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

Reporting Checklist

Solano
Annual Report PY4
June 13, 2020

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

SOLANO
PY4 ANNUAL REPORT
February 1, 2020

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

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.*

The Solano Whole Person Care (WPC) pilot continues to succeed in outreach and engagement and has served 205 unduplicated clients through PY4. During this time period, the focus has been on building care coordination, building capacity to implement data-driven practices, and operationalizing sustainability.

Successes

Solano WPC continues to be successful in receiving referrals from emergency rooms (NorthBay, Sutter and Kaiser), primary care clinics (Family Health Services and La Clinica) county programs (Mental Health and Substance Abuse Services), and community programs (Resource Connect, Caminar and Prevention Engagement Program). Solano WPC continues to receive the Partnership Healthplan of high-utilizer source of potential clients. Solano WPC is continuing to explore the opportunity to broaden its referral source to capture individuals being released from the jail setting.

Solano WPC has been successful in increasing integration and coordination with Mental Health, Substance Abuse, Family Health Services and WPC. WPC has also meet with the Medi-Cal Program and now can coordinate with Medi-Cal in the field. Also, WPC has worked with Partnership Healthplan of California to help their clients identify their primary care provider. Solano WPC also has coordinated with Shelter Solano and Partnership Health of California's Complex Care.

Challenges

The biggest challenge WPC faces are clients being referred to the Solano WPC the most complex clients in Solano County with housing as their number one challenge. Solano County does not have enough housing options to meet the needs of low-income Solano County residents and especially clients with Mental Health, substance abuse issues, chronic disease and homeless or at-risk of homeless. Navigating this system is challenging.

Lessons Learned

Sustainability continues to be a focus of the Solano WPC pilot. Solano County Health and Social Services Department (SCHSSD) is in the process of reorganization and has recently hired a navigation team. SCHSSD is currently in the process of determining how the navigation team can support the WPC program through its final year and take over the care of clients after the program ends.

III. ENROLLMENT AND UTILIZATION DATA

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]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	18

Item	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12	Annual Unduplicated Total
Unduplicated Enrollees	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	13	32

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.

FFS	Costs and Aggregate Utilization for Quarters 1 and 2						
	Month 1	Month 2	Month 3	Month 4	Month 5	Month 6	Total
Service 1							
Utilization 1							
Service 2							
Utilization 2							

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FFS	Costs and Aggregate Utilization for Quarters 3 and 4						
	Month 7	**Month 8**	**Month 9**	**Month 10**	**Month 11**	**Month 12**	**Annual Total**
Service 1							
Utilization 1							
Service 2							
Utilization 2							

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

PMPM		Amount Claimed						
	Rate	Mont	Month 2	Month 3	Month 4	Month 5	Month 6	Total
Bundle #1	$454	$42,	$45,400	$38,136	$38,590	$39,498	$39,952	$243,798
MM Counts 1		93	100	84	85	87	88	537
Bundle #2	$							
MM Counts 2								

PMPM		Amount Counts						
	Rate	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12	Total
Bundle #1		$41,314	$43,130	$30,418	$22,700	$26,332	$33,142	$197,036
MM Counts 1		91	95	67	50	58	73	434
Bundle #2								
MM Counts 2								

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

IV. NARRATIVE – Administrative Infrastructure

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.

BACS commenced services August 2018 to present. Solano County continues to provide oversight in the monitoring of policies and procedures through ETO documentation and data reports, from the monthly stakeholder group WPC Planning and Operations and from monthly meetings with BACS. This communication method helps keep everyone abreast of emerging issues and determine solutions to any issues that arise.

Solano WPC ROI was updated to make it easier for clients to complete. All of the WPC policy and procedure documents were reviewed and updated. BACS staff were trained on the updated policy and procedures.

V. NARRATIVE – Delivery Infrastructure

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.

IT Infrastructure

Efforts to Outcomes (ETO) has been used to serve as the Solano WPC client database to be able to track metrics. ETO also allows partners, such as our primary care public health nurses, to see all of the work that WPC staff have been doing with clients, access their care plans, and to contribute their own notes in the client record. One major limitation of ETO is that it does not link to the existing data systems, such as the county's behavior health or primary care EHRs, and the reporting functionality is limited.

We have identified a Microsoft Dynamics platform that will replace ETO to provide more robust functionality and reporting. The additional WPC funding that Solano was awarded will be used to fund this project. A vendor has been identified to build and implement this system, and contract negotiations to procure their services are currently underway.

Housing Services

BACS operates a transitional housing program under Solano's Mental Health Services Act and four (4) housing spots continued to be reserved for WPC clients are continually full. BACS now employs two full-time housing coordinator who works exclusively on assisting WPC clients with housing. The housing coordinator works in conjunction with Coordinated Entry and many community partners.

