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

Napa County Whole Person Care
Annual Report PY2 2017
4/2/2018

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.

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.*

With a launch date of July 1, 2017, Napa's pilot has completed six months of program operations within the reporting period of January 1 – December 31, 2017. The first six months of 2017, the Napa County Whole Person Care pilot has focused on establishing the infrastructure required to support changes to the local service system as well as the program design and client flows at the heart of service delivery and systems change efforts. The second half of the year focused on launching and ramping up program operations. Here are our annual highlights by category:

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

In 2017 the Napa pilot initiated a significant amount of orienting conversations/presentations with pilot and community partners in the early portion of the year and by the end of the year were actively collaborating with most service and data partners. Existing departmental and organizational silos that have existed for years made it challenging to pose a new pilot as a way to collaborate and do business differently to realize better health outcomes for clients. Partners within and outside of the agency were cautious of the flexible nature of the program and were unsure about the ability to share data. Although the pilot still has some work to do around integrating partners into the program, the pilot has realized several successes:

- Actively working with our local hospital partner on not just the WPC SOAR services bundle but on a **data sharing technology platform and a contract to provide care coordination** for WPC clients (including complex care coordination).
- Launched a **care coordination workgroup** of health coordination partners. Napa's MCO, FQHC and primary hospital participate in these meetings. Napa started initial case management coordination discussions with our MCO's regional care coordination manager.
- L**aunched Napa's Coordinated Entry system** (CES) into housing and its associated PMPM services bundle for Whole Person Care. This is a multi-agency effort with members of Napa's homeless continuum of care. As part of this system, we launched a multi-agency housing coordination collaborative to case conference the most vulnerable clients who are on Napa's prioritized list

for housing. This meeting includes community housing partners as well as health and other services partners.

Consolidated entry points into housing and services for vulnerable clients through the CES system mentioned above and through intake and outreach integration between WPC's primary services contractor and HHSA's multidisciplinary care triage team for mental health and alcohol and drug services.

- HHSA, Napa's Housing Authority, Napa Police Department and Abode Services meet regularly to **coordinate efforts in serving vulnerable homeless residents**. Although this is more of a systems-level coordination and not just for WPC, this meeting gels the homeless systems change coordination between the City, County and Housing Authority.

Increasing coordination and appropriate access to care:

Napa's pilot is very housing focused with an emphasis of connecting WPC clients to housing as quickly as possible to serve as a platform for health. Therefore, service interventions are housing focused and most health interventions sit in fee for services and through partnering. There is a need for targeted coordination for meeting complex health need that clients face as they await permanent housing. However, the pilot has realized some real successes with care coordination and has goals for more comprehensive care planning and interventions in PY3. Successes:

- Established **care coordination collaborative** (referenced above) that has been designing referral pathways and coordinating care services for vulnerable clients in the community, including WPC clients.
- Working to **contract with our hospital partner** who offers care coordination and complex care management programs in the community.
- **Integrated outreach, triage and access to housing and behavioral health services for clients**. This is primarily for HHSA behavioral health services, though includes linkages to other behavioral health services.

Reducing inappropriate emergency and inpatient utilization:

Napa has secured some of the data to understand the baseline emergency and inpatient utilization for WPC-enrolled clients, but it does not represent the entire baseline for the program. This data is not yet collected, as new instructions are for baseline data to include clients enrolled through June 30, 2018. Therefore, we have not yet developed targeted interventions for specific WPC clients based on the data. We have, however, incorporated strategies and interventions to attempt to reduce utilization more broadly for the WPC cohort based on utilization data from the time enrollments into WPC began. This is outlined in our PDSA cycles around reduction in utilization (please refer to PDSA reports) among the WPC cohort. Successes:

- **Secured utilization data** from MCO (including data for homeless WPC eligible clients), set ongoing data collection schedule
- **Selected a contractor for WPC client care coordination** (see care coordination sections)

- **Launched the CES system** to prioritize vulnerable clients for housing interventions

Improving data collecting and sharing:
The pilot has realized some significant achievements in data collection and sharing in 2017, while some challenges still remain. The pilot made great strides in 2017 in terms of identifying the data needed for reporting and evaluation purposes, analyzing and finding the legal pathways to that data, accessing the data and having a means by which we analyze the data for reporting and program improvement. For more detail on the successes and challenges of this area, please see the data sections below and refer to the Data Summary & Achievements document included as part of this report.

