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

Placer County Health and Human Services
Annual Narrative Report, Program Year 4
May 15, 2020

REPORTING CHECKLIST

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

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

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

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.

In 2019, the Placer WPC Pilot transitioned fully to the "Maintenance" Phase of development. WPC is fully-staffed, policies are written, and novel circumstances are managed adeptly through adapting existing processes when needed. Staff continue to provide excellent service to high-need, engagement-resistant clients. We continue to partner with community organizations and have developed a reputation as a reliable program with excellent follow through.

Increasing integration among county agencies, health plans, providers, and other entities

As has been the case in prior years, Placer WPC management, supervisor, and team members continue to meet regularly with community partners. Meetings and communications are regularly evaluated, with meeting frequency modified to meet program and partner needs. Team members have developed extensive work relationships with our various partners, creating additional flexibility and strength in the collaboration our program employs. These efforts continue to have positive impact on our integration with community partners.

Increasing coordination and appropriate access to care

Our collaboration with primary care partners continues to help us quickly arrange services for our members. We coordinate effectively and support member health care access and experience. Our integration with mental health services allows us to transition our acutely mentally-ill individuals to high level Full Service Partnership programs.

Reducing inappropriate emergency and inpatient utilization

WPC staff receive immediate e-mail notification when members go to regional hospitals. 96% of our members received a case management visit within seven days of going to the ED. Post-discharge from the ED or hospital admissions, case managers worked to link members to primary care, specialty care, and medical respite providers to reduce preventable ED visits.

Improving data collecting and sharing; achieving quality and administrative improvement benchmarks

Placer County fully integrated utilization of Avatar, our existing Electronic Health Record system. Part of our work during this period was helping the County develop infrastructure to modify and expand abilities to enter and retrieve data, helping the entire County. Information on important metrics is entered directly into the system at the time staff enter notes. As mentioned before, this reduced workload by eliminating additional paperwork, increased efficiency, and improved data tracking processes.

Additionally, we have developed partnerships and info sharing agreements with the local Sutter Hospitals and Chapa De Indian Health Primary providers to have access to medical records real-time, significantly improving info sharing and client services.

Increasing access to housing and supportive services

The WPC Housing Coordination Team expanded our landlord network in the community, building trusting relationships to increase their willingness to house our members, and continued to provide housing subsidies. We have engaged in extraordinary measures to ensure goodwill with our participating landlords. An example includes our willingness to work extensively with landlords during a bedbug outbreak that occurred to assist them in mitigation. We received additional grant funding in the amount of $1,000,000 from Sutter Health to purchase housing. Simultaneously, we've developed an RFP to provide additional supportive housing services.

Improving health outcomes for the WPC population

Our members continue to enjoy improved health outcomes compared to the general population. Members receive support related to appointment follow-up, medication assistance, and consultation with WPC nursing staff intimately familiar with their medical concerns. Medical Respite services operated at 7.1 beds (average per month) with capacity to meet additional needs as they arise.

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	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	11	48

Item	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12	Annual Unduplicated Total
Unduplicated Enrollees	36	13	27	[redacted]	[redacted]	13	148

*For **Fee for Service (FFS),** please report your total costs and utilization for each service. These reports should tie to your budget, invoice and utilization report. Add rows as needed.*

Costs and Aggregate Utilization for Quarters 1 and 2							
FFS	Month 1	Month 2	Month 3	Month 4	Month 5	Month 6	Total
Service 1	NA	NA	NA	NA	NA	NA	NA
Utilization 1	NA	NA	NA	NA	NA	NA	NA
Service 2	NA	NA	NA	NA	NA	NA	NA
Utilization 2	NA	NA	NA	NA	NA	NA	NA

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	NA	NA	NA	NA	NA	NA	NA
Utilization 1	NA	NA	NA	NA	NA	NA	NA
Service 2	NA	NA	NA	NA	NA	NA	NA
Utilization 2	NA	NA	NA	NA	NA	NA	NA

