State of California - Health and Human Services Agency

Department of Health Care Services

Whole Person Care

Lead Entity Narrative Report

Monterey County
Year-End PY4
Revised June 24, 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.

1. Increasing integration among county agencies, health plans, providers, and other entities – Social and Clinical collaborations

Challenges: Our funded and non-funded community partners are fully engaged and coordinating well.

Successes: Our network of partners now consists of 71 individuals who are invited to meet monthly to discuss coordination, emerging challenges, and sustainability. Members represent public health, behavioral health, clinic services, hospital discharge planners, hospital emergency department discharge planners, transitional and supportive care housing operators, our Medi-Cal provider, housing placement partner, Community Foundation, Social Services, our Continuum of Care, shelter & day service operator, sobering center operator, CSU Monterey Bay, county probation and city police departments, a variety of specialized homeless services providers, HIV/Hep C testing agency, nonprofit housing developers, and the Housing Authority.

Lessons Learned: Monthly coordination meetings have resulted in direct benefits for our enrollees. It is not uncommon that up to four agencies coordinate to achieve a single housing placement for one of our enrollees.

2. Increasing coordination and appropriate access to care

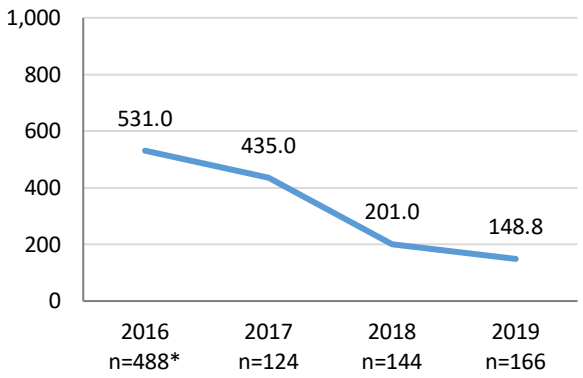
Challenges: While there is a small amount of overlap between our funded provider scopes of work, we feel there is enough variety in provider specialties for an enrollee to benefit from receiving services for more than one homeless services provider. We think multiple "open doors" serve our enrollees and potential enrollees well.

Successes: With the initiation of WPC, Monterey County began assembling a network of focused medical, behavioral health, AOD treatment, social services, housing, life skills education, transportation, and legal resolution strategies to address a wide variety of homeless services.

Lessons Learned: Our Director of Nursing, WPC Supervising Public Health Nurse, and Nurse Case Managers have advocated for our enrollees by coaching our partners to focus on collaborative coordination. We stress in our monthly social-clinical meetings that our mutual client successes made possible through the strength of our cooperation.

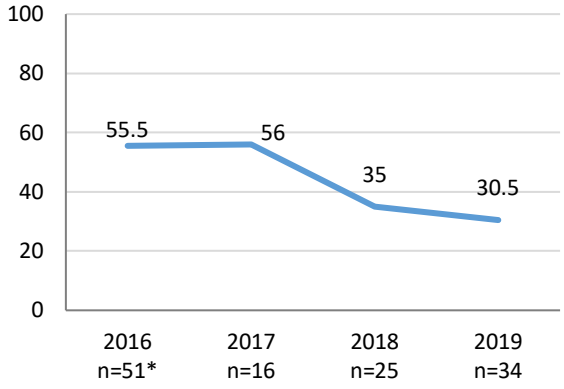
3. Reducing inappropriate emergency and inpatient utilization

WPC Enrollee ED visits Rate per 1,000 Member Months
Monterey County, 2016 to 2019



*2016 data is a baseline projection.
Source: WPC Universal Variant Reports, 2016-2019
Prepared by Monterey County Health Department, Administration Bureau, March 2020

WPC Enrollee Inpatient discharges Rate per 1,000 Member Months
Monterey County, 2016 to 2019



*2016 data is a baseline projection.
Source: WPC Universal Variant Reports, 2016-2019
Prepared by Monterey County Health Department, Administration Bureau, March 2020

4. Improving data collecting and sharing

Challenges: Monterey County does not have a case management system thus we do not have a user-friendly method for Whole Person Care data reporting. We can't import data from EPIC, AVATAR, and MEDITECH, or accept input data from our vendors. The variety of data sources and processes required for each report is therefore a difficult process to conduct.

Successes: We are also in the process of purchasing licenses for Conduent, a data sharing platform that provides a variety of visual data displays, to inform community partners, governing entities, and the public of program performance. Meanwhile, we use our WPC website to post enrollment, utilization, and health outcome data. These data are shared with WPC Social and Clinical members and the WPC Operations members at their monthly meetings.

Lessons Learned: in late 2019 we learned our method of counting enrollees was flawed. We have considered only people receiving PMPM services as enrolled, while other LEs were counting any persons receiving any type of WPC-provided services through any funded partner. In November 2019 we were asked to go back to January 2019 to recreate our enrollment. We were also instructed to obtain Medi-Cal numbers for all people being served, not only those receiving PMPM services. We created a tool for our funded partners to obtain client Medi-Cal numbers and revised our monthly enrollment data. It was not possible to collect Medi-Cal numbers on every person served in 2019, we know that the unduplicated number we present, 328, is an undercount.

