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

COUNTY OF MENDOCINO
ANNUAL – PY4
Submitted: May 7, 2020
Revised: 7/15/20

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.

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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

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.

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

In Program Year 4, we altered our schedule to accommodate bi-monthly Steering Committee Meetings. On the alternate months, the Lead Entity meets with individual partner organizations on an individual basis, which provides partner agencies with the opportunity to speak candidly about how the program is working for their agency. The feedback has been positive thus far. Communication has been strengthened between partners outside of the Steering Committee Meetings.

Through this process we have learned that agency staff were willing to talk to the LE about issues that they didn't feel were either relevant to the whole group or didn't feel comfortable to share with the whole steering committee.

- ✓ *Increasing coordination and appropriate access to care:*

Our partners continue to attend our Complex Case Conferences and reach out to each other in-between meeting times for client related discussion. Our web-based Care Coordination platform, Vertical Change, launched mid-year and continues to be used by all partners. Users completed a use survey to gather additional feedback to identify areas for improvement; the survey results will be communicated to the vendor to guide further system development.

The Wellness Coaches have been working in coordination with the clinics to make sure that appointments for clients have been made and kept. Both the Mendocino Coast Clinic and the Mendocino Community Health Clinic enter WPC client appointments, update medication lists, and send 'tasks' to Wellness Coaches through Vertical Change. This has streamlined communication between the clinics and the Wellness Coaches.

We have faced some challenges with the fact that we didn't contract with all of the medical clinic providers. We don't have the agreements in place to share data. Wellness Coaches end up putting in the appointment information and anything else that might be relevant, instead of those other clinics putting in the data. In the limited time before

implementation we hadn't thought to include the other medical clinics, and that we could keep enrollment to the clients receiving care with the two contracted clinics. Our expectation was quickly challenged and we didn't have the capacity to reach all of the clinics or doctors that our clients used as primary care.

✓ *Reducing inappropriate emergency and inpatient utilization:*
We continue to be concerned about the accuracy of the data for our metrics for several reasons. We are currently investigating the situation with DHCS and Partnership HealthPlan. This has been an ongoing process and has been challenging.

✓ *Improving data collecting and sharing:*
Vertical Change Care Coordination web-based platform was adopted and began a slow rollout in May, 2019. We are finding anecdotally that information is being shared in a meaningful way between the Wellness Coaches and the local Emergency Department. Vertical Change is able to capture metric reporting requirements, compliance monitoring, and client outcomes within the platform so that we can collect data more efficiently.

✓ *Achieving quality and administrative improvement benchmarks;*
We have continue to implement improvements towards our administrative benchmarks. The Quality Improvement practices inform us of when it is appropriate to update Policies and Procedures.

✓ *Increasing access to housing and supportive services:*
In the first half of Program Year 4, a 37-unit Permanent Supportive Housing complex opened in Ukiah, and 20 of our enrollees were housed. WPC has been working closely with the Adult System of Behavioral Health to provide coordinated support to those residents. Overall, however, housing continues to be a challenge for our enrollees and the general community. There are several funding opportunities in the near future to expand the housing inventory.
One of our partner agencies pursued the permit to open a homeless service day center. The day center in Ukiah opened this summer, and has been providing shower and laundry services, with the hopes of providing housing services in a collaborative way with other agencies. The day center is underfunded currently to really thoroughly meet this goal.
This agency also runs the winter shelter, and have applied for a year round shelter permit. At this time, it is unclear if the City of Ukiah will approve of the year-round shelter permit.
HHSA also submitted a letter of interest for the One-Time Housing Funds for Whole Person Care Pilot, from the $100 million set aside in the California State budget for the WPC pilots. We were funded for that request.

✓ *Improving health outcomes for the WPC population.*

The administrative team has been working on developing the skills and exposure to resources for the Wellness Coaches so that they may better serve enrollees.
The program has been able to pay for short term hotel stays to assist homeless enrollees through challenging medical conditions. This has assisted enrollees through times of temporary homelessness, shelter before being housed, pre and post medical procedures, and other circumstances that have kept them out of hospitalization or ED visits. The medical respite program we have, supported through the partner hospital, has had a high barrier to access. There is an acknowledgement in the community that there is a need for a low barrier medical respite and plans are being explored to address this need. We are hoping to have more information in the annual narrative. As noted previously, we are investigating the accuracy of data that we receive from Partnership HealthPlan to see how our efforts are working.