SUD Treatment participation, Employment Coordinator, and Legal Advocacy

Solano WPC continues to be successful in linking clients with substance use disorder to treatment. BACS employs a Substance Use Specialist who works in the field and makes a direct linkage to the county's Substance Abuse Services staff who helps client get connected to services. BACS also employs an employment coordinator to help their clients with employment and a new services is Legal Advocacy to help clients get social security benefits or disability.

VI. NARRATIVE – Incentive Payments

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.

A new incentive payment was added this to ensure clients for PY4 for 50% of clients have a care plan completed before discharge from a skilled nursing facility or from respite care. Our records system was updated so that BACS staff can document date admitted into respite or SNF and date discharged.

We continue to work with BACS to complete care plans in a timely manner. Our data analyst pulls monthly reports for all clients who are due for an initial or annual care plan and provides this list to the BACS program manager.

For incentive has not been full attained for the first part of the year [redacted] and for the second part of the year [redacted] The total payment for this incentive was nothing since we have not our goal of 50%. The challenges have been that we don't know when they are discharged, client goes AWOL or we did not know they were in respite care and find out after discharge. Strategies to meet this goal are to: 1) continue to send monthly updates to BACS about clients that are known to be in respite care 2) remind clients at each contact that if they go to respite care to contact Care coordinator and 2) routinely check common respite care locations for WPC clients.

VII. NARRATIVE – Pay for Outcome

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.

Comprehensive Care Plan within thirty (30) days of enrollment
PY4 Goal: 92 participants or 80% enrolled
Total earned in PY4: $20,000
A primary responsibility under the Care Coordinator includes establishing a comprehensive care plan near the onset of client interaction. Once enrolled, procedures automatically begin with scheduling time for recurring care conferences. The WPC client is educated on the various resources such as assistance in applying for social services, social security income, and affordable housing. Solano WPC has completed [redacted] initial care plans on time for PY4.

At the beginning of PY3 we were meeting this goal; however, in the transition from our previous vendor to our current vendor, several care plans were completed late. Additionally, our current vendor was struggling with reconnecting with newly enrolled clients after they had been discharged from the hospital. We have changed program procedures to enroll clients upon discharge from the hospital, rather than prior to discharge, in an effort to remedy this issue. We are also exploring other strategies to help reach the care plan goal.

Housing Services
PY4 Goal: Housing is provided or obtained for at least ten (10) individuals per quarter; housing assistance is provided to all clients demonstrating housing instability based on multi-model assessment and care plan.
Total earned in PY4: $18,850
Solano WPC provides clients three (3) different levels of housing depending on the need and availability, including emergency/crisis, transitional and permanent housing. In the first half of PY4, [redacted] individuals were referred for housing services. Of these, [redacted] were provided housing services. Some clients have received both emergency housing and then transitioned to permanent or transitional housing. Several clients also required multiple housing referrals during this period. Once housed, Solano WPC works closely with the client to develop housing plans, screening for public assistance programs, linkages, and creating an established rental history.

[redacted]

[redacted]

Substance Use Disorder (SUD) Treatment Participation
Total Earned in PY4: $5,000
PY4 Goal: Clients enrolled and participated in SUD treatment (unduplicated); 25 cumulative or 20% eligible. A total [redacted] clients were referred for substance use issues in PY4, and [redacted] were successfully connected to treatment services. This has been a continuing success of our program.

VIII. STAKEHOLDER ENGAGEMENT

Stakeholder Engagement - In the text below or as an attachment to this report, 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. 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.

The stakeholder meeting includes:

- WPC Steering Committee – it was decided to combine the Steering Committee and the Panning and Ops meeting since the same individuals were attending.
- Planning and Operations Committee – meetings were held on 7/18/19, 8/15/19, 9/19/19, 10/17/19 and 11/21/19.
- WPC Project Meeting (internal meeting) and meetings held on 7/23/19, 8/20/19, 9/3/19, 10/1/19, 11/5/19 and 12/3/19.

WPC Steering Committee Meetings and Planning and Ops discussion topics and decisions:

- Coordination: learned how to use the PHC transportation benefit and ways to overcome challenges, collaborated with Coordinated Entry about helping WPC clients find housing, collaborated with Shelter Solano on how to refer, learned about changes to SUD services, collaborated with Mental Health Access line and what to expect when calling and how to help clients access MH services, collaborated with Adult Protective Services, and collaborated with Family Health Services (county's FQHC clinic).
- ETO documentation – trained partners on ETO use and documentation
- Challenges with referrals– Improved the response time that BACS WPC staff responded to referral agency that referral was received, Updated the referral to make it easier to identify who to refer to WPC, continues to be challenge to find clients when referred from ED, ED now calling BACS WPC staff to meet at ED prior to discharge.
- Challenges with Housing. 1) Learned the difference between Shelter, Inc. and how Mission Solano operates and how to refer.
- Care Conference Challenge – BACS is not meeting their benchmark for case conferences. Recommended holding weekly case conference meetings and inviting PHC, FHS and ED staff.