Unduplicated enrollees

2017	2018	2019
12	52	328

5. Achieving quality and administrative improvement benchmarks

Challenges: Unfortunately, we use a time-consuming, tedious Excel sorting routine to drill down on enrollees with particular health conditions and cross tabulate with types of services received. Some of the spreadsheets we maintain are:

- Incoming referrals, referral sources, and enrollment determinations
- Enrollees by CIN, name, enrollment date, completed consent forms, disenrollment date and reason
- enrollment by CIN, Name, and the specific entities the enrollee has granted permission to share data
- Enrollee by agencies and organizations that the enrollee has consented for data sharing
- Case management data per case manager
- Enrollment and utilization counts based on vendor reports
- Enrollment and utilization counts based on EPIC and Avatar extracts
- Referrals of high utilizers provided by our Medi-Cal provider and safety net hospital
- Member months for reports and invoicing
- Buss pass inventory

Juggling these and more spreadsheets is a challenge. We continue trying to provide reports that are error-free, but the number of moving parts make it difficult for us to reach our goal.

6. Increasing access to housing and supportive services

Challenges: Rents in Salinas have increased by more than 50 percent in the past five years, about five times the national average. The average rent for an apartment in Salinas is $1,647, a 7% increase compared to the previous year, on top of a 3% increase the year prior. Our Housing Authority is out of vouchers, and people with vouchers have difficulty affording move-in costs. Our housing placement partner estimates that with a Housing Choice Voucher, about $4,000 is needed for application fees, first and last month's rent, security, and utility deposits, and if required, pet deposits.

Successes: We were able to house 19 enrollees in 2019 using housing choice vouchers. Our housing support services partner worked with landlords and enrollees to create these successful matches.

Lessons Learned: There is much about housing our enrollees that is outside of our control. Unfortunately, the Housing Authority of Monterey County has run out of housing vouchers, be they Housing Choice or Place-Based Vouchers. However, two place-based developments opened in December with 40 apartments set aside for WPC enrollees. Move-in will occur in January 2020. Two low/very low income housing developments are the horizon in south county and Marina, and the County submitted a $2.4 million No Place Like Home application.

7. Improving health outcomes for the WPC population

Successes: compared to 2018, improvements were seen in 2019 percentages of:

- Enrollees with BP<140/90 age 18-59
- Enrollees with BP<150/90 age 60-85
- Enrollees with depression remission at 12 months
- Enrollee All-Cause Readmissions at 30 days

Maintenance: compared to 2018, maintenance was seen in 2019 percentage of:

- Enrollees with HbA1c ≤8.0%

Challenges: compared to 2018, challenges were seen in 2019 percentages of:

- Enrollees with BP<140/90 age 60-85 with diabetes dx
- Enrollees with AOD treatment within 14 days
- Enrollees with AOD treatment within 30 days

Lessons Learned: A drop of enrollees with BP<140/90 age 60-85 with diabetes diagnosis from 75% to 25% seems to indicate a data input error, for which we will discuss with the PHNs and analysts to determine if data are being entered in and pulled from the appropriate places. Decreases were seen in the percentages of Enrollees with AOD treatment within 14 and 30 days, for which we will discuss program intake availability with our behavioral health and AOD partners.

Monterey WPC Enrollee Health Outcomes

Measure	2017	2018	2019
Enrollees with BP<140/90 age 18-59	60%	56%	61%
Enrollees with BP<140/90 age 60-85 with diabetes dx	60%	75%	25%
Enrollees with BP<150/90 age 60-85	67%	71%	72%
Enrollees with HbA1c ≤8.0%	45%	40%	40%
Enrollees with depression remission at 12 months	14%	0%	0%
Enrollee All-Cause Readmissions at 30 days	21%	22%	11%
Enrollees with AOD treatment within 14 days	37%	55%	40%
Enrollees with AOD treatment within 30 days	21%	51%	39%

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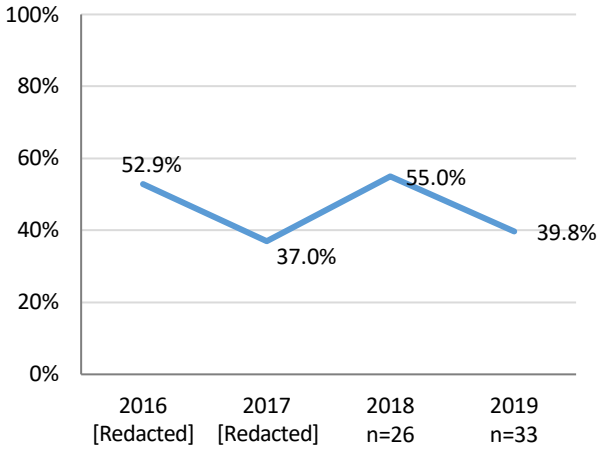
WPC Enrollee who received Initiation & Engagement of Alcohol & Other Drug Dependence Treatment within 14 Days of Diagnosis

