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

San Joaquin County
Annual Narrative Report, Program Year 5
April 5, 2021

REPORTING CHECKLIST

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

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

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

Whole Person Care

San Joaquin County
Annual Narrative Report, Program Year 5
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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.

1. **Increasing integration among county agencies, health plans, providers, and other entities** – SJC WPC has developed effective partnerships with both County and non-County agencies and has continued to collaborate on coordination and integration to improve services to high-risk, complex individuals. Challenges included new workflows in response to COVID-19, outreach and engagement in the field while following COVID-19 guidelines and stay at home orders, and implementing processes with multiple agencies to identify, enroll, and place high-risk individuals in Project Room Key motel in response to COVID-19. Successes include increase engagement with homeless individuals at Project Room Key motel and shelters, the ability to quickly respond to the homeless population during the pandemic based on partnerships, data sharing, and increased utilization of Activate Care.

2. **Increasing coordination and appropriate access to care** – While we faced both challenges and successes, including responding to COVID-19, we continued to find innovative and effective approaches to provide services and supports to the homeless population. We increased our coordination as our program was a leading participant in various partnerships including COVID-19 response meetings, Continuum of Care committees, hospital and shelter meetings, and multiple other partnerships. These efforts helped to ensure agencies were able to focus on their scope of work while having access to other agencies to lean on and make sure the population was appropriately served.

3. **Reducing inappropriate emergency and inpatient utilization** – There were three primary factors that played a role in the reduction of inappropriate emergency and inpatient utilization. The first was Project Room Key, the second was extended shelter hours, and the third was the ability to have medical and behavioral health staff available at the shelters daily allowing them to help make assessments and provide services.

4. **Improving data collecting and sharing** – In PY5, we saw improvement with data collecting and sharing. Agencies widely shared the WPC consent which provided us the ability to compliantly collect and share information. We used Activate Care to track consents, share information, and coordinate care. One of our staff was assigned to data enter historical information as well as new information to provide as much data to partners collaborating on an individual.

5. **Achieving quality and administrative improvement benchmarks** – We continue to see improvements in both quantity and quality of data collected. While data collection does continue to have challenges including gathering from multiple partners, combining data, and reporting, we are encouraged that we will continue to integrate electronic systems into Activate Care and develop a shared language to help us with data quality and improvement.

6. **Increasing access to housing and supportive services** – In PY5, we were able to place several individuals into permanent housing as well as help people obtain documents and income needed to put them on the path of permanent housing. One successful collaboration was with Dignity Health and STAND. Through this collaboration, we were able to place 11 individuals who were previously homeless into permanent housing. Since the project was so successful, we are planning to replicate the model.

7. **Comprehensive Care Plan** – Activate Care continues to allow us to improve care coordination, reduce duplication of efforts, track outreaches and other engagements, and share data. Utilization of the platform increased with the need to coordinate in response to COVID-19. New partners joined the platform and most individuals with access began using the system at a higher rate.

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	170	63	70	40	45	54	442

Item	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12	Annual Unduplicated Total
Unduplicated Enrollees	83	32	32	167	48	58	862

Whole Person Care

San Joaquin County
Annual Narrative Report, Program Year 5
April 5, 2021

*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
Recuperative Care	$30,175.00	$20,995.00	$26,520.00	$23,715.00	$23,970.00	$41,735.00	$167,110.00
Recuperative Care Utilization	355	247	312	279	282	491	1,966
Care Coordination	$1,123.00	$617.65	$1,066.85	$1,066.85	$729.95	$786.10	$5,390.40
Care Coordination Utilization	20	11	19	19	13	14	96
BHS Integration Team	$50,594.10 (369.30 hrs)						
BHS Integration Team Utilization	1,610	1,356	1,407	1,444	1,248	1,157	8,222
DNU-Field Based Engagement of Homeless Individuals	0	0	0	0	0	0	0

