State of California - Health and Human Services Agency

Department of Health Care Services

Whole Person Care

Lead Entity Narrative Report

Napa County Whole Person Care

PY5 Annual Report (January 1, 2020 – December 31, 2020)

Submitted: May 15, 2020 Revised: July 8, 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.

Whole Person Care

Napa County Whole Person Care
PY5 Annual Narrative
May 15, 2020

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.

Throughout PY4, Napa's WPC pilot worked to overcome operational challenges identified in the first quarter, develop new service and program guidelines for funds approved via the Rollover Budget, and implement an innovative and elaborate mobile community clinic program to deliver mass vaccinations to eligible clients. PMPM Bundle enrollments remained steady throughout the year and near capacity, including new SOAR advocacy benefit services. In addition, new MOU's were developed and signed with FFS partners to address the operational challenges that resulted in a recoupment in PY3. Key accomplishments and operational challenges are outlined below.

Increased access to housing and supportive services:

As a housing-focused pilot, access to housing is essential for the success of Napa's program. The pilot continues to succeed with securing housing resources through the use of flexible funding, dedicated housing navigators and landlord-focused housing specialists, and an expanded outreach and tenancy care team. Truly high-volume housing placement remains elusive.

Key successes include:

- The Coordinated Entry System launched in mid-2017. By the end of calendar year 2018, CES had 293 households enrolled and 65 households housed in 18 months. In the first six months of 2019, CES served 472 unduplicated households, of which 25 households were housed via the Coordinated Entry System.
- Housing Navigation and Housing Specialist dedicated support for Whole Person Care clients resulted in a total of 55 WPC clients assisted into housing (with or without subsidy, including staying or re-uniting with family for permanent tenure) in the first six months of PY4.

- Successful application for new capital and subsidy dollars from California Homeless Emergency Aid Program (HEAP) and California Emergency Solutions, Housing (CESH) Program, and Homeless Housing Assistance and Prevention (HHAP).
- Negotiation for use of California Homeless Emergency Aid Program (HEAP) funds for capital improvement investments in exchange for 6 dedicated/set-aside CES-RRH units in new very-low income housing project, with potential for 5 additional CES-PSH units by the end of the year.

Operational Challenges

In PY3, Napa was a year and a half into the implementation of the Napa WPC Pilot. Although the Pilot expected to be further along in systems implementation, Napa continued in some aspects of the Pilot to work on building the infrastructure necessary to deliver services to WPC eligible clients and to collect and track data from those encounters. The scope and scale of these challenges became evident in early 2019, as the PY3 Annual Report was being assembled. This timing is important, as full understanding of the issues and measures to resolve them did not occur until late-March 2020.

Among the areas in which the Pilot experienced key challenges in PY4 which were unable to be resolved in PY4, and required pivoting away from several Fee-for-Services originally included in the WPC

- Delivery Infrastructure: Developing and implementing a successful workflow for a dedicated Eligibility Worker has proved elusive due to staffing shortages. The pilot has worked to ensure process for priority service for WPC clients and better tracking/reporting, however the line is significantly under-billed owing to much less staff-time available than planned.
- Fee for Service: The pilot developed and proposed several new FFS programs in PY4, to replace those deemed unworkable during PY3. These new FFS programs (Client Move In Funds, Landlord Recruitment Funds, Landlord Risk Mitigation Funds) each required significant investment in the development of protocols, processes, tracking and reporting before they could be implemented. Therefore implementation did not occur until later in the year, leading to under-billing in the first year of execution. The pilot does not anticipate under-billing in PY5.

Incentive Payments: The rollout of the Mobile Community Based IZ Clinic Program also required extensive planning and it took time to acquire all the supplies necessary. This lead to launch in Q4 of the year. Four mass-vaccination clinics were held before the end of the year, when the incentive was written assuming a total of 8. Therefore the line overall is under-billed.

