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

County of San Diego
Annual Narrative Report,
Program Year 5
Submitted: May 24, 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	ϒ Completed Narrative report ϒ 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	ϒ Customized invoice
3. Variant and Universal Metrics Report **Submit to:** SFTP Portal	ϒ 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	ϒ Care coordination, case management, and referral policies and procedures, which may include *protocols and workflows.)* ϒ 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	ϒ Completed WPC PDSA report ϒ Completed PDSA Summary Report
6. Certification of Lead Entity Deliverables **Submit with associated documents to:** Whole Person Care Mailbox and SFTP Portal	ϒ Certification form

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

Whole Person Care

County of San Diego
Annual Narrative Report, Program Year 5
April 1, 2021

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.

Increasing integration among county agencies, health plans, providers and other entities
We continued efforts around addressing resources for individuals who may be hard to engage with a range of community partners. One large effort took place for a WPW eligible family who had taken up residence in a County park. A broad collaborative effort with Parks staff, Sheriff's Homeless Assistance Resource Team (HART) team and the WPW providers resulted in the family moving into temporary housing and a referral to the mainstream voucher program through our Housing Authority.
Additionally, our Team is working closely with our local MCP's through the Healthy San Diego collaborative to share ideas and work on CalAIM documents and planning, discussing strategies to make the transition and contracting processes as easy as possible.

Increasing coordination and appropriate access to care
During the reporting period we initiated activities to support a structured transfer to Behavioral Health Services and the Health Homes Program with guidance from the Clinical Review Team (CRT). With the completion of the Services Transition Plan we incorporated this into our case conferencing structure, holding weekly case conferencing sessions between the services providers to ensure a smooth transition on both the services side and sharing of collateral documentation for continuity of care.

Reducing inappropriate emergency and inpatient utilization
With our intensive wrap around care coordination services in our SIT and HAT teams we have achieved a decrease in Inpatient Utilization by 34% over PY4 and by 63% over baseline.

Improving data collecting and sharing
Long planned for work on building a data bridge from our local Homeless Management Information System (HMIS) and Community Information Exchange (CIE) lead by

211San Diego was completed allowing for data elements from program intake and exit to be viewable in ConnectWellSD. Additional work on the "Who's In Jail" feature will take place into 2021, which will enable users to get a notification when an enrollee has been booked by the Sheriff's Department

Achieving quality and administrative improvement benchmarks
With the increase in hours for our TEP position we were able to ensure timely quality assurance of case related data in our ConnectWellSD care coordination platform and provide detailed feedback. Particular areas of focus were on timely completion of assessments and updating of the appointments interface.

Increasing access to housing and supportive services
We continue to utilize the Housing, Disability and Advocacy Program (HDAP) funds available through CDSS to provide interim and permanent housing options for individuals who are working through the SSI/SSDI application process with our local legal advocacy entity, Legal Aid Society of San Diego. Locally the HDAP legal advocacy services have a 48% approval rating with an average length to disposition of 5.5 months.

Improving health outcomes for the WPC population
During this reporting period we decreased the number of days spent in the hospital for new enrollees by 6% over PY4, and for those who have been permanently housed for a year therewas a 57% reduction. Additionally, during PY5 we decreased the number of ED visits for new clients after being permanently housed for 12 months by 29%.
Also during PY5 we saw a decrease in the number of days in Psych Inpatient units for those who were housed for a year of 57%.

