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

Whole Person Care

Lead Entity Mid-Year or Annual Narrative Report

Reporting Checklist

Orange County Whole Person Care
Annual and Program Year 3
Revised May 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.*

Increase Integration:

Successes: In PY3, the Orange County WPC Pilot increased integration between Behavioral Health Services, CalOptima, community hospitals, community clinics and recuperative care facilities through the continuance of monthly WPC Collaborative meetings and monthly subgroup meetings focused on specific topics such as improving the coordination of care and assisting the clients in securing housing (see below for more information). In addition, the County of Orange launched WPC Connect (see attachment A), an online platform which allows hospitals, CalOptima, community clinics, Behavioral Health Services, public health agencies and recuperative care providers to share information regarding the status of their homeless clients. This platform has improved integration of service provision among agencies in the county by allowing providers to share data which should improve treatment planning for the client. In addition to using WPC Connect for this project, WPC staff have met with local hospitals about using the WPC Connect system to meet the requirements of Senate Bill 1152 for their homeless patients. As more providers use WPC Connect, the more integrated service provision will occur between agencies.

Challenges: Some of the providers have been slow adopters of the WPC Connect system. This is driven partly by understanding why a separate BAA is required, understanding of what is exactly required to be connected to the system, impact to other workload, willingness to share data, using a new technology, and staff turnover.

Lessons Learned: Continual training on new technology (and the project) is needed to ensure buy-in of agencies. Additional administrative intervention and education will also be necessary to get providers to use WPC Connect for client service referrals functionality.

Increase Coordination/Access to Care:

Successes: Coordination and access to care has been improved through the implementation of WPC Connect, which allows medical providers to update relevant information into a patient's collaborative care plan and refer them to services if they

are new to the WPC Program. The system will send alerts to other members of the patient's care team that the patient received a hospital visit. As other homeless-service agencies interact with the homeless patient, all necessary medical coordination history, as well as linkages to community services and documentation for housing readiness will be in one place. This cross sharing of information is central to the project and will ensure the right services are provided for each homeless patient while reducing duplication of efforts across providers. Other successes related to WPC Connect is its ability to share care plans and upload/share pertinent patient records for the continuity of care; the ability to send referrals and track statuses of the service request; the identification of a care team and contact information of providers which allows for the coordination of care; the ability to update the last known locations and contacts to improve patient tracking; and the creation of a virtual care neighborhood which has brought providers into a connected environment. In 2018, the following providers completed seven Business Associate Agreements (BAA's) with Safety Net Connect, the provider who manages WPC Connect: Korean Community Health Center (11/16/18), St. Jude Hospital (11/20/18), Illumination Foundation (12/5/18), Hurtt Family Medical Center (12/7/18), Monarch Health (12/7/18), Colette's Children Home (12/11/18), and Families Together (12/27/18), Five of the seven agencies began using WPC Connect during 2018.

Second, it has become evident that the homeless population is prone to becoming lost once they leave a facility, transfer between facilities, or return to the streets without measures in place to mitigate this occurrence. The homeless population by its very nature is transient. In addition, individual providers often provide case management services within their organization, so there is not one person who knows where the client is at all times, or takes that responsibility to know. To address this gap, a provider subcommittee was formed to strategize ways to track and serve clients who may be on the streets or become disengaged from services. From this subcommittee the concept of a Core Care Coordinator arose and a PDSA on this concept was created (see PDSA for more information). It is our intention to align this function with the Health Home CB-CMEs.

Lastly, the WPC team identified providers to pilot a pet fostering program for homeless clients who need a safe place to leave their pet while they are in an inpatient setting. The provision of preliminary behavioral assessments of the animal and veterinary care will be done through a contract with *Healthcare & Emergency Animal Rescue Team (HEART)* which is contracted with *American Family Housing* (an organization that provides a continuum of housing and support services to homeless). American Family Housing employs previously homeless and currently rehoused clients to serve as foster homes for pets of the currently homeless WPC clients.

Challenges: During 2018, there were three major challenges in care coordination. First, the original estimated timeline for the development and use of WPC Connect was optimistic. It took longer to establish BAAs with the providers and Safety Net Connect, to train the providers, and have them begin entering data into the system. This was partly due to turnover in provider staff and the need for more intensive program support education than anticipated. Second, WPC staff have had to work to break the silos of individual providers, particularly as it relates to introducing the concept of a Core Care Coordinator. WPC staff have faced resistance of providers who are concerned that introduction of this position would somehow threaten their WPC funding. WPC staff have been working to secure funding for this position.

Lastly, piloting of the pet fostering program was delayed due to procedural agreements between providers.

Lessons Learned: As pet fostering is outside of the usual scope of the WPC project, HCA staff have had to learn to navigate the veterinary, pet healthcare and foster organizations (HEART).

Reduce inappropriate ER/Inpatient Utilization:

Successes: During 2018, WPC staff held a series of meetings with CalOptima related to obtaining client level emergency room and inpatient utilization data. Client level data is needed to fully understand and evaluation emergency room and hospital utilization among the WPC population. CalOptima has agreed to provide client-level data related to the date of service, length of stay in the hospital, diagnoses, and medical claims related to the hospitalization. As soon as this data is received by WPC staff, it will be analyzed to examine any trends in utilization usage, subgroup differences, and any correlations to primary care visits.

