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

Placer County Health and Human Services
Annual PY3
April 2, 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

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Annual PY3
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.*

**Please limit responses to 500 words. If additional information is needed, please contact your assigned Analyst.*

During 2018, the Placer WPC Pilot has been steadily transitioning out of the "Planning and Early Implementation" phase to the "Early Maintenance" and "Maintenance" phase of the project. Most of the staff have been hired, policies have been put in place, and contracted partners have begun providing services.

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

Placer WPC management, supervisor, and team members have continued to meet regularly with community partners. Meetings and communications were regularly evaluated and increased or decreased as needed. WPC staff are encouraged to focus on building and maintaining positive relationships with our partners. These efforts have had a positive impact on our relationships with community partners.

Increasing coordination and appropriate access to care

Our collaboration with primary care has helped us get our members into services more quickly and has allowed us to coordinate effectively on member healthcare issues. We have also been able to get our members into FSP level mental health services more often.

Reducing inappropriate emergency and inpatient utilization

Team members receive immediate notification if a member goes to a local emergency room. 95% of our members have received a case management visit within seven days of going to the ED. Case managers help link members to primary care, specialty care, and medical respite in order to reduce inappropriate emergency room visits.

Improving data collecting and sharing; achieving quality and administrative improvement benchmarks

During this reporting period Placer County contracted with Intrepid Ascent to do a thorough assessment of all Whole Person Care data and information processes as there had been internal disagreements about what would be the best long-term solution for data sharing vs. how much various options would cost. Our data infrastructure needs were being met, but we wanted to see if there were improvements that could be made to our data collecting systems and to our data sharing capabilities. After fully analyzing the report, we determined that building upon current data infrastructure systems that we have in place was the best solution at the time. Since then we have made tremendous strides into getting all of our data within the Avatar EHR.

Increasing access to housing and supportive services

We have started providing more rental subsidies to our members. This has been an important part of housing some of our more vulnerable and hard to house clients. We received another $1,000,000 grant from Sutter Health to purchase housing and began working on an RFP to provide additional supportive housing services.

Improving health outcomes for the WPC population

Our Pilot expanded our Medical Respite services in 2018 from five beds to eight beds. We were also able to hire a full-time nurse which had been an ongoing difficulty since the program inception. During this reporting period we had 41 people who stayed at least two weeks at Medical Respite. Of these, 30 out of 41 (73%) had improved physical health at the end of their stay. This was well ahead of our 45% target. Additionally, we were able to add an Extra Help nurse to provide additional support to medical respite and to the program.

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	2	14	11	9	8	70

Item	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12	Annual Unduplicated Total
Unduplicated Enrollees	6	20	11	3	3	1	44

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	NA	NA	NA	NA	NA	NA	NA
Utilization 1	NA	NA	NA	NA	NA	NA	NA

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	NA	NA	NA	NA	NA	NA	NA
Utilization 1	NA	NA	NA	NA	NA	NA	NA

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

Amount Claimed								
PMPM	Rate	Month 1	Month 2	Month 3	Month 4	Month 5	Month 6	Total
Bundle #1: Comprehensive Complex Care Coordination	**$1,481**	**$145,138**	**$143,657**	**$136,252**	**$131,809**	**$125,885**	**$115,518**	**$798,259**
MM Counts 1	0	98	97	92	89	85	78	539
Bundle #2: Medical Respite Care Program	**$8,845**	**$44,225**	**$44,225**	**$53,070**	**$61,915**	**$53,070**	**$70,760**	**$327,265**
MM Counts 2	0	5	5	6	7	6	8	37
Bundle #3: Housing Services	**$1,681**	**$156,333**	**$154,652**	**$149,609**	**$146,247**	**$142,885**	**$131,118**	**$880,844**
MM Counts 3	0	93	92	89	87	85	78	524
Bundle #4: Engagement	**$2,102**	**$54,652**	**$50,448**	**$77,774**	**$94,590**	**$109,304**	**$96,692**	**$483,460**
MM Counts 4	0	26	24	37	45	52	46	230

