State of California - Health and Human Services Agency
Department of Health Care Services
Whole Person Care
Lead Entity Narrative Report

Marin County Health and Human Services
Annual Narrative Report, Program Year 5
April 1, 2021

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.

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:
Success:

- Project Homekey was a unique opportunity to acquire Permanent Supportive Housing. WPC, Community Development Agency, and Emergency Operations Center worked with stakeholders to apply for three properties, two of which were purchased.

Lesson learned:

- The state's process was not reflective of county government process and timelines. Community engagement needs to start early for projects to be successful.

Increasing coordination and appropriate access to care:
Success:

- Our COVID response was catapulted by WPC trust and data sharing. See how we identified people for Project Roomkey, described in our Q3 triage PDSA

Lesson learned:

- "Infrastructure" investments in data sharing and trust pay off in unexpected ways and are important even when the immediate financial return isn't obvious.

Reducing inappropriate emergency and inpatient utilization:
Success:

- A pilot on EMS transports for high users was successful at reducing utilization and increasing care coordination. See Ambulatory PDSA Q1-3 EMS high users.

Lesson learned:

- While there was community support for continuing the pilot, it was not strong enough to contribute funding. In addition. EMS call volume decreased during COVID so high users were less of a pain point.

Improving data collecting and sharing:

Success:

- WPC joined an Equity Action Team working on data sharing and care coordination with privacy/compliance, IT, Social Services, Behavioral Health. Goal: increase staff knowledge so as to increase staff comfort and coordination. We created an inventory/catalog of HHS data systems and are evaluating client overlap across different programs.

Lesson learned:

- Data sharing culture is still a challenge.
- There is an enthusiasm for this work among managers and directors
- Having Social Service data sharing incorporated into the SHIG will be helpful. https://www.chhs.ca.gov/ohii/shig/

Achieving quality and administrative improvement benchmarks:

Success:

- A number of WPC contracts with our community-based partners who provide services needed to be modified or extended for WPC extension into 2021. This was accomplished without service interruption.

Challenge:

- Pressure on the WPC business unit skyrocketed as many were pulled away to the COVID response even while there was increased workload due to new funding opportunities and increased concern about visible homelessness by the public and elected officials.

Increasing access to housing and supportive services:

Success:

- Expected end of WPC funding led to successful grant applications for additional funding to continue the existing level of housing case management needed to create Permanent Supportive Housing out of housing vouchers in apartments. Examples: CMSP LICN grant and HHAP.

Lesson learned:

- Funding for supportive services is necessary to use vouchers to end homelessness.

Improving health outcomes for the WPC population:

Challenge:

- Shocking and tragic level of deaths due to alcohol and other substance use and some related to mental illness. These lives are part of the indirect COVID death toll, as lack of opportunities for community connection, lack of adequate access to dry places with power and WIFI, and reduced level of in person interaction with care givers took their toll.

Lesson learned:

- Coroner data may not accurately reflect someone's membership in the community of those experiencing homelessness or recently housed. This makes it difficult to quantify change in death rate or specifically increase in overdose death rate. We hope to analyze the various data sources so that we can start collecting this data in the future.

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	74	43	59	*	*	24	215

Item	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12	Annual Unduplicated Total
Unduplicated Enrollees	23	*	11	*	11	*	277

*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	$5,203.78	$7,903.85	$540.01	$3,043.72	$981.84	$6,332.90	$24,006.10
Utilization 1	106	161	11	62	20	129	489
Service 2 Screening Assessment & Referral	*	*	$2,889.96	*	*	$2,201.87	$6,468.00
Utilization 2	*	*	21	*	*	16	47
Service 3 Person-Centered Care Plan	*	*	*	*	*	*	$9,190.37
Utilization 3	*	*	*	*	*	*	43
Service 4 Client Move-In Fee	*	*	*	*	*	*	$23,472.10
Utilization 4	*	*	*	*	*	*	13
Service 5	*	*	*	$7,678.66	$1,706.37	$1,706.37	$12,919.65

Costs and Aggregate Utilization for Quarters 1 and 2

FFS	Month 1	Month 2	Month 3	Month 4	Month 5	Month 6	Total
Field-Based Engagement of Homeless Individuals							
Utilization 5	*	*	*	63	14	14	106
Service 6 VI-SPDAT Assessment	$0	$0	$0	$0	$0	$0	$0
Utilization 6	*	13	*	*	*	*	23
Service 7 90+ Day Residential SUD & 3rd Episode Treatment	*	$0.00	*	$0.00	$0.00	$0.00	$3,901.50
Utilization 7	*	0	*	0	0	0	27

