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

Monterey County
Annual Narrative Report, Program Year 5
Submitted: April 5, 2021
Revised: April 29, 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.

Whole Person Care

Monterey County
Annual Narrative Report, Program Year 5
April 29, 2021

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.

OVERALL:

Challenges: In the last half of 2020, Monterey County's WPC program remained greatly impacted by our COVID-19 response that was set into motion on March 15. Two of our PHNs were assigned to COVID tracing and investigation, and our remaining two were each limited to 2.5 days per week. This significantly decreased our ability to conduct PMPM case management and caused us to cease enrolling new clients. Our supervising PHN's dedication to WPC was also reduced from five days per week to three days per week. The WPC program manager assumed much of the social services aspects of case management. The program manager was also assigned responsibility for the coordinating medically-vulnerable referrals to our non-COVID positive Project Roomkey program. Our WPC program's Chronic Disease Prevention Specialist left the county for another employment opportunity in July, and the position remained vacant for the rest of 2020. A retired Office Assistant III was brought in for 18 hours per week to help with essential support functions.

Successes: We adjusted and innovated as best as possible to continue conducting crucial activities. Our practice of face-to-face encounters with enrollees and potential enrollees occurred via telehealth whenever possible. The community partner whose subcontract we expanded was invaluable to the delivery of our case management. We hired a formerly retired Office Assistant to provide consenting and recordkeeping supports. We continued our expanded services in geographically remote areas of the county through a new partnership that includes city management. City of Salinas CESH funding allowed our funded Chinatown Health Engagement program to hire additional CSUMB graduates to provide additional outreach and social work case management teams, and our close coordination and integration with nurse case management is successful. Our other funded community partners who provide food and housing supports, legal services, outreach, sobering center services, and transportation continue to perform their scopes of work.

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

Challenges: Our funded and non-funded community partners continue to be engaged through adaptations and continue to coordinate with us, especially around the challenges presented by COVID safety among the homeless populations.

Successes: We are working closely with the City of Salinas and partners (funded and non-funded) working in the areas of greatest homeless population densities. We have concentrated on providing handwashing stations, working with outreach teams who carry COVID-prevention messages and refer potential clients to us, and internal staff recruitment. Our network of community partners now consists of 71 individuals who 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, Department of Social Services, our Continuum of Care, shelter & day service operator, sobering center operator, CSU Monterey Bay, a variety of specialized homeless services providers, nonprofit housing developers, and the Housing Authority.

Lessons Learned: Our adaptations to the ways we formerly conducted our program are allowing us to continue serving current enrollees with essential services. Adaptations include telehealth, leaning more heavily on our community partners, and re-aligning duties among our WPC staff.

2. Increasing coordination and appropriate access to care

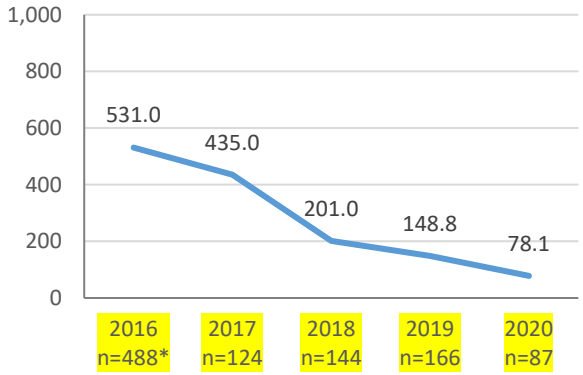
Challenges: Monterey County's Clinic Services system is relying more heavily on telehealth rather than face-to-face appointments. If warranted, in-person appointments are scheduled. Most Behavioral Health appointments are conducted via tele-health, but in-person appointments remain difficult to schedule. Our substance use treatment facilities have ceased their detox operations due to COVID-19.

Successes: For the most part, our enrollees continue to receive needed health care through our county's Clinic Services, another nonprofit Medi-Cal accepting clinic system, or Doctors on Duty. We continue to work closely with hospital discharge planners for our mutual patients, and work with Skilled Nursing Facility intake planners as needed.

Lessons Learned: Our ability to persist during these times of rapid change is due to our flexibility and thoughtful adaptations.