To assist in determining possible reasons behind the increase in ambulatory care/emergency room visits and inpatient utilization compared to baseline, WPC developed PDSAs to identify contextual events that occurred in Orange County which may have led to more homeless clients seeking hospital services. A subgroup of WPC collaborative members met to provide a listing and timeline (see PDSA for more information) of potentially impactful events. This timeline will be useful when examining multiple metrics such as the two indicated above. For example, the timeline tells us that there several large scale events that occurred in 2016, particularly in the last quarter of 2016 which may have influenced the increase in emergency room and inpatient utilization among WPC clients. This increase is also consistent with data on the number of hospitalizations and number of bed days among the overall homeless population in Orange County starting in 2016 (PY1). The majority of WPC activities began in 2017 (PY2) which may have influenced both the increase of these metrics between the baseline and PY2 and the decline in these metrics between PY2 and PY3 (see section on Pay for Outcomes).

WPC staff also collaborated with CalOptima about the possibility of having CalOptima pay for medical respite care for clients who need hospice or chemotherapy. CalOptima is scheduled to formally request funds for these services at their Board meeting in April 2019. If CalOptima is able to serve these clients in medical respite care, it is hoped that they will not need to be seen in the emergency room or be hospitalized for ongoing health issues.

Challenges: It has been a challenge to be able to analyze project metrics without client level data. Obtaining client-level data from out Managed Care Plan has taken longer than expected due to negotiations related to the metrics desired by WPC staff, mostly due to HIPAA concerns. CalOptima has been a great partner in helping to address the data needs, and we have resolved these concerns in early 2019.

Lessons Learned: Without aggregate metrics, it is difficult to determine the reasoning behind trends and data findings. Thus, WPC staff realize that it is important to capture contextual events rather than relying solely on metrics in order to tell the complete client story. For example, use of recuperative care prior to the implementation of the WPC was negotiated and paid for by individual hospitals, with not all hospitals using the service due to the various administrative reasons, and many rarely approving more than 15 days regardless of client medical need. As a result, the WPC Program grossly underestimated the true need for recuperative care and when the WPC centralized authorization and payment under its umbrella, there was a significant increase recuperative care referrals, all of which required an ER referral. Once this trend was identified, the WPC quickly responded with recommendations for referrals to go directly to recuperative care without the need for an ER referral, as appropriate to the enrollees' medical needs. Additionally, articles on services implemented by the WPC program may have led more clients to seek services. In addition, future proposals or projects should expect that there will be an initial increase in services rather than a decline compared to baseline metrics.

Improved Data Collection/Sharing:

Successes: As mentioned above, a major success during PY3 was the launch of WPC Connect. This has allowed for real-time data collection, reporting and data sharing between agencies. With the implementation of WPC Connect, WPC staff began transitioning to manual data collection and reporting of data directly into WPC Connect, which receives a direct eligibility feed from CalOptima. This feed has reduced the need for WPC staff to manually look up Medi-Cal eligibility for potential clients. Automatic data feeds are also occurring daily from five non-WPC funded hospitals, with more expected. These hospitals have agreed to share their data as they see the utility of the project and the data system in serving homeless clients in the county.

In addition to the implementing a new data system, WPC staff held a series of meetings with CalOptima and Behavioral Health Services related to the provision of client level data for WPC clients. As a result of the meetings, WPC staff received a dataset of all public health and behavioral health encounter data for WPC clients served by Health Care Agency programs from 2016-present. In addition, WPC staff received all substance abuse treatment admission (and discharge) data for any clients who may have entered substance abuse treatment. In early 2019, WPC staff will also receive all hospital-related encounter data for WPC clients who have been served to date. CalOptima has also agreed to provide the total sum of Medi-Cal claims paid for each member. This will allow WPC staff to examine costs in relation to the types of Medi-Cal services provided to the client. Receipt of this data is crucial to being able to tell the complete story of the WPC program, by total and subset WPC populations. CalOptima has been a great data sharing partner.

Challenges: Converting from a manual data collection process to an on-line process can be difficult and result in delays in obtaining data for the project. For example, as providers only began inputting data in WPC Connect in the last quarter of 2018, it will take a while for all the state metric data to be available, especially data that is dependent on providers. This delays the ability of WPC staff to collect, analyze and present some of the state metric data, especially the optional metrics. WPC staff also experienced the possessiveness and protection of client data even when data sharing agreements are in place and providers have been attending collaborative meetings. WPC staff have also experienced some difficulty obtaining monthly PMPM data from providers, especially those who experience staff turnover. In addition, obtaining “true” costs is difficult as providers only receive capitated rates.

Lessons Learned: Data sharing by partners may take longer than expected and the process for obtaining data should be done as early in the process as possible. All partner expectations may need to be communicated multiple times. In addition, WPC staff may need to meet with partners multiple times to explain the project, its expected outcomes, and the data required to show project effectiveness.

Achieve Quality/Administrative improvement benchmarks:

Successes: Conducting PDSA’s is crucial to making course corrections in the WPC program (if necessary). In the PY2 and the first half of PY3, WPC staff created more than 20 PDSA’s. In order to improve the quality of the PDSA’s, WPC staff decided to only conduct the five requisite state PDSA’s, and two optional PDSA’s related to housing and sustainability. This refinement of PDSA’s and reduction in number in the latter half of 2018 has allowed WPC staff to perform more targeted quality improvement efforts.