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	43	38	41	41	30	31	224

Item	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12	Annual Unduplicated Total
Unduplicated Enrollees	25	*	*	0	0	0	262

*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: O&E	$36,312	$34,680	$32,436	$32,232	$34,272	$29,988	$199,920
Utilization: O&E	178	170	159	158	168	147	980
Service: Medical Respite	$0	$0	$0	$0	$0	$0	$0
Utilization: Medical Respite	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: O&E	$19,788	$11,220	$2,244	$0	$0	$0	$33,252
Utilization: O&E	97	55	11	0	0	0	163

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: Medical Respite	$0	$0	*	*	*	*	$4,500
Utilization: Medical Respite	0	0	*	*	*	*	18

*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
PMPM Phase 2:	$851	$230,621	$239,131	$254,449	$278,277	$279,979	$289,340	$1,571,797
MM Counts Phase 2:		271	281	299	327	329	340	1,847
PMPM Phase 3:	$681	$43,584	$45,627	$42,903	$42,903	$38,136	$48,351	$261,504
MM Counts Phase 3:		64	67	63	63	56	71	384
PMPM High Acuity:	$3,952	$217,360	$193,648	$221,312	$185,744	$169,936	$158,080	$1,146,080
MM Counts High Acuity:		55	49	56	47	43	40	290
Short-Term & Interim Housing Assistance:	$1,436.36	$0	$0	$0	$0	$0	$0	$0
Short-Term & Interim Housing Assistance Counts:		0	0	0	0	0	0	0

Amount Claimed for Quarters 3 and 4

PMPM	Rat	Month	Month	Month	Month 10	Month 11	Month 12	Annual Total
PMPM Phase 2:	$85	$279,12	$258,70	$230,62	$195,73	$173,604	$155,733	$1,293,520
MM Counts Phase 2:		328	304	271	230	204	183	1,520
PMPM Phase 3:	$68	$57,204	$58,566	$64,014	$57,885	$49,713	$41,541	$328,923
MM Counts Phase 3:		84	86		85	73	61	483
PMPM High Acuity:	$3,952	$165,98	$126,46	$126,46	$102,75	$75,088	$67,184	$663,936
MM Counts High Acuity:		42	32		26	19	17	168
Short-Term & Interim Housing Assistance:	$1,436.36	$0	$0		*	$31,599.92	*	$64,636.20
Short-Term & Interim Housing Assistance Counts:		0	0	0	*	22	*	45

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

The formal enrollment period for the project ended on August 7, 2020 based on exceeding the project-wide enrollment goal of 800 with an overall enrollment of 881. Prioritized enrollments were accepted after August 7 based on available funds and space on the SIT and HAT teams.

The Medical Respite Beds included in FFS and the Short-Term Housing Assistance in PMPM are not included in the QUE due to being captured using alternative methods but have been included in the Utilization tables above.

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.

During this report period we continued to see staffing shifts due to broader County needs due to the pandemic. These included moving time from the Administrative Secretary II to an Office Support Specialist and expanding our Temporary Expert Professional (TEP) position to support data-related projects. In September we saw the retirement of Susan Bower, who played a lead role in the initial program design and implementation of Whole Person Wellness. Susan's retirement ushered in a direct oversight line to our Division Director, Omar Passons.

Locally we have continued to be a contributing partner to the Healthy San Diego workgroup for CalAIM ensuring a strong thread between the MCP's, HHSA, and CBCME's. We also initiated the requirement of the completion of our Services Transition Plan for all enrollees as of September 1 and have completed the verification of the Plans in case files. We utilized these Plans to inform our targeted transition of individuals to ACT and SBCM-level of care in our Behavioral Health Services programs. The transition activities involved frequent case conferencing, tracking of referrals and enrollments, and follow up support appropriate transition of care.

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.

Work on several items identified in the gaps analysis have been completed, including the data bridge through the Community Information Exchange (CIE) and the Homeless Management Information System (HMIS) as well as alerts from our local health Information Exchange (HIE) for both admissions and discharges from area hospitals. Other work noted on the Mid-Year Narrative has been completed with the exception of an update to the Care Plan membership administrative functionality which was changed to allow for an additional Care Plan member to be identified rather than a single user, as well as the “Who’s In Jail” alerts which will be moved to work in PY6.