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	17	[redacted]	16	20	[redacted]	23	100

Item	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12	Annual Unduplicated Total
Unduplicated Enrollees	38	18	23	[redacted]	[redacted]	22	224

Whole Person Care

Napa County Whole Person Care
PY5 Annual Narrative
May 15, 2020

*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
Respite Care $115	$18,400	$11,960	$4,255	$3,910	$16,455	$9,660	**$64,630**
Utilization 1	160	104	37	34	143	84	**562**
Client Move In Funds	$0	$0	$0	$0	$0	$0	$0
Utilization 9	0	0	0	0	0	0	0
Please note: FFS 2 through 8 are reported in the narrative section below							

Costs and Aggregate Utilization for Quarters 3 and 4							
FFS	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12	Annual Total
Respite Care $115	$10,120	$14,835	$11,730	$11,385	$4,945	$3,901	**$121,555**
Utilization 1	88	129	102	99	43	34	**1057**
Client Move In Funds	$0	$0	$0	[redacted]	[redacted]	[redacted]	[redacted]
Utilization 9	0	0	0	[redacted]	[redacted]	[redacted]	[redacted]
Please note: FFS 2 through 8 are reported in the narrative section below							

*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*

Whole Person Care

Napa County Whole Person Care
PY5 Annual Narrative
May 15, 2020

Amount Claimed								
PMPM	Rate	Month 1	Month 2	Month 3	Month 4	Month 5	Month 6	Total
Mobile Engagement	$650	$50,050	$49,400	$46,800	$48,100	$43,550	$47,450	**$285,350**
MM Counts ME		77	76	72	74	67	73	**439**
Coordinated Entry	$776	$61,304	$64,408	$50,700	$52,768	$52,768	$60,762	**$352,304**
MM Counts CE		79	83	78	68	68	78	**454**
Tenancy Care	$191	$10,505	$10,505	$11,460	$13,752	$13,561	$13,561	**$73,344**
MM Counts TC		55	55	60	72	71	71	**384**
SOAR	$510	[redacted]	$6,120	[redacted]	$7,650	$8,160	$7,650	**$41,820**
MM Counts S		[redacted]	12	[redacted]	15	16	15	**80**

Amount Claimed								
PMPM	Rate	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12	Total
Mobile Engagement	$650	$68,250	$76,700	$75,400	$72,800	$63,700	$72,800	**$715,000**
MM Counts ME		105	118	116	112	98	112	**1100**
Coordinated Entry	$776	$58,976	$59,752	$60,528	$65,960	$65,960	$63,632	**$373,808**
MM Counts CE		76	77	78	85	85	82	**937**
Tenancy Care	$191	$13,561	$14,707	$15,662	$13,752	$15,662	$16,808	**$90,152**
MM Counts TC		71	77	82	72	82	88	**856**
SOAR	$510	$7,650	$7,650	$7,650	$7,650	$10,200	$11,220	**$52,020**
MM Counts S		15	15	15	15	20	22	**182**

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

Since program launch in July 2017 the pilot has done well identifying, engaging and enrolling clients. A small number of clients [redacted] are subsequently dis-enrolled for a number of different reasons, which include Medi-Cal eligibility issues, refusal of services and moving out of county. The pilot has taken steps to address these issues, though still anticipates enrollment fluctuations throughout the duration of the pilot, with corresponding fluctuations in program bundle enrollment and service utilization.

For PMPM services, Tenancy Care remains lower than anticipated when the application was written four years ago, due to the incredibly tight rental market in Napa and the difficulty of placing clients with high barriers into scarce housing. Nonetheless, significant progress has been made in PY4 and enrollment is as close as it has ever been to the original projected enrollment levels. Enrollment in the Mobile Engagement, Coordinated Entry and SOAR bundles were all increased via budget adjustment and rollover, due to successful program utilization.

MOU's for three additional FFS lines (Client Move in Funds, Landlord Incentive Funds and Landlord Risk Mitigation Funds) have also been established, allowing funds to be utilized during the second half of the year. Client Move In Funds are actual costs incurred for individual clients, and service utilization counts are fractions of the total unit amount as incurred in each month surrounding move-ins. Landlord Incentive and Risk Mitigation funds were not utilized in PY4, due to the complications of establishing the legal-documentation side of the program. The Pilot expects to have service utilization in PY5 for these lines. Finally, the two remaining FFS lines (OLE Health and Housing Related Legal Assistance) are contracts.

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.

Successes from PY4 include:

- Onboarded new Homeless Services Coordinator.
- Refined/improved Care Coordination according to new contract.
- Refined and implemented Policies and Procedures, Guidelines and Tracking forms for WPC Client-Property Owner Risk-Mitigation and Incentives Program, designed to provide critical client gap-funds for securing rental units for WPC clients.
- Finalized MOU's with three FFS partners.

Challenges:

A primary infrastructure challenge involves data sharing with the Pilot's MCO, Partnership Health Plan (PHP). The Outreach Team has improved the rate of ROI's on-file for enrolled clients to better than 95%. Unfortunately, data sharing policies at PHP continue to lead to the denial of as much as 25% of ROI's on file, due to small errors like a birth-date written below the date-line, or an illegible signature. While PHP is surely working within the highest standards of PHI and PII protection, the lack of flexibility or understanding of the complexity of securing a signature, let alone additional data, from some of the pilots highest acuity clients is challenging

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.

