State of California - Health and Human Services Agency **Department of Health Care Services**

Whole Person Care

Lead Entity Mid-Year or Annual Narrative Report

Reporting Checklist

COUNTY OF MENDOCINO
ANNUAL – PY3
April 1, 2019

The following items are the required components of the Mid-Year and Annual Reports:

Component	Attachments
1. Narrative Report **Submit to:** Whole Person Care Mailbox	☐ Completed Narrative report ☐ List of participant entity and/or stakeholder meetings *(if not written in section VIII of the narrative report template)*
2. Invoice **Submit to:** Whole Person Care Mailbox	☐ Customized invoice
3. Variant and Universal Metrics Report **Submit to:** SFTP Portal	☐ Completed Variant and Universal metrics report
4. Administrative Metrics Reporting (This section is for those administrative metrics not reported in #3 above - the Variant and Universal Metrics Report.) **Note: If a Policy and Procedures document has been previously submitted and accepted, you do not need to resubmit unless it has been modified.** **Submit to:** Whole Person Care Mailbox	☐ Care coordination, case management, and referral policies and procedures, which may include *protocols and workflows.)* ☐ Data and information sharing policies and procedures, which may include *MOUs, data sharing agreements, data workflows, and patient consent forms.* One administrative metric in addition to the Universal care coordination and data sharing metrics. Describe the metric including the purpose, methodology and results.
5. PDSA Report **Submit to:** Whole Person Care Mailbox	☐ Completed WPC PDSA report ☐ Completed PDSA Summary Report
6. Certification of Lead Entity Deliverables **Submit with associated documents to:** Whole Person Care Mailbox and SFTP Portal	☐ Certification form

NOTE: The WPC Quarterly Enrollment and Utilization Report is submitted on a quarterly basis to the DHCS SFTP site.

Whole Person Care

County of Mendocino
Annual Report PY 3
April 1, 2019

I. REPORTING INSTRUCTIONS

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

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

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

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

II. PROGRAM STATUS OVERVIEW

Please provide a brief overview of your program's successes and challenges and any lessons learned during the reporting period. Structure your responses in alignment with the WPC program's goals using the following as headers (from STC 112): *increasing integration among county agencies, health plans, providers, and other entities; increasing coordination and appropriate access to care; reducing inappropriate emergency and inpatient utilization; improving data collecting and sharing; achieving quality and administrative improvement benchmarks; increasing access to housing and supportive services; and improving health outcomes for the WPC population.*

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

We have continued to strengthen our integration and communication across project partners, with county agencies, mental health care providers, and primary health care clinics. During PY3 we continue to have regular, monthly steering committee meetings. All partner agencies continue to attend and participate regularly. Partnership Health Plan has also started attending these meetings this program year.

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

Coordination of care between agencies had a lot of growth in PY3. In July we had our first monthly Multi-Disciplinary Team Meeting (MDT) that we call Complex Case Conferencing.

The Wellness Coaches have been working in coordination with the clinics to make sure that appointments for clients have been made and kept. The inland clinic has been giving information on the last appointment each enrollee had and if they made it to the appointment, cancelled, or no-showed, if they have follow ups to their appointments, if they have up-coming appointments or need to have appointments made. The coast clinic has been faxing schedules for client appointments to the Wellness Coaches two weeks before the appointments.

There has still been some higher level administrative go-between that we hope will lessen in the next program year as the communication between the clinics and Wellness Coaches strengthens.

Wellness Coaches are more frequently going in to the clinic visits with enrollees.

- ✓ *Reducing inappropriate emergency and inpatient utilization:*

Our data shows an improvement with a decline in ED visits per 1000 member months over our mid-year report, and that had been a drastic decline from our baseline report. Our data showed a slight increase in In-Patient Utilization.

✓ *Improving data collecting and sharing;*

Our WPC collaboration partners have been using the ShareFile program with mixed regularity and enthusiasm.