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	$5,934.55	$11,297.63	$9,495.28	$11,825.14	$11,121.79	$20,968.75	$29,940.65
Utilization 1	135	257	216	269	253	477	2096
Service 2 Screening Assessment & Referral	*	$1,964.08	*	*	*	*	$13,899.67
Utilization 2	*	13	*	*	*	*	92
Service 3 Person-Centered Care Plan	*	*	*	*	*	*	$12,150.00
Utilization 3	*	*	*	*	*	*	54
Service 4 Client Move-In Fee	*	*	*	*	*	*	$47,173.00
Utilization 4	*	*	*	*	*	*	46
Service 5 Field-Based Engagement	*	*	*	*	*	*	$23,871.16

Costs and Aggregate Utilization for Quarters 3 and 4

FFS	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12	Annual Total
of Homeless Individuals							
Utilization 5	*	*	*	*	*	*	145
Service 6 VI-SPDAT Assessment	*	*	*	*	*	*	$2,640.00
Utilization 6	*	*	*	*	*	*	44
Service 7 90+ Day Residential SUD & 3rd Episode Treatment	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$3,901.50
Utilization 7	0	0	0	0	0	0	27

*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 for Quarters 1 and 2

PMPM	Rate	Month 1	Month 2	Month 3	Month 4	Month 5	Month 6	Total
Bundle #1 Comprehensive Case Management	$270	$13,230	$12,150	$15,120	$13,230	$12,420	$16,470	$86,620
MM Counts 1		49	45	56	49	46	61	306
Bundle #2 Housing-based Case Management	$540	$100,980	$103,680	$98,820	$102,600	$98,280	$93,960	$598,320
MM Counts 2		187	192	183	190	182	174	1108
Bundle #3 Case Management for Individuals with Mental Health Conditions	$462.33	$22,191.84	$23,578.83	$22,654.17	$23,578.83	$24,503.49	$24,503.49	$141,010.65
MM Counts 3		48	51	49	51	53	53	305

Amount Claimed for Quarters 1 and 2

PMPM	Rate	Month 1	Month 2	Month 3	Month 4	Month 5	Month 6	Total
Bundle #4 Housing Locator	$700	*	$9,100	*	*	$0	$0	$21,000
MM Counts 4		*	13	*	*	0	0	30

Amount Claimed for Quarters 3 and 4

PMPM	Rate	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12	Annual Total
Bundle #1 Comprehensive Case Management	$270	$16,200	$15,660	$13,500	$11,880	$12,960	$9,450	$162,270
MM Counts 1		60	58	50	44	48	35	601
Bundle #2 Housing-based Case Management	$540	$105,300	$96,660	$104,760	$38,880	$44,820	$49,140	$1,037,880
MM Counts 2		195	179	194	72	83	91	1922
Bundle #3 Case Management for Individuals with	$462.33	25,428.15	$24,503.49	$25,428.15	$23,578.83	$24,965.82	$25,428.15	$290,343.24

Amount Claimed for Quarters 3 and 4

PMPM	Rate	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12	Annual Total
Mental Health Conditions								
MM Counts 3		55	53	55	51	54	55	628
Bundle #4 Housing Locator	$700	$17,500	*	$13,300	$16,800	$12,600	*	$95,200
MM Counts 4		25	*	19	24	18	*	136

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

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.

Much of the administrative infrastructure work in Program Year 5 centered on moving the Whole Person Care engine from being a pilot to an ongoing program.

The team worked on allocating funding sources through State and Local grants to secure sustainable housing-based case management funding after Whole Person Care funding ends, in part because CalAIM may not prove an effective off-ramp for our most critical services.

We made important progress in stable and appropriate staffing for our work. This includes:

- Reclassification of our Accountant II into a Dept Analyst II and converting that position from ending 12/31/20 to being a permanent position
- Converting our existing Dept Analyst II (data analyst) position from ending 12/31/20 to being a permanent position

We began a request for proposal contract process to select a new (or continue with our current) vendor for WIZARD, our care coordination and data sharing platform. We extended our contract with our current vendor, which was set to end 12/31/20, to end in Q3 2021 to allow time for contracting and potentially system migration and training.

All of this work happened in a year when a large majority of our team was deployed to COVID emergency work for a significant percent of our time.

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.

