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

Small County Whole Person Care Collaborative
Annual Report PY 3
April 2, 2019

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

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

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

I. REPORTING INSTRUCTIONS

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

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

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

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

II. PROGRAM STATUS OVERVIEW

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

The Small County Whole Person Care Collaborative (SCWPCC) became fully operational in PY3. In the second half of the year, our counties increased the number of clients served, stabilized the workflows and decreased the number of individuals disenrolled. Further, we progressed in the following program goals:

1. *Increasing integration among county agencies, health plans, providers, and other entities –*

One of the absolute best outcomes of Whole Person Care (WPC) has been the increased collaboration and coordination among our various partners. The hospitals in each county have authorized individuals to work with each WPC lead entity. Mariposa and San Benito have several points of contact within each hospital and hospital staff are providing the data needed for WPC staff to coordinate care and track/confirm utilization. Notification of client presentation to the emergency department (ED) is occurring with some regularity in Mariposa. San Benito is still working with their contact to ensure more consistency in ED notifications. The hospital in Mariposa County has included a field in their electronic health record (EHR) to flag WPC clients so that notification is as rapid and consistent as possible. There continues to be workflow and training needs for hospital staff, but the field is a very good start. The hospital in San Benito is now contacting WPC staff regularly to work together to enroll individuals into WPC and on discharge plans. The law requiring hospitals establish that patients waiting to be discharged have a place to live (SB 1152) went into effect, and has been a compelling incentive for communication to occur. The Collaborative and Counties individually continue to work extremely well with our health plan partners. In 2018, we were able to automate data sharing reports for each health plan, which includes data on the progress of their members. This is provided on a monthly basis. We continue to receive referrals, as well as reports on utilization and other relevant data, from the Plans for our shared clients. This helps to better manage their care and our reporting to the State. Diverse stakeholders continue to attend Leadership Meetings within each county for overall program information and problem solving as well as with staff for direct client care.

2. Increasing coordination and appropriate access to care;
Staff in each of the Counties have contacts at a variety of agencies. They can work with those teams to access services needed by clients, such as accessing primary care appointments or housing services. Mariposa County staff were able to get a no-show, no appointment policy changed at the local Medi-Cal provider after working with the client and provider staff to ensure timely arrivals and stabilized behavior of clients. This ensured that clients were able to access the healthcare services they needed in an area with extremely limited numbers of medical providers. San Benito staff began working with their hospital to assist them with linking their eligible and enrolled patients to housing services and other programs as needed.

3. Reducing inappropriate emergency and inpatient utilization;
The numbers served are small in our rural counties, so one very high utilizer can skew results. Despite this, our teams have, mostly, been able to stabilize and/or reduce ED visits and hospitalizations. See the tables below. One of the key take-aways from the data is that one high utilizer in each county accounted for the increase in hospitalizations (Mariposa) and in ED visits (San Benito). However, the increases both occurred in the first three months of enrollment. Looking at the data across time, the longer individuals stay in WPC the more stable they become. Note that our aggregate comparisons of individuals with baselines positive for ED and/or hospitalizations all show stabilization or actual reduction at 6 months or longer.

Mariposa Table 9.

Table 9. Pay for Outcomes Incentive – Summary ED and Hospitalization Reduction

Time Frame	Number of Members (ED Use)	Average Reduction ED Use	Number of Members (Hospitalizations)	Average Reduction Hospitalizations
3 months	12	-1.00 (46.15%)	6	0.50 (75.00%)
6 months	6	-1.83 (50.00%)	3	-0.67 (-40.00%)
12 months	1	-7.00 (63.64%)	1	0.00 (0.00%)

San Benito Table 8.*

Table 8. Pay for Outcomes Incentive – Summary ED and Hospitalization Reduction

Time Frame	Number of Members (ED Use)	Average Reduction ED Use	Number of Members (Hospitalizations)	Average Reduction Hospitalizations
3 months	12	0.33 (-25.01%)	6	-0.33 (-40.00%)
6 months	6	-0.50 (17.65%)	4	-1.00 (-80.00%)
12 months	0	0.00 (0.00%)	0	0.00 (0.00%)

*Please note that in Column Three, rows 3 and 4, there is a slight error on San Benito Table 8. The negative/positive value of the percentage should be the same as the whole number value. The numbers are correct, but our system applied the incorrect negative/positive for those items.

4. Improving data collecting and sharing-

The Collaborative is constantly reviewing and improving data collection, sharing, and reporting. In 2017 and 2018, we focused on ensuring that reports required for DHCS were codified into the system. Toward the end of 2018, we began to plan for increased reports using the data we were already collecting; as well as, planning changes to our system structure to accommodate data elements we were not already capturing but needed for enhanced (non-DHCS required) reports. We have a contract with an evaluator to assist us in ensuring statistically accurate capture and reporting. We also have ongoing dialogue with front line staff and managers for input into design, efficiency, error corrections, and "Wouldn't it be nice if we could" data capture and analysis needs. The presentation of data is improving as well due to the experience of our evaluator. These graphs and tables are presented regularly to the Community Partners/Leadership Committee meetings each county routinely provides. We have automated reporting for Anthem and California Health and Wellness that returns a database-friendly file format. Further, we continue to work with them to refine the report based on their needs. We began planning for Health Plan care management staff to have real time access to our system for the improvement of client outcomes. This sharing is done as appropriate based on client consent and in compliance with privacy laws. Health Plan staff only have access to the information of shared clients.