The collaboration of partners started using an online data sharing platform, ShareFile. This platform only lets us store static documents but has been proven useful in holding documents such as; Releases of Information, Intake Forms, notes from Case Conferences, and other program documentation. Even though this platform has its limitations, for those that have embraced the practice of using ShareFile it is much easier to share their client care plan, activities, and successes. It has also been more helpful for the administrative staff to look at the enrollees cases and understand what is going on with that enrollee.

There has been a growing acceptance that we need to move to a case management platform; this is an improvement to the resistance that was being expressed in the beginning of Program Year 3.

✓ *Achieving quality and administrative improvement benchmarks;*

During Program Year 3 partner agencies have signed our Whole Person Care County Charter, which outlines Purpose, Vision, Strategies, Tactics, and Target Populations. Our policies and procedures have been completed at a county level and our service contractor has created policies for the wellness coaches around serving enrollees. As needed, there have been several changes and improvements to policies and forms to help improve the project. Quality Improvement has been implemented around SUDT referrals, beneficiary membership cards, case conferencing, and care coordination.

✓ *Increasing access to housing and supportive services:*

More enrollees are homeless than we had originally anticipated. Wellness coaches are working to complete enrollee applications for Housing Choice vouchers and low-income apartments. There is a shortage of housing in the county at all price levels, which creates a strain on inventory. In the next year, our community will start and complete several low-income housing projects, including one specifically for the severely mentally ill, and we will soon have more information on how that impacts our enrollees. With such limited options we are moving forward with discussion of creative housing solutions, which have yet to be defined.

✓ *Improving health outcomes for the WPC population.*

The first half of PY3 has been focused on training wellness coaches and facilitating their ability to develop relationships with enrollees. Wellness coaches have been deepening their relationships and trust to create better care plans and goals that improve health outcomes.

The second half of PY3 we have been able to move forward in assisting enrollees with access to healthcare, increased social activity, and focusing on other goals that improve the overall health of the enrollees.

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	19	25	60	30	21	20	175

Item	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12	Annual Unduplicated Total
Unduplicated Enrollees	21	22	7	4	8	4	241

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: Medical Respite	0	9	0	21	31	5	66
Utilization 1	0	0	0	0	0	0	0
Service 2: Mental Health Transitional Support	0	1	5	30	166	173	375
Utilization 2	0	0	0	0	0	0	0

Costs and Aggregate Utilization for Quarters 3 and 4							
FFS	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12	Total
Service 1: Medical Respite	33	30	0	0	0	0	129
Utilization 1	0	0	0	0	0	0	0
Service 2: Mental Health Transitional Support	166	218	203	190	235	309	1696
Utilization 2							

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	32,640	53,040	102,000	125,664	141,984	155,856	612,816
MM Counts 1		40	65	125	154	174	191	751
Bundle #2	$564	0	0	0	0	0	0	0
MM Counts 2		0	0	0	0	0	0	0

Amount Counts								
PMPM	Rate	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12	Total
Bundle #1	$816	152,592	164,832	157,488	143,616	146,064	123,216	887,808
MM Counts 1		187	202	193	176	179	151	1,088
Bundle #2	$564	0	0	0	7,332	6,204	9,588	23,124
MM Counts 2		0	0	0	13	11	17	41

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

Our rate of enrollment increased considerably during the first half of Program Year 3. Use of our Fee for Services for Mental Health Transitional Support increased as well. As a result, we developed a clear policy of how to monitor and provide a level of quality control for the approval and authorization process for Fee For Service services.

Over the course of the program year we were able to identify an ideal enrollee capacity. In the beginning of the year, the agencies providing the services needed to be able to pay expenses they incurred before the enrollments began. In that rush they over enrolled and it was a challenge to balance their caseloads. We are using the approved DHCS budget as a guide to how many people to enroll and how many to assign to each Wellness Coach. We were also able to implement a policy to determine when someone would be moved to the bundle #2 level of service. Moving someone to the lower level service bundle allowed for balanced caseloads with high-intensity clients and lower intensity clients.

