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

Mendocino County
Annual Narrative Report, Program Year 5
April 1, 2021

REPORTING CHECKLIST

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

Component	Attachments
1. Narrative Report **Submit to:** Whole Person Care Mailbox	☐ Completed Narrative report ☐ List of participant entity and/or stakeholder meetings *(if not written in section VIII of the narrative report template)*
2. Invoice **Submit to:** Whole Person Care Mailbox	☐ Customized invoice
3. Variant and Universal Metrics Report **Submit to:** SFTP Portal	☐ Completed Variant and Universal metrics report
4. Administrative Metrics Reporting (This section is for those administrative metrics not reported in #3 above - the Variant and Universal Metrics Report.) **Note: If a Policy and Procedures document has been previously submitted and accepted, you do not need to resubmit unless it has been modified.** **Submit to:** Whole Person Care Mailbox	☐ Care coordination, case management, and referral policies and procedures, which may include *protocols and workflows.)* ☐ Data and information sharing policies and procedures, which may include *MOUs, data sharing agreements, data workflows, and patient consent forms.* One administrative metric in addition to the Universal care coordination and data sharing metrics. Describe the metric including the purpose, methodology and results.
5. PDSA Report **Submit to:** Whole Person Care Mailbox	☐ Completed WPC PDSA report ☐ Completed PDSA Summary Report
6. Certification of Lead Entity Deliverables **Submit with associated documents to:** Whole Person Care Mailbox and SFTP Portal	☐ Certification form

NOTE: The WPC Quarterly Enrollment and Utilization Report is submitted on a quarterly basis to the DHCS SFTP site.

I. REPORTING INSTRUCTIONS

Pursuant to the Whole Person Care Agreement and the Special Terms and Conditions of California's Medi-Cal 2020 §1115 Medicaid Demonstration waiver, each WPC Program Lead Entity ("Lead Entity") shall submit Mid-Year and Annual reports for the duration of the WPC Program. The WPC Reporting and Evaluation guidelines, Attachment GG, provide the requirements for the Mid-year and Annual report.

The Mid-Year Report narrative contains data January-June 30, and is due August 31 for Program Years (PYs) 3-5.

The Annual Report narrative contains data from January 1 through December 31, and is due April 2 each program year. The Annual Report is not meant to be duplicative of narratives provided in the Mid-Year Report, but aims to capture a complete picture of accomplishments and challenges during the Program year.

The Lead Entity is required to submit these reports to the Whole Person Care inbox at: 1115wholepersoncare@dhcs.ca.gov.

II. PROGRAM STATUS OVERVIEW

Instructions: Please provide a brief overview of your program's successes and challenges and any lessons learned during the reporting period. Structure your responses in alignment with the WPC program's goals using the following as headers (from STC 112): increasing integration among county agencies, health plans, providers, and other entities; increasing coordination and appropriate access to care; reducing inappropriate emergency and inpatient utilization; improving data collecting and sharing; achieving quality and administrative improvement benchmarks; increasing access to housing and supportive services; and, improving health outcomes for the WPC population.

Please limit responses to 500 words. If additional information is needed, please contact your assigned Analyst.

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

Our pilot kept the intention of the every other month Steering Committee meetings and we were planning on having a planning meeting for the transition of WPC on the off months. As with the first half of PY 5, it has been challenging with the COVID-19 to operate in a normal structure. Not only LE staff, but other agency staff have been working on other assigned duties in response to the pandemic. Our Steering committee meetings happened in July and November.

- ✓ *Increasing coordination and access to care:*

We continued to have our Complex Case Conferences on the third Friday of the month. During the first half of the year there was a little bit of a struggle trying to maintain our normal meetings, but quickly figured it out and there was only one of these meetings canceled as agencies were figuring out how to operate in the pandemic.
By the second half of the year there was a good grasp on what medical visits could be done through telehealth and which ones would have to be done in person.

Our Roomkey Project (funded through a different program) ran out of money in early July, so we had to take a step back in putting people experiencing homelessness with high risk factors (not positive cases) into motels so that they can shelter in place. In October, funding was made available again and we slowly opened up to some of the most vulnerable people with multiple health factors. What we learned in the first half of the year about our ability to coordinate and screen people was still working. While in the motels the individuals needed coordinated case management by community partners, it was important to the success of the program. Partners that participated in these activities were Behavioral Health Provider Agencies, Medical Clinics, Hospitals, Domestic Violence Shelters, Veteran's Administration, County Office of Education, homeless service providers, parole, and more.

