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

Ventura County
Annual Narrative Report, Program Year 4
Submitted: May 1, 2020 Revised: July 20, 2020

## REPORTING CHECKLIST

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

| Component | Attachments |
|---|---|
| **1. Narrative Report**<br>**Submit to:** Whole Person Care Mailbox | ☐ Completed Narrative report<br>☐ List of participant entity and/or stakeholder meetings *(if not written in section VIII of the narrative report template)* |
| **2. Invoice**<br>**Submit to:** Whole Person Care Mailbox | ☐ Customized invoice |
| **3. Variant and Universal Metrics Report**<br>**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.)**<br><br>**Note: If a Policy and Procedures document has been previously submitted and accepted, you do not need to resubmit unless it has been modified.**<br><br>**Submit to:** Whole Person Care Mailbox | ☐ Care coordination, case management, and referral policies and procedures, which may include *protocols and workflows.)*<br>☐ 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**<br>**Submit to:** Whole Person Care Mailbox | ☐ Completed WPC PDSA report<br>☐ Completed PDSA Summary Report |
| **6. Certification of Lead Entity Deliverables**<br>**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

Ventura County

Annual Narrative Report, Program Year 4 REV 3

***Submitted: May 1, 2020; Revised July 20th, 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

*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.*

Key accomplishments for PY 4 include:

- Continued intensive enrollment of patients engaging 1,244 individuals through mobile outreach and enrolling 154 new unduplicated participants by year end.
- One Stop/Care Pods launched at two new sites: Ventura County Medical Center and North Ventura Avenue
- 154 Care Pod Events, 27 Backpack Medicine Events, 642 Recuperative Care Bed Days

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

Regular Leadership and Clinical Care meetings with the COHS, Gold Coast Health Plan (GCHP) resulted in sharing of data, shared learnings, and alignment of care coordination with the health plan; Participation in Community Heath Needs Assessment with plan and area hospitals resulted in progress towards regional health information exchange.

***Increasing coordination and appropriate access to care;***

Met with engagement-focused programs across multiple agencies, including Behavioral Health and Public Health, to identify opportunities for broader outreach and integration of services.

***Reducing inappropriate emergency and inpatient utilization;***

Coordinated workflows with ER and hospital discharge teams, implemented procedure for WPC Medical Director to amend care plans following multidisciplinary case review. Implemented hospital and clinic level incentives for scheduling primary care visit within 7 days of discharge.

***Improving data collecting and sharing;***

*Built out 15 Universal and Variant Metrics Reports in data warehouse; reported against 6 new access to care and health outcomes metrics, including prior year baseline calculations.*

Collaborative software purchase for care coordination platform and registry products, electronic data exchange with Behavioral Health Department

***Achieving quality and administrative improvement benchmarks;***

Developed and implemented social needs survey administering to 100% of new patients and 62% of existing patients in a three-month period. Completed two new PDSA cycles on CHW/CSW Visits and Timely, Accurate, and Complete Data Collection.

***Increasing access to housing and supportive services; and,***

Successful application for One Time Housing Funds from the Governor's 2019-2020 Budget (funding source is State General Funds) to allow creation of a Whole Person Care flexible housing pool

143 housing services provided, 95% of homeless patients referred received housing services.

***Improving health outcomes for the WPC population.***

Collected and monitored health outcomes across more than 32 utilization, health status, and access to service metrics as reported in Section IV of this report (Pay for Outcomes).

***Challenges:***

Open staff vacancies and a lengthy hiring freeze continued to impact program implementation and staff caseloads throughout PY 4; however, 5 open positions (4 Community Services Worker and 1 Alcohol and Drug Treatment Specialist) were filled by year-end.

***Lessons Learned:***

During hiring freeze, caseloads and, thus, enrollment were allowed to fall to manageable levels through disenrollment of patients lost to follow-up despite significant engagement. Patients remaining, though more actively engaged skewed toward higher needs impacting year over year achievement of some outcomes.

