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

Orange County Whole Person Care
Annual Narrative Report, Program Year 4
July 14, 2020 Revision 4

REPORTING CHECKLIST

The following items are the required components of the Mid-Year and Annual Reports:

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

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

I. REPORTING INSTRUCTIONS

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

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

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

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

II. PROGRAM STATUS OVERVIEW

Instructions: Please provide a brief overview of your program's successes and challenges and any lessons learned during the reporting period. Structure your responses in alignment with the WPC program's goals using the following as headers (from STC 112): increasing integration among county agencies, health plans, providers, and other entities; increasing coordination and appropriate access to care; reducing inappropriate emergency and inpatient utilization; improving data collecting and sharing; achieving quality and administrative improvement benchmarks; increasing access to housing and supportive services; and, improving health outcomes for the WPC population.

Please limit responses to 500 words. If additional information is needed, please contact your assigned Analyst.

Increase Integration:

Successes: The WPC Program continued to hold monthly meetings with the medical, behavioral health and social service providers. These meetings have focused on topics that affect all providers such as access to recuperative care, housing services, and care coordination at the health plan level. This has allowed for shared learning and platform enhancements to further collaborate and communicate between organizations. In addition to onsite meetings, the program has been meeting with interested community resource providers such as Veteran support services to continually expand the provider community. In partnership with the Vendor, there have been multiple enhancements to the platform, WPC Connect, to accommodate for additional data integration areas such as online assessments availability of the PHQ-9, PRAPARE, and VI-SPDAT. All enhancements resulted in better adoption through ease of use, brought more value to the participating organizations, and provided richer data for the WPC Program to report on progress made. The use of WPC Connect has improved integration of service provision among agencies in the county by allowing providers to share data that should improve treatment planning for the client. In addition, all enhancements had a priority of increasing ease of use, better adoption, bringing more value to the participating organization

Challenges: Eight of Orange County's 25 hospitals continue to be reluctant to use WPC Connect because they have their own data systems. This has mainly been driven by their concern about the work required to enter data on a client into the system. Some providers have expressed concern about the burden of entering information into their own data system and then into WPC Connect.

Lessons Learned: It is important to have the WPC Connect vendor present at the meetings, which allows for a quick resolution to any program or technically related hurdles.

Increase Coordination/Access to Care:

Successes: Similar to the integration of services, coordination and access to care continues to improve with the use of WPC Connect. The data system allows each provider to manage a client's coordinated care plan in real time, allowing every member of the enrollee's care team to have access to the same care plan. During 2019, the WPC Program has expanded to include housing-related services and coordination. Enhancements have been made in WPC Connect to accommodate the viewing and sharing of housing coordination efforts. The WPC Connect platform now allows medical, behavioral, recuperative care, social, and housing services to be shared in one platform. These additions better support the coordination of all services and care for the WPC clients reducing the duplication of services as providers can see what services are currently being provided by other agencies.

Another success was the addition of providers to the WPC program. In 2019, 27 Business Associate Agreements were signed with Orange County providers. The addition of these partners increases care coordination for the WPC clients.

Challenges: The biggest challenges to care coordination continues to be the use of WPC Connect by the non-WPC funded providers as they did not have an incentive to enter their data into the data system. Without all of the providers entering data into the data system, it is impossible to coordinate care fully

Lessons Learned: It is important to have the data system vendor attend provider meetings as this they can often provide an immediate solution should a technical hurdle be identified.

Reduce inappropriate ER/Inpatient Utilization:

Successes: Emergency department utilization continued to decrease since PY2. From PY2-PY4, emergency department utilization decreased 24.3%. As compared to PY3, emergency department utilization decreased 1.0%.

In addition, inpatient utilization has steadily decreased since PY2. Inpatient utilization decreased 23.2% from PY2 and 8.5% compared to PY3.

Challenges: It has been a challenge to be able to analyze project metrics without the data dictionary for the CalOptima claims and utilization files.

Lessons Learned: Case level data is crucial for examining reasons behind trends and the impact of different populations on the indicators. Without a data dictionary, it is nearly impossible to be able to accurately analyze and interpret data.

Improved Data Collection/Sharing:

Successes During 2019, all of the funded WPC providers began utilizing WPC Connect for data collection, data sharing between providers and reporting. With more providers actively using WPC Connect, more effective and secure care coordination efforts began to evolve. Providers were also able to view their client's service utilization history and recent hospitalizations via an Admit, Discharge, and Transfer (ADT feed) in the WPC Connect Platform.

Challenges: There continue to be challenges with all providers utilizing the data system. Reasons include staff burden and workload, and competing data systems.

Lessons Learned: WPC staff needed to be more involved with the conversion from manual data collection to on-line data collection and be prepared to meet with partners multiple times to explain the project, its expected outcomes, and the data required to show project effectiveness. In addition, it is important to have the Vendor present at the onboarding of new organizations as they can address any technical issues that an individual organization may have specific to their needs.

Achieve Quality/Administrative improvement benchmarks:

Successes: In 2019, the biggest success in improving the quality of the data has been the implementation and expansion for the use of WPC Connect platform by providers. Having providers enter their client data directly into a data system has reduced the number of possible manual errors when reporting activity for a client. This has also reduced the possibility of errors made by WPC staff when analyzing the manual data submitted. The WPC system automatically includes multiple data quality checks that have assisted with data analysis.

