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

Sonoma County, Department of Health Services
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 with meetings
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	No updated documents at this time.
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.

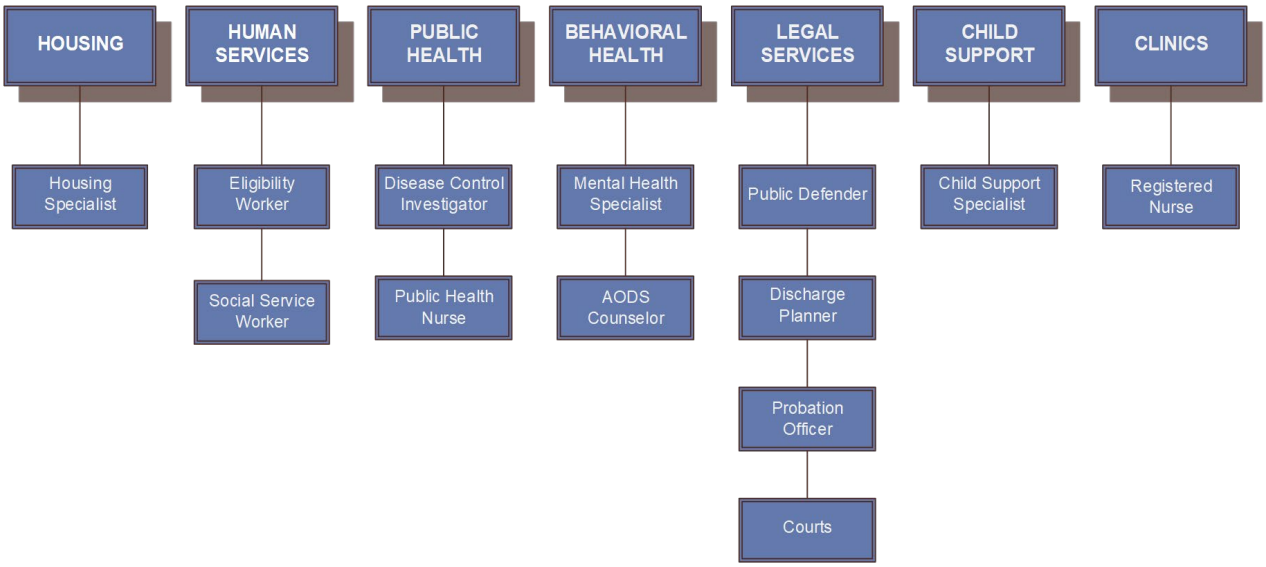
Improving data collecting and sharing

Significant contributors to Sonoma County's homeless problems continue to be high housing costs, low vacancy rates, and displacement due to the recent wildfire disasters, lack of adequate behavioral health services.

Whole Person Care Goals include Improving health, well-being and self-sufficiency outcomes of clients, increasing successful shelter and housing placements, increasing the number of people accessing services, improving referrals, access and sustained engagement of clients, increasing coordination of services and reduction in duplicate services, and to decrease expenditures per client.

To do this, we use an integrated data hub that combines data from safety net source systems to give an integrated holistic view of the client. It is a cloud-based, mobile care coordination shared by all including community-based organizations with participation and referral capability.

The model includes:



Improving health outcomes for the WPC population – in the past year Whole Person Care staff helped clients achieve the following goals:

- (92%) Enrolled in Medi-Cal
- (10%) Enrolled in General Assistance
- (68%) Enrolled in CalFresh
- (31%) Enrolled in SSI
- (31%) Placed in a Shelter or Temporary Housing
- (30%) Placed in Permanent Housing
- (64%) Enrolled in Coordinated Entry
- (6%) Placed in residential substance use treatment
- (5%) Enrolled in Mental Health services

Increasing integration among county agencies, health plans, providers, and other entities

We have increased integration by instituting weekly IMDT meetings as well as allowing staff to attend more community meetings with referring agencies. We have also increased communication regarding the referral process with community providers and with Sonoma County Behavioral Health.

We have dramatically increased access to hotel and housing vouchers including better navigation for clients and covering a variety of moving costs.

Staff are working to balance Outreach and Engagement (OE) and Intensive Case Management (ICM), and improving their skills at identifying what is not working and coming up with solutions to address problems through continuous quality improvement.

Outreach and Engagement (OE) Staffing:

Position	**FTE**
Senior Client Support Specialist	2.5
Behavioral Health Clinician	1.0

Challenges:

- COVID 19 limits out outreach ability
- County and City “sweeps” of homeless encampments make finding and outreaching to referrals difficult as they are moved and often do not have cell phones

Successes:

- Increase in the number of referrals we are receiving and processing to ICM
- Improved time between referral and assignment to ICM
- ICM has had a waitlist at times due to the increase in referrals serving more clients

Intensive Case Management (ICM) Staffing:

Position	**FTE**
Senior Client Support Specialist	1.0
Behavior Health Clinician	1.0
AODS Counselor II	1.0
Social Services Worker II VACANT	0.5

Challenges:

- The current staffing limits how many individuals we can have open to ICM (our ratio is 1FTE to 20 individuals)

Successes:

- Staff are able to focus solely on case management making them more effective and efficient in supporting clients on their care plan.

