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

Small County Whole Person Care Collaborative
Annual Narrative Report, 2020
March 22, 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	☐ X Completed Narrative report ☐ X 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	☐ X Customized invoice
3. Variant and Universal Metrics Report **Submit to:** SFTP Portal	☐ X 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	☐ X 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	☐ X Completed WPC PDSA report ☐ X Completed PDSA Summary Report
6. Certification of Lead Entity Deliverables **Submit with associated documents to:** Whole Person Care Mailbox and SFTP Portal	☐ Certification form

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

Whole Person Care

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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.

The data presented in this report will be significantly influenced by the wind-down of the program in both counties. Numbers of enrolled will be smaller as will the overall metrics. The overall acuity level of the clients skewed lower due there being a greater proportion of established clients in the program versus newer, higher acuity, clients in the final six months of WPC.

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

In Mariposa, relationships overall continue to be good. This un-siloing of roles across departments and community agencies will be one of the greatest benefits of WPC. Unfortunately, hospital notification of WPC clients accessing the ED continued to be intermittent. Hospital staff only notified WPC 6 times in the previous six months although WPC clients accessed the ED 32 times. The staffing instability at the hospital and the loss of the EHR flag for WPC in the ED system make consistent notification a challenge. As this report is written, the Nursing Director and ED Director have tendered their resignations, which is illustrative of how challenging it has been to maintain a notification protocol. The County placed their Community Information Exchange project on hold due to the pandemic, but as of this writing it is ramping up again. One of the strongest outcomes of WPC has been the relationship built between the County and the Medi-Cal Managed Care health plans. Both the behavioral health and WPC teams continued to meet with health plans on transition, data sharing and shared client navigation. Mariposa was also a recipient of Anthem's BHI grant. This allows for WPC-like navigation for high utilizer populations. Staff have been working even more closely with Anthem staff as several WPC staff shift to the BHI project. This will have the additional benefit of keeping experienced, qualified WPC staff within the County to be ready to provide services when DHCS transitions to CalAIM.

In San Benito, the hospital continued to discuss shared clients with the WPC program three of the final six months. This reflects the downward trend in enrolled clients due to the wind-down of the WPC program. While Mariposa's strategy was to maintain a higher census of clients, San Benito chose to hand off or graduate (as appropriate) clients each month and not fill in the vacancies. WPC staff have continued to meet with their health plan partner on transition, data sharing and client navigation. With COVID, their work with other County departments maintained the fast-paced level seen in the previous months, as they continued to manage the housing needs of their clients. WPC staff continued to work in-person on staggered shifts working closely with the shelter and COC. This ease of communication, and the location of the shelter next door to WPC, allowed for a rapid response to client housing needs. With limitations on the number of clients able to be housed in the shelter, and WPC's processing of hotel vouchers and HEAP benefits, clients would immediately know where they would be.

2. Increasing coordination and appropriate access to care

For both Mariposa and San Benito, even as the program wound down, access to the managed care health plan Case Management staff helped with linking clients to additional services. The health plan Managed Care programs were involved in the graduations or hand-offs of all member clients. Anthem was the primary entity involved. Mariposa had only one client that was a member of California Health and Wellness as the WPC program was being closed. Further, the Anthem Nurse Manager continued to attend all WPC meetings, including multi-disciplinary meetings. Throughout our time together, she has provided invaluable troubleshooting within the health plan, knowledge of programs and assisted with clinical insights for our largely social work and behavioral health staff. Our administrative contacts at both health plans have worked diligently with us to create reporting systems where we are sharing utilization information as quickly as possible so the work of the WPC care team could be informed for greater efficacy.

The trend continued of decreasing time for clients to access their first primary care visit after enrollment. At the end of the program, the time was less than 15 days post enrollment (see Figure 1). Both San Benito and Mariposa Counties continue to overperform on the goal of ensuring clients access to providers, when needed, within 60 days. By the third quarter, there was greater medical care access than earlier in the pandemic, but appointments were still limited due to the need for physical distancing. Staff continued to work diligently to ensure client access to medical providers under these conditions, and as a result, 100% of new enrollees in the third quarter received appointments (see Figure 2). Given the wind-down, there were no new enrollees in December, therefore no new client appointments occurred.

Figure 1. Average Time to PCP Appointment (Redacted)

Figure 2. Visits to Primary Care (Redacted)

Staff also worked with additional clients on accessing specialty care and transportation, which has been challenging in Mariposa County. San Benito and Mariposa counties also leveraged Anthem telehealth providers via Live Online to increase access to care and decrease congregation indoors for traditional appointments. Telehealth has been a crucial tool to prevent gathering yet increase connection to care during the pandemic.