Achieving quality and administrative improvement benchmarks:
PY2 was a ramp-up and initial launch period for Napa's WPC pilot, which included hiring new positions, engaging partners in new collaborative groups, developing financial tracking and monitoring systems and contracting with service providers. The WPC administrative infrastructure staffing supported these efforts. See the Administrative Infrastructure section below for more detail. Major successes:

- The pilot was **successful in securing access to the necessary reporting data** and by December had completed preliminary data extractions from all of the reporting sources.
- **Developed a system to monitor Medi-Cal enrollment issues** for WPC clients when potential clients are in danger of or become dis-enrolled from Medi-Cal, or are enrolled in out-of-county Medi-Cal.
- **Completed the program's evaluation plan** and developed program monitoring benchmarks with a schedule to review reporting metrics and outcomes data on a regular basis in PY3.
- **Piloted the use of the software Tableau for data visualization** on program enrollment. This will serve as the platform for the pilot's program monitoring and metric dashboards to be developed in PY3.

Increasing access to housing and supportive services:
As a housing focused pilot, access to housing is essential for the success of Napa's pilot. The pilot has realized some significant gains in securing housing resources, though housing placement continues to be a challenge, particularly after Napa's fire disaster in October of 2017.The pilot secured new and flexible housing grants for its Flex Pool and Abode Services has started to engage in master leasing of units to make it easier to place high-acuity clients. Abode has also started to explore shared housing as a solution for some clients in a tight and expensive housing market that makes it difficult to use HUD and State housing subsidies on individual units. Please see the Barriers section below for further detail on this topic. Successes:

- Flex Pool established
- Coordinated Entry System launched
- Landlord Engagement group leveraged to build relationships with landlords

- New and flexible housing grants secured
- Use of master leasing
- Piloting shared housing
- Piloting using rapid re-housing resources as bridge housing for highly vulnerable clients who need permanent supportive housing, but that housing is not yet available.

Overall Challenges

Each of the above areas comes with its own challenges that the pilot experienced in PY2. Please refer to those sections below for further detail on challenges and see the section below on overall barriers experienced by the pilot during PY2 and as we move into PY3.

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	0	0	0	0	0	0	*

Item	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12	Annual Unduplicated Total
Unduplicated Enrollees	55	21	*	16	16	*	117

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	0	0	0	0	0	0	0
Service 2							
Utilization 2	0	0	0	0	0	0	0

FFS	Costs and Aggregate Utilization for Quarters 3 and 4						
	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12	Total
Service 1							
Utilization 1	0	0	0	0	0	0	0
Service 2							
Utilization 2	0	0	0	0	0	0	0

Whole Person Care

Napa County Whole Person Care

Annual Report PY2 2017

4/2/2018

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	Month 1	Month 2	Month 3	Month 4	Month 5	Month 6	Total
Bundle #1	$650	$0	$0	$0	$0	$0	$0	$0
MM Counts 1	0	0	0	0	0	0	0	0
Bundle #2	$776	$0	$0	$0	$0	$0	$0	$0
MM Counts 2	0	0	0	0	0	0	0	0
Bundle #3	$191	$0	$0	$0	$0	$0	$0	$0
MM Counts 3	0	0	0	0	0	0	0	0

PMPM		Amount Claimed						
	Rate	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12	Total
Bundle #1	$650	$13,650	$17,550	$16,250	$23,400	$31,850	$33,150	$135,850
MM Counts 1		21	27	25	36	49	51	209
Bundle #2	$776	$28,712	$39,576	$39,576	$38,024	$38,800	$40,352	$225,040
MM Counts 2		37	51	51	49	50	52	290
Bundle #3	$191	$*	$*	$*	$*	$*	$*	$3,438
		*	*	*	*	*	*	18

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

Napa's pilot did not begin enrollment until July 1 of PY2. Therefore, service enrollment and utilization for Jan-Jun is zero across the board and the tables above reflect that. Since July the pilot has been doing well in enrolling clients, though clients fall off of enrollment for a number of different reasons: Medi-Cal eligibility issues, refusal of services and moving out of county. The pilot has taken steps to address each of these issues, though we still anticipate enrollment fluctuations throughout the duration of this pilot, and therefore fluctuations in service bundle enrollment and services utilization.

