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

Placer County
Annual Report PY2
4/26/2018

The following items are the required components of the Mid-Year and Annual Reports:

Component	Attachments
1. Narrative Report **Submit to:** Whole Person Care Mailbox	☐ Completed Narrative report ☐ List of participant entity and/or stakeholder meetings *(if not written in section VIII of the narrative report template)*
2. Invoice **Submit to:** Whole Person Care Mailbox	☐ Customized invoice
3. Variant and Universal Metrics Report **Submit to:** SFTP Portal	☐ Completed Variant and Universal metrics report
4. Administrative Metrics Reporting **(This section is for those administrative metrics not reported in #3 above - the Variant and Universal Metrics Report.)** **Note: If a Policy and Procedures document has been previously submitted and accepted, you do not need to resubmit unless it has been modified.** **Submit to:** Whole Person Care Mailbox	☐ Care coordination, case management, and referral policies and procedures, which may include *protocols and workflows.)* ☐ Data and information sharing policies and procedures, which may include *MOUs, data sharing agreements, data workflows, and patient consent forms.* One administrative metric in addition to the Universal care coordination and data sharing metrics. Describe the metric including the purpose, methodology and results.
5. PDSA Report **Submit to:** Whole Person Care Mailbox	☐ Completed WPC PDSA report ☐ Completed PDSA Summary Report
6. Certification of Lead Entity Deliverables **Submit with associated documents to:** Whole Person Care Mailbox and SFTP Portal	☐ Certification form

NOTE: The WPC Quarterly Enrollment and Utilization Report is submitted on a quarterly basis to the DHCS SFTP site.

Whole Person Care

Placer County

Annual Report PY2

4/26/2018

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.*

Placer County WPC has made steady progress on the pilot goals during this reporting period.

Increasing Integration
WPC has prioritized meeting with our most important partners. We work with management and direct care staff to improve and coordinate services. Formal agreements are put into place as needed, and we believe it makes a positive difference for long-term care coordination between agencies.

Increasing Coordination
Working at the management level and the direct service provider level has helped increase coordination and access to care. When there are difficulties between programs, it is often a result of misunderstandings or institutional barriers. As WPC has built positive relationships with so many partners, we are finding that we can make constructive strides in coordinating services.

Reducing Inappropriate Utilization
An important early success was implementing PreManage. PreManage gives our team real-time notifications when a member goes to the hospital so we can provide timely intervention. We have focused on enrolling members not adequately served by other programs, while we also keep reasonable caseload sizes. Staff link members to preventive healthcare to avoid emergencies. Relationships with the health plans create opportunities to work through medical authorization problems. Our Medical Respite program allows us to provide a home-like setting where members can safely heal rather than returning to the hospital, which would likely happen if they were on the streets due to physical health conditions.

Improving Data Collecting and Sharing
Our efforts have focused on improvements within our own county system. Having WPC added to the ASOC EHR system was more difficult than anticipated. Setting up data collection systems has been steadily improving. Although data sharing has not moved as quickly as predicted, we are now able to receive data from the hospitals, the health

plans, and behavioral health. This level of sharing is unprecedented, and we expect to be able to utilize this data to further improve coordination and treatment outcomes.

Achieving Benchmarks

PY2 has focused on implementing mechanisms to measure both quality and administrative improvement. PDSAs have allowed us to implement processes and make improvements. The PDSA process will continue to support ongoing adjustments to WPC policies and procedures. Placer has done a good job of meeting our benchmarks, and as the team continues to build experience and expertise, we anticipate further improvement.

Increasing Access to Housing and Supportive Services

Our pilot has emphasized working with the homeless. A donation from Sutter Health allowed Placer to purchase homes with fourteen (14) total bedrooms. A WPC contractor provides supportive housing for our members. Recent data indicates there are fewer homeless in Placer this year, as compared to the year before. This is particularly significant as homelessness across the country continues to rise.

Improving Health Outcomes

We are having a positive impact on member health. We measure PHQ-9 scores and complete a suicide risk assessment for every member, not just clients identified as having depression. Our Medical Respite program demonstrated a reduction of hospital readmissions and members have improved health when they leave the program.

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	0	0	0	48	*	*	*

Item	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12	Annual Unduplicated Total
Unduplicated Enrollees	20	17	20	24	*	*	158

For **Fee for Service (FFS),** please report your total costs and utilization for each service. These reports should tie to your budget, invoice and utilization report. Add rows as needed.