Challenges: Several providers continue to be hesitant to use WPC Connect and/or are only entering a portion of their clients in WPC Connect This created extra workload challenges for not only the providers but also for WPC staff and our Vendor to support a manual and online processes.

Lessons Learned: Conducting workflow analysis meetings with the Vendor allowed for issues and concerns be addressed immediately.

Increase Access to Housing & Supportive Services:

Successes: A major success occurred in Q3-Q4 of 2019. WPC staff issued three short-term contracts to Housing Navigation and Sustainability providers to attend to clients not linked to County Behavioral Health Services (BHS). This has been a major gap in the county, and this population accounts for approximately 40% of the WPC clients. In November of 2019, the Orange County United Way began providing Housing Navigation services to non-BHS clients. In December, the Orange County Housing Collaborative signed a short-term contract and began providing Housing Navigation services. In addition, WPC staff created a monthly Housing Navigation and

Sustainability Collaborative. This meeting has been highly attended with representatives providing Housing Navigation services and from the Orange County Housing Authority.

Challenges: Until Q4 of 2019, only clients linked with BHS receiving Housing Navigation and Sustainability Services. This left a huge gap for clients not linked to those services.

Lessons Learned: It is important to have the referral process established and vetted by all parties prior to sending referrals for services. Without this process established, confusion can occur as to who is providing which services and how data will be collected and reported.

Improve Health Outcomes:

Successes: WPC staff received updated client-level data health and behavioral health service data. This will allow for a careful examination of health outcomes. These data are pending and will be submitted in a revised Universal Variant Metric Report and a descriptive analysis of results.

Challenges: Collecting health outcome data and reporting some of the metrics has been challenging. Health outcome data comes from a variety of data sources such as the county's internal data systems. As these all are in differing formats with different client identifiers, it has been a challenge to analyze and report on several of the health indicators such as suicide risk assessment and health care utilization. The data source for collecting depression readmission at 12 months or major depressive disorder-suicide risk assessment metrics has yet to be finalized, primarily because the PHQ-9 screening tool required for these WPC metrics criteria is not administered consistently in all BHS clinics. Consequently, limited data for depression readmission at 12 months or major depressive suicide risk assessment was available through BHS data system IRIS. However, after applying the criteria for the measures, the numbers were negligible and could not be reported.

Lessons Learned: Case level data is crucial for health outcome data. Without a data dictionary, it is nearly impossible to be able to accurately analyze and interpret the health outcome data. It is also important to continuously meet and brief all levels of staff on the intent of the project and how their data can contribute to the project's evaluation, with the ultimate goal of improving the lives of homeless clients and keeping them out of the emergency departments unnecessarily. To address the inconsistent implementation and reporting of the PHQ-9 screening tool, implementation of additional tools and instruments may be require contractually in order to obtain the information necessary. This is often a result of protectiveness of the agency of their data, which is understandable.

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	268	456	385	384	344	251	2,088

Item	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12	Annual Unduplicated Total
Unduplicated Enrollees	303	382	250	219	230	170	3,642

*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 Utiization for Quarters 1 and 2							
FFS	Month 1	Month 2	Month 3	Month 4	Month 5	Month 6	Total
Service 1: $130.30/ bed day	$247,179.10	$219,164.60	$229,849.20	$271,154.30	$312,589.70	$257,472.80	$1,537,409.70
Utilization 1	1,897	1,682	1,764	2,081	2,399	1,976	11,799
Service 2							
Utilization 2							

Costs and Aggregate Utilzation for Quarters 3 and 4							
FFS	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12	Annual Total
Service 1: $130.30/ bed day	$292,653.80	$352,722.10	$380,997.20	$412,660.10	$375,524.60	$408,881.40	$3,760,848.90
Utilization 1	2,246	2,707	2,924	3,167	2,882	3,138	28,863
Service 2							
Utilization 2							

*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	$121	$373,043	$401,720	$409,222	$447,821	$508,684	$507,837	$2,648,327
MM Counts 1		3,083	3,320	3,382	3,701	4,204	4,197	21,887
Bundle #2	$216	$69,552	$72,792	$73,224	$30,240	$24,840	$22,896	$293,544
MM Counts 2		322	337	339	140	115	106	1,359
Bundle #3	$207.50	$57,477.50	$56,232.50	$59,137.50	$61,212.50	$51,045	$51,460	$336,565
MM Counts 3		277	271	285	295	246	248	1,622
Bundle #4	$1,594	$0	$0	$0	$0	$0	$0	$0
MM Counts 4		0	0	0	0	0	0	0
Bundle #5	$122.87	$0	$0	$0	$0	$0	$0	$0
MM Counts 5		0	0	0	0	0	0	0
Bundle #6	$960	$0	$0	$0	$0	$0	$0	$0
MM Counts 6		0	0	0	0	0	0	0
PY2 PMPM	Rate	Month 1	Month 2	Month 3	Month 4	Month 5	Month 6	Total
Bundle #1	$121	$0	$0	$0	$0	$0	$0	$0
MM Counts 1		0	0	0	0	0	0	0
Bundle #2	$216	$0	$0	$0	$0	$0	$0	$0
MM Counts 2		0	0	0	0	0	0	0
Bundle #3	$207.50	$0	$0	$0	$0	$0	$0	$0
MM Counts 3		0	0	0	0	0	0	0