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	12	[redacted]	[redacted]	[redacted]	[redacted]	0	26

Item	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12	Annual Unduplicated Total
Unduplicated Enrollees	[redacted]	15	[redacted]	23	44	11	123

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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		[redacted]	$4,774	[redacted]			$9,548
Utilization 1	0	[redacted]	31	[redacted]	0	0	52
Service 2	$64,650	$80,400	$107,100	$76,500	$63,600	$22,800	$415,050
Utilization 2	431	536	714	510	424	152	2,767

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							
Utilization 1	0	0	0	0	0	0	0
Service 2	[redacted]			[redacted]	$20,850	$61,650	$85,500
Utilization 2	[redacted]	0	0	[redacted]	139	411	570

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*For **Per Member Per Month (PMPM),** please report your rate, amount claimed and member months by PMPM type. These reports should tie to your budget, invoice and utilization reports. For "Bundle #" below, use the category number as reported in your submitted Quarterly Enrollment and Utilization Report. Add rows as needed*

Amount Claimed								
PMPM	Rate	Month 1	Month 2	Month 3	Month 4	Month 5	Month 6	Total
Bundle #1	$816	$117,504	$112,608	$110,976	$97,920	$97,920	$85,680	$622,608
MM Counts 1		144	138	136	120	120	105	763
Bundle #2	$564	$9,024	$9,024	$8,460	[redacted]	[redacted]	$10,152	$50,196
MM Counts 2		16	16	15	[redacted]	[redacted]	18	89

Amount Claimed								
PMPM	Rate	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12	Total
Bundle #1	$816	$66,912	$70,176	$65,280	$90,576	$137,088	$410,352	$570,384
MM Counts 1		82	86	80	111	168	172	699
Bundle #2	$564	$9,588	$10,152	$8,460	$9,024	$9,024	$10,716	$56,964
MM Counts 2		17	18	15	16	16	19	101

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

Our enrollment numbers had a large variance during the year depending on the number of Wellness Coaches that were employed. As the staffing was changing we were trying to not over tax the existing or new Wellness Coaches with too much of a case load.
At the end of the year there was a push to enroll to maximize the budget, as it would be impossible to support this program without the PMPM.

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. Megan spends about half of her time in the administration of the WPC pilot program, coordination of the steering committee, meeting with project partners, strategic planning with LE leadership, and sustainability planning.

Program Coordinator: Heather Criss, Program Administrator, is assigned to monitor and assist contractors with grant functions, policy and procedures, fiscal management, partner agency outreach, etc. Heather is primarily responsible for reporting and communication with DHCS. This position is completely supported by WPC and was created for WPC program activities to support Quality Improvement.

Data Analyst: Angela Kelley, Dept. Analyst, is assigned to manage our Care Coordination platform and data collection for reporting. This position is completely supported by WPC and was created solely for WPC program activities to support data collection and 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.

The following represents the elements of our Delivery Infrastructure and status as of PY 4.

Data and Evaluation Infrastructure:
We were able to implement using Vertical Change, a web-based Care Coordination platform. Our local hospital, our Wellness Coaches and our two community clinics are actively using the program.

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.

Whole Person Care is working with community partners at the new homeless day center, Building Bridges. This center is a collaboration of agencies that offer assistance with navigating housing issues, Street Medicine, and offer services for showers and laundry. This is a new and much-needed resource in our inland communities.

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. 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:
Incentive payments are made annually. We contracted only $65,000 of the available $150,000 in our budget. The contracted hospital, Adventist Health Ukiah Valley, met 66% of their objective for Steering committee meetings attended in which we paid them $7,500 of their $15,000 allocated in their contract. They attended 100% of their care coordination meetings in which we paid $30,000 allocated in their contract, and their participation in data sharing and online care coordination objective and was paid $20,000 allocated in their contract total paid out was $57,500.

Clinic Incentives:
Incentive payments are made annually. Both clinics met 100% of their participation goals, Mendocino Community Health Clinics received $70,000, and Mendocino Coast Clinics received $70,000. Totaling $140,000 paid in incentives. (We didn't contract the $10,000 left over in our budget as we were hoping to contract with another clinic but our rollover was not approved in enough time to establish a new contract with another clinic partner.)

Behavioral Health Provider Incentives:

Incentive payments are made annually. Redwood Quality Management Company met 100% of their objectives, totaling $140,000 paid in incentives. Redwood Quality Management Company subcontracts with other Behavioral Health Service Providers.