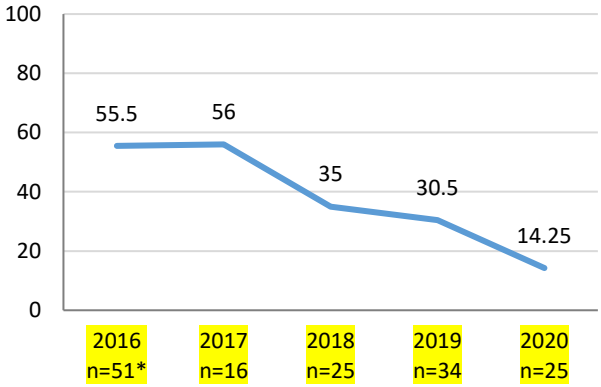
3. Reducing inappropriate PMPM enrollee emergency and inpatient utilization

PMPM Enrollee ED visits per 1,000 Member Months
Monterey County, 2016 to 2020



*2016 data is a baseline projection.
Source: WPC Universal Variant Reports, 2016-2020. Prepared by Monterey County Health Department, March 2021

PMPM Enrollee Inpatient discharges per 1,000 MM
Monterey County, 2016 to 2020



*2016 data is a baseline projection.
Source: WPC Universal Variant Reports, 2016-2020. Prepared by Monterey County Health Department, March 2021

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. We hope to have a case management system available to us with the implementation of CalAIM and have provided our Medi-Cal Care Plan with our system requirements.

Successes: We recently purchased 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. We created DataShare Monterey County http://www.datasharemontereycounty.org/ and will post the 2020 Year End outcomes to the site. We recently posted our final PY4 Year End report on our website.

Lessons Learned: Below, our 2020 Year-End unduplicated PMPM enrollee data indicate 159 individuals were served with comprehensive nurse case management. We attribute the 2020 drop-off in total people served to the reassignment of our public health nursing staff to COVID investigation activities, thereby restricting our number of new enrollees.

Unduplicated PMPM enrollees and rolling percent change, 2017-2020

PY2 2017	PY3 2018	PY4 2019	PY5 2020
44	101	342	249
% Change from Prior Year	230%	779%	567%

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 and are further hampered by being short-staffed. 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. We hope to have a case management system available to us with the implementation of CalAIM and have provided our Medi-Cal Care Plan with our system requirements.

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 Monterey County is $2,157, a 7% increase compared to the previous year, on top of a 3% increase the year prior. The average apartment size is 787 square feet. 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 month's rent, security, and utility deposits, and if required, pet deposits.

Successes: We newly placed **54** PMPM enrollees in permanent housing in 2020 using place-based housing choice vouchers and the Project HomeKey Program. Since WPC inception in January 2017, we have permanently housed **134** PMPM enrollees. All housed enrollees receive up to one year of continuing support services through Monterey County public health nurses or our nonprofit housing partners.

Lessons Learned: Two low/very low income housing developments are on the horizon in south county and the City of Marina, the County is using its $2.4 million No Place Like Home award to provide scattered housing for people who are homeless and have a mental illness diagnosis. Our Project HomeKey is a 104 room hotel that is being refurbished into very low income studio apartments.

7. Improving health outcomes for the WPC population

Monterey WPC Enrollee Health Outcomes

Measure	2017	2018	2019	2020
Enrollees with BP<140/90 age 18-59	60%	56%	61%	31%
Enrollees with BP<140/90 age 60-85 with diabetes dx	60%	75%	25%	0%
Enrollees with BP<150/90 age 60-85	67%	71%	72%	43%
Enrollees with HbA1c ≤8.0%	45%	40%	40%	57%
Enrollees with depression remission at 12 months	14%	0%	0%	8%
Enrollee All-Cause Readmissions at 30 days	21%	22%	11%	5%
Enrollees with AOD treatment within 14 days	37%	55%	40%	24%
Enrollees with AOD treatment within 30 days	21%	51%	39%	18%

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	66	52	*	*	*	13	163

Item	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12	Annual Unduplicated Total
Unduplicated Enrollees	37	13	*	18	*	*	86

Whole Person Care

Monterey County
Annual Narrative Report, Program Year 5
April 29, 2021

*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 2: Respite Center (no vendor)	$0	$0	$0	$0	$0	$0	$0
Utilization 2	0	0	0	0	0	0	0
Service 3: Housing Placement & Support (Interim) $77.28	$0	$0	$0	$0	$0	$0	$0
Utilization 3	0	0	0	0	0	0	0
Service 4: Targeted Outreach (CSUMB) $288.22	*	$18,157.86	*	$0	$0	$0	$23,345.82
Utilization 4	*	63	*	0	0	0	81
Service 5: Onsite Housing Sustainability Services (Mid-Pen) $480.00	$10,080	$10,080	$10,080	$10,080	$10,080	$10,080	$60,480
Utilization 5	21	21	21	21	21	21	126