Amount Claimed								
PMPM	Rate	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12	Total
Bundle #1	$121	$514,492	$529,738	$524,656	$516,549	$519,816	$438,383	$5,691,961
MM Counts 1		4,252	4,378	4,336	4,269	4,296	3,623	47,041
Bundle #2	$216	$18,576	$16,848	$15,552	$11,664	$11,664	$12,096	$379,944
MM Counts 2		86	78	72	54	54	56	1,759
Bundle #3	$207.50	$41,915	$46,065	$48,762.50	$48,140	$49,177.50	$42,330	$612,955.00
MM Counts 3		202	222	235	232	237	204	2,954
Bundle #4	$1,594	$0	$0	$0	*	*	$22,316	$41,444
MM Counts 4		0	0	0	*	*	14	26
Bundle #5	$122.87	$0	$0	$0	$0	$0	$0	$0
MM Counts 5		0	0	0	0	0	0	0
Bundle #6	$960	$59,520	$63,360	$74,880	$83,520	$97,920	$99,840	$479,040
MM Counts 6		62	66	78	87	102	104	499
PY 2 PMPM	Rate	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12	Total
Bundle #1	$121	$78,408	$174,482	$186,219	$199,892	$214,654	$219,978	$1,073,633
MM Counts 1		648	1,442	1,539	1,652	1,774	1,818	8,873
Bundle #2	$216	$0	$0	$0	$0	$0	$39,096	$39,096
MM Counts 2		0	0	0	0	0	181	181
Bundle #3	$207.50	$0	$0	$56,233	$65,155	$72,833	$75,738	$269,957.50
MM Counts 3		0	0	271	314	351	365	1,301

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

Unduplicated Enrollees: Orange County understands that DHCS has requested that unduplicated enrollee number include only those considered "initially enrolled" in the WPC Program during PY 4 (no prior enrollment in PY 2 or PY 3). Given this understanding, the numbers reported reflect only those person enrolled in Orange County's WPC Program for the very first time in PY 4.

FFS:

FFS #1 - Recuperative Care (bed days): The FFS amount identified in the report reflects the County's actual fully audited days per month provided and the actual cost during the Program Year of providing these services for PY 4. With additional funding allocated through WCP Round 3, Orange County proposed providing 21,813 bed days. 11,625 bed days were reported in the mid-year report at an average cost per bed day of $89.19. A total of 28,863 bed days were actually provided, which is 132% over the targeted number primarily due to providers being able to address the specialty needs identified in the Round 3 proposal timelier than anticipated. The annual cost per bed day equates to $130.30 per bed day; however, since a significantly lower rate was used for the first six months (due to over-estimating the amount of non-WPC revenues to be received, the amount per bed day for the balance of the funding was calculated at $158.03 per bed day for the annual invoice. The WPC receives additional outside funding for recuperative care, so only the net amount is billed to WPC.

FFS #2 –Move In Bundle: This FFS category was approved effective July 1 with an additional allocation of WPC funds. Given the activity in PMPM #6 that is related to this FFS item, the WPC Program believes there may be expenditures related to this category that have not yet been invoiced to the County, and is not yet able to be captured in WPC Connect, so we are unable to include them on in the 2019 reporting. Should funding permit, and pending DHCS approval, Orange County may request to claim these PY 4 costs on the PY 5 invoice should invoices be received eventually be received for this period with proper documentation.

PMPM:

PMPM #1 – Hospital & Clinic Homeless Navigation Services: Orange County's PY 4 target member months for this service is 35,184 which target was approved via the mid-year budget adjustment for PY 4, including additional funding added to this line item. The final annual amount achieved was 47,041, which is 134% of the adjusted targeted amount.

The additional services beyond what was anticipated in the mid-year adjustment is in large part to the increase in funding and service levels for an existing WPC Participating Hospital and the addition of two new hospitals to the WPC Connect system for reporting.

PMPM #2 – Drop-In Center Supportive & Linkage Services: Orange County's PY 4 target member months for this service was initially 1,800 which was reduced to 1,282 in the PY 4 mid-year budget adjustment given the trends of transitioning persons from receiving supportive and linkage services in shelters to receiving the services in more appropriate community organizations. The annual amount of member months actually provided was 1,759 or 137% of the adjusted target member months. While lower than the initial target, the transition trend was not as large as initially projected, resulting in more member months provided than anticipated.

PMPM #3 – SMI Specific Outreach and Navigation Services provided by County Outreach and Engagement Staff: Orange County's PY 4 Annual member months for this service was initially 3,583 which was reduced to 2,499 with the mid-year budget adjustment. The actual number of member months provided for PY 4 was 2,954 or 118% of the adjusted target months. The actual member months is 82% of the original target which is reflective of the difficulty in newly enrolling more "service resistive" clients into the WPC, and the resulting total is reflective of the persistence and hard work of the SMI Outreach & Engagement teams.