For PMPM services, the SOAR contract is still not finalized due to a stall in the contracting process related to the fires both on HHSA's side as well as the contractor's side. Therefore, SOAR member months remain at zero. The pilot anticipates that this contract will be finalized in the first half of PY3 so that services can begin within PY3. Tenancy Care was lower than anticipated in PY2 due to overall difficulty placing clients into housing. For those placed in housing, sometimes other grants covered the costs of housing services and therefore clients did not need to enter the Tenancy Care

bundle. This will not be the case in the future as caseloads grow and therefore requiring the use of layered funding for services staff to serve a larger group of folks in Tenancy Care.

In FFS, contracts are still not finalized with contractors for respite and detox/sobering. This again is due to contracting stalls as well as the detox/sobering contractor changing part way through the contracting process for these services. Further, the respite center did not open until May 2017. In the interim, WPC clients do have access to these services, though there are not additional requirements such as data sharing and prioritized referrals that come with the final contracts.

Finally, FFS that are services paid with county match are those non-Medi-Cal billable services used by the WPC-eligible population, per the pilot's original program budget. Those expenses are reflected in our program invoice.

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.

PY2 was a ramp-up and initial launch period for Napa's WPC pilot, which included hiring new positions, engaging partners in new collaborative groups, developing financial tracking and monitoring systems and contracting with service providers. The WPC administrative infrastructure staffing supported these efforts.

Major program highlights through mid-year are included in the Mid-Year Report. Successes from the later part of the year include:

- Retained all internal administrative staff (all were hired by June and no turnover!)
- Actively engaged HHSA staff across divisions who held access to key reporting data for the pilot. Staff met with them directly with HHSA's privacy officer to clarify the pathways to sharing reporting data. The pilot was successful in securing access to the necessary data and by December had completed preliminary data extractions from all of the reporting sources.
- Engaged HHSA's Self Sufficiency Division staff and developed a system to monitor Medi-Cal enrollment issues for WPC clients when potential clients are in danger of or become dis-enrolled from Medi-Cal, or are enrolled in out-of-county Medi-Cal. The pilot tracks a small cohort of these clients to quickly resolve Medi-Cal enrollment issues.
- The pilot's external evaluator, Resource Development Associates, completed the program's evaluation plan and developed program monitoring benchmarks with a schedule to review reporting metrics and outcomes data on a regular basis in PY3.
- The pilot continued to work with Harvard's Government Performance Lab to update performance-based contracting measures for the next fiscal year.
- Worked more closely with Napa's MCO, Partnership Health, to start process of coordinating care. Up to this point, discussions had involved data sharing and reporting.
- Determined that PreManage was not a fit for the pilot due to concerns around liability if there were to be a data breach. Instead, the pilot considered a new platform, ActMD, which our hospital partner will begin to use in mid-2018.
- Piloted the use of the software Tableau for data visualization on program enrollment. This will serve as the platform for the pilot's program monitoring and metric dashboards to be developed in PY3.

- Benefitted from ongoing homeless systems change technical assistance from consultants on developing a community housing pipeline and strategizing around the upcoming Health Homes program. Also continued to benefit from implementation consulting through the development of policies and procedures, tools and project management documents.
- Throughout 2017 Napa spent considerable time identifying and vetting care coordination/case management technology platforms with county IT staff and health partners. IT is also supporting the development of an agency "data warehouse," which serves as a data depository and data matching tool that will feed into the care management platform and will also pull the necessary data for WPC metrics reporting. During the reporting period, IT has vetted various software vendors and has built the infrastructure for the data warehouse.

Challenges:

- It is important to note that infrastructure staffing was not in place starting January 1 of PY2. The first half of PY2 involved hiring several positions, some of which were not on board until April 2017. Further, staffing hours attributed to WPC work were not as high as they should have been even after considering hiring delays in PY2. This is due to the fact that some key WPC staff spent significant hours in October and November working at the county's Local Assistance Center after the wildfires.
- It has been challenging to find easy ways to track some data for outcomes improvement, as the HMIS database does not always capture everything our program might want to analyze to evaluate program operations and client outcomes. An example is length of time from housing document readiness to housing placement. This is currently tracked through service encounters in HMIS and our contractor's Salesforce database. Further, Abode Services staff are new to some of these requirements, so training staff to enter data in a standardized way has taken time to get off the ground. The pilot is leveraging bi-weekly data improvement workgroups to address this challenge and others related to HMIS data.

Without a universal consent form for clients in the WPC program, it has been challenging to coordinate services and track data, as several forms are used for various programs that lay outside of the homeless systems. See below on how the pilot is managing this challenge.

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.

Napa's WPC program delivery infrastructure provides staffing support for ramp-up and start-up prior to full program enrollment. It also supports the development of a care coordination technology infrastructure and program evaluation.