Both counties continued to use social needs screening tools to assist them in helping identify other needs, and work with the client to access those resources. Staff created graduation packets filled with the contact information for all their providers and resources. Clients were trained on the use of this tool. All packets contained the contact number of Health & Human Services for service access beyond WPC.

3. Reducing inappropriate emergency and inpatient utilization

Although there were less clients in WPC overall, at least four of the remaining clients in the third and fourth quarters were traditionally high users of the hospital and ED system. Despite this, WPC staff and clients made further reductions in ED and inpatient rates. Some of this was due to the continuation of the pandemic and clients remaining uncomfortable accessing the hospital. However, as reported in the Mid-Year Report, we continue to attribute the bulk of the reduction to clients having stable shelter. Gains in client independence made at the time of the Mid-Year Report have remained. Clients continue to access services better, are remaining sober and using hospital services far less. Especially in Mariposa, most of the remaining unsheltered clients found permanent supportive housing because of Project Roomkey and other housing funding.

The tables below show significant decreases. Some limitations are that FFS clients (non-managed care) can have limited pre-enrollment ED and Hospitalization data to use as a comparison. This is particularly an issue in San Benito where public transportation is better, and FFS clients may have used facilities in the many adjacent counties. It is also important to note that due to small numbers in each of the counties one outlier can skew the rates – and both counties have at least one outlier. With those limitations in mind, we feel that overall, the data shows that the longer individuals stay in WPC the more stable they become.

Table 1. Mariposa Utilization Data

Table 9. Pay for Outcomes Incentive – Summary ED and Hospitalization Reduction				
Time Frame	**Number of Members (ED Use)**	**Average Reduction ED Use**	**Number of Members (Hospitalizations)**	**Average Reduction Hospitalizations**
3 months	26	-0.38 (-17.54%)	12	-0.42 (-41.67%)
6 months	31	-0.84 (-28.57%)	19	-0.37 (-38.90%)
12 months	27	-1.59 (-39.09%)	19	-0.37 (-33.34%)

Table 2. San Benito Utilization Data

(Redacted)

4. Improving data collecting and sharing

The Collaborative shares performance data at our monthly business meetings for the purpose of identifying areas for improvement and communicating possible barriers. Several PDSA projects have been the result of this process. Improvements in Care Plan rates and medication lists are two examples. A one-page dashboard report pulls together the key performance indicators and is used for reports to leadership, stakeholders, and partners. This process was facilitated using an outside evaluator who consulted with WPC throughout the term of the program. In Mariposa County, these performance review habits have been integrated into their BHI program.

We also reviewed data exports and reports from the eClient management system on a bimonthly basis to check on data entry quality. The quarterly meetings are used for professional development, but also for training on data entry and understanding what information is being requested. These trainings are bi-directional with staff providing feedback on what systems and workflows are realistic, how the technology is working, and what features would make the data collection work more efficient and accurate.

Administration, staff, and our health plan partners worked throughout the program on data sharing, report structure and data elements. This monthly report continued to evolve as the needs of the health plan changed. They would find utility is different information, and would request the teams to add the element to the report. This was an extremely collaborative process, which included shared problem solving to figure out how to meet the data needs of the health plan. To the greatest extent possible, we would try to use the existing pool of data instead of adding new fields and staff entry to the eClient management system – although we needed to do so a few times. Health plan staff had access to the shared client record and would use this tool for MDT meetings.

In San Benito, data sharing continued with the hospital smoothly, although the hospital's participation in shared client meetings continued to wane. This is attributed to the pandemic given their stable participation in all other years of WPC. In Mariposa, hospital

