State of California - Health and Human Services Agency

Department of Health Care Services

Whole Person Care

Lead Entity Narrative Report

County of San Diego, Health and Human Services Agency
Mid-Year/Annual Narrative Report, Program Year PY4
Revised July 10, 2020

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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May 1, 2020

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

Behavioral Health Medical Director continues to share co-chair duties of the Clinical Review Team (CRT) with a representative of one of the MCP's. The CRT has incorporated discussions around services transition through CalAIM with representatives of county agencies such as Behavioral Health and Medical Care Services, alongside a robust representation of the six MCP's who have signed the WPW MOU.

Achieving quality and administrative improvement benchmarks

Between July and December 2019 we issued three Program Guidances to our providers to increase quality and administrative controls. 2019 003 Client Completion of WPW and Transition to Health Homes Program, July 2019, details guidance on the decision making structure for the determination of closure and referral to Health Homes. 2019 004, FFS and PMPM Billable Criteria, October 2019, updated previous guidance to clarify the billable criteria for the Outreach and Engagement Phase and Case Management Months. 2019 001-R, WPW Disenrollment, clarified past guidance on case closure and the length of time outreach shall be undertaken to locate an inactive individual, and when to disenroll when incarceration or committal to an IMD occurs.

Increasing Coordination and Appropriate Access to Care

A subcommittee of the CRT was formed in September 2019 to address barriers to accessing Behavioral Health Strength Based Case Management (SBCM) and ACT level programs. Actions included increased access to CCBH for WPW providers, dedicated service slots in SBCM programs, and case conferencing for individuals who transitioned to SBCM and would close out of WPW.

Reducing Inappropriate Emergency and Inpatient Utilization

The Ambulatory Care (AMB) measure increased by 17% in PY4 over PY3, but decreased by 41% from baseline. The number of acute inpatient discharges increased by 28% in PY4 over PY3, but decreased by 43% from baseline. The outcomes that we have seen are consistent with the WPC Self-Report Metrics, Baseline PY2 and PY3 for Number of ED Visits per 1,000 WPC Member Months Self-Reported and Number of ED Visits Followed by Discharge per 1,000 Medi-Cal Member Months for PY2 Enrollees Varied by Target Population, as presented by UCLA at the Learning Collaborative Convening in September 2019.

Improving Data Collecting and Sharing

ConnectWellSD (CWSD) data entry has been fully initiated, with all reporting and quality assurance activities relying on the care coordination data entered into the platform. WPW's use of CWSD was highlighted at a semi-annual HHSA Management convening as a best practice for integrating data from contracted providers and increasing remote quality assurance activities.

Increasing Access to Housing and Supportive Services

Utilizing CDSS HDAP funds individuals have been housed through the life of our project. As of December 31, 2019, our ever enrolled and housed percentage was 50%; number ever permanently housed with a 6 month retention rate of 84% and a 12 month retention rate of 76%. These rates of retention are consistent with those identified by the National Alliance to End Homelessness for permanent supportive housing models. More analysis to determine causes of drop off at 12 months would be necessary to determine causes and areas of improvement.

Improving Health Outcomes

The High Acuity Teams (HAT) were initiated in May 2019. These teams have a lower case ratio due to the severity of needs that some participants are presenting with. As of October 2019, all six HAT teams were fully staffed and were at or near capacity. Utilization of the Clinical Review Team (CRT) for process discussions of HAT cases was initiated in July 2019. Average length of time spent on a HAT caseload through the end of 2019 is 127 days, with the minimum at 27 and maximum at 273. Additionally we have seen promising results with this service delivery model, including:

- Of those HAT clients where it has been at least 3 months since their HAT enroll date (as of Dec 31, 2019), there was an overall 4% decrease in the number of ED visits in the 3 months pre-HAT vs the 3 months post-HAT;
- Of those HAT clients where it has been at least 6 months since their HAT enroll date (as of Dec 31, 2019), there was an overall 23% decrease in the number of ED visits in the 6 months pre-HAT vs the 6 months post-HAT.