By mid-year, the primary PMPM services contractor, Abode Services began program enrollment on July 1 of PY2. Since that time, Abode has been hiring up remaining service staff, training them, enrolling clients into WPC and providing the service interventions of care and services planning, outreach, housing navigation, landlord liaising and tenancy sustaining support, in addition to operating other major initiatives in Napa's homeless system that support WPC (Flex Pool, shelter and CES access points and administers housing resources within CES).

During this time, Abode staff and the HHSA WPC team developed a targeted by-name list for WPC enrollment that included client vulnerability scores for housing (clients that would be prioritized for CES) as well those clients who were frequent users of local hospitals and emergency departments between 2013 and 2016 (according to a data match with Partnership Health). This led to a dual-pronged approach to enrollment: find those who score high on the housing vulnerability index as well as those who are frequent users and target those folks first. The team found that high scorers on the housing assessment (VI-SPDAT) are not necessarily frequent users.

Since program enrollment began on July 1, Napa officially launched its CES system after the homeless Continuum of Care approved updated CES policies and procedures that were developed throughout the first half of PY2. These efforts were led by Napa's WPC Coordinated Entry Manager with support from WPC and system-wide technical assistance consultants.

Abode services staff co-located with HHSA's Multidisciplinary Care Unit to coordinate triage efforts and client access to a package of housing and behavioral health services. These efforts led to the care unit team agreeing to use HMIS as their main services database.

HHSA's plan to contract with our FQHC for the Nurse Case Manager position unfortunately fell through in the latter half of PY2 due to the FQHC experiencing

considerable staff turnover. By the end of PY 2, the pilot instead chose to negotiate with the community's care coordination arm of the primary hospital in Napa: Queen of the Valley's CARE Network to access an entire team of clinical and social work care coordination and complex care coordination staffing to fulfill the functions of the nurse case manager and gain access to a much higher level of support for WPC care coordination.

After securing additional HMIS licenses for the pilot in the summer, HHSA formed am HMIS and data team focused on project managing the pilot's care coordination technology platform, operationalizing HMIS to improve WPC enrollment and accommodate new service programs and ways of tracking services. The team also is responsible for PDSA cycles around data and care plans.

The pilot's external evaluator completed the pilot's evaluation plan by the end of PY2 and proposed the use of ongoing outcomes meetings focused on analyzing metrics and outcomes data to improve the program and develop interventions when needed. The team also introduced the Self Sufficiency Matrix and one other assessment tool to better triage clients and to contribute to overall program evaluation.

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.

During the reporting period, Napa completed one of its incentive goals: **behavioral health data was added to HHSA's internal Data Mart**. By mid-year, the pilot completed a great deal of work around gaining access to data and building the infrastructure of the Data Mart to be able to extract and use data that is added to it. By the end of PY3, behavioral health data had been extracted and added into HHSA's internal Data Mart, which will be used for a number of different things from providing consistent data feeds updated daily to creating flat files for use in data sharing technology platforms. The pilot had planned the addition of this data would not happen until early PY3, but we were in fact successful in the addition of this data by December 2017.

In PY2 Napa did not meet the remaining incentives listed below. This is due to the pilot not yet contracting with a care coordination data technology platform. Napa's plan to implement PreManage was halted when negotiations were ultimately not successful for the platform's parent company to assume more of the risk for security breaches in the data. HHSA did not want to take the risk of ultimately being held responsible for data security breaches (even if they were caused by the platform's company) that could cost the county a considerable amount of money and credibility should they occur. The pilot is instead looking to adopt a care coordination platform company with whom our hospital partner, Queen of the Valley, is currently in the process of contracting. The software, ActMD, has proven to be very user friendly and has successfully integrated HMIS data in another community within the Queen of the Valley's network: Humboldt. This platform, like PreManage, also contains community hospital data and can accommodate other data feeds. The pilot may contract separately with ActMD or may join a combined contract with Queen of the Valley, depending on how negotiations pan out around data security and liability. Here are the unmet incentives from PY2:

- **Submission of Admission, Treatment and Discharge records to data technology platform by one health partner.**

Implementation of data technology platform.

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.