## 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** | 23 | 16 | 11 | [redacted] | [redacted] | [redacted] | 78 |

| Item | Month 7 | Month 8 | Month 9 | Month 10 | Month 11 | Month 12 | Annual Unduplicated Total |
|---|---|---|---|---|---|---|---|
| **Unduplicated Enrollees** | 20 | [redacted] | 13 | 18 | [redacted] | [redacted] | 154 |

# Whole Person Care

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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** | $8,286.08 | $6,732.44 | $6,344.03 | $5,437.74 | $14,112.23 | $5,826.15 | $46,738.67 |
| **Utilization 1** | 64 | 52 | 49 | 42 | 109 | 45 | 361 |
| **Service 2** | $27,706.16 | $30,409.20 | $32,267.54 | $43,079.70 | $36,491.04 | $25,678.88 | $195,632.52 |
| **Utilization 2** | 164 | 180 | 191 | 255 | 216 | 152 | 1158 |
| **Service 3** | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| **Utilization 3** | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| **Service 4** | [redacted] | [redacted] | [redacted] | [redacted] | [redacted] | [redacted] | $3,750 |
| **Utilization 4** | [redacted] | [redacted] | [redacted] | [redacted] | [redacted] | [redacted] | 25 |

| 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** | $9,580.78 | $19,938.38 | $11,652.30 | $12,040.71 | $13,464.88 | $16,442.69 | $129,858.41 |
| **Utilization 1** | 74 | 154 | 90 | 93 | 104 | 127 | 1,003 |
| **Service 2** | $43,586.52 | $44,093.44 | $32,605.42 | $31,760.72 | $26,692.52 | $31,422.84 | $405,793.88 |
| **Utilization 2** | 258 | 261 | 193 | 188 | 158 | 186 | 2,402 |
| **Service 3** | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| **Utilization 3** | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| **Service 4** | $0 | $0 | $0 | $0 | $0 | [redacted] | [redacted] |
| **Utilization 4** | 0 | 0 | 0 | 0 | 0 | [redacted] | [redacted] |

# Whole Person Care

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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 Engagement Bundle | $318.21 | $8,909.88 | $13,364.82 | $19,410.81 | $14,637.66 | $13,046.61 | $7,637.04 | $77,006.82 |
| MM Counts 1 | | 28 | 42 | 61 | 46 | 41 | 24 | 242 |
| Bundle #2 Care Coordination Bundle | $269.69 | $60,410.56 | $56,904.59 | $53,938.00 | $50,971.41 | $46,656.37 | $42,341.33 | $311,222.26 |
| MM Counts 2 | | 224 | 211 | 200 | 189 | 173 | 157 | 1154 |
| Bundle #3 Field-based CC Bundle | $223.74 | $198,009.90 | $187,941.60 | $183,019.32 | $158,184.18 | $149,010.84 | $136,481.40 | $1,012,647.24 |
| MM Counts 3 | | 885 | 840 | 818 | 707 | 666 | 610 | 4526 |

| Amount Claimed | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| **PMPM** | Rate | Month 7 | Month 8 | Month 9 | Month 10 | Month 11 | Month 12 | Total |
| Bundle #1 Engagement Bundle | $318.21 | $10,500.93 | $9,228.09 | $7,000.62 | $11,773.77 | $8,909.88 | $10,500.93 | $134,921.04 |
| MM Counts 1 | | 33 | 29 | 22 | 37 | 28 | 33 | 424 |
| Bundle #2 Care Coordination Bundle | $269.69 | $61,489.32 | $59,871.18 | $57,713.66 | $72,007.23 | $69,849.71 | $68,501.26 | $700,654.62 |
| MM Counts 2 | | 228 | 222 | 214 | 267 | 259 | 254 | 2,598 |
| Bundle #3 Field-based CC Bundle | $ 223.74 | $133,796.52 | $130,887.90 | $129,545.46 | $129,321.72 | $127,308.06 | $126,413.10 | $1,789,920.00 |
| MM Counts 3 | | 598 | 585 | 579 | 578 | 569 | 565 | 8,000 |

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

Declining enrollment across PY 4 is was to inability to fill vacant positions during an Agency wide hiring freeze in the context of system-wide layoffs. Clearance was obtained in PY 4 Q4 to fill all 5 open WPC positions and this was completed by the end of PY 4 Q4. Approval to create and fill 7 new positions by year end as approved in the realignment budget request submitted in PY 4 Q3 was not obtain and this incentive item was carried over for PY 5.

