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

Shasta County Health and Human Services Agency
Annual Narrative Report PY4
March 31, 2020

REPORTING CHECKLIST

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

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

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

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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.

- **Increasing integration among county agencies, health plans, providers, and other entities;**
  - The Pilot Team continues to meet semi-monthly on the second and fourth Tuesdays however, team collaboration is becoming a fluid, regular part of the day-to-day work of teamlets and the pre-scheduled meetings are becoming less essential for coordinated case management.
  - We continue to review eligible referrals as a group on a twice monthly basis. This helps to begin sharing information about potential participants as early as possible and review relevant, ongoing conditions as a group prior to initiating outreach efforts.
- **Increasing coordination and appropriate access to care;**
  - As the necessity of utilizing our regular team meetings for care coordination diminished, we looked towards incorporating community training sessions to fill gaps in understanding of our system of care in Shasta. Towards the end of PY4, our team held a series of strategy sessions to discuss our needs for successful service provision in the coming year. We plotted out the trainings that would help fill those needs, created a calendar, and invited local service providers to attend a yearlong series of monthly trainings to begin in 2020. These trainings will serve to further educate and connect providers in our system of care on the resources available in our community, in preparation for the end of the pilot.

- **Reducing inappropriate emergency and inpatient utilization;**
  - Health Literacy education remains a top priority for RNs and case managers working with WPC participants in the teamlets. Education around the maintenance of chronic conditions, local non-emergency resources, and the need for regular medical visits has proven effective for many WPC participants.

  - The implementation of the mobile crisis team has supported efforts to dissuade mental health related visits to ERs by giving community members and law enforcement an urgent needs resource during business hours. The ability to write 5150's and transport people to the correct resources, instead of the ER has been a boon for our emergency service professionals. During the reporting period, the mobile crisis team transported 185 people to the hospital or appropriate service provider, mitigating expensive ambulance rides. In addition, the team conducted 199 evaluations for 5150 status, which would likely have been done by emergency service providers, had the mobile crisis service not been available.
  - The Sobering Center has had difficulty with obtaining the required medical clearance to admit participants and circumvent inappropriate ER utilization. Solutions are still needed to mitigate the need for medical clearance with potential participants without having to utilize an ER referral process. However, during the reporting period, of the [redacted] admissions to the sobering center, [redacted] transitioned into detox services and continued on from there to residential treatment. The service seems to be working, once folks get into the center.

- **Improving data collecting and sharing;**
  - Our multiparty, bi-directional release of information allows us to share information amongst the Pilot Team. We had been able to shorten this form during the first half of PY4, but a reversal by our HIPAA team on the interpretation of 42 CFR Part 2 and the details required for authorizing information sharing with non-treating providers caused us to revert back to the longer form during the second half of the year.
  - Our billing and data collection spreadsheet to track mobile crisis team and sobering center activity continues to provide useful information for service oversight, billing/invoicing, and collection of basic outcomes data for tracking. The mobile crisis team and our project coordinator were able to fine tune the delivery of services to accurately reflect the pilot goals and contract requirements through deep analysis of contacts and interventions provided through this spreadsheet. As a result 617 contacts in PY4 were connected to community resources and there were 244 interventions in cases of reported suicidal ideation.
- **Achieving quality and administrative improvement benchmarks;**
  - Having built our pilot with the administrative measures as milestones, we successfully established policies and procedures from our system model. Policies and procedures include comprehensive care plans, care coordination, referral infrastructure, data and information sharing. These policies and procedures were updated and revised to accommodate the growth and advancement of the pilot in the previous reporting year and have been adjusted this year to include graduate feedback surveys.