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	16	14	19	21	26	50	146

Item	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12	Annual Unduplicated Total
Unduplicated Enrollees	55	39	30	28	37	36	371

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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: O&E	$19,992	$17,748	$23,868	$25,908	$19,584	$8,568	$115,668
Utilization 1: O&E	98	87	117	127	96	42	567

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: O&E	$15, 708	$8,364	$9,996	$11,424	$18,156	$23,868	$203, 184
Utilization 1: O&E	77	41	49	56	89	117	996

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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
Phase 2	$851	$126,799	$122,544	$136,160	$144,670	$140,415	$157,435	$828,023
MM Counts: Phase 2	$851	149	144	160	170	165	185	973
Phase 3	$681	$32,007	$39,498	$38,136	$38,817	$38,817	$39,498	$226,773
MM Counts Phase 3	$681	47	58	56	57	57	58	333
Phase 6	$3,952	$0	$0	$0	[redacted]	[redacted]	$102,752	$162,032
MM Counts Phase 6	$3,952	0	0	0	[redacted]	[redacted]	26	41

Amount Claimed								
PMPM	Rate	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12	Total
Phase 2	$851	$190,624	$209,346	$205,091	$209,346	$208,495	$217,856	$2,068,781
MM Counts: Phase 2	$851	224	246	241	246	245	256	2,431
Phase 3	$681	$42,903	$42,222	$44,265	$42,903	$47,670	$42,222	$488,958
MM Counts: Phase 3	$681	63	62	65	63	70	62	718
Phase 6	$3,952	$118,560	$146,224	$201,552	$209,456	$209,456	$217,360	$1,264,640
MM Counts: Phase 6	$3,952	30	37	51	53	53	55	320

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

As part of implementing Third Sector Capital's enrollment model in April 2019, the outreach and engagement (FFS) period was shortened and contractors began enrolling eligible individuals into WPW within 30 days of their first Face to Face encounter. This resulted in a significant drop in the number of FFS encounters and an increase in the number of participants receiving comprehensive case management services in the PMPM phases. In addition, in order to maintain the appropriate caseload numbers for regular Service Integration Teams (SITs) and High Acuity teams (HATs), WPW contractors have been meeting the required number of weekly disenrollments as part of the Third Sector enrollment model. As of December 2019, the projected number of total WPW enrollments based on the Third Sector enrollment model was 853, which is above the 800 target number.

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.

All Administrative positions were filled during the reporting period of July – December 2019. The Homeless Systems Coordinator brought on in June 2019 assumed all project management duties with leadership support from the Administrator. A one (1) FTE Epidemiologist II was assigned to the project to provide data support, analysis and reconciliation. The WPW team has also been leading efforts to determine implications of the CalAIM proposal and bolstering relationships with local MCP's to best support pathways for continuity of care. A CalAIM workgroup will be stood up in January 2020 with leadership from the MCP's and incorporating partners from Health Homes.

Additionally, the WPW team has been working on a Shared Housing model whose initial implementation will be supported by the Whole Person Care One Time Housing Funds. This model will include supports for roommate matching through a software platform, landlord incentives not limited to a particular jurisdiction within the County, risk mitigation funds for damages beyond a deposit, and options for real estate liaison positions. Based on our calculations a shared housing model will save between 18 and 31% on rents by utilizing larger units over studios and one bedrooms, and create access to support networks through relationship building.

The Third Sector Capital Partners enrollment model remains in use for weekly tracking of enrollments and staffing for WPW through December 2020.

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.

During the July – December reporting period, we worked closely with CWSD management to continue to position the WPW care coordination module for potential future uses in other care coordination programs. Enhanced Care Management line item funding allowed for increased functionality for the following items:

- Add alerts when MediCal will expire
- Clean up assessment functionality for in-progress or cancelled assessments
- Add additional radio button options for Outcome Plans
- Remove frequency and time requirements for Care Plan objectives which requires excessive data entry
- Update Care Plan membership admin functionality, dynamically adding supervisors

Our WPW team continues to work closely with San Diego Health Connect, lead for Health Information Exchange (HIE) for access to hospital records as well as 211San Diego, lead for Community Information Exchange (CIE) the platform used for Health Homes referrals. Work on bridges to both HIE and CIE will roll over to 2020.

Reporting and quality assurance functions are fully functioning at this point. Monthly quality assurance is completed by the WPW team and provided to contracted providers for edits, reconciliation and quality of care recommendations.

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 WPW pilot tracks the following Incentive metrics:

50% of enrollees will have been enrolled within 1 month of their first outreach and engagement encounter. For PY4 this metric has been met. With increased visibility and consistent relationship development with hospital social workers we have been able to receive referrals prior to discharge, allowing our SIT teams to engage faster and more efficiently.
Total earned: $200,000; $133,333.33 paid to People Assisting the Homeless (PATH) Central and South/East WPW Service Regions and $66,666.67 paid to Exodus Recovery, North WPW Service Region.

