State of California - Health and Human Services Agency

Department of Health Care Services

Whole Person Care

Lead Entity Narrative Report

Small County Whole Person Care Collaborative

Annual Narrative Report, Program Year 2019

Submitted: May 27, 2020

Revised: July 10, 2020 (REV2)

REPORTING CHECKLIST

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	☐ X 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	☐ X Customized invoice
3. Variant and Universal Metrics Report **Submit to:** SFTP Portal	☐ X 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	☐ X Care coordination, case management, and referral policies and procedures, which may include *protocols and workflows.)* ☐ X 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	☐ X Completed WPC PDSA report ☐ X Completed PDSA Summary Report
6. Certification of Lead Entity Deliverables **Submit with associated documents to:** Whole Person Care Mailbox and SFTP Portal	☐ X Certification form

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

Whole Person Care

Small County Whole Person Care Collaborative
Annual Narrative Report, 2019
May 27, 2020 (REV 2)

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

Instructions: 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.

Please limit responses to 500 words. If additional information is needed, please contact your assigned Analyst.

PY4 is has shown stability, continuing growth and refinement in serving clients and achieving programmatic goals. In the below program goals, we are progressing as follows:

1. *Increasing integration among county agencies, health plans, providers, and other entities –*
In Mariposa, the WPC team continues to have challenges automating the alert system for WPC clients. As mentioned in the mid-year report, the hospital underwent significant staff turnover at which time WPC lost their contact and several supportive leaders. Since the mid-year report, WPC staff have found new contacts, but the level of communication has still not returned to pre-turnover levels. The Healthcare District is consumed with a variety of other programs and requirements, which make it difficult for them to prioritize implementing more robust WPC procedures.

San Benito continues to have solid relationships with their hospital and behavioral health department, and has been invited to attend as well as present at quality improvement meetings within behavioral health. Their Community Partner meetings continue to be well-attended. Both counties enjoy an excellent working relationship with their health plan partners. In the fourth quarter, transition updates were included as a recurring item during monthly data sharing meetings. They have also been responsive to documenting complaints on their transportation contractor, LogistiCare and regular attendees at MDT meetings. The RN manager for Anthem is particularly helpful in working with teams to connect clients to resources and problem solve through issues.

2. Increasing coordination and appropriate access to care;
In 2019, Mariposa added a social needs screening tool. They tested it initially on newly enrolled clients and found that its use did reveal unmet needs they would not normally have identified. The results from the tool have assisted them in linking clients more quickly with needed services like food and legal support. Staff continue to assist clients

with accessing primary and specialty care as well as housing navigation. We have been tracking time to accessing primary care through our system – with the scheduling of a first appointment being used as a proxy for access. Because our numbers are small and one outlier can skew the results significantly, we predominantly look at days to PCP appointment overall to see that the numbers are staying within a 60-day period. The table below is an excerpt from our status report. In Q1, you will see a higher amount of days to PCP visit than subsequent quarters. This is due to [redacted] complex needs and needed urgent specialty care prior to being able to see a PCP.

Excerpt from SCWPC Status Report - 2019 [REDACTED]

In 2019 mid-year report, we discussed the difficulty Mariposa County was experiencing with the transportation benefit from the health plans. In the latter part of the year, there was a meeting to address this with the health plans. A complaint documentation tool was created by the WPC team that is shared with the health plans. We understand that this is a problem that other counties have and will not be solved quickly. The Mariposa WPC team continues to drive clients to appointments when LogistiCare, the transportation vendor, fails. Communication with outpatient clinics continues to occur with success, especially in Mariposa County, where clients can be locked out of receiving services and where the sparse number of providers to residents is a real barrier.

3. Reducing inappropriate emergency and inpatient utilization;
Both WPC teams are continuing to work with their hospital partners as well as provide direct assistance to clients. They are getting clients into primary care and helping them get their non-medical needs met. This personal connection, the ability for a trusted staff person to intervene, is essential to interrupt the utilization pattern. All these activities contribute to the continuing decrease in ED visits and hospitalizations. Again, the numbers served are small in our rural counties, so one very high utilizer can skew results. Also, Mariposa is seeing an increase in the complexity of clients they are serving. For clients that have stagnated in reducing unnecessary ED visits, they decided

to introduce a cash incentive for reduction. They originally tested this [redacted], which appeared successful. Overall, our teams, with their clients, continued to reduce both ED visits and hospitalizations. See the tables below. Similar to last year, looking at the data across time, the longer individuals stay in WPC the more stable they become.

