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

Whole Person Care

Lead Entity Mid-Year or Annual Narrative Report

Reporting Checklist

City of Sacramento
Annual PY3
April 2, 2019

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

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

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

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I. REPORTING INSTRUCTIONS

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

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

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

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

II. PROGRAM STATUS OVERVIEW

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

Increasing integration among agencies, health plans, providers, and other entities. In the second half of PY3, Pathways continued to make inroads towards increasing and improving integration between organizations serving the Pathways population. The program initiated referral processes with Mercy San Juan Hospital, UC Davis Medical Center, Kaiser (for non-members only), Aetna, and Anthem. In addition, a Data Sharing Agreement with Sacramento County was executed and processes for coordination with County Mental Health were established. This integration allowed for Pathways to connect enrollees to reSTART Rapid Rehousing units that required ongoing, intensive case management as a prerequisite for placement.

Increasing coordination and access to appropriate care, housing, and supportive services. Pathways increased enrollment significantly during this reporting period (cumulative program enrollment nearly doubled). Service provider staffing capacity expanded and the program continued to support care coordination across providers through the refinement and augmentation of the Shared Care Plan (SCP) Portal. In October 2018, Lutheran Social Services of Northern California joined Pathways as a Housing Services provider, supporting enrollees in accessing housing options. By the end of 2018, nearly 200 Pathways enrollees, or 20%, had been housed through the program. All Pathways providers increased their panel sizes and established consistent weekly check-in meetings with their fellow Pathways providers for care coordination and case conferencing. Provider staff usage of the SCP Portal increased significantly during this time. As the number of staff who actively used the system increased, numerous functionality issues and bugs arose, necessitating additional SCP training and system updates.

Reducing inappropriate utilization and improving health outcomes. During this period, the Pathways Support Team worked more closely with Pathways providers to assess and document the specific strategies and data needed to improve health outcomes and reduce avoidable hospitalizations. Both Anthem and Molina began sharing utilization data with the Pathways Outreach and Referral provider, providing near real-time utilization for the care teams to appropriately respond to. Although all Pathways clinic "Hub" providers began accessing hospitalization information for

enrollees, they were not all fully utilizing the CareQuality technology available to them to receive pull queries in a timely, consistent manner that let them know when an enrollee is hospitalized. However, when providers do receive hospitalization information, they are quickly engaging with enrollees and hospital staff to set up appointments and address their needs.

Improving data collecting and sharing. Pathways executed a Data Sharing Agreement with Sacramento County during this period, which provided the foundation for on-the-ground care coordination for individuals enrolled in Pathways and linked to County Mental Health. In addition, by December 1, 2018, all Pathways providers had moved away from tracking services in Excel and were actively using the SCP Portal for care planning, service tracking, and information sharing.

Achieving quality and administrative improvement benchmarks. The program continued to work to improve administrative benchmarks and improve program quality. Pathways launched a Learning Community where direct service staff and program managers received multiple trainings on how to use the SCP Portal, conducting PDSAs, and best practices for communication to improve care coordination.

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	87	27	16	25	51	36	242

Item	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12	Annual Unduplicated Total
Unduplicated Enrollees	48	131	72	102	27	44	666

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
ICP+ Bed Days Cost	$0	$0	$0	$0	$0	$0	$0
ICP+ Bed Days Util	0	0	0	0	0	0	0

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Costs and Aggregate Utilization for Quarters 1 and 2							
Outreach & Referral FFS Cost	$159,266.31	$144,628.32	$201,178.49	$92,707.25	$91,331.03	$86,326.60	$775,447.40
Outreach & Referral FFS Util	1,273	1,156	1,608	741	737	705	6,220

Costs and Aggregate Utilization for Quarters 3 and 4							
FFS	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12	Annual Total
ICP+ Bed Days Cost	$0	$0	$0	$0	$0	$0	$0
ICP+ Bed Days Util	0	0	0	0	0	0	0
Outreach & Referral FFS Cost	472	663	657	666	925	1190	10,793
Outreach & Referral FFS Util	$52,772.35	$74,127.26	$73,456.42	$74,462.67	$97,170	$95,748	$1,285,471.40

