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 5
Submitted: April 29, 2021
Revised: June 30, 2021

REPORTING CHECKLIST

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

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

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

I. REPORTING INSTRUCTIONS

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

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

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

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

II. PROGRAM STATUS OVERVIEW

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

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

Increase Integration:

Successes: In 2020, WPC staff transitioned to virtual monthly meetings with the medical, behavioral health, social service, and housing providers due to COVID 19 restrictions. These meetings focused on topics such as access and referrals to recuperative care, housing services, and care coordination with the client's health plan. These monthly meetings increased communication between organizations and allowed WPC staff and providers to share best practices and updates. In addition, the WPC Pilot Program met with multiple interested community partners, to expand the WPC provider community within our housing services.

The use of WPC Connect Platform has improved the integration of data into one system used by multiple providers such as clinics, hospitals, housing providers, and recuperative care providers. This has also improved service provision among the agencies in the county by allowing providers to share data and access real-time Admit, Discharge, and Transfer (ADT) data from 10 local hospitals that improves timely treatment planning and coordination of the transfer of care for the client.

Challenges: While 18 of the county's 25 hospitals have been on boarded onto WPC Connect, currently seven of the 15 hospitals are using the data system. The 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: Regardless of program you are running, you need one mandated system that everyone is obligated to use.

Increase Coordination/Access to Care:

Successes: The largest success related to access to care and increasing coordination of the housing navigation and sustainability program. Another success was the addition of providers to the WPC program. During PY5, nine new Business Associate Agreements were signed with Orange County providers. The addition of these partners increases care coordination for the WPC clients. In addition, WPC staff trained the Office of Care Coordination and all the housing providers on the use of the WPC Connect Platform.

Challenges: The biggest challenge to care coordination has been the pandemic which has affected the ability of providers to conduct in-person warm handoffs with clients and transport them to needed services.

Lessons Learned: Identifying the relevant data that needs to be tracked and recorded.

Reduce inappropriate ER/Inpatient Utilization:

Successes: Emergency department utilization has decreased substantially since PY2. From PY2 to PY5, emergency department utilization decreased 48.9%. There was a 32.5% decrease from PY4 and a 33.2% decrease from PY3.

There were similar trends regarding inpatient utilization, which has also steadily decreased since PY2. For example, there was a 50.8% decrease in inpatient utilization compared to PY2; a 41.4% reduction from PY3; and a 35.3% reduction compared to PY4.

Challenges: As the metrics provided here are in aggregate form, it is not possible to analyze subgroup differences such as which type of WPC clients are performing best on the metrics. In addition, not having direct access to these data delays WPC's ability to analyze and report these.

Lessons Learned: Case level data is crucial for examining reasons behind trends and the impact of different populations on the indicators. Having direct access is necessary for being able to report on the impact of the WPC program on the target population and in a timely fashion.

Improved Data Collection/Sharing:

Successes: With more providers actively using WPC Connect, more efficient care coordination efforts began to evolve. In addition, WPC staff have been partnering with other agencies and departments in Orange County in the development of a more robust care coordination and data sharing platform.

Challenges: With the onset of the COVID pandemic, several providers reported challenges with their ability to input data into the WPC Connect Platform due to staff reductions.

Lessons Learned: You need one mandated system that everyone is obligated to use. Early on during a project, it is crucial to identify the relevant data that needs to be tracked and recorded. Crucial to tie care coordination data to billing.

Achieve Quality/Administrative improvement benchmarks:

Successes: Standardization of the programmatic monthly reporting by the housing providers significantly improved the quality of the administrative data.

Overall, the Orange County WPC program met all proposed benchmarks such as reduction in emergency room and inpatient utilization, housing as discussed below.

Challenges: Having direct access is necessary for being able to report on the impact of the WPC program on the target population and in a timely fashion.

Lessons Learned: Crucial to not only examine data from the system and programmatic reports in order to reconcile monthly billing.

Increase Access to Housing & Supportive Services:

Successes: The biggest success in the housing arena for 2020 was the solicitation and master agreement allowing for successful negotiation with four providers for the provision of housing navigation and supportive services.