Costs and Aggregate Utilization for Quarters 1 and 2

FFS	Month 1	Month 2	Month 3	Month 4	Month 5	Month 6	Total
DNU-Field Based Engagement of Homeless Individuals Utilization	0	0	0	0	0	0	0
DNU-Re-Entry	0	0	0	0	0	0	0
DNU-Re-Entry Utilization	0	0	0	0	0	0	0
DNU-211 Care Coordination	0	0	0	0	0	0	0
DNU-211 Care Coordination Utilization	0	0	0	0	0	0	0
DNU-Employment	0	0	0	0	0	0	0
DNU-Employment Utilization	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
Recuperative Care	$19,805.00	$16,405.00	$18,870.00	$20,060.00	$18,785.00	$10,540.00	$271,575.00
Recuperative Care Utilization	**233**	**193**	**222**	**236**	**221**	**124**	**3,195**
Care Coordination	$3,593.60	$3,818.20	$2,582.90	*	$842.25	*	$17,069.60
Care Coordination Utilization	**64**	**68**	**46**	*	**15**	*	**304**
BHS Integration Team	$150,747.95 (1,100.35 hrs)						
BHS Integration Team Utilization	**1,478**	**1,489**	**1,453**	**1,980**	**1,820**	**2,236**	**18,678**
DNU-Field Based Engagement of Homeless Individuals	0	0	0	0	0	0	0
DNU-Field Based	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
Engagement of Homeless Individuals Utilization							
DNU-Re-Entry	0	0	0	0	0	0	0
DNU-Re-Entry Utilization	0	0	0	0	0	0	0
DNU-211 Care Coordination	0	0	0	0	0	0	0
DNU-211 Care Coordination Utilization	0	0	0	0	0	0	0
DNU-Employment	0	0	0	0	0	0	0
DNU-Employment Utilization	0	0	0	0	0	0	0

Whole Person Care

San Joaquin County
Annual Narrative Report, Program Year 5
April 5, 2021

*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
Population Health PMPM	*	$32,536.14	$24,643.71	$29,797.95	$27,865.11	$28,026.18	$34,791.12	$177,660.21
MM Counts 1		202	153	185	173	174	216	1,103
PMPM High-Intensity Bundle	*	$8,019.04	$11,026.18	$13,030.94	$9,522.61	$6,014.28	$6,014.28	$53,627.33
MM Counts 2		16	22	26	19	12	12	107
PMPM Low-Intensity Bundle	*	$0	$0	$0	$0	*	$0	*
MM Counts 3		0	0	0	0	*	0	*

Amount Claimed for Quarters 3 and 4

PMPM	Rate	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12	Annual Total
Population Health PMPM	$161.07	$41,717.13	$50,414.91	$51,864.54	$51,381.33	$37,529.31	$41,878.20	$452,445.63
MM Counts 1		259	313	322	319	233	260	2,809

Amount Claimed for Quarters 3 and 4

PMPM	Rate	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12	Annual Total
PMPM High-Intensity Bundle	$501.19	$19,045.22	$9,522.61	$8,520.23	$7,016.66	$6,014.28	$10,023.80	$113,770.13
MM Counts 2		38	19	17	14	12	20	227
PMPM Low-Intensity Bundle	*	*	$9,888.16	$6,018.88	*	*	*	$23,645.60
MM Counts 3		*	23	14	*	*	*	55

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

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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.

Position	PY5 Approved Fund Amount	PY5 Mid-Year Invoice	PY5 Annual Invoice
Department Applications Analyst III	$10,000.00	$0	$0
Management Analyst II	$179,784.00	$70,053.07	$80,547.16
Accountant II	$25,004.00	$0	$0
Public Health Nurse	$143,627.00	$21,865.40	$40,244.25
Community Health Education Outreach/Registered Nurse	$183,373.00	$76,989.84	$76,989.84
Community Health Education and Outreach Events	$10,000.00	$0	$0
Learning Collaborative	$6,769.00	$0	$0
Office Specialist	$75,000.00	$40,935.45	$44,724.94
Office Supplies	$5,000.00	$951.59	$868.19
COVID Office Specialist	$50,000.00	$0	$11,712.94

- **Department Applications Analyst III** – In the original application process, a full-time Application Analyst was identified to help support WPC pilot. Due to an original delay in hiring and onboarding, most of the technical responsibilities fell to the Management Analyst with support from an outside partner, Intrepid Ascent. We reduced the budget for this position from $159,163.00 to $10,000.00. At PY5 Annual, we did not invoice anything for this line item.
- **Management Analyst II** – The Management Analyst is responsible for overseeing, creating, and implementing all aspects of the pilot. This person

coordinates with all partners and played a primary role in the COVID-19 response for the homeless in San Joaquin County. This position was originally intended to assist SJC Behavioral Health Services, but instead the incumbent has functioned at a higher level based on the needs of WPC. This position is also the primary staff person to work with local health plans on the transition to CalAIM. We increased the funding for this position from $139,784.00 to $179,784.00 with the plan to transition this position into a higher category. At annual, this position was fully staffed and invoiced $80,547.16 with the PY5 total $150,600.23, or 84% of Approved Fund Amount.