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

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Amount Claimed								
PMPM	Rate	Month 1	Month 2	Month 3	Month 4	Month 5	Month 6	Total
Housing Bundle #1 Rate	$375	$28,500	$20,625	$27,750	$43,125	$45,750	$47,250	$213,000
Housing Bundle MM Counts 1		76	55	74	115	122	126	568
Enhanced Case Management & Navigation Services Bundle #2 Rate	$537	$154,119	$165,396	$171,840	$163,248	$169,155	$176,673	$1,000,431
Enhanced Case Management & Navigation Services MM Counts 2		287	308	320	304	315	329	1,863
Lower Level Case Management & Navigation Services Bundle #3 Rate	$282	$8,178	$8,178	$7,896	$13,254	$12,690	$12,690	$62,322
Lower Level Case Management & Navigation Services MM Counts 3		29	29	28	47	45	43	221

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Amount Counts								
PMPM	Rate	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12	Annual Total
Housing Bundle #1 Rate	$375	$64,875	$131,625	$122,250	$148,125	$127,875	$124,875	$932,625
Housing Bundle MM Counts 1		173	351	326	395	341	333	2,487
Enhanced Case Management & Navigation Services Bundle #2 Rate	$537	$186,876	$229,836	$239,502	$277,092	$277,092	$272,796	$2,483,625
Enhanced Case Management & Navigation Services MM Counts 2		348	428	446	516	516	508	4,625
Lower Level Case Management & Navigation Services Bundle #3 Rate	$282	$12,972	$18,330	$20,304	$23,124	$23,970	$22,560	$183,582
Lower Level Case Management & Navigation Services MM Counts 3		46	65	72	82	85	80	651

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

IV. NARRATIVE – Administrative Infrastructure

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

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

From July 1 through December 31, 2018, the City of Sacramento slightly reduced support for the administrative infrastructure required for running everyday activities for Pathways. The program continues to be led by the City of Sacramento's Homeless Services Coordinator, who oversees a project management team comprised of City staff and consultants who provide day-to-day operational support for the program, as well as IT, policy, financial, compliance, legal, and clinical subject matter expertise.

Project management leadership provides oversight to ensure that program design and policies adhere to the state-approved application and City goals. The project management team was initially led by the Program Director, who was responsible for the timely and successful implementation of the program on behalf of the City of Sacramento, working closely with the Senior Program Manager to oversee the team.

During the first six months of PY3, the Program Director, Program Senior Analyst, and Administrative Assistant were heavily involved in the design and launch of the program. Staffing resources were frontloaded to support key activities that were needed for this ramp up. After full launch on May 1, 2018, the Senior Program Manager and the Program Analyst assumed more of the day-to-day management of the program with support from the Administrative Analyst. The Program Director and Program Senior Analyst were still involved in the oversight of the program but their day-to-day activities tapered down following full launch. The Senior Program Manager, Program Analyst, and Administrative Analyst continued to provide support in several key areas, including overseeing and meeting program deadlines and milestones; providing program analysis; drafting program materials, memos, and reports; logistical support and content development for internal meetings, governance committees, and external stakeholder meetings; communications support and materials in coordination with service providers and City communications staff; and service provider contract management and invoicing support. City staff and the project management team work closely together to oversee the budget and track expenditures in the program.

Data management, data analysis, IT infrastructure, quality control, and service delivery subject matter experts (SMEs) support program data collection and reporting; the build out of IT infrastructure and data sharing policies, procedures, and workflows; regular tracking of outcome metrics and PDSAs; and service provider training and quality improvement through Learning Community Sessions. These SMEs report back to the Senior Program Manager on any data quality or data reporting/analysis issues, as well as the on the ground service delivery implementation challenges and learnings.