Challenges: There are several challenges encountered by the housing providers such as client documents such as birth certificates, driver's license, social security cards, etc and income which can either delay the obtainment of a housing voucher or make the client ineligible for housing vouchers.

Lessons Learned: It is important to provide housing and document readiness immediately after the client is referred for matching to a housing voucher, to facilitate a warm handoff between providers, improve client engagement and minimize the risk of the voucher expiring due to these kinds of delays as they are time sensitive.

Improve Health Outcomes:

Successes: Due to contractual implementation of the PHQ-9 depression and suicide screening tool, increased administration by WPC recuperative care providers to WPC members, and increased data entry into the WPC Connect Platform by WPC recuperative care providers of PHQ-9 assessments, more WPC members were screened for possible behavioral health and mental health issues that we may not have otherwise been aware of.

Challenges: There were several onboarding challenges with providers such as training staff to on how to use the PHQ-9 in the WPC Connect Platform, getting providers to consistently administering and collecting PHQ-9 data.

Lessons Learned: Lack of direct access to quality data such as HEDIS, behavioral health services data and lack of significant sample of PHQ-9 and other metrics limits our ability to analyze and compare meaningful data related to health outcomes. Having a singular, mandated data system for data still seems to be the best possible solution.

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	197	233	166	178	125	169	1068

Item	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12	Annual Unduplicated Total
Unduplicated Enrollees	213	86	158	63	112	102	834

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 5 (no prior enrollment in PY 2, PY 3, or PY 4).

Given this understanding, the numbers reported reflect only those person enrolled in Orange County's WPC Program for the very first time in PY 5.

*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.*

FFS	Month 1	Month 2	Month 3	Month 4	Month 5	Month 6	Total
Service 1: $152.21/ bed day	$458,760.94	$449,780.55	$541,715.39	$546,129.48	$463,479.45	$373,979.97	$2,833,845.78
Utilization 1	3,014	2,955	3,559	3,588	3,045	2,457	18,618
Service 2: $2,676.17/client	*	*	*	*	*	*	$37,466.45
Utilization 2	*	*	*	*	*	*	14

Costs and Aggregate Utilization for Quarters 3 and 4

FFS	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12	Annual Total
Service 1: $152.21/ bed day	$324,511.72	$327,555.92	$317,966.69	$292,395.41	$252,973.02	$168,344.26	$4,517,120.95
Utilization 1	2,132	2,152	2,089	1,921	1,662	1,106	29,680

Costs and Aggregate Utilization for Quarters 3 and 4

FFS	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12	Annual Total
Service 2: $2,676.17/client	*	$85,637.59	$42,818.80	$58,875.85	*	$42,818.80	$323,817.15
Utilization 2	*	32	16	22	*	16	121

*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	$121	$347,875.00	$318,714.00	$292,094.00	$287,859.00	$290,642	$272,492	$1,821,413.00
MM Counts 1		2,875	2,634	2,414	2,379	2,402	2,349	15,053
Bundle #2	$216	$16,200	$25,272.00	$23,544.00	$11,448.00	$7,128.00	$24,840.00	$108,432.00
MM Counts 2		75	117	109	53	33	115	502
Bundle #3	$207.50	$43,575	$41,292.50	$41,292.50	$27,805.00	$18,882.50	$19,297.50	$196,295.00
MM Counts 3		210	199	199	141	99	98	946
Bundle #4	$1,594	$44,632.00	$57,384	$65,354.00	$51,008.00	$35,068.00	$51,008.00	$304,454
MM Counts 4		28	36	41	32	22	32	191

Amount Claimed for Quarters 1 and 2

PMPM	Rate	Month 1	Month 2	Month 3	Month 4	Month 5	Month 6	Total
Bundle #6	$960	$102,720.00	$134,400.00	$151,680.00	$158.400.00	$121,920.00	$190,080	$859,200
MM Counts 6		107	140	158	165	127	198	895