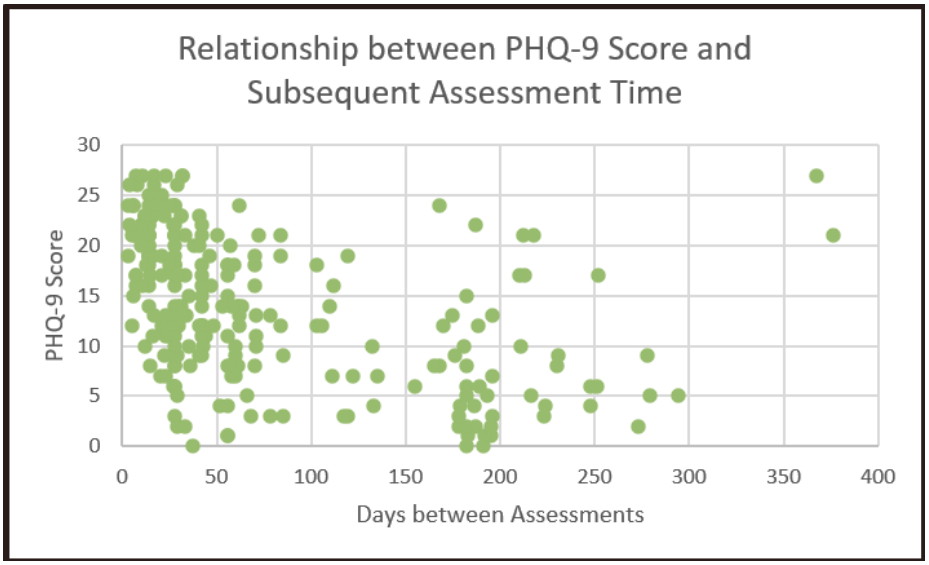
notification of ED use and participation in client meetings was intermittent. Although the pandemic limited their capacity, hospital collaboration had fallen the previous year. Data was shared from WPC to the hospital, but return data from them difficult to access. Multiple requests would need to be made, and staff turnover continued as a barrier.

5. Achieving quality and administrative improvement benchmarks

The Collaborative has established several benchmarks outside of the DHCS required metrics. While three are highlighted, it is important to note that the wind-down of WPC impacted some of these metrics. Not only were there less clients enrolled, but San Benito also suffered staff attrition. Three benchmarks follow:

a) We strive to ensure that all clients receive a PHQ-9 assessment at intake (with intake defined as within 30 days of enrollment). Subsequently, we have a reassessment protocol depending on score. Initially, less than 90% of enrollees were receiving a PHQ-9 at intake. This occurs for a variety of reasons, which can include client engagement issues, hospitalizations, and transportation challenges. Staff were trained to recognize this tool as a priority for completion. Other barriers were tackled, such as access to transportation and lengthening the engagement period to improve program “fit”. At the time of the Mid-Year Report, staff had achieved a rate of 90.6% receiving an assessment at intake. Currently, staff have achieved a 91.4% rate, and an average of 8.7 days from intake to assessment. This is a significant improvement. As is demonstrated in Figure 3, the days between assessments for those with the highest scores is within an acceptable timeframe. These graphs help us to see outliers clearer and perform a deeper dive into specific cases to determine if there is any team improvement needed.

Figure 3. Relationship Between PHQ-9 Score and Assessment Time



b) Our internal benchmark is for all clients to have a medication list documented at intake (within 30 days of enrollment), and existing clients asked about changes to their medications at each appointment (unless impractical). This process was relatively new in Q1 of 2019. Staff had improved with each quarter until the last 6 months of 2020. Ideally, we want to see the red line following close to the tops of the green bars, as in Q1 2020 (see Figure 4 below). Unfortunately, this measure has not been a part of WPC long enough and without the impacts of the pandemic to really integrate the practice and be able to demonstrate this graphically. The wind-down of the program and significant decrease in clients in San Benito, our leader in performing medication list updates, is apparent in the Figure 4 graph. Since no new clients were enrolled in December, there were no lists at intake.

Figure 4. Medication Lists at Intake and Updated for New Enrollees

(Redacted)

The next graph (Figure 5) allows us to take a closer look at how many times the medication lists were updated, if there were changes or remained stable. While the previous graph and benchmark looks at new clients, this measure looks at existing clients. Ideally, medication lists are updated regularly. If there are no updates to client medications, Staff are trained to check a box indicating that the question about medication updates has been asked. While we are not able to derive an answer on the overall health of clients, we can suspect that there is movement in their care. We are pleased that staff worked to ensure medication lists were updated for clients as wind-down occurred. The most recent medication list at program exit was provided to clients as part of their exit folder.

Figure 5. Stable and Changed Medication Lists

(Redacted)

c) SCWPCC continued to see an increase in successful program exits (see Figure 6). In 2019, the teams focused much of their effort on their graduation protocols. These required more clarity on defining success. Care Plans improved with more revisiting of already documented client-driven goals with the client. With wind-down, increased client independence, a strong focus on self-advocacy, and in some cases, additional support by health plan or county programs, most clients felt ready to exit WPC. Those that were not ready, were handed off to other programs and are reflected in the neutral exits number. Most clients have been pleased to see their progress from enrollment to graduation and have expressed gratitude for the staff and program that has helped them recover their lives and health.