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	**132**	85	**68**	**124**	**147**	**124**	**680**

Item	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12	Annual Unduplicated Total
Unduplicated Enrollees	175	163	169	144	106	20	1,457

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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 *Outreach & Engagement*	**$181,177**	**$169,426**	**$174,913**	**$197,979**	**$191,229**	**$215,558**	**$1,130,283**
Utilization 1	**3,731**	**3,489**	**3,602**	**4,077**	**3,938**	**4,439**	**23,276**
Service 2 Short-term *Recuperative Care Services*	$24,440	$17,940	$18,590	$15,080	$14,170	$13,130	$103,350
Utilization 2	188	138	143	116	109	101	795

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 *Outreach & Engagement*	$204,438	$196,959	$204,826	$240,518	$191,569	$136,405	$2,304,998
Utilization 1	4,210	4,056	4,218	4,953	3,945	2,809	47,467

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 2 Short-term *Recuperative Care Services*	$14,300	$14,040	$14,170	$6,500	$9,360	$4,160	$165,880
Utilization 2	110	108	109	50	72	32	1,276

*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
Bundle #1 – PMPM Category 1 (Intensive Case Management)	$1,366	$58,738	$53,274	$49,176	$25,954	$24,588	**$20,490**	$232,220
MM Counts 1		43	39	36	19	18	**15**	170

Amount Claimed for Quarters 3 and 4

PMPM	Rate	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12	Annual Total
Bundle #1 – PMPM Category 1 (Intensive Case Management)	$1,366	$28,686	$31,418	$31,418	$30,052	$42,346	$35,516	$431,656
MM Counts 1		21	23	23	22	31	26	316

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.

The administrative staff in PY5 continued to focus on maximizing use of funds in light of COVID and working with the Community Development Commission staff to incorporate housing support dollars; continuing collaboration activities with the ACCESS program; additional software development and analysis for evaluation. Contractors additionally had administrative costs to manage staffing transitions for COVID response, staffing changes, and reduced staff capacity.

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.

During PY5, Quarters 3 & 4

- Staff response to COVID pandemic
- Support for providing direct service to WPC eligible clients in the community

The following staff were used to provide the above named services:

- Senior Office Assistant (0.41 FTE)
- Housing Navigator (0.13 FTE)

Contracted partners also provided indirect administrative support to delivery of direct services including data entry, scheduling, and billing, and COVID response outreach including assisting clients to move into temporary housing.

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.

Staffing Incentive:

Incentives are to be provided to 3 community health centers who met the hiring and retention of nurse outreach and engagement and case management staffing requirements. Each community health center is eligible for a maximum $10,000 incentive payment each PY based on their ability to hire and retain WPC Pilot staff. Each health center will be evaluated individually and will be able to earn their incentive based on their individual performance whether or not the other health centers achieved their staffing goals. For this period, Sonoma was able to meet 50% of the targeted achievement. Total payment earned by Sonoma County and partners: $30,000

- Petaluma Health Center earned $10,000
- Santa Rosa Community Health earned $10,000
- West County Health Centers earned $10,000

Sustainability Meetings:

Incentive is available to FQHCs and Peer contractors, each is eligible to receive $5,000 for attending 4/4 transition meetings held with WPC key staff, Department of Health Services' leadership, and Partnership Health Plan leadership. Meeting purpose is to identify processes for:

• Encounter data – reporting to managed care plan, trainings for staff on codes to use for billing, transferring data, etc.

• Crosswalks to match services with in lieu services thru plan, care coordination agreements, etc.

• Close out messaging – making sure beneficiaries know how to continue to access services, sustainability plans with partners

• Determining accountability for beneficiaries

No meetings were held due to COVID, staff transitions, and CalAIM delays. No incentives for this will be paid.

VI. NARRATIVE – Pay for Outcome

Instructions: Referencing the Whole Person Care Universal and Variant Metrics Technical Specifications, please provide a detailed explanation of the status of your program's performance on the pay-for-outcome metric(s). For the Mid-year report, only report those measures that are reported semi-annually; for the Annual report, please report all. Provide details that demonstrate what was achieved for each outcome, any challenges, and any lessons learned. Reimbursement will occur for achieved outcomes based on proposed annual target and methodology. Please limit your responses to 500 words.