PMPM #4 –Jail In-Reach and Release Services: These are new services funded through the WPC Round 3 funds. The WPC Program did not anticipate this program would produce member months until PY 5; however, early reporting indicated there would be reportable services in PY 4 and a budget adjustment was approved reflecting a projected 22 member months. Actual reporting came in at 26 member months range County's PY 4 Annual member months for this service is 26 or 118% more than anticipated.

PMPM #5 – Core Care Coordination Services: This program was delayed to align with the CB-CME Health Home requirements, so no services were provided in PY 4.

PMPM #6 –Housing Navigation & Sustainability Services: These are new services funded through the WPC Round 3 funds. The initial amount funding was 280 member months; however, due to WPC's partnership with three of the four Housing Authorities in Orange County providing vouchers specifically for WPC enrollees who are medically fragile,

member months for this line item were exceeding projections. WPC requested a budget adjustment to increase member months to 446 and actuals were 499, or 112% over the adjusted projection.

Revised quarterly Utilization and Enrollment reports for 2019 have been submitted to correspond with the above numbers.

Program Year 2 – Supplemental Funding:
While every effort was made to expend the additional funds Orange County received for Program Years 4 and 5, an inquiry was submitted regarding the possibility of reallocating any of the projected unexpended funds from PY 4 to cover the PY 2 over-expenditures. Accordingly, the following is included in the PY 4 invoice and these services were submitted with the Utilization and Enrollment Reports for PY 2:

PMPM #1 – Hospital & Clinic Homeless Navigation Services: Orange County's PY 2 target member months for this service was 3,552. Actual utilization for this service exceeded this target by 8,873 member months which is included in the above figures and in the approved PY 4 Budget Adjustment request reflected on the invoice for PY 2 services.

PMPM #2 – Drop-In Center Supportive & Linkage Services: Orange County's PY 2 target member months for this service is 900. Actual utilization for this service exceeded this target by 181 member months which is included in the above figures and in the approved PY 4 Budget Adjustment request reflected on the invoice for PY 2 services

PMPM #3 –SMI Supportive & Linkage Services: Orange County's PY 2 target member months for this service is 300. Actual utilization for this service equaled 1,361 member months. However, due to an incorrect PMPM amount noted on the PY 2 annual invoice, the amount paid for 300 member months actually equates to 360 member months, bringing the amount requested to make PY 2 payment whole down to $269,958 for 1,301 additional member months vs. the $338,889 requested in the PY for budget adjustment for 1,633 member months for PY 2. This correct amount is reflected above and in the invoice.

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.

County Administrative Support to Implement and Administer the WPC:

There are no changes in the staffing that administratively supports and administers the WPC for Orange County. Orange County expects to expend all of its administrative support dollars provided to oversee the WPC Program and ensure implementation of the WPC funded services.

CalOptima Administrative Support:

CalOptima continues to fund 2 FTE of Personal Care Coordinators to aid in improving communication and coordination of Medi-Cal benefits for WPC beneficiaries among and between the Managed Care Plan and hospitals, community clinics, recuperative care, County Behavioral Health Services, and the drop-in centers. CalOptima recognized the value of this position particularly in assisting persons struggling with homelessness and the community providers trying to assist them.

IV. NARRATIVE – Delivery Infrastructure

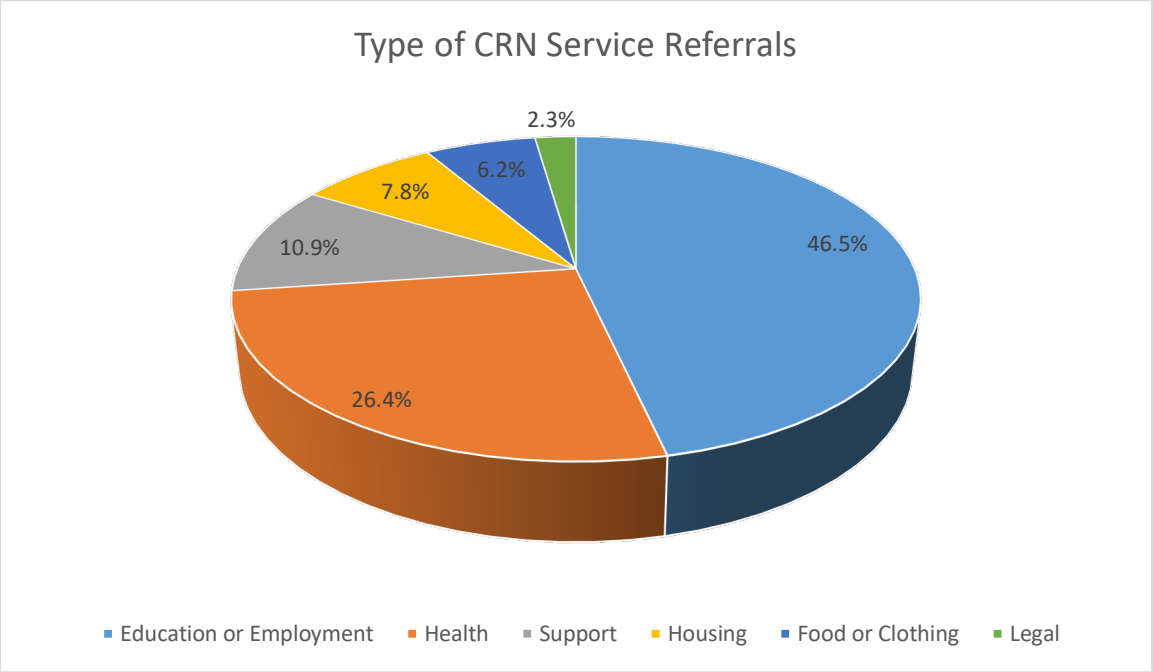
Instructions: Please describe the delivery infrastructure that has been developed as a result of these funds and how it relates to achievement of pilot goals. Reimbursement will be based on actual pilot expenditure for the final deliverable or outcomes, up to the limit projected or estimated costs in 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.