Figure 6. Type of Program Exit by Quarter

(Redacted)

6. Increasing access to housing and supportive services

Our internal goal is that 100% of clients referred for housing services receive housing services. However, clients may not receive services for a variety of reasons, including leaving the program after being referred, becoming hospitalized or referral backlogs. For this measure, we use the DHCS required V&U Report as well as a housing metric on our Status Report, which looks at a larger universe of clients than the DHCS report. At the Mid-Year Report, the teams were at 94.52% of clients receiving housing services.

With our wind-down, staff only enrolled one additional person who was referred for housing services, and that individual chose to leave the county to live with a family member. Thus, they ended up not receiving or needing the housing services they were referred for.

With the pandemic, WPC teams were involved in the massive push to get clients into shelters to adhere to the stay-at-home order. All WPC clients were sheltered as of June 30, and as mentioned previously in this report, many had improved health outcomes as a result. Since the Mid-Year Report, ten additional individuals were assisted in finding permanent housing. Most found permanent supportive housing. Others moved in with family and two others were found housing in senior apartments. Table 3 below is a count of clients that our teams housed. This excludes those who were found places in shelters or other very temporary situations. It also includes individuals housed by team members during the engagement phase.

Table 3. Disposition of Homeless Clients

(Redacted)

(16) Clients housed prior to enrollment are assigned a value of 0 days for this measure.

7. Improving health outcomes for the WPC population.

The PHQ-9 (self-report depression assessment) is one of the tools we use to measure changes in health status. Clients continue to report decreased feelings of depression from intake to 12 months or disenrollment. This is occurring in both populations with and without a depression/dysthymia diagnosis, with the greatest gains realized by those with a diagnosis who were in WPC for 12 months (see Table 4 below).

Table 4. PHQ-9 Scores by Diagnosis and Time Enrolled at Intake and Post-Enrollment

Inclusion Criteria	Number of Clients	Average PHQ-9 Score at Intake	Average PHQ-9 Score Post-Enrollment	Percent Change	Effect Size Estimate (Cohen's D)
Clients without Diagnosis					
Discharged Clients	74	12.3	8.8	-28.5%	0.5
Clients Enrolled for 12 Months	45	12.2	8.9	-26.5%	0.5
Clients with Depression/Dysthymia					
Discharged Clients	21	13.0	9.9	-23.8%	0.4
Clients Enrolled for 12 Months	11	13.3	7.9	-40.4%	0.8

The Collaborative uses a client-centered, strengths-based and recovery planning model in the work performed with clients. We measure the extent to which clients achieve goals they have set for themselves and in what time frame. As we track this over time see Table 5), we see the category of enrolled 3 months or more increasing in attainment of two or more goals met. While staff are becoming more expert in working with this population, the change is primarily due to an increase in the number of clients staying in the WPC program, with more time to reach goals. Regardless, it demonstrates continuing movement toward wellness and independence. Of note are the remarkable gains unsheltered clients make the longer they stay in the WPC program.

Table 5. Client Goals Met by Time Enrolled and Status at Enrollment

(Redacted)

Finally, below are success stories directly from staff and clients:

“The client was encountered at the shelter. They were stranded in the community and had a very serious illness for which they had not been receiving specialty care. The client was enrolled in WPC. They were willing to participate in all services that were offered and worked hard to make healthy changes in their life. Client is now set up with the various specialists and will receive ongoing care. This client reports that they feel much better now than a year ago and is very proud of their accomplishments. Client now has doctors that are providing excellent care, a home that they pay rent on time each month, and now has a small savings account. [Client is able to self-advocate for needs such as transportation.] They have stated many times that they do not believe they would have come this far without the support of the Whole Person Care team. Our

team was honored to be an integral part of this individual's journey to wellness. The client is amazing!"

"Client came to WPC with SUD and significant health issues, which lead to high utilization of the emergency department. Client had significant hygiene issues limiting their ability to find assistance. Through Project Roomkey, the client was able to be sheltered. This made all the difference. With this stability, client has remained sober and is now willing to shower. WPC team has provided medical support, needed healthcare equipment, and assisted them with receiving temporary disability. Client has a surgery scheduled to address a health issue and has decreased ED utilization from double digits to two!"

"This client was homeless, staying at the homeless shelter, and has struggled with a variety of serious illnesses that were not being managed. Client had lost their driver's license due to multiple DUIs, had much debt and little income.

