State of California - Health and Human Services Agency

Department of Health Care Services

Whole Person Care

Lead Entity Narrative Report

Marin County

Annual Narrative Report 2019

Revised 7/15/2020

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

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

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I. REPORTING INSTRUCTIONS

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

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

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

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

II. PROGRAM STATUS OVERVIEW

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.

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

Success:

- The county's WPC team built deeper relationships with Social Services and brought two Social Services staff onto our team, including a General Relief Navigator

Lesson learned:

- Social services information is critical to really providing wrap around care for vulnerable individuals. However, the culture of data sharing is not aligned with the training and protocols in social services necessarily

Increasing coordination and appropriate access to care:

Success:

- The twice-monthly meeting of all the safety-net providers has become an integral community-wide anchor event

Lesson learned:

- Having a community of providers across disciplines who know and trust each other yields faster and more appropriate care

Reducing inappropriate emergency and inpatient utilization:

Success:

- There is cross-sector interest and engagement in using Human Centered Design innovation techniques to address the problem of high users of EMS ambulance services

Lesson learned:

- There are a variety of models communities elsewhere have tried, elements of which could apply in Marin

Improving data collecting and sharing:

Success:

The use of WIZARD, our care coordination platform changed:

- We simplified the platform to facilitate easier and more effective use
- We integrated with the Homeless Management Information System and prepared to integrate with our safety net hospital
- The number of users and clients expanded massively
- We systematized ROI validation by adding half time admin staff who use protocols we developed in 2019 for Quality Assurance

Challenge:

- Data sharing culture is still sometimes a challenge

Lesson learned:

- Data gets appreciated and consumed by a wide variety of providers, however creating and adding data to our care coordination platform tracks closely with who and how we are paying to do so in our contracts

Achieving quality and administrative improvement benchmarks:

Success:

- More data sharing agreements (DSAs) were established. There are now 36 participating entities in the county

Challenge:

- Partners had a hard time filling empty positions
- Developing plans for long-term sustainability remained a challenge

Increasing access to housing and supportive services:

Success:

- More clients are getting and staying housed

Lesson learned:

- Pairing housing case management with housing vouchers for scattered site apartments is working to create new Permanent Supportive Housing in Marin

Improving health outcomes for the WPC population:

Success:

- The Assertive Community Treatment model we've implemented under WPC is spreading to county Behavioral Health teams

Challenge:

- The distinctions between Medical CM and M2M somewhat artificial (all CM is BH CM)

Lesson learned:

- It is difficult to assess true health outcomes with incomplete data from our managed care plan

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	106	70	87	93	80	73	509

Item	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12	Annual Unduplicated Total
Unduplicated Enrollees	89	58	36	54	26	57	829

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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 Information & Referral	$2,217	$2,486	$7,660	[redacted]	$6,316	$6,383	[redacted]
Utilization 1	33	37	114	[redacted]	94	95	[redacted]
Service 2 Screening Assessment & Referral	$2,254	[redacted]	$3,240	$1,691	$1,691	$7,185	[redacted]
Utilization 2	16	[redacted]	23	12	12	51	[redacted]
Service 3 Person-Centered Care Plan	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
Utilization 3	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
Service 4 Client Move-In Fee	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
Utilization 4	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
Service 5 Field-Based Engagement of Homeless	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
Utilization 5	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]

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Costs and Aggregate Utilization for Quarters 1 and 2							
Service 6 VI-SPDAT Assessment	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
Utilization 6	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
Service 7 90+ Day Residential SUD & 3rd Episode Treatment	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
Utilization 7	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]

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 Information & Referral	$3,261	$4,140	$2,601	$2,565	$3,004	$2,601	[redacted]
Utilization 1	89	113	71	70	82	71	[redacted]
Service 2 Screening Assessment & Referral	$2,488	[redacted]	[redacted]	[redacted]	$1,610	[redacted]	[redacted]
Utilization 2	17	[redacted]	[redacted]	[redacted]	11	[redacted]	[redacted]
Service 3 Person-Centered Care Plan	$450	$675	$1,350	$2,700	$900	[redacted]	$6,075

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Costs and Aggregate Utilization for Quarters 3 and 4							
Utilization 3	2	3	6	12	4	0	27
Service 4 Client Move-In Fee	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	$44,262
Utilization 4	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	18
Service 5 Field-Based Engagement of Homeless	[redacted]	$4,493	$3,089	[redacted]	[redacted]	[redacted]	$10,952
Utilization 5	[redacted]	16	11	[redacted]	[redacted]	[redacted]	39
Service 6 VI-SPDAT Assessment	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
Utilization 6	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
Service 7 90+ Day Residential SUD & 3rd Episode Treatment	$7,793	$3,221	$3,117	[redacted]	$1,974	$3,221	$19,325
Utilization 7	75	31	30	[redacted]	19	31	186*

*Utilization for service 7 “90+ Day Residential SUD & 3rd Episode Treatment” was over-claimed at mid-year by 4 units. To adjust for the over-payment, the invoice was adjusted to show 182 units for July-Dec. Actual utilization for Jul-Dec was 186.

