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

Shasta County Health and Human Services Agency
Annual Report 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.

Whole Person Care

Shasta County Health and Human Services Agency

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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.*

Increasing integration among county agencies, health plans, providers, and other entities;

- The WPC Pilot Team includes members from the Lead Entity, two Federally Qualified Health Centers, HHSA Regional Services Housing, and Partnership HealthPlan of California (PHC). The Pilot Team meets at least twice monthly.
- Additional success includes interactions with hospital staff and WPC staff for referrals to WPC and care coordination.
- Challenges include community perception of WPC. Lessons have been learned about the clarity and consistency of our communications with the public and healthcare providers.

Increasing coordination and appropriate access to care;

- Many of the people enrolled in WPC have had significant challenges in effectively and appropriately utilizing complex systems and services. Case management has been instrumental in assisting WPC participants understand and interact appropriately with a variety of community services and care providers.
- Challenges include the astonishing acuity of participant illness and need. Lessons have been learned about defining success from the participant's point of view.

Reducing inappropriate emergency and inpatient utilization;

- RNs and case managers have helped increase health literacy by working with WPC participants to inform and educate about healthcare options.
- Challenges revolve around some participants comfort in utilizing ED services. We have learned that some WPC participants are using the ED specifically to access medications that have been lost, stolen or misused.

Improving data collecting and sharing;

- Our multiparty, bi-directional release of information allows us to confidently share information amongst the Pilot Team.
- With the challenges of determining who can have access to information and when, we have begun using the ROI as part of the referral packet. We learned this has also allowed for better connection to services for those not

eligible for WPC as well as safer and more speedy engagement with those who are eligible.

Achieving quality and administrative improvement benchmarks;

- Having built our pilot with the administrative measures as milestones, we successfully, established policies and procedures from our system model. Policies and procedures include comprehensive care plans, care coordination, referral infrastructure, data and information sharing. These policies and procedures have been updated and revised to accommodate the growth and advancement of the pilot.
- Challenges remain in our understanding of the HEDIS measures regarding the WPC adaptations. Data collection from alcohol and drug resources and for those participants with Medicare are significant challenges.

Increasing access to housing and supportive services;

- Housing seems to be a significant reason for people to engage with WPC. Our housing case management works quickly to help unsheltered participants obtain shelter and work towards more permanent housing.
- Housing and homelessness are prominent needs in Shasta County and one of the challenges is around the idea that Whole Person Care has a new source for housing and shelter. Even with intensive case management, appropriate housing options are a limited but critical resource. To avoid misunderstanding when we promote WPC, we now focus more on coordination of care rather than just housing and medical case management.

Improving health outcomes for the WPC population.

- WPC Participants have a medical case manager, housing case manager and an RN working collaboratively with them to address their priority health and housing goals. This team has assisted participants in increasing health literacy about health care, health systems and healthy choices. Teams have assisted participants in obtaining shelter and housing, which has been a significant step towards improving health outcomes and overall quality of life. Teams have also assisted participants repair relationships, learn skills for daily living, connect with resources such as benefits, foods, dental care, substance use treatment, credit repair and other daily supports. Improvement in health outcomes reported here pertains more to the Participant's goals and objectives instead of as reported in the metrics.
- Challenges arise when "our" perceptions of appropriate choices differ from the Participants'. The differing views of needs and appropriate treatment, services or interventions may happen between providers or between a participant and the care team. Harm reduction strategies are a frequent discussion item at our Pilot Team meetings.

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					*	26	*

Item	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12	Annual Unduplicated Total
Unduplicated Enrollees	26	26	0	*	*	*	102

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
Service 1	0	0	0	0	0	0	0
Utilization 1	0	0	0	0	0	0	0
Service 2	0	0	0	0	0	0	0
Utilization 2	0	0	0	0	0	0	0

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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
Service 1	0	0	0	0	0	0	0
Utilization 1	0	0	0	0	0	0	0
Service 2	0	0	0	0	0	0	0
Utilization 2	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
Intensive Medical Case Management	$595.00					0	0	0
MM Counts 1						0	0	0
Housing Case Management	$816.41					0	0	0
MM Counts 2						0	0	0