COVID's impact on WPC delivery infrastructure:

- Business Unit Staffing:
    - Our unit was activated as Emergency Operations Center (EOC) Care and Shelter section members or Disaster Service Workers early in the pandemic. This left little time to keep the WPC afloat.
    - Unit staff were impacted by personally contracting COVID and by stress and burnout from the greatly increased volume, urgency, and impact of work.
- Shelter changes:
    - Marin's shelters reduced capacity and stopped new admissions for much of the spring. Fall saw admissions restart on a reduced basis with COVID testing at intake
    - Non-congregate shelter (Project Roomkey): We ran a motel for families and two motels for adults in the spring and summer. This was a rare occurrence of county staff providing direct shelter management and case management services. These were transferred to contracts with homeless service providers in the summer, but we remain involved.
    - Our rate of housing people increased during the pandemic, in part because it was easier to find people.
- Housing changes:
    - New Permanent Supportive Housing (Project Homekey): Although supplemented through a different federal program, Marin submitted applications for three properties in Homekey Round 1 and purchased two of them. They are being used as non-congregate shelter until they are converted to Permanent Supportive Housing later in 2021.
- Encampments:
    - Encampments became more visible and more of a public concern, though most people in encampments have been homeless in Marin for many years.
    - This visibility has increased citizen and elected officials' concerns, which increases communication needs.

WPC program sustainability:

In January 2020 we were in full planning mode for a half-day "Partner day of learning" conference on WPC program sustainability that would occur in April. The plan was to invite our contracted providers plus broader care community and feature:

- Results of the qualitative evaluation we had commissioned
- Update on WPC waiver and CalAIM
- Other funding goals for sustainability of housing case management
- Presentations by each contracted partner to show each other something new they tried as a result of WPC and what the results were, with the goal of accelerating spread and preservation of successful changes
- Small group activities for reinforcing community building
- Question and answer

Then COVID hit. Our day of learning was pushed back and transformed into two popular 2.5-hour online sessions, which took place in August and September. Over 100 partners were invited to participate, and the sessions were recorded for those who couldn't attend.

Subsequently, we met with each contracted partner one by one. At these meetings we went over their current contract, funding plans for 2021 on, contract performance, and the result of a self-assessment we sent them ahead of time asking about how well they felt they do in specific areas and what else they need from us to succeed. We are using the results of these conversations to plan learning opportunities for 2021.

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 PY5 Achieved: 20 clients at $5,000/client; Marin County's Behavioral Health System earned a total of $100,000. 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: PY5 amount earned - $5,000

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

Housing Service Providers: $5,000

- Marin Housing Authority- Attendance at 91%, payment at $2,500
- St. Vincent de Paul Society -Attendance at 100%, payment at $2,500

County Divisions: $2,500

- Behavioral Health – Attendance at 93%, payment at $2,500

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 85% of the outreach coordination meetings in 2020.

County Partners: $15,000

- St. Vincent de Paul Society -Attendance at 100%, payment at $5,000

- Community Action Marin – Attendance at 91%, payment at $5,000
- Buckelew – Attendance at 91%, payment at $5,000

Incentive: Sustainability Plan with Partners

- With the anticipated sunset of Whole Person Care in December 2020, Marin County is committed to sustaining relationships and services created under the 1115 waiver. With DHCS approval, Marin County is anticipating bringing partners to the table to create an effective dialogue and plan to sustain the vision Whole Person Care created. A total of $100,000 were earned.

Community partners: $50,000

- Ritter Center, payment at $6,250
- Homeward Bound of Marin, payment at $6,250
- Downtown Streets Team, payment at $6,250
- Marin City Health and Wellness, payment at $6,250
- Marin Housing Authority, payment at $6,250
- San Rafael Police Dept, payment at $6,250
- Marin Community Clinics, payment at $6,250
- St. Vincent de Paul Society, payment at $6,250

County Partner $50,000

- Whole Person Care, payment at $50,000

Incentive: Engagement with Partnership HealthPlan on WPC Transition Plan - County Partners

In August and September the Whole Person Care business unit team hosted two interactive sustainability sessions with a wide range of partners attending. Partnership Health Plan was an engaged partner at these meetings and subsequently we had two meetings just with Partnership Health Plan: one about Whole Person Care data sharing and the WIZARD platform and the other about Whole Person Care sustainability, including ECM and ILOS under CalAIM.