Reduced enrollment across PY 4 occurred largely due to attrition via a standardized disenrollment procedure added to the Care Coordination Policies and Procedures in PY 3 to that involves significant effort to locate and engage a patient prior to disenrollment. Patients lost to follow-up are dis-enrolled after 8 attempts to contact across 2 months by phone and in-person visits, attempts to locate via coordination with other shared providers, review of contact information in the behavioral health and HMIS records for potential changes, and review of jail records for potential incarceration. Dis-enrolled patients are allowed to re-enroll at any time.

## 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.*

In PY4, the Program Director, Informatics Team, Database Analyst, Administrative Assistant, and QI Coordinator attended to the day to day implementation of the program.

The QI Coordinator and Database Analyst monitored program metrics as well as documentation quality, timeliness, and completeness as part of an ongoing quality improvement efforts and oversaw the implementation of 5 required and 2 optional PDSA cycles.

The Informatics team reformatted and loaded large data exports from Cerner, Avatar, and Gold Coast Health Plan into the data warehouse and compiled and validated standardized reports for the calculation of the Ambulatory Care ED and Inpatient Utilization metric, as well as the follow-up after ED for mental health incentive. They built out 15 additional metrics reports in the data warehouse for year-end pay for outcomes reporting in support of timely, consistent, and accurate reporting. Ongoing, they will focus on monthly claims and encounter data exchange with the MediCal Managed Care Plan to allow more frequent calculation and monitoring of program metrics.

The WPC Medical Director participated in weekly multidisciplinary case review meetings and documented updates to the care plan within the electronic health record for new enrollees, priority cases, and persons with ED or IP visits each week.

The WPC Financial Manager is unfilled, and will remain so, with these duties provided by in-house resources on an in-kind basis.

Counsel reviewed documents for the WPC One Time Housing Funds, advised on applicability of County Shelter Crisis Declaration for zoning related to One Stop/Care Pod placement, and advised on pending legislation relevant to WPC (AB1122). The total cost was $6,168.75.

The pilot spent $2,207.35 on office supplies.

Indirect amount reported of $802,072.50 is based on 5% of direct costs totaling $16,041,450.04.

Total Administrative Infrastructure expenses invoiced for the period: $1,140,404.13.

## 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.*

IT Development and Centralized Enterprise Infrastructure expenditures of $150,000 each supported the ongoing development of the data warehouse integral to the capture of data from multiple sources and WPC data exports for the Universal and Variant Metrics calculations. An additional 15 universal and variant metrics reports were built out in the data warehouse allowing timely and consistent reporting of these metrics.

Care Pod operating costs of $43,676.97 covered the pod rental fees, supplies, and operating costs at two existing sites, River Haven and El Buen Pastor, as well as, two new sites, VCMC and N. Ventura Avenue, which were added late Q2.

EpiCenter software providing partial visibility into ED visits across area hospitals pending launch of Manifest Medex regional HIE in PY 5 ($13,625).

The Ventura County Whole Person Care project purchased the Cerner HealtheCare care coordination platform, HealtheRegistries and HealtheAnalytics software at a total cost of $980,016 in collaboration with the Behavioral Health Department. This collaborative purchase will allow for cross-departmental data exchange in the future and shared care planning via the care coordination platform. These packages will be implemented in PY 5 Qs 1 and 2.

PAM, AlertGPS, Tonic forms buildouts, and Manifest Medex (alternate software to Edie) were planned for implementation in PY 4 but have been rolled over into PY 5.

Total Delivery Infrastructure expenditures for the period: $1,337,317.97

## 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 achieved in PY 4 Qs 3 and 4 Include:

**Housing services:** payment trigger: documented housing services; achievement: 33 services, $4,950,' payable to county partners

**Care plans completed within 30 days of enrollment:** payment trigger: 80% of care plans completed plan within 30 days of enrollment; achievement: [redacted] care plans completed within 30 days of enrollment in second half of PY 4, annual total [redacted] care plans completed within 30 days of enrollment or [redacted] for PY 4, triggering incentive payment of $41,500, payable to county partners

**Annual care plans completed within 30 days of enrollment anniversary:** payment trigger: 60% of care plans completed within 30 days of enrollment anniversary; [redacted] plans completed within 30 days of enrollment anniversary in second half of PY 4, [redacted] care plans completed within 30 days of enrollment or 60.14% for PY 4, triggering incentive payment of $111,250, payable to county partners

