system of care falls short of serving those who might no longer need intensive inpatient services, but are not yet ready to live independently. WPC participants who are discharged from inpatient services and onto the streets are likely to decompensate and find themselves back in the emergency rooms. Access to appropriate respite care would serve to mitigate that gap in service.

IV. 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	6	23	10	14	15	7	75

Item	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12	Annual Unduplicated Total
Unduplicated Enrollees	12	15	10	8	9	7	61

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
Service 1	0	0	0	0	0	0	0
Utilization 1	0	0	0	0	0	0	0
Service 2	0	0	0	0	0	0	0
Utilization 2	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
Service 1	0	0	0	0	0	0	0
Utilization 1	0	0	0	0	0	0	0
Service 2	0	0	0	0	0	0	0
Utilization 2	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
Bundle #1	$595.00	$ 24,990.00	$ 33,915.00	$ 38,080.00	$ 40,460.00	$ 48,195.00	$ 44,625.00	$ 230,265.00
MM Counts 1	0	42	57	64	68	81	75	387
Bundle #2	$816.41	$ 34,289.22	$ 44,902.55	$ 48,168.19	$ 56,332.29	$ 59,597.93	$ 61,230.75	$ 304,520.93
MM Counts 2	0	42	55	59	69	73	75	373

Amount Counts								
PMPM	Rate	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12	Total
Bundle #1	$595.00	$ 42,840.00	$ 47,600.00	$ 51,170.00	$ 48,195.00	$ 45,220.00	$ 39,865.00	$ 274,890.00
MM Counts 1	0	72	80	86	81	76	67	462
Bundle #2	816.41	$ 62,047.16	$ 66,945.62	$ 71,844.08	$ 66,945.62	$ 62,863.57	$ 53,883.06	$ 384,529.11
MM Counts 2	0	76	82	88	82	77	66	471

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

During this reporting period the Staffing process was designed and implemented. This increased pilot participation in candidate review and referral process. The pilot team were able to discuss as group a candidate's future with Whole Person Care. Were we the best fit and what the team may be able to offer both inside and outside of the program.

The information included here are all enrolled members including those that were "Administratively Enrolled". This means that they are open to outreach only services. Once the Comprehensive Care Plan is completed then they are Enrolled into the program to receive full services. The metrics submitted are based on those members that were Enrolled for full services. Of the 157 referrals that were administratively enrolled during 2018 – 77 where enrolled into services.

Of the 147 individual members administratively enrolled during the reporting period, 76 were enrolled into services.

IV. NARRATIVE – Administrative Infrastructure

Please describe the administrative infrastructure that has been developed specifically for the WPC program and how it relates to achievement of program goals. Reimbursement will be based on actual costs expended and employees hired/employed for the WPC pilot, and only up to the limit of the funding request in the approved budget.

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

Administrative Infrastructure includes the HHSA Adult Services personnel required for the day-to-day implementation, monitoring and evaluation of the WPC pilot program. The personnel included in administrative infrastructure are responsible for data collection and program reporting, management of contract partners, management of program budgets and fiscal administration, and data analysis and PDSA activities. This category also includes costs for licensing software for HHSA personnel and partner entities to collect and analyze program data and support reporting on pilot program metrics.

The HHSA personnel includes the Community Development Coordinator, the Program Manager and the Senior Staff Services Analyst. During the reporting period the Community Development Coordinator transitioned into the Program Manager Role and less than the full-time allocation was utilized. The Community Development Coordinator position was open and unfilled for the last few months of PY3. Additional HHSA personnel from the contracts and fiscal units were assigned to the WPC pilot on a .25fte basis for supporting contract and budget needs. The Senior Staff Services Analyst position was filled for the entirety of PY3, but staff time was underutilized for a period of time, due to emergency re-allocation of staff during the Carr Fire in August 2018.

The Community Development Coordinator and Senior Staff Services Analyst: facilitate and support the WPC Pilot Team; guide the Pilot Team in refining the WPC system model; polish and adapt the policies and procedures; provide resources and guidance to enable the identification and enrollment of WPC Participants; gather referrals for staffing; create and improve mechanisms for documentation, information sharing, data storage and reporting; distribute reports, tracking spreadsheets and program specific data; present WPC to community partners and utilize the PDSA cycles to adapt and refine the WPC Pilot with the Pilot Team as needed.

During this reporting period, as with the prior, the uniqueness of the Whole Person Care pilot came to light in terms of the demand for time and effort from fiscal and contracts staff. Several meetings were required for understanding, planning and revising the PY3 Budgets Rollovers and Adjustments. The unique payment system required more time than originally anticipated. The same was true with the contracts staff. Due to the unique components and approaches in the WPC Pilot more time than anticipated was spent creating, refining, negotiating and approving contracts.

