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

Shasta County
Annual Narrative Report, Program Year 5
April 1, 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

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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.
  - Project Room Key is an added resource for our agencies and partners. During PY5 there were 36 participants sheltered thru this program for an average of 4 months and a total of 138 months during 2020.+
- **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. We plotted out the trainings that would help fill knowledge gaps and invited local service providers to attend a yearlong series of monthly trainings in PY5. These trainings began in January with a presentation about inpatient and ED transitions and dispositions related to mental health. The trainings were impacted by the Coronavirus Pandemic and came to a halt.

- **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 464 people to the hospital or appropriate service provider, mitigating expensive ambulance rides. In addition, the team conducted 474 evaluations for 5150 status, which would likely have been done by emergency service providers, had the mobile crisis service not been available.
- **Improving data collecting and sharing;**
  - 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, 352 contacts in PY5 were connected to community resources and there were 145 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. The end of PY5 saw the implementation of the Medi-Cal Organized Delivery System for drug and alcohol services, which we anticipate will facilitate future benchmarks in this area.
- **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 2020 rollover tenancy support fee-for-service benefit began utilization during March and was helpful with housing stabilization. Of the 37 instances/25 participants who utilized this resource in PY5, 14 have graduated the program, * continue to be enrolled in services, and * were disenrolled for various reasons.

- **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 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 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 than those 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.
  - An unexpected and unique aspect of services came out of the pandemic's creation of Project Room Key. Throughout the first 3 ½ years of the program our participant demographic skewed to the above 50 age group. More specifically the 50-59 age group far outnumbered the other age groups. Since Project Room Key our population became more balanced

between the age ranges with 30-39 year olds now out pacing the other groups.

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	18	*	*	12	*	13	65

Item	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12	Annual Unduplicated Total
Unduplicated Enrollees	15	21	*	*	*	11	66

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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
Sobering Center $	$ -	*	$ -	$ -	$ -	$ -	*
Sobering Center Utilization	0	*	0	0	0	0	*
Mobile Crisis Team $	$17,731.56	$12,089.70	$19,074.86	$17,597.23	$11,955.37	$13,970.32	$92,419.04
Mobile Crisis Utilization	132	90	142	131	89	104	688
Tenancy Support $	$ -	$ -	*	*	*	*	$13,586.37
Tenancy Support Utilization	0	0	*	*	*	*	22

Costs and Aggregate Utilization for Quarters 3 and 4

FFS	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12	Annual Total
Sobering Center $	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Sobering Center Utilization	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Mobile Crisis Team $	$16,253.93	$ 13,701.66	$15,716.61	$23,776.41	$ 15,044.96	$ 8,865.78	$ 93,359.35
Mobile Crisis Utilization	121	102	117	177	112	66	695
Tenancy Support $	*	*	*	*	*	*	*
Tenancy Support Utilization	*	*	*	*	*	*	15

*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
Medical Case Management	$ 595.00	$ 48,195.00	$49,385.00	$44,625.00	$ 45,815.00	$41,055.00	$ 47,005.00	**$ 276,080.00**
MCM Counts 1		81	83	75	77	69	79	464
Housing Case Management	$ 816.41	$ 71,027.67	$66,945.62	$63,679.98	$ 64,496.39	$59,597.93	$ 66,945.62	**$ 392,693.21**
HCM Counts 2		87	82	78	79	73	82	481

Amount Claimed for Quarters 3 and 4

PMPM	Rate	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12	Annual Total
Medical Case Management	$ 595.00	$ 46,410.00	$51,170.00	$36,890.00	$ 37,485.00	$34,510.00	$ 39,865.00	**$ 246,330.00**
MCM Counts 1		78	86	62	63	58	67	**414**
Housing Case Management	$ 816.41	$ 61,230.75	$62,863.57	$46,535.37	$ 41,636.91	$45,718.96	$ 51,433.83	**$ 309,419.39**
HCM Counts 2		75	77	57	51	56	63	**379**

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 160 referrals that were administratively enrolled during 2020 – 59 were enrolled into services.

The tenancy support fee for service allowance (FFS #3) approved in our rollover was utilized 37 times and by 25 participants during PY5, in the amount of $25,083.38. 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 had 695 billable contacts during this reporting period.

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. 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, Program Manager, and Community Development Coordinator positions were all 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 were difficult to acquire and implement. At the end of PY4 we were able to complete the addition of SharePoint as a resource for team access to WPC participant records and care plans. This resource has been of great benefit to all team members and administration, allowing for everyone to be on the same page and access records whenever needed from the cloud.

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 five 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 PY6. During the reporting period, there were only 2 peer support specialists employed by HHSA and 0 active volunteers.