PMPM		Amount Claimed						
	Rate	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12	Total
Intensive Medical Case Management	$595.00	0	0	$27,965.00	$27,965.00	$26,775.00	$22,610.00	$105,315.00
MM Counts 1	0	0	47	47	45	38	177	0
Housing Case Management	$816.41	0	0	$32,656.40	$35,105.63	$35,922.04	$31,023.58	$134,707.65
MM Counts 2		0	0	40	43	44	38	165

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

Enrollment began in May of 2017 as part of a PDSA process to develop referrals and Teamlet initial contact with the participant. Due to this there were * clients enrolled from May 10, 2017 to May 31, 2017. As June 2017, progressed documents and processes were further defined. It was during this period there was a great deal community education and this also increased referrals rates.

The PMPM tracking and billing processes were not developed until the 3rd Quarter. PMPM billing began September 1, 2017 and the procedure and processes for this component of the pilot began design in July.

The information included here are all enrolled members including those that were “Administratively Enrolled”. This means that they are open to outreach only services. Once the Comprehensive Care Plan is completed then they are Enrolled into the program to receive full services. The metrics submitted are based on those members that were Enrolled for full services. Of the 102 individuals that were administratively enrolled during 2017 – 50 where enrolled into services.

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.

Administrative Infrastructure includes HHSA personnel required for the day-to-day implementation, monitoring and evaluation of the WPC pilot program. The personnel included in administrative infrastructure are responsible for data collection and program reporting, management of contract partners, management of program budgets and fiscal administration, and data analysis and PDSA activities. This category also includes costs for licensing software for HHSA personnel and partner entities to collect and analyze program data and support reporting on pilot program metrics.

The HHSA personnel hired includes the Community Development Coordinator and the Senior Staff Services Analyst. Both of these positions were filled in the first quarter of 2017. Additional HHSA personnel from the contracts and fiscal units were assigned to the WPC pilot on a .25fte basis for supporting contract and budget needs.

The Community Development Coordinator and Senior Staff Services Analyst: facilitate and support the WPC Pilot Team; guide the Pilot Team in refining the WPC system model; polish and adapt the policies and procedures; provide resources and guidance to enable the identification and enrollment of WPC Participants; create and improve mechanisms for documentation, information sharing, data storage and reporting; and have utilize the PDSA cycles to adapt and refine the WPC Pilot with the Pilot team as needed.

During this reporting period, the uniqueness of the Whole Person Care pilot was brought to light in terms of the demand for time and effort from fiscal and contracts staff. Several meetings were required for understanding, planning and revising the PY2 Budget Rollover and Adjustments. The unique payment system required more time than originally anticipated. The same was true with the contracts staff. Due to the unique components and approaches in the WPC Pilot more time than anticipated was spent creating, refining, negotiating and approving contracts.

Software for tracking program metrics- software to track client encounters, as well as program progress and outcome measures needed to meet the metric reporting obligations of the WPC pilot has not yet been purchased. The database continues to meet this need as the Senior Staff Services Analyst explores software options.

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.

Delivery Infrastructure includes: funding for the mental health resource center, coordination of the Continuum of Care (CoC) for Redding and Shasta County, licensing of a new Homeless Management Information System (HMIS), and training for WPC pilot staff and partners to build capacity for cross agency coordination, educate staff on data and information sharing policies and procedures, and support data collection, reporting, and PDSA activities. In the first part of PY2 50% of the costs for medical case management teams and housing case management teams are included in the delivery infrastructure to allow for time spent developing the programs and establishing data sharing agreements across agencies.

The Mental Health Resource Center is operated through a contract with Hill Country Health & Wellness Center. Continuum of Care Coordination is facilitated via a contract with Suzy Cochems. The contract for HMIS is in place and trainings for the new system began late in 2017.

Contracts with two Federally Qualified Health Centers (FQHC), for medical case management, were developed and waiting final Board of Supervisor approval at the end of PY2. During the first part of the year, Shasta Community Health Center and Hill Country Health & Wellness Center had each assigned one RN and one medical case manager to the WPC Pilot Team. Partway through the year both FQHCs experienced staffing changes with the loss of the RN. Nurses from each clinic were made available to the medical case managers, but the Pilot Team acutely felt the lack of not having program dedicated RNs. At the end of PY2, Hill Country Clinic had hired an RN and Shasta Community was in the interview process. Shasta Community Health Center was also in the process of hiring additional medical case managers and supervisory staff.