Mariposa ED and Hospitalization Utilization

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	[redacted]			
6 months				
12 months				

San Benito ED and Hospitalization Utilization

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	[redacted]			
6 months				
12 months				

4. Improving data collecting and sharing-
We are constantly working to improve data gathering, synthesis and distribution. We implemented a medications reconciliation form in our eClient system in late 2018. San Benito was able to integrate this process in their workflow fairly rapidly. Mariposa had some challenges with data entry and the process used to update the list. They implemented a revised workflow, tested its application, and improved their compliance with this standard and our ability to track this work by Quarter 4 2019.

Medication List - Mariposa

Month[6]	Enrolled Clients	Clients with Medication List at Intake[7]	Clients with Updated Medication List[8]
Q4 2017	[redacted]	NA	0 (0%)
Q1 2018		NA	0 (0%)
Q2 2018		NA	0 (0%)
Q3 2018		NA	[redacted]
Q4 2018		NA	
Q1 2019		[redacted]	
Q2 2019			
Q3 2019			
Q4 2019			
October 2019			
November 2019			
December			

We updated our large Status Report to add more measures, which we could pull from existing data and worked with our evaluation consultant to clean up other measures. For example, we took out early data and data generated from our old Plumas County colleagues so that we could have a more accurate understanding of how we are doing in our program. In 2017 and early 2018, we were still unsure about how to capture some data, what that should look like, even the program was continuing to evolve on basic levels. We built greater stability in the second half of 2018, but it was in 2019 that our teams were able to practice in a largely more static program design.

In 2019, we also began to design a one-page dashboard document for quick synthesis, and distribution to all stakeholders. The data and dashboard changes were conceived in the last month of 2019, but were refined and implemented in 2020.

Community Partner meetings continued on schedule in San Benito County. Mariposa County had more difficulty. Given that the meetings were moved to quarterly in PY4, wildfire disasters caused the cancellation of two. In the end, Mariposa was only able to host one official Leadership meeting, but does provide ongoing updates to key partners through routine channels -such as in existing meetings focused on other topics.

Our eClient Management system – eWPC, continues to have flaws. However, the overall number of complaints has decreased. The extensive work in 2018 and in early 2019 has made the capture and reporting pieces more stable. On the capture side, we initiated color coding so that staff knew which fields were critical for reporting. This has helped ensure that staff are entering needed data. For this report, for example, there were far fewer incomplete fields essential to reports. On the reporting side, we are seeing less errors involving less clients, but help tickets to fix logic bugs must occur every single reporting period.

As reported in the mid-year report, we have been able to include health plans and Mariposa's housing contractor in using the eWPC system. Health plan staff continue to access the system. The Housing contractor staff had more difficulty integrating access and editing into their workflow. This has been one of many complaints Mariposa County WPC has had with their vendor. Despite this, there has been documenting of client assistance directly from the vendor helping drive shared information in real-time with Care Coordinators. This piece has been valuable when it occurs.

5. Achieving quality and administrative improvement benchmarks-

Previously, we stated that as a Collaborative, we track a budget to actuals for our FFS and bundle units. These are provided and discussed at regular Collaborative Business or Quarterly meetings. Corrective action is also discussed if needed. We also allow on-demand report runs for any staff person so they can review data specific to their county. We did complete the updating of the Status Report, which includes more demographics, process and outcomes measures. Some of the measures include other ways of looking at the DHCS Variant and Universal metrics, such as housing services. In this example, we are further breaking apart the groups to Homeless/at risk at intake and not homeless or at risk at intake. We examine staff compliance with housing services by N and percentage at each step of the process. In this way, we can see where, if any, clog points are and what is happening in the non-at risk/homeless group of clients. This has been beneficial to review. We were able to see a trend in this group that showed an increase precariousness in previously stable housing, which changed workflow to include housing assessment earlier post enrollment. This resulted in more VISPDAT assessments to total enrolled (note: Several enrolled in mid-December, thus all assessments were not able to be completed in the time frame.).

