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

County of Marin
Annual Report and Program Year 3
04/01/2019

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.

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I. REPORTING INSTRUCTIONS

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

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

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

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

II. PROGRAM STATUS OVERVIEW

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;

Much of 2018 was focused on building trust and relationships with the key providers in the community and reorienting them to our new model of collaboration. This work included many stakeholder meetings where by-name client lists were reviewed and service plans were developed.

planned, procured, launched, and began using a care coordination platform. All the while we focused on increasing the number of highly vulnerable clients we served with intensive case management services to show the value of the work to the parts of the system that have been on the sidelines.

We greatly increased the number of case management contracts and types and added the jail Social Worker to the WPC team as well as an Eligibility Worker from Social Services, thereby deeply integrating their departments into the work of WPC.

increasing coordination and appropriate access to care;

In 2018, our main contractor providing housing-based case management established an Assertive Community Treatment team to deliver wrap-around team-based care to the WPC clients they serve. We also launched a bi-weekly case conference meeting for all the program's case managers and other ancillary staff who serve on care teams such as the jail social worker and Public Assistance staff.

We also prepared for onboarding of hospital teams into WIZARD to allow "passive" coordination for those not getting intensive case management.

reducing inappropriate emergency and inpatient utilization;

We made major progress in our work with the two larger hospitals in our community in 2018 to share data, develop protocols, and coordinate effective discharges from the hospital back to the community. We also laid the foundation for a 2019 PDSA on frequent EMS users in partnership with our largest police and fire departments, three hospitals, behavioral health, homeless service providers, etc.

improving data collecting and sharing; achieving quality and administrative improvement benchmarks;
We invested a lot of time and energy working with our compliance and legal office and the Partnership Health Plan to work out what data are permitted to be shared between our organizations for the purposes of Whole Person Care operations. That has resulted in a willingness on their part to provide our Business Unit with expanded targeted enrollment lists as well as more complete data-sharing on the program's enrollees for the purposes of metrics tracking and reporting.

increasing access to housing and supportive services;
The convergence and coordination between the Whole Person Care Business Unit and the homeless service providers continued to pay large dividends as we leveraged the available WPC services to augment mainstream vouchers and develop supportive housing for the most vulnerable chronically homeless residents of the county. We also managed to leverage this work to gain 28 additional federal housing vouchers and expect to continue using our model to bring in more housing resources.

and improving health outcomes for the WPC population.
Fundamentally, we focused on allowing those involved in care for our clients to develop a centralized client-centered care plan that is accessible to the entire care team. We consider this the basis of improving health outcomes for the target population. We also managed to house many of those we served with the philosophy that the greatest health care intervention you can provide to someone experiencing homelessness is a home. The metrics we have submitted, in some cases, don't reflect the targeted work we did to connect our clients with their medical home given that we had such a massive surge in enrollment right at the end of the year, but that was also a major focus of our work.

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	16	23	4	1	1	0	43

Item	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12	Annual Unduplicated Total
Unduplicated Enrollees	4	14	12	81	552	23	686

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.

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Costs and Aggregate Utilization for Quarters 1 and 2							
FFS	**Month 1**	**Month 2**	**Month 3**	**Month 4**	**Month 5**	**Month 6**	**Total**
Information & Referral	$6,750.00	$2,520.00	$720.00	-	-	-	$9,990.00
Utilization 1	75.00	28.00	8.00	-	-	-	111.00
Screening, Assessment & Referral	$882.00	$2,205.00	$441.00	$1,176.00	$441.00	-	$5,145.00
Utilization 2	6.00	15.00	3.00	8.00	3.00	-	35.00
Person-Centered Care Plan	-	-	-	-	-	-	-
Utilization 3	-	-	-	-	-	-	-
Client Move-In Fee	-	-	-	$27,011.47	$2,701.15	$2,701.15	$32,413.77
Utilization 4	-	-	-	10.00	1.00	1.00	12.00
Field-Based Engagement of Homeless Individuals	-	-	-	-	-	-	-
Utilization 5	-	-	-	-	-	-	-