Community Referral System (CRN)

The CRN is a free, web-based referral app designed to facilitate relationships with community clinics, hospitals, and social service agencies in order to provide holistic care for their clients. The mission of CRN is to bridge service gaps, create a stronger network of services and achieve a healthy empowered community. The CRN provides an additional resource, meant to supplement and enhance services provided by existing community based social service referral agencies.

In 2019, the WPC-funded social services component of the CRN processed **625** social service referrals, representing a 178.1% increase from 2018. Almost 70% (n=425) of the referrals occurred in the second half of the year. The majority of services provided were educational or employment related (46.5%, i.e. workshops), followed by health-related (26.4%), support services (10.9%), housing-related (7.8%), food or clothing-related (6.2%), and legal-related (2.3).



The CRN program also added **36** vendors to take referrals in 2019, with slightly more than half (n=19) occurring during the second half of 2019. Thus, the goals for 2019 were met.

WPC Connect:

eReferral and Case Management Coordination
Secure messaging between organizations to coordinate patient care
Client service tracking and outcome reporting
Developed authorization module to approve recuperative care services
Continual hospital ADT feeds from five local hospitals
Loads Eligibility Data daily
Linked to the County Health Plan (CalOptima)
Connected 11 Hospitals and medical centers
Connected 9 Federally Qualified Health Centers and community clinics
Connected two shelters
Connected to Behavioral Health Services
Linked four recuperative care sites
Linked to the Community Resource Network (CRN)

In 2019, there have continued to be challenges with onboarding a few WPC providers but WPC Connect has successfully brought on more WPC providers and non-WPC funded providers. The Vendor team has collaborated with WPC staff to provide additional onsite trainings and workflow analysis to new and existing WPC providers.

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.

The following incentive payments were approved with the additional funding added effective July 1, 2019:

WPC Connect Enhancements: The target for this incentive was to amend the contract with our vendor to add services. The contract with the vendor was amended in August 2019, thereby achieving the full incentive payment, Amount earned = $8,425.00 paid to the county partners that support the work of several agencies/departments within the system

Homeless Data Integration: The target for this incentive was to execute a contract with our vendor. The contract with the consultant was executed in August, 2019, thereby achieving the full incentive payment, Amount earned = $8,425.00 paid to the county partners that support the work of several agencies/departments within the system

Recuperative Care: The target for this incentive was to increase the average number of beds to 60-65. With the additional funding provided July, 2019, Orange County significantly increased the number of recuperative care beds, including adding specialty beds. Prior to these additional funds, the number of filled beds at any given time averaged from 40 to 45. Orange County was able to increase the average census to a range of 60 to 65 by December 31, 2019, thereby achieving the full incentive payment, Amount earned = $25,275.00 paid to the county partners that support the work of several agencies/departments within the system

Hospital and Community Clinic Navigation – The target for this incentive was to execute contract amendments. Amendments were executed in July, 2019, thereby achieving the full incentive payment, Amount earned = $25,275.00 paid to the county partners that support the work of several agencies/departments within the system

SMI Specific Care Coordination – The target for this incentive was to train expanded staff on WPC Program and using WPC Connect. Expanded staff were trained on WPC Connect over a three-month period from August 2019 through October 2019, thereby achieving the full incentive payment, Amount earned = $25,275.00 paid to the county partners that support the work of several agencies/departments within the system

Jail In-Reach and Release Services – The target for this incentive was to train new staff on WPC Program and using WPC Connect. New Staff were trained on WPC Connect in September, 2019, thereby achieving the full incentive payment, Amount earned = $25,275 paid to the county partners that support the work of several agencies/departments within the system

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.

For Orange County, there are five Universal Metrics, five Variant Metrics, and seven optional metrics that need to be reported on at this time.

Universal Metrics:
Ambulatory Care- Emergency Department (AMB-ED)-COMPLETE
Inpatient Utilization – General Hospital/Acute Care (IPU)-COMPLETE
Follow-Up After Hospitalization for Mental Health-PENDING
Initiation and Engagement of Alcohol and Other Drug Dependence-PENDING
Comprehensive Care Plan-COMPLETE

Partially Achieved: WPC continued to see a decrease in rates of Ambulatory Care-Emergency Department and Inpatient Utilization. In comparison to PY2, there was a 24.3% decrease in Ambulatory Care-Emergency Room visits and a 23.2% decrease in Inpatient Utilization. However, the reduction for PY 4 was only 1% for ER utilization as compared to PY 3. The lower reduction was expected due to education activities for providers on alternative community-based medical care as described in the PDSA. As a result, Orange County is unable to claim the $87,225 for the outcome associated with achieving its ER utilization reduction over the baseline year.