As part of the Health and Human Services Agency, the Regional Services Branch, Housing Unit began with two housing case managers and hired and assigned a third case manager to the WPC Pilot Team. Direct supervisory support was included and has proven to be a necessary support due to the intensity of need within the caseloads for WPC.

The initial RFP for the Housing Support Volunteer Program did not elicit any responses. The RFP was released a second time and had a response that required negotiations.

At the end of PY2 the negotiations were unresolved and due to the unique funding structure of WPC, unlikely to result in a viable agreement. Additional options have been discussed and will be explored in PY3.

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.

Several of these items are in planning or initial stages of development and implementation. Timelines for this reporting period have not allowed for all incentive payments to be made.

Incentive Payments in the future may include the following:

HMIS incentive to input a homeless person's intake information into the Homeless Management Information System (HMIS). Estimate a total of 150 WPC participants per year and $10 per HMIS entry. CoC Coordinator and HHSA housing case managers will conduct this activity. The incentive payments will be split as follows: 100 for CoC and 50 for housing case management based on completion of HMIS data entries.

- The housing case managers have entered 107 participant's intake information into the HMIS system during PY2.
- The total of 107 entries at $10 each is a total incentive of $1070.00

Sobering Center incentive for each WPC enrolled participant in the sobering center who enters detox program and stays at least 72 hours. Estimate that of WPC participants served by sobering center 50 will enter detox annually.

- The Sobering Center has not begun. No incentive payments available at this time.

Housing Support Volunteers incentive will be paid to HHSA Housing Support Volunteer Program for each 100 home visits to WPC enrolled participants completed per volunteer. Estimate 5,000 home visits per year.

- The Housing Support Volunteer Program has not begun. No incentive payments are available at this time.

Housing case management incentive for each WPC enrolled participant who stays in permanent housing for at least six consecutive months. Estimate 50 per year; 75% of incentive paid to housing case management and 25% to intensive medical case management.

- Based upon a calculation of WPC full months we have one participant that was housed six consecutive months in December. The seventh month occurred in January.
- Due to some confusion about calculation parameters, this incentive will be claimed in the next reporting period.

Reduced ED utilization incentive for each WPC enrolled participant who has <2 emergency department visits for six consecutive months. Estimate 50 per year; 75% of incentive paid to intensive medical case management and 25% to housing case management.

- There five members that met this metric.
- The total of five members, times $500.00, is a total incentive of $2500.00

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.

The measure selected is "Increase follow-up within 7 days post-discharge for Mental Illness [Adults] for the WPC target population." The pilot goal is to increase follow-up by 5% per year. In PY2 the metric payment is based on maintaining baseline established through reporting in PY1.

Pay for Metric Outcome Achievement incentives only include enrolled WPC Participants in the measurement of performance on this measure. For the reporting period of January through December 2017 No participants that were hospitalized for mental illness.

In the coming reporting periods, we aim to achieve follow-up within seven days post-discharge for mental illness for any WPC Participants needing inpatient hospitalization. It is our hope that with the Pilot Team providing multiple layers of care coordination and developing relationships with ED staff and mental health providers, follow-up will become an expedited and natural course of case management.

There were no mental health hospitalizations for enrolled Whole Person Care clients during 2017. This is a sharp reduction in mental health hospitalizations that occurred prior to enrollment the program.

While many participants have had psychiatric inpatient hospitalizations prior to enrollment, during May through December 2017, none of the WPC Participants required this level of care. At this time, it is difficult to draw conclusions as to the reasons for this difference due to a very limited sample size and a short time frame.

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.