The Hill Country Mobile Crisis Team continued to provide fee for service activity during this reporting period. The team received 695 billable calls between July and December 2020. Analysis of calls to the mobile crisis team revealed that 83% of calls came from community members, while the remaining 17% 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

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 for CoC and 50 for housing case management based on completion of HMIS data entries.

  The housing case managers have entered 71 participant's intake information into the HMIS system during the second six months of PY5.

  The 71 entries were paid at $10 each for a total incentive of $710.00.
- Sobering Center incentive for each WPC enrolled participant in the sobering center who enters detox program and stays at least 72 hours. Estimate that of WPC participants served by sobering center 50 will enter detox annually. During the second half of PY5, zero participants in the Sobering Center service transitioned into detox services following their stay at the sobering 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 has one volunteer 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 17 members who were permanently housed more than 6 months during this period.

  The total of 17 members, times $500.00, is a total of $8,500.00.
- 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 30 participants who reduced their emergency department visits to fewer than two, during the reporting period. However, we were only able to pay for 19 members meeting this incentive.

The total of 19 participants at 500.00, is a total of $9,500.00.

V. 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.

[Remove brackets and input response here, size 12 Arial font only]

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 2020 and * participants were hospitalized for mental illness and referred back to Shasta County Adult Services – Mental Health for follow-up/outpatient care.

There were * mental health hospitalizations for enrolled Whole Person Care clients during 2020. The * discharges correlate to the * 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 * participants were discharged during January through December 2020. Of those * only * was referred back to Shasta County Adult Services for follow-up outpatient care. Of the * referred back all * met this metrics threshold. The requirement threshold to be met during PY5 was 60%. All * that were contacted within 7 days of hospitalization discharge resulted in a 100% threshold, above the required 60%.

VI. 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.

- 07/01/2020 - SHARC data presentation and steering committee guidance – Zoom Meeting -
- 07/13/2020 – SharePoint Training – Go-To-Meeting
- 07/14/2020 – WPC Pilot Team Meeting – Go-To-Meeting –
- 07/28/2020 – WPC Pilot Team Meeting – Go-To-Meeting –
- 08/11/2020 - WPC Pilot Team Meeting – Go-To-Meeting –
- 08/11/2020 – SharePoint Training – Go-To-Meeting -
- 08/11/2020 – Mobile Crisis Team Quarterly Meeting
- 08/12/2020 - SHARC data presentation and steering committee guidance – Zoom Meeting -
- 08/25/2020 - WPC Pilot Team Meeting – Go-To-Meeting –
- 09/02/2020 - SHARC data presentation and steering committee guidance – Zoom Meeting -
- 09/08/2020 - WPC Pilot Team Meeting – Go-To-Meeting –
- 09/09/2020 – WPC Supervisor's Meeting
- 09/22/2020 - WPC Pilot Team Meeting – Go-To-Meeting –
- 10/07/2020 - SHARC data presentation and steering committee guidance – Zoom Meeting -
- 10/13/2020 - WPC Pilot Team Meeting – Go-To-Meeting –
- 10/27/2020 - WPC Pilot Team Meeting – Go-To-Meeting –
- 11/04/2020 - SHARC data presentation and steering committee guidance
- 11/10/2020 - WPC Pilot Team Meeting – Go-To-Meeting –
- 11/24/2020 - WPC Pilot Team Meeting – Go-To-Meeting –
- 12/02/2020 - SHARC data presentation and steering committee guidance
- 12/08/2020 - WPC Pilot Team 2020 Wrap Party – Go-To-Meeting –
- 12/09/2020 – 2020 DHCS WPC Appreciation Event – Zoom Meeting –
- 12/21/2020 – SharePoint Training – Go-To-Meeting -
- 12/23/2020 – SharePoint Training – Go-To-Meeting -

VII. PROGRAM ACTIVITIES

Care Coordination

A. Briefly describe 1-2 successes you have had with care coordination.
    1. MDT meetings with Mental Health providers and the medical and housing teams of WPC have become more prevalent and are helping clients to avoid miscommunications and overlaps in service between providers. They are also aiding in mitigating housing and service losses for clients struggling or transitioning in their housing.
    2. 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 adjust in advance of changes.

B. Briefly describe 1-2 challenges you have faced with care coordination, and lessons learned from those challenges.
    1. The coordination meetings have become shorter and less informative due to the nature of teleconferencing. While the in-person meetings garnered a shared sense of purpose and comradery. The teleconferencing has created a less personal environment and little need to engage in conversation. Due to this the meetings have become short and perfunctory.
    2. While care coordination continues between and among the teams trends and information does not carry up to the Lead Entity in a natural organic way. The teleconference meetings separate the Lead Entity from the teams and do not often know the current events or information.