VI. 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.

In the second half of PY3, Pathways Delivery Infrastructure budget funds were primarily directed to 1) the augmentation and improvement of the Pathways SCP Portal in Salesforce, 2) subject matter expertise to support service delivery and technology implementation, and 3) technical support required for 2019 contracting. Per the approved Budget Rollover and Adjustment requests and accompanying narratives submitted, delivery infrastructure funds for ICP + respite care beds are expected to be utilized in PY4 due issues in securing the required physical space.

From July through December 2018, the Pathways Data Management Entity (Sacramento Covered) worked to improve and augment the SCP Portal, contracting with IT developer Ten2Eleven to support this build-out. The program also deployed subject matter experts from Intrepid Ascent and Desert Vista Consulting to continue to support these augmentations and improvements. Additional functionality and augmentations to the SCP Portal during this time included:

- Expansion of licensed users to accommodate additional Pathways service provider staff;
- Development of a “Ticketing System" that enables users to create tickets to report issues and bugs, make change requests, and submit support questions. The Ticketing System allows staff the ability to better track and work toward resolution on outstanding issues compared to less-organized email and phone communication logged in a local word document or spreadsheet;
- Improvements to the SCP Portal functionality, including updates to the user-interface to more easily access information; addition of new fields to more accurately and consistently capture critical data like emergency department visits, and increased editing ability across partners;
- Intensive user training to service provider staff on the SCP Portal to transition providers off of manual Excel service tracking to only using the SCP Portal to record services; and
- Improving and expanding the SCP system functionality for reporting, monitoring, and to share with external partners as static documents.

IT subject matter experts also worked on and supported other critical components of the Pathways IT delivery infrastructure, including:

- Site Visits with Pathways Hub and Outreach providers to support the refinement of IT policies, procedures, and workflows;
- Reviewing partners' requested changes to Data Sharing Agreements and making strategic recommendations to support program and City goals; and
- Development of an approach and workplan for the Hospital Notification pilot to support bi-directional data sharing and integration between Pathways partners.

Delivery infrastructure funds were also directed to legal, financial, and service delivery subject matter experts to support the operationalization of the program. Specific deliverables included:

- Finalization of PY3 Incentive Agreement contracts;
- Service provider contract development for Outreach, Hub, and Housing service provider contracts, contract extensions, contract amendments, and contract renewals;
- Compilation and review of required insurance documentation for final execution of contracts;
- Onboarding and orientation of Lutheran Social Services of Northern California on the program model and service delivery processes and procedures;
- Support for program and provider-level PDSAs and quality improvement practices; and
- Service provider invoicing and review process; and

Development of an Online Toolkit for all contracted service providers to have access to the program manual, policies, and procedures and other program information.

VIII. 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.

Pathway to Health + Home incentive payments are earned and paid on an annual basis. For PY3, 26 Pathways partner organizations executed Incentive Agreements. Incentive amounts for these organizations fall within the maximum amounts for three different categories of providers (hospitals, managed care plans, and community-based partners) as defined in the City's DHCS-approved application:

Hospitals: Up to $100,000 per organization ($295,000 total)

1. Dignity Health
2. Sutter Health
3. UCD Davis Health

Managed Care Plans: Up to $100,000 per organization ($490,000 total)

4. Access Dental Plan/Avesis
5. Aetna
6. Anthem Blue Cross
7. Health Net
8. Liberty Dental
9. Molina Healthcare

Community-Based Partners: Up to $250,000 per organization ($1,015,000 total)

10. 211 Sacramento (CBO)
11. Elica Health Centers (clinic)
12. Health and Life Organization, Inc. (clinic)
13. Lutheran Social Services of Northern California (CBO)
14. One Community Health (clinic)
15. Peach Tree Health Clinic (clinic)
16. River City Medical Group (CBO)
17. Sacramento Covered (CBO)
18. Sacramento Fire Department (government agency)
19. Sacramento Native American Health Center (clinic)
20. Sacramento Police Department (government agency)
21. Sacramento Self-Help Housing (CBO)

22. Sacramento Steps Forward (CBO)
23. The Salvation Army (CBO)
24. TLCS, Inc. (CBO)
25. WellSpace Health (clinic)
26. Volunteers of America — Northern CA and NV (CBO)