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	$121	$272,613.00	$259,666.00	$251,438.00	$237,160.00	$231,160.00	$232,925.00	$3,306,446.00
MM Counts 1		2,253	2,146	2,078	1,960	1,912	1,925	27,327
Bundle #2	$216	$23,976.00	$27,216.00	$28,512.00	$30,024.00	$30,240.00	$33,048.00	$281,448.00
MM Counts 2		111	126	132	139	140	153	1,303
Bundle #3	$207.50	$17,845.00	$17,637.50	$16,392.50	$14,110.00	$13,072.50	$13,280.00	$288,632.50
MM Counts 3		86	85	79	68	63	64	1,391
Bundle #4	$1,594	$54,196.00	$55,790.00	$49,414.00	$44,632.00	$43,038.00	$39,850.00	$591,374.00

Amount Claimed for Quarters 3 and 4

PMPM	Rate	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12	Annual Total
MM Counts 4		34	35	31	28	27	25	371
Bundle #6	$960	$278,400.00	$338,880.00	$344,640.00	$361,920.00	$356,160.00	$362,880.00	$2,902,080.00
MM Counts 6		290	353	359	377	371	378	3,023

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 numbers include only those considered "initially enrolled" in the WPC Program during PY 5 (no prior enrollment in PY 2, PY 3, or PY 4). Given this understanding, the numbers reported reflect only those persons enrolled in Orange County's WPC Program for the very first time in PY 5.

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 5. With additional funding allocated through WPC Round 3, Orange County proposed providing 27,266 bed days. A total of 29,680 bed days were actually provided, which is 108% 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 $152.21. WPC receives additional outside funding for recuperative care, so only the net amount is billed to WPC. However, since a lower rate was used for the first six months (due to estimating the amount of non-WPC revenues to be received), the amount for the balance of the funding was calculated at $184.79 per bed day for the annual invoice which also reconciles the first 6 months for an annual total of $4,516,983.96 (with a rounding error variance of $29.94).

While $184.79 is greater than the negotiated rate of $180.50 per bed day, the actual rate per bed day for all of PY 5 is $152.21.

FFS #2 –Move In Bundle: This FFS category was approved effective July 1 2019 with an additional allocation of WPC funds. The WPC Program has been working collaboratively with the Housing Authorities in Orange County and have been allocated housing vouchers specifically for our clients. In PY 5, 121 clients received support from funds available through the Move-In Bundle averaging $2,676.17 per client which is less than the maximum available of $4,500 per client.

PMPM:

PMPM #1 – Hospital & Clinic Homeless Navigation Services: Orange County's PY 5 target member months for this service is 44,147 and the actual number of member months provided was 27,327. The large variance in the actual number of member months is directly attributeable to the impact of COVID-19 and directly corresponds to the significant reduction in hospital emergency departments and inpatient utilization also seen in PY 5. As a result of capacity reduction efforts for homeless shelters and known homeless congregations, WPC Beneficiaries who had been receiving homeless navigation services through specific staff located in the emergency departments and through community clinics had instead been diverted to other homeless programs specifically set up for COVID mitigation, resulting in a significant decrease in the number of member months in this category.

PMPM #2 – Drop-In Center Supportive & Linkage Services: Orange County's PY 5 target member months for this service was 1,464 and the actual number of member months provided was 1,303. The variance in the actual number of member months is directly attributeable to the impact of COVID-19. As a result of capacity reduction efforts for homeless shelters and known homeless congregations, WPC Beneficiaries who had been receiving homeless navigation services through the Drop-In Centers had instead been diverted to other homeless programs specifically set up for COVID mitigation, resulting in a decrease in the number of member months in this category as the capacity of the centers decreased to accommodate social distancing requirements.

PMPM #3 – SMI Specific Outreach and Navigation Services provided by County Outreach and Engagement Staff: Orange County's PY 5 Annual member months for this service was 5,254 and the actual number of member months provided was 1,391. The variance in the actual number of member months is directly attributeable to two factors: 1) the impact of

COVID-19 and 2) the difficulty in enrolling more “service resistive” clients into the WPC Program. As a result of capacity reduction efforts for homeless shelters and known homeless congregations, WPC Beneficiaries living with SMI had been receiving outreach and engagement services at shelters, Drop-In Centers, and in the community, including encampments. Due to social distancing requirements, Outreach staff were limiting their activities and these clients were also diverted to other homeless programs specifically set up for COVID mitigation, reducing the volume of clients remaining in shelters, Drop-In Centers, and encampments..