- **Accountant II** –This position was originally added to the application to help support the pilot with monitoring, tracking and providing financial reporting and invoicing for the Mid-Year and Annual invoices as well as supporting the Budget Adjustment and Rollover process. Based on the needs within the department and limited access to this position, we requested a reduction of funds for PY5 from $35,004.00 to $25,004.00. At PY5 Annual, we did not invoice anything for this line item.
- **Public Health Nurse** – The funding for this position was split between two organizations, Community Medical Centers (CMC) and SJC Public Health Services (PHS), as PY5 mid-year. In the second half of PY5, funding was solely allocated to PHS. At annual, this position was staffed and invoiced $40,244.25 with the PY5 total $62,109.65, or 43% of Approved Fund Amount.
- **Registered Nurse (Community Health Education Outreach)** – This entire line item was allocated to the SJCC Population Health team. This team provided services and supports to the homeless in the Project Room Key motel, COVID House for COVID positive, and encampments as allowed. We are invoicing $76,989.84 with a PY5 total of $153,979.68 or 84% of Approved Fund Amount.
- **Community Health Education and Outreach Events** – We did not invoice anything for this line item as we did not conduct any health education or outreach events through WPC. Education and outreach were done on a regular basis as part of the work.
- **Learning Collaborative Meetings** – We did not invoice anything for this line item as there was no travel for the Learning Collaborative based on COVID-19.
- **Office Specialist** – This position is responsible for supporting the WPC pilot with daily operations, reporting, Activate Care, data entry and all other areas of the program as needed. With a significant increase in referrals and data entry needs, we hired a part-time Office Worker to support the workload. We are invoicing $44,724.94 with a PY5 total of $85,660.39 or 114% of Approved Fund Amount. Based on overspending on this line item, we are requesting the overspend of $10,660.39 paid through the underspend on COVID Office Specialist line item.
- **Office Supplies** – We invoiced a total of $868.19 with a PY5 total of $1,819.78, or 36%, in office supplies needed to support the WPC pilot at Annual PY5.
- **COVID Office Specialist** - This position is responsible for supporting the WPC pilot with all COVID support. With a significant increase in referrals and data

entry needs, we hired a part-time Office Worker to support the workload. A total of $11,712.94, or 23%, is being invoiced at Annual PY5.

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.

Item	PY5 Approved Fund Amount	PY5 Mid-Year Invoice	PY5 Annual Invoice
Hardware/Software	$140,000.00	$1,159.85	$3,971.83
Health Information Exchange	$435,827.00	$900.00	$67,338.25

- Hardware/Software items – This budget area allowed us to purchase hardware and software items as needed to support the pilot. Expenses we incurred included cell phones, tablets, and Zoom subscriptions. Cell phones were provided to Behavioral Health, Correctional Health, SJCC Population Health, and Public Health team members. Cell phones and tablets provide access to Activate Care and other necessary websites for services and housing. We are invoicing $3,971.83 with a PY5 total of $5,131.68, or 4% of Approved Fund Amount.

- Health Information Exchange – We saw a significant increase in utilization of this line item. We completed a couple integrations from the General Hospital, some user learning collaboratives, a newsletter, and development of a few reports. We originally anticipated more integrations, assessment forms, and reports, but due to COVID-19, integrations and other data systems in this category were developed and implemented at a reduced rate. We are invoicing $67,338.25 with a PY5 total of $68,238.25, or 16% of Approved Fund Amount.

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.

Item	PY5 Approved Fund Amount	PY5 Mid-Year Invoice	PY5 Annual Invoice
Health Information Exchange	$358,459.50	$82,611.25	$113,292.50
Medical Transition Program	$120,000.00	$60,000.00	$60,000.00
Community Transition Program	$179,999.50	$42,000.00	$22,000.00
Consent Forms	$75,000.00	$0	$0
Data Sharing/Care Management	$175,000.00	$0	*
Medi-Cal Eligibility	*	*	*
Homeless Management Information System Data Entry	$200,000.00	$0	$200,000.00
Continuum of Care	$200,000.00	$0	$200,000.00
Post-Incarceration Medi-Cal	$90,000.00	$0	$0
Patient Advocate/Navigator	$15,000.00	$868.68	$0

- **Health Information Exchange** – SJCHIE partially achieved their incentive requirements by providing HIE Infrastructure Development, Case Management Infrastructure, Data Management, and support with Activate Care. Total invoiced at annual PY5 was $113,292.50, or 32%. This is paid to the Intrepid Ascent on behalf of the SJCHIE that supports the work of several agencies within the system.