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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 Comprehensive Case Management	$270.00	$5,940.00	$9,990.00	$8,100.00	$9,450.00	$12,420.00	$10,530.00	$56,430.00
MM Counts 1		22	37	30	35	46	39	209
Bundle #2 Housing-Based Case Management	$540.00	$84,240.00	$86,940.00	$83,700.00	$83,160.00	$91,260.00	$93,420.00	$522,720.00
MM Counts 2		156	161	155	154	169	173	968
Bundle #3 Case Management for Individuals with Mental Health Conditions	$462.33	$12,482.91	$16,643.88	$19,417.86	$18,493.20	$19,880.19	$19,880.19	$106,798.23
MM Counts 3		27	36	42	40	43	43	231
Bundle #4 Housing Locator	$700.00	[redacted]	$8,400.00	$9,100.00	$14,700.00	[redacted]	[redacted]	[redacted]
MM Counts 4		[redacted]	12	13	21	[redacted]	[redacted]	[redacted]

Amount Claimed								
PMPM	**Rate**	**Month 7**	**Month 8**	**Month 9**	**Month 10**	**Month 11**	**Month 12**	**Total**
Bundle #1 Comprehensive Case Management	$270.00	$13,230.00	$8,910.00	$10,260.00	$11,610.00	$12,960.00	$11,880.00	$68,850.00
MM Counts 1		49	33	38	43	48	44	255.00
Bundle #2 Housing-Based Case Management	$540.00	$91,800.00	$90,180.00	$87,480.00	$105,300.00	$100,980.00	$98,820.00	$574,560.00
MM Counts 2		170	167	162	195	187	183	1,064.00
Bundle #3 Case Management for Individuals with Mental Health Conditions	$462.33	$19,880.19	$19,417.86	$17,106.21	$19,880.19	$20,342.52	$18,955.53	$115,582.50
MM Counts 3		43	42	37	43	44	41	250.00
Bundle #4 Housing Locator	$700.00	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	$22,400.00
MM Counts 4		[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	32.00

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

We reported four quarterly Enrollment and Utilization Reports for the calendar year. We have significantly reduced the amount of corrections from the previous year by implementing a billing policy and confirming our providers are abiding by strict deadlines of reporting. We also developed a more effective quality assurance process for our Enrollment and Utilization Reports.

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 program year 4, Marin County has had little to no staff turnover in the Whole Person Care Business Unit Division. The team has worked on allocating funding sources through State and Local grants to secure sustainable housing-based case management funding after 2020.

In program year 4, we brought on a Support Service Worker II who jointly worked with the Substance Use Disorder program in Behavioral Health and assisted in the Whole Person Care Business Unit. They assisted the program staff in entering and reviewing ROIs in the unit's care coordination platform.

In 2019, the Division Director unified and coached the Whole Person Care Business Unit by creating attainable goals through PDSA and advocating to county leaders when necessary. Their campaigning has been instrumental in creating sustainable systems in the homeless division.

The Department Analyst II, Epidemiologist has created a streamlined process for developing, managing, and communicating data as the programs lead on the care coordination platform. In addition to leading programs data management, the Department Analyst II has coordinated with outside consultants to develop and publish Marin County's WPC evaluation.

The Senior Department Analyst serves as a change agent, coordinating with Behavioral Health Programs, hospitals, and health care clinics. In program year 4, the Senior Department Analyst executed a memorandum of understanding between the county's behavioral health programs and the Whole Person Care program. Much of their work has been a cornerstone in building and maintaining new relationships for the success of the program.

The Homeless Policy and Service Oversight Team made up of the Senior Department Analyst and the Sr. Program Coordinator continue to guide the marriage of coordinated entry system and housing- based case management services. Their work has been instrumental in delivery of Whole Person Care's services through community-based organizations.

The Accountant II continues to work with the Department Analyst II in streamlining value-based payment models and assists the Division Director in budget planning for sustainable services after 2020.

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 program year 4, Marin County Whole Person Business Unit worked with Applied Survey Research in executing the Point in Time Count. The final report confirmed our successes in recording a 28% decline in chronic homelessness (from 359 individuals to 257), 11% decline in youth homelessness (from 1[redacted] youth to [redacted]), and a 7% decline in the total amount of people experiencing homelessness (from 1,117 to 1,034). This achievement was achieved through strong relations with county partners, collaborations with county behavioral health programs, and coordinated entry. Details available here: https://www.marinhhs.org/sites/default/files/files/servicepages/2019_07/2019hirdreport_marincounty_final.pdf

In 2019, the Marin WPC team collaborated with local partners and the counties behavioral health to create a case manager training to assist in implementation of Coordination of Care Platform among case managers to ensure consistency in data reporting.