The implementation of WPC Connect has also improved the quality of the data as the contractors have implemented multiple data quality checks. In addition, the receipt of

the data feeds and uploading of provider data has reduced the chances of data entry errors.

Challenges: Moving from manual entry to an automated system has taken longer than expected. As the automated systems did not get implemented until the second half of PY3, WPC staff have had to balance manual data reporting with direct entry.

Lessons Learned: It is important to plan that implementing a new system and obtaining buy-in may take longer than expected. In addition, data quality control is extremely important, especially if providers are manually providing data. Providing technical assistance and training is crucial and needs to occur multiple times and in multiple venues.

Increase Access to Housing & Supportive Services:

Successes: The U.S. Department of Housing and Urban Development (HUD) awarded $98.5 million to 285 local public housing authorities across the country to provide permanent affordable housing to nearly 12,000 additional non-elderly persons with disabilities. The WPC program was contacted by the Orange County Housing Authority and the cities of Santa Ana and Anaheim who received HUD grants that a limited number of housing vouchers were available for WPC clients. The Orange County Housing Authority wanted to target recuperative care clients who were discharged from area hospitals but too sick to recover safely in shelters or on the street, and thus who were at high risk of readmission. The Housing Authority believed that this target population would fill a gap regarding housing resources for the homeless population. Colette's Children's Home, a WPC funded provider, agreed to provide Housing Navigators to assist the client in finding appropriate housing facilities which take the voucher. The Housing Navigators will also provide transportation to the housing sites and assist the client in obtaining furniture and other needed supplies for their home.

Challenges: It has taken longer than expected to finalize the process for the Housing Authority to receive voucher referrals. In addition, there was not a system in place for non-BHS WPC clients to receive the available housing vouchers. As housing services are not the primary focus of the project, obtaining outcomes on housing services from providers has been difficult. For example, WPC staff have been unable to obtain the optional metrics related to days in independent living or permanent supportive housing and number of homeless days. With more housing providers participating in the WPC project, this data is expected to be collected in PY4.

Lessons Learned: One of the most important lessons learned is that as clients and organizations learn of the program, there will be an increase in the requests for participation particularly related to housing services. Appropriate resources need to be allocated to handle the increase in demand.

Improve Health Outcomes:

Successes: A major success of PY3 were the agreements with agencies to provide client-level data. This will allow for a careful examination of health outcomes such as a reduction in the use of inpatient medical services, increased compliance with medication, development of a comprehensive care plan and receipt of case management and mental health services. For example, CalOptima has agreed to provide client-level data on hospital utilization and pharmacy claims. The latter information will allow WPC staff to evaluate medication compliance, particularly among diabetic clients. To date, this information has been lacking. In PY3, there was a concerted effort to focus on evaluation of the WPC project including improving data collection methods and data sources.

Challenges: Collecting health outcome data and reporting some of the metrics has been challenging. In PY3, WPC staff has had to rely on HEDIS metrics or anecdotal information. The data source for collecting the depression and suicide risk information has yet to be finalized, primarily due to changes in how BHS services were implanted in Orange County and staff resources. In addition, the exact suicide risk assessment to be used was not finalized as providers use different assessments, indicators or do not collect the data at all. The measure and procedures were ongoing in 2018. Thus, no data was collected on depression readmission at 12 months or major depressive disorder-suicide risk assessment. This data will be collected beginning PY4. It was determined that this information should be collected on clients in recuperative care as they are with the provider long enough to do the assessments, including the follow-up. WPC staff also faced some unwillingness of partners to provide data on the WPC clients. This is often a result of protectiveness of the agency of their data, which is understandable.

Lessons Learned: Data sharing agreements should be completed as early in the process as possible. It is crucial to be able to identify any and all possible data elements to be requested of a participating partner. It is also important to continuously meet and brief all levels of staff on the intent of the project and how their data can contribute to the project's evaluation, with the ultimate goal of improving the lives of homeless clients and keeping them out of the emergency departments unnecessarily.

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	539	372	326	340	426	365	2368

Item	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12	Annual Unduplicated Total
Unduplicated Enrollees	345	392	308	273	283	243	1844

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 Respite Care	$111,869.52	$124,419.80	$134,740.34	$119,132.12	$93,904.14	$73,199.36	$657,265.29
Utilization 1 $180.50	1,756	1,953	2,115	1,870	1,474	1,149	10,317

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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 Respite Care	$80,079.72	$96,707.25	$76,958.08	$86,195.59	$93,075.95	$102,823.12	$1,193,187.60
Utilization 1 $180.50	1,257	1,518	1,208	1,353	1,461	1,614	18,728

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
Hospital and Clinic Homeless Navigation Services	$121	$243,210	$260,997	$278,300	$311,938	$340,736	$364,089	$1,799,270
MM Counts 1		2,010	2,157	2,300	2,578	2,816	3,009	14,870
Supportive and Linkage Services Provided by Drop-in Center Providers	$216	$60,912	$53,784	$60,264	$57,672	$60,048	$53,568	$346,248
MM Counts 2		282	249	279	267	278	248	1,603
SMI Specific Outreach and Navigation Services Provided by County Outreach Staff	$207.50	$99,185	$91,922.50	$74,907.50	$43,990	$37,557.50	$31,747.50	$379,110
MM Counts 3		478	443	361	212	181	153	1,828