FFS	Costs and Aggregate Utilization for Quarters 1 and 2						
	Month 1	Month 2	Month 3	Month 4	Month 5	Month 6	Total
Service 1	N/A						
Utilization 1	N/A						
Service 2	N/A						
Utilization 2	N/A						

FFS	Costs and Aggregate Utilization for Quarters 3 and 4						
	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12	Total
Service 1	N/A						

Utilization 1	N/A						
Service 2	N/A						
Utilization 2	N/A						

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

PMPM		**Amount Claimed**						
	Rate	Month 1	Month 2	Month 3	Month 4	Month 5	Month 6	Total
Comprehensive Complex Care Coordination (CCCC)	$1,521					4,563	44,109	48,672
MM Counts 1		*	*	*	*	*	29	32
Medical Respite Care Program	$8,826						*	*
MM Counts 2		*	*	*	*	*	*	*
Housing Services	$1,603				*	*	30,457	52,899
MM Counts 3		*	*	*	*	*	19	33
Engagement	$2,112				101,376	114,048	73,920	289,344
MM Counts 4		*	*	*	48	54	35	137

PMPM		**Amount Claimed**						
	Rate	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12	Total
Comprehensive Complex Care Coordination (CCCC)	$1,521	71,487	100,386	126,243	164,268	156,663	98,865	775,710
MM Counts 1		47	66	83	108	103	102	509
Medical Respite Care Program	$8,826	*	*	*	*	*	*	150,042
MM Counts 2		*	*	*	*	*	*	17
Housing Services	$1,603	57,708	81,753	105,592	139,461	150,682	153,888	687,687
MM Counts 3		36	51	64	87	94	96	428
Engagement	$2,112	78,144	40,128	31,680	23,232	25,344	*	209,088
MM Counts 4		37	19	15	11	12	*	99

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

The WPC Pilot began hiring direct service staff in April, 2017. As a result, WPC members were enrolled beginning in April, with increasing enrollment as PY2 progressed. As additional staff were hired and trained, enrollment continued to increase to meet program goals.

As the program developed, we discovered areas where our members required additional services. For example, we learned our Medical Respite was almost always full, and there was more need for those services than we had anticipated. To meet that need, we have requested to increase our Medical Respite member months in 2018.

Additionally, because this is a population that often loses their Medi-Cal coverage for one reason or another, we have enrolled additional members so that we reduce the risk of not having enough member months over the course of the year.

No changes were made to the data reported at Mid Year.

*We exceeded our budgeted MM Counts for Quarters 3 and 4 in CCCC, Housing and Engagement. We would like to claim the full overages in CCCC and Engagement and an additional 161 MMs in Housing. This will still allow us to rollover the funds necessary to increase our Medical Respite beds for CY 2018.

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 for Pilot Year 2 includes our Staff Services Analyst and our WPC Consultant/Evaluator. The Staff Analyst is embedded with the team and works closely with all team members to ensure timely and accurate reporting. Our Consultant/Evaluator is IDEA Consulting, and they work closely with the Staff Analyst, the Program Manager, and senior level staff to review data and provide important feedback on program implementation. WPC and IDEA meet together on the phone at least once a week, in person as needed, and exchange e-mail communications regularly to ensure that everyone is on the same page with data tracking and reporting. This ensures that we provide the most accurate data analysis possible. Thus, any improvements to service delivery can be made in a timely manner.

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.

Some items included in the delivery infrastructure portion of our application include the following: an automated care management system, county IT staff, four (4) vehicles, computers and related equipment, and cell phones.

After reviewing care management systems, it was decided that we would utilize and modify the current EHR (Avatar) that is used by Placer County ASOC. Implementation of using Avatar continued to be slower than expected, as collaboration between multiple divisions was more complicated and time consuming than anticipated. Therefore, WPC continues to do most of its tracking through the completion of daily activity logs that include service tracking and key event tracking. Although this method can be cumbersome, everyone has worked together effectively to ensure that data input is timely and accurate.

As part of the ongoing quality improvement process, we have been able to make headway on staff being able to directly input their data into Avatar. This will allow us to more quickly run reports and will increase efficiencies as IDEA will not need to manually enter data provided by WPC staff. We anticipate that we will be able to have data integrated seamlessly from the PreManage software program as well. These current efforts are a result of County IT staff increasing the time dedicated to WPC, which will allow us to make the needed improvements to our data tracking and reporting system.