Amount Counts								
PMPM	Rate	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12	Total
Bundle #1: Comprehensive Complex Care Coordination	**$1,481**	**$115,518**	**$114,037**	**$114,037**	**$106,632**	**$106,632**	**$106,632**	**$663,488**
MM Counts 1	0	78	77	77	72	72	72	448
Bundle #2: Medical Respite Care Program	**$8,845**	**$ 70,760**	**$ 70,760**	**$ 70,760**	**$ 70,760**	**$ 70,760**	**$ 70,760**	**$424,560**
MM Counts 2	0	8	8	8	8	8	8	48
Bundle #3: Housing Services	**$1,681**	**$134,480**	**$132,799**	**$129,437**	**$122,713**	**$124,394**	**$126,075**	**$769,898**
MM Counts 3	0	80	79	77	73	74	75	458
Bundle #4: Engagement	**$2,102**	**$102,998**	**$121,916**	**$128,222**	**$115,610**	**$96,692**	**$71,468**	**$636,906**
MM Counts 4	0	49	58	61	55	46	34	303

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

We were well ahead of our target enrollment numbers for PY3. There is a great need for Whole Person Care services and our philosophy is that if we have high-need, high-risk referrals for individuals that seem to be falling through the cracks by being denied services at other places then we have continued to enroll. We were notified that we could request additional funding for PY4 and PY5 and we look forward to sending in a proposal that will allow us to add more direct services to our vulnerable population.

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.

**Please limit responses to 500 words*

Expended funds for Administrative Infrastructure in 2018 were for the Staff Services Analyst (salary and benefits), the WPC Consultant, and indirect costs.

The Staff Services Analyst works closely with the team to ensure timely and accurate data reporting, provides data analysis and interpretation, communicates regularly with the WPC consultant, and works closely with county IT staff to develop more effective data reporting/analysis methods.

IDEA Consulting is our data consultant and they meet at least one time per week with WPC staff to ensure that data is recorded and tracked accurately. They also communicate with the team regularly throughout the week and provide other administrative services such as helping to prepare reports.

During this reporting period we also received additional consulting from Intrepid Ascent who did a full evaluation of our program's data infrastructure. At the time we found that our data collection, sharing, and analysis was adequate to run our program, but had questions about what the best long-term solutions would be. We were considering whether or not to utilize and improve upon our current data systems or to purchase a more expensive system that might provide us with better results. Due to their analysis we have emphasized improving upon our current data collection system primarily through the use of Avatar as the cost outweighed the perceived benefit of implementing a new system. One specific change that we implemented was inputting data directly into Avatar and creating reports from that system rather than having staff need to fill out a spreadsheet with data tracking, send it to our Contractor, and have them reenter the data into their own system. Our increased use of Avatar has saved staff time, has allowed us to run reports more easily, and has decreased our overall costs.

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.

**Please limit responses to 500 words*

Delivery Infrastructure funds during this period were expended on; Care Management Tracking and Reporting Portal, IT Workgroup and Support, Fleet Vehicles, Computer Equipment, and Space Costs.

Our Care Management Tracking and Reporting Portal is PreManage and it is essential to delivering our Pay for Outcome services in a timely manner and it also provides some information for our data tracking needs. During PY3 we increased the amount of 7-day follow-up visits to 95%.

We purchased four vehicles which has allowed us to better provide services to our members. This includes mid-size vehicles that have helped us in transporting member wheelchairs and even helping members move when needed.

We have continued to purchase computer equipment so that staff have the tools they need to do their work. All staff have what they need, but we have continued to add extra-help staff so there are ongoing expenses in this area as we bring on additional team members to meet the needs of our client population.