Amount Counts								
PMPM	Rate	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12	Total
Hospital and Clinic Homeless Navigation Services	$121	$378,730	$395,670	$390,104	$385,385	$385,990	$380,908	$4,116,057
MM Counts 1		3,130	3,270	3,224	3,185	3,190	3,148	34,017
Supportive and Linkage Services Provided by Drop-in Center Providers	$216	$54,000	$45,576	$56,376	$44,496	$42,120	$37,152	$625,968
MM Counts 2		250	211	261	206	195	172	2,898
SMI Specific Outreach and Navigation Services Provided by County Outreach Staff	$207.50	$30,502.50	$22,410	$23,032.50	$43,160	$51,045	$52,705	$602,165
MM Counts 3		147	108	111	208	246	254	2,902

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

Unduplicated Enrollees: Orange County understands that DHCS has requested that unduplicated enrollee number include only those considered "initially enrolled" in the WPC Program during PY 3 (no prior enrollment in PY 2, even if dis-enrolled in PY 2 and re-enrolled in PY 3). Given this understanding, the numbers reported reflect only those person enrolled in Orange County's WPC Program for the very first time in PY 3.

FFS: Orange County only has Recuperative Care identified under the FFS category. The FFS amount identified in the report reflects the County's actual fully audited days per month provided and the actual annual cost of providing these services for the entire 12-month PY3 period. These amounts will differ from the Mid-year PY 3 report and invoice, as well as the annual PY3 invoice, since it provides the total days and cost for the year. As such, the PY 3 annual invoice serves as a reconciliation between what was reported and claimed during mid-year PY3 (10, 175 days at $62.25/day) and what the final actual cost and services for the year in its entirety (18,728 days at $63.71/bed day). As a result, the annual PY 3 invoices reflects the adjustments necessary to result in the entire year paid at the correct amount (8,553 days at $65.45/day).

Days Reported Mid Year	**Audit Days Jan-Jun**	**Amt Claimed Mid-Year**	**Audited**	**Due County/ (Retain by DHCS)**
10,175	10,317	$633,393.75	$657,265.29	$23,871.54
Days Reported Annual	**Audit Days July - Dec**	**Amt Claimed Annual**	**Audited Annual**	**Due County/ (Retain by DHCS)**
8,553	8,411	$559,793.85	$535,839.71	$(23,954.14)
Total Days Reported	**Total Audit Days**	**Total Claimed**	**Total Audited**	**Total Due**
18,728	18,728	$1,193,187.60	$1,193,105.00 *Max Budget*	(82.60) *See Invoice Summary Page*

PMPM: Member months reported for all categories are as approved in the extension application.

PMPM #1 – Hospital & Clinic Homeless Navigation Services: Orange County's PY 3 target member months for this service is 26,640. For the PY3 Mid-year report, 14,994 member months were reported. Following a final audit of PMPM #1 services, this number is actually 14,870 member months. The total member months for PY 3 Q3 and Q4 totals 19,147 member months; however, 19,023 are being claimed to adjust for the PY 3 Mid-Year. In total, 34,017 member months were provided. Orange County has submitted a request that this overage be covered from the additional funds recently made available by DHCS.

PMPM #2 – Drop-In Center Supportive & Linkage Services: Orange County's PY 3 target member months for this service is 1,800. For the PY3 Mid-year report, 1,953 member months were reported and as a result, Orange County claimed its maximum budget at that time. Following a final audit of PMPM #2 services, this number is actually 1,603 member months. The total member months for PY 3 Q3 and Q4 totals 1,295 member months; however, 1,098 are being claimed to adjust for the PY 3 Mid-Year over reporting. In total, 2,898 member months were provided; however, while the invoice the invoice shows 3,051 member months total for PY 3 Mid-Year and the PY 3 Annual, the net payment will reflect the actual 2,898 member months as follows:

MM Reported Mid Year	**Audit MM Jan-Jun**	**Mid Year Paid**	**Amt Claimed Mid-Year**	**Audited Mid-Year**	**Due County/ (Retain by DHCS)**
1,953	1,603	1,800	$388,800.00	$346,248.00	$(42,552.00)
MM Reported Annual	**Audit MM July - Dec**	**Annual Paid Requested**	**Amt Claimed Annual**	**Audited Annual**	**Due County/ (Retain by DHCS)**
1,098	1,295	1,098	$237,168.00	$279,720.00	$42,552.00
Total MM	**Total Audit MM**	**Total Paid**	**Total Claimed**	**Total Audited**	**Total Due**
3,051	2,898	2,898	$625,968.00	$625,968.00	$0

Orange County has submitted a request that this overage be covered from the additional funds recently made available by DHCS.