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Costs and Aggregate Utilization for Quarters 3 and 4							
FFS	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12	Total
Information & Referral	$5,850.00	$2,160.00	$2,070.00	$2,700.00	$2,340.00	$8,820.00	$23,940.00
Utilization 1	65.00	24.00	23.00	30.00	26.00	98.00	266.00
Screening, Assessment & Referral	-	-	-	$147.00	$882.00	$765.00	$1,794.00
Utilization 2	-	-	-	-	6.00	6.00	12.00
Person-Centered Care Plan	-	$225.00	$900.00	-	-	-	$1,125.00
Utilization 3	-	1.00	4.00	-	-	-	5.00
Client Move-In Fee	$14,983.55	$2,996.71	$5,993.42	$5,993.42	$8,990.13	$2,996.71	$41,954.00
Utilization 4	5	1	2	2	3	1	14
Field-Based Engagement of Homeless Individuals	-	-	-	-	-	-	-
Utilization 5	-	-	-	-	-	-	-

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

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Costs and Aggregate Utilization for Quarters 1 and 2							
PMPM	Month 1	Month 2	Month 3	Month 4	Month 5	Month 6	Total
Comprehensive Case Management	-	-	-	-	-	-	-
MM Counts 1	-	-	-	-	-	-	-
Housing-Based Case Management	$14,040.00	$23,220.00	$27,000.00	$25,920.00	$27,540.00	$25,920.00	$143,640.00
MM Counts 2	26.00	43.00	50.00	48.00	51.00	48.00	266.00
Case Management Mild to Moderate	-	-	-	-	-	-	-
MM Counts 3	-	-	-	-	-	-	-

Costs and Aggregate Utilization for Quarters 3 and 4							
PMPM	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12	Total
Comprehensive Case Management	$1,620.00	$3,240.00	$4,860.00	$6,480.00	$8,370.00	$6,210.00	$30,780.00
MM Counts 1	6.00	12.00	19.00	23.00	31.00	23.00	114.00
Housing-Based Case Management	$27,540.00	$34,560.00	$35,640.00	$74,893.00	$84,497.00	$84,700.00	$341,830.00
MM Counts 2	51.00	64.00	67.00	140.00	159.00	159.00	640.00
Case Management Mild to Moderate		$462.33	$2,773.98	$4,160.97	$4,160.97	$8,321.94	$19,880.19
MM Counts 3	-	1.00	6.00	9.00	9.00	18.00	43.00

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

No additional information provided

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.

In Program Year 3 Marin County rounded out the Whole Person Care Business Unit and brought on a Senior Department Analyst with a rich background in human-centered design and LEAN processes. She is focused largely on our relationships with traditional health care partners such as hospitals and clinics. Additionally, she has a strong background in IT and is leading our work on integration of the program's care coordination platform with the county's Health Information Exchange and the Homeless Management Information System.

The Technology Systems Specialist II has been the county's lead on everything related to the Health Information Exchange (Marin Health Gateway), which is now consuming ADT feeds from the county's largest hospital (more detail provided in Delivery Infrastructure)

The Department Analyst II, Epidemiologist has continued to develop data management and analysis systems and serves as the team's lead on the program's care coordination platform. Much of her time and effort was spent on system design and development of a plan for data migration from the program's internal tracking and coordination platform to the web-based vendor-supported platform.

We also hired an Accountant II who has developed billing and tracking systems to complement much of the work that was done to modernize and streamline our contracts with our service providers. Her work has helped show county leadership the path toward development of performance-based contracts.

The Department Analyst II (Homelessness) and Sr. Program Coordinator manage all the county's homelessness-related policy work, funding, and services including; Coordinated Entry, Homelessness Policy Steering Committee (Continuum of Care), and oversight of all state and county-funded projects. They have been instrumental in the development of the Housing Case Management service in Marin. This service has been married up with Coordinated Entry and special Section 8 vouchers that are set aside by agreement between Marin HHS and the local Housing Authority.

As a result, Whole Person Care and Coordinated Entry were successful in housing 89 individuals who had been experiencing chronic homelessness in Marin in Program Year 3.

The WPC Business Unit used marketing dollars from this category to develop two videos that the county is using to tell the story of the success of Whole Person Care and Coordinated Entry with traditional partners as well as new ones. The videos have been instrumental in gaining trust and telling our story as we develop new relationships to grow the set of partners coordinating care for the county's most vulnerable clients.