WPC pilots did not collect baseline data in 2017, as this was moved to 2018 to better reflect program enrollees through June, 2018. Therefore, baseline-related metrics are shifted into PY3 per guidance from DHCS. That leaves one metric available for the pilot to achieve: **Place 15 homeless people into housing**. The pilot achieved that outcome by the end of PY3. Here are the pilot's PY2 outcomes metrics:

- **Maintain baseline for hospital readmission**
- **Assess and maintain baseline for self-reported health status**
- **Measure and maintain baseline for suicide risk**
- **Place 15 homeless people into housing**

Abode Services was able to place 15 homeless WPC clients into housing by year-end. Abode supported the placement of nearly 50 additional homeless folks into housing during that time period – though most of those clients were not WPC eligible or did not enroll in the program. The pilot is working to improve engagement strategies to ensure that WPC eligible clients actually enroll in WPC and the pilot is targeting the enrollment of homeless people who are high on the prioritization list for housing. These efforts should increase the number of WPC homeless clients Abode is able to place into housing in PY3.

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.

During this reporting period, Napa built its meetings structure for the WPC pilot and expanded on that structure throughout PY2. Attached please find a list of all policy meetings held with participating entities and stakeholders in PY2, along with a summary (including topics and decisions) of the proceedings. We have included a sampling of agendas for the meetings listed, for further support and documentation of the meeting proceedings.

IX. PROGRAM ACTIVITIES

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

As mentioned before, Napa's pilot considers housing as the primary intervention to realize better health outcomes for WPC clients. Therefore, the pilot does not have *distinct* care coordination services or services bundles, as the focus is on placing WPC clients into housing as quickly as possible and using that stability as a platform to address health needs. This strategy is only effective to the extent that homeless WPC clients are placed into housing, which has been a challenge (please read below regarding overall program challenges). Therefore, the pilot has recognized the need for more support in coordinating care, particularly for clients who remain unhoused. In the meantime, the pilot has leveraged its health coordination collaborative as well as better integrated with HHSA's behavioral health care unit to accommodate basic care coordination activities in PY2. Please refer to the pilot's PDSA reports for detailed information on successes and challenges and how the pilot is addressing the challenges. Successes in care coordination include:

- **Commitment from hospital partner's care coordination arm to serve WPC clients**. Napa had planned to partner with our FQHC to satisfy care coordination requirements; however, this process failed due to high staffing turnover at the FQHC, which included turnover of selected staff for this service. As a result, both parties halted the negotiations and contracting process and Napa instead turned to other partners. By year-end of PY2, Queen of the Valley's Care Network agreed to enter negotiations to provide care coordination and care planning support for the WPC cohort.

- **Created interim care and services planning development and tracking in HMIS**. Current care plans for clients include services linkages and housing support for the WPC cohort. These plans and activities are currently tracked in the pilot's HMIS database and will migrate to the pilot's care coordination technology platform once that is adopted. The pilot has established a data workgroup to focus on improving access to this data and making sure staff are entering data in a standardized way. WPC partners including FFS providers, the Multidisciplinary Care Unit and the SOAR program provider staff have access to this data and use HMIS as their primary database (MC unit staff still in the process of migrating to this database). In addition, the pilot has started the process of case conferencing basic care coordination activities and housing supports in monthly case conferencing meetings for housing/CES and separate behavioral health case conferencing with the MCU.

Co-location of Abode Services and HHSA's Multi-disciplinary Care Unit: Abode Services and HHSA's Multidisciplinary Care Unit have integrated outreach, triage and access to housing and behavioral health services for clients. This is primarily for HHSA behavioral health services, though includes linkages to other behavioral health and primary health services. This has realized successes in part due to the decision in PY2 to co-locate these organizations in the same suite on the HHSA campus. The teams meet weekly to better integrate access to housing and health services for WPC clients which has led to improvements in systems navigation for these clients. Specifically, more appropriate referrals are made to both the MCU and Abode, and the collaborative prevents duplicative referrals to community services and allows for easier service referral follow up and updates to service/care plans.

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

Please refer to Napa's PDSA cycles for detailed care coordination and care planning challenges and how the pilot is dealing with these challenges each quarter. Here are some highlights of the challenges the pilot faced in PY2:

- **Care Coordination Technology Platform**: The pilot had planned on contracting with PreManage for its WPC care coordination needs in PY2, though this process was abandoned after the parities could not come to an agreement on liability fo data security breaches within the software. The CMT contract stalled in the contrac approval stage due to ongoing questions about the acceptable level of the County's liability as well as some challenging technical requirements. The decision to abandon this technology solution came in light of the pilot's primary hospital partne choosing a different platform at the end of 2017 after considering both PreManage and another solution: ActMD. Since the pilot would be contracting with the hospita in PY3 for care coordination and care planning, the pilot decided that pursuing ActMD would be the best option for long-term data sharing and care coordination abilities for vulnerable clients. The challenge now is to ensure the timely vetting o ActMD and ensuring that the contracting process does not drag on. The pilot has developed incentives in PY3 using rollover funding to ensure this challenge is prioritized and that a team of staff is focused on launching the platform in PY3.