PMPM #3 –SMI Supportive & Linkage Services: Orange County's PY 3 target member months for this service was 720 at the time that the PY 3 Mid-year invoice was submitted. For the PY 3 Mid-year report, 2,047 member months were reported and as a result, Orange County claimed its maximum budget at that time. Since that time, a PY 3 mid-year budget adjustment increased the total member months to 1,561. Since funding for 720 was all that was claimed in the PY 3 Mid-year, this

would allow for Orange County to submit a claim for an additional 841 member months with the PY 3 Annual invoice. Following a final audit of PMPM #3 services, the actual number of member months provided for PY 3 Q1 and Q2 is 1,828, still exceeding the amount reimbursed. The final amount for PY 3 is 2,902 member months, with 1,074 member months provided for PY 3 Q3 and Q4; however, 2,182 are being claimed to cover the overage from Mid-year as follows:

MM Reported Mid Year	**Audit MM Jan-Jun**	**Mid Year Paid**	**Amt Claimed Mid-Year**	**Audited Mid-Year**	**Due County/ (Retained by DHCS)**
2,047	1,828	720	$149,400	$379,310	$229,910
MM Reported Annual	**Audit MM July - Dec**	**Annual Paid Requested**	**Amt Claimed Annual**	**Audited Annual**	**Due County/ (Retained by DHCS)**
2,182	1,074	2,182	$452,765	$222,855	$(229,910)
Total MM	**Total Audit MM**	**Total Paid**	**Total Claimed**	**Total Audited**	**Total Due**
4,229	2,902	2,902	602,165.00	602,165.00	$0

Orange County has submitted a request that this overage be covered from the additional funds recently made available by DHCS.

Revised quarterly Utilization and Enrollment reports for Quarter 1 through Quarter 4 of 2018 have been submitted to correspond with the above numbers.

IV. NARRATIVE – Administrative Infrastructure

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

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

County Administrative Support to Implement and Administer the WPC:
Both staff were hired to help implement and administer the WPC. The previously reported staff member who was brought on in a non-benefit position has now been placed in a benefited position and Orange County will expend all of its administrative support dollars.

CalOptima Administrative Support:
CalOptima hired the Personal Care Coordinator to aid in coordinating Medi-Cal benefits for WPC beneficiaries being served by hospitals, community clinics, recuperative care, County Behavioral Health Services, and the drop-in centers. CalOptima recognized the value of this position particularly in assisting persons struggling with homelessness and the community providers trying to assist them and used its own funding to add a second Personal Care Coordinator to the team.

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.

Community Referral System (CRN)

The CRN is a free, web-based referral app designed to facilitate synergistic relationships with community clinics, hospitals, and social service agencies in order to provide holistic care for their clients. The mission of CRN is to bridge service gaps, create a stronger network of services and achieve a healthy empowered community. The CRN provides an additional resource, meant to supplement and enhance services provided by existing community based social service referral agencies, such as 2-1-1 Orange County (211-OC) and its network of providers.

The WPC program has funded the expansion of the social services component of the CRN. From January 1, 2018 to December 31, 2018, over **400** total social service referrals went through the system.

Adding vendors to take referrals vs making referrals has been a challenge; however, the goals for 2018 were met. The WPC team is working with the CRN provider to reach broader audiences and expects that goals will be far exceeding in PY 4.

WPC Connect:

Program and Test System
Load Eligibility Data
Connect 2 Hospital
Link 4 participating entities

The timeframe to bring individual hospital IT departments on board with the WPC Connect plan have been challenging, but we successfully brought on 5 hospitals in PY 3, exceeding the goal of 2 Hospitals. There has been some understandable confusion with the hospital community as the ER linkage to WPC Connect is a separate component from access to WPC Connect. The WPC had to take a step back to be sure everyone was on the same page.

Linking the 4 participating entities has been more challenging than anticipated due to the discussion under Section II, Increase Coordination/Access to Care, it took longer to establish BAAs with the providers and Safety Net Connect, to train the providers, and have them begin entering data into the system. This was partly due to turnover in

provider staff and the need for more intensive program support education than anticipated. While we were successfully able to connect 5 community partners, we requested to roll-over the funds to PY4 in anticipation that it may not happen since go live did not occur until November, 2018.

VI. NARRATIVE – Incentive Payments

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

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

Training of WPC Clinics and Hospitals on the Coordinated Entry Process by 211 OC
Only one training was provided on the Coordinated Entry System. Unknown to the WPC Program, the County's housing program had been implementing steps to transfer responsibility of the CES from the contracted provider (211 OC) to the County. This occurred on July 1, 2018. The County is in the process of modifying the CES process, so no additional trainings have been provided. These funds were addressed the PY 3 Budget Adjustment request.

VII. NARRATIVE – Pay for Outcome

Referencing the Whole Person Care Universal and Variant Metrics Technical Specifications, please provide a detailed explanation of the status of your program's performance on the pay-for-outcome metric(s). For the Mid-year report, only report those measures that are reported semi-annually; for the Annual report, please report all. Provide details that demonstrate what was achieved for each outcome, any challenges, and any lessons learned. Reimbursement will occur for achieved outcomes based on proposed annual target and methodology.

For Orange County, there are five Universal Metrics, five Variant Metrics, and seven optional metrics that need to be reported on at this time.