CalOptima, Orange County's Medi-Cal, provided emergency department costs for WPC clients. The cost for an emergency department visit of all WPC clients to date is $216,062 per thousand members per year, averaging $127 per emergency department visit. For currently enrolled WPC clients, this cost is reduced to $181,306 per thousand members per year or $124 per emergency department visit. This is a significant reduction since 2017, which had a rate of $192,976 per thousand members per year or $140 per emergency department visit.

The costs for inpatient hospitalizations have varied since 2017, rising slightly in 2019. For example, the inpatient hospitalization cost for all WPC clients to date is $5,322,096 per thousand members per year, averaging $7,208 per inpatient hospitalization. For currently enrolled WPC clients, this cost is reduced to $4,036,965 per thousand members per year or $6,953 per inpatient hospitalization. The cost for inpatient

hospitalization has increased since 2017 when cost per thousand members per year was $3,634,049 or $6,833 per inpatient hospitalization.

WPC Staff have received case level mental health and substance abuse data from the County's Behavioral Health Services. WPC staff have encountered some delays, however, in analyzing two of the Universal Metrics: Follow-Up After Hospitalization for Mental Health and Initiation and Engagement of Alcohol and Other Drug Dependence, which are pending. In particular, due to finalizing the PY4 Annual Report and Utilization records, staff have had to redo the data processing needed for these two metrics. The reason why these pending metrics are highlighted as successes is that staff believe that these metrics will include sizable number of cases allowing for compressive analysis of these metrics. These data will be submitted in a revised Universal Variant Metric Report and a descriptive analysis of the results.

All clients (100%) receive a Comprehensive Care Plan when they enroll in WPC. This Care Plan is facilitated through the use of WPC Connect, which allows providers to coordinate the care of incoming and existing clients. In 2019, there were 4,602 new WPC enrollees that received Comprehensive Plans.

Challenges: As noted above, WPC staff have had delays in analyzing all the universal metrics. It is expected that these results are forthcoming.

Lessons Learned: It is extremely difficult to analyze the various data sets. It is extremely important to have someone on staff who understands complex datasets and is able to link various datasets together.

Variant Metrics:
Comprehensive Diabetes Care-COMPLETE
Depression Readmission at 12 Months-PENDING
Major Depressive Disorder-Suicide Risk Assessment-PENDING
Housing Services-COMPLETE
All Cause Readmission-COMPLETE

Achieved: Compared to PY2, there has been a 10.0% decrease in the number of WPC clients who had an HBA1c of greater than 8%. This decrease is even larger when comparing to PY3, at 11.7%.

Major Depressive Disorder – Suicide Risk Assessment data was obtained through PHQ-9 data and active diagnosis of Major Depression or Dysthymia. To address the inconsistent implementation and reporting of the PHQ-9 screening tool, WPC contractually required recuperative care providers to implement the PHQ-9 to WPC adult clients within 24 hours of admission and to document the results through WPC Connect. The PHQ-9 Assessment tool was launched in WPC Connect in October 2019. This new feature was included in the updated user guide, the *What's New* October 2019

edition, and highlighted during the October WPC Collaborative meeting. In addition, a PHQ-9 referral algorithm was developed to assist the recuperative care providers make appropriate follow-up referrals based on PHQ-9 scores. This referral algorithm was uploaded in WPC Connect and appears after the PHQ-9 scores have been entered.

Since the launch of the PHQ-9 tool in WPC in October 2019, the number of available PHQ-9 scores for WPC clients has increased noticeably. Based on preliminary results from Oct.-Dec. 2019, the number of PHQ-9 scores available for CY 2020 is expected to exceed those of prior years.

Housing data were obtained related to percent of clients receiving housing services, days homeless, days sustaining housing, and clients sustaining housing for six or more months. In 2019, 77.6% of clients referred for housing services received those services, a slight reduction from the previous reporting period.

Lastly, all cause readmissions decreased, 54.2% in PY4 to compared to PY3, 55.66% decreased compared to PY2, and 49.1% from baseline.

Challenges: As with any new requirements that is rollout, it takes time to get programs to go on board and to train staff on the new process. In 2019, only one of the recuperative care providers had actually started recording their clients' PHQ-9 score in WPC Connect. Audits of the remaining recuperative care providers revealed that one of the recuperative care provider have been conducting the PHQ-9 assessments, however, they did not know to record the data in WPC Connect. The remaining recuperative care providers were not conducting the assessments. Additional trainings will be provided to these recuperative care providers on contractual requirements to conduct assessments as well as how to record data in WPC Connect. In addition, although available PHQ-9 scores collected have increased compared to prior year, based on metric criteria, results cannot be calculated for another year when follow-up PHQ-9.