- **Delay in securing distinct care coordination support for WPC clients**: As mentioned before, Napa's pilot requires more distinct care coordination support for WPC clients. We thought this would be resolved by contracting with our FQHC; however, this solution was ultimately not viable. This led to the need to secure another resource for these services, which was time consuming in the latter part of PY2. The pilot has since secured commitment from another partner

instead, but further delays are expected in the early part of PY3 as the contracting process is initiated.

- **The team does not yet have a program release of information** that will allow for care coordination data to be shared with all WPC services partners in real time. For now, there are multiple ROIs, which is troublesome to manage. This is particularly true if a client revokes consent for one organization but not for another. The pilot is involving the HHSA privacy/security division (particularly forms creation staff) to support the creation of the ROI in PY3 and will potentially partner with these staff to help monitor and manage client consent between services partners throughout the duration of the pilot.

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

Napa has realized considerable success with data and information sharing in PY2, though still has a ways to go with sharing data for care coordination purposes. In PY2, the pilot identified needed data for program operations and reporting, gained access to all reporting data, developed legal pathways for sharing data and tailored the HMIS database to work as WPC's centralized database for enrollment and PMPM services tracking. Please see Attachment C for a summary of the pilot's challenges and successes, updated data policies and associated data documents and tools.

Pilot successes:

1. The team developed and continually updated an **analysis of privacy regulations** that guide the sharing of data with the WPC team and with the external evaluation team was conducted. This analysis is used to inform discussions with County Counsel about the regulations underpinning different data sources, and the ability of the Napa County WPC team to access the data required for reporting and share this data with the external evaluator to use as part of the evaluation.

2. Napa County WPC **started a trial of Tableau**, visualization software which will be used to enhance the availability of data for tracking PDSA progress and outcomes over time. The WPC data team has, so far, built a draft dashboard for tracking WPC enrollees and PDSA cycles and has been reviewing these dashboards with WPC partners on a regular basis to ensure that the dashboard meets stakeholder requirements. In 2018, the data team will work to improve the dashboards' functionality and interoperability with HHSA's Data Mart.

3. Data from County' behavioral health Electronic Health Record System was incorporated into **the County's Data Mart**. The Data Mart is the repository for data needed for reporting and PDSA purposes in order to increase the usefulness and accessibility of data for quality improvement and evaluation purposes. In the future, the visualization software will update automatically from the data warehouse, making the data analysis process more timely and efficient.

4. The WPC team is working with Abode, the primary service provider in WPC, to **improve the quality of the data being collected in the HMIS system**. The HMIS improvement group tackled two improvement projects in 2017: improving the documentation for Releases of Information and improving the completion rates of self-reported health and mental health status for WPC clients. In addition, the group revised and clarified the way WPC enrollment is tracked in the HMIS system, making it easier to track service encounters across programs and providers.

5. Finally, Napa County WPC is in the process of **integrating HHSA's Multidisciplinary Care Unit team data into HMIS**. This integration is necessary for the MH access team to share clients more easily across the homeless system and to allow for more streamlined service planning across the system of care for WPC clients.

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

Though the pilot has realized successes throughout 2017 regarding data sharing, there is still work to be done in terms of sharing data for WPC between partners who are not part of HHSA. Partners seem to be very willing to share data up front, though once this process operationalizes, the pilot has experienced that road blocks tend to emerge. Partners are sometimes unsure what access to data and sharing it regularly really means discussions are had around the logistics of sharing either reporting or care coordination data. Challenges in PY2 include:

1. **Privacy and data sharing**: There are some ongoing challenges associated with data sharing and privacy in the Napa County WPC project.
    - Following the start of the enrollment into WPC, the WPC discovered that the **Release of Information** that had been approved and had been implemented was not sufficient to allow data sharing outside of the HMIS system. This meant that physical and mental health data which was available to the WPC administrative team could not be shared with Abode, the main service provider, because they are homeless (not health) service providers. The WPC team is working on a release of information that can

be used to share data more completely across agencies. In the meantime, the WPC partners are having clients sign multiple agency ROIs to share data in case conferences.