Both counties have onboarded new staff. Because of this, there have been challenges with data entry consistency. We provide eWPC/eBHS data collection training at each of the quarterly in-person meetings for the Collaborative. We also make changes to the data system to limit errors, such as using a data picker versus staff entering a variety of date formats. Both the training and system changes have helped, but do not cure all the entry issues. As such, chart audits are necessary each time we prepare a report to research numbers that do not appear correct on the reports.

5. Achieving quality and administrative improvement benchmarks-

Staff have fully integrated PDSA performance into at least two of their four weekly meetings per month. However, it is still a struggle to be prospective. Staff are stretched with client care and management responsibilities. Quality improvement staffers are spread across entire divisions in our rural counties, and are not dedicated to training and work specifically with WPC. Managers monitor the V&U report for progress toward stated goals in the application as well as determining where gaps in service are. Ensuring the accuracy of reports through our eBHS system has been a challenge throughout 2018. We anticipate our core reports being solidified so that in PY4 we can move to increased monitoring reports and system enhancements that will allow us more robust project management and a deeper understanding of gaps and successes.

At mid-year, we had enrolled 41 new individuals. By the end of PY3, we had enrolled 65. Although some individuals were disenrolled over the course of the year, Mariposa ended 2018 with coordinating care for 24 clients/month and San Benito 16/month.

While we are under our projected enrollment stated in the application, we are achieving successes with this highly complex and intensive client population. ED and Hospitalizations are decreasing, or stabilizing, over time. Depression scores for all clients are decreasing. By July, 100% of Mariposa clients had a PCP. Staff have found shelter for nearly 65% of their homeless clients in Mariposa and approximately 20% of homeless clients in San Benito. This is remarkable given the lack of housing stock and overwhelming need.

6. Increasing access to housing and supportive services;

In 2018 housing continues to be a challenge due to the limited affordable housing stock available in both counties. However, staff have been able to find placements in assisted living, sober living, subsidized housing and board and cares. Mariposa housed 11 of their 17 homeless or at-risk of homelessness clients. In San Benito, they found housing for 6. Additionally, Mariposa has been able to find funding and programs that assist at-risk of homelessness clients with property fixes that will allow them to stay in the homes they have. This funding from nonprofit and other sources un-affiliated with WPC has provided amenities such as, a ramp for a client with mobility challenges and fixing a leaking roof in a substandard property in which another client was living. These services have also assisted clients with accessing needed paperwork required to rent or gain access to programs that can assist an individual with qualifying for aid.

7. Improving health outcomes for the WPC population.

WPC staff have assisted clients with some astonishing improvements in health outcomes. In one county, a homeless individual who presented with significant mental health issues was provided with linkages to primary care, stable shelter housing, and transportation to specialty care. The individual was able to receive a diagnosis of an operable brain tumor. After removal of the tumor, the client's mental health issues improved significantly. This person can manage living on their own with limited support. In another county, one client was stabilized to such an extent that they are now able to hold a part-time job.

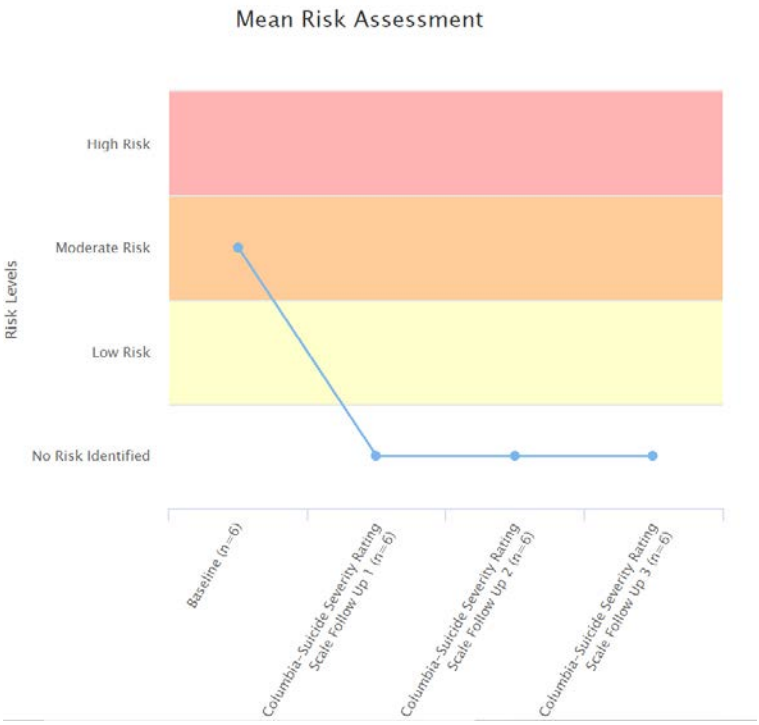
When looking at the data for PHQ-9, a self-report measure of depression level, we see a decrease in depression levels over time. For the State, this measure in the V&U only looks at clients with diagnosis of depression and/or dysthymia after 12 months in WPC. Additionally we measure 100% of clients within two weeks of enrollment and reassess as indicated by the score. A score of 4 or below results in the next assessment being in given in six months. A score of 5 or above results in more frequent monitoring depending on acuity level. The chart below shows enrolled individuals with four assessments. The trend is down. In running this assessment chart to examine mean scores for those with less assessments and those with more, the trend line is the same; levels of self-report depression decrease. The larger the number of assessments, the higher the acuity of the client and/or the longer the client has been enrolled. Even in this measure of higher acuity clients, the scores have decreased.