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.

In January the Marin Health Gateway began receiving admissions/discharges/transfer (ADT) transmissions from Marin General Hospital and set up a process using the Gateway's patient matching software to take in only those ADTs for patients of the Gateway's other member providers. Also, an ADT alert process has been piloted to alert Marin Community Clinics (MCC) providers that their patients have shown activity at Marin General Hospital. This same process will also provide ADT alerts to the other Gateway participant members, including County Behavioral Health and Recovery Services (BHRS) and three other Marin County FQHCs (Coastal Healthcare Alliance, Marin City Health and Wellness and Ritter clinics).

In June the Marin Health Gateway began working to create interfaces with MCC. Once these interfaces were completed and security of the transmissions tested, MCC began the process of querying for and retrieval of records for their patients in the Gateway.

By December initial technical discovery period for interfaces was completed with Redwood Community Healthcare Coalition, who hosts the eCW medical records system instances for three Marin County FQHCs (Coastal Health Alliance, Marin City Health and Wellness and Ritter Clinic), and the County's EMS agency. Work on those interfaces is on hold pending the completion, testing, and user acceptance of the MCC/BRHS/Marin General interfaces, as work on those interfaces will inform the development of future interfaces.

Also in December the Gateway's application for membership in the California Trusted Exchange Network (CTEN) was submitted and accepted, pending the completion of testing with two partner HIOs. This will connect the Gateway to other CTEN member HIOs in California to allow Gateway providers to query those organizations for records on the Gateway participant member's patients.

During these months, staff has evaluated two large CMS grants for expanding the Gateway's capabilities; one for integrating EMS with a local hospital and the other for onboarding other hospital and outpatient providers to the Gateway.

In October 2018 Marin County implemented ACT.MD's hosted case management/care coordination platform, branded as "WIZARD" for Marin. Since implementation, the number of client profiles, active system users, and overall system activity have grown steadily.

This is already resulting in blinders to holistic care being removed in hospitals, jail, clinics, street services, and mental health care run by and contracted by the county. Specific patient stories show how transformational this change is, now that caring professionals throughout the systems of care can see if a client has Whole Person Care case management, can connect with the case manager securely through WIZARD, and can refer new potential clients to the program if they aren't already in the system.

- RFP released Feb. 13, 2018
- Contract awarded April 3, 2018
- Approved by Board of Supervisors June 8, 2018
- Data migration began from the temporary Google Suite system to WIZARD late Sept.
- WIZARD user training Oct. 2nd and 3rd, 2018
- WIZARD go-live Oct. 4th, 2018

Clients in WIZARD may be enrolled in Case Management or they may be in WIZARD without active Case Management, potentially to be enrolled.

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.

Incentive: Implementation and Adoption of a Care Coordination IT System
Federally-qualified Health Centers

- Marin Community Clinics - $20,000
- Ritter Center- $20,000

Housing Service Providers
- Downtown Streets Team- $20,000
- St. Vincent's de Paul Society of Marin- $20,000
- Homeward Bound- $20,000

County Systems:
- BHRS- $30,000
- Social Services- $30,000

Total Earned: $160,000

Incentive: Enhanced Transitions for Severely Mentally Ill
- BHRS - $45,000 (nine clients at $5,000/client)

Total Earned: $45,000

Incentive: Barrier Identification and Resolution

- WPC Business Unit: Barrier 1 – Earned $15,000
- WPC Business Unit: Barrier 2 – Earned $15,000
- WPC Business Unit: Barrier 3 – Earned $15,000

Total Earned: $45,000

Incentive: Barrier Resolution for Severely Mentally Ill Homeless Patients

- The County earned $15,000 upon adoption by the WPC Team of a community-wide agreed upon list of patients to target.