Universal Metrics:
Ambulatory Care- Emergency Department (AMB-ED)
Inpatient Utilization – General Hospital/Acute Care (IPU)
Follow-Up After Hospitalization for Mental Health
Initiation and Engagement of Alcohol and Other Drug Dependence
Comprehensive Care Plan

Achieved: Compared to PY2, WPC saw a decrease in rates of Ambulatory Care-Emergency Department and Inpatient Utilization. There was a 24% decrease in Ambulatory Care-Emergency Room visits and a 16% decrease in inpatient utilization.

Challenges: The WPC project collected much of the data on clients manually during PY3. As a result, Medi-Cal verification took longer than expected. This caused delays in sending client CINs to CalOptima for them to run the metrics. In addition, access to data particularly related to mental health and substance abuse has been challenging. As a result, data for these metrics is unavailable for PY3.

Lessons Learned: Any delay in the process of data collection anywhere along the chain of the project will cause delays in data collection and analysis for the whole project. This can cause frustration among partners and WPC staff in producing data for evaluation.

Variant Metrics:
Comprehensive Diabetes Care
Depression Readmission at 12 Months
Major Depressive Disorder-Suicide Risk Assessment
Housing Services
All Cause Readmission

Achieved: Compared to PY2, WPC saw a decrease in rates of All Cause Admissions. There was a 3% decrease in All Cause Admissions.

Challenges: Data for the metrics such as comprehensive diabetes care requires manual chart review by CalOptima staff. This causes delays in reporting the metrics. In addition, data related to depression and suicide risk has been delayed as it required partners agreeing on the instrument and data collection.

Lessons Learned: Instruments to be used to assess individual risks such as suicide should be agreed upon at the onset of the project. This would reduce delays in data collection.

Optional Metrics:

Members Linked to Case Management
Percent of Referrals Resulting in Linkage to Services from County Behavioral Health
Increase in Primary Care Physician Office Visits
Number of Days Psychiatrically Hospitalized
Number of Days in Independent Living or Permanent Supportive Housing
Number of Homeless Days
Compliance to Medications

Achieved: During PY3, WPC staff met with WPC partners to develop data sharing agreements to obtain client-level data for the optional metrics. Client level data for behavioral health services was received in late PY3.

Challenges: Access to data particularly related to mental health and substance abuse has been challenging as partners are often very protective about the sharing of data, even with partners with whom they have data sharing agreements. As a result, data for these metrics is unavailable for PY3. In addition, data relating to housing is not yet available from the partners.

Lessons Learned: Any delay in the process of data collection anywhere along the chain of the project will cause delays in data collection and analysis for the whole project. In addition, the sharing of data dictionaries for the multiple datasets will facilitate the data sharing agreements and speed the delivery of client-level data. Often, partners have much more data than is required for a project. Without knowing all data that is relevant to the project and available, it often takes multiple meetings to finalize agreements on the data to be shared.

Metrics tied to Payment:

1) "15% reduction in ER utilization over baseline": Although there was a decrease in ER utilization in PY3 compared to PY2, our Pay for Outcomes measure is tied to a 15% decrease over baseline. Unfortunately, the ER utilization in PY3 was 31.25% higher than the baseline rates, so no payment was claimed for this metric. Orange County has submitted a request to DHCS to consider modification of the metric to reflect the decrease in ER utilization from PY 3 to PY 2 and the overwhelming success of the WPC's Recuperative Care Program

that was the unintentional driver for the increased ER visits. Please see memo dated May 24, 2019.
Total budgeted: $87,225
Total amount claimed: $87,225 – pending DHCS consideration

2) "25% of persons newly admitted to Recuperative Care will receive a Comprehensive Care Plan upon discharge": 100% of our clients admitted to Recuperative Care received a Comprehensive Care Plan upon discharge in PY3.
Total budgeted: $87,225
Total amount claimed: $87,225

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.

Date	Activity
January 12, 2018	WPC Collaborative Update of WPC PY 2 data and services through November 30, 2018. Recuperative Care Referrals – PY 2 Actuals and approach to PY 3 with given funding. Review of Recuperative Care Dashboard
January 24, 2018	Recuperative Care Sub-Committee – Referral Processes
February 9, 2018	WPC Collaborative Check-In Recuperative Care - Staying within budget for 2018 – census to be at around 34 clients per day - Options to increase funding – Send any ideas to WPC@ochca.com Check-In WPC Connect - Hospitals – St.Joe's and St. Jude to connect. WPC Care Plan Platform – meeting with representatives from each area to get input/feedback
February 20, 2018	WPC Hospital Meeting Check in on referrals to recuperative care – advise of approach to stay within budget. Options for supplementing WPC dollars with CalOptima IGT opportunity
March 20, 2018	WPC Hospital Meeting Update on New Recuperative Care Policies and Procedures; Recuperative Care providers present to hear feedback and provide response and their feedback to hospitals.
April 6, 2018	WPC Collaborative Check In on how new Recuperative Care P&P going Check in on WPC Connect – proceeding as planned. Data loaded and tested, input from test group being evaluated for system changes. Reminder of DHCS timelines for Baseline and Metrics Reporting Planning for next WPC Meet & Greet