Meetings between Behavioral Health Provider agencies and Redwood Quality Management Company, who hires the Wellness Coaches, increased significantly at this time. With face to face contact being limited it was more important to coordinate care so that the needs of the clients could be met with as little risk as possible.

Now that the virtual meeting routine has been established we plan on having our steering committee meetings regularly again. We have also been working on the planning for future WPC iterations by opening discussions with Partnership HealthPlan about or online care coordination platform and new services that they are already starting to offer.

Coordination with the COMPASS (their Population Health Team) at Adventist Health Ukiah Valley grew stronger as their team came out of furlough. The nurse case manager started a weekly check in to address Wellness Coach's questions around medical issues.

✓ *Reducing inappropriate emergency and inpatient utilization:*

It appears that COVID-19 reduced emergency room visits because of the fear that one might become infected.

We continued to work on this as we have done in the past, encouraging and assisting with primary and dental care appointments. Giving our enrollees access to other meaningful activities that encourage healthy behaviors, both physically and mentally. WPC was one of the few programs that was still meeting in person on a regular basis, even though it was reduced, with clients in our county. The mental health conditions that our clients face made it difficult for us to not get out and see how they were doing in person.

✓ *Improving data collecting and sharing:*

We continue to use Vertical Change as our care coordination and data sharing platform to share data in a systematic way. Most of the partners are using this and enthusiastic about the implications. Some of our partners do not feel the same and despite that incentives that are given do the minimum needed. We are still working with them to see the value in this process especially as funding is uncertain moving forward.

We have been working with the developer to address changes needed, and next year hope to report some improvement in usage.

✓ *Achieving quality and administrative improvement benchmarks:*

We continue to review our policies and procedures. We continue to use the PDSA approach to all of our programmatic challenges.

✓ *Increasing access to housing and supportive services:*

Housing inventory continues to be a great concern in our county. There are several projects in the process of being developed, but this takes time to see the results.

Our Mendocino County Homeless Services Continuum of Care passed a new strategic plan to address homelessness. Moving forward funded projects would have to be done in alignment with this plan.

WPC funded the inland shelter, which opened up a 7 day a week drop in homeless services shelter, to develop a road map of services. This road map would define what services are available, what a client can expect when asking for services, and which community partners play a role, as well as when they would be expected to step in. This road map must be in alignment with the Strategic Plan. People experiencing homelessness can use the showers, do laundry, and use the computers to access the internet in this facility. They also go to receive support in finding housing, so HMIS is used, Coordinated Entry, filling out voucher or apartment applications.

Project Homekey funded through the state has provided our county with the support to purchase a location with 56 doors. We are in the planning phase and are hoping to open up next spring. We were able to use a significant amount of the one-time housing funds to support this project and are planning on having up to 10 spots for WPC enrollees, as well as the other qualifying Medi-Cal enrollees.

✓ *Improving health outcomes for the WPC population:*

Wellness Coaches and the Behavioral Health Case Managers have been working more closely to coordinate care. Each identifying important physical and mental health related appointments and supporting each other and the enrollee on making the appointment and ensuring that the enrollee has the means to get there.

With more communication by phone with each client, more client contact was able to be made throughout each month. Depending on the client about half of the contacts would be over phone and done multiple times a week, with in person visits being every other week. This made it easier to talk to the client more times per week.

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	*	0	0	0	0	*	*

Item	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12	Annual Unduplicated Total
Unduplicated Enrollees	*	*	12	*	*	*	44

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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	$2,156	$4,312	$9,394	$6,160	$7,238	$6,776	$36,036
Utilization 1	14	28	61	40	47	44	234
Service 2	$4,350	$4,350	$9,000	$7,200	$42,150	$28,350	$95,400
Utilization 2	29	29	60	48	281	189	636

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	*	$4,774	*	$9,240	$8,162	$8,778	$70,994
Utilization 1	*	31	*	60	53	57	461
Service 2	$18,450	$9,750	$6,450	$4,500	$6,150	$43,050	$183,750
Utilization 2	123	65	43	30	41	287	1,225

*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	$816	$117,504	$106,896	$102,816	$97,920	$93,024	$85,680	$603,840
MM Counts 1		144	131	126	120	114	105	740
Bundle #2	$564	$8,460	$10,716	$10,716	$10,152	$9,588	$9,588	$59,220
MM Counts 2		15	19	19	18	17	17	105

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	$816	$88,944	$87,312	$100,368	$103,632	$109,344	$108,528	$598,128
MM Counts 1		109	107	123	127	134	133	733
Bundle #2	$564	$9,024	$8,460	$8,460	$8,460	$9,024	$9,024	$52,452
MM Counts 2		16	15	15	15	16	16	93

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

We had a slow decline in enrollees over the first half of the year. The largest factor being that reduction in face to face meetings was difficult for some enrollees and they stopped engaging in the program. Once our Wellness Coaches felt more comfortable going out in the field, and as possible enrollees needed more contact, it was easier to bring up our number of clients being served through the end of the year.