For the V&U measure, we have not had a client with diagnosed depression and dysthymia continuously enrolled for 12 months, and thus do not have diagnosis specific data available at 12 months for that measure. However, in looking at their scores over time prior to the 12-month mark, we see that, overall, PHQ-9 scores are decreasing. Eleven of the 14 individuals with a diagnosis of depression and/or dysthymia had two or more PHQ-9 assessments. Of the 11, eight show an overall decrease in PHQ-9. The 3 individuals with higher than baseline scores show only modest increases and some stabilization of depression level.

PHQ-9 Graph – Full Population SCWPCC

We also see risk reductions in those most acute who require a suicide risk assessment. Whole Person Care results in closer monitoring and diminished risk. The chart below shows individuals who required a suicide risk assessment based on the Collaborative protocol and their subsequent assessments. These individuals showed no risk as they were followed and assisted in WPC. Individuals in this dataset may not have major depressive disorder (as required by DHCS for this measure). However, we assess all clients with indicators, such as a high PHQ-9 score, that indicate significant psychological stress.

Suicide Risk Graph – Full Population SCWPCC



In PY4, we will begin to structure our system to capture more data on primary care access as well as code in more monitoring reporting using existing data.

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	4	10	7	14	1	2	38

Item	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12	Annual Unduplicated Total
Unduplicated Enrollees	2	11	5	8	3	4	71

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

Costs and Aggregate Utilization for Quarters 1 and 2							
FFS	Month 1	Month 2	Month 3	Month 4	Month 5	Month 6	Total
Service 1	$22,745	$23,881	$31,517	$11,725	$2378	$7448	$99,694
Utilization 1	72	70	102	39	7	19	309
Service 2	2,500	-	-	-	2,000	-	4,500
Utilization 2	5				4		9

Costs and Aggregate Utilization for Quarters 3 and 4							
FFS	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12	Annual Total
Service 1	17,817	19,798	12,216	13,489	11,276	11,198	185,488
Utilization 1	56	63	44	41	34	36	583
Service 2	-	2,500	-	-	-	-	7,000
Utilization 2		5					14

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

Amount Claimed								
PMPM	Rate	Month 1	Month 2	Month 3	Month 4	Month 5	Month 6	Total
Bundle #1	m$1,721 sb$1,657	9,944	28,109	36,268	58,772	54,055	37,094	224,242
MM Counts 1		7	17	22	36	33	22	137
Bundle #2	m$1,389 sb$1,936	4,854	7,477	19,233	21,029	22,965	18,266	93,824
MM Counts 2		4	6	13	13	14	10	60

Amount Counts								
PMPM	Rate	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12	Total
Bundle #1	m$1,721 sb$1,657	36,966	54,048	55,897	62,525	67,624	69,473	346,533
MM Counts 1		22	32	33	37	40	41	342
Bundle #2	m$1,389 sb$1,936	13,552	6,650	15,783	14,394	19,655	12,458	82,492
MM Counts 2		7	4	9	8	11	7	106

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

Despite our former colleagues in Plumas withdrawing from the Collaborative at the end of June 2018, we were able to continue to increase clients through our efforts growing the WPC program. The first half of the year was focused on increasing our client numbers. As such, outreach and engagement numbers are higher than in the second half of the year. The team's time was split between caring for an increasing number of complex clients and continuing outreach so that open slots could be filled as they became available. In the second half of the year there is more stability of the number of clients as compared to the first half. Respite care continued to be used much less than anticipated.

The picture was the reverse for Care Coordination bundles. As we were building the program, the numbers were larger. However, some enrollees were not a good fit. By the second half of the year, the numbers became relatively stable. It has been a monumental success to go from 6 clients in January to 41 by December.

The use of housing shifted in an unanticipated way. Some of the decline from the first half of the year was attributed to the addition of new staff in San Benito who had to be trained to administer the VISPDAT. Further, in Mariposa, significant issues occurred in the county that took time away from the housing vendor. Staff at the vendor were not documenting housing support activities nor were they billing. Mariposa staff has met with the leadership of this nonprofit partner and expects these numbers to increase in PY4. They continue to monitor them closely.