Incentive Agreements offered for 2018 required achievement of the following triggers detailed in the City of Sacramento's approved WPC application:

1. Governance Participation
    a. 50% attendance of Steering Committee Meetings
    b. 75% attendance of Steering Committee Meetings
2. Universal Screening Tool Development and Adoption
    a. 50% of beneficiaries screened annually
    b. 75% of beneficiaries screened annually
3. Universal Consent Form Development and Adoption (Hospitals and CBOs only)
    a. 50% of beneficiaries consented annually
    b. 75% of beneficiaries consented annually
4. WPC Clinical Protocols, Policies & Procedures
    a. 50% of beneficiaries screened annually
    b. 75% of beneficiaries screened annually
5. Active Involvement in Barrier Identification and Resolution (CBOs and MCPs only)
    a. 25% participation in activity
    b. 50% participation in activity
    c. 75% participation in activity
    d. 90% participation in activity
6. Referral Support - Target List Development
    a. 75% participation in workgroup meetings
    b. Provide referrals to pilot (minimum of 5 per month)
7. Data Sharing (Planning & Adoption)
    a. Reach 50% of annual goal (50% of enrollees have data shared in PY3)
    b. Reach 75% of annual goal (50% of enrollees have data shared in PY3)

Additional requirements beyond DHCS-approved triggers were also included in the PY3 Incentive Agreements to support more robust coordination and data sharing. These additional requirements include submission of timely and accurate point-of-contact information to support real-time care coordination and expedited access, signed documentation attesting to the adherence of Pathways policies and procedures, and data sharing as needed to meet DHCS reporting requirements.

X. 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 City of Sacramento reports annually on four Pay-for-Outcome metrics for Pathways: All-Cause-Readmissions (ACR), Ambulatory Care (AMB), Inpatient Utilization (IPU), and Housing Services. Note that DHCS provides state-calculated rates for ACR, AMB, and IPU metrics, which will determine our official achievement of DHCS-approved benchmarks. Below is the current status of each metric.

Housing Services
Our PY3 Housing Services is 90%, meaning that 90% of all enrollees referred to housing services in PY3 actually received housing services. The PY3 rate is an 84% increase over the Baseline rate (49%) and well over the program's 5% goal for PY3.

Pathways has been successful in reaching this benchmark due to our program framework that requires all new enrollees to be referred to housing services. Housing services are provided by Sacramento Self-Help Housing and Lutheran Social Services of Northern California. In addition, the Pathways Outreach entity, Sacramento Covered, supports enrollees both assigned to the housing providers and those interested in HUD Continuum of Care housing available through the Coordinated Entry System. Pathways Community Health Workers (CHWs) document when an enrollee is referred to housing services in the SCP Portal and subsequent housing services are actively tracked in the SCP. Incorporation of data elements required to report on this metric into the SCP allows the program to easily track and report accurate data on the measure.

Ambulatory Care (AMB)
In PY3, data show an AMB rate of 517 emergency department visits per 1,000 Pathways member months (or 2,507 emergency department visits total). Our PY3 rate is a 46% increase from our Baseline rate (353 per 1,000 member months).

All-Cause-Readmissions (ACR)
In PY3, data show 14% or 211 of 1,509 inpatient discharges resulted in a 30-day readmission following that inpatient stay. Our PY3 ACR rate reflects an increase of one percentage point, or a 7% increase, from our Baseline rate (13%).

Inpatient Utilization (IPU)
In PY3, data show an IPU rate of 184 inpatient discharges per 1,000 Pathways member months (or 891 inpatient discharges total). Our PY3 rate is a 125% increase over our Baseline rate (82 inpatient discharges out of 1,000 Pathways member months).

Our pilot is still working on the reporting processes, EHR/SCP data entry workflows, and IT infrastructure to understand the trends underlying the increases in our hospitalization rates.