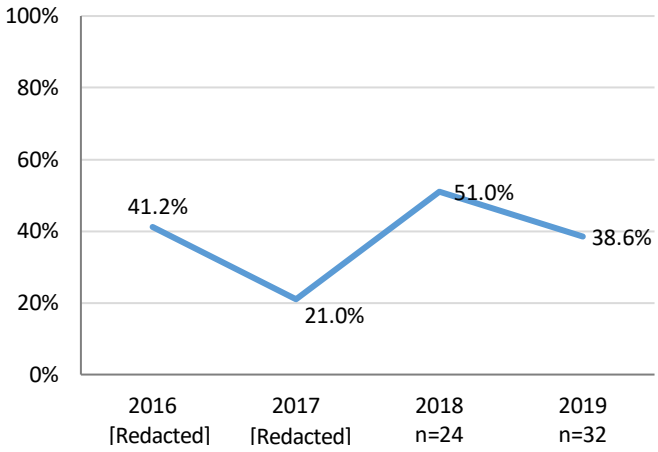
Monterey County, 2016 to 2019



2016 data is a baseline projection.
Source: WPC Universal Variant Reports, 2016-2019
Prepared by Monterey County Health Department, Administration Bureau, March 2020

WPC Enrollee who received Initiation & Engagement of Alcohol & Other Drug Dependence Treatment within 30 Days of Initiation Visit

Monterey County, 2016 to 2019



2016 data is a baseline projection.
Source: WPC Universal Variant Reports, 2016-2019
Prepared by Monterey County Health Department, Administration Bureau, March 2020

III. ENROLLMENT AND UTILIZATION DATA

Item	Month 1	Month 2	Month 3	Month 4	Month 5	Month 6	Unduplicated Total
Unduplicated Enrollees	**115**	**19**	**17**	**12**	**26**	**21**	**210**

Item	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12	Annual Unduplicated Total
Unduplicated Enrollees	**25**	**13**	**15**	**34**	**19**	**26**	**342**

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Fee for Service (FFS).

Costs and Aggregate Utilization for Quarters 1 and 2							
FFS	**Month 1**	**Month 2**	**Month 3**	**Month 4**	**Month 5**	**Month 6**	**Total**
Service 2: Respite Center (no vendor) $164.89	$0	$0	$0	$0	$0	$0	$0
Utilization 2	0	0	0	0	0	0	0
Service 3: Housing Placement & Support (Interim) $77.28	**$1,159**	**$1,159**	**$1,159**	**$1,159**	**$1,159**	**$1,159**	**$6,955**
Utilization 3	15	15	15	15	15	15	90
Service 4: Targeted Outreach (CSUMB) $288.22	**$16,429**	**$22,769**	**$16,429**	**$30,551**	**$36,316**	**$19,599**	**$142,092**
Utilization 4	58	82	53	105	127	68	493
Service 6: Sobering Center (Sun Street) $216.65	[redacted]	[redacted]	**$8,449**	**$6,716**	**$8,883**	**$7,583**	**$36,397**
Utilization 6	[redacted]	[redacted]	39	31	41	35	168

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Costs and Aggregate Utilization for Quarters 1 and 2							
FFS	**Month 1**	**Month 2**	**Month 3**	**Month 4**	**Month 5**	**Month 6**	**Total**
Service 8: Housing Navigation (CCCIL) $2,575	**$95,275**	**$87,550**	**$90,125**	**$113,300**	**$133,900**	**$141,625**	**$661,775**
Utilization 8	**37**	**34**	**35**	**44**	**52**	**54**	**256**
Service 9: Rapid Rehousing (CCCIL) $2,575	**$95,275**	[redacted]	**$90,125**	**$0**	**$0**	[redacted]	**$288,400**
Utilization 9	**37**	[redacted]	**35**	**0**	**0**	[redacted]	**112**
Service 10: Franciscan Workers Case Management (FWJS) $303.33	**$269,964**	**$235,081**	**$211,118**	**$203,231**	**$219,308**	**$40,646**	**$1,179,347**
Utilization 10	**890**	**775**	**696**	**670**	**719**	**134**	**3,884**
Service 11: Mobile Crisis Team (BH) $1550.	**$57,350**	**$44,950**	**$58,900**	**$55,800**	**$63,550**	**$80,600**	**$361,150**
Utilization 11	**0**	**0**	**0**	**0**	**0**	**0**	**0**

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Costs and Aggregate Utilization for Quarters 1 and 2							
FFS	**Month 1**	**Month 2**	**Month 3**	**Month 4**	**Month 5**	**Month 6**	**Total**
Service 12: Medical-Legal Partnership (CRLA) $139.20	**$0**	**$0**	**$0**	**$0**	**$0**	**$6,403 Flat fee. See Note Below**	**$6,403 Flat fee. See Note Below**
Utilization 12	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Service 13: Access Specialist (Sun Street) unused $40.00	$0	$0	$0	$0	$0	$0	$0
Utilization 13	**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 2: Respite Center (no vendor) $164.89	$0	$0	$0	$0	$0	$0	$0
Utilization 2	0	0	0	0	0	0	0
Service 3:	**$1,159**	**$1,159**	**$1,159**	[redacted]	[redacted]	[redacted]	**$6,955**