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 following represents the status of our build-out of administrative infrastructure:

Project Director: Megan Van Sant, Senior Program Manager, is assigned to take primary responsibility for the Whole Person Care program. Since the project's inception, Megan has facilitated stakeholder engagement and serves as the overall administrative lead for the program.

Program Coordinator/Program Coordinator COVID-19: Heather Criss, Program Administrator, is assigned to monitor and assist contractor with grant functions, policy and procedures, fiscal management, partner agency outreach, etc. Heather is primarily responsible for reporting and communication with DHCS. Heather's time was primarily spent working on COVID-19 response during the last 6 months.

Data Analyst: Angela Kelley, Dept. Analyst, is assigned to manage our Care Coordination platform and data collection for reporting.

Fiscal Analyst: Mary Alice Willeford is responsible for the fiscal duties related to the Whole Person Care program.

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.

Data and Evaluation Infrastructure:

Our Pilot continues to support Vertical Change as our web-based Care Coordination platform. Our local hospital, our Wellness Coaches, a few Behavioral Health providers, and our two community clinics are actively using the program.

We hired a consultant who had been working with these agencies to bring them into the collaborative over the last few years.

Clinic Information Platform Delivery Tier 1 and 2:

In other years this payment was in the incentive category and has moved to infrastructure, as the clinics' medical information is a backbone in our program and is necessary to inform our Wellness Coaches. Payments are made annually. Both clinics met 100% of their participation goals, Mendocino Community Health Clinics received $72,000, and Mendocino Coast Clinics received $60,000. Totaling $132,000 paid in 2021.

Homeless Services Infrastructure:

WPC works closely with the County's Continuum of Care (CoC). In addition, many of the agencies that work with WPC are also involved in the CoC. Their area of services includes providing assistance in applications for vouchers and low-income apartments. Wellness Coaches ensure that our homeless enrollees participate in the Coordinated Entry program so that they have an active chance of prioritization as new subsidized housing units come available.

We continued to support the Homeless Services Day Center and Emergency Shelter in inland Mendocino County. This facility has showers, laundry, restroom, groups,

computer, and housing navigation services in their location, as well as the overnight shelter.

WPC played a vital role in the Project RoomKey, a pandemic response to shelter high risk people experiencing homelessness. We were able to house a significant portion of this segment into permanent housing, and were able to reunite another portion with family and friends that would let them stay in their homes. This was a huge success overall.

The county unit that administers WPC also has a new Homeless Outreach Pilot Project that is being used to bring in partners who have not been at the table, such as law enforcement and the city. This team was tasked with engaging individuals and families who have not been connected to services. Although we have a lot of what we think are successes, it has also highlighted a lot of gaps in our social safety net system.

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.

Our incentive component is largely designed to encourage and stimulate participation in Steering Committee and Complex Case Conferences (Adult Multidisciplinary Team) meetings, as well as the use of our Care Coordination Platform.
Our Behavioral Health contracts are an exception, completely based on the ability to coordination care for each WPC Enrollee every month with their Wellness Coach, contracts were based on caseloads.

The structure is built on a tiered model as follows:

Criteria	Description	Payment Terms
Full Participation	70% or more meetings attended	100% of payment
Partial Participation	40% to 70% of meetings attended	50% of payment
Incomplete Participation	less than 40% of meetings attended	0% of payment

Hospital Incentives:
Incentive payments are made annually. We contracted $50,000 Adventist Health Ukiah Valley, met 100% of their objective for meetings attended in which we paid them $25,000. They met 10% of their participation in data sharing and online care coordination objective and was paid $0 as allocated in their contract total paid out was $25,000.

Behavioral Health Provider Incentives:
Incentive payments are made annually. Redwood Quality Management Company met 100% of their objectives, totaling $53,000 paid in incentives.
Other Behavioral Health Providers were incentivized for Coordination with WPC Wellness Coaches:
Mendocino Coast Hospitality Center Met 100% of their coordination goals and was paid $36,000.
Manzanita Services Met 99% of their coordination goals and was paid $35,670.