Whole Person Care

Placer County Division of Public Health
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*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: Comprehensive Complex Care Coordination	**$1,361**	**$95,270**	**$89,826**	**$93,909**	**$93,909**	**$95,270**	**$89,826**	**$558,010**
MM Counts 1		70	66	69	69	70	66	410
Bundle #2: Medical Respite Care Program	**$9,713**	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	**$407,946**
MM Counts 2								42
Bundle #3: Housing Services	**$1,757**	**$133,532**	**$122,990**	**$122,990**	**$131,775**	**$142,317**	**$144,074**	**$797,678**
MM Counts 3		76	70	70	75	81	82	454
Bundle #4: Engagement	**$2,176**	**$67,456**	**$67,456**	**$73,984**	**$80,512**	**$71,808**	**$80,512**	**$441,728**
MM Counts 4		31	31	34	37	33	37	203

Amount Claimed								
PMPM	**Rate**	**Month 7**	**Month 8**	**Month 9**	**Month 10**	**Month 11**	**Month 12**	**Total**
Bundle #1: Comprehensive Complex Care Coordination	$1,361	$92,548	$102,075	$106,158	$119,768	$130,656	$130,656	$681,861
MM Counts 1		68	75	78	88	96	96	501

Amount Claimed								
PMPM	**Rate**	**Month 7**	**Month 8**	**Month 9**	**Month 10**	**Month 11**	**Month 12**	**Total**
Bundle #2: Medical Respite Care Program	$9,713	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	$427,372
MM Counts 2		[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	44
Bundle #3: Housing Services	$1,757	$154,616	$165,158	$177,457	$187,999	$193,270	$195,027	$1,073,527
MM Counts 3		88	94	101	107	110	111	611
Bundle #4: Engagement	$2,176	$150,144	$128,384	$169,728	$ 141,440	$102,272	$104,448	$796,416
MM Counts 4		69	59	78	65	47	48	366

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

Placer County Whole Person Care continues to overenroll clients in direct services. This aligns with our program emphasis on the “whatever it takes” model. As our numbers indicate, we have exceeded our PMPM bundle goals. We effectively increased staff availability and improved effectiveness which resulted in significant successes.

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.

Expended funds for Administrative Infrastructure in 2019 were for the Staff Services Analyst (salary and benefits), the WPC Consultant, and indirect costs.

The Staff Services Analyst continues to work closely with the team to ensure timely and accurate data reporting, provide data analysis and interpretation, communicates regularly with the WPC consultant, and works closely with County IT staff to develop more effective data reporting/analysis methods.

Our data consultant, IDEA Consulting, meets with the staff analyst once a week to ensure data was recorded and tracked accurately. They also communicate with the manager to assist in other administrative services. These include report preparation and conducting collaboration surveys.

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.

Delivery Infrastructure funds during this period were expended on; Care Management Tracking and Reporting Portal, IT Workgroup, and Support and Space Costs.

Our Care Management Tracking and Reporting Portal is PreManage, an internet based platform from Collective Medical that is essential for us to meet our Pay for Outcome metrics as well as data for our universal and variant metrics.

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.

ASOC provides us with reports on inpatient psychiatric hospitalization, mental health treatment and diagnoses, and substance use services per quarter. ASOC provided reports on time during 2019. Reports provided by ASOC allowed us to verify that we met goals related to WPC metrics. Payments of $16,800 have already been earned by ASOC.

Incentive payments have also be made to California Health and Wellness for their reports in the amount of $525 for Program Year 4.

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 3challenges, and any lessons learned. Reimbursement will occur for achieved outcomes based on proposed annual target and methodology. Please limit your responses to 500 words.

The Placer WPC team continues to prioritize meeting all Pay for Outcome metrics and in 2019 we successfully accomplished all of those goals.

Variant Metric – All-Cause Readmissions (ACR): 65% of clients who are discharged from an index hospital stay and are not re-hospitalized within the next 30 days.

For PY4 we had [redacted] instances where members met criteria to be included in this metric. There were [redacted] that resulted in a rehospitalization within 30 days for a [redacted] ACR rate. Having [redacted] avoid a rehospitalization exceeded the PY4 goal of 65%. Our 24/7 medical respite program is essential in helping us meet this metric. Total earned: $36,755

Universal Metric – 70% of clients seen in the emergency department with a CCCC visit within 7 days.