Software for tracking program metrics- software to track client encounters, as well as program progress and outcome measures needed to meet the metric reporting obligations of the WPC pilot has been selected and is in the design build-out process. The database continues as a stop-gap until SharePoint can be operationalized. It is our intent to have SharePoint implemented by the end of the 2nd Quarter of PY4.

V. NARRATIVE – Delivery Infrastructure

Please describe the delivery infrastructure that has been developed as a result of these funds and how it relates to achievement of pilot goals. Reimbursement will be based on actual pilot expenditure for the final deliverable or outcomes, up to the limit projected or estimated costs in the approved budget.

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

Delivery Infrastructure includes: funding for the mental health resource center, coordination of the Continuum of Care (CoC) for Redding and Shasta County, licensing of a Homeless Management Information System (HMIS), and training for WPC pilot staff and partners to build capacity for cross agency coordination, educate staff on data and information sharing policies and procedures, and support data collection, reporting, and PDSA activities. In the second part of PY3 50% of the costs for medical case management teams and housing case management teams are included in the delivery infrastructure to allow for time spent developing the programs and establishing data sharing agreements across agencies.

The Mental Health Resource Center is operated through a contract with Hill Country Health & Wellness Center. Trainings are still being provided to increase utilization and effectiveness of the HMIS system.

Contracts for medical case management are maintained with two Federally Qualified Health Centers (FQHC). During this reporting period both centers (Shasta Community Health Center and Hill Country Health & Wellness Center) experienced staffing changes. As with staffing in all other areas of the pilot, the FQHC partners were impacted by the Carr fire emergency. Direct service staff and others lost their homes to the fire and were taken away from their jobs for other emergency needs. At the end of the reporting period, Hill Country Clinic had a full team of RN and Medical Case manager, while Shasta Community Health Center had one full team of two case managers, two RNs and dedicated program supervisory staff.

As part of the Health and Human Services Agency, the Regional Services Branch, Housing Unit began with two housing case managers and hired and assigned a third case manager to the WPC Pilot Team. Direct supervisory support was included and has proven to be a necessary support due to the intensity of need within the caseloads for WPC. At the end of this reporting period, we were still battling staffing shortages due to the Carr and CAMP fires and other emergent issues related to staff health and burnout. The caseloads for the Housing Unit were intense due to staff shortage, trauma from impacts of the fire on both staff and participants, and a dearth of housing following the destruction of over 20,000 homes in the Carr and Camp Fires.

We continue work with the peer-support volunteer program that currently exists within the HHSA. This program has trained 16 people in peer support services and delivered five peer volunteers who regularly deliver volunteer services with the housing case managers.

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.

VI. NARRATIVE – Incentive Payments

Incentive Payments include the following:

HMIS incentive to input a homeless person's intake information into the Homeless Management Information System (HMIS). Estimate a total of 150 WPC participants per year and $10 per HMIS entry. This activity will be conducted by CoC Coordinator and HHSA housing case managers. The incentive payments will be split as follows: 100 for CoC and 50 for housing case management based on completion of HMIS data entries.

The housing case managers have entered 86 participant's intake information into the HMIS system during PY3. Due to the estimated cap of 150 we were only able to pay for the remaining 63.

The total of 63 entries at $10 each is a total incentive of $630.00

Sobering Center incentive for each WPC enrolled participant in the sobering center who enters detox program and stays at least 72 hours. Estimate that of WPC participants served by sobering center 50 will enter detox annually. This incentive was not paid in 2018, due to a late start at the end of the year and, thus, no admissions in 2018.

Housing Support Volunteers incentive will be paid to HHSA Housing Support Volunteer Program for each 100 home visits to WPC enrolled participants completed per volunteer. Estimate 5,000 home visits per year. No incentive was paid in 2018 for this incentive, due to a high/quick turnover rate with the trained volunteers.

Housing case management incentive for each WPC enrolled participant who stays in permanent housing for at least six consecutive months. Estimate 50 per year; 75% of incentive paid to housing case management and 25% to intensive medical case management.

There were 24 members who were permanently housed more than 6 months during this period.

The total of 24 members, times $500.00, is a total of $12,000.00.

Reduced ED utilization incentive for each WPC enrolled participant who has <2 emergency department visits for six consecutive months. Estimate 50 per year; 75% of incentive paid to intensive medical case management and 25% to housing case management.

There 32 members that met this metric.
The total of 13 members, times $500.00, is a total incentive of $16,000.00

Sobering Center research and implementation incentives which include: research, supplies, protocol development, services, and data systems reports were paid to Empire Recovery Center in December of 2018 in the amount of $131,000. This incentive amount included:

- An incentive of $10,000 for conducting research on other preexisting sobering centers through site visits ($5,000 per visit, up to 2 visits.)
- An incentive of $120,000 for satisfactory creation of protocols and reporting forms, along with a fully executed contract for services and initiation of outreach to community groups in an effort to begin services.
- An incentive of $1,000 for participation in Whole Person Care Pilot Team meetings ($500.00 per meeting for 2 meetings attended.)