XII. STAKEHOLDER ENGAGEMENT

Stakeholder Engagement - In the text below or as an attachment to this report, please provide a complete list of all program policy meetings you have held with participating entity/ies and/or stakeholders during the reporting period, and a brief summary, with topics and decisions, of the proceedings. The list of meetings will not count against your word limit. Please Note: Do not include meetings held as part of providing WPC services (e.g. care planning, MDT meetings). Meeting information provided in the Mid-Year Report does not need to be resubmitted.

During this reporting period, Pathways transitioned from a monthly governance committee meeting schedule to quarterly meetings. At the start of the program, monthly meetings were needed to secure input and buy-in on program design and implementation efforts leading up to full launch. Post-full launch, the program transitioned to a quarterly meeting schedule, while kicking off the Learning Community for Pathways service providers.

Pathways held a total of eight governance committee meetings from July through December 2018:

1. August 2, 2018 — Pathways Steering Committee Meeting
2. September 6, 2018 — Pathways Executive Committee Meeting
3. September 20, 2018 — Pathways Service Delivery Committee Meeting
4. September 20, 2018 — Pathways IT Committee Meeting
5. November 1, 2018 — Pathways Executive Committee Meeting
6. November 1, 2018 — Pathways Steering Committee Meeting
7. December 20, 2018 — Pathways Service Delivery Committee Meeting
8. December 20, 2018 — Pathways IT Committee Meeting

Committee meetings during this period focused on:

- Assessing the program's service delivery model in full launch;
- Strategizing on processes to increase Pathways provider capacity;
- Sharing program best practices; Informing stakeholders of program progress in the roll-out of the SCP Portal; and
- Soliciting input on the hospital notification pilot design.

In addition, the committee meetings provided a venue for individual partner organizations to share their organizational mission and services and their unique role in Pathways with the goal of deepening partners' understanding of the entire system of care for individuals experiencing homelessness. City updates on related homeless services and programs, for example the Triage Shelter and the Homeless Emergency Aid Program (HEAP), were also shared.

Key decisions made and actions taken by the committees in the second half of PY3 included: 1) approval of a service delivery and budgeting approach to support expanded Pathways service provider capacity and ramp-up to 1,000 enrollees by July 2019; 2) input on a Virtual Hub approach to serving Pathways enrollees not assigned to one of the three Pathways Hubs; and 3) input on approach for hospital notifications pilot.

XIII. PROGRAM ACTIVITIES

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

(1) Coordination between Sacramento Covered's CHWs and Sacramento Self-Help Housing's Housing Specialists to help enrollees navigate and secure Housing Choice Vouchers (HCV) is a particularly strong example of successful care coordination during this reporting period. The HCV voucher application requires extensive documentation, including income verification, with documents expiring after 30 days. Working together, Sacramento Covered and Sacramento Self-Help Housing developed a process to expedite the process to prepare, finalize, and submit HCV applications, assisting more than 100 Pathways enrollees apply for HCV vouchers.

(2) During the second half of PY3, coordination between the Pathways contracted providers increased significantly as staff became more comfortable with using the online SCP Portal and developed consistent cross-provider meetings for care coordination and case conferencing. By the end of PY3, each time staff made contact with an enrollee, a detailed note was recorded in the SCP Portal. These notes not only kept Pathways providers connected, they also allowed staff to keep tabs on enrollee progress and location and provided critical information needed for staff to develop strategies to better support enrollees. Daily usage of the SCP Portal was particularly useful for chronically ill enrollees in need of extensive follow-up.

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

(1) Despite increased coordination among Pathways service providers, coordination with external partners to ensure that individuals are enrolled in the most appropriate program continued to be a challenge for the program. Of the Pathways enrollees, about 20 individuals were linked to other programs, for example Sacramento County's Flexible Supportive Re-housing Program (FSRP) during the reporting period, requiring the City, County, the City's Triage Shelter operator, and the Pathways team to come together to assess which individuals were linked to which programs and who was transitioning to permanent housing.

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

(1) With support from the program, Pathways community clinics providers are now using their electronic health record systems to access critical clinical information from other providers and hospitals through CareQuality. While not all Hub providers are using this technology consistently, they at least now have the capability to exchange health care information in real-time.