VISPDAT Assessments - Collaborative [REDACTED]

The Status Report allows staff to more closely monitor the data resulting from their work. In 2020, we shifted our business meetings to focus on review of this report to look for improvement opportunities.

We are also tracking compliance with the PHQ-9 assessment protocol. There is a table in the Status Report that monitors this compliance. Mariposa, for example, had difficulty tracking and administering the assessment for clients who fell in the middle of the scoring matrix -not depressed but also not depression-free. They initiated a PDSA and tool to track client assessment status and have improved their work as a result.

In 2019, additional training with one-to-one follow up on PDSAs was provided. Staff have slowly been able to integrate this practice into their workflow. The quality of the PDSAs from staff have improved overall; however, staff turnover does impact quality somewhat as new staff must retrain on how to do this work. This takes time to integrate.

6. Increasing access to housing and supportive services;

We increased the percentage of referred clients receiving housing services. At the time of the mid-year report, we were at 77%. By the end of 2019, our percentage was up to 86%. We have been tracking this measure over the last year, which includes discussing it at quarterly meetings and bi-monthly standing business meetings. Some of the percentage deficit was due to data entry errors, enrollments at the end of the year (thus no housing navigation activities were able to be provided before the end of the year), and at the more problematic end of the spectrum, staff availability and vendor performance.

In the first six months of 2019, staff were able to move [redacted] clients from homelessness to being sheltered. Staff increased this by another [redacted] individuals, for a total[redacted] individuals sheltered. Of the [redacted] additional individuals, most were found space in an emergency shelter. [redacted] were in transitional housing. [redacted] had temporary housing, and f[redacted] had permanent housing [redacted] with subsidy and [redacted] without subsidy) by the end of the year. [redacted] in an emergency shelter, reverted to homelessness.

We track this work over time. The table below shows the number of clients housed (not temporary or shelter) since inception of WPC.

Number of Clients Housed Over Time - Collaborative

	Homeless at Enrollment
Number of clients	[redacted]
Clients housed in program	
Prior to Enrollment	
Within 3 months of Enrollment	
Within 6 months of Enrollment	
Within 12 months of Enrollment	
Longer than 12 months after Enrollment	
Average time to housing[12]	138.4 days
Returns to homelessness after housing	[redacted]

Mariposa County continued to have communication and billing issues with their nonprofit housing navigation vendor. The vendor has also had some staff turnover. As a result, much of the housing navigation work has been shifted to either WPC staff or their COC. The numbers of individuals housed or sheltered specific to Mariposa have decreased as a result.

7. Improving health outcomes for the WPC population.

Our main measure of wellness is the PHQ-9 score, a self-report measure of depression level. We have several ways we look at the data. In the mid-year report, we provided some graphs that showed a score decrease over time. For this report, please see the table below that shows scores in aggregate for the Collaborative. It not only views the data over time but whether the client has a diagnosis of MDD. We wanted to see what difference was, if any, between the depression scores for each group. What was fascinating to see is that the group with the clinical diagnosis was the group with the greatest decrease. Fortunately, all groups at all time levels show a decrease in self-assessed depression.

PHQ-9 Scores - Collaborative

PHQ-9 Scores (Depression)

Inclusion Criteria	Number of Clients	Average PHQ-9 Score at Intake	Average PHQ-9 Score Post-Enrollment	Percent Change	Effect Size Estimate (Cohen's D)
Clients without Diagnosis					
Discharged Clients	[redacted]	13.5	10.8	-20.4%	0.4
Clients Enrolled for 12 Months	[redacted]	14.8	9.5	-35.8%	1.0
Clients with Depression/Dysthymia					
Discharged Clients	[redacted]	12.3	9.1	-25.6%	0.4
Clients Enrolled for 12 Months	[redacted]	12.0	5.3	-55.8%	1.3

On the Variant and Universal Metrics Report (V&U), our data indicates that [redacted] our enrollees scored below a 5 on the PHQ-9, which is considered depression remission. Although this appears low, with this complex population, it is extremely rare for any of the assessments to be under 5. People are entering WPC significantly more depressed than previous enrollees. The decrease in depression self-assessment, albeit with a score of 5 or over, is a victory for our clients and staff. San Benito initiated a variety of activities to promote the connectedness of their clients to help decrease depression levels. Clients report positive feelings toward activities that they help conceive of, plan and implement as well as those with practical application, such as accessing phones.