Homeless Service Provider Incentives:
Incentive payments are made annually. We contracted only $70,000 of our $140,000 approved budget. Redwood Quality Management Company met 100% of their objectives, totaling $70,000 paid in incentives. Redwood Quality Management Company subcontracts with other Homeless Service Providers. Multiple agencies were subcontracted through RQMC who provided Homeless Services, some of the incentives were distributed to these agencies.
The other half of the money, not contracted, was tied up because we had not had approval on our budget from DHCS and the county was reluctant to start a contract without that approval. We did have plans to these funds to support the new Homeless Services Center, a multiagency collaboration to provide a streamlined and coordinated effort to housing services as well as a center for providing activities, linkages to services, showers, and laundry facilities to people experiencing homelessness. This center serves many WPC enrollees as well as others who meet our pilot's criteria.

(The late approval of the rollover funds this year led to a delay in being able to process a contract amendment in our jurisdiction which led to not being able to spend the money, it could have been put to good use.)

NARRATIVE – Pay for Outcome
Instructions: Referencing the Whole Person Care Universal and Variant Metrics Technical Specifications, please provide a detailed explanation of the status of your program's performance on the pay-for-outcome metric(s). For the Mid-year report, only report those measures that are reported semi-annually; for the Annual report, please report all. Provide details that demonstrate what was achieved for each outcome, any challenges, and any lessons learned. Reimbursement will occur for achieved outcomes based on proposed annual target and methodology. Please limit your responses to 500 words.

The first half of PY4 was spent on developing infrastructure. We have been working to get things up and running with our wellness coaches. Most of the wellness coaches are new hires to the agencies and having them trained to work with clients and document has been key. We have been finding ways to track data and get the information from partners.

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Health Outcome	Current Status Annual of PY4
2.1-Ambulatory care – ED Visits	✓ Outcome not achieved based on DHCS data. This item was not invoiced for in PY4 Partnership HealthPlan has provided data, our baseline was 609/1000 mm, and this reporting period we were at 295/1000 mm.
2.2-Follow-Up after Hospitalization for Mental Health	✓ Outcome not achieved. This measurement has been running at 100% for previous reporting periods and this time around is reflecting 92%. This item was not invoiced for in PY4

Administrative outcome	Current Status Annual of PY4
Establish WPC team with bi-monthly meeting schedule	✓ Outcome achieved. Documentation of meeting attendance available. ✓ No challenges in attendance for meetings. ✓ Meetings continue to be scheduled bi-monthly instead of bi-weekly. ✓
Care coordination and care management policy	✓ Completed and uploaded to DHCS. ✓ Partners have policies and procedures on how to implement them. ✓ There are procedures in place to update the policy as necessary.
Data Sharing policy	✓ Completed and uploaded to DHCS. ✓ Partners have policies and procedures and assistance on how to implement them. ✓ There are procedures in place and we update the policy as necessary.
Referral Infrastructure Policy	✓ Completed and uploaded to DHCS. ✓ Partners have policies and procedures on how to implement them. ✓ There are procedures in place to update the policy as necessary.

VI. 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.

Narrative: Stakeholder Engagement
Schedule of meetings and topics have been kept for our documentation. Attendance in the meetings has been recorded so that we may be able to account for the participation of all partners. All partner agencies have been actively engaged in the steering committee meetings and its objectives.

Meeting Date	Stakeholders Present	Topics and Decisions
1/7/19 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	Enrollment Review Policy Review 2019 Planning
3/4/19 Steering Committee Meeting	County of Mendocino HHSA Mendocino County Health Clinics Mendocino Coast Clinics Redwood Quality Management Consultant Mendocino County BHRS Partnership HealthPlan	Managing referrals and waitlist Transitions of Care Policy Co-Enrollment Chart Coordination of Care
5/6/19 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 Partnership HealthPlan	Follow-up referral list Collaboration with Law Enforcement Informal Analysis and Review of Major Program Elements

Meeting Date	Stakeholders Present	Topics and Decisions
2/4/19	County of Mendocino HHSA Mendocino Coast Clinic	Program discussion about clinic perspective
4/1/19	County of Mendocino HHSA Redwood Quality Management Company	Program discussion from agency perspective.
6/13/19	County of Mendocino HHSA Mendocino Community Health Clinic	Program discussion from clinic perspective.

VII. PROGRAM ACTIVITIES

Briefly describe 1-2 successes you have had with care coordination.
(1) Our Complex Case Conferences are now scheduled every 3rd Friday, and new partners are participating, including Palliative Care, Mendocino Behavioral Health and Recovery, Ukiah Valley Adventist Health, and our wellness coaches. (2) We have developed a relationship with the major law enforcement agencies in our communities. Our ROI allows us to share information about our clients and our law enforcement liaison reaches out to us with referrals or information if they encounter one of our enrollees. Larger system conversations have been launched because of this relationship building.

