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

Ventura County Health Care Agency
Annual Report, PY 2
5/4/2018

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

Ventura County Health Care Agency

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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.*

The Ventura County Whole Person Care Pilot worked intensively build the infrastructure for a successful first program year including:

- Recruited, hired, and trained and supported Engagement and Care Coordination teams with >80% of staff completing training in priority topics.
- Began intensive enrollment of patients effective 7/1/17 as planned engaging 710 individuals through mobile outreach and enrolling 446 by year end.
- Ramping up services provided to more than 835 care coordination encounters with WPC Team Members by year end.
- Successfully launched expansion application activities including Care Pods and Recuperative Care (635 bed days of recuperative care provided by year end).
- Aided in Thomas fire disaster response efforts enrolling WPC patients from Red Cross and Winter Warming Shelters.
- Identified a new homeless high-risk target population to be served in rollover request to begin in PY 3.

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

A Waiver Integration and Oversight Committee supported coordination between waver programs and partner agencies. Monthly Leadership and Clinical Care meetings with the COHS, Gold Coast Health Plan (GCHP) resulted in regular sharing of data, shared learnings, and alignment of care coordination with the health plan. Provider and partner outreach through more than 37 stakeholder presentations helped to promote the program and build a referral base for program enrollment.

Increasing coordination and appropriate access to care

Detailed care coordination and referral workgroup meetings with key agency partners such as Behavioral Health and Alcohol and Drugs resulted addressed barriers to data sharing at the implementation level and laid the groundwork for access to the electronic health record for patients held in common.

Reducing inappropriate emergency and inpatient utilization

Data on ED and IP utilization collected and analyzed in collaboration with GCHP through 2 quarterly PDSA cycles resulting in actionable insights on the need for improved data sharing across hospital systems and strategies to support communications between WPC care coordination teams and other area hospital ED and hospital discharge case managers.

Improving data collection and sharing
Formed technology committee to define WPC technology needs, preview multiple vendor software packages, draft requirements for an RFQ for a vendor technology solution, and define data elements for sharing across systems. Formed data governance committee to oversee data and information sharing across the pilot and other waiver efforts. Developed data and information sharing process map, policies and procedures, and forms. Developed internal processes to collect and track required reports and metrics.

Achieving quality and administrative improvement benchmarks
Developed Data and Information Sharing and Care Coordination Policies and Procedures to guide these critical aspects of program implementation and reviewed them through 4 successive PDSA cycles. Completed quarterly PDSA cycles on 5 required and 1 optional (Q1) and 5 required and 2 optional (Qs2-4) quality and administrative benchmarks.

Increasing access to housing and supportive services
Coordinated with Human Services Agency and Continuum of Care to use Homeless Management Information System to access housing through County Coordinated Entry System and to streamline referrals for WPC-clients eligible for the new Housing and Disability Access Program providing temporary shelter for individuals with a Social Security Disability application in process. Wrote HUD Emergency Solutions Grant application to provide supportive housing slots for 15 WPC-enrolled patients (pending). 260 housing services provided to WPC-enrolled patients.

Improving health outcomes for the WPC population
Laid the groundwork to collect, study and report on health outcomes across more than ten utilization, health status, and access to service metrics.

Challenges include the sheer volume of tasks, planning, and coordination required to launch such a large and comprehensive effort across described domains. RFQ for technology and ongoing work towards data sharing continue to be priorities. Realization that the majority of services take place out of our immediate system where we lack access to electronic health records prioritizes the need for systems level coordination with other area hospitals and provider networks.
Lessons Learned include the need for continual focus now at the implementation level to support successful adoption of envisioned strategies, continued partner engagement.

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	0	0	0	0

Item	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12	Annual Unduplicated Total
Unduplicated Enrollees	*	*	68	103	99	116	446

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	0	0	0	0	0	0	0
Utilization 1	0	0	0	0	0	0	0
Service 2	0	0	0	0	0	0	0
Utilization 2	0	0	0	0	0	0	0

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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	$*	$4,011.40	$12,810.60	$18,892.40	$26,009.40	$20,315.80	*
Utilization 1	*	31	99	146	201	157	*
Service 2	$*	$11,318.98	$14,359.90	$18,921.28	$20,272.80	$55,074.44	*
Utilization 2	*	67	83	112	120	325	*