This client's initial goals were to improve their health to enjoy their grandchildren, get the driver's license reinstated, work on mental health, and interact more with other people in recovery. Client is now over 2 years sober and is nearly finished with DUI requirements to get back their license. Client has acquired auto insurance and has current registration. With the support of the WPC team, they now have SSI income. This has allowed for enough money to begin paying bills and becoming more independent. Housing has been maintained with the support of the Permanent Supportive Housing Program, and the client is proud of paying their bills on time. Client stays on top of doctor's appointments and can arrange rides for themselves.

Client now keeps in touch with family and attends family functions when possible, including being grateful for the ability to spend more time with the family. Client has repeatedly said that they would not be where they are today without the support of the Whole Person Care team and the Permanent Supportive Housing team. We have enjoyed seeing this individual blossom!"

"Client presented to WPC with high ED utilization, chronic health conditions and SUD issues. Client had been homeless on and off for decades. Needed to obtain documents needed for accessing public services. WPC team assisted client with monumental effort of obtaining documents. Then, team worked with client to obtain an income, get their documents, and obtain an apartment. Client cried when they received the documents and when they obtained the apartment. Client can live on their own with the support of an IHSS and contacts WPC infrequently for advice. Client had zero ED visits."

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	*	*	0	*	*	*	11

Item	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12	Annual Unduplicated Total
Unduplicated Enrollees	*	0	0	0	0	0	16

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*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	**$5,850.72**	**$5,119.38**	**$13,585.77**	**$14,007.42**	**$19,876.80**	**$5,425.36**	**$63,865.45**
M $250	$0	$0	$2250	$4500	$5250	$2500	$14,500
SB $365.67	$5850.72	$5119.38	$11335.77	$9507.42	$14626.80	$2925.36	$49,365.45
Utilization 1	**16**	**14**	**40**	**44**	**61**	**18**	**193**
M	0	0	*	18	21	*	58
SB	16	*	*	26	40	*	135
Service 2	0	0	0	0	0	0	0
Utilization 2	0	0	0	0	0	0	0

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	**$11,772.37**	**$5,850.72**	**$3,656.70**	**$0**	**$0**	**$365.67**	**$85,510.91**
M $250	$7,750	$0	$0	$0	$0	$0	$22,250
SB $365.67	$4,022.37	$5851	$3,656.70	$0	$0	$365.67	$63,260.91
Utilization 1	**42**	**16**	*****	**0**	**0**	*****	**262**
M	31	0	0	0	0	0	89
SB	11	16	*	0	0	*	173

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	0	0	0	0	0	0	0
Utilization 2	**0**	**0**	**0**	**0**	**0**	**0**	**0**

*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		**$104,782**	**$96,433**	**$87,956**	**$86,299**	**$77,822**	**$74,572**	**$527,864**
	M $1,721.02	$5,5072	$53,351	$48,188	$48,188	$43.025	$44,746	$292,570
	SB $1,657	$4,9710	$43,082	$39,768	$38,111	$34,797	$29,826	$235,294
MM Counts		**62**	**57**	**52**	**51**	**46**	**44**	**312**
1		32	31	28	28	25	26	170
M:		30	26	24	23	21	18	142
SB:								
Bundle #2		**$15,488**	**$13,004.90**	**$9,680**	**$14,141.40**	**$12,752.50**	**$13,299.60**	**$78,366.40**
	M $1,389	0	$1,388.90	0	$8,333.40	$6,944.50	$5,555.60	$22,222.40
	SB $1,936	$15,488	$11,616	$9,680	$5,808	$5,808	$7,744	$56,144.00
MM Counts		*	*	*	*	*	*	**45**
2		0	*	0	*	*	*	16

Amount Claimed for Quarters 1 and 2

PMPM	Rate	Month 1	Month 2	Month 3	Month 4	Month 5	Month 6	Total
M: SB:		*	*	*	*	*	*	29

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	 M $1,721.02 SB $1,657	**$79,799.60** $51,630.60 $28,169	**$74,764.58** $49,909.58 $24,855	**$69,601.52** $44,746.52 $24,855	**$67,944.52** $44,746.52 $23,198	**$56,163.46** $39,583.46 $16,570	**$52,775.44** $37,862.44 $14,913	**$928,903.12** $561,049.12 $367,854
MM Counts 1 M: SB:		**47** 30 17	**44** 29 15	**41** 26 15	**40** 26 14	**33** * *	**31** * *	**548** 326 222
Bundle #2	 M $1,389 SB $1,936	**$13,552** $0 $13,552	**$21,296** $0 $21,296	**$23,232** $0 $23,232	**$15,488** $0 $15,488	**$7,744** $0 $7,744	**$1,936** $0 $1,936	**$161,614.40** $22,222.40 $139,392.00
MM Counts 2 M: SB:		***** 0 *	***** 0 *	**12** 0 12	***** 0 *	***** 0 *	***** 0 *	**88** 16 72

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

Deceasing numbers reflect the wind-down of WPC. Mariposa decided to transition housing work away from their housing contractor to their COC and staff, which were not payable entities per the original contract with the State. Thus, there is no WPC billing for this work.