Costs and Aggregate Utilization for Quarters 1 and 2

FFS	Month 1	Month 2	Month 3	Month 4	Month 5	Month 6	Total
Service 6: Sobering Center (Sun Street) $216.65	$5,202.38	$5,202.38	$5,202.38	$5,202.38	$5,202.38	$5,202.38	$31,414.25
Utilization 6	30	34	17	20	27	17	145
Service 8: Housing Navigation (CCCIL) $2,575	$185,400	$190,550	$195,700	$149,350	$177,675	$185,400	$1,084,075
Utilization 8	72	74	76	58	69	72	421
Service 9: Rapid Rehousing-Tenancy Support (CCCIL) $2,574.09	$33,463.17	$41,185.44	*	*	*	*	$108,111.78
Utilization 9	13	16	*	*	*	*	42
Service 10: Community Based Case Mgt (FWJS) $308.33	$106,065.52	$238,339.09	$293,530.16	$440,911.90	$384,795.84	$263,930.48	$1,727,572.99
Utilization 10	344	773	952	1,430	1,248	856	5,603
Service 12: Medical-Legal Partnership (CRLA)	$2,174.83	$6,382.33	$7,088.17	$11,424	$11,424	$13,137.6	$51,630.93

Costs and Aggregate Utilization for Quarters 1 and 2

FFS	Month 1	Month 2	Month 3	Month 4	Month 5	Month 6	Total
Utilization 12							370.91
Service 13: Access Specialist (Sun Street)	$11,472.28	$11,472.28	$11,472.28	$11,472.28	$11,472.28	$11,472.28	$68,833.50
Utilization 13							119.77

Costs and Aggregate Utilization for Quarters 3 and 4

FFS	Month 1	Month 2	Month 3	Month 4	Month 5	Month 6	Total
Service 2: Respite Center (no vendor)	$0	$0	$0	$0	$0	$0	$0
Utilization 2	0	0	0	0	0	0	0
Service 3: Housing Placement & Support (Interim) $77.28	$0	$0	$0	$0	$0	$0	$0
Utilization 3	0	0	0	0	0	0	0
Service 4: Targeted Outreach (CSUMB) $288.22	$0	$0	$0	$0	$0	$0	$0

Costs and Aggregate Utilization for Quarters 3 and 4

FFS	Month 1	Month 2	Month 3	Month 4	Month 5	Month 6	Total
Utilization 4	0	0	0	0	0	0	0
Service 5: Onsite Housing Sustainability Services (Mid-Pen) $480.00	$10,080	$10,080	$10,080	$10,080	$10,080	$10,080	$60,480
Utilization 5	21	21	21	21	21	21	126
Service 6: Sobering Center (Sun Street) $216.65	$7,799.40	$9,315.95	$6,066.20	$6,499.50	$4,116.35	$5,199.60	$38,997.00
Utilization 6	36	43	28	30	19	24	180
Service 8: Housing Navigation (CCCIL) $2,575	$157,075.00	$167,375.00	$159,650.00	$,180,250.00	$175,100.00	$167,375.00	$1,006,825.00
Utilization 8	61	65	62	70	68	65	391
Service 9: Rapid Rehousing-Tenancy Support (CCCIL) $2,574.09	*	*	*	*	*	*	*
Utilization 9	*	*	*	*	*	*	*

Costs and Aggregate Utilization for Quarters 3 and 4

FFS	Month 1	Month 2	Month 3	Month 4	Month 5	Month 6	Total
Service 10: Community Based Case Mgt (FWJS) $308.33	$456,945.06	$405,762.28	$316,346.58	$349,954.55	$458,795.04	$261,772.17	$2,249,575.68
Utilization 10	1,482	1,316	1,026	1,135	1,488	849	7,296

*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 Complex Care Management Team	$706.25	$72,037.50	$67,800.00	$65,681.25	$62,856.25	$57,912.50	$54,381.25	$308,668.75
Bundle #1 MM Counts		102	96	93	89	82	77	539

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 Complex Care Management Team	$706.25	$75,568.75	$74,156.25	$76,275.00	$80,512.50	$74,156.25	$69,918.75	$450,587.50
Bundle #1 MM Counts		107	105	108	114	105	99	638

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

Please note: FFS activities 12 and 13 are subcontracts with community partners that are based on flat monthly fees and have been moved to Delivery Infrastructure..