50% comprehensive care plan created within 30 days. For PY4 this metric has been met. As the SIT teams have increased their capacity to serve this population, they have streamlined their operations for ensuring all necessary documentation is completed in a timely manner.
Total earned: $200,000; $133,333.33 paid to People Assisting the Homeless (PATH) Central and South/East WPW Service Regions and $66,666.67 paid to Exodus Recovery, North WPW Service Region.

Institution Transition Enrollment Incentive
For each individual transitioning from jail or an Institute for Mental Disease (IMD) a one-time annual payment will be made to People Assisting the Homeless (PATH) or Exodus Recovery when an individual is re-enrolled following release. Total earned: $4,000 at mid-year.
The WPW participants that enter into jail or an IMD have been found to not remain in the institutional setting long enough for their Medi-Cal coverage to lapse and therefore are never disenrolled from WPW.

New: Hepatitis A Immunization Incentive; 55% of WPW participants enrolled during Calendar Year 2019 who are lacking a complete immunization record will receive at least one dose of Hepatitis A vaccine during Calendar Year 2019. For PY4 this metric

has not been me. Although rosters with matching immunization information were provided to our WPW contracted providers, the intensity of this work and timing needed to achieve the numerical metric for this incentive did not support achievement.

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.

Our WPW Pay for Outcomes have led to the following outcomes and challenges:

Decrease number of days spent in the hospital by new WPW clients during their first 12 months of enrollment by 5% compared to the 12 months immediately prior to pilot enrollment. For PY4 this metric was not met, resulting in a 15% increase. There are [redacted] individuals that account for a third of all hospital days. The individuals were all part of our HAT teams, with some indicated in CCBH for SMI and/or SUD and some indicated in shared data from the Sheriffs department. If these individuals are excluded, then there's a 5% decrease overall in the number of hospital days pre- and post- 12 months enrollment.
Total earned: $0

Decrease number of ED visits for new WPW clients during their first 12 months of enrollment by 5% compared to 12 months immediately prior to pilot enrollment. For PY4 this metric was met. We attribute this to the success of our SIT teams in maintaining high needs individuals on their caseloads ensuring that their physical health needs are being met through PCP connections.
Total earned: $400,000

Decrease number of hospital days spent in Psychiatric Inpatient Units in the County by new WPW clients during their first 12 months of enrollment by 5% compared to 12 months immediately prior to pilot enrollment. For PY4 this metric was met with a decrease in the number of days spent in our County's PSU. We attribute this to the success of our SIT teams in maintaining high needs individuals on their caseloads through incorporation of licensed clinicians ensuring that their behavioral health needs are being met, including earlier detection of decompensation and intervention and through connections to County BHS and other lower levels of care accessed through community-based providers.
Total earned: $300,000

80% of new WPW clients will be seen by a primary care provider within 60 days of enrollment in the program. For PY4 this metric was met, , up from the previous year. This success is likely due to the increased ties between our SIT teams

and local FQHCs, who provide the primary care for the majority of our participants, and the incorporation of field-based nursing staff subcontracted through FQHC's and added to SIT teams. Additionally, the length of time that clients spend in the Outreach & Engagement phase has been dramatically reduced from 90 to less than 30 days further supporting a faster connection to care for all new enrollees.
Total earned: $304,428

New Metric - Increase the percentage of people who retain permanent housing at 6 months over the prior year by 5%. For PY4 this metric was met, with an increase over PY3. We attribute this to the varied utilization of HDAP funds for housing interventions ranging from SRO, shared housing, master leasing, and market rate apartment leasing. Our SIT team staff also include a Housing Navigator who maintains relationships with active property management staff to problem solve issues and concerns as they arise and reduce the number of evictions.
Total earned: $200,000

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.

WPW continues to uphold many of the administrative structures initially established in the beginning stages of the pilot. These include a monthly management committee comprised of our WPW providers, all seven Managed Care Plans (MCP), leadership from the San Diego/Imperial Counties Hospital Association, the local Continuum of Care, 211SanDiego, and various County departments including Sheriffs, Medical Care Services, Behavioral Health, Housing and Community Development Services, and Aging and Independence Services.

Additionally, we provide the infrastructure for the twice monthly Clinical Review Team (CRT), facilitated by the Behavioral Health Medical Director and a representative of one of our MCPs. CRT allows our service providers to consult with leadership from our MCPs on our hardest to serve, those on the case load of the High Acuity Teams. CRT provides a much-needed platform for our providers to use one another's expertise, problem solve with County leaders, and support the development of the MediCal system of care to be our clients advocate and voice.