The Collaborative is excited to share with the State again our table examining achievement of self-directed goals. As a reminder, the Collaborative uses the Strengths Assessment and Recovery Model with all clients. In this model, the client is at the center

of their decision-making and focus is placed on the strengths the client has (vs. the deficits) to achieve the goals they set for themselves. Clients often begin with large, long-term goals. The Care Coordinator's job is to help the client break these down into smaller, more short-term achievable goals. Examples are, "I want to be able to pay my rent." "I want to decrease the amount of medication I take." "I want to be able to see my kids." "I want to get my driver's license back."

The following table shows the [redacted] clients who have achieved one or more goals and those that achieved two or more goals by condition at enrollment and across time. As previously stated, the longer clients are enrolled, the greater number of them reach their goals. Also, continuing is the trend that, given the complexity of the issues clients present with and challenges they face, at least half are meeting goals after being enrolled 3 or more months. This underscores that it takes some time to develop trust, complete all the paperwork and assessments, and begin to work together to address client needs. Also note that meeting goals is much more difficult when a person is homeless or at risk of homelessness, justice involved or presenting with a substance use issue. Again, we are extremely proud that our clients are achieving goals they have set for themselves. All these goals link directly to social determinants of health and strongly associate with increased stability and wellness over time.

	Number of Clients	Met One or More Goals	Met Two or More Goals
Chronic Health Condition			
Enrolled Less than 3 Months			
Enrolled 3 Months or More			
Mental Health Condition			
Enrolled Less than 3 Months			
Enrolled 3 Months or More			
Substance Use Disorder			
Enrolled Less than 3 Months			
Enrolled 3 Months or More			
Justice Involvement			
Enrolled Less than 3 Months			
Enrolled 3 Months or More			
Homeless			
Enrolled Less than 3 Months			
Enrolled 3 Months or More			
At Risk of Homelessness			
Enrolled Less than 3 Months			
Enrolled 3 Months or More			

Finally, we would like to share some client stories as written by care coordination staff. These make clear the complex, multi-faceted needs clients have to navigate to get their lives back on track. Pronouns and other potentially identifying information have been removed.

"[redacted] California ID on [redacted]
Birth certificate is on the way
[redacted] receive SS Card
[redacted] in the process of getting into Senior Apartments (above information is required to complete application)"

"[redacted] recently visited the WPC office to report that they have been approved to buy their own home. [redacted] expressed pride in the ability to provide for themself and loved ones and wanted to thank staff for their support. [redacted] indicated that the Mariposa County WPC program and staff were an integral part of their current status and overall improved wellbeing."

"[redacted] featured in local press [redacted]
Physical and behavioral health is stable
[redacted] housed but may move [redacted] because of improved family relations
[redacted] to graduate [redacted]
Lawyer for SSI
Very proactive with appointments
Graduated for substance abuse"

"Through the support of the WPC program, [redacted] able to establish a primary care physician, request referrals for specialty treatment and connect with psychiatric services within the local community. [redacted] feeling empowered for the first time since being incarcerated ([redacted]. [redacted] hopeful they will be able to continue improving their quality of life and wellbeing and thanked the WPC team for their support. Future [redacted] goals include stable housing and reunification with estranged family members"

There are challenges too, which WPC is there to help the client address, so they stay their course:

"[redacted] car.
[redacted] got a job [redacted] First day of work [redacted]
[redacted] opened a bank account with first paycheck [redacted]
[redacted] finished all their court appearances
Due to an unreliable car, [redacted] lost job in [redacted] but is looking for any kind of work closer to home"

III. ENROLLMENT AND UTILIZATION DATA

Instructions: 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	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	22

Item	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12	Annual Unduplicated Total
Unduplicated Enrollees	11	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	31