Total Earned: $24,000

- Partnership Health Plan $12,000
- County Whole Person Care $12,000

COVID incentives:

Incentive: Shower and Charing Station Outreach including Boat Dwellers

- Marin County proposed an incentive to build trust and begin outreach by having a community partner already experienced in providing shower services expand their number of service locations (including at the marina used by boat dwellers), their times of day/week services are available, and add charging capacity for those who do not have a shower appointment. The incentive is to encourage the partner to find ways to expand, not to pay for these services. These interactions with caring humans will support the wellbeing of people experiencing homelessness and will be an opportunity for outreach and engagement into housing, medical, behavioral health, and other services by building trust.
  Our partners earned a total of $80,000 by adding at least two new times/locations aligned with other resource pop-up offerings weekly for at least three months for target population use during COVID-19 pandemic.

Community Partners: $40,000

- Downtown Streets Team, payment at $20,000
- SF Marin Food Bank, payment at $20,000

County Partners: $40,000

- Whole Person Care, payment at $40,000

Incentive: COVID Info and Resource Sharing Events

Marin County proposes an incentive to have a safe and socially distanced COVID information, screening and testing program. The incentive is to spur the partners to set up outdoor handwashing, plan for a line monitored by warm and caring staff (in PPE) who shared information about resources and COVID, and periodic on site COVID screening and testing by health care professionals in order to monitor for COVID spread among the community experiencing homelessness in Marin. Our partners earned a total of $40,000 by providing at least one COVID information with occasional COVID screening and testing over at least three months.

- St Vincent De Paul, payment at $20,000
- Whole Person Care, payment at $20,000

Incentive: Outreach services to homeless encampments – COVID-19

- Marin proposed an incentive to encourage providers to visit the encampments weekly, provide information about resources, build trust, conduct verbal COVID screening, and provide essential social connection. We are aware of 19

encampments with approximately 120 people living in them across multiple municipalities in Marin. Our partners earned a total of $70,000 by going three times a week to at least two homeless encampments ranging in size from 15-35 individuals, to bring information and outreach services for at least two months.

County Partners: $35,000

- BHRS – $8,750
- CAO - $8,750
- Sheriff's Office - $8,750
- Whole Person Care Unit - $8,750

Community Partners: $35,000

- Community Action Marin - $7,000
- City of Novato - $7,000
- City of San Rafael – $7,000
- Street Chaplaincy - $7,000
- Downtown Streets Team - $7,000

Incentive: On Site medical Support for Individuals at Roomkey Motels

- Marin proposed an incentive for an RN to provide COVID-19 screening, train county workers in conducting COVID-19 screening, and triage emergent medical issues as they arise. Given the lack of person to person interaction and given the strict rules for staying in the room 22 hours a day, these in person interactions are critical for client's emotional and mental well-being, in addition to supporting their physical health. Our community earned a total of $20,000 for assessing at least 25% of motel clients for at least three months at no fewer than two Project Roomkey motel sites.

Community Partners $10,000

- Ritter Center, payment at $10,000

County Partners $10,000

- Whole Person Care

Incentive: COVID-19 Staff Collaboration Meetings

Marin implemented a regular huddle of providers involved in this shelter expansion to discuss individual clients, systems problems, and collaborate around support needed. This payment has been earned by team engagement with our partners during daily collaboration meetings for at least two months.

County Partners: $20,000

- Whole Person Care Unit - $10,000

- Behavioral Health - $10,000

Community Partners: $50,000

- Ritter - $10,000
- Homeward Bound- $10,000
- St Vincent de Paul Society- $10,000
- San Rafael Police Department- $10,000
- Marin Community Clinics- $10,000

Incentive: Capacity Building with Local Health Department in Latinx neighborhoods with high positivity rates – COVID-19

Marin proposed an incentive to partner with trusted Community Based Organizations already working with the Latinx community to provide testing on site, resource referrals, and collaborate on public information campaigns and on assessing community needs. Partnering will include sharing a social worker from the advocacy organizations between Marin County's emergency response teams and the home organizations in order to leverage the expertise of the organizations on a program designed to give aid to a population they know well and to direct county resources to most effectively address unmet needs in this Medi-Cal eligible COVID-19 WPC population to be tested and safely isolate and quarantine. Our partner has earned a total of $60,000 by conducting testing on site weekly for at least two months at a minimum of one conveniently located site and providing resources to at least 150 individuals to safely isolate/quarantine per month for at least 2 months.