**Follow-up after mental health ED visit:** payment trigger: at least 50% follow up after ED visit for MH; [redacted] follow-ups completed in second half of PY 4; [redacted] [redacted] for PY 4; triggering incentive payment of
$4,000, payable to county partners

**Meeting attendance expense coverage**, 0, $0 This incentive was not earned.

**Care Pod community service events,** payment trigger: completed events; 121 completed events, triggering incentive payment of $1,210,000, payable to lead entity

**Implement SMBP in Clinics** – did not implement due to clinic capacity to adopt new changes during significant budget reductions. This incentive was not earned.

**Implement PAM in Clinics** -- did not implement due to clinic capacity to adopt new changes during significant budget reductions. This incentive was not earned.

**Open Two Emergency Shelter Navigation Centers** – Ventura Arch Shelter launch, originally scheduled for December, 2019 was delayed slightly to January, 2020 while occupancy permits were obtained, item carried over to PY 5 via PY 4 to PY 5 Rollover Request. This incentive was not earned.

**Timely follow-up after hospitalization – hospital incentives**, payment trigger # of follow-up visits scheduled by hospital within 7 days of hospital discharge; [redacted] 7-day follow-ups scheduled out of [redacted] inpatient discharges, [redacted] triggering incentive payment of $34,800 payable to VCMC and Santa Paula hospitals.

**Timely follow-up after hospitalization – clinic incentives**, payment trigger: # of follow-up visits scheduled by clinics within 7 days of hospital discharge' [redacted] 7-day follow-up appointments scheduled out of [redacted] inpatient discharges, [redacted], triggering incentive payment of $101,100, payable to VCHCA Ambulatory Care Clinics.

**Strengthen referral linkages at ER discharge** – payment trigger: submitted workflows; workflows submitted to DHCS 12/31/2019 triggering incentive payment of $100,000, payable to county partners

**Strengthen referral linkages at Hospital discharge** – payment trigger: submitted workflows; workflows submitted 12/31/2019 -- triggering incentive payment of $100,000, payable to lead entity.

**Backpack Medicine** – payment trigger: completed backpack medicine events; 27 backpack medicine events were held County-wide in PY 4 - triggering incentive payment of $270,000, payable to lead entity.

**Fill all outstanding vacancies** – payment trigger: 5 outstanding vacancies filled: 4 Community Services Worker III, and 1 Alcohol and Drug Treatment Specialist. Vacancies were filled by 12/31/2020 -- triggering incentive payment of $100,000, payable to county partners

**Creation, approval, and filling of 7 new fixed term positions** – This incentive was not earned. The incentive will be carried over to PY 5 via PY 4 to 5 Rollover Request.

## VII. 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.*

The Ventura County Whole Person Care Pilot reported on the following universal and variant metrics for PY 4:

**Follow-up within 30 days post hospital MH visit:** target 10% improvement over baseline 67%; PY 4 77.78%; % change of 16.09%; MET; data source: PY 4 Universal and Variant Metrics Template. $550,000

**New AOD visits**

- ***Treated within 14 days***, target 10% improvement over baseline, baseline 39%; PY 4 49.69%; % change 27.41%; MET; data source: PY 4 Universal and Variant Metrics Template. $350,000
- ***Treated within 30 days plus engagement***, target 10% improvement over baseline, baseline 17%; PY 4 37.19%, % change 118.76%; MET; data source: PY 4 Universal and Variant Metrics Template. $400,000

**CHW/CSW Training,** target 70%; PY4 88.00%; 18% over target; MET; data source: PY 4 Universal and Variant Metrics Template. $500,000

**HbA1c <8.0,** target 10% improvement over baseline, baseline 47%; PY 4 54.02%; % change 14.94%; MET; data source: PY 4 Universal and Variant Metrics Template. $550,000

**Depression Remission**, target 10% improvement over baseline; baseline 0%; PY 4 11.54%; % change 11.54%; MET; data source: PY 4 Universal and Variant Metrics Template. $550,000

**Suicide Risk Assessment,** target 10% over baseline; baseline 0%, PY4 43.09%, % change 43.09%; MET; data source: PY 4 Universal and Variant Metrics Template. $550,000