Total Earned: $15,000

Incentive: Case Conference Attendance for Collaborative Partners

Federally Qualified Health Clinics: $2,500
- Marin Community Clinics $5,000- 53%
- Marin City Health and Wellness- $5,000 – 12%
- Ritter Center- $5,000 –100% attendance. * **Contract stipulates a $2,500 payment.**
- Coastal Health Alliance- $5,000 –0%

Housing Service Providers: $0
- Marin Housing Authority- $5,000 – 41%
- St. Vincent's de Paul Society of Marin- $5,000 – 83%
- Homeward Bound- $5,000 – 47%
- Buckelew Programs- $5,000 – 6%

Total Earned: $2,500*

Incentive: Completion of Care Plan for 80+% of Clients Within 30 Days of Enrollment for Housing Case Management Bundle and Medical Case Management Bundle
- Homeward Bound of Marin (HBOM): $9,675
- Marin Community Clinics (MCC): $225
- St. Vincent De Paul (SVDP): $4,950

Total Earned: $14,850

Incentive: Coordinated Entry Training

Federally Qualified Health Clinics: $60,000
- Marin Community Clinics – $20,000
- Marin City Health and Wellness- $20,000
- Ritter Center- $20,000
- Coastal Health Alliance- $0

County Systems: $60,000
- BHRS- $30,000
- Aging and Adult- $30,000

Total Earned: $120,000

Incentive: Contract Coordination and Modernization

County $200,000
- The County will earn a $50,000 payment if it centralizes contract management for homeless services as evidenced by a reduction in the volume of contracts and the number of individual contract managers ($50,000)
- will earn a $50,000 incentive for the first three contracts they successfully transition to a performance-based model. ($50,000 x 3 = $150,000)
- Homeless Service Providers $270,000
- Downtown Streets Team - $90,000
- St. Vincent's de Paul Society of Marin- $90,000
- Homeward Bound- $90,000
- Buckelew Programs- $0
- Ritter Center- $0

Total Earned: $470,000

See attachment for more incentive achievement details

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.

Currently, we have two Community Health Clinics (CHC) providing services within the County of Marin: Marin Community Clinics (MCC) and Ritter. To earn these metrics, the Community Health Clinics needed to request payments for demonstrating achievement of the selected outcomes by providing completion rates in PY 3 of 60% of new enrollees in screening & assessments and timely comprehensive care plans. Of the selected outcomes, Marin Community Clinics has successful completion rates for PHQ-9 and Ritter has successful completion rates for PHQ-9 and Suicide Risk.

There were challenges in our CHCs meeting the completion rate thresholds in PY 3. The WPC team did not consistently present assessment data to our partners. Transitioning from a temporary data collection system to WIZARD, the care coordination platform, caused delays for our partners to identify gaps in assessments and document assessments. Additionally, in PY 3 the WPC team began working on developing guidance for actions following assessment results but had not finalized the guidance. Therefore, there were staff at our CHCs who did not feel well enough equipped to administer assessments. In PY 4, the WPC team has provided monthly assessment completion data to our partners and has added guidance based on assessment results into WIZARD.

- Social Determinants of Health [SDOH] screening completed with 60% of enrollees and increase by 5% each year (PY 4 and 5)
    - MCC: 6/15 complete (40%)
    - Ritter: 24/64 (37.5%)
- Self-reported health status assessment completed with 60% of enrollees and increase by 5% each year (PY 4 and 5)
    - MCC: 6/15 complete (40%)
    - Ritter: 24/64 (37.5%)
- PHQ-9 (for depression) screenings completed with 60% of enrollees and increase by 5% each year (PY 4 and 5)
    - MCC: 12/13 (92%)
    - Ritter: 27/39 (69%)
- SBIRT (for substance use) screenings completed with 60% of enrollees and increase by 5% each year (PY 4 and 5)
    - MCC: Did not earn
    - Ritter: Did not earn
- Suicide Risk Assessment completed with 60% of enrollees with positive screening for depression (PHQ-9) and increase by 5% each year (PY 4 and 5)
    - MCC: 6/13 (46%)
    - Ritter: 26/39 (67%)

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.

See Attachment titled, *"Marin WPC 2018 Stakeholder Meetings"*

IX. PROGRAM ACTIVITIES

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

1. Implementation of the program's care coordination platform has resulted in increased care coordination possibilities and actualities

2. We made use of the county's behavioral health hospital liaison to coordinate between the county's psychiatric crisis stabilization unit, inpatient psychiatric unit at the hospital, and WPC case managers. Related, we also developed policies for instances when a client may have a WPC case manager and a county behavioral health case manager.