Secondly, with the success of the WPC Program, beneficiaries open to working with the outreach staff had been successfully moved to SMI clinics and receiving services. The remaining clients in the field are more service resistive and take more time and effort for the outreach staff to build relationships before they can offer any WPC services.

PMPM #4 –Jail In-Reach and Release Services: These are new services funded through the WPC Round 3 funds and the target member months for PY 5 is 621 member months. Actual reporting came in at 371 member months and, as with other PMPM categories, is attributable to COVID-19 and social distancing requirements.

PMPM #5 – Core Care Coordination Services: This program was deleted due to implementation of Health Homes.

PMPM #6 –Housing Navigation & Sustainability Services: These are new services funded through the WPC Round 3 funds and the target member months for PY 5 is 1,858 member months. Due to WPC’s partnership with four Housing Authorities in Orange County providing vouchers specifically for WPC enrollees who are medically fragile, actual member months for this line item far exceeded projections at 2,139 member months. Due to the reductions in the above PMPMs, Orange County WPC is requesting consideration of moving funding to this PMPM line item, and the PMPM remains underexpended for PY 5..

Revised quarterly Utilization and Enrollment reports for 2020 have been submitted to correspond with the above numbers.

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 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. CRN is currently receiving referrals from 114 agencies, with 21 of them being new additions in PY5.

In PY5, the WPC-funded social services component of the CRN processed **591** social service referrals. The impact of COVID during PY5 can be seen by the appearance of COVID-related. The highest percentages of services during PY5 were COVID-related (23.5%), followed by behavioral health (19.3%), dental-related (17.9%), health insurance-related (13.0%), health-related (11.0%), food and clothing *, and health-related *. Less than * of the referrals were education or employment related, legal related, or supportive services.

(Chart redacted)

WPC Connect:

eReferral and Case Management Coordination
Secure messaging between organizations to coordinate patient care.
Client service tracking and outcome reporting
Authorization module to approve and track recuperative care services and utilization.
Bed Availability Feature to display Recuperative Care beds available for stays
Assessments - PHQ-9, PRAPARE, and VI-SPDAT
Housing client tracking of awarded vouchers
Document repository to store client documents
Utilization and activity reporting

Data Connections:

- *Loads Enrollment Medi-Cal and Health Homes Program Data from the County Health Plan (CalOptima)*
- *Service feed from Behavioral Health Services*
- *Admit, Discharge, and Transfer (ADT) hospital data feeds from10 local hospitals*

- *Linked to the Community Resource Network (CRN)*

WPC Providers by Type:

- *15 Hospitals and Medical Centers*
- *10 Federally Qualified Health Centers and community clinics*
- *5 Recuperative Care Sites*
- *County Health Plan*
- *4 Shelters*
- *11 Housing Sustainability Providers*
- *5 Community Resource Providers:*
  - *Behavioral Health Services*
  - *Correctional Health services*
  - *Inmate Re-entry program*
  - *Public Health Nurses*
  - *Hospital community support service provider.*

The vendor conducts workflow analysis prior to each training to further increase system adoption for each WPC Provider.

Homeless Data Integration

WPC staff, along with WPC's software developer Safety Net Connect staff, collaborated with other County agencies and departments in the development of the System of Care Data and Integration System (SOCDIS) which is an enhanced care coordination platform which will serve as succession solution for WPC Connect following conclusion of the pilot.

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.

Recuperative Care: The target for this was reached for the mid-year invoice. No additional funds are being claimed.