The teams are working with slightly less clients than projected in the application. Mariposa anticipates increasing their number to 28 by PY4, and San Benito will be increasing to 30. All the clients San Benito is serving are homeless with complex needs and intense behavioral issues. They have taken slightly longer to grow their population served.

IV. NARRATIVE – Administrative Infrastructure

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

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

The Collaborative structure developed to apply for these funds continues to work well for the small counties. Having a dedicated staff as one point of contact for completing reports, managing vendors, draft development, planning, organizing, and training has helped to keep the program on track. In verbal and survey responses, the Quarterly In-Person collaborative meetings continue to provide benefit to staff and increase quality and consistency of the work. In addition to professional development, the in-person trainings provide opportunities for updates and training on eBHS/eWPC changes, creation of protocols, case conferencing to traverse barriers, and collaboration/information sharing across counties. In PY3, we had training on self-care, PTSD, Strengths Assessment and Recovery Plan, PDSA, calculating return on investment (for directors), beginning motivational interviewing and a motivational interviewing reboot session later in the year. The use of a modified Agile methodology (the rapid testing of possible solutions to challenges) to solve problems and gain valuable staff input into operational systems has been a boon for quickly getting answers and solutions.

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.

The delivery infrastructure in each county, in terms of establishing partnerships and data sharing, continues to expand and strengthen. In Mariposa, their hospital partner, John C. Fremont Healthcare District (JCF), created a WPC flag in their ED EHR so that WPC clients could more easily be identified, and staff contacted. JCF has had some staff turnover, and WPC staff has been diligent in ensuring strong connections be established rapidly. JCF contacts WPC staff regularly to coordinate and advance beneficial client care. In San Benito, the relationship with their hospital partner, Hazel Hawkins Hospital (HHH), has continued to expand. In addition to having created a regular data sharing methodology for shared clients, San Benito WPC is benefiting from increased contact by hospital staff to assist homeless inpatients. Beyond data sharing, they work with WPC staff to determine eligibility for the WPC program and coordinate housing and other supports prior to discharge. This element of their relationship has been advanced by the new SB 1152 law. HHH is leveraging WPC staff skills, talents and relationships to help ensure their compliance with this law.

The Collaborative continues to struggle with the system stability and reporting components of their eBHS/eWPC eClient management system. While data input has not been an issue. The system works well and changes in the staff interface are easy to implement and train on. Reporting has been a challenge. The developers do not appear to test the reports as changes to the “data in” side are made – creating a difficult situation to meet reporting requirements. In PY4, changes will be made to address this issue.

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.

The Collaborative has six incentive payment structures, as outlined below. All these incentive payments are billed annually.

Incentive – Hospital Notification of ED visit, Mariposa:
This incentive is structured to incentivize the hospital Emergency Department to contact WPC staff at the time a shared client presents to the ED. They receive $150/contact. The eBHS/eWPC system is designed to capture this information on the Emergency Department Form. If the ED calls, the pertinent information is entered, such as date and reason for visit, and submitted in the system. As indicated in Mariposa Table 5 below, the ED contacted staff 23 times for a monetary value of $3,450. However, because we only budgeted for 10 units, our invoice reflects compensation for only 10 ED notifications at a total of $1,500. Unfortunately, we did not budget enough incentives for this critical activity. Despite the lack of incentives, staff are working to improve the frequency of ED notification. The frequency with which the ED contacts staff is the subject of one of their PDSA improvement projects.

Incentive – Hospital Involvement in Care Coordination, Mariposa:
This incentive is structured to incentivize the hospital for communication regarding at least one client over the period of one week. The eBHS/eWPC system is designed so that there are two locations in the Care Plan where staff can indicate if the Hospital participated in a care coordination meeting or contacted them in some other way in the normal course of coordinating care for the client outside of an MDT or Care Coordination meeting. The incentive is no more than $300/week for at least one contact. As indicated in Mariposa Table 6 below, the Hospital participated 88% of the weeks in 2018 for a total of 46 of 52 weeks. Mariposa compensated them $13,800 for this work.

Incentive – Provider Referral, Mariposa:
This incentive was structured to incentivize providers in the county to refer potentially eligible clients to WPC for $75 per eligible referral. The incentive was not sufficient to be compelling, and county entities have a history of working well together – adding to money not being a major motivation.

The Mariposa team attempted to engage their providers in the county to make referrals. Early on, this was very difficult, though they do receive some referrals now. The largest source of their referrals is from their Health Plan partners and other programs under Behavioral Health Services, the Lead Entity for the Pilot under which WPC is housed. Interestingly, 6% of referrals are self-referred individuals, which indicates value and good reputation in the community (See pie chart below). While provider referrals are accepted, they are not needed for program recruitment. We anticipate releasing these funds or shifting them in the next budget adjustment process. No incentive funds were paid in 2018.

Mariposa Incentives Table 5 and Table 6.