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Costs and Aggregate Utilization for Quarters 3 and 4							
FFS	**Month 7**	**Month 8**	**Month 9**	**Month 10**	**Month 11**	**Month 12**	**Annual Total**
Housing Placement & Support (Interim) $77.28							
Utilization 3	**15**	**14**	**14**	[redacted]	[redacted]	[redacted]	**160**
Service 4: Targeted Outreach (CSUMB) $288.22	**$16,429**	**$22,769**	**$16,429**	**$30,551**	**$36,316**	**$19,599**	**$142,092**
Utilization 4	**577**	**81**	**130**	**63**	**65**	**43**	**1,452**
Service 6: Sobering Center (Sun Street) $216.65	**$1,300**	**$3,466**	**$8,449**	**$6,716**	**$8,883**	**$7,583**	**$36,397**
Utilization 6	**33**	**40**	**49**	**43**	**31**	**28**	**392**
Service 8: Housing Navigation (CCCIL) $2,575	**$95,275**	**$87,550**	**$90,125**	**$113,300**	**$133,900**	**$141,625**	**$661,775**
Utilization 8	**61**	**62**	**63**	**64**	**61**	**77**	**644**
Service 9: Rapid Rehousing	[redacted]	[redacted]	**$90,125**	[redacted]	[redacted]	**$15,450**	**$288,400**

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Costs and Aggregate Utilization for Quarters 3 and 4							
FFS	**Month 7**	**Month 8**	**Month 9**	**Month 10**	**Month 11**	**Month 12**	**Annual Total**
(CCCIL) $2,575							
Utilization 9	[redacted]	[redacted]	**0**	[redacted]	[redacted]	**11**	**132**
Service 10: Franciscan Workers Case Management (FWJS) $303.33	**$269,964**	**$235,081**	**$211,118**	**$203,231**	**$219,308**	**$40,646**	**$1,179,347**
Utilization 10	**1056**	**1181**	**948**	**1195**	**1125**	**896**	**10,285**
Service 11: Mobile Crisis Team (BH) $1550.	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Utilization 11	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Service 12: Medical-Legal Partnership (CRLA) $139.20	**$2,174.83**	**$6,382.33**	**$7,088.17**	**$11,424.00**	**$11,424.00**	**$13,137.60**	**$51,266.93 Flat fee. See Note Below**
Utilization 12	**0**	**0**	**0**	**0**	**0**	**0**	**0**

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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 13: Access Specialist (Sun Street) $40.00	**$11,472.25**	**$11,472.25**	**$11,472.25**	**$11,472.25**	**$11,472.25**	**$11,472.25**	**$68,833.50 Flat fee. See Note Below**
Utilization 13	**0**	**0**	**0**	**0**	**0**	**0**	**0**

NOTE: FFS activities 12 and 13 are subcontracts with community partners that are based on flat monthly fees. Service 12 is attorney reimbursement at an hourly rate, and Service 13 is an annual contract for a flat monthly rate.

*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	**$706.25**	**$51,556**	**$52,969**	**$59,325**	**$69,919**	**$73,450**	**$84,750**	**$391,969**
Bundle #1 MM Counts		**58**	**60**	**69**	**77**	**88**	**105**	**457**

Amount Claimed								
PMPM	**Rate**	**Month 7**	**Month 8**	**Month 9**	**Month 10**	**Month 11**	**Month 12**	**Total**
Bundle #1	**$706.25**	**$74,156.25**	**$81,218.75**	**$83,337.50**	**$79,806.25**	**$73,450.00**	**$73,450.00**	**$465,418.75**
MM Counts 1		**105**	**115**	**118**	**113**	**104**	**104**	**1,116**

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

Corrections were made to mid-year PMPM data. The total PMPM at mid-year was 457, and not 555. This error was due to non-recorded dis-enrollments that were discovered in November 2019.

IV. NARRATIVE – Administrative Infrastructure Updates since July 1, 2019:

- Our PY4 Mid-Year Budget Adjustment proposal was approved in October 2019.
- Two WPC staff, County Housing Manager, and City of Salinas Planning Director attended the DHCS September 9-10 in-person convening in Sacramento.
- Our 1-day WPC Fall Convening of partner case managers was held on November 7. A highlight was a panel discussion held by four WPC enrollees. 161 invitations were emailed, and 70 people attended
- WPC Staff participated in all Whole Person Care Administrative conference calls

The WPC Operations Committee meets monthly to discuss the overall operations of the program. The participants include Monterey County Health Department executive leaders many of who oversee staff that are part of our WPC Social and Clinical Committee. Meetings include updates provided by DHCS, updates on the progress of committee members' action items which range from data management software tool and agreements, staffing challenges, finances, and quality improvement efforts.