  - Updates to policies and procedures have been small and infrequent, as they were designed by the direct service providers doing the work with experiential knowledge of the services themselves, in partnership with administrative personnel of Lead Entity.
  - Data collection from alcohol and drug resources and for those participants with Medicare continue to pose challenges. Toward the end of PY4, WPC staff were able to gain access to SacValley Med Share, which has helped address the issue of Medi-Medi referrals. WPC staff are now able to screen ED/IP admission criteria and medical history for Medi-Medi referrals prior to the staffing meetings.
- **Increasing access to housing and supportive services;**
  - The housing case managers work extensively with participants to teach skills for obtaining and maintaining a home (not just temporary shelter.)
  - Shasta County is challenged with a significantly limited housing stock, especially appropriate affordable housing (room and board, board and care, shared housing, etc.). The housing case managers are resourceful, skilled in the housing first approach, and work diligently to help our participants connect with the services, supports and resources necessary for becoming homed. The 2019 rollover tenancy support fee-for-service benefit began utilization during June and was very helpful with housing stabilization. Of the 23 participants who utilized this resource in half of PY4, [redacted] have graduated the program, 12 continue to be enrolled in services, [redacted] relocated out of the area, [redacted] disenrolled. [redacted] Participants utilized the fee for service post-mortem to have the unit cleaned following [redacted] passage in the unit. This mitigated damage to landlord relationship with WPC service providers and loss of a housing resource.

- **Improving health outcomes for the WPC population;**
  - WPC Participants have a medical case manager, housing case manager and an RN working collaboratively with them to address their priority health and housing goals. This team has assisted participants in increasing health literacy about health care, health systems and healthy choices. Teams have assisted participants in obtaining shelter and housing which has been a significant step towards improving health outcomes and overall quality of life. Teams have also assisted participants repair relationships, learn skills for daily living, connect with resources such as benefits, food, dental care, substance use treatment, credit repair and other daily supports. Improvement in health outcomes reported here pertains more to the Participant's goals and objectives instead of as reported in the metrics.
  - Challenges arise when service provider perceptions of appropriate choices differ from the Participants'. The differing views of needs and appropriate treatment, services or interventions may happen between providers or between a participant and the care team. Harm reduction strategies are a frequent discussion item at our Pilot Team meetings.

- As much of our work in improving health behaviors is a harm reduction approach, it is difficult to utilize standard markers of improved health outcomes in many instances. We are looking to find ways to document health behavior change as a supplemental measure and how this can be applied to indicating improvements in a population health measurement.
- One additional challenge that is becoming increasingly problematic is the lack of medical and behavioral respite facilities in the area. The system of care falls short of serving those who might no longer need intensive inpatient services, but are not yet ready to live independently. WPC participants who are discharged from inpatient services and onto the streets are likely to decompensate and find themselves back in the emergency rooms. Access to appropriate respite care would serve to mitigate that gap in service.

III. ENROLLMENT AND UTILIZATION DATA

Instructions: For the Mid-Year report, provide data for January-June 30 of the Program Year and for the Annual Report, provide data for January-December 31 of the Program Year.

The tables below should reflect enrollment and utilization numbers, consistent with your invoice and quarterly enrollment and utilization reports.

For revisions of enrollment and utilization data submitted during the Mid-Year Report (Months 1-6), changes should be made in bold. Additionally, note explicitly in the additional box at the end of this section if no changes were made to the Mid-Year reported data.

Item	Month 1	Month 2	Month 3	Month 4	Month 5	Month 6	Unduplicated Total
Unduplicated Enrollees	[redacted]	12	[redacted]	11	16	6	61

Item	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12	Annual Unduplicated Total
Unduplicated Enrollees	12	14	[redacted]	[redacted]	17	[redacted]	128

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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	0	0	[redacted]	[redacted]	0	[redacted]	[redacted]
Utilization 1	0	0	[redacted]	[redacted]	0	[redacted]	[redacted]
Service 2	$4,835.88	$3,895.57	$6,850.83	$7,388.15	$9,134.44	$13,164.34	$45,269.21
Utilization 2	36	29	51	55	68	98	337
Service 3	0	0	0	[redacted]	0	[redacted]	[redacted]
Utilization 3	0	0	0	[redacted]	0	[redacted]	[redacted]

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	[redacted]	[redacted]			[redacted]	[redacted]	$3,250.00
Utilization 1	[redacted]	[redacted]			[redacted]	[redacted]	13
Service 2	$17,462.90	$20,418.16	$20,015.17	$15,179.29	$14,373.31	$16,791.25	$149,509.29
Utilization 2	130	152	149	113	107	125	1,113
Service 3	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	$24,374.81
Utilization 3	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	39