Table 5. Incentives – Hospital notification of Emergency Department (ED) Use – All Clients Enrolled Mariposa County (n=30)

Number of times in a month JCF - Emergency Services informed behavioral health of an ED visit (n=6)						
January 2018	**February 2018**	**March 2018**	**April 2018**	**May 2018**	**June 2018**	**July 2018**
0	1	1	2	5	6	1
$0	$150	$150	$300	$750	$900	$150
August 2018	**September 2018**	**October 2018**	**November 2018**	**December 2018**	**Total**	
1	3	0	2	1	23	
$150	$450	$0	$300	$150	$3,450	

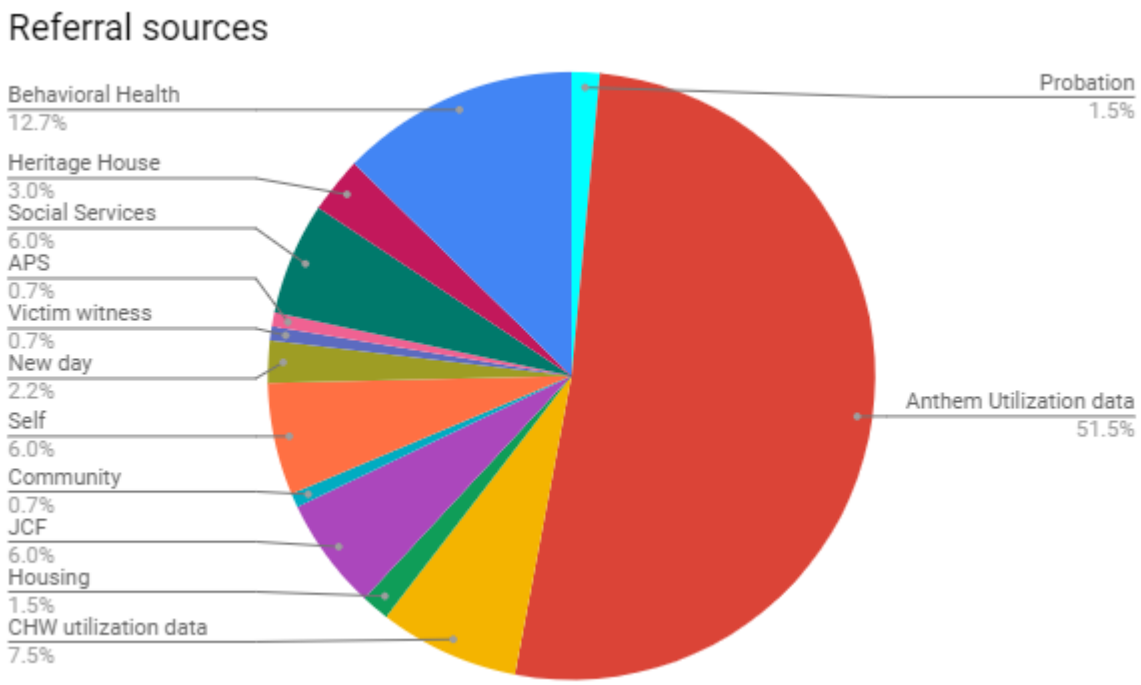
The table above shows how many times JCF - Emergency Services informed the WPC behavioral health staff of a client's ED visit. JCF - Emergency Services will get paid $150 each time they inform the WPC behavioral health staff of a client's ED visit.

Table 6. Incentives – Hospital participation in Care Coordination Meetings – All Clients Enrolled Mariposa County (n=30)

Number of weeks JCF - Emergency Services participated in at least 1 meeting/communication (n=46)		
Yes	**No**	**Number of weeks**
88% (46 week(s))	12% (6 week(s))	46
		$13,800

The table above shows how many weeks JCF - Emergency Services staff participated in at least 1 Care Coordination meeting/communication. JCF - Emergency Services will get paid $300 for each week they participated in at least 1 WPC Care Coordination meeting.

Mariposa Referral Sources Pie Chart



Incentive – Hospital Involvement in Care Meetings, ED Notifiction and/or Weekly Contact, San Benito:
This incentive is structured to incentivize the hospital for any involvment in WPC over the period of a month. The eBHS/eWPC system is designed to capture this information on the Care Plan and on the Emergency Department Forms. Staff, when documenting their work, can select their hospital from a drop down menu when the hopsital has worked with them on any aspect of the program. The hospital is compensated $600 each month they participate. San Benito Table 4 below shows that they pariticpated in 11 of the 12 months. However, due to a data error, January is listed as “0”. The hospital did work with the WPC team and has been compensated for 12 months at a total of $7,200. The data error was discoved during the reporting process and was corrected. The hospital relationship has improved greatly since the beginning of the Pilot. However, staff continue to work with them to improve ED notification. San Benito included a PDSA on this issue.

Incentives- Provider Referrals, San Benito:
This incentive is structured to incentivize specific area providers at $75 per eligible referral to the WPC program. This information is captured on the referral form that is part of the eBHS/eWPC system. As indicated in San Benito Table 5, only 11 referrals were received for a total payment of $825. In 2018, San Benito Health Foundation made one eligible referral and received $75.