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*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 **M 250** **SB 365.67**	13 =3250 35=12798.45 **16,048**	[redacted]	[redacted]	[redacted]	[redacted]	19=4750 55=20111.85 **24,862**	13,000 107,507= **120,507**
Utilization 1	48	[redacted]	[redacted]	[redacted]	[redacted]	74	346
Service 2 **M 500**	0	0	0	0	0	0	0
Utilization 2	0	0	0	0	0	0	0

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	21=5250 87=31813 **37,063**	18=4500 84=30716 **35,216**	17=4250 51=18649 **22,899**	18=4500 34= 12433 **16,933**	[redacted]	18=4500 18=6582 **11,082**	[redacted]
Utilization 1	108	102	68	52	[redacted]	36	[redacted]
Service 2	0	0	0	0	0	0	0
Utilization 2	0	0	0	0	0	0	0
***SBC work exceeded the budget.							

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*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	26=44746 18=29826 **74,572**	26=44746 19=31483 **76,229**	26=44746 21=34797 **79,543**	26=44746 23=38111 **82,857**	25=43025 25=41425 **84,450**	23=39583 29=48053 **87,636**	261,592 223,695= **485,287**
MM Counts 1		44	45	47	49	50	52	287
Bundle #2	m$1,389 sb$1,936	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	15,279 151,008= **166,287**
MM Counts 2		[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	89
** SBC work exceeded the budget.								

Amount Claimed								
PMPM	Rate	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12	Total
Bundle #1	m$1,721 sb$1,657	27=46467 36=59652 **106,119**	28=48188 40=66280 **114,468**	28=48188 40=66280 **114,468**	30=51630 35=57995 **109,625**	31=53351 36=59652 **113,003**	33=56793 34=56338 **113,131**	304,617 366,197= 670,814 **Annual=1,156,101**
MM Counts 1		63	68	68	65	67	67	685
Bundle #2	m$1,389 sb$1,936	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	26,391 189,728****= 216,119 **Annual=382,406**
MM Counts 2		[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	206

***SBC work exceeded the budget.
**** SBC work exceeded the budget.

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

As the Housing (PMPM2) utilization numbers show for Mariposa, they continued to struggle with their vendor relationship. For both counties, the Care Coordination (PMPM1) numbers show that they were able to maintain the growth they realized in PY3, increase their numbers judiciously, and then maintain a higher number census through the end of PY4. FFS1 numbers reflect the differing approach of each county. Mariposa has had more consistency with their client load. They were the first county to have more [redacted] stay in WPC for a year, and has therefore been more conservative with the number of potential clients they target for outreach. As they transitioned from PY3 to PY4, their outreach numbers were minimal. However, as graduation dates for long-time WPC clients and those performing well approached, they began to increase the targeted outreach number mid-year to fill upcoming openings. San Benito, in contrast, has [redacted] substance abuse challenges, which has made their client load less predictable. They also made a stronger push to serve more clients in PY4. The FFS1 utilization reflects much more outreach to fill newly available slots and ensuring a pipeline of clients for openings made vacant by the challenge of keeping people with substance use disorders engaged.

IV. NARRATIVE – Administrative Infrastructure

Instructions: 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. Please limit your responses to 500 words.

In PY4, the Collaborative saw turnover in staff and/or a shifting of roles in each county. Especially in Mariposa, staff turnover required significant additional training and onboarding time. Fortunately, all staff were able to learn the program and technology rapidly and make contributions for client benefit. A Return on Investment study contract took longer than anticipated to complete with UC Merced. That contract was finalized in Quarter 3 of PY4. Work began immediately. A final product is anticipated by Quarter 1 of 2020.

There were two additional Quarterly In-Person Collaborative meetings since the mid-year report. Staff continue to report the benefit and utility of the trainings. Again, in addition to professional development, the in-person trainings provide opportunities for updates and training on eWPC changes, creation of protocols, case conferencing to traverse barriers, and collaboration/information sharing across counties. The two additional foci of the trainings were Co-Occurring Disorders, Establishing Strong Boundaries, health plan partner benefits and offerings, transition preparation, eWPC data updates and problem solving, and client successes. The Collaborative Administrative team, comprised of the Third-Party Administrator, Fiscal Lead and contracted evaluator, is providing data feedback to staff, so they know what results are occurring due to their work and where improvements can be made. As we always relay, the use of a modified Agile methodology to solve problems and gain valuable staff input into operational systems has been a boon for quickly getting answers and solutions.