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*For **Per Member Per Month (PMPM),** please report your rate, amount claimed and member months by PMPM type. These reports should tie to your budget, invoice and utilization reports. For "Bundle #" below, use the category number as reported in your submitted Quarterly Enrollment and Utilization Report. Add rows as needed*

Amount Claimed								
PMPM	Rate	Month 1	Month 2	Month 3	Month 4	Month 5	Month 6	Total
Bundle #1	$595.00	$41,650.00	$41,650.00	$40,460.00	$41,055.00	$45,220.00	$47,005.00	$257,040.00
MM Counts 1		70	70	68	69	76	79	432
Bundle #2	$816.41	$58,781.52	$55,515.88	$56,332.29	$56,332.29	$61,230.75	$62,047.16	$350,239.89
MM Counts 2		72	68	69	69	75	76	429

Amount Claimed								
PMPM	Rate	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12	Total
Bundle #1	$595.00	$ 47,600.00	$ 45,220.00	$ 40,460.00	$ 41,055.00	$ 47,005.00	$ 45,815.00	$ 267,155.00
MM Counts 1		80	76	68	69	79	77	449
Bundle #2	$816.41	$ 62,863.57	$ 61,230.75	$ 53,066.65	$ 56,332.29	$ 65,312.80	$ 62,047.16	$ 360,853.22
MM Counts 2		77	75	65	69	80	76	442

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

The information included here are all enrolled members including those that were "Administratively Enrolled". This means that they are open to outreach only services. Once the Comprehensive Care Plan is completed then they are Enrolled into the program to receive full services. The metrics submitted are based on those members that were Enrolled for full services. Of the 162 referrals that were administratively enrolled during 2019 – 71 were enrolled into services.

The tenancy support fee for service allowance (FFS #3) approved in our rollover was utilized by 24 participants during PY4, in the amount of $24,374.81. Lead Entity responsibly tracked the utilization of this fee for service and learned from housing case managers that many participants were able to mitigate loss of housing through this benefit. In addition, several landlord-service provider relationships were salvaged by utilizing this benefit for unit damage and cleaning, allowing for continued access to housing options for our participants.

The Mobile Crisis Team saw their first fee for service call in January of this reporting period. Of the contacts made during PY4, 1,113 were deemed billable in accordance with the terms of the contract.

The Sobering Center saw their first fee for service admission in March of this reporting period. Admissions were very limited due to unforeseen issues with medical clearance necessity. Lead entity and contractor are continuing to work on focused solutions with local law enforcement and emergency medical service providers to address the need for medical clearance prior to Sobering Center intake.

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.

Administrative Infrastructure includes the HHSA Adult Services personnel required for the day-to-day implementation, monitoring and evaluation of the WPC pilot program. The personnel included in administrative infrastructure are responsible for data collection and program reporting, management of contract partners, management of program budgets and fiscal administration, and data analysis and PDSA activities. This category also includes costs for licensing software for HHSA personnel and partner entities to collect and analyze program data and report program metrics.

The HHSA personnel includes the Community Development Coordinator, the Program Manager and the Senior Staff Services Analyst. During the current reporting period a new Community Development Coordinator, Rhonda Schultz was hired and began work on January 7, 2019.

Additional HHSA personnel from the contracts and fiscal units were assigned to the WPC pilot on a .25FTE basis for supporting contract and budget needs. The Senior Staff Services Analyst position was filled for the entirety of the reporting period.

The Community Development Coordinator and Senior Staff Services Analyst facilitate and support the WPC Pilot Team; guide the Pilot Team in refining the WPC system model; polish and adapt the policies and procedures; provide resources and guidance to enable the identification and enrollment of WPC Participants; gather referrals for staffing; create and improve mechanisms for documentation, information sharing, data storage and reporting; distribute reports, tracking spreadsheets and program specific data; present WPC to community partners and utilize the PDSA cycles to adapt and refine the WPC Pilot with the Pilot Team as needed.

Software for tracking program metrics- software to track client encounters, as well as program progress and outcome measures needed to meet the metric reporting obligations of the WPC pilot have been difficult. During the reporting period, we were able to complete the addition of SharePoint as a resource for team access to WPC participant records and care plans. This option works similar to a VPN, but does not have analytic, reporting, or detailed data collection features. We continue to utilize the Access database we designed for these purposes.