Participants are:

House, Sarah, Departmental Information Systems Manager, Health IT
Kim, Nan, Clinic Services Management Analyst, Clinic Services Bureau
Lewis, Moira, Director of Nursing, Public Health Bureau
Michie, Kristy, Deputy Public Health Bureau Chief, Public Health Bureau
Miller, Amie, Behavioral Health Director, Behavioral Health Bureau
Pantoja, Elena, Whole Person Care Program Coordinator, Administration Bureau
Ripley, Joe, Finance Manager, Administration Bureau
Sumeshwar, Shibaanee, Privacy Compliance Officer, Administration Bureau
Vega, Ezequiel, Assistant Director of Health, Administration Bureau
Seepersad, Roxann, Epidemiologist, Administration Bureau
Zerounian, Patricia, Whole Person Care Program Manager, Admin Bureau

V. NARRATIVE – Delivery Infrastructure Updates since July 1, 2019:

- One of our BSN Public Health Nurses retired, and her cases were split among the remaining BSNs until another PHN could be hired.
- PHNs coordinated a massive effort to obtain Housing Authority personal and financial data for 60 enrollees to apply for very low income apartments scheduled to open December 2019. This work entailed obtaining identifications, social services benefits, and bank statements, and coordination with our housing provider and Medi-Cal plan provider. Nurses attended Housing Authority interviews with all applicants.

- The health department began exploring a data visualization solution that would display WPC and other department data.
- WPC began discussions with CSUMB to learn their interest in launching a CHW program.

VI. NARRATIVE – Incentive Payments for all of PY4

Incentive	Payment Trigger	Annual Budgeted Units	Achievement	Total $	Entity Paid
Primary Care Clinics	Clinics will receive $20,000 per WPC enrollee scheduled for and successful participation in follow-up appointment within 30 days post discharge or release.	20	100%	We exceeded the budgeted units, so we earned the max for this item $400,000	Monterey County Health Department Clinic Services Bureau
Comment: [redacted] hospitalzed WPC enrollees had primary care clinic appointments within 30 days of their hospital discharge. Our budget only allotted payment for up to 20 enrollees.					
Hospital Incentive	Natividad Medical Center (NMC) will be eligible for $20,000 per WPC enrollee successfully linked to care coordination without a readmission within 30 days. Biannual	20	100%	We exceeded the budgeted units, so we earned the max for this item $400,000	Monterey County Health Department Public Health Bureau (as reassigned by NMC)

Incentive	Payment Trigger	Annual Budgeted Units	Achievement	Total $	Entity Paid
	payments will be made.				
Comment: [redacted] hospitalzed WPC enrollees were not readmitted to NMC within 30 days of their hospital scharge. Our budget only alotted payment for up to 20 enrollees.					
Incentive	**Payment Trigger**	**Budgeted Units**	**Achievement**	**Total $**	**Entity Paid**
Enrollment/re-enrollment of individuals transitioning from Jail (Round 2)	Behavioral Health Clinics will receive $2,000 per enrollment/re-enrollment upon completion of an initial assessment. Limited to one payment per enrollee every 12 months.	112	0 WPC enrollees were discharged from jail in PY4.	$0	Monterey County Health Department Behavioral Health Bureau
Comment: Our attempts to coordinate and exchange data with the jail have been unsuccessful.					
Population Health IT System Business User Plan Completed	We will develop the business user plans once our vendor negotiations are complete.	None	0%	$0	Monterey County Health Department
Comment: We decided not to pursue the purchase of a Population Health system.					
Population Health IT System Vendor Selection & Negotiation	We are currently in the process of identifying a vendor for the population health / case	None	0%	$0	Monterey County Health Department

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Incentive	Payment Trigger	Annual Budgeted Units	Achievement	Total $	Entity Paid
	management system.				
Comment: We decided not to pursue the purchase of a Population Health system.					
Sustainability Planning Sessions	MCHD will receive $10,000 for every month in which substantive sustainability planning occurs	12 months	100%	$120,000	Monterey County Health Department
Comment: We have made great progress on plans to sustain WPC beyond 2020. Key to our plan is the establishment of a Wellness Center that will provide health assessments, treatment, links to social services, education programs, and housing coordination. Three of our valued community partners are participants in this plan. We have also matched City of Salinas CESH funds administered by our COC to launch this plan.					
Permanent Housing Placement	MCHD will receive $[redacted] per enrollee for up to 70 enrollees who are helped into permanent housing	70	[redacted] WPC enrollees were helped into housing	$280,000	Monterey County Health Department
Comment: Through the work of our PHN case management teams and community partners, [redacted] enrollees at mid-year and [redacted] at annual were helped into permanent housing, for a total of 28 in PY4.					
Telehealth Kiosk	MCHD will receive $80,000 each for new telehealth kiosk installation.	3	0	$0	Monterey County Health Department

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Incentive	Payment Trigger	Annual Budgeted Units	Achievement	Total $	Entity Paid
Comment: Our PY4 Mid-Yearudget Reallocation Request will move these budgeted funds into the Permanent Housing Placement incentive.					

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NARRATIVE – Pay for Outcomes

Achievements beyond our goals: In PY4 we achieved all five of our health outcomes, which include:

- **Tobacco assessment and counseling for those enrolled**. Target: 90%. Achievement: 100.00%.
- **Total earned:** $75,000
  - **Achieved:** Of the [redacted] enrollees who received an assessment from public health nurse case managers for tobacco use and counseling, 100 % received counseling for tobacco cessation.
  - **Challenges:** Tobacco assessment is part of our enrollee intake protocol, although charting can lag and sometimes is unrecorded until the error is discovered.