Napa's WPC program delivery infrastructure provides staffing support for and with the goal of full program enrollment.

The primary PMPM services contractor, Abode Services, began program enrollment on July 1, 2017. During and since that time, the pilot has worked with Abode to ensure hiring of necessary service staff; provide policies, procedures and training; enroll clients into WPC Bundles and Fee-For-Services. In addition, lead entity delivery infrastructure staff have provided operating oversight for other major initiatives in Napa's homeless system that support WPC, including the operationalizing of Napa's Flex Pool, Shelter and Coordinated Entry System (CES) access points, and administering housing resources within CES. During this reporting period, the primary PMPM Service Contractor, Abode, has focused on ensuring PMPM enrollments at or exceed capacity, refining referral pathways to establish better two-way communication about the status of referrals with referring providers, and connecting WPC clients to housing and services.

In the first half of 2019, the pilot finished contract development with Queen of the Valley's CARE Network, the care coordination arm of Napa's primary hospital, to access an team of clinical and social work care coordination and complex care coordination staff. WPC and CARE staff identified and enrolled the 40 highest acuity WPC clients into this heightened care coordination program, using PHP data as a primary measure of acuity.

The HMIS Workgroup and Data continued to work on improvements to system design, reporting and tracking. Due to significant HIPPA-related limitations restricting housing case managers from accessing more in-depth care coordination platforms, HMIS remains a primary care coordination tool for the pilot. WPC staff continue to rely on HMIS for care planning activities, monitor WPC enrollment, and tracking new service programs. The data team also is responsible for PDSA cycles around data collection, housing reports, and care plans.

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.

New Care Coordination Contract completion

- **Payment Trigger:** During the first half of PY4, Napa held on average 3 meetings per month with between 5-7 partners in attendance to resolve key barriers related to care coordination, data tracking, reporting, program service expansion (new funds) and performance measurement.
- **Achievement:** Complete Attainment – contract completed
- **Payment**: $30,000
- **Receiving Entity/ies**: -County partners

Active Involvement in Barrier Identification and Resolution

- **Payment Trigger:** Attendance to WPC-Barrier Identification and Resolution meetings for 216 units as documented in meeting minutes.
- **Achievement:** Complete Attainment, demonstrated by meeting minutes and maximum meetings/partners attended to meet or exceed units.
- **Payment**: $216,000
- **Receiving Entity/ies**: Care Coordination Partners, Homeless Services Providers, PSH Providers, Tenancy Care, Self-sufficiency, County partners, FQHC

Housing Case Management

- **Payment Trigger:** Incentive of $500 for each client who stays in housing for at least six consecutive months.
- **Achievement:** Report demonstrating housing tenure for 55 clients who retained housing for six months or longer in 2019.
- **Payment**: $25,000 (max allowable)
- **Receiving Entity/ies**: Homeless services provider

Individual/By Type Immunization Rate Increase

- **Payment Trigger:** Documentation of each 10% increase in the percent of WPC enrolled clients age with a vaccination record in CAIR for FLU, MMR and/or TDAP above the baseline rate of 5%, 5%, and 54% respectively. Each incentive was tracked separately and amount earned was based upon progress of each three and then combined.
- **Achievement:** Partial – 9.6 units out of 21 budgeted units
- **Payment**: $51,460
    - Flu total 91% = 36% increase; Payment from 85% tier, $17,160
    - MMR total 43% = 38% increase; Payment from 40% tier, $22,860
    - TDAP total 76% = 22% increase; Payment from 74% tier, $11,440
- **Receiving Entity/ies**: County partners, Homeless Services Provider

Sub-Population: Older Adult PNUEMO/23 Rate Increase

- **Payment Trigger:** Documentation of each 10% increase in the percent of WPC enrolled clients age 55+ with a vaccination record in CAIR for PNEUMO/23 above baseline rate of 31% and 9% respectively, up to 100% of clients vaccinated.
- **Achievement:** Partial – 1.9 out of 7 budgeted units achieved, 40% tier
- **Payment**: $5,340
- **Receiving Entity/ies**: County partners, Homeless Services Provider