2. **Contracting with an appropriate technological solution** to use in system-wide care coordination has taken time. In 2017, the WPC team developed the technical requirements for a care coordination system and tested several different platforms. The platform that the County chose to implement, PreManage, was delayed in the contracting process for several months due to ongoing legal and technical challenges. In the meantime, the care coordination arrangements in WPC changed, with the local Queen of the Valley Hospital taking over the primary responsibility for care coordination. The WPC team plans to adopt the care coordination platform being used by Queen of the Valley in 2018.

Release of Information forms that are employed in each Behavioral Health and Social Service department will make it difficult to track and monitor revocations of consent as well as limitations to data sharing that are requested by clients. As such, WPC has a longer term plan to implement a universal release of information form which will address some of these challenges and make it easier to share information across services.

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

The pilot has made some considerable achievements in data collection for reporting purposes in PY2. Although there continue to be some minor challenges in accessing future reporting data (see above), the pilot continues to have ongoing access to reporting data that is located within HHSA and the pilot gained access to all external reporting data for this annual report. Data collection/reporting successes:

- **Data access and availability**: By mid-year, the pilot had identified all needed data sources for reporting purposes. By year end, the pilot had successfully negotiated access to these data. All of the data required for WPC metrics reporting, PDSA cycles and evaluation activities have been identified and accessed. This process required WPC staff to develop a detailed data collection map of all variables, identify data sources, ensure that the appropriate framework was in place to share the data with the WPC team, establish secure data sharing sites, and pilot data collection methods in preparation for the annual report.

- **External evaluation**: an external evaluation team, Resource Development Associates (RDA), was selected to assist Napa County WPC to track the program's operational effectiveness and outcomes. RDA interviewed program stakeholders, ran a project kick off meeting, reviewed all data sources and

developed an evaluation plan that will be used to guide all data collection and program evaluation efforts over the life of the grant.

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

The pilot continues to experience some challenges around data collection and reporting. For example:

- Although Partnership Health Plan, the County's Managed Care Organization, had an existing BAA in place with Napa County prior to WPC and has been sharing quarterly reporting data with the pilot, **PHP requested that the county enter into new BAA and data sharing agreements** in order to share data required for reporting purposes. This was in light of several WPC pilots suddenly asking for reporting data without already having BAAs with Partnership. This led Partnership to reexamine its requirements for BAAs for WPC specifically and resulted in Napa needing to alter its BAA to accommodate this. Given the significant length of time it takes to have contracts approved through the County's contracting system, there may be delays in accessing PHP data for the next reporting period; however, the pilot is doing all it can to expedite this process as much as possible.
- **Data collection for care coordination**: Care coordination data is shared primarily through HMIS when it can be, but care coordination data with external health partners requires individual release of information forms with data shared in care coordination meetings. The pilot is anxious to contract with a care coordination technology platform as soon as possible. It has been challenging to find the right fit for the county that will work in the long term. Once the pilot is successful in finding this solution, care coordination data will be able to be shared more easily across internal and external partners and will allow for a streamlined way for partners to jointly create, access and managing WPC client care plans.

Data collection standardization in HMIS: It has been challenging to bring WPC enrollment and services up to smooth operations very quickly, rolling out new procedures and methods of data tracking at program launch. It has taken services staff longer than anticipated to become familiar with the new processes and ways of collecting data inside HMIS and in other systems. At the beginning of program operations, not all services staff were entering data correctly or in the right place and sometimes were not collecting assessment data in the correct way. Therefore, the HHSA WPC team created a data workgroup that focuses on 1-2 key issues areas in WPC data collection and troubleshoots them until the next bi-weekly meeting. The group tracks progress on this

and in PDSA cycles in a data visualization software so the team can see progress against the key issue areas. So far, this process has been very successful, but minor issues still remain in data collection. The group will continue to work through them.

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

Napa is experiencing similar barriers at year-end to what it experienced at mid-year. These major barriers are staffing and contracting for WPC service interventions, data sharing and the availability and accessibility of housing as a platform for better health outcomes for WPC clients.

- **Staffing/Contracting:** Abode services continued to face challenges in the latter part of PY2 in hiring WPC outreach workers as well as housing navigation staff for coordinated entry. The team provided needed outreach services, but with a much smaller team than needed for full WPC operations. This was not a big issue in PY2 because July-December was a time of enrollment ramp-up and therefore the outreach and coordinated entry teams did not have full caseloads that entire time. However, by December, the outreach and CES teams were still not fully staffed and the caseloads are nearing capacity. To address this, HHSA has filled in internal county workers to support outreach and CES functions when needed and Abode has hired a recruiter to help fill remaining positions in the beginning of PY3.