- **Coordinated Case Management** of those enrolled for 12 months. Target 25%. Achievement: [Redacted] Achieved
- **Total earned:** $75.000
  - **Achieved:** [redacted] enrollees were enrolled in 12 months of coordinated case management headed by public health nurse case managers with connections to behavioral health, social services, and housing case managers.
  - **Challenges:** Of the [redacted] individuals who were enrolled in July-December 2018, [redacted] of were still receiving WPC services at the end of 2019. Reasons for ceasing enrollment have been death, moving out of the area, enrollee feeling no need to continue, and being dismissed from the program due to non-compliance or aggressive behaviors.

- **Comprehensive Care Plan for Enrollees** –within 30 days of enrollment Target: 50%. Achievement: [Redacted] Achieved
- **Total earned: $100,000**
  - Achieved in 2019: [redacted] enrollees were recipients of a comprehensive care plan within 30 days of enrollment that was coordinated by public health nurse case managers with connections to behavioral health, social services, and housing case managers.
  - **Challenges:** Our intake process includes conducting a comprehensive health, mental health, socio-economic, and needs assessment which is the basis of the care plan. The process sometimes requires two to three sessions with the enrollee which can impact our ability to get the care plan done within 30 days of initial contact.
  - **Lessons Learned:** Whenever possible, we attempt to have a plan of care outlined by the second session with our new enrollee.

- **Suicide Risk Assessment** for WPC enrollees. Target: 60%. Achievement: 100%
  - **Achieved:** All [redacted] of our enrollees who had been diagnosed with major depression were assessed by a behavioral health clinician for suicide risk to identify appropriate care coordination for therapy, social supports, and other suicide preventative services.
  - **Challenges:** We previously scheduled suicide risk assessment as a follow up to an assessment of depressive disorder, which required a second appointment with our Behavioral Health clinicians.
  - **Lessons Learned:** Suicide risk assessment is now a part of a larger, comprehensive set of assessments that are conducted early in our relationships with our enrollees.

- **Mental/medical/SUD appointment.** Target: 80%. Achievement: [Redacted]
  - **Achieved:** [redacted] enrollees had a medical, mental health, or SUD appointment within 30 days of hospital discharge as coordinated by public health nurse case managers.
  - **Challenges:** Monterey County does not have an electronic master patient index that is shared by our hospitals, therefore, we many times are unaware of the hospitalization of our enrollees. One of our four hospitals, Natividad, is owned by the County, making it easier to know if our enrollees have been admitted there. We have requested but have not been able to create data sharing agreements with the other three hospitals.
  - **Lessons Learned:** Our nurse case managers frequently check in with their assigned enrollees to limit the possibilities of being unaware of enrollee hospital admittance.

VII. STAKEHOLDER ENGAGEMENT

WPC Social and Clinical Committee meets bi-weekly to discuss and determine the most efficient way to provide wrap around services for our clients. This includes establishing data sharing agreements between agencies, developing case management tools, sharing successes, and addressing barriers. Some of our successes to date include developing a referral form; referral response form; and participant consent form to facilitate enrollment. We also have been working on increasing prioritization efforts for our WPC enrolled participants by discussing the best way to identify and process clients faster. Since we don't have an established population health software platform to share information quickly and efficiently; we are meeting with agencies one on one to develop data sharing and assessment tools that can be utilized while we wait for the software to be purchased and developed. Looking forward to the end of the program year we are planning to continue working together to determine best practices and address barriers as they arise.

Our participants are:

Arana, Leticia, MCHD Public Health Bureau
Arrizon, Haydee, Central Coast Center for Independent Living
Carvey, Gabe, Salinas Police Department
Castillo, Alyssa, Salinas Valley Community Hospital
Ceralde, Marisa, Salinas Valley Community Hospital
Cohen, Dominique, MidPen Housing
Da'Silva, Charles, Monterey County Corrections
Gonzales, Roci, Central Coast Center for Independent Living
Gustus, Mary, MCHD Public Health Bureau
Friedrich, Karen, Natividad Medical Center
Hanni, Krista, MCHD Administration Bureau
Hathcock, Eddie, Sun Street Centers
Indula-Allen, Jennifer, Community Hospital of the Monterey Peninsula
Juarez, Trini, Salinas Valley Community Hospital
Kaelin, Aaron, Monterey County Probation
Katz, Phyllis, CA Rural Legal Assistance
Lewis, Moira, MCHD Public Health Bureau
Majeski, Tawyna, Monterey County Behavioral Health
Mauldin, Lindsey, MCHD Public Health Bureau
McKensie, Katrina, Coalition of Homeless Services Providers
Medearis-Peacher, Peggy, Department of Social Services
Medera, Maria, Housing Authority of Monterey County
Mendoza, Ana, MCHD Public Health Bureau
Mitchell, Barbara, Interim, Inc, housing services