IV. NARRATIVE – Delivery Infrastructure

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

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

Delivery Infrastructure includes: funding for the mental health resource center, coordination of the Continuum of Care (CoC) for Redding and Shasta County, licensing of a Homeless Management Information System (HMIS), a Mobile Mental Health Crisis Team, a Sobering Center, and training for WPC pilot staff and partners.

Contracts for medical case management are maintained with two Federally Qualified Health Centers (FQHC). During this reporting period both centers (Shasta Community Health Center and Hill Country Health & Wellness Center) experienced staffing changes. At the end of this reporting period, Hill Country Clinic had a full team of RN and Medical Case manager, while Shasta Community Health Center had two full teams and dedicated program supervisory staff.

As part of the Health and Human Services Agency, the Regional Services Branch, Housing Unit provides case managers. We continue to struggle to find a full housing team. Issues cited for slow hiring and retention of case managers are related to staff health and burnout and a limited pool of qualified candidates in the region. The caseloads for the Housing Unit are 20-25 participants per caseworker, however the complexity of housing issues related to participant conditions and traumas, along with the shortage of housing in our community lead to intense demands on housing case managers, which is difficult to endure for extended periods of time.

We continue work with the peer-support volunteer program that currently exists within the HHSA. This program has trained 11 people in peer support services and delivered [redacted] volunteers who regularly provided volunteer services with the housing case managers. Towards the end of PY4, we experienced a set-back in the MHSA Academy, which produces peer support volunteers. The program was put on pause due to a staffing shortage and has plans to resume in mid PY5. At the end of PY4 there were only [redacted] peer support specialists employed by HHSA and [redacted] active volunteer.

The Hill Country Mobile Crisis Team delivered their first fee for service activity during this reporting period. After some difficulty building call volume in the beginning of the year, the team received 1,113 billable calls as of Dec 31, 2019. Analysis of calls to the mobile crisis team revealed that 91% of calls came from community members, while the

remaining 9% were law enforcement related. The call volume was never high enough to expand the service team to round the clock availability. MCT service hours for the two alternating teams consisting of a clinician and a case manager were Monday through Friday from 8:30AM to 7:00PM

Empire Recovery Center's Sobering Center also delivered their first fee for service activity during this reporting period and experienced limited success. Unanticipated complications with acquisition of medical clearance for admission to the sobering center have partially stalled participant entry. Despite the difficulties with garnering admissions to the facility, the sobering center saw a small success with getting participants to accept treatment. Of the 13 participants that were admitted to the center during the reporting period, [redacted] voluntarily chose to enter detox treatment following their stay.

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 Payments include the following:

- HMIS incentive to input a homeless person's intake information into the Homeless Management Information System (HMIS). Estimate a total of 150 WPC participants per year and $10 per HMIS entry. This activity will be conducted by CoC Coordinator and HHSA housing case managers. The incentive payments will be split as follows: 100 ($1,000) for CoC and 50 ($500) for housing case management based on completion of HMIS data entries. (for a total payment of $1,500)

  The housing case managers have entered 77 participant's intake information into the HMIS system during the second six months of PY4.

  Of the 77 entered 34 entries were paid at $10 each for a total incentive of $340.00 due to the cap of 150 entries.

- Sobering Center incentive for each WPC enrolled participant in the sobering center who enters detox program and stays at least 72 hours ($37.50 per client). Estimate that of WPC participants served by sobering center 50 will enter detox annually.

  [redacted] participants in the Sobering Center service transitioned into detox services following their stay at the sobering center, however only [redacted] remained in detox for 72 hours or longer. In designing this incentive, we failed to account for the fact that the length of stay in detox is predicated on medical necessity and not solely on participant dedication to or completion of treatment. Amount earned was $[redacted] paid to the sobering center contractor, Empire Recovery Center.

- Housing Support Volunteers incentive will be paid to HHSA Housing Support Volunteer Program for each 100 home visits to WPC enrolled participants completed per volunteer. Estimate 5,000 home visits per year.

  The Housing Support Volunteer Program had four volunteers providing services. The Volunteer program did not provide 100 home visits to any WPC enrolled participants during this period and due to this there is no incentive payment due.