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
Bundle #1	$318.21	0	0	0	0	0	0	0
MM Counts 1		0	0	0	0	0	0	0
Bundle #2	$269.69	0	0	0	0	0	0	0
MM Counts 2		0	0	0	0	0	0	0
Bundle #3	$223.74	0	0	0	0	0	0	0
MM Counts 3		0	0	0	0	0	0	0

PMPM		Amount Claimed						
	Rate	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12	Total
Bundle #1	$318.21	$*	$19,410.81	$25,138.59	$31,821	$31,502.79	$36,912.36	*
MM Counts 1		*	61	68	100	99	115	*
Bundle #2	$269.69	$*	$8,360.39	$14,293.57	$21,844.89	$21,575.20	$21,844.89	*
MM Counts 2		*	31	53	81	80	81	*
Bundle #3	$223.74	$*	$14,095.62	$28,862.46	$51,683.94	$73,386.72	$98,445.60	*
MM Counts 3		*	64	127	231	328	439	*

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.

Administrative infrastructure put in place during the second half of PY 2 is as described in the Mid-Year Report with the addition of computer and equipment purchases for the Care Coordination Staff hired through the PMPM bundles.

As described in the rollover request, submitted November 2017, program needs for data analysis, QI, administrative support, and fiscal support were largely met by part time coverage through existing staff as represented in the attached invoice generating cost savings.

The Medical Director has been appointed and will begin the first quarter of PY3. The Behavioral Health Director is appointed but paid for through existing resources.

Mobile van purchase and conversion was set aside in lieu of launching the mobile outreach care pods which serve a similar outreach function.

Cubicle purchases were deferred until the first quarter of PY 3 to aligned with a planned move to a new office location with the exception of 1 chair that was purchased in advance and billed in the PY 2 Annual Invoice.

Indirect amount reported is based on 5% of actual costs.

V. NARRATIVE – Delivery Infrastructure

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

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

Delivery infrastructure implemented in the second half of PY 2 included continued research into potential vendors for the WPC technology platform. As this platform, in the long run, will likely serve a broader purpose beyond Whole Person Care and must be robust enough to blend with existing infrastructure and to meet multiple needs, careful consideration is being put into this substantial purchase.

Recognizing the need to understand the state of the art from a growing field of care coordination platforms with differing features, the Technology Workgroup formed during the first half of PY 2 previewed products from six vendors in addition to the eight previewed in the first half of PY 2 along with second round previews from a handful of vendors.

The informaticist assigned to WPC began the implementation of a data warehouse to be used for WPC and PRIME reporting which will form the primary technology interface between a future technology platform for Whole Person Care and existing electronic health records. The informaticist with support from the information technology team began a detailed mapping of data elements from the Cerner electronic health record that may need to be exchanged with a future technology platform and began to interview vendors on how these data elements might align with their infrastructure. These efforts were reported to the Data Governance Committee on 7/7 and 10/31/17.

With the intensive enrollment of WPC patients in the second half of PY2, WPC staff also met with Cerner developers to create WPC-specific enhancements to better identify and support WPC-eligible and enrolled patients directly at the point of care such as a WPC enrolled and eligible button in the HER; and live rolling reports of enrolled and eligible patients in the ER, hospitalized, discharged, and with future appointments and associated work flows.

Intensive planning went into the launch of the Mobile Outreach Care Pods during the second half of PY2. A vendor was identified and contracted, implementation sites and community partners identified, internal projects committee and Board of Supervisors approval to proceed attained, and supplies purchased for the launch of the first Care Pod event December 15, 2017.

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 following incentive payments were earned during the second half of PY 2:

260 housing services were completed by WPC team members in alignment with those services described in the approved WPC application for a total of $45,500 claimed, payable to the Lead Entity.

358 out of 446 patients had a care plan within 30 days of enrollment for a total of $179,000 claimed, payable to the lead entity

Twenty-three of 29 or 79.3% ED* visits (should be hospitalizations) for mental health were followed up within 30 days. Twenty-three eligible follow-ups for an incentive payment of $11,500 were claimed payable to the Lead Entity.

Care Pod Community Services Events were held at the new Care Pod site in Santa Paula on 12/15, 12/22, and 12/29/17 for an incentive payment claimed of $30,000 payable to the Lead Entity.

* This metric should actually read inpatient hospitalizations according to universal metric specs. This was an error in the original application. This metric was calculated on the basis of inpatient hospitalizations.

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 Annual Report and WPC Universal and Variant Metrics Reporting Template submitted with the Annual Report, included metrics for the following pay-for-outcome measures. For the highlighted metrics below, these metrics have been attained and rates will be submitted to DHCS by 5/31/2018.