County Partners: $30,000

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

Community Partners: $30,000

- Canal Alliance - $15,000
- North Marin Community Services - $15,000

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 our baseline of 41 percent in the first half of 2019 to at least 50 percent. In the second half of 2020, we met this goal for the first time. Marin County WPC achieved a rate of 61 percent. The major change that occurred in this time period was a change in the admissions criteria of our shelter due to COVID. For the entire period, with the exception of people exiting Project Roomkey, admissions to the shelter were limited to people with case management. There are two ways this could have affected exits: one, by having a higher level of housing-based case management than was previously available to people, people were better able to complete their housing plans and exit to permanent housing, and two, people with housing-based case management were more likely to have a pathway to a housing voucher which allowed them to be permanently housed.

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.

Please see attached list of meetings.

VIII. PROGRAM ACTIVITIES

Care Coordination

A. Briefly describe 1-2 successes you have had with care coordination.
    1. Keeping clients on public benefits – in late summer a new Eligibility Worker II joined our team part time to help case managers. We're getting positive feedback from case managers on how this helps keep churn low.
    2. We increased the rate of housing placements by 46% during the pandemic.
B. Briefly describe 1-2 challenges you have faced with care coordination, and lessons learned from those challenges.
    1. Reduction of in-person outreach due to pandemic concerns among staff/service provider organizations, causing people to be more disconnected from the system of care.
    2. Lesson learned: In person services are a critical and foundational component of our homelessness service programs. People experiencing homelessness face many challenges receiving services through technology, and outreach is nearly impossible without face to face interaction.

Data Sharing

A. Briefly describe 1-2 successes you have had with data and information sharing.
    1. We added a new service provider, Catholic Charities, to WIZARD, to our participating entities covered by our universal Release of Information and to our service provider network.
    2. Coordination of care for inmates leaving custody is impossible without the ability to data share. Clinic partners work directly with our re-entry social worker to schedule medication pick up and appointment upon release so that services are not interrupted. Weekly Medi-Cal intakes are coordinated for inmates leaving custody, so their Medical benefits are not interrupted and are active upon release.
B. Briefly describe 1-2 challenges you have faced with data sharing, and lessons learned from those challenges.
    1. Because in person services are reduced, we have had fewer opportunities to offer our Release of Information to clients therefore the rate of new releases signed is low.
    2. Integration of hospital alerts into WIZARD is not working perfectly, but are important to case managers.
    3. Staff turnover processes are not communicated to new staff filling the role – for example, our process for Medi-Cal enrollments for new staff. We were able to plug new staff into roles so that responsibilities are clear.

4. Lessons learned: We plan to have the outcome of our care coordination RFP result in an improved care coordination technology implementation to improve the hospital alerts and simplify workflow to make training new staff easier.

Data Collection

A. Briefly describe 1-2 successes you have had with data collection and/or reporting.
    1. Changed coordinated entry rules to allow VISPDAT assessment by phone. This is important because being assessed with the VISPDAT is how people experiencing homelessness enter the Coordinated Entry system to access both housing vouchers and the Housing Case Management provided by Whole Person Care. Since fewer partners were conducting the VISDPAT in person, it was very important to offer this by phone.
    2. WPC universal ROI allowed to be conducted over the phone during COVID emergency.
B. Briefly describe 1-2 challenges you have faced with data collection and/or reporting.
    1. Difficulty serving clients face to face due to pandemic means challenge in gathering information from them (assessments, etc.).
        i. Lesson learned: For people experiencing homelessness it's important to offer choices in service modality – often people have phone service or WIFI/charging access periodically but not consistently so technology can be a barrier, but transportation can also be a barrier to in person services.

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

- CalAIM may not be a very complete replacement for the work done in Marin.
- Lack of available housing opportunities both now and in the future
- Welfare and Institution Code provision for WPC data sharing set to expire 12/31/21
- Services still limited due to pandemic impacts, pilot projects we had planned have been postponed. Outreach is limited still. The way we deliver services has changed in ways that may not client centered.
- Contractor oversight is not our strong point.

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.

PDSA Attachments: (see attached)

- Marin PDSA Summary 2020 Q3 Q4.xlsx
- PDSA 1 Ambulatory - 2020 Q3 EMS High Users.doc
- PDSA 1 Ambulatory - 2020 Q4 Overdoses in WIZARD.doc
- PDSA 2 Inpatient - 2020 Q3-4 - Hospital alerts into WIZARD.doc
- PDSA 3 Care Plan - 2020 Q3-4 Roomkey Care Plan.doc
- PDSA 4 Care Coordination - 2020 Q3-Q4 Housing-Focused Shelter.doc
- PDSA 5 Data - 2020 Q3-4 - ROI Simplification.doc
- PDSA 6 Other - 2020 Q3 Triage for Roomkey.doc