The number of enrollees in housing-based and mild-to-moderate case management increased throughout PY 4.

Health Information Exchange: While plans for robust, county-wide Health Information Exchange continue to develop, Marin's WPC team implemented aspects of individual information exchanges to support holistic care and address social determinants of health:

- Homeless Management Information System (HMIS) integration with WIZARD, WPC's care coordination platform:
    - Daily files are sent of HMIS records into WIZARD for WPC clients, with identity management/patient matching done on the WIZARD side
    - Fields loaded include VISPDAT (homeless vulnerability assessment), veteran status, permanent supportive housing program, and others

  - This allows critical housing related information to display to users of WIZARD who do not have access to HMIS

- MarinHealth (local safety net hospital) ADT integration into WIZARD was specified, planned and tested (to go live in early 2020):

  - Entire WIZARD panel to be sent to MarinHealth for matching purposes weekly
  - Admission and Transfer alerts for matching individuals to load from MarinHealth into WIZARD in nearly real time for Emergency Department admissions, Inpatient Admissions, and Inpatient discharges from all relevant hospital departments
  - If the client has a WPC case manager that case manager will be alerted that their client is at the hospital now or was recently with next steps suggested

- Potential opioid overdose alerts from EMS:
  - EMS data is processed weekly to identify potential opioid overdoses.
  - Initial conversations began to consider loading this data to WIZARD, with a case manager alert. To pursue in early 2020.

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.

Incentive: Enhanced Transition for Severely Mentally Ill

- County Behavioral Health PY4 Achieved: 14 clients at $5,000/client; Total earned: $70,000. A payment of $5,000 per successful client engagement in county services upon transition to an appropriate lower level of care is proposed to incentivize the unit to work with and support this population, limited to one such payment per enrollee per 12-month period.

Incentive: Case Conference Attendance for Collaborative Partners

- To support the representatives of participating entities, an incentive of $5,000 will be earned by partners who attend at least 90 percent of the year's monthly case conferences.

Federally Qualified Health Clinics: PY4 amount earned: $7,500

- Marin Community Clinics- Attendance at 100%, payment at $5,000
- Ritter Center- Attendance at 100%, payment at $2,500

Housing Service Providers: PY4 amount earned: $17,500

- Homeward Bound- Attendance at 93%, payment at $5,000
- Downtown Streets Team- Attendance at 100%, payment at $2,500
- Whole Person Care -Attendance at 100%, payment at $5,000
- Behavioral Health – Attendance at 93%, payment at $5,000

Incentive: Completion of Care Plan for 80+% of Clients Within 30 Days of Enrollment for Housing Case Management Bundle and Medical Case Management Bundle

- Homeward Bound of Marin (HBOM): PY4 amount earned: $10,800 (48 x $225 per client)

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Summary			
	HBOM	**Ritter**	**SVDP**
Total New WPC Enrollees (2019)	55	34	[redacted]
Care Plan Completed in 30 Days	48	17	[redacted]
Percentage Earned	87%	50%	[redacted]
Percentage Based on Contract	80%	90%	80%
Incentive Earned	Yes	No	No

Incentive: Participation in Outreach Coordination – Community Partners

- Payment will be earned at the end of the year for each partner that has attended at least 80% of the outreach coordination meetings in 2019.

County Partners: PY4 amount earned: $26,666

- Behavior Health – Attendance at 88%, payment at $13,333
- Whole Person Care Unit – Attendance at 88%, payment at $13,333

Incentive: Client Authorization for Release of Information Training

- Payment is triggered upon completion of a training by at least one staff person from a partner organization.

Community Partners: PY4 amount earned: $21,000

- St Vincent De Paul- $3,000
- Marin Community Clinics - $3,000
- Marin City Health and Wellness- $3,000
- Ritter Center- $3,000
- Housing Authority of Marin- $3,000
- Downtown Streets Team - $3,000
- Homeward Bound of Marin - $3,000

County Partners: PY4 amount earned: $30,000

- Behavioral Health - $15,000
- Whole Person Care Unit - $15,000

Incentive: Execution of Memoranda of Understanding between the WPC Business Unit and Key County Partners

- A formal MOU between the WPC Business Unit and the HHS' Behavioral Health and Recovery Services Division was signed by both parties in February 2019.
- *County Behavioral Health and WPC Unit: PY4 amount earned: $20,000*

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.