(2) By December 2018, there was a significant increase in the amount of data entered into the SCP by providers and all providers were using the SCP Portal regularly to initiate, complete, and update enrollee SCPs. The increase of data inputted into the SCP included data and information on enrollee emergency department visits that was accessed by the Pathways Hub providers in their EHRs.

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

(1) One data sharing challenge that has surfaced concerns how and with whom Pathways data is shared, access to the SCP Portal, and what the appropriate data sharing agreements are to facilitate data sharing. Multiple entities have requested data from the Data Management Entity, including the Pathways Support Team; Sacramento Steps Forward, which administers the Sacramento County's Homeless Management Information System (HMIS), and other partners, such as managed care plans. For example, HMIS is a regional data system designed for homeless service providers to collect and track client-level data, including history of homelessness, services needed, and connection to housing and services. Even though all individuals must consent to have their data entered into HMIS, the Pathways Data Management Entity has expressed concerns about entering Pathways data into HMIS because the system is used by a number of users outside of the Pathways contracted providers. These concerns have delayed this data entry and potentially have created data gaps in HMIS. Moving forward, all programmatic data entry requirements will be more explicitly outlined in contract language to ensure that providers comply with the City's data sharing expectations for the program.

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

(1) By December 2018, all Pathways providers were actively using the SCP Portal for automated service tracking, which feeds into Enrollment and Utilization Report, and manual service tracking using Excel was completely phased out. Moving forward, we anticipate that the SCP Portal will not only streamline reporting on service utilization, but also increase data integrity.

(2) Another key data collection success resulted from the execution of the Data Sharing Agreement with the Sacramento County Department of Health and Behavioral Health Services. This allowed the program to establish a data collection process with the County to report on two metrics the program was previously unable to report on — Follow-Up after Mental Hospitalization (FUH) and Initiation and Engagement of Alcohol and Drug Treatment (IET). County data staff provided disaggregated hospitalization and follow-up treatment data.

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

(1) The data aggregation processes for the Enrollment and Utilization Reports were significantly more complicated in the second half of PY3. Following full launch, service providers were initially entering service data into multiple formats, i.e. Excel service trackers and the Salesforce SCP Portal. Issues with the aggregation process for multiple files resulted in underreporting for the PY3 Quarter 3 Enrollment and Utilization Report, requiring an overhaul of the data quality review process and the resulting resubmission of the report.

(2) An additional challenge included communicating workflows required for data collection for the permanent housing metric. The metric requires Pathways housing providers to track homeless enrollees who have been housed continuously for six months and of those enrollees, those who have reached the seventh month of being continuously housed. The program that some of these enrollees had graduated or disenrolled from Pathways prior to six months of being permanently housed, requiring staff time for follow up that was outside of the scope of work within their contracts. The program addressed this issue by including reporting support as a requirement of Incentive Agreements and updating contract language for 2019 to include this tracking and reporting, even if the individual is no longer enrolled.

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

At this juncture, implementation of the Health Homes Program (HHP) by the managed care plans without collaboration and coordination with the City and Pathways providers, including a lack of an official agreement on how the programs will handle overlapping eligible populations, is undoubtedly the largest potential barrier to the success of the pilot. The program anticipates a significant number of Pathways enrollees will also be eligible for HHP and most services provided by Pathways are duplicative of HHP services on paper. However, on the ground Pathways has operationalized a high-touch, collective impact model in which "no one organization does it all." Pathways enrollees are served by care teams comprised of CHWs, clinical care coordinators, and housing specialists, working across organizations to leverage each other's strengths to support and stabilize enrollees. Not only would shifting the Pathways population to HHP have a significant financial impact on the program, it will also impact the continuity of care for enrollees and potentially the quality of care. If the managed care plans choose to enroll eligible Pathways clients into HHP, the program will be obligated to disenroll those individuals from Pathways. We are concerned that transitioning Pathways enrollees to CB-CMEs will impact the parity of care, particularly with housing services, and disrupt the relationships and client trust established by Pathways staff.

XIV. PLAN-DO-STUDY-ACT

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

List PDSA attachments