**Homeless Receiving Housing Services**, target 60%, PY 4 95%, 35% over target; MET; data source: PY 4 Universal and Variant Metrics Template. $350,000

**6 CHW/CSW Encounters**, target 60%, achieved 60.57%, .57% over target; MET; data source: PY 4 Universal and Variant Metrics Template. $350,000

**6 CHW/CSW Encounters, target 55% (PY 3 threshold)**, achieved 60.14%; 5.57% over target; MET; data source: PY 4 Universal and Variant Metrics Template. $450,000

**All Cause Readmissions**, target 10% improvement over baseline, baseline 23% (DHCS), PY 4 28.3% (DHCS); % change 23.04% (DHCS), NOT MET; data source: DHCS.

**Controlling Blood Pressure 140/90 18-59 w/ HTN**, target 5% improvement over baseline, baseline 21%, PY 4 57.67%, which is a percent change of 175%; MET; data source PY 4 Universal and Variant Metrics Template. $450,000

**NEW Metrics in PY 4:**

**COPD - Long-Acting Bronchodilator Therapy**, target 5% improvement over prior year, PY 3 80.00%; PY 4 84.62%; % change 5.78%; MET; data source: LE calculations. $450,000

**COPD – Performing Spirometry**, target 5% improvement over prior year, PY 3 50%; PY 4 68.63%, 37.26%; MET; data source: LE calculations. $450,000

**Patient Activation Measure** – did not implement in PY 4, rolled over to PY 5

**30-Day In-Patient Psychiatric Readmission** – target 5% improvement over prior year, PY 3 17.12%, PY 4 6.06%, % change -64.6%; MET; data source LE calculations.$450,000

**SBIRT**

- ***SBIRT Completed,*** target 5% improvement over prior year, PY 3 40.61%; PY 4 52.64%, % change 29.62%; MET; data source: LE calculations. $225,000
- ***Active Referral to Treatment***, target 5% improvement over prior year, PY 3 3.63%; PY 4 30.32%, % change 735.26%; MET: data source: LE calculations $225,000
- ***Brief Interventions***, target 5% improvement over prior year, PY 3 16.67%; PY 4 29.8%, % change 78.76%; MET; data source: LE calculations $225,000
- **Treatment/MAT Access**, target 5% improvement over prior year, PY 3 0%; PY 4 35.56%, % change 35.56%; MET; data source: LE calculations $225,000

**Social Needs Screen** developed, submitted to DHCS 10/31/2019, MET $250,000

**Social needs screens completed within 30 days of new enrollment:** target 80%, PY 4 100%; 20% over target; MET; data source: LE calculations $350,000

**Social needs screens currently enrolled:** target 60%, PY 4 62%, 2% over target; MET; data source: LE calculations. $200,000

**Implement 4 Quarterly PDSA Improvement Cycles on 6 CHW/CSW metric**; MET; data source: PY 4 AR $250,000

**Implement 4 Quarterly PDSA Improvement Cycles on timely/complete/accurate documentation for all CHW/CSW visits**; MET; data source: PY 4 AR $250,000

**Motivational Interviewing Training**, complete with 80% attendance, 2 sessions 12/12/19 and 12/19/19 completed with 100% attendance; MET; data source: sign-in sheets. $45,000

**Medication Reconciliation**, target 75%, PY 4 88.46%, 17.94% over target; MET; data source: LE calculations.$350,000

**Enrolled WPC patients with primary care appointment within program year**, target 80%, PY 4 83.72%, 4.65% over target; MET; data source LE Calculations $350,000

**ED Visits**, target 10% improvement over prior year; PY 3 364.38/1,000 MM (DHCS); PY 4 366.9/1,000 MM (DHCS), % change .07%; NOT MET; data source: DHCS.

**Inpatient Utilization**, target 10% improvement over prior year, PY 3 103.55/1,000 MM (DHCS), achieved 101.58 per 1,000 MM (DHCS), % change -1.95%; NOT MET; data source: DHCS

**75% of WPC enrolled patients meeting with WPC staff member within 30 days of an in-network hospital discharge - including a documented case review entered into Cerner electronic health record by WPC Medical Director for the period 10/1/2019-12/31/2019,** target 75%, PY 4 86.05%, 14.73% over target, MET; data source: LE calculations. $200,000.

