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 Mendocino
Annual PY2
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.*

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

We have made significant progress with increasing integration across project partners, including county agencies, mental health care providers, and primary health clinics. During PY2, our project partners established regular bimonthly meetings of our Steering Committee. Participation at these meetings has exceeded expectations. In PY3, our primary Medi-Cal managed care plan, Partnership HealthPlan, will be joining our Steering Committee meetings.

✓ *Increasing coordination and appropriate access to care:*

During the first five months of PY2, we spent significant time developing processes and protocols for enrollment, including developing a fully vetted and approved Release of Information form. Enrollment of beneficiaries did not begin until the month of December 2017. As a result of the fledgling status of our program, we have not yet seen evidence of increased coordination of care during the Program Year.

✓ *Reducing inappropriate emergency and inpatient utilization*

As a result of very limited and young enrollment in PY2, we have not yet seen evidence of reduced inappropriate emergency and inpatient utilization. We look forward to tracking those outcomes in future years of the program.

✓ *Improving data collecting and sharing;*

Our WPC collaborative has made significant progress in developing systems of collecting and sharing data. Notably, we collaboratively developed an approved Release of Information form that will allow data to be shared across all entities.

✓ *Achieving quality and administrative improvement benchmarks;*

During PY2, we made progress in developing shared protocols and processes for WPC enrollment and the referral process. We have work to do, however, on developing shared Care Coordination and Data Sharing policies.

✓ *Increasing access to housing and supportive services*

Enrollment during PY2 was limited to just 21 new enrollees in the month of December 2017. Since our programs is still so new, we have yet to document increased access to housing and supportive services during PY2. We remain concerned, however, that a relatively large percentage of our WPC enrollees are homeless or living in precarious housing. We had hoped to achieve a more balanced mix of housed and homeless enrollees. We will be monitoring this factor closely in the coming month.

✓ *Improving health outcomes for the WPC population.*

Our focus in PY2 has been the development of enrollment processes and procedures, gaining agreement on data sharing and care coordination protocols, and building trust and rapport amongst project partners. We will develop baseline metrics for PY2, but do not anticipate being able to report on improved health outcomes until 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	0	0	0	0	0	21	21

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
1. Medical Respite Services	0	0	0	0	0	0	0
1.Utilization	0	0	0	0	0	0	
2. Mental Health Transitional Support	0	0	0	0	0	0	0
2.Utilization	0	0	0	0	0	0	0
3. Family Finding	0	0	0	0	0	0	0
3. Utilization	0	0	0	0	0	0	0

Whole Person Care

County of Mendocino

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FFS	Costs and Aggregate Utilization for Quarters 3 and 4						
	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12	Total
1. Medical Respite Services	0	0	0	0	0	0	0
1.Utilization	0	0	0	0	0	0	
2. Mental Health Transitional Support	0	0	0	0	0	0	0
2.Utilization	0	0	0	0	0	0	0
3. Family Finding	0	0	0	0	0	0	0
3. Utilization	0	0	0	0	0	0	0

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	$816	0	0	0	0	0	0	0
MM Counts 1		0	0	0	0	0	0	0
Bundle #2	$564	0	0	0	0	0	0	0
MM Counts 2		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	$816	0	0	0	0	0	$17,136	$17,136
MM Counts 1		0	0	0	0	0	21	21
Bundle #2	$564	0	0	0	0	0	0	0
MM Counts 2		0	0	0	0	0	0	0

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

Please note that we began enrolling individuals in the month of December 2017, and thus, our annual total is just 21 enrollees. (Please also note that as of March 31, our enrollment is at 119 individuals.)

As a result of our fledging enrollment in PY2, we did not make use of any of our Fee For Service options.

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.

During PY2, we focused on identifying and/or hiring staff to facilitate this program. The following represents the status of our build-out of administrative infrastructure:

Project Director: This position was identified immediately upon grant approval. Megan Van Sant, Senior Program Manager, was re-assigned to take primary responsibility for the Whole Person Care program. Since the project's inception, Megan has facilitated stakeholder engagement and is primarily responsible for reporting and communication with DHCS.

Program Coordinator: Heather Criss, Program Administrator, was transferred from another County of Mendocino position to accept the duties of the WPC Program Coordinator in the month of November, 2017. However, her transition was delayed due to the need to complete several urgent non-WPC program needs, as well as seek a replacement for her previous position. During this transitional time, a part-time contractor, Carol Mordhorst, was retained to assist with the start-up phase of the program.

Data Analyst: This position was not filled during PY2. We anticipate filling this position in PY3.

Fiscal Analyst: This position was identified and filled immediately upon grant approval. Mary Alice Willeford is responsible for the fiscal duties related to the Whole Person Care program.

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.

The following represents the elements of our Delivery Infrastructure and current status as of the end of PY2.