The Third-Party Administrator provides bi-monthly business meetings to facilitate communication between the Collaborative and Counties and problem solve issues with the help of one another. There are also director-level meetings once per month (or a written update if needed) to ensure all levels of staff are informed about the progress and help determine direction of WPC. In PY5, we anticipate shifting the structure and purpose of these meetings. For the business meetings, we will likely shift to mostly data informed quality improvement model, with time for communicating the status of items such as the transition. For Directors, we will shift to transition discussions. A dashboard of a variety of WPC metrics will be provided for reference and questions as desired.

The Administrative team addresses all of the DHCS questions, reports, meetings, provides transition leadership and a cadence to required elements of the program to ensure compliance. All staff that provide administrative infrastructure for each county have been extremely important in ensuring fiscal compliance and local program leadership as well as transition preparation as we enter into the last year of WPC.

IV. NARRATIVE – Delivery Infrastructure

Instructions: 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. Please limit your responses to 500 words.

In Mariposa, their housing partner has had significant difficulty in complying with the MOU. While they provide some support to some clients, they entirely miss others and, when they bill, charge the PMPM rate for too few or too small of activities. The WPC Manager has provided remediation several times, but the practice of billing is very new to this nonprofit. Additionally, not one staff person is assigned. There is not enough volume of WPC clients to justify a dedicated staff person. As such, there is limited continuity of knowledge and turnover of staff who can be shifted to other programming within the nonprofit or leave their job. Mariposa staff have performed much of the housing work themselves, which is not reflected in the utilization data. Further, they are shifting the work of housing navigation to the County COC little by little. Mariposa's hospital partner, though verbally supportive of WPC work, has not been able to recover from the turnover earlier in the year. Staff are spread thin and allocated to compliance related work as opposed to community project work. Since WPC lost the tracking flag function on the old ED electronic record, it has been more difficult for ED staff to know who is a WPC client when they present. Developing a workflow to review the shared list every time a person presents has not been easy. Notifications have occurred this year, but not at the level they did previously. Hospital participation in MDT meetings or other client connected communication has decreased as well.

In San Benito, they continue to receive daily information from their social worker contact. Their contact has also been able to integrate ED notifications with his work. The collaboration between agencies around SB 1152 has continued, and the hospital organized standing SB 1152 meetings for related agency partners is also continuing, resulting in more communication across entities and better coordination of services for homeless individuals. San Benito Behavioral Health has integrated the WPC Program Manager into some of their quality and staff meetings further making seemless data sharing and availability of services to SBC clients.

Improvements and stability of the eWPC system has improved since the mid-year report. There were far less data entry errors because of changes to the system (we changed the color of report related fields to red) and training at each in-person quarterly meeting. For this report, there were only a handful of errors, most were data entry and one was vendor logic issues. As described in the mid-year report, better documentation, multiple points of testing and individual change signoffs were some of the process changes put in place. These are showing dividends in terms of less issues needing to be researched. The system continues to have quirks, bugs and timeout challenges, but those have lessened overall. We are mostly having problems with vendor project management follow through, which we are trying to remediate by requesting that they activate their ticketing system reminder tool and use calendar alerts or some other method to track activities and status. A very positive change was the creation and refinement of a health plan report that significantly reduced the time managers needed to share data with health plan partners.

V. NARRATIVE – Incentive Payments

Instructions: 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. Please limit your responses to 500 words.

The Collaborative has four remaining incentive payment structures, as outlined below.

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. [redacted]
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. In PY4, [redacted] a total payment of $1,350 for John C. Fremont Health Care District.

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. In PY4, John C. Fremont Health Care District participated in only 45 of 52 possible weeks, earning a total payment of $13,500.

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. In PY4, the Hazel Hawkins Hospital participated in all 12 months, earning a total payment of $7,200.

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. Providers, Hazel Hawkins Hospital, San Benito Health Foundation and Community Homeless Solutions, submitted a combined 30 successful referrals in PY4, earning a total payment of $2,250.