- 7/5/17- Shasta Health Assessment and Redesign Collaborative (SHARC) steering committee guidance and data review
- 7/11/17- WPC Pilot Team Meeting, mental health programs and resources presentations
- 7/12/17- Mercy Medical Center WPC presentation to nurses and social workers
- 7/17/17- Admin team and housing staff, program check-in
- 7/18/17- WPC Pilot Team meeting (all pilot team meetings focus on program planning, care coordination, data utilization review or systems, training needs)
- 7/20/18- Admin team and Shasta Community Health Center (SCHC), program check-in
- 7/20/17- WPC presentation to Crisis Residential and Recovery Center staff
- 7/25/17- WPC Pilot Team meeting
- 7/25/17- Admin team and Hill Country Clinic (HCC), program check-in
- 7/27/17- WPC meeting about referrals with Mercy Hospital ED navigator
- 8/1/17- Admin team and Partnership HealthPlan of California (PHC), program check-in
- 8/2/17- SHARC data presentation and steering committee guidance
- 8/8/17- WPC Pilot Team meeting
- 8/8/17- WPC meeting about referrals with CMSP staff
- 8/10/17- WPC presentation to Visions of the Cross (Drug Medi-Cal provider) about referrals and care coordination strategies
- 8/14/17- WPC presentation to Empire Recovery (Drug Medi-Cal provider) about referrals and care coordination strategies
- 8/16/17- WPC presentation to Perinatal Services (Drug Medi-Cal provider) about referrals and care coordination strategies
- 8/21/17- WPC presentation to Right Road Recovery (Drug Medi-Cal provider) about referrals and care coordination strategies
- 8/22/17- WPC Pilot Team meeting
- 8/25/17- WPC meeting with Nurse Family Partnership about referring to either program
- 8/28/17- Admin team and housing staff, program check-in
- 8/29/17- Admin team and SCHC, program check-in
- 8/29/17- Admin team and HCC, program check-in
- 8/30/17- Admin team and PHC, program check-in

- 9/6/17- SHARC data presentation and steering committee guidance
- 9/7/17- WPC presentation to Right Road Recovery all staff meeting
- 9/12/17- WPC Pilot Team meeting
- 9/25/17- Admin team and housing staff, program check-in
- 9/26/17- WPC Pilot Team meeting
- 9/26/17- Admin team and HCC, program check-in
- 9/27/17- Admin team and PHC, program check-in
- 9/27/17- Admin team and SCHC, program check-in
- 10/4/17- SHARC presentation of PY2 mid-year report, steering committee guidance
- 10/10/17- WPC Pilot team meeting
- 10/17/17- WPC Pilot team meeting- housing first, boundaries and strengths based training
- 10/19/17- Budget rollover rules review and planning, agency leaders and fiscal staff
- 10/23/17- Admin team and housing staff, program check-in
- 10/24/17- WPC Pilot team meeting
- 10/25/17- Admin team and PHC, program check-in
- 10/26/17- WPC presentation to all Shasta County Health and Human Services Agency Adult Services staff- focus on collaboration and care coordination strategies
- 10/26/17- WPC presentation to Dignity Connected Living
- 10/30/17- Admin team and SCHC, program check-in
- 11/1/17- SHARC data presentation and steering committee guidance
- 11/6/17- Admin team and HCC, program check-in
- 11/14/17- WPC Pilot Team meeting
- 11/27/17- Admin team and housing staff, program check-in
- 11/28/17- WPC Pilot Team meeting
- 11/29/17- Admin team and PHC, program check-in
- 12/6/17- SHARC data presentation and steering committee guidance
- 12/12/17- WPC Pilot Team meeting
- 12/28/17- Admin team, housing leadership and contracts staff discuss Housing Support Volunteer Program

IX. PROGRAM ACTIVITIES

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

(1) Care coordination strategies have enabled the WPC Pilot Team members to quickly and efficiently wrap services around some of our community's most high needs citizens. Several participants have been able to access a team of providers that address their needs in a personalized and focused manner leading to permanent housing and significant health improvements.

(2) For participants who are beyond the scope of practice for WPC, we have been able to use care coordination strategies to assist people in connecting with the appropriate level of care in a supported manner.

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

(1) Community perception of WPC and our abilities has been challenging. We have worked among the Pilot Team and steering committee to clarify our messages and make sure we are all communicating the same details about the WPC Pilot.

(2) The acuity of participant needs has been an unforeseen challenge. Far more time and resources has been spend focusing on activities of daily living and basic social skills than was anticipated in the planning phases. Helping participants understand systems and gain the skills needed to navigate systems has taken a lot of collaboration, creativity and shared efforts.