Sub-Population: HEP-A & HEP-B Immunization Rate Increase

- **Payment Trigger:** Documentation of each 10% increase in the percent of WPC enrolled clients with a an initial vaccination record in CAIR for all Whole Person Care clients in CAIR above baseline rate, documentation of second/follow-up dosage at six-month mark or beyond for HEP-A, and within one month for HEP-B, and documentation of third/final dosage at six month mark for HEP-B. Payment on the PY4 Annual invoice is for the initial dosage.
- **Achievement:** Partial – 18 out of 21.25 budgeted unit achieved
- **Payment**: HEP-A & HEP-B Initial Dose(s) total: $102,960
    - HEP-A total 94%: 60% increase; payment from 90% tier, $34,320
    - HEP-B total : 87% 87% increase; payment from 80% tier, $68,640
- **Receiving Entity/ies**: County partners, Homeless Services Provider

Sub-Population: FLU Immunization Rate Increase (complete attainment):

- **Payment Trigger:** Documentation of each 10% increase in the percent of WPC enrolled clients with a vaccination record in CAIR for all clients with zero or one record in CAIR above baseline rate.
- **Achievement:** Complete Attainment (100%) - Documentation of increase in the percentage of WPC enrolled clients with a vaccination record in CAIR above baseline rate of 11%, up to 100% increase.
- **Payment**: $42,650.00
- **Receiving Entity/ies**: County partners, Homeless Services Provider

Video Production of Staff Training for Community Based Clinics

- **Payment Trigger:** Production of the video for training for all clinical care delivery staff covering clinic set up, workflow, safeguards, documentation, screening protocols and follow-up.
- **Achievement:** Attained – Video produced and used for training all clinical care delivery staff, covering training for set up, workflow, safeguards, documentation, screening protocols and follow-up. Video allowed for rapid training and deployment of rotating staff for Mobile IZ clinics while ensuring uniform process and program delivery.
- **Payment**: $40,000.00
- **Receiving Entity/ies**: County partners

Mobile/Community Based Clinic Form Templates

- **Payment Trigger:** Copies of the form/templates (including screening forms, check-in processes, injection Q&A posters, marketing materials, staffing models, etc
- **Achievement:** Attained **-** The pilot created of a suite of forms, marketing materials, posters, guidelines and outreach protocols for execution of the Napa WPC Mobile Community Based Clinic effort. Creation of the form/templates (including screening forms, check-in processes, injection Q&A posters, marketing materials, staffing models, etc.) supports current and future efficient execution of successful, scalable mobile IZ clinical care delivery program, as well as a sharable set of templates usable (or replicable) by other WPC teams interested in similar work.
- **Payment**: $40,000.00
- **Receiving Entity/ies**: County partners

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.

Baseline-related metrics were shifted into PY4 per guidance from DHCS. The pilot achieved five of six possible measures/outcomes in PY4. The outcomes are listed below, with explanation of the status of program performance for each.

Pay for Outcome: **Reduce ED admissions by 10% from baseline for all clients enrolled in PY2**
Achievement Reached: **attained based on DHCS-run data.**
Attestation of Achievement: **Variant & Universal Metrics Report**
Payment Amount: **$25,000**

Pay for Outcome: **80% of clients placed into housing through Coordinated Entry at least 6 months prior will have maintained housing**
Achievement Reached: **attained - 81% of clients placed**
Attestation of Achievement: **Housing Report**
Payment Amount: **$25,000**

Pay for Outcome: **Place 50 WPC homeless clients into housing**
Achievement Reached: **attained – 55 housed**
Attestation of Achievement: **Housing Report**
Payment Amount: **$50,000**

Pay for Outcome: **Homeless Services Staff Training for Community Based Clinics**
Achievement Reached: **attained – 4 trainings completed**
Attestation of Achievement: **Sign-in Sheets for trainings**
Payment Amount: **$20,000**

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.

During the reporting period, Napa held regular policy and program planning meetings with participating entities and stakeholders. Attached please find a list of all policy and program meetings held with participating entities and stakeholders in PY4. This document includes a description of each meeting, the regularly scheduled dates (or in the case of ad-hoc meetings, a note if it was a single/stand-alone meeting or one called multiple times during the year), a summary of the meeting content and decisions, and list of attendees. Included with this summary document are a sample of agendas for each of the meetings listed.