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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.

Several line items will be underutilized. With the tremendous uncertainty of WPC continuing, turnover in key leadership positions and the pandemic using all surplus capacity, county leadership made the decision to discontinue the WPC program in the second half of the year. Mariposa lost their outstanding HHSA Director and Deputy Director in the mid-point of the year. This was in addition to two other key positions left unfilled from the beginning of 2020. Toward the end of the year, WPC lost their Administrative Director. In San Benito, a key Social Worker took another job in another County leaving just one Care Manager to manage the shrinking caseload. Much of the surplus is due to staff and contractor salaries.

Despite the turnover, the front-line staff and leads continued to perform exemplary work connecting clients to resources, implementing program improvement projects, conducting meetings to share information and coordinate care and receive training. The Administrative Director stayed on the team through October, then shifted from Administrative and Data responsibility to just Data. Two quarterly trainings were implemented for staff. The first brought back Dr. Beth Cohen to help with staff self-care in times of COVID. Staff were suffering under the weight of WPC responsibilities and shifted roles to fill pandemic needs. For example, WPC staff in Sen Benito carried their current load, but had to work long hours to find, assess and assist homeless individuals (primarily non-WPC) so that they were moved into shelter as quickly as possible. There is limited capacity in small counties, so all staff had to float into different roles in 2020. By August, the ramp up and planning for surge had been done, homeless individuals sheltered, and all the other communications, site preparations, and scheduling issues were finalized or made routine. Staff had more time to shift back to WPC and maintain a more normal schedule, so we really wanted to focus on staff care. In December, leadership focused on staff celebration and brought a trainer in to work with them on documenting their skills acquired throughout WPC. In both trainings, we had information sharing with health plan partners, a review of data and improvement projects, and discussions of client successes.

IV. NARRATIVE – Delivery Infrastructure

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

Please note the narrative submitted during the Mid-Year Report will be considered part of the Annual Report and will not need to be resubmitted. Include updates, notable trends, and highlights of achievements/progress as well as any changes since the prior report. Please limit your responses to 500 words.

The most significant under expenditure was in the Software Vendor line item. The bulk of this line item was intended for the Mariposa Health Information Exchange (HIE) project. This project was delayed due to the pandemic. This also impacted the Local Software Support line item since these funds were intended to support the use of a project manager to work on the WPC and HIE connected items. Because of the delay, Mariposa did not have an opportunity to purchase the systems and services it had planned prior to December 31, 2020.

Training and travel were impacted by the pandemic. Funds were left in this line item at the time of the midyear report not knowing whether some in-person work would be possible. The training line item was based on the contracting of several outside experts to provide professional development. Their costs were less than anticipated.

Housing Supports and Transportation in San Benito were underutilized given the pandemic changing transportation modes and staff being reallocated to sheltering over 200 homeless individuals both WPC and non-WPC. The WPC specific Housing Supports were not as needed or relevant during the crisis.

V. NARRATIVE – Incentive Payments

Instructions: Please provide a detailed explanation of incentive payments earned during the Reporting Period. Elaborate on what milestones were achieved to allow the payment, the amount of each payment, and to whom the payment was made. The lead entity will only be permitted to invoice for actual incentive payments made.

Please note the narrative submitted during the Mid-Year Report will be considered part of the Annual Report and will not need to be resubmitted. Include updates, notable trends, and highlights of achievements/progress as well as any changes since the prior report. Please limit your responses to 500 words.

Incentive – Hospital Notification of ED visit, Mariposa:
The hospital has still engaged with WPC despite the pandemic, albeit at a limited scale. Since mid-year, there were an additional six notifications, earning a total payment of $900 (6 notifications x $150 per notification) for John C. Fremont Health Care District.

Incentive – Hospital Involvement in Care Coordination, Mariposa:
Typically, this incentive has higher utilization than the ED notification because this connects directly with the hospital care of shared clients who have complex needs. We again see the “COVID-effect” in this line item where less than half of the available units have been expended. This trend continued throughout the year. Since the mid-year, John C. Fremont Health Care District participated in seven additional meetings (annual total 23 of 52 possible weeks), earning a total payment of $2,100 (7 meetings x $300 per meeting).