Lessons Learned: Although recuperative care providers were informed about the contractual requirements and updated as new requirements and resources are rolled-out, this does not always reach the appropriate staff. Direct follow-ups with providers need to take place sooner in order to assess whether the information was received and was being implemented.

Optional Metrics:
Members Linked to Case Management-COMPLETE
Percent of Referrals Resulting in Linkage to Services from County Behavioral Health-PENDING
Increase in Primary Care Physician Office Visits PENDING
Number of Days Psychiatrically Hospitalized PENDING
Number of Days in Independent Living or Permanent Supportive Housing-COMPLETE

Number of Homeless Days-COMPLETE

Achieved: All clients (100%) receive case management when they receive WPC services. This case management is facilitated through the use of WPC Connect which allows providers to coordinate the care of incoming and existing clients. In 2019, there were 7,797W PC enrollees that received case manager.

WPC Staff have received case level mental health and substance abuse data from the County's Behavioral Health Services. WPC staff have encountered some delays, however, in analyzing three of the optional Metrics: Percent of Referrals Resulting in Linkage to Services from County Behavioral Health, Increase in Primary Care Physician Office Visit, and Number of Days Psychiatrically Hospitalized, which are pending. In particular, due to finalizing the PY4 Annual Report and Utilization records, staff have had to redo the data processing needed for these two metrics. The reason why these pending metrics are highlighted as successes is that staff believe that these metrics will include sizable number of cases allowing for compressive analysis of these metrics. These data will be submitted in a revised Universal Variant Metric Report and a descriptive analysis of the results.

In relation to days homeless, the number of days homeless decreased from 365.5 days to 331.8 days between PY3-PY4. Clients receiving housing sustainability services averaged 74.6 days in independent living or permanent supportive housing. Among clients receiving housing sustainability services, 82.8% sustained housing for 6 months or more.

Challenges: As noted above, WPC staff have had delays in analyzing all the universal metrics. It is expected that these results are forthcoming.

Lessons Learned: Any delay in the process of data collection anywhere along the chain of the project will cause delays in data collection and analysis for the whole project

Metrics tied to Payment:

1) "15% reduction in ER utilization": In PY3, Orange County was to modify the metric to reflect a decrease in ER utilization from the previous year. The reduction was only 1% for ER utilization as compared to PY 3. The lower reduction was expected due to education activities for providers on alternative community-based medical care as described in the PDSA. As a result, Orange County is unable to claim the $87,225 for the outcome associated with achieving its ER utilization reduction over the previous year.
2) "25% of persons newly admitted to Recuperative Care will receive a Comprehensive Care Plan upon discharge": Almost 100% of our clients admitted

to Recuperative Care to date receive a Comprehensive Care Plan upon discharge in PY4 (some leave of their own accord within a day or two of admission, so it is not possible to achieve this with these clients whom exit on their own accord.

3) *Housing Services*

a. Clients engaged in Housing Navigation- Goal 54: Actual 87

b. Number of Clients Housed – Goal 36: Actual 86

c. Number receiving Peer Mentoring – Goal 70: Actual: 159

d. Number Sustaining Placement > 6 months – Goal 35: Actual 149 (cumulative from PY 3)

Total budgeted: $969,757 Total amount claimed: $882,532

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.

Date	Activity
July 26, 2019	WPC Collaborative WPC New Format Discussion WPC Updates Round 3 Funding Safety Net Connect
August 23, 2019	WPC Collaborative WPC Updates WPC Evaluator Update Program Dashboard Data Metrics Recuperative Care
September 4, 2019	Jail Release Recuperative Care Meeting Existing Services from Correctional Health Services New Services-Jail Release Recuperative Care
September 6, 2019	Core Care Coordination Review of Core Care Coordination Scope of Work
September 18, 2019	Jail Release Recuperative Care Meeting Target Population Overview of the Jail Release Recuperative Care Overview of Illumination Foundation Overview of Project Kinship Overview of Correctional Health Services Referral process prior to release dates/discharge planning Background check for Illumination Foundation (staff) who are assigned to Jail Release

Date	Activity
September 20, 2019	WPC Collaborative WPC Housing for Non-Behavioral Health Clients
September 20, 2019	HHP/WPC Crossover
September 24, 2019	Community Referral Network Meeting
September 27, 2019	Core Care Coordination
October 9, 2019	Jail Release Recuperative Care Meeting Discussion of Draft PHQ-9 Referral for WPC Clients in Recuperative Care
October 15, 2019	Jail Release Recuperative Care Meeting Admission Criteria to Pearl House and the Orange County Rescue Mission
October 18, 2019	HHP/WPC Crossover Background and Timeline Eligibility and Enrollment Services Outreach and Engagement Program Future
October 24, 2019	Jail Release Recuperative Care Meeting Discussion of the types of clients-Correctional Health Services Jail Release SMI and SUD Expectations and Limitations Transportation Linkages-Adult Behavioral health services Type of Mental health conditions for SMI
October 25, 2019	HHP/WPC Crossover
November 4, 2019	HHP/WPC Crossover
November 15, 2019	WPC Collaborative PHQ-9 Recuperative Care Safety Net Connect HHP Select Services – RFP
November 15, 2019	HHP/WPC Crossover