Meeting Name	Date(s)	Description	Attending Stakeholders
Metrics Meeting	Monthly, last Wed of each month	Review Bundle enrollments, housing data, self-reported health status data, and program/service issues for barrier resolution.	Abode, QVMC, RDA, HHSA and HHP staff.
Housing Prioritization Meeting (CES)	Bi-Monthly, 2nd and 4th Thursday of every month	Review CES list and housing placements, resolve barriers to client housing.	Abode, NPD, QVMC, Buckelew, Catholic Charities, HHSA-MH, HHSA-SSSD, OLE Health, and HHP staff.
Respite Care Meeting	Semi-Monthly (Jan, Mar, June, Aug, Oct, Dec)	Review enrollment protocol, Outreach connection/workflow, data sharing protocols and resolve barriers to billing/data sharing/enrollment status.	Catholic Charities, Abode, HHSA and HHP staff.
City-County WPC Program Meeting	Monthly	Review program activities, coordination with Outreach and City PD, refine/resolve communication and problem solving triage process.	NPD, Housing Authority, PIO's for City and County, County AH, HHSA, Abode and HHP staff.
OLE Health – Ad Hoc	6 meetings (Jan, May, June, Aug, Oct, Nov)	Review/refine referral process, develop referral form and tracking for two-way referral communication between OLE and Outreach regarding WPC clients.	OLE Health, Abode, HHP staff.
SSSD-Eligibility Work Flow	6 meetings (May, June, June, July, Aug, Oct)	Review/refine referral process, develop referral form and tracking for two-way referral communication between OLE and Outreach regarding WPC clients.	HHSA-SSSD, Abode, HHP staff.

VIII. PROGRAM ACTIVITIES

Briefly describe 1-2 successes you have had with care coordination.

Napa's pilot considers housing the primary intervention to realize better health outcomes for WPC clients. Therefore, the pilot does not have *distinct* care coordination services or services bundles, as the focus is on placing WPC clients into housing as quickly as possible and using that stability as a platform to address health needs. This strategy is only effective to the extent that homeless WPC clients are placed into housing, which has been a challenge (please read below regarding overall program challenges). Therefore, in PY3, the pilot recognized the need for more support in coordinating care, *particularly for clients who remain unhoused*, and began to leverage its health coordination collaborative to accommodate basic care coordination activities. These activities intensified in PY4, with an emphasis on codifying functions into existing case conferencing activities, finalizing the care coordination contract with Queen of the Valley, and making progress toward implementing a care coordination software platform. Successes included:

- **Capacity building**. Bringing Care Coordination/Queen of the Valley staff into Housing Prioritization Meetings (run by Coordinated Entry) to increase understanding of how housing placement and CES works, ensure individualized advocacy and key information about highest acuity clients is shared in order to prioritize housing for the most vulnerable WPC clients.

- **Integrated Executive Level problem solving**. Expanded engagement from executive level staff at Care Coordination and Housing Prioritization meetings in order to bring swifter resolution to barriers identified by community partners (such as delays with Mental Health Assessments for WPC clients eligible for PSH.)

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

Please refer to Napa's PDSA cycles for detailed care coordination and care planning challenges and how the pilot is dealing with these challenges each quarter. Here are some highlights of the challenges the pilot faced in PY4:

- **Expanded/Enhanced Care Coordination with HHSA-Mental Health**. Staffing vacancies and leadership changes have prevented the furthering of work intended to improve care coordination between Abode and HHSA-Mental Health during this reporting period. Work is underway to re-engage key staff as roles and responsibilities have solidified in order to improve service-response times and communication between housing and service case managers from both agencies.

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

- **Public Health IZ Data Sharing:** Napa County WPC initiated a planning process with HHSA-Public Health to develop a baseline immunization rate across WPC enrolled clients for FLU, MMR, TD/TDAP, HEP-A, HEP-B and PHUEMO/23. In addition, protocols for information sharing were established in order to support a proposed WPC-IZ Program in the second half of PY4.

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

- **Fee for Service Data Sharing Agreement with Self-Sufficiency.** We are unable to secure approval or a process by which CIN numbers can be stored in HMIS. This leads to the need for time-consuming data collection and validation processes in order to create and verify the quarterly Enrollment and Utilization Report (EUR). Without permission/agreement to include this data in HMIS (or conversely a way to store the information in HMIS but restrict user-access to it), data must be exported and shared via spreadsheets requiring multiple steps of user-entered data. The process is fraught with data-entry error instances, and consumes a significant amount of staff time.

Briefly describe 1-2 successes you have had with data collection and/or reporting.