**Optional Variant M7: Percentage of participants who received recuperative care services who are not admitted to the ED or as an inpatient within 90 days of discharge,** target 55%, PY 4 73.08%, 32.88% over target, MET; data source LE calculations. $350,000.

## VIII. 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.*

Please see attached List of Participant Entity and/or Stakeholder Meetings for the Ventura County Whole Person Care Pilot during the reporting period.

## IX. PROGRAM ACTIVITIES

| **Briefly describe 1-2 successes you have had with care coordination.** |
|---|
| 1. Coordination with hospital and ED discharge teams resulted in documented workflows and the capture of baseline rates for timely clinic follow-up after hospital discharge reported under incentives section of the report.<br>2. Creation of social needs survey with input from multiple agencies launched in PY 4 Q4. |

| **Briefly describe 1-2 challenges you have faced with care coordination, and lessons learned from those challenges.** |
|---|
| 1. Staff vacancies across most of PY 4 affected caseloads and the ability to enroll new patients via intensive engagement. As overall enrollment was allowed to decline due to attrition the population retained skewed towards a more engaged but higher need population, negatively impacting some metrics as compared with PY 3. Lessons learned: staff vacancies and patient retention impact metric achievement.<br>2. PDSA cycles around CHW/CSW visits and care plans yielded desired improvements however this metric and annual care plan completion. Lessons learned: these must be closely monitored to ensure meeting PY 5 targets. |

| **Briefly describe 1-2 successes you have had with data and information sharing.** |
|---|
| 1. Collaborative software purchase with Behavioral Health Department in support of health/behavioral health data exchange and shared care planning.<br>2. Community Health Needs Assessment with Public Health Department and local area hospitals identified regional health information exchange as a priority with a software vendor (Manifest Medex) agreed in PY 4 Q4. Software will be purchased and launched early PY 5. |

| **Briefly describe 1-2 challenges you have faced with data sharing, and lessons learned from those challenges.** |
|---|
| 1. A collaborative software purchase with the Behavioral Health department revealed a strong desire to electronically exchange data and integrate health and behavioral health records. Lessons learned through this process are that there are many real and perceived barriers that will need to be addressed through the software implementation process. |

| **Briefly describe 1-2 successes you have had with data collection and/or reporting.** |
|---|
| 1. Built out 15 universal and variant metrics reports in the data warehouse allowing for on demand report generation.<br>2. Contracted with EHR provider Cerner for care coordination platform, patient registries, and analytics product. |

| **Briefly describe 1-2 challenges you have faced with data collection and/or reporting.** |
|---|
| 1. Need to identify reason for discrepancy between pilot and DHCS calculations for ED and IP metrics. Staff will engage DHCS to discuss potential solutions.<br>2. Despite a focused PDSA effort on timely documentation this remains to be a challenge among frontline, non-licensed staff with ambitious caseloads. Transition to a new care coordination platform should minimize data entry burden and manage through automation many processes that are currently manual processes. As with any new software, there will be an implementation learning curve. |

| **Looking ahead, what do you foresee as the biggest barriers to success for the WPC Program overall?** |
|---|
| 1. Ambitious metrics targets and implementation goals across PY 5 alongside the need to adapt WPC learnings into CalAIM.<br>2. Staff retention and attention to ambitious targets through this transition and the inevitable uncertainty it generates. |

## X. 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. Reducing ED Utilization,4 Reports
2. Reducing Avoidable Inpatient Utilization and Readmissions, 4 reports
3. Ensuring Comprehensive Care Plan Development, 4 reports
4. Care Coordination, Case Management, and Referral Policies and Procedures Development, 4 reports
5. Data and Information Sharing Policies and Procedures Development, 4 reports
6. CHW Training, 4 reports
7. 6 CSW Visits, 4 reports
8. Timely, Complete, Accurate Data Entry, 4 reports

Completion of the above PDSAs #s 1-6 is reflected in the Ventura County Whole Person Care Pilots Pay for Reporting section of the PY 4 Invoice. Completion of PDSA's #7 and 8 is reflected in the Pay for Outcomes section of the PY 4 Invoice.