Please note: FFS activities 5 is subcontracted with community partners that are based on flat monthly fees, and is not client specific. The total units are based on the approved amount per unit for these items.

Infrastructure for Quarters 3 and 4.

Please note: DO NOT PAY OUT for FFS 8 and 10 in quarters 3 and 4.

TOTAL 2020 PY5 Member Months: 1,177

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.

- Our PY4 Year-End Invoice and Rollover was approved in May 2020 and the Year-End Report was approved in June 2020 and posted to our website. Our PY5 Reconciled Budget was provided to us in June 2020.
- Our Deputy Director of Health, who provided administrative oversight of WPC operations and budgeting but who was not budgeted for DHCS reimbursement, took a position in the county CAO's office in February 2020.
- WPC Staff participated in all Whole Person Care Administrative conference calls.
- A number of critical WPC positions changed in the first half of PY5:
- Our Deputy Director of Health, who provided administrative oversight of WPC operations and budgeting but who was not budgeted for DHCS reimbursement, took a position in the county CAO's office in February 2020. This position has not yet been filled.
- Our Director of Nursing who had oversight of department nursing staff, including WPC nursing staff, retired in July 2020. This position was not filled until February 2021.
- Our WPC Office Assistant III retired at the end of 2019 and her WPC tasks were assumed by a Chronic Disease Prevention Specialist, who left the department's employment in July 2020. This position has not yet been filled.
- Our four LVNs were reassigned full time to COVID tracing. This resulted in having no active Spanish-speaking WPC staff.
- We brought a retired OA III back temporarily for 18 hours per week to again support our public health nurses.
- 2 of our 4 WPC PHNs were reassigned to COVID tracing & investigation in March 2020.
- Our WPC Supervising PHN and two remaining PHNs were assigned to 20 hours per week to COVID tracing.

The WPC Operations Committee met monthly from January to March to discuss the overall operations of the program. In-person meetings have ceased due to COVID-19, but operatives communicate frequently throughout the day via telephone. Operation Committee meetings included 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:
Gustus, Mary, PHN, Supervising Public Health Nurse, Public Health Bureau
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
Seepersad, Roxann, Epidemiologist, Administration Bureau
Zerounian, Patricia, Whole Person Care Program Manager, Admin Bureau

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.

The PY 5 Mid-Year budget adjustments provided for the following activities in our 2020 delivery infrastructure:

- Additional handwashing stations with daily servicing were placed in areas where unsheltered people congregate. This activity is intended to reduce the spread of communicable disease in our target population with the goal of reducing emergency department and hospital inpatient use and was approved in the mid-year PY5 budget adjustment.
- Weekly stipends were provided to volunteer peer outreach workers. This activity is related to identifying qualified potential WPC enrollees with the goal of serving up to 500 individuals during the life of the pilot and was approved in the mid-year PY5 budget adjustment.
- Through a subcontract with a community partner, our WPC Access Specialist was assigned case management duties for select enrollees who are permanently housed but still in need of follow up services. This activity is related to providing ongoing case management to enrollees with the goal of serving up to 500 individuals during the life of the pilot and was approved in the mid-year PY5 budget adjustment.
- Our Medical Legal Partnership provider hired a legal secretary. This activity is related to providing ongoing case management to enrollees with the goal of removing barriers to medical and mental health care, housing, employment, transportation, social benefits, and other services that inhibit wellbeing and safety. This activity was approved in the mid-year PY5 budget adjustment.
- The Chinatown Health Engagement Center was provided additional funds to assist with operational costs. This activity is related to providing direct health and mental health services to enrollees with the goal of reducing emergency department and hospital inpatient use and was approved in the mid-year PY5 budget adjustment.

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	Payment Trigger	Annual Budgeted Units	Year-End Achievement	Total $	Entity Paid
Primary Care Clinics (Outcome Metric #25)	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	7	$140,000	Monterey County Health Department Clinic Services Bureau
Comment: At mid-year, [REDACTED] hospitalized WPC enrollees had primary care clinic appointments within 30 days of their hospital discharge. At year-end, [REDACTED] out of 16 hospitalized WPC enrollees had primary care clinic appointments within 30 days of their hospital discharge.					
Hospital Incentive (Outcome Metric #20)	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 payments will be made.	20	3	$60,000	Monterey County Health Department Public Health Bureau (as reassigned by NMC)
Comment: At mid-year, [REDACTED] hospitalized WPC enrollees were not readmitted to NMC within 30 days of their hospital discharge. At year-end, [REDACTED] hospitalized WPC enrollees were not readmitted to NMC within 30 days of their hospital discharge.					