By completing this Delivery Infrastructure work, we are making the work of determining eligibility and resource deployment for potential participants and those already enrolled more seamless and available as one login rather than several separate platforms. Direct access to our local HMIS supports universal metric determination for homelessness and housing metrics, as well as supporting CCP development based on housing and homelessness history. Work on the CCP application functions support easier review and quality assurance on the program side, encouraging timely updates and encouraging achievement of metrics associated with CCP completion and annual review.

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.

Our WPW pilot tracks the following Incentives:

55% of enrollees will have been enrolled within 1 month of their first outreach and engagement encounter. For PY5 this has been met with an achievement rate of 72%. Our SIT teams continue to refine their progressive engagement skills in the field while our referring partners work to ensure the best referrals are getting connected.

Total earned: $200,000 at annual reporting period. $133,333.33 payment to PATH and $66,666.67 payment to Exodus.

55% of enrollees will have a Comprehensive Care Plan complete within 30 days of enrollment. For PY5 this has been met with an achievement rate of 56%. Although we met this metric it was challenging for our providers due to the pandemic, resulting in a decrease from PY4 of 7%.
Total earned: $200,000 at annual reporting period. $133,333.33 payment to PATH; $66,666.67 payment to Exodus.

Institution Transition Enrollment Incentive
For each individual transitioning from jail or an Institute for Mental Disease (IMD) a one-time annual payment of $2,000 will be made to People Assisting the Homeless (PATH) or Exodus Recovery when an individual is re-enrolled following release.
No dollars claimed for the July – Decemberreporting period.
The WPW participants that enter into jail or an IMD have been found to not remain in the institutional setting long enough for their Medi-Cal coverage to lapse and therefore are never disenrolled from WPW.

Expand Countywide Respite capacity by 14 beds in 2020. For PY5 this have been achieved with the establishment of the 14 medical respite beds for use by WPW participants being discharged from inpatient settings but not quite ready to return to their housing.
Total earned: $188,799.40; $134,860 payment to PATH and $53,804 payment to Exodus.

Completion of Services Transition Plans for those enrolled as of September 1, 2020. This was verified individually through our CWSD platform. Contracted providers completed 462 individual Services Transition Plans in preparation of transitioning care to other social services programs and/or the Health Homes Program. Maximum approved payment is $143,542.40. Payment is pro-rated based on completion rate. PATH achieved 98% of transition plans completed and Exodus achieved 88%.

Total earned: $136,843.38; $47,368.86 payment to PATH, $21,052.83 payment to Exodus, and $68,421.96 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.

San Diego elects to use the COVID-19 Alternative Payment method for Pay for Outcome payments in Program Year 5. We achieved 75% of our Pay for Outcomes in Program Year 4. San Diego will receive 75% payment in Program Year 5, in the total amount of $2,118,559.69.

Decrease number of avoidable days spent in the hospital by new WPW clients during their first 12 months of enrollment by 5% compared to the 12 months immediately prior to pilot enrollment. This metric was met with a 6% decrease.

Decrease number of ED visits for new WPW clients during their first 12 months of enrollment by 5% compared to 12 months immediately prior to pilot enrollment. This metric was met with an 18% decrease.

Decrease number of Psychiatric Inpatient Units in the County by new WPW clients during their first 12 months of enrollment by 5% compared to 12 months immediately prior to pilot enrollment. This metric was met with a 38% decrease.

80% of new WPW clients will be seen by a primary care provider within 60 days of enrollment in the program. This metric was not met. We saw a 22% decrease in PY5 over PY4, likely due to challenges in getting individuals to agree to go in for PCP visits and decreased availability of appointments during the pandemic.

Increase the percentage of people who retain permanent housing at 6 months over the prior year by 5%. This metric was not met. We continued to see the same housing retention rate of 90% that was achieved in PY4, which is well above the national trend of housing retention that hovers around 85%.

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.