The county process for purchasing vehicles has been time consuming, but we recently received Board of Supervisor approval to purchase the vehicles outlined in the pilot budget and expect those purchases to happen soon. In the interim, the WPC team has been able to use vehicles from Fleet Services.

We have made several modifications to the budget for delivery infrastructure during the budget revision process. At the time of this writing, we have not received final word on what may or may not be accepted from our proposals. We are hopeful that everything will meet necessary standards as communication between Placer and DCHS has been timely and effective.

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.

Primary Care Providers can receive incentive payments for reserving time for a Primary Care appointment for Whole Person Care members. None of these incentive payments were made in 2017. However, as WPC membership continues to grow and members need timely access to primary care services, we recognize the need to expedite the implementation of MOUs and a process for tracking and paying providers for incentive payments. It is our goal to have the process fully developed and implemented by the end of PY3.

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.

The WPC team and IDEA Consulting have developed a comprehensive data collection system to collect the required universal and variant metrics, member demographics, service level data, and outcomes. For January – December 2017, the data for these metrics are shown below:

Universal Metric – 70% of WPC members with a primary diagnosis of mental illness who are seen in the emergency department will have a CCCC visit within 7 days. (Metric Met)

Placer County's WPC team has identified 142 Emergency Department (ED) visits during PY2 for WPC members who were enrolled in Comprehensive Complex Care Coordination (CCCC). The WPC team followed up with the member within seven (7) days of their ED visit for 130/142 (92%) of the visits. The implementation of PreManage through Collective Medical Technologies has allowed us to receive timely notification of emergency room visits so we have been able to accurately track a metric that would typically be incredibly hard to monitor. Because the system is so effective, we were able to provide a high rate of post-ED visits within seven days.

Universal Metric – 80% of WPC members with a Serious Mental Illness (SMI) will receive a CCCC service following discharge from a psychiatric hospital within 30 days. (Metric Met)

In PY2, there were seven (7) discharges from a psychiatric hospital for WPC members. Members were followed up and received a service within 30 days for six (6) of those discharges (86%).

Universal Metric – 70% of WPC members will have a completed Assessment and Tailored Plan of Care within 30 days of enrollment to WPC. (Metric Met)

There were 122 WPC members enrolled in CCCC during the PY2 reporting period. Of the members enrolled in CCCC, 122 members (100%) received a WPC Assessment within 30 days of enrollment to CCCC, and 120 members (98%) received a Tailored Plan of Care within 30 days of enrollment to CCCC.

Variant Metric – Percent of WPC members discharged from Index Hospital Stay who are not re-hospitalized within the next 30 days. Goal: 55% (Year 2), 60% (Year 3); 65% (Year 4); 70% (Year 5). (Metric Met)

There were 19 General Hospital discharges in PY2. Of the 19 discharges, 13 did not have a re-hospitalization within the next 30 days (68%).

Our data system has continued to evolve as we have made ongoing improvements. Initially, there was a focus on outreach to potential WPC members, while we worked to identify the data elements needed to meet the required metrics, outcomes, and services related to each bundle. Now, we have fully developed the data system needed to capture the data required for our metrics. The WPC team works closely together to ensure that all members are followed closely to achieve positive outcomes and reduce ED and hospital utilization. Despite the ongoing changes and improvements to our system, the Placer WPC Pilot has had tremendous success in meeting and surpassing our goals.

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.

Placer County's Whole Person Care (WPC) Pilot targets direct services to a population with multiple needs. We gather data from various partners, share information with multiple programs, and work throughout the community to improve treatment integration. WPC regularly works with more than twenty other entities to reach program goals.

Leadership and team members meet regularly with partners to work through challenges that may arise. Agreements have been developed to bolster collaboration and communication among community service providers. In addition, there are regularly scheduled case management meetings, not specifically included the meetings list below, where we meet with multiple entities to coordinate program services.

During the first year of the program, WPC management and service providers have emphasized building strong relationships with community partners, private non-profits, and other county programs. Many have been eager to collaborate with a new program that has attention and resources. There are some programs, however, that have been slow to embrace a brand new program, which brings new staff, new ideas, and new approaches to service delivery. Because there are important players who have been less invested in the vision offered by WPC, the program has intentionally slowed down on some goals to make sure we are successful as we continue to work towards effective integration and collaboration throughout the system.