Data Sharing

A. Briefly describe 1-2 successes you have had with data and information sharing.
    1. Implementation of SharePoint during Plan Year 5 has increased communication among team members and the Lead Entity.
    2. Data is secure and current.
B. Briefly describe 1-2 challenges you have faced with data sharing, and lessons learned from those challenges.
    1. Prior to SharePoint we had HIPAA data breaches.
    2. 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.

Data Collection

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

1. The DHCS provided spreadsheets are challenging. The spreadsheets are heavily locked down to control formatting. This is understandable when dealing with multiple data sources. The need to normalize the data is crucial. However, the locked spreadsheet makes data difficult to review or edit. The formatting is not consistent throughout the spreadsheet. In addition, the data verification that DHCS' data team uses reports one error at a time. This results in multiple revisions and signed certifications. It is challenging to get repeated certifications signed by Directors, whom are often working off-site.

2. Another challenge to data reporting is the inability to clearly reflect what we are seeing and doing in our work through our reporting tools. The tenancy support FFS rollover has been critically helpful for our participants. The way in which it is required to be reported to DHCS is less so. The QEUR requires that each participant who uses the service in a given month show 1 usage. This number needs to match the count in the invoice and the narrative. However, the dollar amounts spent by a participant varies and one count does not reflect that in any way. The invoice is locked down so that if we put in a count to match the QEUR, it calculates based on $4,500 per count and over charges. If we alter the count so that the calculation is accurate, we are asked to revise. We cannot clearly report the usage of this item due to the locking of the templates and what we do report is problematic.

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

    1. An ongoing issue with data collection and reporting has been consistent communication and expertise. We have not been able to establish a consistent conduit for communication and date/reporting requests.

2. Staff turnover at providers causes lapses in data integrity.

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

1. The complexity of the issues we are working to address in Whole Person Care is deep and our mechanisms for conveying progress, process, and problems are often one dimensional. Our target participants are navigating a convoluted system of care while living with dual-diagnosis chronic health conditions, disability, stigma, and isolation. If our goal is to mitigate the damaging effects of these factors on our communities, then it is important that we have measurement and reporting tools that hone-in on this complexity. A decrease in number of participants living on the streets is certainly a worthy goal and a benefit to the community, but this measure does not demonstrate quality of life - or engagement in health services. The real benefits of multidisciplinary coordination of care for our most vulnerable populations are not captured in a QEUR or variant metrics report.

2. The future of Whole Person Care has become nebulous due to the limitations and setbacks forced upon us by The Coronavirus Pandemic. The delay in implementation of and planning for CalAIM has led to certain setbacks in our pilot. Primarily, we are concerned with losing partnerships with our providers due to their uncertainty with the future of the program. There are also concerns about gaps in service delivery for clients who remain in need at the end of PY5 and what we should do related to ongoing enrollment. We are not certain whether we should be putting together our final outcomes data and analyses – or just rolling ahead with another year of regular service provision and data collection.

3. Flexible program structures would seriously aid in service provision that meets the needs of our human participants. Looking to circumvent emergency medical services by connecting community members to more relevant, targeted health care is a valiant goal, but the reality that crisis do not happen only between the hours of 9am and 5pm is glaringly apparent. When a participant is in need and the only providers available to assist are emergency room staff, it is difficult to argue against accessing that service. Additionally, if the appropriate services are not adequately funded and staffed, providers will not be able to offer them through an enhanced care management benefit and we will be left with the same issues we faced before the inception of Whole Person Care.

VIII. 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 Q3-Q4 PY5 2020 - Why ED
2. Shasta WPC PDSA Ambulatory Care 2 Q3-Q4 PY5 2020 - Health Literacy
3. Shasta WPC PDSA Care Coordination 1 Q3-Q4 PY5 2020 - Est Care Coord
4. Shasta WPC PDSA Care Coordination 2 Q3-Q4 PY5 2020 - Referral System to Staffing
5. Shasta WPC PDSA Comprehensive Care Plan 1 Q3-Q4 PY5 2020 - Design CCP
6. Shasta WPC PDSA Data 1 Q3-Q4 PY5 2020 - Sharing Data
7. Shasta WPC PDSA Data 4 Q3-Q4 PY5 2020 – SharePoint
8. Shasta WPC PDSA Inpatient Utilization 1 Q3-Q4 PY5 2020 – Why IP
9. Shasta WPC PDSA Other 2 Q3-Q4 PY5 2020 - Elig Criteria