- Housing case management incentive for each WPC enrolled participant who stays in permanent housing for at least six consecutive months. Estimate 50 per year; 75% of incentive paid to housing case management and 25% to intensive medical case management.

  There were 11 members who were permanently housed more than 6 months during this period.

  The total of 11 members, times $500.00, is a total of $5,500.00.

- Reduced ED utilization incentive for each WPC enrolled participant who has <2 emergency department visits for six consecutive months. Estimate 50 per year; 75% of incentive paid to intensive medical case management and 25% to housing case management.

  There were 34 members who reduced their emergency department visits to under 2 during the reporting period.

  The total of 34 members at 500.00, is a total of $17,000.00.

- Service and Program Barrier Reduction Incentive. This incentive was not utilized during PY4. There was no achievement for the first milestone of community learnings, in which all other milestones were predicated. The first milestone was operationalized through collection of graduate feedback surveys, of which we were only able to obtain [redacted] from our direct service providers. The main problem with collecting the surveys was that service providers felt too overwhelmed by the pre-existing workload to administer surveys to participants who no longer required services. This was an obstacle that we were not able to overcome during the 6 months we had to work on it.

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

The measure selected is "Increase follow-up within 7-days post-discharge for Mental Illness [Adults] for the WPC target population." The pilot goal is to increase follow-up by 5% per year. In PY4 the metric payment is based on follow up by 5% or more over PY3.

Pay for Metric Outcome Achievement incentives include enrolled WPC Participants in the measurement of performance on this measure. For the reporting period of January through December 2019 and [redacted] participants were hospitalized for mental illness and referred back to Shasta County Adult Services – Mental Health for follow-up/outpatient care.

There were [redacted] mental health hospitalizations for enrolled Whole Person Care clients during 2019. The [redacted] discharges correlate to the [redacted] mental health discharges reported last plan year. Showing a consistent reduction of psychiatric hospitalizations pre-enrollment in Whole Person Care vs. during enrollment.

While many participants have had psychiatric inpatient hospitalizations prior to enrollment only [redacted] participants were discharged during January through December 2019. Of those [redacted] only [redacted] were referred back to Shasta County Adult Services for follow-up outpatient care. Of the [redacted] referred back only [redacted] met this metrics threshold. The requirement threshold to be met during PY4 was 55%. The [redacted] that were contacted within 7 days of hospitalization discharge resulted in a 50% threshold, under the required 55%. Due to this no pay for metric took place.

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.

- 7/3/19 – SHARC data presentation and steering committee guidance
- 7/9/19- WPC Pilot Team meeting – Landing the WPC Plane Discussion – What do we need to meet our goals in 2020?
- 7/10/19-SHARC data presentation and steering committee guidance
- 7/18/19 -Sobering Center Meeting – issues with participation and referrals, medical clearance.
- 7/23/19- WPC Pilot Team meeting – Care Coordination Focus
- 8/6/19 – Bridges Out of Poverty Training – Service Provider training on culture of poverty and tools for successful provision of services to persons experiencing poverty.
- 8/7/19- SHARC data presentation and steering committee guidance
- 8/13/19- WPC Pilot Team meeting- Landing the WPC Plane Continued – brainstorming action steps for successful end of pilot
- 8/14/19 – Mobile Crisis Mental Health Response Workshop
- 8/27/19- WPC Pilot Team meeting- Care Coordination focus
- 9/4/19- SHARC data presentation and steering committee guidance
- 9/10/19- WPC Pilot Team meeting cancelled due to WPC Convening in Sac
- 9/24/19- WPC Pilot Team meeting- Care Coordination focus
- 10/2/19- SHARC data presentation and steering committee guidance
- 10/8/19 -WPC Pilot Team meeting – Narcan Kits and training, CRRC resource training
- 10/22/19 - WPC Pilot Team meeting- Care Coordination focus
- 11/6/19 - SHARC data presentation and steering committee guidance
- 11/12/19 -WPC Pilot Team meeting – Self Care, Viewing of Documentary “A New High”
- 11/19/19 – Mobile Crisis Team meeting – scope of practice, billing, referrals, 5150 holds
- 11/26/19 - WPC Pilot Team meeting- Care Coordination focus
- 12/4/19 - SHARC data presentation and steering committee guidance
- 12/10/19 – WPC Pilot Team meetings – SharePoint Usage, training calendar 2020, success stories

VIII. PROGRAM ACTIVITIES

Briefly describe 1-2 successes you have had with care coordination.