We had set a goal of increasing the rate of "exits to permanent housing" from the shelter from 41 percent in the first half of 2019 to at least 50 percent in the first half of 2019. The biggest challenge the Marin County Whole Person Care Business Unit encountered was lowering barriers and bringing in more vulnerable people than we had anticipated. We learned that a harm reduction, housing-first focused shelter that prioritizes the most vulnerable creates additional operational challenges. No funds were claimed for this outcome on the annual invoice.

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.

Attached is the PY4 WPC Meeting Tracker.

VIII. PROGRAM ACTIVITIES

Briefly describe 1-2 successes you have had with care coordination.
1. We collaborated with the Prop 47 court's multi-disciplinary team and used WPC case management as a tool to assist the court. 2. Care coordination around mental illness was greatly increased by the launch of our new Homeless Mentally Ill Outreach and Assessment team which launched this year. This bilingual team works in the field to engage with people experiencing homelessness so that enough trust can be built to conduct the screenings and assessments needed to determine appropriate level and type of care. In addition, this team is able to connect with other parts of our care ecosystem as part of wrap-around care for our clients.

Briefly describe 1-2 challenges you have faced with care coordination, and lessons learned from those challenges.
1. Two of our main FQHC partners providing Medical Case Management had ongoing problems with RN staff to do this work (both had to let staff go and then found it very difficult to attract and hire qualified replacements), meaning they were not able to provide the number of units allocated in their contract for Medical Case Management, and real patient needs were not being coordinated to the degree intended. 2. Our main community partner (and others) providing Housing Case Management suffered from large amounts of case manager turnover and had a difficult time attracting and retaining qualified replacement staff. While we were still able to get people housed, every unfilled position put more pressure on the remaining staff making it more likely they will also leave. We learned that this work is really hard, staff pay is low compared to cost of living in the area, many face long commutes. It is possible that secondary trauma may also play a role.

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

1. Homeless outreach coordination: Previously a number of different organizations were conducting outreach to people experiencing homelessness, in order to build rapport, identify needs, and connect them to assessments related to housing, mental health care, etc. In 2019 we contracted a position to coordinate all the different outreach teams and work. This team meets weekly, uses a shared list of clients, and coordinates directly to reduce duplication and reach unreached populations.
2. Executing a Data Sharing Agreement with MarinHealth (formerly Marin General Hospital) was much harder than anticipated. When we finally achieved this success, it enabled data sharing for the integration of Admission and Discharge alerts and gave a formal foundation for the person by person care coordination we had already been doing with hospital staff.

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

1. The Social Services Public Benefits department within our organization employs staff who are trained with different professional ethics and procedures around sharing client data than we use in Whole Person Care. Having the client's release of information honored when our Jail Re-entry Social Worker needs to confirm Medi-Cal or other benefits information prior to release continues to be a challenge.
2. We rely on Partnership Health Plan to provide utilization data for our Whole Person Care reporting. While there has been some improvement in their willingness to do so, they continue to deny us data for people who have a signed release in a number of circumstances (for instance, they were enrolled with Partnership and we have a signed release for the period of time whose data we are requesting, yet the client subsequently was disenrolled from Partnership Health Plan – in this case they won't give us their data). There are other examples as well. All their restrictions end up reducing our denominator and making it difficult to draw meaningful information from our metrics and other data.

Briefly describe 1-2 successes you have had with data collection and/or reporting.
Our enrollment and utilization reporting process has greatly improved. We have standardized our monthly billing process with our partners through the creation of a billing policy, streamlined collecting data from our care coordination platform, and implemented quality assurance measures. Universal and Variant Metric data collection has improved through clear and timely communication with staff from each of our data sources.

Briefly describe 1-2 challenges you have faced with data collection and/or reporting.
While collecting data from our care coordination platform has improved, we have continued challenges with the limited type and quality of data we have access to. Additionally, collecting data on depression remission and suicide risk assessment burdens our FQHC partners. Due to the clinical nature of the specification, we do not have access to the data in our care coordination platform.

Looking ahead, what do you foresee as the biggest barriers to success for the WPC Program overall?
The pilot has established new care coordination norms relationships built on trust, data sharing agreements, our release of information, and our care coordination platform, WIZARD. We are concerned that CalAIM may not retain these foundational elements of our program, resulting in the gradual drift back to status quo of silos and vulnerable clients being left to try to coordinate their own care. In addition, the COVID-19 pandemic has pulled virtually our entire staff away from Whole Person Care into the Emergency Operations Center. It has seriously hampered the ability of our community-based partners (the engine of our program) to do their vital face to face work with clients. Without us to run the contracts and keep data sharing and coordination going and without partners to do the work, we are concerned that our valuable progress may be in jeopardy.

IX. 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.

PDSAs attached.