Briefly describe 1-2 challenges you have faced with care coordination, and lessons learned from those challenges.
(1) Most of the Care Coordination that is taking place is still happening on a personal level. Trust is an important factor in willingness to reach out to communicate. Partner agency staff has built relationships with WPC staff and a lot of the communication is over phone or through email. The partners are not documenting that interaction on our platform. We are working on systematic approaches with our shared data platform. Developing a system where there is accountability is going to be important moving forward. At this time the incentives are driving the process, the partner agencies still see the platform as an extra level of data entry. Yet, we have high hopes that Vertical Change will improve the Care Coordination at a systems level. The Wellness Coaches were hired and housed at the Behavioral Health agencies to make access to Care Managers and therapists easy and efficient. Communication with and within some of the agencies has been much more challenging than we had anticipated. We have learned a lot about the capacity and structure of the system we are working in and have developed a plan to address this moving forward. Briefly, we intend to transfer the placement of Wellness Coaches from the sub-contractor level to be under the employment of our primary contractor – Redwood Quality Management Corporation. This change will become effective in January 2020.

Briefly describe 1-2 successes you have had with data and information sharing.
1. Implementation of the Vertical Change case management platform was completed. Initial training was provided in June. Our system partners and our wellness coaches are entering client data into the platform. Our partners are beginning to share stories of the positive impact of having real-time access to data about our clients. 2. The contractor with the County Jail, Naphcare, has agreed to use Vertical Change to access Medication Lists and upload their client plan.

Briefly describe 1-2 challenges you have faced with data sharing, and lessons learned from those challenges.
1) Even with positive feedback from partners already using Vertical Change and enthusiasm from new users, two of the four contracted partners are still reluctant to take up their part in putting in data into the system. We are looking at how we need to structure our incentive contracts moving forward.

Briefly describe 1-2 successes you have had with data collection and/or reporting.
(1) Collection of patient data for the Controlling Blood Pressure and Diabetes Care metrics continues to be simple and efficient for those enrollees who have primary care from Mendocino Coast Clinics or Mendocino Community Health Clinics. (2) The Care Coordination platform is also being used to track data that had been previously tracked in a much more tedious process. It is going to be streamlined moving forward and the county is using their data analyst to capture this information before the next reporting period.

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

1. Substance Use and Disorder Treatment data continues to pose a huge challenge on many levels. The diagnosis date for a client is rarely readily available. Furthermore, our SUDT county program documents diagnosis at the intake interview, not previous to having interaction with a client. We don't have access to treatment data outside of the county program, and it is not clear what type of programs are eligible to be counted as treatment, such as going to a 12 step program, Red Road Recovery, or other types of treatment. This metric doesn't document true successes either, just timely treatment. For example, it took 60 days for one of our clients to access treatment after diagnosis and he has been sober, housed, and doing really well for many months. Yet under the current metric he would not be counted as a success. We will address these concerns about this metric in the comments section on the metrics reporting.

2. We are currently trying to work with Partnership to revisit the data in our health outcomes and make sure that all of the metric reports are as accurate as possible.

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

Our Wellness Coaches are exploring other, more permanent, job opportunities due to the uncertainty of a WPC program year extension. Having an unstable workforce is detrimental to the success of the program.

As late entries into the WPC program through Round 2, the program work and its structure were implemented quickly. Through the PDSA process, most of our start-up issues have been worked through and improved. Other issues are still being worked out and improved. The results of this work will be felt long after the first round of funding is over, but there are concerns about whether or not the efforts put in will be reflected in the metric data in the current timeframe.

Far more of our WPC beneficiaries are homeless than previously projected. It is clear that the lack of housing in our area will continue to be a huge barrier to success. Having a secure place to live is fundamental to supporting physical and mental health. While people are not housed, they encounter challenges with making any goals that are aimed at sobriety or overall health improvement. We have a limited housing inventory for all pricing levels. Lack of housing and lack of access to healthy foods are still the biggest barriers to success for our clients.

IX. 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. Ambulatory Care Qtr 3
2. Ambulatory Care Qtr 4
3. Care Coordination
4. Comprehensive Care Plan Qtr 3
5. Comprehensive Care Plan Qtr 4
6. Data Sharing
7. Inpatient Utilization Qtr 3
8. Inpatient Utilization Qtr 4