Mobile Crisis Team start up and implementation incentives which include: assembly and training of MCT, procurement of physical infrastructure, development of protocols, deployment of MCT, and development of monthly reports were paid to Hill Country Clinic in December of 2018 in the amount of $305,000. This incentive amount included:

- Assembly and training of mobile crisis teams ($80,000 per team, with three teams assembled and trained: $240,000.)
- Procurement of tools, supplies, and supports for mobile service delivery: $35,000.
- Satisfactory development of protocols for safety, referral, response, communication, and care coordination: $10,000.
- Deployment of mobile crisis team to begin services: $10,000.
- Development of monthly team reports: $10,000.

Housing Volunteer Program startup and implementation incentive:

The Housing Volunteer Program Coordinator contract was signed, coordinator trained and the volunteer program began for an incentive of $10,000

The Comprehensive Training Plan was completed and approved for an incentive of $5,000.

29 housing volunteers were recruited and trained for an incentive of $5,000. in PY3, paid to the County of Shasta HHSA.

VIII. 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.

The measure selected is "Increase follow-up within 7-days post-discharge for Mental Illness [Adults] for the WPC target population." The pilot goal is to increase follow-up by 5% per year. In PY2 the metric payment is based on maintaining baseline established through reporting in PY1.

Pay for Metric Outcome Achievement incentives include enrolled WPC Participants in the measurement of performance on this measure. For the reporting period of January through December 2018 and 4 participants were hospitalized for mental illness.

There were 4 mental health hospitalizations for enrolled Whole Person Care clients during 2018. This is a sharp reduction in mental health hospitalizations that occurred prior to enrollment the program.

While many participants have had psychiatric inpatient hospitalizations prior to enrollment only 7 participants were discharged during January through December 2018. Of those 7 only 4 were referred back to Shasta County Adult Services for follow-up outpatient care. All 4 (100%) met this metric.

IX. 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.

- 7/10/18- WPC Pilot Team meeting – Capacity and Graduation, Stigma and Discrimination Mitigation, Critical Needs and Successes from Teamlets
- 7/11/18-SHARC data presentation and steering committee guidance
- 7/24/18- WPC Pilot Team meeting – Care Coordination Focus
- 7/24/19- Mercy Home Health – WPC Services and referrals - Presentation
- 7/25/18- Mercy Medical Center – WPC Services and referrals- Presentation to RNs
- 8/9/18- SHARC data presentation and steering committee guidance
- 8/14/18- WPC Pilot Team meeting- Data and Reporting/Carr Fire and WPC Participants – damages/losses/needs current and future/innovations and successes
- 8/18/18- Mercy Medical Center – WPC services and referral requirements presentation to RNs
- 8/28/18- WPC Pilot Team meeting- Care Coordination focus
- 8/29/18- WPC Orientation meeting for new RN staff at Shasta Community Health Center
- 9/5/18- SHARC data presentation and steering committee guidance
- 9/11/18- WPC Pilot Team meeting- PY3 Semi-Annual Update Group Input on Accomplishments and Challenges/Expansion of Care Coordination/Project Homeless Connect/Future Trainings
- 9/25/18- WPC Pilot Team meeting- Care Coordination focus
- 10/3/18- SHARC data presentation and steering committee guidance
- 10/9/18 -WPC Pilot Team meeting – Learning Collaborative update/Recruitment/Sobering Center and Medical Respite Insights
- 10/24/18 - WPC Pilot Team meeting- Care Coordination focus
- 11/13/18 -WPC Pilot Team meeting – Isolation and Opioid Addiction/WPC video production/data and reporting update
- 11/27/18 - WPC Pilot Team meeting- Care Coordination focus
- 9/5/18- SHARC data presentation and steering committee guidance
- 12/11/18 – WPC Pilot Team meetings – Project Planning/Goals vs Metrics/Care Coordination mapping/Future Trainings

X. PROGRAM ACTIVITIES

a.) Briefly describe 1-2 successes you have had with care coordination.
(1) Care coordination strategies continue to enable the WPC Pilot Team members to quickly and efficiently wrap services around some of our community's most high needs citizens. Several participants have been able to access a team of providers that address their needs in a personalized and focused manner leading to permanent housing and significant health improvements. (2) For participants who are beyond the scope of practice for WPC, we have been able to use care coordination strategies to assist people in connecting with the appropriate level of care in a supported manner. (3) Following the devastating fires in Redding during the summer of 2018, we were proud to have been able to locate 100% of the whole person care participants and help ensure their health and safety throughout the course of the disaster.