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

1. Uptake and acceptance of the program's care coordination platform was slow and difficult with some of the larger systems partners, which impeded opportunities for collaboration between community providers, the hospital, and the county's behavioral health system. We learned the importance of written standards (data sharing agreement) and the value of MOUs between the county's large systems and the Whole Person Care Business Unit.

2. As we've grown the number of services and number of contracts, we've found that the approach to care coordination and case management varies greatly across our providers and have learned that we must bring more training to our partners and remain closely connected to them in their service delivery.

c.) Briefly describe 1-2 successes you have had with data and information sharing.
1. We got an updated formal data sharing agreement cleared by county counsel and the county's compliance officer, creating a clear, consistent understanding among the program's participating entities about what may, should, and cannot be shared under the program. 2. Implementation of the care coordination platform resulted in the development of care teams for clients, allowing for true coordination of care and implementation of multi-disciplinary care.

d.) Briefly describe 1-2 challenges you have faced with data sharing, and lessons learned from those challenges.
1. We struggled to get data from our managed care plan to assist in the development of targeted enrollment lists that matched our local priorities. We adapted our approach and rely largely on our local health care providers (hospitals and FQHCs) to use data from their own Electronic Health records to identify patients who meet our enrollment criteria. We learned that we can operate our program with integrity and rely on local partners and their data. 2. We have also learned that no matter how many data sharing agreements and systems we put in place, that the system is full of people. Many of the people in the system have long held beliefs that they cannot share data despite updates to regulations and the existence of a client-signed consent for the release of information. It is necessary to constantly remain engaged at the front-line/person-to-person level to educate about what may and may not be shared.

e.) Briefly describe 1-2 successes you have had with data collection and/or reporting.
We have developed a clear process for data-sharing with our managed care plan, Partnership, and have implemented a data-sharing hub for sharing of information to and between them and other key data-reporting partners. This has made the movement and sharing of data faster and easier.

f.) Briefly describe 1-2 challenges you have faced with data collection and/or reporting.
There were challenges for our CHCs meeting the completion rate thresholds in PY 3. The WPC team did not consistently present assessment data to our partners. Transitioning from a temporary data collection system to WIZARD, the care coordination platform, caused delays for our partners to identify gaps in assessments and document assessments. Additionally, in PY 3 the WPC team began working on developing guidance for actions following assessment results but had not finalized the guidance. Therefore, there were staff at our CHCs who did not feel well enough equipped to administer assessments. In PY 4, the WPC team has provided monthly assessment completion data to our partners and has added guidance based on assessment results into WIZARD.

g.) Looking ahead, what do you foresee as the biggest barriers to success for the WPC Program overall?
Our front-line service providers are exhausted, and we are concerned in the short-term about compassion fatigue and burnout for the workforce. We are concerned about our sustainability options; especially given we don't have operational service delivery partnership with our managed care plan. Lastly, we have made major systems changes with our contracted providers and are more focused now on changes to our own internal county systems and are well aware that the ability to continue making sweeping change internally will not be easy.

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.

1. PDSA 1 Ambulatory Care Q3: Using ED visits/hospitalizations to determine eligibility among target population
2. PDSA 1 Ambulatory Care Q4: Eliminating healthcare utilization requirement to determine eligibility among target population in place of guidance to our partners
3. PDSA 2 Inpatient Q3: Working with Marin General Hospital on care coordination for homeless individuals
4. PDSA 2 Inpatient Q4: Working with Marin General Hospital on care coordination for homeless individuals
5. PDSA 3 Care Plan Q3: Discovery and Planning for ACT.md, Marin WPC's care coordination platform.
6. PDSA 3 Care Plan Q4: Implementation of ACT.md, Marin WPC's care coordination platform.
7. PDSA 4 Care Coordination Q3: Care coordination: Co-case management with Behavioral Health and Recovery Services
8. PDSA 4 Care Coordination Q4: Care coordination: Co-case management with Behavioral Health and Recovery Services
9. PDSA 5 Data Q3: Implementation of the care coordination platform to facilitate data sharing for person-centered care
10. PDSA 5 Data Q4: Data sharing policy changes
11. PDSA 6 Other, Q3: 457-INFO as a Care Coordination Hub for Marin WPC
12. PDSA 6 Other, Q4: Invoices and Billing

See Attached Table and PDSA Worksheets