Moreno, Edward, MCHD Health Officer/Director of Public Health
Morla, Tiffanie, MCHD Public Health Bureau
Muir, Thomas, Community Hospital of the Monterey Peninsula
Nahas-Wilson, Elizabeth, MidPen Housing
Padgett, Stephen, CSUMB
Pantoja, Elena, MCHD Administration Bureau
Perales, John, Veterans Resource Center
Rager, Melanie, Central Coast Alliance for Health
Rhoads, Gina, Central Coast Alliance for Health
Rogers, Infanta, Natividad Medical Center
Romero, Maria, Natividad Medical Center
Rowland, Glorietta, Monterey County Department of Social Services
Ruiz, Jorge, Central Coast Center for Independent Living
Sanchez, Patricia, MCHD Public Health
Seepersad, Roxann, MCHD Administration Bureau
Serrano, Emerita, Central Coast Center for Independent Living
Sims, William, Monterey County Probation
Smith, Jacqueline, CSUMB Chinatown Learning Center
Tomaselli, Sarafina, Monterey County Department of Social Services
Torres, Rodrigo, Community Human Services
Tuazon, Joy, MCHD Public Health Bureau
Vargas, Clara, Monterey County Department of Social Services
Wilson, Roxanne, Coalition of Homeless Services Providers
Wyatt, Anastacia, County of Monterey Economic Development
Yant, Allison, Monterey County Department of Social Services
Zerounian, Patricia, MCHD Administration Bureau

PY4 Stakeholder Meetings

Please note: Meeting agenda and notes are available for all Stakeholder Meetings listed below.

Meeting Date	# of Attendees	Primary Discussion Topics
1/14/19	18	Successes and challenges; potential for shared housing for WPC enrollees; potential for IHHS worker status of one WPC client in Shared Housing; establishing a Salinas Community Action Team; housing for legal aliens and people without birth certificates.
2/11/19	23	Successes and challenges; Monterey Community Action Team update; update on establishing a Salinas Community Action Team; increasing rental rates;

Meeting Date	# of Attendees	Primary Discussion Topics
		sustainability discussion; food and hotel vouchers for undocumented people after hospitalization
3/11/19	26	Successes and challenges; SB-1152 Presentation; Clients with dual agency applications; Discuss continuance of WPC after December 2020 - how will community partners be affected and what are possible solutions; bed availability at Hacienda and other new low income housing.
4/18/19	26	Successes and challenges; sustainability update; Medi-Cal training for partners.
5/13/19	27	Successes and challenges; WPC enrollment update; Emergency Solutions Grants Program and HDAP Updates; Housing Resource Center Updates – CalWORKs and CalFresh; Sustainability for WPC partners; committee co-chair final nominations and vote.
6/10/19	21	Successes and challenges; enrollment update; Place-based housing voucher application submittals for 40 apartments; Year-round Temporary Shelter update; Regional Emergency Shelter construction update; Sustainability through establishment of Chinatown Wellness Center; PHN Outreach to encampments.
7/8/19	0	Meeting canceled
8/9/19	29	Successes and challenges; HOT Team progress; Enrollment statistics; PHN recruitment; Update on Place-based voucher housing development; Fall case management Convening agenda and speakers.
9/19/19	29	Successes and challenges; WPC Outcomes for January-June 2019 (review of mid-year report); Fall case management Convening plans.
10/14/19	14	Successes and challenges; Update on all WPC projects; Update on Place-based voucher housing construction and applications; Sustainability (PHN recruitment, training, and new partnerships)
11/11/19	0	Meeting canceled
12/9/19	30	Successes and challenges; Safety during outreach activities; Presentation on the progress on homelessness after SB 1152; Review of PHN/partner trainings on Public Guardian, Safety in the Community, APS HITS, Narcan, Hep).

VIII. PROGRAM ACTIVITIES

Briefly describe 1-2 successes you have had with care coordination.
We have dedicated partners and close collaboration around our efforts to permanently house our enrollees. The greatest challenge has been to locate affordable housing within a very low inventory of housing under $2000 per month. Our mid-year budget adjustment gave us the opportunity to hire a property management firm that handles 500+ low income units. An agreement with the property management firm will be finalized in early 2020.

Briefly describe 1-2 challenges you have faced with care coordination, and lessons learned from those challenges.
1. We had worked with our Probation department to obtain referrals from them. However, the referrals we received were unacceptable for enrollment because of the violent histories of the referees. Our PHNs sometimes must meet with clients one-on-one, and we will not put them in danger. We spoke with Probation about referring people who are more suitable to our program, but the nature of the referrals were still unsuitable. 2. Our Continuum of Care attempted to organize a number of homeless service provider agencies and nonprofits to conduct outreach to encampments throughout the county. Our staff twice assembled at the designated time and place only to find that we were the only agency in attendance. We postponed further involvement in this particular type of outreach until the time when more agencies would participate along with us.

Briefly describe 1-2 successes you have had with data and information sharing.
1. We worked with new City of Salinas subcontractors to develop outcome measures prior to the finalization of their contracts. We believe this contributed to great acceptance of the measures and reporting formats.

Briefly describe 1-2 challenges you have faced with data sharing, and lessons learned from those challenges.
1. In compiling our enrollment and health outcome data we continually found unexplained discrepancies between our quarterly and semi-annual reports. After much investigation we realized that PHNs were going into spreadsheets from months past to update record with new information. Our solution was to set a “closed” date for PHN input on all monthly tracking sheets, protecting the

sheets, and requiring the PHNs to report any updates occurring in past months to the WPC coordinator who then coordinated those changes with our epidemiologist.