PY5 Pay for Outcomes:

We **achieved** our goals on the following metrics:

- **Variant Metric: 30 day All-Cause Readmissions:**
  - PY5: 5% reduction from PY4, $70,000 payment if achieved
  - **Achieved:** Data show a 39% decrease in all-cause readmissions observed from PY4 to PY5 (decrease in rate from 37.5% to 26.98%)
- **Variant Metric: Decrease Jail Recidivism:**
  - PY5: 5% reduction from PY4, $70,000 payment if achieved
  - **Achieved:** Data show a 9% decrease in incarcerations observed from PY4 to PY5 (Decrease from 84.66 to 77.07 incarcerations/1000 member months)

We **did not achieve** our goals on the following metrics:

- **Universal Metric: Ambulatory Care – Emergency Visits:**
  - PY5: 5% reduction from PY4, $70,000 payment if achieved
  - **Not Achieved:** Data show a 7.7 % increase observed from PY4 to PY5 (increase from 314.29 visits/1000 member months to 338.47/1000 member months)
- **Universal Metric: Inpatient Utilization – General Hospital/Acute Care:**
  - PY5: 5% reduction from PY4, $70,000 payment if achieved
  - **Not achieved:** LE data shows a 15.9% increase in inpatient utilization observed from PY4 to PY5 (Increase from 34.92 to 40.46 discharges)
- **Variant Metric: Percent of homeless receiving housing services that were referred to housing services:**
  - PY5: 5% increase from PY4, $70,000 payment if achieved
  - **Not achieved**: LE data shows an 8.3% decrease between PY4 and PY5 in homeless receiving housing who had been referred for housing services (decrease from 36/40 to 94/114 individuals receiving housing services)

In 2020, the context of COVID-19 and shelter-in-place may have contributed to Whole Person Care clients' utilization of medical resources. County-wide, data show many

residents delayed their routine medical care due to COVID-19 concerns and decreased accessibility. This may have led to an increased need for emergency care and hospitalizations due to complications arising after care was delayed too long.

Additionally, the jail observed a significant decrease in bookings overall following the March, 2020 Shelter-in-Place orders at the discretion of local law enforcement. A zero dollar bail schedule was also enacted which has increased the number of bookings that are released the same day.

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.

Meeting Descriptions:

Whole Person Care Interdepartmental Multi-Disciplinary Team (IMDT) Care Coordination - meetings held every Wednesday from 9-12. Agencies include Community Development Commission (housing authority), Human Services, Department of Health Services (Behavioral Health; DHS-BH), Adult and Aging, Child Support Services, Probation. WPC Intensive Case Management clients are discussed and the group utilizes Watson Care Manager to add client notes and track program progress/updates. Workflows, case studies, communication and COVID response are covered weekly.

VIII. PROGRAM ACTIVITIES

Care Coordination

A. Briefly describe 1-2 successes you have had with care coordination.
    1. Connections with local resources streamline client access to health care and Mental health treatment helping us to meet client's needs.
    2. Utilizing WCM staff are able to see progress and needs of clients care coordination instead of having to email or call other providers
B. Briefly describe 1-2 challenges you have faced with care coordination, and lessons learned from those challenges.
    1. Documentation continues to be a barrier; each clinic wants their own forms filled out- working with clinic to have more universal forms to cut back on duplicating work. We will continue to work with our clinics and move towards implementing standardization of the forms.
    2. Transportation continues to be an issue, COVID restrictions limit transport abilities. We are still exploring other alternative to deliver the same level of services to our clients.

Data Sharing

A. Briefly describe 1-2 successes you have had with data and information sharing.
    1. Keeping better outcomes has let us know where we are succeeding and where we still need to improve
    2. WCM holds most information reducing staffs time having to check several data base systems
B. Briefly describe 1-2 challenges you have faced with data sharing, and lessons learned from those challenges.
    1. Although we had more success with our data, Sonoma still looking at ways to improve our outcome data. Currently, we are exploring alternatives and other methods to improve data outcome with our partners.

Data Collection

A. Briefly describe 1-2 successes you have had with data collection and/or reporting.
    1. Having access to lots of different agency systems (HSD, HMIS, MADF, SCBH, local FQHCs, *etc…*) allows staff to research new referrals and have more successful in locating them.

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

1. Locating clients continues to be our biggest struggle. Staff are only successful in finding about 30-40% of the referrals assigned to their caseloads. Increased access to phones for homeless clients would be helpful. We are planning to coordinate with our partners to determine a more efficient way to contact our clients.

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

Housing continues to be the biggest barrier for our clients, there are not enough housing resources, housing navigators and wrap around services to support the need. Staff shortages in these programs also make this a barrier with high caseloads making the work even more difficult.

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. Ambulatory Care – PY5
   Q3, Q4
2. Inpatient utilization – PY5
   Q3, Q4
3. Comprehensive Care Plan – PY5
   Q3, Q4
4. Care Coordination – PY5
   Q3&4
5. Data Infrastructure – PY5
   Q3&4
6. Other – PY5
   Health Center Contracting – Q3&4