Date	Activity
May 18, 2018	WPC 102 and Meet & Greet - In-depth overview of Recuperative Care; intro of new vendor - Intro of CalOptima PCC and vision for her role in WPC - Understanding Medi-Cal Long Term Services and Supports Overview of SMI targeted services: Housing Navigation and Sustainability
June 20, 2018	Recuperative Care Sub-Committee – What is working/needs improvement? Building blocks for PDSA.
July 13, 2018	WPC Collaborative Recuperative care sheet introduced that will serve as a handy one-page document on our Recuperative Care Partners, services, and resources – will be shared with the Collaborative - Discuss UCLA Survey that will be sent out to the Leadership team as part of PDSA data compilation - Recuperative Care – Announcement on those accepting new WPC clients; contract approval underway for additional partner - Discuss State Bill No. 1152 – hospital discharge process of homeless patients - Upcoming Site Visit of assisted living facility - Seen approx. 450 WPC members
August 10, 2018	WPC Collaborative As of 6/30/2018 served over 3,300 WPC members BHS has met goals PY3 Metrics sent to the DHCS *Recuperative Care –Kevin Alexander (BHS) joined and actively supporting Illumination Foundation - Call to discuss gaps of those “too sick” for our facilities and fall in a gap - CalOptima awarded $10 M to WPC Recuperative Care; CalOptima dollars to be added to the WPC budget once BOS approves – possible change in reimbursement structure
August 24, 2018	WPC System Demo meeting - WPC Connect system demo by Safety Net Connect, Teresa Lin - Open for questions regarding electronic system - WPC BAA update – Universal Consent update

Date	Activity
October 5, 2018	WPC Collaborative Discussed Plan-Do-Study-Act next steps
November 2, 2018	WPC Collaborative Check in all subcommittees
November 30, 2018	WPC Collaborative - WPC Connect officially Live - BAAs must be signed and submitted– training of electronic system follows - OC Housing Authority – needs MOU for access to system have received 44 vouchers targeted to Recuperative Care - Hurtt Clinic pending BAA - Pursuing hospice care contract - Work to commence for Pet program for pets of clients

IX. PROGRAM ACTIVITIES

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

The WPC program strives to coordinate services which address the multiple needs of the client including health care, mental health services, recuperative care, and housing services. The following is a success story related to care coordination from one of the WPC outreach and engagement programs. Sally (not real name) enrolled in the College Community Services Peer Mentoring Program in June 2018. Despite completing the enrollment Sally did not keep in touch or answer her door with Peer Mentoring for almost a month. The Peer Mentor (PM) remained persistent and was eventually able to build rapport with Sally and develop a relationship. After a few appointments Sally became disengaged again for a few weeks. The PM did multiple home visits a week, and kept in touch with her Outreach Worker to collaborate on connection, and eventually PM was able to re-engage Sally in services. Sally admitted to relapsing and using substances. PM provided resources to AA and NA meetings, and accompanied Sally to meetings. Over time, Sally was able to advocate for herself and build personal relationships with her daughters and granddaughter that were not possible while Sally was using. With a new found sobriety PM assisted Sally by creating stability in her life, by teaching her how to organize herself and home.PM taught client to maintain a schedule, so that she could attend much needed medical and mental health appointments. With the PM 's assistance, Sally was able to navigate vital resources for sobriety. In addition, Sally learned how to access food banks, use public transportation, and navigate local health resources. PM linked Sally to community resources such as Wellness Center Central in order to understand about her mental illness and learn how to use hobbies as self-care. At the end of 6 months Sally was working on quitting smoking and was over two months sober. Sally was engaging in family relationships not possible before due to substance use. With the assistance of a PM that believed in Sally she was able to seek out help for her addiction. If not for the persistence of a PM who was determined to offer Sally other positive opportunities, she would be in jeopardy of losing her housing. The Peer Mentoring program strives to assist individuals maintain their housing by guiding individuals through small obtainable steps that are the client’s greatest needs. In Sally's case stability, organization, and sobriety were her most important needs to having a stable home.

A second success story is the agreement of providers to develop a Core Care Coordinator. This is a new concept for a number of the providers. The Core Care Coordinator will serve three primary purposes:

- Engagement – developing trusting relationships, providing emotional support, assessing needs, defining service goal for immediate needs
- Resource Management - developing and/or expanding resources for beneficiary referrals. Information – providing information to beneficiaries about other services

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

During 2018, there were three major challenges in care coordination. First, the original estimated timeline for the development and use of WPC Connect was optimistic. It took longer to establish BAAs with the providers and Safety Net Connect, to train the providers, and have them begin entering data into the system. This was partly due to turnover in provider staff and the need for more intensive program support education than anticipated. Second, WPC staff have had to work to break the silos of individual providers, particularly as it relates to introducing the concept of a Core Care Coordinator. WPC staff have faced resistance of providers who are concerned that introduction of this position would somehow threaten their WPC funding. WPC staff have been working to secure funding for this position.

In addition, WPC staff have found that there is a gap in services for clients who do not meet the criteria for recuperative care but are not sick enough to be served in a skilled nursing facility. In addition, there are currently no services for clients that may have a medical need that does not meet the criteria for traditional recuperative care and have behavioral health concerns.

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

The biggest success in PY3 was the launch of WPC Connect. Providers are excited about the data system and began submitting data on a monthly basis to WPC Connect. Multiple trainings and presentations were made regarding the system, resulting in non-funded partners who are interested in using the data system.