Hospital and Community Clinic Navigation – The target for this incentive reflected the addition of new hospital providers to the WPC Connect platform and to see additional WPC beneficiaries that would have been reflected in the member months. As indicated above under the PMPM write up, COVID and its corresponding mitigation strategies resulted in fewer member months than projected. However, the hospitals did come onto the platform, received training, and have been actively participating as clients present so this incentive of $73,527.55 was earned and paid to county partners that support the work of several agencies/departments within the system

Housing Navigation and Sustainability – Non-SMI Program Capacity – The target for this was reached for the mid-year invoice. No additional funds are being claimed.

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.

Metrics tied to Payment:

1) "20% reduction in ER utilization over PY 4": The reduction was 32.5% for ER utilization comparing PY 5 to PY 4. The PY4 rate according to DHCS data was 344.24. The PY5 rate was 300.88, resulting in a 12.60% decrease. Since this payment is earned based on DHCS data, this metric was not achieved.
2) "85% 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 PY5 (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). Amount earned for Mid-year was $43,612.50 and $90,834.42 was earned for the annual invoice.
3) Recuperative Care - BHS Focused – Goal occupancy % achieved December 31 of each PY. The goal occupancy for BH focused recuperative care is 70%. The occupancy percentage achieved by December 31 for PY5 is 70.88%, thus meeting our goal. This percentage reflects a decrease from PY4 which was at 79.03% and attributed to the impact of the COVID-19 pandemic during 2020.
4) Housing Services
   a. Clients engaged in Housing Navigation- Goal 120: Actual 221. Thus, the goal was surpassed within the first six months of PY5. Amount earned for Mid-year was $177,252, and $44,313.05 was earned for the annual invoice.
   b. Number of Clients Housed – Goal 80: Actual 233. Amount earned for Mid-year was $177,253, and $44,313.25 was earned for the annual invoice.
   c. Number receiving Peer Mentoring – Goal 145: Actual: 234. Amount earned for Mid-year was $177,253, and $44,313.25 was earned for the annual invoice.
   d. Number Sustaining Placement > 6 months – Goal 77: Actual 203. In 2020, 203 of the 247 clients who enrolled on or before June 30, 2020 to be eligible

for this benchmark (82.2%) individuals sustained their placement for six months or longer. Thus, WPC met this metric Amount earned for Mid-year was $108,124.33 and $113,441.92 was earned for the annual invoice.

Universal Metrics:

Ambulatory Care- Emergency Department (AMB-ED)-COMPLETED
Inpatient Utilization – General Hospital/Acute Care (IPU)-COMPLETED
Follow-Up After Hospitalization for Mental Health- COMPLETED
Initiation and Engagement of Alcohol and Other Drug Dependence-PENDING, TO BE COMPLETED BY MAY1 PER DISCUSSION WITH DHCS
Comprehensive Care Plan-COMPLETED

Achieved: As noted earlier WPC continued to see a decrease in rates of Ambulatory Care-Emergency Department and Inpatient Utilization. Emergency department utilization has decreased substantially since PY2. From PY2 to PY5, emergency department utilization decreased 48.9%. There was a 33.2% decrease from PY3 and a 32.5% decrease from PY4.

There were similar trends regarding inpatient utilization, which has also steadily decreased since PY2. For example, there was a 50.8% decrease in inpatient utilization compared to PY2; a 41.4% reduction from PY3; and a 35.3% reduction compared to PY4.

For the first time, WPC staff were able to analyze and present rates for Follow-Up After Hospitalization for Mental Health. There were 519 psychiatric hospitalizations in 2020 to WPC Clients and 342 WPC clients with a follow up visit within 30 days of psychiatric hospital discharge, a 66% follow-up rate after hospitalization for mental health.

The majority of clients (93.7%) receive a Comprehensive Care Plan when they enroll in WPC. This Care Plan is facilitated through the use of the WPC Connect Platform, which allows providers to coordinate the care of incoming and existing clients. In 2020, there were 5,537 WPC clients that received Comprehensive Care Plans.

Challenges: WPC staff have had delays in analyzing all the universal metrics due to a corrupt data file within the Behavioral Services department at the county. 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. It is also crucial for project staff to have direct access to data sets in order to remove delays in receiving data.