Date	Activity
November 20, 2019	HHP/WPC Crossover Case Management Core Care Coordination Health Promotion Comprehensive Transitional Care Individual and Family Support Services Referral to Community and Social Supports
December 2, 2019	WPC Housing Collaborative Updates on Contracts and Service Delivery Referral, Navigation and Sustainability Process WPC Connect Demonstration RFA Release
December 13, 2019	HHP/WPC Crossover Outreach and Engagement for HHP Members Experiencing Homelessness Housing Navigation and Sustainability Services Accompaniment Services Non-Medical Transportation Care Coordination Participation
December 30, 2019	HHP/WPC Crossover

VIII. PROGRAM ACTIVITIES

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

1. The onboarding of additional providers to the WPC project has allowed for increased care coordination of all client needs.
2. The WPC Program has expanded to include housing-related services and related coordination of housing services.

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

1. The biggest challenges to care coordination continues to be the use of WPC Connect by the non-WPC funded providers as they did not have an incentive to enter their data into the data system.

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

1. In 2019, 27 new Business Associate Agreements were signed with Orange County providers. This increases the amount of data that is shared between WPC providers.

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

1. Similar to the challenge with care coordination, the biggest challenges to data sharing continues to be the use of WPC Connect by the non-WPC funded hospitals as they did not have an incentive to enter their data into the data system

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

1. All of the funded WPC providers began utilizing WPC Connect for data collection, data sharing between providers and reporting. NOTE: The reluctance noted above is for non-WPC funded hospitals.
2. The Housing Navigators and Sustainability providers have created a universal data collection/referral form

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

1. Some providers are concerned staff burden related to data collection required by the program and subsequently not consistently providing data for the project.

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

SUSTAINABILITY AFTER WPC ENDS

Achieving desirable outcomes after transition to the Managed Care plan under Cal-AIM

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:

Below is a list of the PDSA's that occurred during PY1-PY4.

- OCPDSA 1 – UHM: Ambulatory Care (AMB) – Emergency Department Visits PY4 Quarters 1-2
- OCPDSA1 – UHM Ambulatory Care PY4 Quarters 3-4
- OCPDSA 2 – UHM: Inpatient Utilization – General Hospital/Acute Care (IPU) PY4 Quarters 1-2
- OCPDSA2 – UHM Inpatient Utilization PY4 Quarters 3-4
- OCPDSA 3 – UHM: Follow-up After Hospitalization for Mental Illness (FUH) PY4 Annual-DELETED
- OCPDSA 4 – UHM: Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET) PY4
- Annual-DELETED
- OCPDSA 5 – UAM: Beneficiaries with Comprehensive care plan, accessible by the entire care team, within 30 days of enrollment and annually PY4 Annual
- OCPDSA 6 – UAM: Care Coordination, Case Management, and Referral Infrastructure PY4 Annual
- OCPDSA 7 – UAM: Data and Information Sharing Infrastructure PY4 Annual
- OCPDSA 8 – VAM: Members in Recuperative Care linked to CalOptima Case Management PY4 Annual
- OCPDSA 9 – VHM: 30-Day All Cause Readmissions PY4 Annual
- OCPDSA 10 – VHM: Comprehensive Diabetes Care PY4 Annual
- OCPDSA 11 – VHM: Suicide Risk Assessment PY4 Annual
- OCPDSA 12 – VHM: Housing Supportive Services PY4 Annual
- OCPDSA 13 – OAM: Link all WPC Beneficiaries referred to Recuperative Care to a CalOptima Case Manager PY4 Annual – Duplicate of PDSA 5 - Deleted
- OCPDSA 14 – OHM: Increase in Primary Care Physician (PCP) Office Visits PY4 Annual

- OCPDSA 15 – OHM: Increase in Appropriate Medication Utilization PY4 Annual – Combined with PDSA 14 - Deleted
- OCPDSA 16 – OHM: Increase in Recuperative Care Beneficiaries Completing Assessments for Coordinated Entry Process PY4 Annual
- OCPDSA 17 – OAM: Percent of Referrals from WPC Participating Entities Linked to Behavioral Health Services PY4 Annual
- OCPDSA 18 – OHM: For WPC SMI Population, Decrease in Number of Days for Psychiatric Hospitalization PY4 Annual
- OCPDSA 19 – OHM: For WPC SMI Population, Reduction in Depressive Symptoms as Measured by the Symptom Distress Subscale for Beneficiaries Scoring in the Clinic Range PY4 Annual
- OCPDSA 20 – OHM: For WPC SMI Population, Decrease in the Number of Mental Health Emergencies Experienced PY4 Annual
- OCPDSA 21 – OHM: For WPC SMI Population, Decrease in the Number of Days Homeless PY4 Annual
- OCPDSA 22 – OHM: For WPC SMI Population, Increase in the Number of Days in Independent Living or Permanent Supportive Housing PY4 Annual
- OCPDSA 23 – Communication with Recuperative Care Partners Regarding the Entry of Clients into Recuperative Care PY4 Annual
- OCPDSA 24 – UAM: Defining Core Care Coordination CCC PY4 Annual
- OCPDSA 25 – Housing PY4 Annual