Incentive – Hospital Involvement in Care Meetings, ED Notifiction and/or Weekly Contact, San Benito:
The Hazel Hawkins Hospital in San Benito typically works with WPC each month resulting in full disbursement of their allocated incentive. However, all WPC oriented meetings with the hospital and referrals to WPC from the hospital stopped in the mid part of April due to the pandemic. Hospital engagement did begin again in June intermittently. Since the mid-year, Hazel Hawkins Hospital participated in WPC meetings regarding shared clients three additional months, earning a total payment of $1,800 (3 months x $600 per month).

Incentives- Provider Referrals, San Benito:
Referrals stopped almost completely due to the pandemic as Hazel Hawkins Hospital, San Benito Health Foundation and Community Homeless Solutions raced to meet all the infectious disease requirements and address client sheltering needs. This trend continued into the second half of the year. Since the mid-year, no referrals were submitted, earning no payment.

Incentives – Housing Placements, San Benito:
One client was placed in permanent senior housing, earning $1,000 paid to county partners.

VI. NARRATIVE – Pay for Outcome

Instructions: Referencing the Whole Person Care Universal and Variant Metrics Technical Specifications, please provide a detailed explanation of the status of your program's performance on the pay-for-outcome metric(s). For the Mid-year report, only report those measures that are reported semi-annually; for the Annual report, please report all. Provide details that demonstrate what was achieved for each outcome, any challenges, and any lessons learned. Reimbursement will occur for achieved outcomes based on proposed annual target and methodology. Please limit your responses to 500 words.

The Small County Whole Person Care Collaborative (SCWPCC) elects to use the COVID-19 Alternative Payment method for Pay for Outcome payments in Program Year 5. SCWPCC achieved 100% of our Pay for Outcomes in Program Year 4. SCWPCC will receive 100% payment in Program year 5, in the total amount of $44,120.

Both San Benito and Mariposa Counties achieved their 5% reduction over baseline for ED visits and hospitalizations, earning them and their partners incentives as follows:

Mariposa: $5,000 each for Mariposa County Health & Human Services, John C. Fremont Healthcare District, Alliance for Community Transformations, and the Mariposa County Probation Department.

Table 9. Pay for Outcomes Incentive – Summary ED and Hospitalization Reduction

Time Frame	Number of Members (ED Use)	Average Reduction ED Use	Number of Members (Hospitalizations)	Average Reduction Hospitalizations
3 months	26	-0.38 (-17.54%)	12	-0.42 (-41.67%)
6 months	31	-0.84 (-28.57%)	19	-0.37 (-38.90%)
12 months	27	-1.59 (-39.09%)	19	-0.37 (-33.34%)

San Benito: $3,824 each for San Benito County Health & Human Services, San Benito County Behavioral Health Department, San Benito County Probation Department, San Benito Health Foundation, and Hazel Hawkins Hospital.

(Redacted)

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.

1. San Benito was not able to host a Partners Meeting in the third or fourth quarters of 2020 due to the pandemic. The WPC Program Manager did speak to department directors and managers regularly regarding clients and COVID matters.
2. San Benito held weekly WPC staff meetings through November 3, 2020. (agendas attached)
4. Mariposa was not able to host their Community Leadership Meeting in the third and fourth quarters of 2020 due to the pandemic. The WPC Administrative Lead did speak with department deputies and managers regularly regrading program requirements and COVID matters.
5. Mariposa held weekly WPC staff meetings. (agendas/minutes attached)
6. Business Meetings for managers occurred once monthly until the departure of the Administrative Director in November. (agendas attached)
7. Directors Meetings are held monthly, often with a written report substituting for a telephonic meeting. Directors' meetings stopped in November given the decision to terminate the WPC program. (agendas attached)
8. The Collaborative met quarterly for staff professional development, program communication, feedback, and other operational trainings. (agendas attached)

MDT and other patient care meetings were held as needed throughout the reporting period.

VIII. PROGRAM ACTIVITIES

Care Coordination

A. Briefly describe 1-2 successes you have had with care coordination.
    1. The pandemic required the close collaboration with various departments and community organizations. WPC enabled the counties to meet the challenges of the pandemic more easily because there already was infrastructure in place for communication and servicing, such as for housing. San Benito is a good example of how the staff were able to shift seamlessly to processing vouchers for all homeless individuals (not just WPC) rapidly. They had already had a good working relationship with the shelter (next door to the WPC office), HEAP program experience with Housing (WPC is under that umbrella) and contacts with the Hospital, Behavioral Health, and community agencies (for finding homeless individuals).
    2. In Mariposa, WPC staff worked with JCF Healthcare District to get appointments for multiple clients with chronic and/or acute healthcare conditions. Appointments have been limited due to the pandemic, but through their relationships with JCF staff, were able to communicate the urgency for more timely service. As a result, individuals with complex challenges were able to stay out of the Emergency Department and have less temptation to self-medicate pain with substances.