b.) Briefly describe 1-2 challenges you have faced with care coordination, and lessons learned from those challenges.
(1) Community perception of WPC and our abilities has been challenging. We have worked among the Pilot Team and steering committee to clarify our messages and make sure we are all communicating the same details about the WPC Pilot. We also continue to reach out to our community partners with consistent messaging and improved communication. In light of the fires, which devastated our housing stock, a renewed focus on housing has taken foot in our community. The need to emphasize the care coordination aspect of our program and re-iterate that it is not a housing program has been constant. (2) The high acuity of participants needs continues to be a challenge. Far more time and resources has been spend focusing on activities of daily living and basic social skills than was anticipated in the planning phases. Helping participants understand systems and gain the skills needed to navigate them has taken a lot of collaboration, creativity and shared efforts. The weight of these additional services combined with a dearth of qualified applicants for open positions on the teams has led to high burnout among direct service providers.

c.) Briefly describe 1-2 successes you have had with data and information sharing.
(1) Toward the end of PY2, the Pilot Team switched the referral process to a model that includes having the ROI signed as part of a referral packet. Having the ROI signed at the outset continues to allow for a more coordinated approach to eligibility determination. All members of the pilot team share information and insights that pertain to the participant's care which makes for a quicker connection into services, or for those not eligible, connection to appropriate services and programs. We are now looking at ways to extend care coordination to other community services/entities/agencies. (2) During the fourth quarter, we established a monthly care coordination/collaboration meeting inviting agency partners to share their knowledge and ask questions of our program in an effort to improve participant outcomes.

d.) Briefly describe 1-2 challenges you have faced with data sharing, and lessons learned from those challenges.
(1) One fundamental challenge with data and information sharing revolves around how much information to share, when and with whom. Operating under the premise of "only enough to do the job" or "Need to Know vs. Nice to Know" has been helpful. We have learned to be clear about expectations across industries and general information sharing guidelines. Finding a software program or technology option that allows for all Pilot Team members to access the data and participant information in one will also be helpful. SharePoint seems to be one option that is cost effective, meets privacy and security concerns and provides the needed functionality for a small pilot. There are ongoing discussions and contracting in place for a governance plan to implement SharePoint.

e.) Briefly describe 1-2 successes you have had with data collection and/or reporting.
1) The database, spreadsheets, paper copies of ROIs and comprehensive care plans sent via encryption still allow for functional data collection and reporting. The Database allows for information to be customized and presented in graphs and charts that help to inform our stakeholders. These formats also allow for functional collection of data from our participating entities to inform the required reports to the State. While a system that allows all of this information to be shared or accessed in one location is preferred, all of the necessary components have been created and are easy to use and access. 2) During this reporting period, we have developed good rapport with our DHCS Analyst, Amy. She has been very supportive and helpful in providing guidance and swift communication.

f.) Briefly describe 1-2 challenges you have faced with data collection and/or reporting.
1) Delays in claims data, especially for those with Medicare, continues to be challenging in determining eligibility and reporting on metrics or baseline data. Reporting on the metrics has been challenging due to a lack of clarity from DHCS as well as in the HEDIS measures with the WPC adaptations. 2) There remain varied interpretations of HIPAA laws and data sharing agreements, which impede and delay data collection during critical reporting timeframes.

g.) Looking ahead, what do you foresee as the biggest barriers to success for the WPC Program overall?
We feel that the greatest barrier to the success of our program has been and continues to be community-wide misconceptions about the importance of housing to a coordinated care program. The ability to locate a safe place to live is obviously an important part of a person's recovery from complex health conditions, but public concern with "getting people off the streets" has overshadowed the intensive care components of this program, which we feel, are deeply vital to its success. The challenges of navigating a complicated system of care while living with dual-diagnosis chronic health conditions, disability, stigma, and isolation are not solved by housing. These challenges require intensive case management across the spectrum of services and are necessary to address the health disparities we see for people of limited economic means in our community. If resources are not devoted to system-wide administrative, executive, technological, and direct service infrastructure which serve to connect and streamline a fractured system of care, we will be left with many isolated people deteriorating in – and alongside their homes.

XI. 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.*

List PDSA attachments
• Shasta WPC PDSA Ambulatory Care 1 PY3 2018 - Why ED • Shasta WPC PDSA Ambulatory Care 2 PY3 2018 - Health Literacy • Shasta WPC PDSA Care Coordination 1 PY3 2018 - Est Care Coord • Shasta WPC PDSA Care Coordination 2 PY3 2018 - Referral System to Staffing • Shasta WPC PDSA Comprehensive Care Plan 1 PY3 2018 - Design CCP • Shasta WPC PDSA Data 1 PY3 2018 - Sharing Data • Shasta WPC PDSA Data 4 PY3 2018 – SharePoint • Shasta WPC PDSA Inpatient Utilization PY3 2018 – Why IP • Shasta WPC PDSA Other 2 PY3 2018 - Elig Criteria