Mental Health Resource Center Infrastructure:
Start-up costs were incurred for the development of and the initial baseline staffing for the resource center located in Fort Bragg. This resource center was sorely needed in one of our more isolated locations in our rural community. As of the end of PY2, the resource center is fully functioning and is serving as an important administrative and social hub for a large portion of Whole Person Care enrollees in Fort Bragg.

Data and Evaluation Infrastructure:
We anticipate that our needed infrastructure for Data and Evaluation will be developed in PY3. Although we made significant progress in developing shared goals for data sharing, no funds were used for this purpose in PY2.

Homeless Services Infrastructure:
During PY2, the County of Mendocino entered into an agreement with a consultant to develop recommendations for our homeless service infrastructure. We anticipate that the results of that contract will be developed in the early months of PY3. As such, we anticipate expending funds for this purpose in PY3, rather than PY2.

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.

Our incentive component is largely designed to encourage and stimulate participation in Steering Committee, Ad-Hoc Data, and Collaborative Care (Adult Multidisciplinary Team) meetings. With just a few exceptions, attendance at these meetings by key project partners has exceeded expectations.

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: Our primary partner hospital, Adventist Health of Ukiah Valley, attended 67% of required meetings. As a result, this partner received 50% of their approved payment.

Clinic Incentives: Our two primary health clinic partners, Mendocino Coast Clinics and Mendocino Community Health Clinics, each attended 100% of all required meetings. As a result, these partners received 100% of their approved payment.

Behavioral Health Provider Incentives: Our primary behavioral health provider, Redwood Quality Management Corporation, attended 83% of all required meetings. As a result, this partner received 100% of their approved payment.

Homeless Service Provider Incentives: Our collaborative group was not yet at the appropriate point in our team development process to welcome the homeless services providers to our team. We anticipate including these providers in PY3.

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.

During PY2, our program focused on developing the infrastructure and capacity necessary to begin enrollment of beneficiaries into Whole Person Care. Our goal for our Health Outcomes was to establish and maintain baseline. With a relatively small cohort of enrollees in the month of December 2017, we are not confident that our enrollee population is sufficient to develop an accurate and useful baseline measurement. In response, **we will seek clarification and guidance from DHCS on how to accurately establish baseline measurements**. Nonetheless, the following represents current status of our program's performance on pay-for-outcome metrics.

Health Outcome	Current Status at end of PY2
Ambulatory care – ED Visits	✓ Results are pending Data Use Agreement with Partnership HealthPlan. (In process, but not yet approved.)
Inpatient utilization	✓ Results are pending Data Use Agreement with Partnership HealthPlan. (In process, but not yet approved.)
Follow-up after hospitalization for mental illness	✓ This data is readily available from our primary Mental Health subcontractor. However, results are pending clarification from DHCS on the appropriate baseline population.
Initiation and engagement of AOD treatment	✓ This data is readily available from our County Substance Abuse and Dependency Treatment programs. However, results are pending clarification on the appropriate baseline population.
Comprehensive diabetes care	✓ Results for our December 2017 enrollee population have been obtained from enrollee's primary health care clinic site.

Controlling blood pressure	✓ Results for our December 2017 enrollee population have been obtained from enrollee's primary health care clinic site.
Suicide risk assessment	✓ This data is readily available from our primary Mental Health subcontractor. However, results are pending clarification from DHCS on the appropriate baseline population.

Administrative outcome	**Current Status at end of PY2**
Establish WPC team with monthly meeting schedule	✓ Outcome achieved. Documentation of meeting attendance available.
Proportion of beneficiaries with a comprehensive care plan, accessible within 30 days of enrollment	✓ Goal not yet achieved. Of the 21 enrollees as of December 2017, care plans were not yet accessible to the entire team because our ShareFile system was not yet operable. We anticipate that such a system will be fully operable by the end of the first quarter of PY3.
Care coordination and care management policy	✓ In development. We have requested and received an extension for this deliverable to May 1, 2018.
Data Sharing policy	✓ In development. We have requested and received an extension for this deliverable to May 1, 2018.
Percent of homeless who are permanently housed	✓ Data pending. Indicator will track outcomes for our homeless population who have achieved at least 6 months of permanency in housing. At the end of PY2, none of our enrollees had been enrolled for more than 6 months.

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.