There were 185 Emergency Department (ED) visits during this reporting period for members enrolled in Comprehensive Complex Care Coordination (CCCC). WPC followed up with the member within seven days of their ED encounter on [redacted] Total earned: $73,511

Universal Metric—Follow-Up After Hospitalization for Mental Health (FUH): 80% Clients with an SMI will receive CCCC service following discharge from psychiatric hospital within 30 days.

There were [redacted] discharges from a psychiatric hospital for WPC members. All [redacted] members received a CCCC service within 30 days of that discharge [redacted]. The PY4 goal was 80%.

We continue to have a low number of clients who receive psychiatric hospitalizations. One of the primary reasons for this is that we have continued to successfully refer seriously mentally ill individuals to Full Service Partnership (FSP) programs. Once the members are engaged with FSP they can receive the services they need from them and we discharge to avoid duplication of services. Total earned: $18,900

Universal Metric—Comprehensive Care Plan: 70% of members with a completed assessment and tailored plan of care within 30 days of enrollment to WPC (CCCC).

There were 53 new WPC members enrolled in CCCC. [redacted] new CCCC bundle members [redacted] received both a WPC Assessment and a Tailored Plan of Care within 30 days. Total earned: $136,598

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.

Adult System of Care (ASOC)

WPC team members meet with ASOC each week in a system collaboration meeting. We discuss shared cases, new programs, and how to better coordinate treatment. WPC and ASOC attend many of the same meetings and work together closely on various projects. An example of this was our Programs providing equal support to add a Contractor scheduled to add 24 more Permanent Supportive Housing beds.

Advocates for Mentally Ill (AMI) Housing

WPC sends two Housing Coordinators and the Housing Lead to meet with our contractor once per month to discuss housing updates and discuss programming decisions. In between these meetings, there are phone and in-person meetings to with our colleagues on an as needed basis as issues arise.

Anthem Blue Cross Updates

We have established collaborative monthly meetings with Anthem about data sharing and case management items.

California Health and Wellness Updates

Due to CHW availability, we have productive biannual phone calls and on-going contact to review to review data sharing and case management issues.

City of Roseville Housing Authority

The WPC manager, Housing Team lead, and a housing coordinator attend monthly meetings with City of Roseville Housing Authority. Multiple agencies involved with homelessness in Roseville also attend these meetings. Staff at the City of Roseville (along with ASOC) are taking a leadership role in the implementation of the 49 by 4/9 program and WPC regularly participates in those meetings as well.

Chapa De Indian Health Program

WPC Supervisor and case management leads meet monthly with Nursing and administrative staff to collaborate on shared clients and discuss areas where we can assist one another in meeting client needs.

Collective Medical Technologies (CMT)

CMT is our vendor for the PreManage program that provides ED notifications. The system is running well and we have phone meetings with them on as needed basis only.

The Gathering Inn (TGI)

WPC staff attend weekly case management meetings with shelter staff and community partners at both the Roseville and Auburn locations. WPC also participates in monthly meetings with TGI and Behavioral Health to improve system coordination.

HRCS (Housing Resource Council of the Sierras)

HRCS is the continuum of care for Placer and Nevada Counties. Several community partners participate in HRCS (Placer County, City of Roseville, PIRS, Stand Up Placer, AMIH, The Gathering Inn, Volunteers of America, ASOC, Sierra Foothills AIDS, Public Health, HHS Admin, and others). WPC management participates in the monthly HRCS meeting. The WPC manager and the Housing Team lead both attend HRCS data management meeting. WPC has recently started returning all phone calls received on the Continuum of Care (CoC) Coordinated Entry hotline. There had not been sufficient follow up on this line before WPC stepped in to make sure that it was happening.

Medical Respite

The Program Supervisor, a Public Health Nurse, and case managers attended collaboration meetings with our medical respite provider (The Gathering Inn). Management occasionally attends meetings if contract-related issues need review. A WPC nurse goes to medical respite every weekday.

QI Meetings

WPC Program Manager, Analyst, and Team leadership meeting at least monthly to discuss program items and review policies, procedures, and PDSAs as necessary.