Hazel Hawkins Hospital made 6 eligible referrals and received $450. Community Homeless Solutions made 4 eligible referrals and received $300. Providers were not submitting eligible referrals early in 2018. After much outreach and education to provider organizations as well as changes to the referral form, San Benito WPC is receiving more quality referrals – just not a large number. Most of the client recruitment occurs through WPC staff outreach.

Incentives – Community Events, San Benito:
This incentive provides compensation to community groups to host events where homeless individuals can be recruited. The compensation is $500 per event. Given the intensity of the care coordination required for each client, and the ability of staff to successfully recruit on their own, this incentive has not been used often. In 2018, Community Homeless Solutions was the only entity to host a community event. They were compensated $500.

San Benito Incentives Table 4 and 5.

Table 4. Incentives – Hospital Participation – All Clients Enrolled (n=36)

Hazel Hawkins - Memorial Hospital Participated in Care Team Meeting, Weekly Contacts, and/or Notified WPC of ED Use					
January 2018	**February 2018**	**March 2018**	**April 2018**	**May 2018**	**June 2018**
No	Yes	Yes	Yes	Yes	Yes
	$600	$600	$600	$600	$600
July 2018	**August 2018**	**September 2018**	**October 2018**	**November 2018**	**December 2018**
Yes	Yes	Yes	Yes	Yes	Yes
$600	$600	$600	$600	$600	$600

The above table shows whether Hazel Hawkins - Memorial Hospital participated in a care coordination team meeting, weekly contact, and/or notified WPC of ED use in the given month. Hazel Hawkins - Memorial Hospital will be paid $600 for the month for participation.

Table 5. Incentives – Provider Referrals – All Clients Referred (n=11)

Number of completed referral packets for eligibility individuals submitted to WPC						
January 2018	**February 2018**	**March 2018**	**April 2018**	**May 2018**	**June 2018**	**July 2018**
0	0	2	2	1	2	1
$0	$0	$150	$150	$75	$150	$75
August 2018	**September 2018**	**October 2018**	**November 2018**	**December 2018**	**Total**	
2	0	0	0	1	11	
$150	$0	$0	$0	$75	$825	

The table above shows how many completed referral packets for eligibility individuals were submitted to SB WPC. Each provider will get paid $75 for each referral meeting eligibility criteria.

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.

PY3 is the first full year of data we have to review outcomes. SCWPCC has only one pay for outcome metric - a 5% reduction in ED and/or hospitalization use over baseline. We far exceeded that goal. All community partners were compensated as outlined in our application. For both Mariposa and San Benito, the reductions in ED utilization and hospitalization were remarkable and reduction continues to improve over time. Combined with lower scores on the PHQ-9 across the entire population of enrollees with two or more assessments, it is clear that care coordination derives results in the overall health and cost picture for each client.

To determine if outcome goals are met, we look at clients with ED visits and/or hospitalizations pre-enrollment (baseline – data received from Health Plan and/or hospital partners for each member) and post-enrollment (received from community partners and validated by health plan partners) at 3 months, 6 months and 12 months. We chose this methodology in an attempt to eliminate outliers and to get as much of a view of our work as possible over time, given that many clients may not have been enrolled for 12 months. In seeing a larger picture, we can therefore make a determination if there is a reduction trend.

See the tables below for Pay for Outcomes tracking for each county. The table provided in Section II, Program Status, Item 3 is a summary. The tables below will allow you to see more detailed information for both counties.

Mariposa Pay for Outcome Table 7 and Table 8.

Table 7. Pay for Outcomes Incentive – Emergency Department visits – All Enrolled (n=30)				
Time Frame	**Number of Members**	**Average ED Visits Per Person Pre-Enrollment**	**Average ED Visits Per Person Post-Enrollment**	**Average Change in ED Utilization**
3 months	12	2.17	1.17	-1.00 (-46.15%)
6 months	6	3.67	1.83	-1.83 (-50.00%)
12 months	1	11.00	4.00	-7.00 (-63.64%)

Table 8. Pay for Outcomes Incentive – Hospitalizations – All Enrolled (n=30)				
Time Frame	**Number of Members**	**Average Hospitalizations Per Person Pre-Enrollment**	**Average Hospitalizations Per Person Post-Enrollment**	**Average Change in Hospital Utilization**
3 months	6	0.67	1.17	0.50 (75.00%)
6 months	3	1.67	1.00	-0.67 (-40.00%)
12 months	1	2.00	2.00	0.00 (0.00%)

San Benito Pay for Outcomes Table 6 and Table 7.

Table 6. Pay for Outcomes Incentive – Emergency Department visits – All Enrolled (n=36)				
Time Frame	**Number of Members**	**Average ED Visits Per Person Pre-Enrollment**	**Average ED Visits Per Person Post-Enrollment**	**Average Change in ED Utilization**
3 months	12	1.33	1.67	0.33 (25.01%)
6 months	6	2.83	2.33	-0.50 (-17.65%)
12 months	0	0.00	0.00	0.00 (0.00%)

Table 7. Pay for Outcomes Incentive – Hospitalizations – All Enrolled (n=36)				
Time Frame	**Number of Members**	**Average Hospitalizations Per Person Pre-Enrollment**	**Average Hospitalizations Per Person Post-Enrollment**	**Average Change in Hospital Utilization**
3 months	6	0.83	0.50	-0.33 (-40.00%)
6 months	4	1.25	0.25	-1.00 (-80.00%)
12 months	0	0.00	0.00	0.00 (0.00%)

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.