The pilot had notable achievements with data collection in PY4. Although there continue to be some challenges in accessing external reporting data (see above), the pilot has ongoing access to reporting data that is located within HHSA and is making progress on other fronts. Data collection/reporting successes:

- **Data Quality**: Considerable effort continues to improve HMIS data quality in PY4, resulting in notable increases to the number of clients with care plans, housing retention data, and other key program information. The HMIS Workgroup played a central role in overseeing and executing these activities.

Briefly describe 1-2 challenges you have faced with data collection and/or reporting.

Some of the data collection challenges that the pilot experiences include:

1. **ROI challenges:** Partnership Health Plan's data request and data provision timing for WPC client data continues to make access to an analysis of individual utilization data for key metrics functionally inaccessible to the pilot for on-going program evaluation and planning purposes.

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

The Napa WPC Pilot anticipates the following five barriers to success for the WPC Program overall:

1. **COVID-19**
   The pandemic is a significant barrier to service provision due to staff and client vulnerability, shelter in place orders which have required new facilities to shelter and house affected residents – causing staffing to be stretched incredibly thin, and emergency response County-wide to further pull most of our program staff into full-time EOC Operations with no end in sight.
2. **Delayed Data Evaluation**
   Limited and cumbersome access to Emergency Room and In-Patient Utilization Data, as well as general healthcare data, causes significant barriers to timely evaluation of program intervention(s) and results. This barrier means we are unable to iterate/improve service delivery or service expansion efforts quickly during the 4 year implementation window.
3. **Limited Housing Resources**
   A persistent lack of housing that is affordable, combined with a lack of flexible money able to layer with existing State/Federal housing subsidy resource for things such as first month's rent, security deposit(s) and move in costs, and limit housing placements.
4. **Neighborhood Resistance to Permanent Supportive Housing Development(s)**
   Vocal, organized opposition to developments designed to provide housing to highest acuity WPC clients (those with co-occurring disorders and/or experiencing chronic homelessness) threaten to derail construction of a 66-unit supportive housing project with 36 dedicated beds for WPC/CES clients.
5. **Not all Jurisdictions are Mandated to Provide Homeless Services**
   Providing services for individuals experiencing homelessness is not a mandated service for all jurisdictions. Without such a mandate, opportunities for sustainable funding beyond the sunset of WPC in 2020 are limited, given Napa's Managed Care Organization (Partnership Health Plan) has declined to participate in Health Homes. The burden of service falls to Napa County and the largest City in the County, the City of Napa, who jointly fund Homeless Programs. The Whole Person Care Pilot Program has enable Napa County Homeless Services to greatly expand and improve the Outreach, Housing Navigation and Placement Services and Care Coordination to the highest acuity users in the community. These service interventions have resulted in significant numbers of individuals experiencing chronic homelessness with multiple barriers to housing to nonetheless connect to services and be placed into permanent housing. Without Federal, State and Local new resources adequate to meet the need beyond WPC, the system will remain woefully underfunded and successes achieved during the Pilot will not be sustained.

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.

The Napa County Whole Person Care Pilot aims to reduce chronic homelessness and high levels of unnecessary service use among vulnerable homeless people by providing services that are better coordinated, housing focused, client centered, and supported by a culture of continuous learning and improvement. By the end of WPC, vulnerable homeless people in Napa County will have improved access to housing, will stay housed, and will experience improved wellbeing.

In PY4, Napa County WPC continues to focus on reinforcing the foundations needed to support successful PDSA cycles, including:

1. **Ensuring common agenda**. The pilot has worked to expand "The Table" of partners involved in WPC, including new healthcare partners, expanding the number of community organizations that see themselves as a "housing navigation" or "homelessness prevention" partner, strengthening the engagement with law-enforcement and public works entities to address their concerns/impacts of homelessness on other public sectors, and work toward coordinating responses to hold at the forefront providing the best possible care to prevent or resolve homelessness for WPC clients.
2. **Reinforcing a culture of continuous learning**. PDSA cycles are effective when data is used to facilitate learning, growth and change, rather than penalizing underperformance. Promoting a learning culture through PDSA cycles includes supporting curiosity and approaching the Whole Person Care pilot as a problem-solving process rather than an unchanging solution to assisting vulnerable homeless in the community.

3. **Establishing shared measurement systems**. The scope and scale of the Napa population and pilot limit the overall resources available toward investment in robust data-sharing systems. As a result, the team must creatively approach data sharing and measurement tools/systems to leverage available data and support timely review of performance metrics to support PDSA cycles.

Please refer to the attached PDSA report for Napa's PDSA summary and PDSA cycle reports for the third and fourth quarters of 2019.