(Chart redacted)

Variant Metrics:
Comprehensive Diabetes Care- PRELIMINARY DATA, FINAL METRIC IS DELAYED DUE TO REQUIRING INDIVIDUAL CASE REVIEWS. WILL BE SUBMITTED AS SOON AFTER APRIL 1 PER DISCUSSION WITH DHCS
Depression Readmission at 12 Months- PARTIALLY COMPLETED
Major Depressive Disorder-Suicide Risk Assessment- PENDING, TO BE COMPLETED BY MAY1 PER DISCUSSION WITH DHCS
Housing Services- COMPLETED
All Cause Readmission- COMPLETED

Achieved: As noted above, Comprehensive Diabetes Care data is preliminary at the time of this report submission. Collecting and reporting this data requires hand review of case files. The final metric will be updated as soon as the hand review are completed. The preliminary data shows that compared to PY2, there was a 25.2% decrease in the number of WPC clients who had an HBA1c of greater than 8%.This decrease widened to 26.7% in PY3. Compared to PY4, there was a 16.9% decrease in number of WPC clients who had an HBA1c of greater than 8%.

WPC implemented contractual requirements at the end of 2019 to require recuperative care providers to administer the PHQ-9 depression-screening tool to WPC clients. As a result, 2020 saw an increase in the number of PHQ-9 assessments completed by WPC clients compared to prior year. Once the other DHCS denominator and numerator criteria were applied to the data, no clients met the criteria for the numerator. It is anticipated that PY6 results for this metric will be better with significantly higher 2020 and 2021 PHQ-9 numbers to use for the calculation.

[GRAPH REDCATED]

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 2020, 78.5% of clients referred for housing services, received those services.

Lastly, all cause readmissions decreased 0.8% in PY5 compared to compared to PY4, 54.5% decreased compared to PY3, 56% decreased compared to PY2, and 54.5% from baseline.

Challenges: The largest challenges related to these metrics are the insufficient sample size to analyze the PHQ-9 metric and the intensive time required to conduct individual case reviews for the diabetes metric

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. It is also crucial for project staff to have direct access to data sets in order to remove delays in receiving data.

Optional Metrics:
Members Linked to Case Management- COMPLETED
Percent of Referrals Resulting in Linkage to Services from County Behavioral Health-COMPLETED
Increase in Primary Care Physician Office Visits-PENDING
Number of Days Psychiatrically Hospitalized-COMPLETED
Number of Days in Independent Living or Permanent Supportive Housing-COMPLETED
Number of Homeless Days- NOT COMPLETED

Achieved: All clients (100%) receive case management when they receive WPC services. This case management is facilitated through the use of the WPC Connect Platform which allows providers to coordinate the care of incoming and existing clients. In 2020, there were 5,910 WPC enrollees that received case management.

For the first time, WPC staff were able to calculate the Percent of Referrals Resulting in Linkage to Services from County Behavioral Health and Number of Days Psychiatrically Hospitalized. In 2020, 35% of the WPC clients had at least one behavioral health visit. In addition, among clients psychiatrically hospitalized, they averaged 24.61 days per visit.

Clients receiving housing sustainability services averaged 185.3 days in independent living or permanent supportive housing in 2020. The majority of non-BHS clients were ongoing in sustainability as they did not begin housing services until 2020.Among clients receiving housing sustainability services on or prior to June 30, 2020 (those eligible to reach six months), 82.2% sustained housing for six months or more.

Challenges: 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: Increase in Primary Care Physician Office Visits, Number of Homeless Days.

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

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 9, 2020	**HHP Engagement Seminar** Overview of the Health Home Programs (HHP) HHP Targeted Engagement Process Engagement of HHP Clients by WPC Providers
July 10, 2020	**WPC Collaborative** WPC Updates Safety Net Connect WPC PY4 Annual Report Update Housing Update
July 13, 2020	**Housing Navigation and Sustainability Collaborative Meeting** Update on Mainstream Vouchers WPC and HHP Handoff Process WPC Connect Invoice Questions
July 24, 2020	**Orange County Continuum of Care Housing Opportunity Committee Continuum of Care (Coc)** CoC Committee Survey Review Change to Agenda Structure Project-Based Housing Updates Project Homekey Update and Information Gathering OC Housing Finance Trust Update and Information Gathering OC Housing Trust Update and Information Gathering MHSA and NPLH Update and Information Gathering PHA Project-Based Vouchers Updates and Projection Tenant-Based Housing Updates Welcome Home OC Update and Information Gathering Whole Person Care Update and Information Gathering PHA Special Purpose Voucher Updates