We have rented some space at one of the local homeless shelters so that we can provide more direct services and as part of our goal to collaborate effectively and efficiently with our community partners. In this location, the increased collaboration is primarily with The Gathering Inn (where the space is located) and with County Probation and Roseville PD.

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.

**Please limit responses to 500 words*

Incentive payments are made to the Adult System of Care (ASOC) for reports and data that they provide. We adjusted our budget this year to remove incentive payments made to other agencies where the model was not working out as had been intended.

ASOC provides us with reports on inpatient psychiatric hospitalization, mental health treatment and diagnoses, and substance use services per quarter. ASOC provided reports on time for quarter 3 and quarter 4. Reports provided by ASOC allowed us to verify that we met goals related to WPC metrics. Payments of $8,400 have already been earned by ASOC.

During PY3 we removed the budget items for incentive payments to the hospital as their legal team continued to hold up the contract. There has been much more discussion on that topic in the past few months so we may ask to add that back in the future.

During PY3 we also removed the incentive payments for appointments with the FQHCs. Our ability to get clients in for appointments relatively easily, the difficulty of going through the process of completing a contract, and the amount of the payment helped us decide that it removing that incentive was appropriate.

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.

**Please limit responses to 500 words*

Placer WPC team continues to prioritize meeting all Pay for Outcome metrics. Anecdotally, we believe that the increased attention that we give the Pay for Outcome metrics is a good indicator that Payors offering Pay for Outcomes is an effective tool to encourage providers to reach desired goals.

Variant Metric – All-Cause Readmissions (ACR): 60% of clients who are discharged from an index hospital stay and are not re-hospitalized within the next 30 days.

For PY3 we had 40 instances where members met criteria to be included in this metric. There were 12 times that resulted in a rehospitalization within 30 days for a 30% ACR rate. Having 70% avoid a reshospitalization exceeded the PY3 goal of 60%. We believe that our 24/7 medical respite program helped keep this number lower than it likely would have been.

Universal Metric – 70% of clients seen in the emergency department with a CCCC visit within 7 days.

There were 221 Emergency Department (ED) visits during this reporting period for members enrolled in Comprehensive Complex Care Coordination (CCCC). WPC followed up with the member within seven days of their ED encounter on 210 of 221 times (95%).

Although we had a high percentage of follow up visits within seven days we were still able to identify areas for improvement. For example, during the second half of this year we implemented a "Worker of the Day" program that allows an assigned staff person to respond to urgent issues that come up.

Universal Metric—Follow-Up After Hospitalization for Mental Health (FUH): 80% Clients with an SMI will receive CCCC service following discharge from psychiatric hospital within 30 days.

There were three discharges from a psychiatric hospital for WPC members. All three received a CCCC service within 30 days for those discharges (100%). The PY3 goal was 80%.

It has been surprising to us how few of our members receive mental health hospitalizations. It appears we overestimated the number of homeless persons in our community who were suffering from SMI and who were not already participating in other services. In fact, we did not have any clients have a psychiatric inpatient hospitalization in the second half of the year. Another reason that we do not have many psychiatric inpatient hospitalizations is that we are more able to successfully refer clients to FSP mental health services and discharge from WPC.

Universal Metric—Comprehensive Care Plan:
70% of members with a completed assessment and tailored plan of care within 30 days of enrollment to WPC (CCCC).

There were 41 new WPC members enrolled in CCCC. All (100%) received both a WPC Assessment and a Tailored Plan of Care within 30 days.

IX. 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.

**Please limit responses to 500 words*

Advocates for Mentally Ill (AMI) Housing - Our Housing Coordinator, Program Supervisor, and Program Manager meet with our contractor once per month. This meeting was previously held bi-weekly, but has been decreased due to effective collaboration.

Anthem Blue Cross Updates - We have a monthly meeting with Anthem about data sharing. We also have an established relationship with them so that we can discuss shared case management issues that arise. We are beginning to have some conversation with them about models for program sustainability.