1. Incorporation of community partners into care coordination meetings has facilitated a deeper understanding of local resources among teamlets and is serving as a mechanism for educating partners on the practices that are proving most effective in whole person care. Additionally, due to the regular interaction, pilot staff are kept up to date on changes in community partner programs and can make adjustments in advance of changes. In PY4, there were [redacted] WPC participants who lost their Medi-Cal coverage momentarily. Due to the close collaboration between Partnership Health Plan and WPC LE, this lapse of coverage was repaired quickly and allowed WPC participants to avoid an interruption of critical health and housing services.

2. Care Coordination efforts for participants experiencing substance use disorders, mental health conditions, homelessness, and health conditions all at one time have proven critically effective in the case of [redacted] was also connected to mental health care and has begun services with a clinician at Shasta Community Health Center. The dedication of [redacted] teamlet and [redacted] perseverance and commitment have made this care coordination effort a grand success that likely mitigated the loss of a valuable life.

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

1. The cultures and priorities of the various organizations and professions involved in the WPC pilot project in Shasta County can be at odds on occasion. Blending service delivery into a cohesive teamlet when various providers have conflicting philosophies can be a challenge. The multidisciplinary nature of the teamlet allows for varied perspectives on best practices in assisting with participant goals – primarily relating to medical model practices and social work practices. Targeted teamlet meetings that prioritize collaboration have been helpful in finding mutually agreeable solutions for case management.

2. The high acuity of participant needs continues to be a challenge. Far more time and resources has been spent focusing on activities of daily living and basic social skills than was anticipated in the planning phases. Helping participants understand systems and gain the skills needed to navigate them has taken a lot of collaboration, creativity and shared efforts. The weight of these additional services combined with a dearth of qualified applicants for open positions on the teams has led to high burnout among direct service providers. Strategies for incorporating self-care into pilot team meetings and workflows of direct service providers has become a new priority during the reporting period and has proven successful in team building and stress relief efforts.

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

1. During PY4, we continued a monthly care coordination/collaboration meeting inviting agency partners to share their knowledge and ask questions of our program in an effort to improve participant outcomes.
2. Our tracking and analysis of the mobile crisis team contacts has helped the contractor to demonstrate to community stakeholders the importance of the work that they do and informed leadership of the types of calls and concerns prevalent in our community. We had assumed that the majority of calls would come in from our local law enforcement agencies, but they have had surprisingly few calls to the mobile crisis team, whereas 91% of the calls have come from community members themselves. This data tracking has also helped to mitigate strain with local emergency departments regarding a misperceived influx of mental health crises due to the presence of a mobile crisis team. The team tracked calls for 5150 evaluations and the final disposition of those calls. Of 1,113 calls made to the mobile crisis team, 199 of them were for 5150 evaluations. 149 of those calls did not result in a 5150 and instead, 135 calls that may have turned into transportation to the ER for a 5150 evaluation (were there no MCT to intervene,) instead resulted in mobile crisis triage and transportation to alternate, more appropriate service providers.

Briefly describe 1-2 challenges you have faced with data sharing, and lessons learned from those challenges.
One fundamental challenge with data and information sharing revolves around how much information to share, when and with whom. Operating under the premise of "only enough to do the job" or "Need to Know vs. Nice to Know" has been helpful. We have learned to be clear about expectations across industries and general information sharing guidelines. Finding a software program or technology option that allows for all Pilot Team members to access the data and participant information in one place has been fruitful and well-received by team members. The simple, intuitive platform of SharePoint made data entry and utilization easy on our pilot team. Implementation of this product, once we were able to clear the infrastructure and administrative hurdles, was smooth and well-managed. We are now able to display participant records live while going through the staffing process for our WPC pilot teamlets.