  Contracting for services has also posed a challenge in PY2. An already delayed contracting process due to changes in requirements for covered entities was further delayed in PY2 in part due to impacts of the 2017 fire disaster in Napa. The contracting process was halted during the month of the fires and residual delays were experienced for the remainder of the year due to a backlog in contracts. By year end, Napa still needed to finalize contracting for detox and respite care fee for services. At this point, WPC clients can access these services absent agreements, but there are not yet dedicated beds or referral preferences that come with the contracts and there are no agreed requirements to share utilization data for these services. The pilot is hopeful that these contracts will be online in the first half of 2018.

- **Data sharing:** There continue to be a few challenges with data sharing and use in Napa's WPC pilot. A great amount of progress was made in PY2 to identify and

gain access to reporting data for the pilot; however, there is some work to do in PY3 to ensure that we continue to have access to this data (ED/hospital utilization data). Beyond reporting requirements, our external evaluators have identified additional data to collect for program evaluation purposes (per their evaluation plan). We may need to undergo some additional negotiation with partners in PY3 to access this data, particularly since the care coordination technology platform is not yet established.

- **Housing resources and opportunities:** Napa's WPC pilot is housing focused and success depends in large part on the availability of housing resources and opportunities for vulnerable populations so they can realize better health outcomes. In the latter part of 2017, HHSA was able to attract housing resource contributions from health partners: Queen of the Valley and Partnership Health each provided contributions to Napa's Flexible Housing Funding Pool operated by Abode Services. The Partnership Health grant is not yet operational, but the Queen of the Valley grant has been providing needed flexible resources to secure housing for vulnerable clients in the community. There continues to be a challenge in locating housing that is affordable in the community even with housing subsidies. This has been particularly challenging following the fire disaster in the Fall, as landlords raised rents considerably making it more difficult to find housing that met fair market rent standards from HUD. Continued success in securing flexible resources into the Flex Pool will help, but our community needs to invest in changing our fair market rent standard to make it more realistic. Napa plans to invest in HUD's required survey to alter its fair market rent calculation considerations to better reflect market conditions and therefore open up more affordable units in the community. In the meantime, Abode Services has been engaging in active landlord recruitment and will master lease units and pay deposits quickly to ensure that clients can secure housing. There are several housing projects in the community's development pipeline; however, not all of the projects have been approved for construction and even if they are approved, units will not come online until at least two years from now.

The pilot was successful in placing the goal of 15 WPC clients into housing and Abode Services supported 65 homeless individuals (not all WPC) in securing housing between July and December. This is fantastic, but there are many more clients to house in PY3 and beyond, and it will take persistence and creativity to unlock the number of housing opportunities needed throughout the course of this pilot. Abode Services is starting to pursue shared housing as a possible solution and HHSA is aggressively pursuing set aside units in affordable and market rate housing projects currently under construction in the community. We will monitor these initiatives in PY3 to determine success in increasing the available inventory of housing opportunities, and will of course implement other strategies developed during our ongoing meetings with Abode Services and with the homeless Continuum of Care.

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.

The Napa County Whole Person Care Pilot aims to reduce chronic homelessness and high levels of unnecessary service use among vulnerable homeless people by providing services that are better coordinated, housing focused, client centered, and supported by a culture of continuous learning and improvement. By the end of WPC, vulnerable homeless people in Napa County will have improved access to housing, will stay housed, and will experience improved wellbeing.

From January-December 2017, Napa County WPC has focused on building the foundations that will enable PDSA cycles to be successful. We are:

1. Developing a common agenda amongst stakeholders: we have been working to ensure that all stakeholders are working toward a common goal and aware of our common target group.

2. Building a culture of continuous learning: PDSA cycles will be effective if we use data to facilitate learning, growth and change, rather than penalizing services for underperformance. We are building a learning culture by promoting curiosity and by treating the Whole Person Care pilot as a problem-solving process rather than an unchanging solution to assisting vulnerable homeless in the community.

3. Establishing a shared measurement system: we have focused on identifying the data elements and sources to be used for reporting and PDSA cycles

Please refer to the attached PDSA report for Napa's PDSA summary all PY2 PDSA cycle reports.