VI. NARRATIVE – Pay for Outcome

Instructions: 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. Please limit your responses to 500 words.

SCWPCC has only one pay for outcome metric - a 5% reduction in ED and/or hospitalization use over baseline. This is tallied annually. We have continued to realize sustained and significant reductions in unnecessary ED visits and hospitalizations. Several clients were very ill this year, and did have ED visits that were necessary. ED visits are reviewed ad hoc to understand this distinction. The State metric and our regular report only look at the overall ED visits. Please see the tables below for both Mariposa and San Benito. However, note that our numbers are so small one outlier can skew the entire report.

This metric is paid based on DHCS run data. The trigger for payment was achieved. DHCS data showed a reduction from baseline to PY4 that surpassed 5%. The total amount earned was $10,000.

Pay for Outcomes Summary - Mariposa

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	[redacted]			
6 months				
12 months				

Pay for Outcomes Summary – San Benito

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	[redacted]			
6 months				
12 months				

VII. STAKEHOLDER ENGAGEMENT

Instructions: 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. An attachment to this report is also acceptable, please note below if this option is being used. 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.

Both counties have weekly staff meetings and quarterly Community Leadership/Partner meetings. Staff meetings are to communicate program information, work on PDSAs, problem solve and organize staff duties. There are not always formal agendas and minutes taken. Leadership/Partner meetings generally have standing agenda items related to system challenges, updates on WPC, data sharing. Changes to policy are not always discussed. In San Benito, there are generally no formal minutes taken. The meeting dates are as follows:

Mariposa Scheduled Staff meetings

- January: 8, 15, 22, 29
- February: 5, 12, 19, 26
- March: 5, 12, 19, 26
- April: 2, 9, 16, 23, 30
- May: 7, 14, 21, 28
- June: 4, 11, 18, 25

San Benito Scheduled Staff Meetings

- January: 8, 15, 22, 29
- February: 5, 12, 19, 26
- March: 5, 12, 19, 26
- April: 2, 9, 16, 23, 30
- May: 7, 14, 21, 28
- June: 4, 11, 18, 25

Mariposa Leadership Meetings: January 15 (Safety plan discussion, WPC update, use of LogisticCare transport service, discuss referrals), April 16 (WPC update, referrals, care coordination), and October 17 (General updates, health plan information). There was no third quarter meeting due to the wildfire disaster.

San Benito Partners' Meetings: January 16 (Discuss ability for clients to access a variety of services. Policy discussion on hospital discharge) and May 23 (WPC update, open house, client panel/client perspective on issues), December 3 (Used Wellness Coalition Meeting venue as a more efficient way to present to shared stakeholders as opposed to creating a separate meeting just for WPC.). There was no Partner meeting in the third quarter.

In addition to the Community Partners/Leadership meetings and staff meetings, the Collaborative convenes bi-monthly standing business meetings and quarterly in-person training meetings. MDT meetings with care partners and, often the client, occur as needed but at least monthly. I provided a sample of the Mariposa MDT meetings without PHI.

PROGRAM ACTIVITIES

Briefly describe 1-2 successes you have had with care coordination.
1. Most clients are meeting goals after just three months in WPC. 2. More clients are for successful or neutral reasons.

Briefly describe 1-2 challenges you have faced with care coordination, and lessons learned from those challenges.
1. Some clients come to WPC with long-developed unhealthy strategies for coping and navigating life challenges. They consume significant Care Coordination time, which infringes on other client appointments or decreases staff availability to work on other client issues. In PY4, we conducted professional development training on boundaries to give staff the tools needed to identify manipulation, and limit excessive time spent. 2. In Mariposa, working with their hospital has become difficult with limited ED notifications and several medical records requests for specialty care that did not occur in time for WPC client appointments. The hospital has realized significant turnover in key positions, which appears to be leading to this barrier in collaboration and performance.

Briefly describe 1-2 successes you have had with data and information sharing.
1. We have refined the way data is presented in the Status Report. The counties are using these reports for community, stakeholder and partner education. 2. SBC community partner meetings have been well attended, and clients have been empowered to tell their own stories. This has been compelling for hospital, health plan and county agency partners.