Placer WPC uses a strength-based, client-centered approach in its services. Similarly, we use this approach in our work with partnering agencies. We are finding that it is more effective to build solid relationships, make agreements when and where our partners are ready, and press for substantial change only when necessary. While we do believe this approach is best for long-term success, it does sometimes leave us with making smaller, individualized, informal agreements, rather than comprehensive policies that are systemically implemented.

We will continue working with our partners to identify, and agree upon, similar underlying treatment philosophies. As the Pilot continues meeting with community agencies and service providers, we anticipate implementing policies that are more formal and more far-reaching than currently established. Given our success this first year, we are

confident in our program's ability to bring about long-term improvements to collaborative services in Placer County.

Below is a list of the programs/agencies that we work with most often as part of the Placer County WPC Pilot:

- Anthem Blue Cross
- Advocates for Mentally Ill Housing
- California Health and Wellness
- Chapa-De Indian Health
- City of Roseville Housing Authority
- City of Roseville Police Department
- Collective Medical Technologies
- Community Recovery Resources
- Cornerstone Crisis Residential
- Gathering Inn
- Homeless Resource Council of the Sierras
- IDEA Consulting
- Interfaith Food Closet
- Pacific Education Services
- Placer County Adult System of Care
- Placer County Animal Services
- Placer County Housing Authority
- Placer County Human Services
- Placer County Probation
- Placer County Sheriff's Office
- Placer County Substance Use Services
- Salvation Army
- Stand Up Placer
- Sutter Auburn Faith Hospital
- Sutter Community Benefits
- Sutter Roseville Medical Center
- Turning Point Community Programs
- Volunteers of America
- WellSpace
- Western Sierra Medical Clinic

Whole Person Care Coordination and Engagement Meetings
AMIH: 10/2, 11/27, 12/27.
Anthem: 8/29, 10/2.
CA Health and Wellness: 7/3, 7/10, 7/17, 10/30, 11/13.
Chape-De Indian Health: 7/7.
City of Roseville: 9/28.

Homeless Liaison: 7/28, 8/21, 8/30, 9/8, 10/4, 11/30.
HUD/VASH: 7/11, 7/18, 7/25, 8/1, 8/15, 9/19, 10/3, 10/10, 10/17, 10/24, 10/31, 11/14, 11/28, 12/5, 12/12, 12/19.
HRCS (Continuum of Care): 7/9, 7/12, 7/20, 9/13, 11/11, 12/13.
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IDEA: 7/7, 7/31, 8/7, 8/14, 8/21, 8/25, 8/28, 9/5, 9/11, 9/13, 9/22, 9/25, 9/27, 10/2, 10/16, 10/23, 10/30, 11/7, 11/14, 11/21, 11/27, 11/28, 12/5, 12/14, 12/19, 12/28.
IT: 7/20, 7/26, 8/17, 9/21, 9/25, 9/27, 10/25, 11/16, 11/22, 12/27.
Medical Respite: 9/7, 9/18, 9/29, 10/17, 11/16, 11/30, 12/1, 12/13, 12/28.
Operation Makes a Difference: 7/25, 11/14.
Placer Community Benefit Programming: 8/22.
Placer Consortium on Homelessness: 7/6, 8/3, 9/7, 10/5, 12/7.
Roseville HUD: 9/28.
Placer County ASOC and SUD Programs: 7/31, 9/1, 9/11, 10/6, 10/13, 11/16.
Placer County Human Services: 9/14.
Sutter Community Partners: 11/6.
VOA meeting: 6/23, 7/5, 7/19, 8/4, 8/16, 8/29, 9/13, 9/27, 10/25, 11/8, 11/30, 12/13.
WPC Executive Council/WPC Leadership: 7/18, 8/30, 9/22, 10/24, 11/2.
WPC QI: 7/7, 7/14, 7/17, 7/24, 7/28, 7/31, 8/28, 9/5, 9/12, 9/19, 10/10, 10/26, 11/8, 11/15, 11/22, 12/13.

IX. PROGRAM ACTIVITIES

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

(1) A particularly successful component of the Placer WPC Pilot is our Medical Respite program. Our contractor, The Gathering Inn (TGI), has experience running a similar program, so we were able to suspend competition and implement the program more quickly than would be typical through the RFP process. Since inception, the Medical Respite has provided shelter to homeless individuals who have been discharged from an inpatient hospital, or who are too ill to stay at one of the local shelters. While staying at Medical Respite, TGI case management staff works closely with WPC staff to get members to all of their medical appointments, work through authorization problems with managed care, link members to home health care, and help members enroll with In Home Support Services. Additionally, these members become high priority for housing placements, and our collaborations have allowed us to place some members that would have had trouble finding housing without the additional support provided by the collaboration.