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.

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 is primarily responsible for reporting and communication with DHCS.

Program Coordinator: Heather Criss, Program Administrator, was transferred from another County of Mendocino position to accept the duties of the WPC Program Coordinator in April of 2018. During this transitional time, a part-time contractor, Carol Mordhorst, was retained to assist with the start-up phase of the program. Carol Mordhorst was kept on as a contractor through the rest of the county fiscal year.

Data Analyst: This position was filled in November 2018, by Angela Kelley.

Fiscal Analyst: Mary Alice Willeford is responsible for the fiscal duties related to the Whole Person Care program.

V. NARRATIVE – Delivery Infrastructure

Please describe the delivery infrastructure that has been developed as a result of these funds and how it relates to achievement of pilot goals. Reimbursement will be based on actual pilot expenditure for the final deliverable or outcomes, up to the limit projected or estimated costs in the approved budget.

Please note the narrative submitted during the Mid-Year Report will be considered part of the Annual Report and will not need to be resubmitted. Include updates, notable trends, and highlights of achievements/progress as well as any changes since the prior report.

The following represents the elements of our Delivery Infrastructure and status as end of PY 3.

Data and Evaluation Infrastructure:
Partner agencies agreed to an online data-sharing platform and most are logging in and using the platform. This platform is used to warehouse documents such as, enrollment forms, ROIs, notes, and care plans. The platform falls short on ease-of-use and case management.

It has become clear that we need a shared online case management system, and we have invested some time and resources in a small pilot program working with such a system. This has not been fully developed but by PY4 we hope to have it up and running with all staff and partners having logins and receiving training on its use.

Homeless Services Infrastructure:
WPC is working with the County's Continuum of Care (CoC). In 2017, the County had a consultant look at our homeless population, and the report was released in March. The Continuum of Care has workgroups that are using the recommendation from the consultant's report regarding homeless service infrastructure.

There are several community housing projects in the works, some have already broken ground and will be available in Program Year 4, and others that are working on the last pieces of funding to get started. This will help ease some of the difficulty in the shortage of housing inventory.

Many of the agencies that work with WPC are also involved in the CoC, they provide assistance in applications for vouchers and low-income apartments. They also make sure that our enrollees participate in the Coordinated Entry program so that they are on the By-Name List.

VII. NARRATIVE – Incentive Payments

Please provide a detailed explanation of incentive payments earned during the Reporting Period. Elaborate on what milestones were achieved to allow the payment, the amount of each payment, and to whom the payment was made. The lead entity will only be permitted to invoice for actual incentive payments made.

Please note the narrative submitted during the Mid-Year Report will be considered part of the Annual Report and will not need to be resubmitted. Include updates, notable trends, and highlights of achievements/progress as well as any changes since the prior report.

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

The structure is built on a tiered model as follows:

Criteria	Description	Payment Terms
Full Participation	70% or more meetings attended	100% of payment
Partial Participation	40% to 70% of meetings attended	50% of payment
Incomplete Participation	less than 40% of meetings attended	0% of payment

Hospital Incentives:
As of December 31, 2018, our partner, Adventist Health Ukiah Valley, has attended 58% of the required meetings. They received $7,500 for the year for attending meetings. Other incentive payments included $30,000 for attending MDT meetings, and $5,000 for attending Ad-Hoc Data meetings. All incentives totaled $42,500.

Clinic Incentives:
As of December 31, 2018, our two primary health clinic partners, Mendocino Coast Clinics and Mendocino Community Health Clinics, have attended 100% of the required steering committee meetings. Other incentives paid to clinics include signing the WPC Charter and an interagency MOU, attending MDT and Ad-Hoc meetings. All incentives totaled $145,000.