Briefly describe 1-2 successes you have had with data collection and/or reporting.
1. Monterey County does not have a case management system thus we do not have a user-friendly WPC reporting system. Our program manager therefore created partner monthly utilization reporting forms and sends a series of reminders for their timely submittals. Our epidemiologist has set up processes for data collection, merging and analysis needed to produce WPC summary data reports.

Briefly describe 1-2 challenges you have faced with data collection and/or reporting.
1. We unfortunately do not have a shared application that allows our partners to upload data and integrates with our electronic health record system. We searched but could not find an appropriate application that would interface with our hospital, clinic, and behavioral health data systems.

Looking ahead, what do you foresee as the biggest barriers to success for the WPC Program overall?
Lack of affordable, permanent housing units. We have a wide variety of coordinated housing supports but very few affordable apartments that will take Section 8 Housing Choice Vouchers.

IX. PLAN-DO-STUDY-ACT

PDSA Attachments for PY4:

PDSA Reporting Period: January 1 – July 30, 2019					
PDSA Project Name	**Target Population**	**PDSA Type**	**Implementation Date**	**Recent Revision Date**	**# Reports Submitted for this PDSA**
34. Reassess: Faster PCP intake appointments	Enrollees and potential enrollees	Ambulatory Care: relates to new enrollee PCP appointment within 30 days	10/30/2018	Resolved	2
35. Reassess: Shift housing services to partner	Enrollees and potential enrollees	Care Coordination: Efficiency	3/22/2018	Resolved	2
36. Reassess: Removing move-in barriers to housing	Enrollees and potential enrollees	Other: removing housing first barriers	10/3/2018	Resolved	2
37. Reassess: Salinas PD Homeless Outreach Team	Enrollees and potential enrollees	Care Coordination: referral infrastructure	10/17/2018	Resolved	2
38. Reassess: Need intensive nurse case manager recruitment	Enrollees and potential enrollees	Ambulatory Care: relates to accelerating WPC enrollment	12/1/2018	Resolved	2
39. Coordinate with Probation	Enrollees and potential enrollees	Care Coordination: referral infrastructure	3/13/2019	In Progress	1

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PDSA Reporting Period: January 1 – July 30, 2019					
PDSA Project Name	**Target Population**	**PDSA Type**	**Implementation Date**	**Recent Revision Date**	**# Reports Submitted for this PDSA**
40. Community Partnerships for encampment outreach	Potential WPC enrollees	Other: Outreach	6/10/2019	In Progress	1
41. Case Management Solution	Enrollees	Data and Information Sharing	1/1/2019	Resolved	1
42. Patient Education on Chronic Disease Prevention & Triggers	Enrollees	Inpatient Utilization	6/1/2019	Resolved	1
43. Avoiding hygiene related illness	Enrollees and potential enrollees	Inpatient Utilization	Spring 2019	In Progress	1
44. Administrative support for housing eligibility	Enrollees	Administrative	May 2019	Resolved	1
45. Timely updates for consents and care plans	Enrollees	Administrative	April 2019	Resolved	1

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PDSA Reporting Period: July 1 – December 31, 2019					
PDSA Project Name	**Target Population**	**PDSA Type**	**Implementation Date**	**Recent Revision Date**	**# Reports Submitted for this PDSA**
46. CHE alternate pain management	Enrollees and potential enrollees	Ambulatory Care (health outcomes)	7/3/2019	In Progress	1
47. CHE greater social worker presence	Enrollees and potential enrollees	Ambulatory Care (health outcomes)	7/1/2019	In Progress	1
48. CHE medical assessments & services	Enrollees	Inpatient Utilization (health outcomes)	fall 2019	In Progress	1
49. Revisit #43: Avoiding hygiene related illness	Enrollees and potential enrollees	Inpatient Utilization (health outcomes)	12/1/2019	In Progress	2
50. CESH CCCIL housing locator, housing navigators	Enrollees	Comprehensive Care Plan (administrative)	10/1/2019	In Progress	1
51. CESH Interim outreach at libraries and churches	Enrollees and potential enrollees	Comprehensive Care Plan (administrative)	10/1/2019	In Progress	1
52. Revisit #39: Coordinate with Probation	Enrollees and potential enrollees	Care Coordination (administrative)	3/13/2019	Resolved	2
53. Revisit #40: Community Partnerships for encampment outreach	Enrollees and potential enrollees	Care Coordination (administrative)	6/1/2019	Resolved	2

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PDSA Reporting Period: July 1 – December 31, 2019					
PDSA Project Name	**Target Population**	**PDSA Type**	**Implementation Date**	**Recent Revision Date**	**# Reports Submitted for this PDSA**
54. Outcome measures for CESH contractors	Enrollees and potential enrollees	Data (administrative)	11/1/2019	Resolved	1
55. Revised enrollment reporting method	Enrollees and potential enrollees	Data (administrative)	10/31/2019	Resolved	1