(2) Another particularly successful collaboration has been with AMIH (Advocates for Mentally Ill Housing) whom we contract with for permanent supportive housing. Through funding from Sutter Health and Placer County funds, they were able to purchase two homes with a total of 14 bedrooms that are specifically set aside for Whole Person Care members. AMIH staff has regular house meetings with WPC members to help them work through any potential problems that arise in the home. AMIH and the WPC Housing Coordinator communicate regularly to work through any problems that arise. Although AMIH is the property manager and gets to make the final decision about who is admitted to housing, they have worked with us closely to help some members be accepted for housing that they might not typically accept. In some cases, our collaborative relationship has prevented issuance of three-day notices and evictions, allowing us to work with the member to resolve the concerns. This partnership has helped us get people back on their feet so that they can maintain their housing and build a positive rental history.

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

(1) One of our local primary care providers is typically less responsive than the others. It has been an ongoing issue since before Whole Person Care was established. We have had meetings with their leadership and have been given contact information for staff who have been identified as able to help, but the problems have continued. With

most programs we are able to find success through intervening directly with line staff or with management staff, but in this case we continue to have difficulties getting timely services for our members. We continue to look for ways to improve the collaboration and more recently have reached out to Sutter Hospital, which provides them some of their funding, to see if they can help strengthen the relationship to work more effectively. There have been instances where we have just gone ahead and transferred members to other providers, and while this helps the individual, it does not move us ahead with having the program work morecollaboratively with us to improve outcomes. Although this program only has a small percentage of our members, we believe it is worth the effort to continue working with them.

(2) An important issue we have had with care coordination is within our own county system. Although the program has some similarities to a Full Service Partnership program that is typically found in ASOC, our WPC Pilot was placed in Public Health and most direct mental health services are provided by ASOC staff. This has led to some confusion about who is the "primary" case manager if a member is enrolled with WPC and is also a member at ASOC. We are continuing to work through the process of whether a member can, or should, be enrolled in both at the same time. Although meetings and a final decision on this process have taken longer than we expected, it is helping county programs to clarify, streamline, and avoid duplication of services.

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

(1) As described previously, using PreManage has been an excellent tool for us in finding out when our members enter the emergency room. In addition, PreManage has a feature that allows us to share information with the hospitals. We have uploaded our member treatment plans into the system so that they can see what WPC is working on with them. We have also begun some preliminary discussions with Collective Medical Technologies to work with them to have the local primary care clinics participate in PreManage so that we will be able to share health information across multiple providers.

(2) As we have continued to work with the health plans to receive current and baseline data on our members, we have also encouraged them to refer to us their members with the highest emergency room use. We recently began receiving these referrals from California Health and Wellness and are scheduling regular case management consultation phone meetings with them so that we can effectively collaborate on member care. We believe that this kind of information sharing is essential to helping multiple systems work together more effectively, which should improve health outcomes while at the same time reducing costs.

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

(1) We have continued to have some miscommunications and misunderstandings within our own department regarding data and information sharing. Although it is less frequent than when our Pilot was starting, we still have instances where staff at ASOC have inhibited data sharing. Even in preparing this Annual Report, we have had to take issues back to County Counsel that had previously been resolved. Although we appreciate the insistence of being safe with member data, the County Counsel office is often backed up, so getting a response can take several weeks. Despite these challenges, we have found that the process always moves forward and that the correct decision is ultimately made. These kinds of conversations are helping to make improvements to our whole system, which is one of the ultimate goals of the WPC Pilots.

(2) Another problem we continue to have is that, even with organizations with whom we have good data sharing agreements in place, there are times when it takes longer to receive data than agreed upon. In these situations, it has typically been a workload issue, where staff with the other agency has multiple demands, so our data request is put in queue, and it takes longer to get to us than expected. This is a common problem that occurs across many organizations. The lesson learned for us is that it is good to get in requests for data as soon as possible to help avoid any delays that might arise.