South County Homelessness Summit

This quarterly meeting is led by Health and Human Services administration and includes; City of Roseville PD, City of Roseville Housing, Rocklin PD, Lincoln PD, City of Lincoln, The Gathering Inn, Salvation Army, Project Go, ASOC, and WPC management. Placer County Board of Supervisor members occasionally attend which is a great opportunity for them to see what is being done with homeless services in the region.

Sutter Community Partners

WPC attends the monthly meeting held by Sutter Hospital. The meeting includes: The Gathering Inn, Latino Leadership Counsel, WellSpace, Whole Person Care, and Sutter staff. The focus of these meetings is to help community partners receiving funding from Sutter Health improve collaboration. During the course of our Pilot, Sutter Health has donated $2,000,000 to help us procure additional housing resources.

WPC Leadership Council

Placer County HHS Admin, Placer County Public Health, Placer County Human Services, Placer County Housing Authority, Placer County Adult Services, and Whole Person Care meet every month. Community partners are invited to attend and participate as appropriate.

VIII. PROGRAM ACTIVITIES

Briefly describe 1-2 successes you have had with care coordination.
1. Placer County has joined the "Built for Zero—Community Solutions" project. As part of that project Placer is doing an initiative called "49 by 4-9." The goal of that project is to house the top 49 chronically homeless individuals from our Coordinated Entry By-Name-List by April 9 (4/9) of 2020. Partners in this effort include ASOC, TGI, HRCS, WPC and others. WPC enrolled individuals into the program who were not eligible for or who were not in any other program. This has led to WPC being the lead case management staff for over half of the 49 clients. The intense focus on various community partners doing all they can to help house these 49 individuals has led to increased collaboration and cooperation which is having a positive benefit on the system. WPC's willingness to enroll additional clients to make sure that these people are getting services has been an integral part of this project's success. 2. Increased attention was given to the collaboration between WPC and HDAP. The HDAP clinician has been placed within the WPC team to increase the number of SSI/SSDI applications that are completed for our members while the individuals in HDAP get case management and housing services from WPC. This integration has led to higher SOAR application approvals than the national average.

Briefly describe 1-2 challenges you have faced with care coordination, and lessons learned from those challenges.
1. On the other side of the 49 by 4/9 collaboration success was WPC not being able to participate in the national learning sessions put on by Community Solutions Team. Being excluded from that part of the project made it difficult for WPC to collaborate on the 49 by 4/9 project as we were left out of important conversations and left out from early planning meetings. WPC had to keep "beating down the door" to be included so that we could add our essential efforts to this project. The primary lesson learned from this for Placer WPC was to be more aware of power dynamics to ensure that WPC is in a favorable position with power brokers so that we have a seat at the table for homeless services issues. Placer WPC is committed to providing excellent client-centered services in a "whatever it takes" model and we need to make sure that we are getting that message across to decision makers. 2. We have a Permanent Supportive Housing provider that has a long-term relationship with other County providers, but has only been working with Whole Person Care for a couple years. Communication and collaboration with this

agency has been difficult at times due to the Contractor avoiding direct communication with WPC and going through their more established channels instead. We have mostly been able to work through that problem by raising the issue to a higher level and having WPC and provider management communicate directly more often.

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

1. California Health and Wellness and Anthem are both giving us a list of their top 20 utilizers in Placer County. We take that information and compare it against the list of homeless individuals seeking treatment and individuals in ASOC to see if there are additional services that WPC can provide. If they are appropriate for WPC then we attempt to enroll them.

2. WPC has become more integrated into the County's HMIS system. To provide a value-added service, our team volunteered to work on contacting all people who called into Coordinated Entry and attempt to link them to any service for which they might qualify. In the past, people who had a low vulnerability score would sit on the list for an extended period of time and never hear back. By working with our local Continuum of Care we are more effectively coordinating with multiple community partners.