California Health and Wellness Updates - We have a phone meeting every two weeks to review data sharing and case management issues. The meeting is attended by management and by our public health nurse (PHN). We had been receiving data from them on a monthly basis in the past, but they have stated that they now have decreased availability to provide this data and will begin providing the data every six months for the semi-annual and annual reports.

City of Roseville Housing Authority - The WPC manager and housing coordinator attend monthly meetings with City of Roseville Housing Authority. Multiple agencies involved with homelessness in Roseville also attend these meetings.

Collective Medical Technologies (CMT) - CMT is our vendor for the PreManage program that provides ED notifications. We have monthly phone meetings with them to discuss items such as processes, changes, and adding partners to the platform.

The Gathering Inn (TGI) - WPC staff attend weekly case management meetings at the Roseville and Auburn locations. Behavioral Health case managers also attend. WPC also participates in monthly meetings with TGI and Behavioral Health to work through systemic/programmatic issues.

HLT (Homeless Liaison Team) - WPC has two practitioners that work closely with law enforcement (LE). Our LE partners are primarily Placer County Probation, Placer County Sheriff, and Roseville PD. We have also been working more regularly with the Lincoln PD, Rocklin PD, and Auburn PD.

HRCS (Housing Resource Council of the Sierras) - HRCS is the continuum of care for Placer and Nevada Counties. Several community partners participate in HRCS (Placer County, City of Roseville, PIRS, Stand Up Placer, AMIH, The Gathering Inn, Volunteers of America, ASOC, Sierra Foothills AIDS, Public Health, HHS Admin, and others). WPC management participates in the monthly HRCS meeting and the HRCS data management meeting related to implementing HMIS. WPC has been contributing to HMIS integration get off to a successful start.

Medical Respite - Our PHN and Program Supervisor attend case management meetings with our medical respite provider (The Gathering Inn). Management occasionally attends meetings if contract-related issues need review.

QI Meetings - WPC holds monthly QI meetings to work on policy, PDSAs, and quality improvement. The QI team includes three members from WPC. Community partners are asked to participate as needed. During PY4 we intend to increase the number of meetings that we hold and increase the number of team members.

South County Homelessness Summit - This quarterly meeting is led by Health and Human Services administration and includes; City of Roseville PD, City of Roseville Housing, Rocklin PD, Lincoln PD, City of Lincoln, The Gathering Inn, Salvation Army, Project Go, and WPC management.

Sutter Community Partners - WPC attends the monthly meeting held by Sutter Hospital which includes The Gathering Inn, Latino Leadership, WellSpace, and Whole Person Care. The focus of these meetings is to help community partners receiving funding from Sutter Health improve collaboration. Recently, there has been increased collaboration on implementing SB 1152.

WPC Leadership Council -Placer County HHS Admin, Placer County Public Health, Placer County Human Services, Placer County Housing Authority, Placer County Adult Services, and Whole Person Care meet every month. Community partners are invited to attend and participate as appropriate.

X. PROGRAM ACTIVITIES

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

(1) During this reporting period, our Public Health Nurse received access to Sutter Hospital's EHR. This access allows her to more easily find important healthcare information about our shared clients which leads to more effective health care coordination. This partnership has opened the doors for Adult System of Care to have some of their key staff receive this access as well.
(2) We have begun having regular case management meetings with Chapa-De FQHC which has a large percentage of our WPC members. This increased collaboration has allowed us to get some clients in more quickly for appointments and they have an increased understanding of our program which has led to additional referrals to WPC.

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

(1) One of our FQHC partners has been difficult to engage with in collaboration. It is common for phone calls to be unanswered and for our members to have a challenge getting appointments. We have connected with various levels of management and have made some headway, but progress continues to be slow.
(2) Philosophically, we have had differences with multiple partners regarding the Housing First model. We embrace harm reduction and a client-centered approach that focuses on the client's goals rather than our own goals. We have found that it is common in our area for services to be denied or curtailed for any amount of substance use and/or non-adherence to treatment. We have seen instances of programs moving more towards our treatment philosophy, but it continues to be a point of contention when holding case consultations. Implementing newer treatment models requires a paradigm shift and culture change that takes time to build and we believe that we are helping move the needle in a positive direction.