Behavioral Health Provider Incentives:
As of December 31, 2018, our primary behavioral health provider, Redwood Quality Management Corporation, has attended 100% of the required meetings. Other incentives include attending the MDT meetings, Ad-Hoc meetings, Homeless Shelter Service Provider meetings. All incentives totaled $160,000.00.

Homeless Service Provider Incentives:
As of December 31, 2018, four homeless service providers have participated in complex case conferences with our medical clinics and hospital. These providers are Redwood Community Services Inland, Redwood Community Services Coast, Manzanita Services, and MCAVHN. All incentives totaled $40,000.

VIII. 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 first half of PY3 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.

Health Outcome	Current Status at end of PY3
2.1-Ambulatory care – ED Visits	✓ Outcome achieved. There has been a drop in ED visits from the baseline measurement in the first half of PY3. As we move forward in our work, we will see if that trend continues. ✓ Partnership HealthPlan was able to aggregate the data for this metric.
2.2-Follow-Up after Hospitalization for Mental Health	✓ Our baseline metric report showed 100% follow-up and we have been able to maintain the 100% rate. ✓ We consider this a huge success as there were 310 mental health hospitalizations in 2016 baseline year and only 41 for 2018 for our enrolled beneficiaries.

Administrative outcome	Current Status at end of PY3
Establish WPC team with monthly meeting schedule	✓ Outcome achieved. Documentation of meeting attendance available. ✓ No challenges in attendance for meetings. ✓ Meetings continue to be scheduled 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.

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.

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
1/8/18 Steering Committee Meeting	County of Mendocino HHSA Mendocino County Health Clinics Mendocino Coast Clinics Redwood Quality Management Consultant	Review of WPC Charter Review of Project Components Inventory of Overlapping Projects
1/22/18 Steering Committee Meeting	County of Mendocino HHSA Mendocino County Health Clinics Mendocino Coast Clinics Redwood Quality Management Consultant Howard Memorial Hospital Mendocino County BHRS	Review of Referral Process Project Components related to housing SUDT and MOPS/MEPS discussion
1/31/18 Data Ad-Hoc Committee Meeting	County of Mendocino HHSA Mendocino County Health Clinics Mendocino Coast Clinics Redwood Quality Management Consultant Adventist Health Ukiah Valley	Demonstration of Vertical Change Discussion of pros and cons
2/5/18 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	Data Sharing Discussion

Meeting Date	Stakeholders Present	Topics and Decisions
3/5/18 Steering Committee Meeting	County of Mendocino HHSA Mendocino County Health Clinics Mendocino Coast Clinics Redwood Quality Management Consultant Mendocino County BHRS	Discussion on IOPCM vs. WPC Criteria around Clinic Designation Redefine the target population.
3/19/18 Steering Committee Meeting	County of Mendocino HHSA Mendocino County Health Clinics Mendocino Coast Clinics Redwood Quality Management Consultant Mendocino County BHRS	Conceptual Discussion about Data Sharing. Multidisciplinary Team Meetings, what do they look like?
4/2/18 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	WPC Metrics Cloud-Based Shared File System
4/16/18 Overlapping Services Showcase	County of Mendocino HHSA Mendocino County Health Clinics Mendocino Coast Clinics Redwood Quality Management Consultant Adventist Health Ukiah Valley Mendocino County BHRS Partnership HealthPlan	Had a discussion of services provided in the county that are similar to WPC and
5/7/18 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	WPC Conference Update Overlapping Programs Showcase debrief Master Schedule for WPC meetings