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

1. As part of our work with the 49 by 4/9 project we are working closely with Coordinated Entry and the Continuum of Care to link homeless persons to the best available resources even if it's not with Whole Person Care. During this collaboration, we received direction that the various agencies with access to HMIS might not be able to see the list unless the persons that call in actually sign a written release. There were disagreements about whether the Continuum of Care should be a HIPAA covered entity and whether or not persons that are calling for housing services need to give written consent for their information to be shared (recorded verbal consent is given at this time). This was an issue throughout most of the year and there is yet to be full resolution. The lesson here is to be persistent in getting important work completed even when all policy issues do not have final resolution.

2. An ongoing difficulty we have had is having our medical records in Avatar which is primarily used by ASOC. There have been tremendous advantages to this, but there have been problems as well. A problem that arose this year was that additional mental health staff were given authority to bill Medi-Cal so to ensure

that those staff minimize any mistakes in billing, it was made policy that all of these staff must have their progress notes co-signed by a supervisor. WPC has several of these Community Mental Health Worker staff, but our program does not have them bill to Medi-Cal. Despite these staff not billing we have had to follow the same policy which takes a lot more supervisory staff time, without giving us the benefit of bringing in additional resources. At this time, there is not a solution to this issue as we are not able to have input into that policy decision. The lesson we are taking from this is acceptance. Sometimes there are rules that need to be followed even if they are not a good fit for the program.

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

1. On January 1, 2019, we fully implemented moving the great majority of our data collection into our EHR (Avatar). This was a substantial undertaking because we have so little control over other parts of the system (IT and ASOC) that are the primary decision makers about what happens in Avatar. Once we were fully able implement our data collecting and data pulling into Avatar we found that it was easier to collect data and that our data was more accurate.

2. It is worth noting that despite having multiple reports that need to be completed for WPC, we have always completed our reports on time. There are not only the DHCS WPC reports, but we have reports due for HDAP, Sutter Health, and the Continuum of Care. It is a noteworthy success to bring attention to the organization and follow-up that allows these important components to always be done competently and in a timely manner.

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

1. Our ability to collect and report on data has improved throughout the course of the Pilot. The recent update to our data collection methods through Avatar was an improvement, but it has led to other challenges like the need to take time for additional training and the need to set up new quality control procedures to make sure that the data is accurate. However, despite these additional requirements, we found that our new process has been a major improvement.

2. We began a new project this year which was increased data collection and reporting at our monthly Leadership Council meetings. All parts of the system are getting together to review and improved data collection and plan more effectively after reviewing the data. The process was bumpy for many months as we found different parts of the system had different definitions for the same concept and we had to go back many times to get on the same page about

what data we should collect, how we should define the data, and what improvements do we want to make to the system based on our analysis. This process has taught us that having someone directly assigned to the task of data collection and review is essential to making this kind of process move forward effectively.

Looking ahead, what do you foresee as the biggest barriers to success for the WPC Program overall?
The Placer Pilot continues to be extremely effective in outreaching clients, securing stability for members, and continuing to build and strengthen partnerships. At year's end we had successfully housed over 120 people. Our "can do" attitude has produced benefits in available solutions to our members as partners have also moved towards more openness in service provision. These characteristics continue to develop and mature. The biggest barrier to continued success remains the uncertain details about how Whole Person Care will continue in our community after December 31, 2020. We have begun important conversations with our Mental Health Plans and hope to ensure that long-lasting, durable services are put into place.

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:

1. 5 Levels of Collaboration Survey-WPC Evaluation
2. Suicidal Ideation screening tool Cycle 2
3. Weekly Team Meeting Effectiveness
4. Medical Respite Outcomes
5. Time Spent Providing Transportation Cycle 2
6. 30-day hospitalization readmission
7. Housing First
8. By Name List (BNL) Phone Calls
9. Housing Coordinators
10. WPC Referral Process
11. Medical Respite Client Satisfaction Survey
12. Client Resource Reminder Binder
13. WPC Collaboration with Human Services on Medi-Cal eligibility
14. HDAP Referral Outcomes
15. Care Plan sharing in Placer County Mental Health Platform
16. Paperwork Documentation Packets
17. Housing Subsidy Rental Agreements
18. WPC Staff Reviews
19. Housing Application tracking for Clients
20. Premanage Access extension for Placer