MCAVHN: Met 85% of their coordination goals and was paid $30,750.
RCS: Met 95% of their coordination goals and was paid $49,500.
This brings the total for Behavioral Health Incentives to $204,920.00

Homeless Service Provider Incentives:
Incentive payments are made annually. We contracted only $25,000 of our approved budget to the inland emergency shelter, Redwood Community Services (RCS), for beds that were provided to WPC enrollees. We also contracted with RCS and their homeless services day center, named Building Bridges, $125,000 to produce a program manual that outlined the services offered at their facility, what part their community partners play, and what can be expected when entering the center for services, and also to improve and support the function of the services they offer.

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.

11. Universal Metric: Ambulatory Care
Based on our data we believe we met the Pay for Outcome measurement for this Metric.
I have attached a spreadsheet with our accumulative data.

11. Universal Metric: Ambulatory Care - Emergency Department (ED) [per 1000 member months]

Reporting Year	Numerator Total Number of ED Visits	Denominator Total Member Months	Ambulatory_Care ED Visits per 1000 member months
2016 Baseline	585	960	609.38
2017 Annual	*	*	95.24
2018 Midyear	198	753	262.95
2018 Annual	648	2884	224.69
2019 Midyear	261	819	318.68
2019 Annual	223	824	270.63
2020 Midyear	73	967	75.49
2020 Annual	74	825	89.70

13. Universal Metric: Follow-Up After Hospitalization for Mental Health (FUH)

Based on our data we believe we met the Pay for Outcome measurement for this Metric.
I have attached a spreadsheet with our accumulative data.

Reporting Year	Numerator Total Number of Mental Health Follow-Up Within 7 days of Discharge	Denominator Total Inpatient Discharge with Mental Health	Rate
2016 Baseline	302	310	97%
2017 Annual	*	*	100%
2018 Annual	41	41	100%
2019 Annual	71	78	91%
2020 Annual	32	32	100%

Reporting Year	Numerator Total Number of Mental Health Follow-Up Within 30 days of Discharge	Denominator Total Inpatient Discharge with Mental Health2	Rate3
2016 Baseline	310	310	100%
2017 Annual	*	*	100%
2018 Annual	41	41	100%
2019 Annual	72	78	92%
2020 Annual	32	32	100%

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.

Our WPC Pilot has continued with our every other month Steering Committee Meetings. Our plan was to start up an advisory type committee of partners to work out a plan for the future of WPC. Our plan would address strategies that we wanted incorporated into the framework of services provided by Partnership HealthPlan. As COVID -19 impacted everyone, we made some changes, as the uncertainty of what was to come became even less clear, we have put off our discussions about WPC next steps.

Meeting Date	Stakeholders Present	Topics and Decisions
2/3/20 Steering Committee Meeting	County of Mendocino HHSA Mendocino County Health Clinics Mendocino Coast Clinics Redwood Quality Management Consultant Adventist Health Ukiah Valley Mendocino County BHRS Consultant Manzanita Services MCAVHN Mendocino Coast Hospitality Center	Review of Program Core Elements Recent or New Program Changes

Meeting Date	Stakeholders Present	Topics and Decisions
3/2/20 Steering Committee Meeting	County of Mendocino HHSA Mendocino County Health Clinics Mendocino Coast Clinics Redwood Quality Management Mendocino County BHRS Manzanita Services MCAVHN Mendocino Coast Hospitality Center Partnership HealthPlan Redwood Community Services	Review of Revised Release of Information MOUs and Data Sharing Agreement
5/4/20 Steering Committee Meeting	County of Mendocino HHSA Mendocino County Health Clinics Mendocino Coast Clinics Redwood Quality Management Adventist Health Ukiah Valley Mendocino County BHRS Partnership HealthPlan Manzanita Services MCAVHN Mendocino Coast Hospitality Center Redwood Community Services	COVID-19 Check in and Agency WPC Response

Meeting Date	Stakeholders Present	Topics and Decisions
7/13/20	County of Mendocino HHSA Mendocino County Health Clinics Mendocino Coast Clinics Redwood Quality Management Adventist Health Ukiah Valley Mendocino County BHRS Partnership HealthPlan Manzanita Services MCAVHN Mendocino Coast Hospitality Center Redwood Community Services	Check in on program status What we know about WPC moving forward Preparing for 6 month transition
11/2/2020	County of Mendocino HHSA Mendocino County Health Clinics Mendocino Coast Clinics Redwood Quality Management Adventist Health Ukiah Valley Mendocino County BHRS Partnership HealthPlan Manzanita Services MCAVHN Mendocino Coast Hospitality Center Redwood Community Services	Overview of CalAim proposal How to develop a plan for Mendocino County, communication structures, additional partners?