The second success was obtaining client-level data from Behavioral Health Services. This data will allow WPC staff to develop a greater understanding of the clients and examine outcomes.

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

Access to data particularly related to mental health and substance abuse has been challenging as partners are often very protective about the sharing of data, even with partners with whom they have data sharing agreements.

The sharing of data dictionaries for the multiple datasets will facilitate the data sharing agreements and speed the delivery of client-level data. Often, partners have much more data than is required for a project. Without knowing all data that is relevant to the project and available, it often takes multiple meetings to finalize agreements on the data to be shared.

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

The electronic data system, WPC Connect was launched in 2018. Providers began uploading and reporting data to the system and others were trained on the system. The Orange County Board of Supervisors have highlighted the system and its importance in the county.

A link to an article on WPC Connect is located at: http://www.oc-breeze.com/2019/01/03/132907_orange-county-launches-new-technology-to-coordinate-homeless-care-services/

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

The WPC project collected much of the data on clients manually during PY3. Some data collection is still being collected manually as not all providers are submitting data electronically to WPC Connect. This creates additional work for WPC staff to integrate the manual data with the electronic data. As a result, Medi-Cal verification took longer than expected. This caused delays in sending client CINs to CalOptima for them to run the metrics. In addition, access to data particularly related to mental health and substance abuse has been challenging. As a result, data for these metrics is unavailable for PY3.

g.) Looking ahead, what do you foresee as the biggest barriers to success for the WPC Program overall?
Being able to build in all the enhancements and connections into the WPC Connect platform that are desired to fully optimize care coordination for the homeless population by December 31, 2020.

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.

Below is a list of the PDSA's that occurred during PY3.

- OCPDSA 1 – UHM: Ambulatory Care (AMB) – Emergency Department Visits
    - OCPDSA1 – UHM Ambulatory Care PY3 Annual
    - UHM: Ambulatory Care PY3 Semi-Annual
- OCPDSA 2 – UHM: Inpatient Utilization – General Hospital/Acute Care (IPU) PY3 Annual
    - OCPDSA2 – UHM Inpatient Utilization PY3 Semi-Annual
- OCPDSA 3 – UHM: Follow-up After Hospitalization for Mental Illness (FUH) PY3 Semi-Annual
- OCPDSA 4 – UHM: Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET) PY3
    - Semi-Annual
- OCPDSA 5 – UAM: Beneficiaries with Comprehensive care plan, accessible by the entire care team, within 30 days of enrollment and annually PY3 Semi-Annual
- OCPDSA 6 – UAM: Care Coordination, Case Management, and Referral Infrastructure PY3 Semi-Annual
- OCPDSA 7 – UAM: Data and Information Sharing Infrastructure PY3 Semi-Annual
- OCPDSA 8 – VAM: Members in Recuperative Care linked to CalOptima Case Management PY3 Semi-Annual
- OCPDSA 9 – VHM: 30-Day All Cause Readmissions PY3 Semi-Annual
- OCPDSA 10 – VHM: Comprehensive Diabetes Care PY3 Semi-Annual
- OCPDSA 11 – VHM: Suicide Risk Assessment PY3 Semi-Annual
- OCPDSA 12 – VHM: Housing Supportive Services PY3 Semi-Annual
- OCPDSA 13 – OAM: Link all WPC Beneficiaries referred to Recuperative Care to a CalOptima Case Manager PY3 Semi-Annual – Duplicate of PDSA 5 - Deleted
- OCPDSA 14 – OHM: Increase in Primary Care Physician (PCP) Office Visits PY3 Semi-Annual

- OCPDSA 15 – OHM: Increase in Appropriate Medication Utilization PY3 Semi-Annual – Combined with PDSA 14 - Deleted
- OCPDSA 16 – OHM: Increase in Recuperative Care Beneficiaries Completing Assessments for Coordinated Entry Process PY3 Semi-Annual
- OCPDSA 17 – OAM: Percent of Referrals from WPC Participating Entities Linked to Behavioral Health Services PY3 Semi-Annual
- OCPDSA 18 – OHM: For WPC SMI Population, Decrease in Number of Days for Psychiatric Hospitalization PY3 Semi-Annual
- OCPDSA 19 – OHM: For WPC SMI Population, Reduction in Depressive Symptoms as Measured by the Symptom Distress Subscale for Beneficiaries Scoring in the Clinic Range PY3 Semi-Annual
- OCPDSA 20 – OHM: For WPC SMI Population, Decrease in the Number of Mental Health Emergencies Experienced PY3 Semi-Annual
- OCPDSA 21 – OHM: For WPC SMI Population, Decrease in the Number of Days Homeless PY3 Semi-Annual
- OCPDSA 22 – OHM: For WPC SMI Population, Increase in the Number of Days in Independent Living or Permanent Supportive Housing PY3 Semi-Annual
- OCPDSA 23 – Communication with Recuperative Care Partners Regarding the Entry of Clients into Recuperative Care PY3 Semi-Annual
- OCPDSA 24 – UAM: Defining Core Care Coordination CCC PY3 Annual
- WPC Timeline PY1-3 – For Metrics 1 and 2 (PDSA 1 and 2 for PY3 Annual