Internally we hold a twice monthly Internal Coordination meeting with County departments, including Agency Budget, the ConnectWellSD team, Behavioral Health, Office of Business Intelligence, and Medical Services, to discuss the program's metrics, spending, successes and areas to address.

Please see attachment for further detail and dates.

VIII. PROGRAM ACTIVITIES

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

(1) During the reporting period we fully implemented the High Acuity Teams (HATs) with a 1:10 caseload ratio. The HATs have been very successful in providing intensive services for all domains of the lives of our community's most in need individuals. HAT teams spend, on average, 4.3 times as many hours per month with each client as the standard SIT teams do with near daily interaction with clients.

(2) We have found that the top 5 chronic health conditions seen in most in need individuals are heart disease, diabetes, hypertensive disease, arthritis, and COPD. With the incorporation of nursing staff on our HAT teams, the coordination with PCPs and hospital staff has increased dramatically and has allowed participants to transition off of HAT onto a standard Service Integration Team (SIT) after 30-60 days. The integration of medical professionals into traditionally social service-based teams introduces new language, and new understanding of the medical field, to better coordinate care.

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

(1) Our providers have had some difficulty in maintaining staffing levels due to the unprecedented amount of funding for homeless services coming from the State, creating multiple opportunities for new positions in the homeless sector.

(2) During Program Year 4, WPW providers continued to strengthen their relationship with COSD Behavioral Health Services FSP and SBCM program staff to improve the referral process for WPW participants and to educate staff on how both programs could provide collaborative support to participants. One challenge we are working to overcome is the perception that ACT level services and the WPW program provide the same services at the same intensity, so messaging on care coordination and roles and responsibilities has been particularly important.

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

(1) During this reporting period we were able to secure access to CWSD for our MCP care coordinators to allow them to view future appointments, assessments and care

plans. Although not all of our MCPs chose to have staff access and participate in trainings on CWSD, we have found that of those who did it has been a helpful tool to managing care.

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

(1) We continue to only have data from six of our seven regional managed care plans without full signatures to our project's MOU. We also have a percentage of participants who continue to be Fee for Service and have limited claims data from their MediCal services. With CalAIM pending there is greater impetus from both the managed care plans to be interested in the success of care coordination with those who are insured with them, as well as improved messaging for FFS participants on the benefits to being on a managed care plan.

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

(1) During this reporting period we were able to work through privacy concerns to work with San Diego Immunization Registry to cross reference lists of WPW participants with the registry's lists of Hepatitis A vaccine recipients. County privacy staff were thoroughly briefed on the purpose of the need for the information and in the end we were able to provide rosters to our providers for them to focus their efforts on.

(2) In addition, a staff member was granted access to Clarity, the local Homeless Management Information System. With this new access, we were able to verify whether housed enrollees who have disenrolled from WPW retained their permanent housing.

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

(1) As of December 31, 2019, San Diego County had data use agreements (DUAs) with 6 of the 7 Medi-Cal managed care plans in the county (no DUA with Kaiser). The 6 managed care plans provided healthcare claims data on 89% of WPW participants enrolled in 2019. The remaining 11% of enrollees were not assigned to a Medi-Cal managed care plan (i.e., were Fee-for-Service clients), were assigned to an Out-of-

County managed care plan, or were Kaiser clients. This missing data may have impacted our metric calculations, however the level of impact is unknown.

(2) In addition, there were some limitations in the data available to us for the required metric calculations. Some specifications outlined by DHCS for the universal and variant metrics were not met based on data that was provided to us by the managed care plans and other data sharing entities. For example, PHQ-9 data was not available for the Depression Remission metric. Therefore a proxy had to be used (specifically, diagnostic data from the county's Behavioral Health Services) in order to calculate the metric.

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

Although the CalAIM proposal, and subsequent communication from DHCS, has clearly identified a pathway for WPW participants to continue to receive a high level of care, there remains concern around the timing of services transitions, potential contracts with MCPs, and the as yet unfunded outreach to this hard to reach, hard to engage population.

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. Eligibility Criteria
2. Transfer of Care
3. Emergency Department Communication
4. ID Card
5. Care Plan Monitoring
6. Care Plan Screening Tool
7. Care Coordination
8. ConnectWellSD Data
9. Early Enrollee Cohort
10. HIE Coordination