PROGRAM ACTIVITIES

Care Coordination

A. Briefly describe 1-2 successes you have had with care coordination.
    1. WPC appreciated the contribution of the COMPASS team nurse case manager and the new weekly meetings to answer medical questions or talk about specific clients. This forum was a great space to get answers and make a clear plan.

B. Briefly describe 1-2 challenges you have faced with care coordination, and lessons learned from those challenges.
    1. Most Behavioral Health Case managers were not in the field for the remainder of the year. Only a few agencies had a case manager who would do work face to face. It was a challenge sometimes to coordinate, it often left the client out as they don't all have cell phones or zoom capabilities.

       Lesson learned: It has just been a challenging year, on clients, on staff, on agencies, it is important to remember to be supportive and creative when trying to work our solutions, and sometimes you just have to let things pass.

Data Sharing

A. Briefly describe 1-2 successes you have had with data and information sharing.
    1. The inland clinic that we were having a challenge with about entering data into the shared data platform got a new Executive Director and a supportive administrative staff. We are looking forward to the developments that come with this change.

    2. We hired a Data Sharing Collaborative consultant to help organize and connect all the current user of Vertical Change and to think about how to collaborate with new partners moving forward.

B. Briefly describe 1-2 challenges you have faced with data sharing, and lessons learned from those challenges.
    1. This challenge has been ongoing in care coordination, and it has been impacting our data sharing. When the clinic isn't fully participating inputting appointments, med lists, follow-ups, etc. It is a challenge to make sure that our enrollees are doing everything to keep their physical health on tract. Not taking care of that also impacts their mental health. Our Wellness Coached have had to be more diligent at making sure they

fill in the blanks, like they do with clients who are capitated to a clinic that is not a partner in this program.

2. Our Wellness Coaches too have been struggling with getting their data entered in a timely manner. We have been working with their supervisor on ways to improve this and measure it in their individual meetings.

   Lessons from both of these challenges is that it is challenging to sell the idea that a shared data system is important to coordination and client outcomes when your partners don't even use the system properly. We are working on ways to make this more of a priority moving into next year.

Data Collection

A. Briefly describe 1-2 successes you have had with data collection and/or reporting.
   1. There is more confidence in the way we are asking for information from our partners, we now have a system set up with Partnership Health Plan so that they can get our client list and start working on our data requests.

B. Briefly describe 1-2 challenges you have faced with data collection and/or reporting.
   1. As we have gotten more confident in our ability to ask for data, staffing has changed at several agencies and it has been a challenge to get the data back in a timely manner. We just received data from several of our partners this week that the report is due.

   2. This still hasn't been addressed, with the pandemic we haven't had any time to spend, I do want to keep it here so it does not get lost. We get an aggregate data set for our metrics. Our data from Partnership HealthPlan is different than that from DHCS. When our data request was fulfilled the total member months were very different than what our records indicate, so I am not sure when the visits actually occurred, during enrollment, before or after dis-enrollment. We have asked DHCS to help look at our data and see where the errors occurred.

      Lessons learned: It is really important to work more closely and send more frequent reminders about our data needs.

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

Our biggest challenge is not knowing what exactly to plan for moving forward. California Advancing and Innovating Medi-Cal (CalAIM) drafts have been helpful, but until we know if we are getting a PMPM or Case Rate that will actually support the program we can't plan for anything.

VIII. PLAN-DO-STUDY-ACT

Instructions: PDSA is a required component of the WPC program. The WPC PDSA Report template will be used for each PDSA that the LE is conducting. Summary and status reports are required components of your Mid-Year and Annual reports. Please attach all required PDSA documents and completed template demonstrating your progress in relation to the infrastructure, services, and other strategies as described in the approved WPC LE application and WPC STCs. Note: For the Mid-Year Report, submit information from January – June 30. For the Annual Report, submit information inclusive of all PDSAs that started, are ongoing, or were completed during the Program Year.

PDSA Attachments:

1. Care Coordination QTR 3, PY5
2. Care Coordination QTR 4, PY5
3. Data Sharing annual PY5
4. Inpatient Utilization QTR 3, PY5
5. Inpatient Utilization QTR 4, PY5
6. Ambulatory Care QTR 3, PY5
7. Ambulatory Care QTR 4, PY5
8. Comprehensive Care Plan annual, PY5