County-wide Performance Metrics Update
Legislative Activity Updates
Update on UCI Affordable Housing Impact Study
State California NOFA Calendar Review

August 7, 2020 **WPC Collaborative**
WPC Updates
Safety Net Connect
WPC PY4 Annual Report Update
Housing Update

August 10, 2020 **Housing Navigation and Sustainability Collaborative Meeting**
Update on Mainstream Vouchers
Health Home Clients (HHP)
Project Room Key
WPC Connect
Invoice Questions

September 3, 2020 **Intro to SOCDIS Meeting**
General Overview
Integration of Data from WPC Connect
Questions and Answers

September 11, 2020 **WPC Collaborative**
WPC Updates
Safety Net Connect
WPC PY5 Mid-Year Report Update
Housing Update

September 14, 2020 **Housing Navigation and Sustainability Collaborative Meeting**
Contract Management
State Updates
Contract Amendment
Update on Mainstream Vouchers
WPC Connect
Invoice Questions

September 25, 2020 **Orange County Continuum of Care Housing Opportunity Committee Continuum of Care (Coc)**
Project-Based Housing Updates
Project Homekey Update and Information Gathering
OC Housing Finance Trust Update and Information Gathering
OC Housing Trust Update and Information Gathering

MHSA and NPLH Update and Information Gathering
PHA Project-Based Vouchers Updates and Projection
Tenant-Based Housing Updates
Welcome Home OC Update and Information Gathering
Whole Person Care Update and Information Gathering
PHA Special Purpose Voucher Updates
County-wide Performance Metrics Update
Legislative Activity Updates
County-wide Performance Metrics Update
State California NOFA Calendar Review

October 1, 2020 **SOCDIS Program Participation & Associated Services (SNC)**
Integration of Data from WPC Connect
Questions and Answers

November 9, 2020 **Housing Navigation and Sustainability Collaborative Meeting**
WPC Pilot Program
State Updates
WPC Connect
Update on Mainstream Vouchers
Contract and Invoice Questions

November 12, 2020 **Recuperative Care Collaborative Meeting**
WPC Pilot Program
Program Updates and Changes

November 19, 2020 **HASC and Hospital SB1152 Committee Meeting**
Homeless Services Updates

- Office of Care Coordination
  - Project RoomKey
- Whole Person Care
  - WPC Pilot Extension
  - Recuperative Care Updates

Roundtable Discussion
Questions and Answers

November 20, 2020 **WPC Collaborative**
WPC Administrative Updates and Next Steps
Safety Net Connect
Housing Update

December 10, 2020 **Orange County Continuum of Care Housing Opportunity**

Committee Continuum of Care (Coc)
Project-Based Housing Updates
Project Homekey Update
OC Housing Finance Trust Update
MHSA and NPLH Update
PHA Project-Based Vouchers Updates and Projections
Tenant-Based Housing Updates
Welcome Home OC Update and Information Gathering
Whole Person Care Update and Information Gathering
PHA Special Purpose Voucher Updates
County-wide Performance Metrics Update
Homeless Housing, Assistance and Prevention (HHAP) Funding
Recommendation for Homeless System Improvement Strategy

December 14, 2020 **WPC HASC and Hospitals Homeless Services Collaborative Meeting**

- Whole Person Care
  - WPC Pilot Extension
  - Recuperative Care Updates

Roundtable Discussion
Questions and Answers

December 16, 2020 **Care Plus Program - Multi-Disciplinary Team (MDT)**
Launch Prep for SOCDIS
Launch Prep for Care Plus Program
Intro of Multi-Disciplinary Team (MDT) Members
System Training Launch Plan
Questions and Answers

PROGRAM ACTIVITIES

Care Coordination

A. Briefly describe 1-2 successes you have had with care coordination.
    1. The WPC Program continued to expand the scope of service provided to include housing-related services and coordination. Three additional providers were contracted for HNSS during this reporting period.