San Benito had their first full Partner Meeting on October 17, 2018. All partner stakeholders attended. The agenda, presentation, sign-in, and meeting minutes were included in our annual submission to DHCS. Staff presented on the background and status of the WPC program and communicated both successes and challenges. Staff solicited input from the partners. A robust discussion occurred on a variety of issues facing the county and on incentive practices in another agency. San Benito has worked diligently to pull community partners together on a regular basis despite partner push-back on time limitations. In PY4, we anticipate that the partners will meet more regularly given the substantive information and feedback sought at this meeting.

Mariposa held their monthly Leadership (community partner) meetings on July 24, August 28, and September 25. There were no meetings October through December as the frequency shifted to quarterly meetings. There were also too many scheduling conflicts due to the holidays for a meeting to occur. The group agreed to resume Leadership meetings in January 2019. For the July-September meetings, all community partner stakeholders were present. The agenda, minutes and sign in sheets are attached. WPC program status was presented, and input sought on challenges and PDSA improvement projects being conducted. The agendas always include a Review of Policy/Procedure, a discussion of monitoring the MOU's, a review of outcomes data and monitoring PDSA cycles and reporting requirements. In September, the meeting was particularly productive in building relationships with new staff at the hospital. Turnover at the hospital in Q2 left the WPC staff with a change in contact in the ED. The new social worker for the hospital ED was present at the meeting. Issues around consent and managed care involvement were discussed. In each of the meetings, a key outcome was sharing information about processes to coordinate between each partner for the benefit of the client. Additionally, the hospital has been helpful in providing input into potential PDSA improvement projects. Mariposa also held a separate meeting with their Housing vendor on September 28 where clarifying the process for referral, decreasing time to service and when to end service was discussed.

In addition to the Community Partners/Leadership meetings, both San Benito and Mariposa convene staff meetings on a weekly or bi monthly basis to communicate program information, work on PDSAs, problem solve and organize staff duties.

IX. PROGRAM ACTIVITIES

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

(1) Establishing relationships with other providers, persistent calls to shelter facilities, assisted living and working with landlords have been critical. It takes tremendous effort to find all housing types and assist complex clients in keeping their housing. Housing services, such as training on how to communicate, pay bills on time, and complete an application have contributed to this success. Eleven clients were housed in Mariposa and six in San Benito through accessing a variety of shelter types..

(2) One client in each county underwent a huge transformation because of access to needed medical care. After having a medical condition addressed, they were able to live and help themselves with more stability than previously. Both clients were homeless at the time they presented to WPC, and both are now housed.

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

(1) Despite a good working relationship in Mariposa and an increasingly good relationship in San Benito with their hospitals, staff continue to face challenges with timely notification on ED visits and hospital discharge. Project management staff have increased their face to face interactions with hospital contacts and modified notification procedures as needed. Both Mariposa and San Benito submitted PDSAs that address some of the changes they have implemented in an attempt to create more real-time notification. A clear lesson learned is that the person to person relationship is extremely effective. When their hospital contact turned over, Mariposa staff made an effort to meet with the new contact as immediately as possible. This helped them continue making progress advancing the notification process. In San Benito, staff met with several of their contacts in a variety of departments at various times. This assisted in getting issues resolved, such as a change to the universal release, so that more rapid communication could take place. In each case, identifying the pain points – how WPC could help the hospital – was instrumental.

(2) The nonprofit housing services vendor in Mariposa has had difficulty in seeing clients within 30 days. Management staff have responded with closer monitoring and meeting with the vendor at least once in the third quarter of PY3. The MOU monitoring is a standing item on the Leadership meetings of community partners.

(3) In San Benito, they have had some difficulty in getting timely Medi-Cal eligibility information from their Public Assistance Unit. This has resulted in at least two individuals being enrolled then disenrolled.

Staff have attempted to develop better relations and tools to make the eligibility search easier. Presenting a tool on which partners can clearly see what is being requested and for whom has helped communication on eligibility in addition to a staff member personally walking over to their contact in the department to obtain information.

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

(1) Both hospitals serving Collaborative members have regular communication with the WPC lead entity. An excel spreadsheet with client identifying information is shared monthly with the hospitals. In San Benito, client utilization data is communicated back quickly. In Mariposa, client information is also shared bilaterally using excel, but the hospital also contacts WPC staff directly to mitigate unnecessary ED visits and alerts staff to hospitalizations. The ED in Mariposa has implemented a field in their EHR to identify clients as WPC. In both hospitals, much progress has been made in working closely on discharge planning.