Meeting Date	Stakeholders Present	Topics and Decisions
6/4/18 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	Updates on ShareFile, supportive services, AHUV collaboration WPC ID cards PDSA
7/2/18 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	SUDT referral process Health Homes Guidance Mid-Year reflection WPC Charter
9/9/18 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	Enrollment Screening and Disenrollment Process Shared Medication List Housing Program Updates
10/15/18 Steering Committee Meeting	County of Mendocino HHSA Mendocino County Health Clinics Mendocino Coast Clinics Redwood Quality Management Consultant Mendocino County BHRS Partnership HealthPlan	BAA or MOU between agencies Data Sharing SUDT Access
12/3/18 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	Over Lapping program descriptions Presentations by AOT, MOPS/MEPS, Housing Assistance, IOPCM, COMPASS, Palliative Care, Street Medicine, PHP

IX. PROGRAM ACTIVITIES

a.) Briefly describe 1-2 successes you have had with care coordination.
1. Our Complex Case Conferences are scheduled on a regular basis and there are new partners participating who are attending on their own and not receiving incentives to participate. 2. Law enforcement has reached out to us and we are working with them on their high-utilizers, as well as, calling them when we can't find one of our enrollees. We are hoping this relationship and the meaningfulness of it develops over PY4.

b.) Briefly describe 1-2 challenges you have faced with care coordination, and lessons learned from those challenges.
1. A lot of coordination happens because of our small community and relationships between the people assisting enrollees (a person calling another person) rather than the systems change we are hoping for in this program. We are working toward a more sustainable system by implementing a case management/care coordination platform that all the partners will use to record important enrollee information, and be able to see the other agencies/people working with their clients. Working collaboratively to change the culture around data exchange and care coordination will be key to improving the system. A functional care coordination system will help with the continuation of care when employees leaves s job or change positions within an agency.

c.) Briefly describe 1-2 successes you have had with data and information sharing.
1. In the past few months the support of using a coordinated system has increased and we are using the momentum from the community Vertical Change grant to move forward. We have been working with the platform to create the right fields to capture the information/data we would like to know. We plan on full implementation in the first half of Program Year 4.

d.) Briefly describe 1-2 challenges you have faced with data sharing, and lessons learned from those challenges.
1. The ShareFile platform that the Steering Committee agreed to use was more difficult than anticipated. Since it is not great for keeping real time data, a lot of people stopped using ShareFile. This makes for a longer process to find out important information and usually results in having to call the source to get the information.

We learned that sometimes we have should have required partners as part of their contracts and payment to use our preferred care coordination platform rather than incentivize them to voluntarily participate.

e.) 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 has been simple and efficient for those enrollees who have primary care from Mendocino Coast Clinics or Mendocino Community Health Clinics.
2. Partnership HealthPlan has been able to provide us with timely aggregated data.

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

1. Except for our clinic partners, the data for the annual metrics report was difficult to get. Data providers were slow to respond to requests. Staff turn-over required retraining on the metric requirements.
2. The SUDT data poses a huge challenge on many levels. The diagnosis date isn't always readily available, and our SUDT county program counts diagnosis at the intake interview, not previous to having interaction with them. We don't have access to treatment data outside of the county program, and it is not clear what type of programs count as treatment, such as going to a 12 step program, Red Road Recovery, or other types of treatment. This metric doesn't record true successes either, just timely treatment. We have one client that took 60 days to get into 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. We will address these concerns about this metric in the comments section on the metrics reporting.

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

We have enrolled far more homeless WPC beneficiaries than previously projected. It is clear that the lack of housing in our area is going 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 have a challenge 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.

X. PLAN-DO-STUDY-ACT

PDSA is a required component of the WPC program. The WPC PDSA Report template will be used for each PDSA that the LE is conducting. Summary and status reports are required components of your Mid-Year and Annual reports. Please attach all required PDSA documents and completed template demonstrating your progress in relation to the infrastructure, services, and other strategies as described in the approved WPC LE application and WPC STCs. Note: For the Mid-Year Report, submit information from January – June 30. For the Annual Report, submit information inclusive of all PDSAs that started, are ongoing, or were completed during the Program Year.

List PDSA attachments
PDSA-SUDT-Referral PDSA-Membership-Card