- Ambulatory Care Emergency Department (AMB/ED) - 778 Ambulatory Care ED Visits per 1000 Member Months
- Inpatient Utilization (IPU) – 0 Inpatient Discharges per Total Member Months
- Initiation and Engagement of Alcohol & Other Drug Dependence Treatment (IET) – 74% Initiation within 14 Days of Diagnosis, 89% within 30 days of Diagnosis
- Optional Variant Metric: CHW Training (M1), 81.5%
- ***Comprehensive Diabetes Care (CDC-H8) – Attained***
- ***Depression Remission - Attained***
- ***Major Depressive Disorder – Attained***
- ***Housing Services – Attained***
- Follow-Up After Hospitalization for Mental Health (FUH) – 59% within 7 days of discharge, 79% within 30 days of discharge
- Optional Variant Metric: CSW Encounters (M6), 51%
- Optional Variant Metric: Recuperative Care Readmissions within 90 Days of Discharge, 84.2% not admitted within 90 days of discharge

Challenges included the need to coordinate/collaborate with other data owners such as Gold Coast Health plan and Ventura County Behavioral health to account for utilization and services outside of those maintained by the Health Care Agency. Four of the metrics in bold are claimed as attained and rates will be reported to DHCS on 5/31/18 based on revised technical specification. For the CSW encounters metric, 6 months, with the majority of new enrollees joining towards the last few months of PY2, partial-year enrollment confounded the ability to reach a metric envisioning 6 CSW contacts across a full program year. This metric was reported out as being met if one or more CSW visits occurred during a two-month enrollment period.

Lessons learned included acknowledging the lead time and coordination to plan, extract, review, and revise metrics across multiple data sources. Meetings to streamline the process for metric development and refinement will occur across PY3.

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.

See attached program policy meetings held with participating entity/ies and/or stakeholders during the reporting period, and a brief summary, with topics and decisions, of the proceedings.

IX. PROGRAM ACTIVITIES

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

(1) Recruitment, hiring, training and support of a strong, multi-disciplinary care coordination team of licensed and non-licensed staff, including Community Health and Service Workers.

(2) Implementation of a daily huddle process in support of team-based care and patient in Chronic Care Model. Team reviews as a group daily staffing; new patients and their needs to kick of integrated care plan; ER visits; recuperative care visits; and hospital discharges; priority cases; stuck cases, and on the spot training for brief topics or key processes such as PDSAs.

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

(1) Alignment of information needs and work flows between licensed and non-licensed staff.

(2) The need to build documentation skills among non-licensed staff many of whom are new to documenting work in the context of a medical record.

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

(1) Moving data and information sharing from the conceptual to implementation level. Successful meetings with Behavioral Health and Alcohol and Drug programs towards agreement sharing data within the behavioral health record.

(2) With training and ongoing support staff comfort level with enrollment, informed consent and obtaining releases of information.

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

(1) Operationalizing data and information sharing agreements at the systems level to the provider level requiring additional guidance and training to line staff on what type of

information can be shared with which providers for which purposes without release of information. (With lack of clarity, some line staff were defaulting to no sharing without release of information).

(2) Translating data and information sharing agreements at the systems level to access for WPC team members within electronic health record required multiple meetings with a larger group of stakeholders, including QA and billing to understand implications before login access could be granted.

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

Successful calculation of outcome metrics for the first time in collaboration with other data stakeholders including MediCal managed care plan, Behavioral Health. This is critical because, for example, with ED and IP utilization, only 40% of utilization takes place within the HCA-affiliated hospitals (VCMC and Santa Paula) where we have information access through the Cerner Electronic Health Record.

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

Operationalizing details of some metrics, such as continuous enrollment requirements and their impact on how data is reported.

Identifying all potential sources of relevant data in an integrated care environment across multiple systems and providers.

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

Pilots will likely demonstrate significant successes improving care and reducing costs for a very challenging patient population through use of data, systems change, engagement through community workers, and multi-disciplinary care coordination. It may be challenging to sustain these gains and lessons learned without dedicated funding streams or sustainability planning, likely with other key stakeholders.

Housing continues to be the biggest barrier at the patient care level in a high cost low-availability housing and rental market. Available housing was also recently constrained even further due to losses sustained during the Thomas Fire of December 2017 which

affected many Ventura County communities. Many of the care coordination successes we achieve could be more easily sustained if the basic need for housing were more routinely met for more program participants.

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.

List PDSA attachments