- **Medical Transition Program** – This incentive was partially met. The purpose of this program is to support a drop-in clinic and available appointments at San Joaquin County Clinics for homeless individuals released from incarceration and inpatient hospitalization within 14 days of release to help remove some of the

barriers within the homeless population. Total invoiced at annual PY5 was $60,000.00 (6 units), or 50%. This is paid to San Joaquin General Hospital that supports the work of several agencies within the system.

- **Community Transition Program** (previously Re-entry) – This incentive was partially met. In our PY5 budget adjustment we requested re-entry change to Community Transition Program. This program expanded referrals from the County jail to with the incentive for one-time unique new enrollment into WPC. Total invoiced at annual PY5 was $22,000.00 (11 units), or 12%. This is paid to the County of San Joaquin Correctional Health Services that supports the work of several agencies within the system.

- **Consent Forms** – This incentive was not met. Due to difficulty in obtaining consent forms we created this incentive hoping to incentivize partners in getting the consent forms. Unfortunately, we were not able to attain data from partners at mid-year or annual to invoice. At annual we will not invoice for this Incentive.

- **Data Sharing/Care Management** – This incentive was partially met. This incentive was put in place allowing partners to collect payment if they supported the Activate Care platform as it is our method of data sharing and care coordination. Total invoiced at annual PY5 was * (*), or 30%. This is paid to the SJC Behavioral Health Services, SJC Public Health Services, SJCC Population Health, and Health Care Services agency to supports data sharing, data collection, and care management.

- **Medi-Cal Eligibility** – This incentive was partially met. Eligible Medi-Cal is vital to the individuals referred to WPC. To maintain continuous enrollment and receive services, it is critical that Medi-Cal eligibility is checked on a monthly basis and anyone whose Medi-Cal is not eligible, to work with an eligibility worker to regain coverage. Total invoiced at annual PY5 was * (*), or 50%. This is paid to the County of San Joaquin Health Care Services Agency that supports the work of several agencies within the system.

- **Homeless Management Information System (HMIS) Data Entry –** This incentive was fully attained. The HMIS system allows WPC as well as other agencies throughout the County to collect data on the homeless population as well as the housing programs they are eligible for. We expect the HMIS system to play a key role in CalAIM and the sustainability of WPC. Total invoiced at annual PY5 was $200,000.00, or 100%. This is paid to the County of San Joaquin Health Care Services Agency.

- **Continuum of Care Strategic Plan –** This incentive was fully attained. The Continuum of Care (CoC) is designed to promote the goal of ending homelessness. The SJC WPC Lead Entity is committed to working with the CoC as a general member as well as multiple committees including the Strategic Planning, HMIS and Data Committee, Coordinated Entry Committee, and Shelter Committee. Total invoiced at annual PY5 was $200,000.00, or 100%. This is paid to the County of San Joaquin Health Care Services Agency.

- **Post-Incarceration Medi-Cal –** This incentive was not met. One area we have determined as critical is ensuring homeless individuals have access to Medi-Cal and ensure their Medi-Cal is active. Due to COVID-19, our ability to support the individuals needing to obtain their Medi-Cal coverage post-incarceration was significantly hindered. At annual we will not invoice for this Incentive.

- **Patient Advocate/Navigator** – This incentive was not met. A Patient Advocate/Navigator is critical to supporting WPC enrollees with the housing process. Due to COVID-19, the agency we utilized to support our enrollees with the process were not available to provide the level of support they did in the past. At annual we will not invoice for this Incentive.

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 Joaquin County WPC has four Pay for Outcomes: Reduce Emergency Department visits, Increase Housing Services, Clients with HbA1c<8%, and Reduce Inpatient Utilization by 70%. San Joaquin County Whole Person Care elects to use the COVID-19 Alternative Payment method for Pay for Outcome in Program Year 5. SJCWPC achieved 76% of our Pay for Outcomes in Program Year 4. SJCWPC will receive payment in Program year 5 in the total amount of $21,581.92.

- **Reduce Emergency Department visits** – This outcome is based on our ability to reduce the number of emergency department visits based on our entire WPC enrolled population. The target for achievement is a 5% decrease over the previous year. Our rate of ED visits at the Annual report for PY4 was 412, and in annual PY5 was 45.

- **Increase Housing Services** – This outcome is based on our ability to increase enrollees who are referred to a housing service who receive a housing service. The target for achievement is a 5% increase over the previous year. The rate of housing services in PY4 was 100%, and at annual PY5 was 100%.