We continue to hold monthly Management Committee meetings, engaging leadership from our seven MCP's, Hospital Association, Continuum of Care, Public Safety Group, and Behavioral Health Services (BHS). We recently took feedback from our Management Committee stakeholders on the design for the programmatic Dashboard for PY6 planning and will move to producing a quarterly Dashboard that will now include Number Housed, Type of Housing, and Exit Disposition.

During our Internal Coordination meetings, we continue to use the brain trust within HHSA to lead discussions on data projects and transition planning for the pilot. Discussions have resulted in data mining ahead of transitions to SMI-specific services, allowing for greater buy-in and participation from BHS leadership through the transition coordination period.

Clinical Review Team (CRT) continues to be a mainstay of our learning and care coordination for those hardest to serve, and supports important knowledge transfer on navigating the complexities of the healthcare system. This has formed a critical part of County input regarding Cal-AIM implementation as this is an aspect of the pilot that would be important to maintain to maximize the success of Cal-AIM.

Detail of meetings attached.

VIII. PROGRAM ACTIVITIES

Care Coordination

A. Briefly describe 1-2 successes you have had with care coordination.
    1. Through case conferencing with Behavioral Health and their providers we have seen record enrollments in both ACT and SBCM-level services.
    2. The Services Transition Plan that was developed during the Mid-Year program period was incredibly useful in our transition planning with other service providers during this reporting period.

B. Briefly describe 1-2 challenges you have faced with care coordination, and lessons learned from those challenges.
    1. We encountered some pushback from already stretched Behavioral Health service providers when transitioning individuals into their care. We worked through discussions to build an understanding of the benefits of transitioning individuals into SMI-specific services after they have been medically stabilized through their participation in WPW.

Data Sharing

A. Briefly describe 1-2 successes you have had with data and information sharing.
    1. We were able to work through data sharing concerns with a bridge of HMIS through the existing CIE bridge. A notice of these actions went out to the local Continuum of Care for their awareness.

B. Briefly describe 1-2 challenges you have faced with data sharing, and lessons learned from those challenges.
    1. Work for the “Who’s In Jail” alerts in ConnectWellSD has been stalled by ongoing data sharing and privacy conversations with the Sheriff’s Department. Our ConnectWellSD team is working through options for the alerts to be visible for a limited time so that the data does not remain in the care coordination platform.

Data Collection

A. Briefly describe 1-2 successes you have had with data collection and/or reporting.
    1. We have increased our capacity for data mining and reporting through increased hours and cross-training staff, particularly needed during the pandemic when there are many competing needs.

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

    1. We continue to refine our CWSD care coordination platform and maintain active data sharing relationships within Behavioral Health Services and the Sheriffs Department, and have renewed our MOA's for data sharing with the MCP's. This can be challenging when shifting priorities during the pandemic force departmental changes in staffing and new staff are unaware of existing processes and agreements. Additionally for the MCP's there were some questions from some Plans on the County's planned role in CalAIM when it came time to renew the MOA.

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

Local concerns over the CalAIM transition remain, especially given that we have seven MCPs to coordinate the transition of care with. We continue to lift up the best practices and lessons from our local pilot in a variety of stakeholder meetings, particularly those around housing resources in hopes of informing a uniform adoption of ECM and ILOS standards. In addition, the existence of HDAP housing resources has been an asset but even with the planned rollout of Whole Person Care Pilot One Time Housing Funds, there remains a significant need for ongoing funding for housing supply with sufficient operating subsidy for the most high-need individuals in the Pilot. Ensuring sufficient permanent housing linked with supports will maximize the long-term success of high-risk and high-need populations with a history of homelessness overall.

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:

5B. Eligibility Criteria – Homeless Indicator

5C. Transfer of Care

5D. Emergency Department Communication

5G. Care Plan Monitoring

5H. Care Plan Screening Tool

5I. Care Coordination

5J. ConnectWellSD Data

5L. HIE Coordination

5M. Services Transition

5N. Inpatient Utilization