B. Briefly describe 1-2 challenges you have faced with care coordination, and lessons learned from those challenges.
    1. In Mariposa, accessing primary care continues to be a challenge due to provider turn-over and difficulty recruiting providers to our rural area. This poses a challenge for timely, quality care. Further, it can disrupt the clients progress toward self-advocacy, self-efficacy and impact their levels of depression. Staff are not able to control provider changes or shortages. However, they can prioritize clients whose providers are changing to work more closely with - preventing deleterious psychological and physical impacts.

Data Sharing

A. Briefly describe 1-2 successes you have had with data and information sharing.
    1. The automated report sharing information with the health plan partners operated seamlessly. With their access to the entire client record, health plan case management teams were able to work extremely well with WPC care coordinators regarding shared clients.

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

1. Rural hospitals have significant challenges in adding and maintaining automated systems changes that are outside of their typical patient care requirements. These health systems are fragile, understaffed, and underfunded. For them to allocate the resources for data sharing outside the norm, there must be a State mandate, and ideally, additional funding. We have found that in both counties that changes in staff and technology resulted in interruption of automated, contractually required data sharing. This is not including interruptions due to the pandemic. WPC staff were able to address the challenges by using securely emailed client lists. This worked but was not the solution we had envisioned.

Data Collection

A. Briefly describe 1-2 successes you have had with data collection and/or reporting.
    1. Overall, despite WPC staff turnover from time to time and the total number of staff entering data into the system, we were able to maintain quality data entry. It required building in regular review of data entry and addressing any problems quickly with program leads. It required ongoing monthly and quarterly training. For some of the more complex measures, we also documented data entry requirements in a protocol. All these efforts resulted in remarkably clean data.
B. Briefly describe 1-2 challenges you have faced with data collection and/or reporting.
    1. While staff understanding of PDSA methodology has increased, we never quite achieved the level of competency the program desired. Staff turnover has been an issue. Counties also chose to build responsibility for quality improvement projects into the role of all staff, rather than have a CQI staff person responsible. For one county, there was no department that provided that role, for the other, there was not capacity in that department. This left PDSA design and reporting to staff. We had PDSA trainings twice per year, and they were discussed at weekly staff meetings initially. However, 2020 PDSAs were impacted by the pandemic as staff already stretched with their direct service and management work were pulled into other pandemic-related roles. This, in addition to the loss of several key staff positions, left limited capacity for non-day to day work.

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

Although terminated at this time in both Small Counties, the WPC program was highly successful. Both counties realized significant reduction in client utilization, client self-

report of depression remission, client achievement of life goals, and a remarkable shift in how the Department of Health and Human Services works across agencies for more seamless collaboration and coordination. They also greatly improved or created more efficient channels of communication with community groups and managed care health plans. Moving forward to thinking about the transition to CalAIM, Mariposa will be well-positioned for a seamless transition. They have maintained all their staff and are keeping them working in similar roles through their new Targeted Case Management program and the BHI grant through Anthem. Both programs require case management, coordination, collaboration across entities, data capture and use to inform decision-making. San Benito will have a more challenging time in the transition. They have lost 3/5ths of their WPC team, including their program manager and two key social workers, all of whom have left work with the County. Additionally, they will be losing a key director who was involved in WPC since the beginning to retirement. There will be few, if any, staff remaining who have substantial knowledge of the work. While it can be relearned, it will not be as efficient of a process.

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:

Centralized Recurring Client Calendar - cycle 2

First Appointment Delay

COVID19 Impact on Client Care
Client Graduation Satisfaction Survey
Client Support with Telehealth Services
Graduation Packets

Client Facilitated Discharge Plan
Discharge Plan Education Tool

Examine the impact of COVID-19 pandemic on hospital referrals of patients who have been hospitalized or presented in the ED

To determine if providing clients with hotel vouchers will keep them from using the ED and hospital (Cycle 3)
Using the revised Participant Agreement (PA) as a tool to increase client engagement (Cycle 3)
Protocol for Successful Disenrollment (Graduation) from Whole Person Care (Cycle 3)

Weekly support groups with WPC clients to reduce PHQ9 scores (Depression) – (Cycle 4)

Revise system for data and information sharing with Anthem Blue Cross (Cycle 5)