Incentive	Payment Trigger	Annual Budgeted Units	Year-End Achievement	Total $	Entity Paid
Sustain-ability Planning Sessions	MCHD will receive $10,000 for every month in which substantive sustainability planning occurs	10 months	5 months	$50,000	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. The Wellness Center is currently providing services via telehealth. We have also matched City of Salinas CESH funds administered by our COC to staff a new homeless navigation center. At mid-year, 5 out of 10 approved months of planning sessions were conducted. At year-end, another 5 months were conducted, for a total of 10 out of 10 planning sessions conducted.					
Permanent Housing Placement	MCHD will receive $10,000 per enrollee for up to 30 enrollees who are helped into permanent housing	30	24 WPC enrollees were helped into housing	$240,000	Monterey County Health Department
Comment: Through the work of our PHN case management teams and community partners, 39 enrollees at mid-year were helped into permanent housing. At year-end, an additional 24 were placed, for a 2020 total of 54 permanently housed PMPM enrollees in 2020. Our cap for this reimbursement is 30 placements.					
Transitioning Planning with MCP	MCHD will receive $10,000 for every month in which substantive transition planning occurs	12 months	6 months	$60,000	Monterey County Health Department
Comment: MC WPC actively participates in monthly transition planning meetings with our MCP and two other counties – San Benito and Merced – who are served by our MCP. At mid-year, planning had occurred over 6 months, and at year-end, planning sessions had occurred over another 6 months, for a total of 12 months for all of 2020.					

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.

Monterey County elects to use the COVID-19 Alternative Payment method for Pay for Outcome payments in Program Year 5. Monterey achieved 100% of our Pay for Outcomes in Program Year 4. Monterey will receive 100% payment in Program year 5, in the total amount of $400,000.

1. **Mental/medical/SUD appointment.** Target: 80%. Achievement: 0.00%.
   - **Total earned:** $0.00
   - **Achieved:** 0.00.
   - **Challenges:** [REDACTED] enrollee(s) were admitted to the mental health unit in the last half of 2020, and the enrollee(s) did not receive a mental health follow up appointment within 30 days of discharge.
   - **Lessons Learned:** COVID-19 response has cut into our abilities to closely coordinate with our behavioral health bureau**,** which could be the reason why we did not uphold a timely follow up appointment. Alternatively, the lack of follow up could have been complicated by admitted enrollee(s) who were not patient of our behavioral health bureau and was not admitted to our public health hospital. Our county does not have an electronic medical record system shared by all hospitals and the public health department.

2. **Suicide Risk Assessment** for WPC enrollees. Target: 60%. Achievement: 100%
   - **Total earned:** $37,500.
   - **Achieved:** All 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.

3. **Tobacco assessment and counseling for those enrolled**. Target: 90%. Achievement: 100.00%.
   - **Total earned:** $37,500
   - **Achieved:** Of the 159 enrollees, 100% received a tobacco assessment and all those who used tobacco received counseling for tobacco cessation.
   - **Challenges:** Tobacco assessment is part of our enrollee intake protocol, therefore resulting in the 100% achievement for this outcome. We have not had difficulties with this strategy and recommend it to others.

4. **Coordinated Case Management** of those enrolled for 12 months. Target 25%. Achievement: 64%.
   - **Total earned:** $37,500
   - **Achieved:** Of the 32 individuals enrolled in the prior 12 months, 11 (34%) had been enrolled in month 1 and month 12.
   - **Challenges:** We surpassed our goal of keeping our enrollees under care for 12 months. We have learned that this goal will never reach 100% of all enrollees, as enrollees leave our program before the 12 month milestone due to voluntary geographic relocations, voluntarily withdraws, program disenrolled due to noncompliant or violent behaviors, and occasionally, enrollee death.

5. **Comprehensive Care Plan for Enrollees** within 30 days of enrollment. Target: 50%. Achievement: 71%.
   - **Total earned:** $76,000
   - **Achieved:** 113 out of 159 (71%) 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. In the last half of 2020, our public health nurses split their time 50/50 with COVID tracing.
   - **Lessons Learned:** Whenever possible, we attempt to have a plan of care outlined by the second session with our new enrollee.

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.