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

(1) A major success we had in this reporting period was identifying some problems with the baseline data that one of our healthcare plans shared with us. They had provided aggregate baseline data with us that appeared incorrect so we compared it to a complete data set that they had sent us in the past. While reviewing the complete data set we were able to identify areas where the data did not match so we notified them of the discrepancy and they reworked the data they were providing to multiple Pilots. Since this is a health plan that is involved with multiple WPC Pilots we were a little surprised that no one else had seen the mistake yet, but upon further consideration we believe that this is an example of how having a Pilot with more intensive services and a lower caseload allows us to pay more attention to some details that might be missed by Pilots that have much larger member populations to manage.

(2) Two of the partners that we work with most often are the Placer County Adult System of Care and Collective Medical Technologies (PreManage). During this reporting period we were able to have ASOC's Full Service Partnership clients connected to PreManage so that those case managers can receive immediate notification when one of their clients enters a local emergency room. We have reached out to other programs to try to work out having them receive these alerts as well. This is an example of how WPC is able to bring innovation that positively impacts the entire system.

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

(1) We have found that there are instances when, even when we are able to get data from our partners, the process can be slow. It often takes longer than they expect it to and then when we receive the data we find that there are mistakes or there were misunderstandings about what we had wanted. We have been working on increasing in-person communication and making more regular follow-up as needed. During the second half of PY3 we have found that our increased communication with data sharing partners has had a positive impact on collaboration and data sharing.

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

(1) We have begun undertaking a major initiative to integrate our data collection system with our current EHR. Our prior process involved having staff members do a separate Daily Tracking Log of their activities and then have that log scanned to our contracted data analyst. This process took a lot of extra time for our staff and for the contractor to input the data into their Excel files. In addition to the time, there was added expense involved for dual data entry. Our new process has staff directly inputting key event data into Avatar at the same time that they complete their progress notes. This has been a substantial time savings for staff and makes it easier to run reports when we need them.

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

(1) As with other Pilots, we are disappointed by the inability to get needed Medicare data for baseline reporting. We have looked at other avenues to try to piece together parts of the data when possible, but it still leaves us short. A difficulty related to this is that we have anecdotal evidence that this is a population that is benefitting quite a bit from our program so it would be helpful to have the actual baseline data in hand to back that up.

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

As the program has now been providing services to members for almost two years we are finding that we have more members that we could graduate from the program, but who need aftercare services that do not seem to be available elsewhere. We struggle with keeping people enrolled who no longer need the full services that we provide vs. discharging them when they are only newly stable in their life and fear that completely dropping services would put them at high risk for relapse. This is particularly relevant to the clients that are receiving extensive support from our Housing Bundle. We are looking at various ways that we find or provide some kind of aftercare services that will allow members to continue their success without our full array of services so that we can enroll other Placer County residents who would benefit from the WPC Pilot.

XI. 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.

- 5 Levels Collab Survey Effective Response
- 5 Levels Collab Survey WPC Evaluation
- Chart Review & Case Manager Knowledge
- Epic Access for WPC Cycle 1 and Cycle 2
- HDAP Referral Form
- Hospice or Palliative Care for Homeless Clients
- Housing Application Tracking Sheet
- Rental Subsidy Agreement
- Linking Homeless Clients to Services Through Coordinated Entry
- Medical Transportation Training for Clients
- Probate Conservatorship
- Smoking Cessation Course
- WPC Referral Process
- FQHC Access to PreManage - Effect on PCP Visits
- Care Plans Availability in Avatar
- Transition From Paper Charts to Electronic Charts
- Tracking Metrics Change From Manual to Electronic