Briefly describe 1-2 successes you have had with data collection and/or reporting.
1. The database, spreadsheets, paper copies of ROIs and comprehensive care plans sent via encryption still allow for functional data collection and reporting. The Database allows for information to be customized and presented in graphs and charts that help to inform our stakeholders. These formats also allow for functional collection of data from our participating entities to inform the required reports to the State. While a system that allows all of this information to be shared or accessed in one location is preferred, all of the necessary components have been created and are easy to use and access.

Briefly describe 1-2 challenges you have faced with data collection and/or reporting.
1. LE continues to work with DHCS on the HEDIS measures for additional clarity as well as in the HEDIS measures with the WPC adaptations. Partnership Health Plan has added a restriction on data sharing whereas they are requiring six weeks of advanced notice for reporting out on metrics, making it difficult to collect the needed data to share with the state in this report. We requested aggregate data, to ease the constraints of their internal policies related to confidentiality and that helped to get the data we needed in time for incorporation into this report, but hampers our ability to conduct any meaningful analyses on our side. 2. There remain varied interpretations of HIPAA laws and data sharing agreements, which impede and delay data collection during critical reporting timeframes.

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

The challenges of navigating a complicated system of care while living with dual-diagnosis chronic health conditions, disability, stigma, and isolation are not solved by housing. These challenges require intensive case management across the spectrum of services and are necessary to address the health disparities we see for people of limited economic means in our community. Here in Shasta specifically, our health providers are overburdened due to a lack of qualified providers across the continuum. When community members are unable to access primary care, or even case management supports in a timely manner, health conditions can worsen or go overlooked, and lead to more expensive and extreme burdens on our collective human capitol. The difficulty of attracting qualified health care providers into rural areas that lack the resources and leisure activities that populous cities have to offer is a fear for this pilot. At the end of this reporting period we were developing an extensive waitlist, which has only gotten longer in PY5. We don't have the access to enough qualified providers to staff the project to meet the demand for this service in our community. Should the benefits of enhanced care management and in lieu of services be offered as a comprehensive package for our vulnerable community members, we may still be at a loss for quality providers able to meet the demand. The Shasta County Whole Person Care pilot has become burdened with a waitlist of at least 17 qualified referrals per FQHC. The difficulty in locating RNs and case managers willing to accept the emotional demands of this work, qualified to provide these complex services, willing to live in a rural area, and willing to work 8 hour shifts (instead of the standard 3 days,12 hour shifts) has led to a higher demand in our community for the whole person care services than we are equipped to meet.

In addition to the staffing concerns for our community, we also fear a loss of the core component of our program: the care coordination. While we are working hard to advocate in our discussions with our MCP for County administration of contracts and oversight in collaborative care delivery, we worry about the silos that we worked so hard to destroy in WPC being rebuilt by a change in the payment structure for service delivery and a lack of regard for the critical component of the community development, analyst, and general oversight positions that have helped guide the success of this project.

IX. PLAN-DO-STUDY-ACT

Instructions: PDSA is a required component of the WPC program. The WPC PDSA Report template will be used for each PDSA that the LE is conducting. Summary and status reports are required components of your Mid-Year and Annual reports. Please attach all required PDSA documents and completed template demonstrating your progress in relation to the infrastructure, services, and other strategies as described in the approved WPC LE application and WPC STCs. Note: For the Mid-Year Report, submit information from January – June 30. For the Annual Report, submit information inclusive of all PDSAs that started, are ongoing, or were completed during the Program Year.

PDSA Attachments:

1. Shasta WPC PDSA Ambulatory Care 1 PY4 2019 - Why ED
2. Shasta WPC PDSA Ambulatory Care 2 PY4 2019 - Health Literacy
3. Shasta WPC PDSA Care Coordination 1 PY4 2019 - Est Care Coord
4. Shasta WPC PDSA Care Coordination 2 PY4 2019 - Referral System to Staffing
5. Shasta WPC PDSA Comprehensive Care Plan 1 PY42019 - Design CCP
6. Shasta WPC PDSA Data 1 PY4 2019 - Sharing Data
7. Shasta WPC PDSA Data 4 PY4 2019 – SharePoint
8. Shasta WPC PDSA Inpatient Utilization 1 PY4 2019 – Why IP
9. Shasta WPC PDSA Other 2 PY4 2019 - Elig Criteria