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

(1) Whole Person Care has an effective working relationship with IDEA Consulting that is providing the team with excellent collaboration on data collection and reporting. We generally meet with them by phone at least once a week and communicate regularly by e-mail. IDEA has helped us design and implement data collection systems for our services and enrollment, and has helped us develop definitions, policies, processes, and work flow around data collection. The weekly collaboration has helped to improve the quality of data reporting, as well as help staff keep track of which members need follow ups, treatment plans, and other ongoing services. Our metric outcomes reflect the effectiveness of the data collection system.

(2) Although it was originally slow to get data from our health plans, we have recently been able to get historical data on our members from both of our major health plans, which will result in getting the baseline data that we need for our members.

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

(1) One problem that we have had related to reporting is that there are issues related to different understandings of definitions related to the metrics that we are tracking for our reports. The regular phone calls that we have with the DHCS and with consultants have helped to clarify some of the misunderstandings, but there have been times that having so many Pilots with so many different opinions has led to more confusion. In Placer, we have decided that there are some instructions that are very clear and we are attempting to follow those instructions as closely as possible. In the situations where something might be less clear, we believe that it becomes our responsibility to provide additional descriptions for some definitions so that if anyone has a question about what is meant by any given data question we will be able to explain our methodology. Definitions are a common problem in research and Placer appreciates DHCS's willingness to work with the Pilots individually on issues like this, so problems can be solved at a local level, rather than having us be forced to use a definition that does not work well in our area. We think that this most closely relates to the spirit of the WPC Pilots and to the PDSA model.

(2) As explained earlier, we have a close working relationship with IDEA Consulting in working with our data collection and reporting. Our teams communicate regularly, and we have worked out an effective data collection system. At the same time, there are inefficiencies with our system, as staff need to complete a tracking and key event log, and that is then submitted to IDEA, who enters the data into their own tracking system. This basically has data being entered two times when it would be more efficient to only have the data entered once. We are beginning to get more collaboration with our county IT staff and are hoping to begin entering our data directly into Avatar, so that data entry will not need to be done twice. Making the transition will be time consuming, as we will need to develop new systems, put those in place, test them, develop new reports to ensure data is being entered correctly, and go back to enter old data into the new tracking system. However, we do think that it is best to avoid the dual data entry we have now, and it will be best to have all of the necessary data in one place (Avatar), rather than having it in multiple locations.

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

The WPC pilot creates a system that meets the goals of providers and stakeholders across the health system of care. WPC information sharing creates the capacity to identify high need, high risk members when they access the most costly parts of the system: Hospitals, EDs, and/or frequent health care costs related to chronic health conditions exacerbated by MH and/or SUD, and homelessness.

With this WPC vision, the pilot will provide the foundation, funding, and incentives to build a collaborative and coordinated health system of care. This will create the opportunity to discuss the more difficult issues and barriers that prevent timely access to services. Each level of the system has different challenges and opportunities to break down the services silos. As the WPC pilot continues to demonstrate successful outcomes, stakeholders will have ongoing opportunities to share successes and make lasting, positive changes to the health system of care. This will create a system that supports health outcomes for the highest need individuals in Placer County.

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.

Ambulatory Care
Pre-Manage ED Notifications
Pre-Manage Case Manager Updates Cycle 1
Pre-Manage Case Manager Updates Cycle 2

Inpatient Utilization
General Hospital Admit Follow-Up
Nursing Assessment Scheduling
Nursing Assessment Form Evaluation
Nursing Assessment Location Comparison

Comprehensive Care Plan
Comprehensive Care Plan Completion
PreManage Care Plan Upload Timeframe

Care Coordination
Five Levels of Collaboration Survey
WPC Staff Attending Shelter Care Meetings
Potential Member Avatar Check

Data
Anthem Potential Member Search
PC Jail – WPC Member Identification
IDEA Tracking Sheet Data Submission
IDEA Tracking Sheet Data Improvement
Anthem WPC Member Health Data Search
CHW WPC Member Health Data Search
Eligibility Table – Data Potential Members

MMD/Dysthymia & PHQ-9
Embedding the PHQ-9 in the WPC Assessment Form

Suicide Risk

Columbia Suicide Assessment Form Rating

Housing
Housing Intake Questions C1
Housing Intake Questions C2

Other: % of WPC Members who receive services at the MRP and show improvement in their physical health condition at time of discharge.
Medication Compliance Pill Box Use
Medication Understanding Medical Respite Program
Health Improvement Medical Respite Program