B. Briefly describe 1-2 challenges you have faced with care coordination, and lessons learned from those challenges.
    1. A significant challenge was transition from in-person to virtual interaction due to pandemic (from LE through provider/client interactions).

Data Sharing

A. Briefly describe 1-2 successes you have had with data and information sharing.
    1. Increased the number of community partners accessing WPC Connect Platform.

B. Briefly describe 1-2 challenges you have faced with data sharing, and lessons learned from those challenges.
    1. Lack of direct access to certain data sets for analysis such as HEDIS and behavioral health related data.(incomplete data sets)

Data Collection

A. Briefly describe 1-2 successes you have had with data collection and/or reporting.
    1. Enhancement of WPC Connect Platform to include housing navigation and sustainability module.
    2. Improved PHQ-9 data collection by Recuperative Care Providers via the WPC Connect Platform increased depression and suicidal screening of clients.

B. Briefly describe 1-2 challenges you have faced with data collection and/or reporting.
    1. Various provider staffing challenges related to illness and turnover significantly impacted data entry and consistency of entries into WPC Connect Platform resulting from the pandemic.

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

The biggest barrier for the WPC Program overall is that the program is concluding and transitioning to the managed care plan.

VIII. 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:

- OCPDSA 1 – UHM: Ambulatory Care (AMB) – Emergency Department Visits PY5 Quarters 3-4
- OCPDSA 2 – UHM: Inpatient Utilization – General Hospital/Acute Care (IPU) PY5 Quarters 3-4
- OCPDSA 5 – UAM: Beneficiaries with Comprehensive care plan, accessible by the entire care team, within 30 days of enrollment and annually PY5 Quarters 3-4
- OCPDSA 6 – UAM: Care Coordination, Case Management, and Referral Infrastructure PY5 Annual
- OCPDSA 7 – UAM: Data and Information Sharing Infrastructure PY5 Annual
- OCPDSA 8 – VAM: Comprehensive Care Plan: Administrative: Proportion of participating beneficiaries with a comprehensive care plan, accessible by the entire care team, within 30 days PY5 Annual
- OCPDSA 12 – VHM: Other: Housing Services (Medi-Cal Homeless with SMI Beneficiaries) PY5 Annual
- OCPDSA 16 – OHM: Other: Housing Services (Medi-Cal Homeless Beneficiaries Admitted to Recuperative Care) PY5 Annual
- OCPDSA 17 – OAM: Care Coordination: Administrative: Care Coordination, case management, and referral infrastructure PY5 Annual
- OCPDSA 18 – OAM: Inpatient Utilization: Health Outcomes: Inpatient Utilization-General Hospital/Acute Care PY5 Annual
- OCPDSA 20 – OAM: Ambulatory Care: Health Outcomes: Ambulatory Care – Emergency Department Visits PY5 Annual
- OCPDSA 23 – UAM: Care Coordination: Administrative: Care coordination, case management, and referral infrastructure PY5 Annual
- OCPDSA 25 – UAM: Other: Housing Servicves (Medi-Cal Homeless Beneficiaries without SMI) PY5 Annual

(Chart redacted)

SUCCESS STORIES

[Client Picture Redacted to protect PI and PHI]

CLIENT SUCCESS STORY AT BLUE SKY MANOR

Client(s) were admitted at Blue Sky Manor on. [REDACTED].We assisted them with their medical appointments and helped them to find permanent shelters. We learned our client(s) are very ambitious. They never let their current situation change their mind about what they can to do in life.

Statement from the client(s):

"I was sent to Blue Sky and the staff at Blue Sky took very good care of [client(s)] medically helped us locate rooms for rent. The rooms were nice and the landlord is an amazing guy! Without Blue Sky and their caring staff, [we] wouldn't be where [we are] today."