IX. PROGRAM ACTIVITIES

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

(1) **Linkage to Substance Abuse Treatment**
In PY4, Solano WPC has successfully linked [redacted] clients with identified substance use disorders to treatment. This is far above our target of 20%. A significant driver of this success is the addition of a substance abuse specialist to the care team. This individual is able to focus on clients' substance use, identify the most appropriate venues for treatment, and work with clients to encourage them to utilize the linked services. Additionally, WPC staff have identified a county employee in Substance Abuse who is able to expedite referrals for substance abuse treatment for WPC clients.

(2) **Shelter Placement**
In 2018, the County's primary homeless shelter closed. It was reopened in early 2019 as Shelter Solano and is now under new management with new admission criteria. Solano WPC has established a pathway to refer clients to Shelter Solano and has successfully secured placement for clients at the shelter. WPC staff have been leveraging MHSA-funded pathways for placement, so the pathway that they have established will be sustainable after WPC ends. WPC staff also continue to work on establishing pathways to shelter through other avenues, such as Prop 47 funding and through Partnership (our MediCal managed care plan).

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

(1) Discharge Planning
Discharge planning for homeless clients with mobility limitations has been a significant challenge. The hospital social workers often reach out to WPC staff to ask about possible housing options for clients who are ready to be discharged from the hospital. During the early part of this year there were no ADA-accessible respite beds in the County. To date, Partnership and some of the hospitals have secured a few respite beds that can accommodate someone with certain types of mobility limitations. We expect that the addition of those beds will help to alleviate much of this problem.

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

(1) **ETO Training**
Solano WPC has completed training for all county staff, all BACS staff, and all community partners who have been granted access to ETO – our case management database. This training covered privacy/security practices, data entry, and some reporting. Consistent use of the database by all partners will ensure that a better quality of data is collected and reported. Consistent data entry will also help staff who are working with the same clients to find the information necessary to coordinate care for that client.

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

(1) Cross-Departmental Data Sharing
Through building relationships between partner agencies, county staff in various departments, and the WPC vendor, we have been able to collaborate more on care coordination. However, we have discovered that each department within the county operates with their own data systems, none of which are connected to each other. The data system we are currently using for WPC case management (called ETO) also does not connect to any of the existing data systems. This is a significant barrier that requires staff to do extensive manual work to pull records from various systems. With the new WPC funding we were awarded at PY4 midyear, we will be building an IT system that will integrate with existing systems and facilitate this data sharing without requiring manual searching and entry of data.

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

(1) Medi-Cal Data Requests
By working closely with our Medi-Cal managed care provider (Partnership Health Plan), we have been able to streamline our data request process for ED and hospitalization data. We now have a data request template and an established procedure to request data from Partnership. In previous data request cycles there has been several rounds of back-and-forth requests which delayed our receipt of the required data. During this midyear reporting cycle, only one request was needed, and we received our data in a timely manner.

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

(1) **Data Quality**

Data collection and tracking has improved significantly since we converted to ETO midway through PY3. Now we are able to query client data more easily and to track clients throughout the referral process. However, there are certain data points (mostly mental health and substance abuse treatment information) that cannot be stored in ETO. Thus, we rely on other systems that must have data extracted by hand. This process currently has no way to be checked for quality. Additionally, the data that we request from our MediCal managed care plan has been deidentified for PY4. This also does not allow us to do quality checks on the information that we are getting.

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

1. Coordination with hospitals

Through case reviews and discussions with WPC care coordinators we have found that there are several county services that require evaluations from medical providers and/or medical records to be included in the referral packet. In several instances, we have had WPC clients who do not go to primary care and the ED is their only source of medical care. Local ED staff are often unable to keep clients in the ED long enough to complete the evaluations or paperwork required to refer clients to needed services. We are currently looking at ways to either reduce the requirements for what needs to be included in the referral, how to encourage hospitals to complete the referral, and for other innovative ways to get clients referred to the services that they need.

2. Housing and Homelessness – Ongoing

A lack of affordable housing and homelessness continue to be significant barriers to client success. Nearly all of our WPC clients have some form of income, however, very few earn enough to be able to afford market-rate housing in our county.

In addition to the typical barriers we see with housing, our WPC client base has been exceptionally difficult to support due to a lack of accessible housing in Solano County. Given our target population, many of our WPC clients have some form of limitation of their mobility. Currently, we have no respite housing that is accessible to anyone who is wheelchair bound, on crutches, or who can't navigate stairs without assistance. There are a limited number of shelter beds that are accessible.

X. PLAN-DO-STUDY-ACT

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.

For the PY3 Annual Report, the following PDSA documents will be submitted:

- Inpatient Utilization
- Care Coordination
- Comprehensive Care Plan
- Data and Information
- Ambulatory Care
- PDSA Summary Document