(2) At the Collaborative administration level, we implemented an automated report that contains key follow up information on referred members from the Managed Health Plans. Instead of the lengthy and time-consuming process of modifying an excel sheet with the information for each referred member, the eClient management system, eBHS/eWPC, has a built report to pull the information into the health plan format. This has saved considerable time for management staff. Further, we have also created a permission-leveled access to our eBHS/eWPC system for Managed Health Plan case management staff to access real-time client information. Integral to this is their ability to access all consent forms and care plans for shared clients. They only see clients that are assigned to them in their respective health plans. The feedback has been excellent from the Plan case managers.

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

(1) Using the behavioral health data that is shared, it has been difficult to determine if a suicide risk assessment was completed, by what clinician/institution and when. The team will need to perform a systems analysis of how this assessment is recorded (if at all) and how it can be provided more transparently. This is a significant system change challenge.

(2) We continue to have challenges with the accuracy of the basic reports associated with the Pilot for which we established the requirements with our developer over a year ago.

Staff have had to push for, and in many instances, create, processes that are fundamental to software development. The Collaborative chose the development vendor due to their experience in behavioral health, existing platform, and sustainable cost despite their small size and less "flashy" user interface. We will likely develop more tools and processes to ensure a better product through the Pilot and potentially work with an additional vendor for the enhanced reporting we have been working on.

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

With a little over a year of client care data, we are beginning to see where we are succeeding and where we need better information. A benefit of the eBHS/eWPC system is that all assessments are graphed real time. We can see trends right away across county and across the Collaborative. Not only has it assisted in client care planning, and communicating worth to leaders, but it helps provide rapid feedback to the front-line staff that their efforts are making a difference. With the staff turnover we experienced early on in this program, this is an important feature.

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

The eClient management vendor we chose is a smaller company with a simpler system. We chose them for their experience in behavioral health as well as lower cost. However, it has become clear that their capacity is limited in terms of providing the level of quality and complexity we need in our reporting. The system is good at capturing the data and the vendor is responsive to change requests. The difficulty is in getting the information out. Their built-in assessment graphing report is functional. The custom reports remain challenging to get working accurately. The vendor does not seem to have an organized process in which to accommodate changes and test dependent reports to ensure the production of accurate and functional information and systems. Our attempts to streamline and organize the process of working together has resulted in better communication, but not a better reporting product. In PY 4, we will be exploring other options for reporting.

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

We do not see barriers to success currently. The work is advancing remarkably well considering the complexity of the program and the clients. Long term, however, the challenge that we are working on currently is the integration of effective elements into existing programming and the sustainability of the systems created through this project. Clearly, staff will continue to carry their training and relationships with them as they are integrated into other programs, but it is the intensity and scope of care coordination that we would like to preserve and sustain for complex clients as a part of our routine service offerings in each county. Further, we have found that the off-site trainings across counties have been of tremendous assistance. The sharing of materials, promising practices, and operational and/or case problem solving are among the benefits of training across teams. Finally, despite the challenges with the eBHS/eWPC system, its function as a data repository that reflects our workflow is an effective tool, which we will seek funding to maintain.

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

January through June 2018

1. Care Coordination - Partner Calendar
2. Care Coordination - Referral Checklist
3. Data - Client ID Numbering
4. Data - Comprehensive Care Plan, Using eBHS for Care Plans
5. Care Coordination - Staff Roles
6. Care Coordination - Coordination with Managed Care
7. Care Coordination - Assuring Access to Care Plans
8. SBC: Comprehensive Care Plan - Enrollment Paperwork Process 1
9. Comprehensive Care Plan - Enrollment Paperwork Process 2
10. Care Coordination - Increasing Pre-Enrollment Encounters
11. Data - Data sharing System with Hospital 1
12. Data - Data sharing System with Hospital 2
13. Data - Data sharing System with Hospital and Expansion to Behavioral Health
14. CSCC: Data - Improving Change Process and Accuracy in eBHS (3)

July through December

15. Ambulatory Care – Client transportation
16. Comprehensive Care – Increase compliance in first 30 days
17. Comprehensive Care – Determine care plan deadline prior to expiration
18. Care Coordination – Timely recording at MDT meetings
19. Inpatient – Reduce returns to inpatient after lengthy hospitalization
20. Ambulatory Care - ER Visit Notification System – Mariposa
21. Inpatient – Using Respite Care to Reduce Mental Health Hospitalizations
22. Inpatient – Reduce hospitalization by increasing mental health services
23. Inpatient - Post Discharge Plan to Reduce Rehospitalization
24. Ambulatory Care - ER Diversion Through Proactive PCP Appointments
25. Ambulatory Care - Reduce ED Visits with Safety Plan Reminders
26. Ambulatory Care – ED notification system -SBC
27. Ambulatory Care & Inpatient – ED notification system – SBC – cycle 2
28. Care Coordination – Reducing dis-enrollments through increased engagement
29. Comprehensive Care – Team meetings for common SBC-WPC and Anthem Blue Cross clients
30. Comprehensive Care – Temporary, PT staff training to meet 30-day CCP requirement
31. Data – Anthem data improvement
32. CSCC Data – Improving change process and accuracy in eBHS – cycle 4
33. CSCC Data – Improving change process and accuracy in eBHS – cycle 5