- **Clients with HbA1c<8%** - This outcome is based on our ability to increase the number of enrollees who have a diabetes diagnosis to a HbA1c value of <8%. The target for achievement is at least 70% of individuals enrolled will reduce their HbA1c values to < 8%. Based on the information we were able to collect and the decrease in enrollees who had updated tests based on COVID-19, the enrollees with HbA1c<8% in PY4 was 83%, and at annual PY5 was 62%.

- **Reduce Inpatient Utilization by 70%** - This outcome is based on our ability to reduce hospital inpatient utilization of our entire WPC enrolled population. The target for achievement is a 70% decrease over the previous year. Our rate of IPU in PY4 was 63, and at annual PY5 was *.

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.

See attached

VIII. PROGRAM ACTIVITIES

Care Coordination

A. Briefly describe 1-2 successes you have had with care coordination.
    1. The Activate Care platform has allowed the WPC Admin team and partners to share data, document outreaches and engagements, have confidential conversations within the platform, set goals, and support all care coordination functions.
    2. We participate in several Continuum of Care committees and we have found that through our engagement with the Coordinated Entry and Shelter Committees, we have increased our opportunities to develop partnerships and strategies to provide care coordination effectively.
B. Briefly describe 1-2 challenges you have faced with care coordination, and lessons learned from those challenges.
    1. One the biggest challenges we faced is that due to the COVID-19 pandemic, it was difficult to engage some of the community agencies we otherwise would have tried to work with. Based on stay at home orders and other guidelines, connecting with those agencies was more difficult. What we learned that was by establishing scheduled Zoom type calls, we were able to connect and work on care coordination strategies.
    2. Another challenge we faced was that some agencies had to pivot their work to the point that they were no longer able to provide the level of engagement to WPC enrollees that they normally would. We ended up utilizing staff at the motels and shelters to help fill some of the gaps.

Data Sharing

A. Briefly describe 1-2 successes you have had with data and information sharing.
    1. In the first half of PY5 we integrated the San Joaquin General Hospital Emergency Department visits and Inpatient stays into Activate Care. In the second half we audited the information and found there were data fields that were not populating. By the end of 2020, those fields were populating and allowing our teams to have access to referral reason, attending physician and discharge information that was not previously available.
    2. With an increase in partnerships due to COVID-19 response, our WPC Consent was more widely shared, and more consents were completed.
B. Briefly describe 1-2 challenges you have faced with data sharing, and lessons learned from those challenges.
    1. A primary challenge we faced was our inability to integrate our County Jail data system into Activate Care. The integration would have allowed us to share data regarding WPC enrollee bookings and releases. We had hoped to have it in place by mid PY5, but unfortunately, the year ended without the integration.

2. Another challenge we faced was one of our local health plans continued to withhold data on WPC enrollees because we did not have a specific MOU in place. While we have a bigger agreement in place which should allow data sharing, they wanted to implement a specific WPC MOU. This created a problem for us both with data sharing and data collection.

Data Collection

A. Briefly describe 1-2 successes you have had with data collection and/or reporting.
    1. Through assessment forms and customized data fields in Activate Care, we were able to document more client specific information and therefore generate reports allowing us to share our outcomes and metrics.
    2. There was an increase in willingness to share data to respond to the pandemic which allowed us to collect more information and report more accurately.
B. Briefly describe 1-2 challenges you have faced with data collection and/or reporting.
    1. We continue to face data collection challenges from several partners we hoped would utilize Activate Care at a higher rate. We included incentives in contracts to see if that would help but found that it was often not enough to encourage partners to utilize the system.
    2. Another challenge we faced was one of our local health plans continued to withhold data on WPC enrollees because we did not have a specific MOU in place. While we have a bigger agreement in place which should allow data sharing, they wanted to implement a specific WPC MOU. This created a problem for us both with data sharing and data collection.

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

The biggest barrier we face at this time is the uncertainty of how we will transition into CalAIM and how the partnership will develop. We continue to find that the health plan(s) are trying to take the innovation and flexibility of the services and population of WPC and fit it into a traditional model. One of the reasons WPC has worked so well is that it has allowed us to be innovative, flexible, and look at the whole person and not be restricted to working in a narrow focus. We are encouraged by recent conversations with one of our two local health plans, and have a scheduled meeting with our second local health plan, but we are still concerned about the details of how the target populations, funding, data, and collaboration will work.

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.

See attached