WPC Social and Clinical Committee Up through March 2020, the Social and Clinical Committee conducted monthly in-person meetings discuss and determine the most efficient ways to provide WPC enrollees with wrap around services. This included sharing successes and addressing barriers. Some of our successes to date include developing a referral form; referral response form; participant consent form to facilitate enrollment prioritizing enrollees; and discussing the best ways to identify and serve enrollees.

Our in-person meetings ceased as of April 2020 due to COVID-19. Trying to use zoom for our Social and Clinical Committee meetings proved infeasible, as meetings with 25+ people became chaotic with so many participants, many who were hampered with technical difficulties, background noises, and people speaking over each other. Instead of in-person meetings of 25 or more attendees, our public health nurse case managers, LVNs, access specialist, and program manager use Zoom or telephone conversations with key partners to determine specific solutions and address barriers as they arise.

Our community partners 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
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
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
Voit, Aaron, CA Rural Legal Assistance
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

PY5 Stakeholder Meetings

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

Meeting Date	# of Attendees	Primary Discussion Topics
1/13/20	25	Successes and challenges; updates from the City of Salinas on their peer outreach volunteer program; update on WPC enrollees entering into permanent housing; discussion on coordination with Adult Protective Services and Office of the Public Guardian.
2/10/20	36	Successes and challenges; continued updates on WPC enrollees entering into permanent housing; presentation and continued discussion on coordination with Adult Protective Services and Office of the Public Guardian; discussion on the idea of forming a nurse case management task force.
3/10/20	26	Successes and challenges; update on future very low income housing grants and potential developments; challenges faced by newly housed enrollees; PMPM enrollment at PY4 Year End; further discussion on forming a nurse case management task force.

VIII. PROGRAM ACTIVITIES

Care Coordination

A. Briefly describe 1-2 successes you have had with care coordination.
    1. Proof that our investment in care coordination and partnership has paid off is evident in the continued communication and cooperation demonstrated by our funded and non-funded partners after COVID-19 forced us to change our normal operations. Our collaborations in housing identification and sustainability, care management, and traditional homeless services remain strong. Even with limited staff, our comprehensive nurse case management teams were able to provide 539 member months in the first half of 2020, and 638 member months in the second half of 2020.

B. Briefly describe 1-2 challenges you have faced with care coordination, and lessons learned from those challenges.
    1. It is much easier to maintain and nurture partnerships when regular in-person meetings take place. Telephone calls and zoom meetings are less than ideal among 25 or more participants due to technological glitches, inability to speak without talking over each other, and inability to read facial and body language cues.

Data Sharing

A. Briefly describe 1-2 successes you have had with data and information sharing.
    1. We continue to share monthly WPC enrollment data and consent forms with our Medi-Cal provider. We receive nine monthly utilization reports from six funded partners in a timely and complete manner.

B. Briefly describe 1-2 challenges you have faced with data sharing, and lessons learned from those challenges.
    1. We are in our fourth operational year of sharing data and information with our funded and non-funded partners and are not experiencing problems with the procedures we put into place. We would prefer to have an electronic health record system that serves the health department, hospitals, and clinics, but we do not yet have a shared electronic health record system due to funding, logistical, and political challenges.

Data Collection

A. Briefly describe 1-2 successes you have had with data collection and/or reporting.
    1. As we are in our fourth operational year of data collection and reporting, we are not experiencing problems with the procedures we put into place.

B. Briefly describe 1-2 challenges you have faced 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.

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

COVID-19 postponed our 2020 CalAIM transition planning, and we have spent 2020 coping with significant WPC staff reductions. We cut back on enrolling new clients April and continued to provide limited services to all enrollees from April through June. We began enrolling clients again in July. Without knowing for sure if WPC would be extended for PY6, our purpose was to sustain current services through the end of December.

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:

56. Revisit #46 - CHE alternate pain management

57. Revisit #47 - CHE greater social worker presence

58. Revisit #48 - Increase capacity for medical assessments & services

59: Revisit #49 - Avoid hygiene-related illnesses

60: Revisit #50 - Provide housing locator services

61: Revisit #51 - Increase outreach at libraries and churches

62. New Case Manager for housed enrollees

63. Outreach to remote areas

64. Request for Pre-hospital Data

65. Revisit #57 - CHE greater social worker presence

66: Revisit #60 - Provide housing locator services

67: Revisit #61 - Increase outreach at libraries and churches

68. Revisit #62 - New Case Manager for housed enrollees

69. Revisit #63 -Outreach to remote areas

70. Revisit #64- Request for Pre-hospital Data

71. Incorporating CoC data into DataShare Monterey County

72. MSW assistance with RoomKey relocation