Meeting Date	Stakeholders Present	Topics and Decisions
7/26/17	County of Mendocino HHSA Mendocino Cmty Health Clinics	Orientation to WPC project and development of contract components
8/3/17	County of Mendocino HHSA Adventist Health of Ukiah Valley	Orientation to WPC project and development of contract components
8/3/17	County of Mendocino HHSA Mendocino Coast Clinics	Orientation to WPC project and development of contract components
8/18/17	County of Mendocino HHSA Redwood Quality Management Corporation	Orientation to WPC project and development of contract components
9/25/17 Steering Committee Mtg	County of Mendocino HHSA Redwood Quality Management Corporation Mendocino Coast Clinics Mendocino Cmty Health Clinics Adventist Health of Ukiah Valley	✓ Team structure ✓ Timeline goals ✓ Set agenda for the remainder of the year
10/3/17 Steering Committee Mtg	County of Mendocino HHSA Redwood Quality Management Corporation Mendocino Coast Clinics Mendocino Cmty Health Clinics	✓ Overview of client data ✓ Criteria for WPC enrollment ✓ Structure of Adult Multi-Disciplinary Team meetings

10/30/17 Steering Committee Mtg.	County of Mendocino HHSA Redwood Quality Management Corporation Mendocino Coast Clinics Mendocino Cmty Health Clinics Adventist Health of Ukiah Valley	
11/6/18 Care Coordination Advisory Meeting	County of Mendocino HHSA Mendocino Coast Clinics Mendocino Cmty Health Clinics Adventist Health of Ukiah Valley	✓ Overview of current assessments used by stakeholders ✓ Overview of current care plans used by stakeholders ✓ Review and approval of draft Release of Information ✓ Review and approval of intake and enrollment forms
	County of Mendocino HHSA Redwood Quality Management Corporation	
11/13/17 Steering Committee Mtg	County of Mendocino HHSA Redwood Quality Management Corporation Mendocino Coast Clinics Mendocino Cmty Health Clinics Adventist Health of Ukiah Valley	✓ Review of latest draft of charter ✓ Overview of WPC staffing and administrative infrastructure ✓ Report out from Care Coordinator Advisory Meeting ✓ Preliminary discussion of Data Sharing discovery and implementation ✓ Launch plan for first set of enrollees
	Mendocino Coast Clinics	

	Mendocino Cmty Health Clinics	✓ Review of the State Health Information Guidance (SHIG)
12/11/17 Steering Committee Mtg	County of Mendocino HHSA Redwood Quality Management Corporation Mendocino Coast Clinics Mendocino Cmty Health Clinics Howard Memorial Hospital	✓ Update on enrollment of pilot group ✓ Housing options overview
12/21/17 Data Workgroup	County of Mendocino HHSA Redwood Quality Management Corporation Mendocino Cmty Health Clinics Ukiah Valley Adventist Health	✓ Scope of Data Workgroup Project ✓ Initial Data Collection ✓ Review of existing data programs to consider

IX. PROGRAM ACTIVITIES

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

(1) Because our enrollment had just barely begun at the end of PY2, we have not yet had much experience with care coordination. Nonetheless, we believe that our collaborative agreement on the Release of Information and enrollment process has been a success.

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

(1) We have mixed opinions amongst stakeholders as to whether or not to include the WPC beneficiary in Care Coordination meetings. With some trepidation, the group agreed to test out the inclusion of the beneficiary in meetings specific to that person's care and wellness. We plan to use the PDSA process to evaluate the impact and outcome of this specific care coordination strategy.

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

(1) Our Steering Committee reached collaborative agreement on our general principals of data sharing, with the help of the State Health Information Guidance.

(2) Our Steering Committee reached collaborative agreement on the use of a simple shared online database for storing and accessing basic program information.

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

(1) Our Steering Committee has not reached consensus on a single Care Coordination system that all stakeholders are willing to use. None of our stakeholders are willing to engage in "double entry" of information. In addition, we are not all in agreement about the practical and financial feasibility of developing a true and automated Health Information Exchange. Lesson learned: We need to start very small with "baby steps" toward data sharing solutions.

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

(1) Collection of patient data for Controlling Blood Pressure and Diabetes Care has been simple and efficient for those enrollees who seek primary care from Mendocino Coast Clinics or Mendocino Community Health Clinics.

(2) Tracking stakeholder engagement has been efficient and effective through the design of subcontracts that include incentives for program participation.

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

(1) Developing baseline values for such a small enrollee population has been challenging. We are currently seeking guidance from DHCS on establishing baseline.

(2) We anticipate that several of our data collection and reporting elements will be difficult to achieve – particularly those relating to housing permanency and initiation of Alcohol and Other Drug Treatment.

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

Quite honestly, it is too soon to foresee our biggest barriers to success. So far, stakeholder agreement on a robust data-sharing system has been challenging. In addition, I remain concerned that the level of homelessness within our existing enrollee population may be a barrier to success. (At our next Steering Committee meeting, I will seek input from stakeholders on what they foresee as the biggest barriers to success. Stay tuned.)

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) Enrollment Criteria:
WPC.PDSA.1.Mendocino.enrollment.criteria

2) Release of Information
WPC.PDSA.2.Mendocino.release.of.information