Briefly describe 1-2 challenges you have faced with data sharing, and lessons learned from those challenges.
1. The complete 180-degree change in relationship with Mariposa's JCF Hospital has been shocking. Staff turnover and technology system change has driven a significant drop-off in incentive-tied communication. This is combined with addition of high intensity duties to the WPC Program Manager responsibility, which may prevent more focus on creating new communication pathways. With new staff occupying various key positions, it is possible in 2020 that WPC staff will be able to re-engage this partner.

Briefly describe 1-2 successes you have had with data collection and/or reporting.
1. We have increased consistency and decreased data entry errors among staff. Medications lists are being reconciled at a higher rate, and a new social needs screening tool was implemented. 2. We have decreased eWPC system incidence of reporting errors.

Briefly describe 1-2 challenges you have faced with data collection and/or reporting.
1. The Mariposa Housing vendor staff were never able to use the eWPC system to its full potential. Problems at the administrative level and with staff turnover and/or ability to fully focus on the needs of WPC among all their many other programs were major barriers to success. 2. The unnecessarily complex contracting system with the University of California and slow reporting back from two partners required an extension to the timeline for receiving results. We originally hoped to present the data to leaders and other stakeholders by the fourth quarter 2019.

Looking ahead, what do you foresee as the biggest barriers to success for the WPC Program overall?
Success will really be determined in how the transition is handled by the State and Managed Care. We have already demonstrated client success, reduced costs, increased coordination and communication, universal data-sharing and building trust in marginalized communities is possible. There is still some uncertainty about reimbursement, technology to communicate on the ground work, billing, and what will be included as part of the definition of ECM/ILOS – and to what extent reimbursement will compensate for program costs. As we have seen over the last two years, much effort is required by all parties to drive success with clients, this includes the motivation of the client as well. Will ECM and ILOS maintain those key drivers of success and will entities be compensated sufficiently? These are the key questions and potential barriers to success long-term.

VIII. PLAN-DO-STUDY-ACT

Instructions: 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.

PDSA Attachments:

Mariposa:

- PY4 Ambulatory - Anthem LiveHealth Online Services Education and Implementation
- PY4 Ambulatory - ER Visit Reduction through Diversion to Primary Care - Cycle 1
- PY4 Ambulatory - ER Visit Reduction through Diversion to Primary Care - Cycle 2
- PY4 Ambulatory JCF ER Notifications Cycle 1
- PY4 Attachment _C_ Comprehensive Care Plan Tier Assignment
- PY4 Care Coordination - Incentive Program
- PY4 Care Coordination_Medication List
- PY4 Comprehensive Care Plan - Mandatory Demographics Workflow Adjustment
- PY4 Comprehensive Care Plan - Addition of Social Needs Screening Form Cycle 1
- PY4 Comprehensive Care Plan - Addition of Social Needs Screening Form Cycle 2
- PY4 Comprehensive Care Plan - Addition of Social Needs Screening Form Cycle 3

- PY4 Data - PHQ-9 Data Collection Tracking System
- PY4 Data - Client Tags
- PY4 Inpatient Utilization - LVN Home Visits Post Hospitalization
- PY4 Inpatient Utilization - New Specialist Medical Record Follow-up - Cycle 1 - Checklist Attachment
- PY4 Inpatient Utilization - New Specialist Medical Record Follow-up - Cycle 1
- PY4 Inpatient Utilization - New Specialist Medical Record Follow-up - Cycle 2
- PY4 Inpatient Utilization Reduce inappropriate use of the ER for recurring procedures

San Benito:

- WPC PDSA SBC Ambulatory Care & Inpatient Utilization Hotel Vouchers JUL-DEC 19 (2)
- WPC PDSA SBC Ambulatory Care & Inpatient Utilization SB1152 JUL-DEC 19 (1)
- WPC PDSA SBC Care Coordination Revised PA JUL-DEC 19
- WPC PDSA SBC Comprehensive Care Plan Graduation Protocol JUL-DEC 19 (1)
- WPC PDSA SBC Comprehensive Care Plan PHQ9 Scores JUL-DEC 19 (2)
- WPC PDSA SBC Data Anthem Blue Cross JUL-DEC 19