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

(1) Toward the end of PY2, the Pilot Team switched the referral process to a model that includes having the ROI signed as part of a referral packet. Having the ROI signed at the outset has allowed for a more coordinated approach to eligibility determination. All members of the pilot team can now share information and insights that pertain to the participant's care. It also has allowed for quicker connection into services or for those not eligible, connection to appropriate services and programs.

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

(1) Finding a software program or technology option that allows for all Pilot Team members to access the data and participant information in one location has been an ongoing challenge. Options that are cost effective, meet privacy and security concerns and provide the needed functionality for a small pilot seem to be elusive. There are ongoing discussions with Social Solutions for an adaptable product for PY3.

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

The database, spreadsheets, paper copies of ROIs and comprehensive care plans sent via encryption continue to allow for functional data collection and reporting. The Database allows for information to be customized and presented in graphs and charts that help to inform our stakeholders. These formats also allow for functional collection of data from our participating entities to inform the required reports to the State. While a system that allows all of this information to be shared or accessed in one location is preferred, all of the necessary components have been created and are easy to use and access.

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

Delays in claims data, especially for those with Medicare, continues to be challenging in determining eligibility and reporting on metrics or baseline data. Reporting on the metrics has been challenging due to a lack of clarity in the HEDIS measures with the WPC adaptations.

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

Items being used to inform the success, changes or progress of the program do not seem to align well. The baseline data is a small sample of very high needs individuals with complex and individualized circumstances. To expect this sample to adequately and accurately inform the overall changes and success of the program seems misleading. Additionally, the metrics are not providing clear pictures of participant or program success, changes or progress. Overall, it seems difficult to determine from the data being reported how success of program or individual is defined or measured.

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.

Shasta WPC PDSA Ambulatory Care 1 Q2 2017 - Why ED
Shasta WPC PDSA Ambulatory Care 1 Q3 2017 - Why ED
Shasta WPC PDSA Ambulatory Care 1 Q4 2017 - Why ED
Shasta WPC PDSA Ambulatory Care 2 Q3 2017 - Health Literacy
Shasta WPC PDSA Ambulatory Care 2 Q4 2017 - Health Literacy
Shasta WPC PDSA Ambulatory Care 3 Q4 2017 - ED Alert System
Shasta WPC PDSA Care Coordination 1 Q2 2017 - Est Care Coord
Shasta WPC PDSA Care Coordination 1 Q3-Q42017 - Est Care Coord
Shasta WPC PDSA Care Coordination 2 Q4 2017 - Referral System to Staffing
Shasta WPC PDSA Comprehensive Care Plan 1 Q2 2017 - Design CCP
Shasta WPC PDSA Comprehensive Care Plan 1 Q3 2017 - Design CCP
Shasta WPC PDSA Comprehensive Care Plan 1 Q4 2017 - Design CCP
Shasta WPC PDSA Comprehensive Care Plan 2 Q2 2017 - CCP Util
Shasta WPC PDSA Comprehensive Care Plan 2 Q3 2017 - CCP Util
Shasta WPC PDSA Comprehensive Care Plan 2 Q4 2017 - CCP Util
Shasta WPC PDSA Data 1 Q2 2017 - Sharing Data
Shasta WPC PDSA Data 1 Q3-Q4 2017 - Sharing Data
Shasta WPC PDSA Data 2 Q2 2017 – SFTP
Shasta WPC PDSA Data 2 Q3 2017 – SFTP
Shasta WPC PDSA Data 3 Q2 2017 - Alternate to SFTP
Shasta WPC PDSA Data 3 Q3 2017 - Alternate to SFTP
Shasta WPC PDSA Data 4 Q4 2017 – SharePoint
Shasta WPC PDSA Inpatient Utilization Q2 2017 – Why IP
Shasta WPC PDSA Inpatient Utilization Q3 2017 – Why IP
Shasta WPC PDSA Inpatient Utilization Q4 2017 – Why IP
Shasta WPC PDSA Other 1 Q2 2017 - Valid Elig Period
Shasta WPC PDSA Other 1 Q3-Q4 2017 - Valid Elig Period
Shasta WPC PDSA Other 2 Q2 2017 - Elig Criteria
Shasta WPC PDSA Other 2 Q3-Q4 2017 - Elig Criteria
Shasta WPC PDSA Other 3 Q3 2017 - Capturing ED/IP Elig