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 San Diego, Health and Human Services Agency
Annual Narrative Report 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.

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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

San Diego has an integrated Health and Human Services Agency, which includes the County's Housing Authority. As the Whole Person Wellness (WPW) program crosses multiple divisions of HHSA, partners have been involved in the original designing, planning and the continued implementation of the program. In addition to HHSA, the County's Public Safety Group has been engaged in the management oversight of the initiative. During Project Year 3, the WPW Service Integration Teams (SITs) have met with front line staff at various Behavioral Case Management Programs, Assertive Community Treatment (ACT) Programs, and hospitals throughout the county. This has improved communication, coordination, and integration across the spectrum of programs and services throughout the region.

Increasing Coordination and Appropriate Access to Care

SITs continue weekly case conferencing meetings with one of the Managed Care Plans (MCPs) to coordinate care management between the MCP's Complex Care Managers and Whole Person Wellness. Additionally, Service Integration Teams work closely with housing and service providers to jointly identify needs and coordinate access. An example is for those WPW participants who are enrolled in intensive Behavioral Health ACT programs, the SITs have worked closely with the programs and assisted in helping the participants access physical health resources and liaison with the assigned Managed Care Plan, while the ACT program works with the participant to address Behavioral Health needs. Providers work together to identify, coordinate and access appropriate housing. The Service Integration Team provider working in the northern portion of the county has established an agreement with one of the Housing Authorities, where Mainstream Vouchers awarded through HUD are allocated to WPW participants. During Project Year 3, efforts with the Behavioral Health System of Care have also focused on ensuring a clear distinction between the ACT programs and WPW to ensure the programs are complementary, rather than duplicative, of one another. Efforts have also focused on prioritizing access to behavioral health programs for WPW participants.

Reducing Inappropriate Emergency and Inpatient Utilization

The SITs continue to help WPW participants reduce inappropriate emergency department visits and inpatient stays by educating participants on benefits and resources they are entitled to and helping them navigate the system, advocate, and coordinate with the assigned Medi-Cal Plan (MCP). Key strategies include linking participants to primary care in the community and ensuring their Medi-Cal remains active. By helping the participants work with their MCP to ensure their provider is geographically accessible, and advocating on behalf of the participant within the clinic system to ensure timely appointments, participants have improved access to community care which reduced Emergency Department visits by 50%.

Improving Data Collection and Sharing

The ability of the Medi-Cal Plans to share information directly with the contracted providers was established through updated Memorandums of Agreement (Attachments 1AMOA1-6) that specified that the contracted providers were working on behalf of the County. This allowed the Plans and the providers to improve coordination of care. Weekly dashboards (Attachment 1A1) are created through information submitted by the SITs, which include referral sources and number enrolled by MCP. During PY4, a monthly dashboard based off of the 2018 Annual Dashboard (Attachment 1A2) will be produced that will include more detailed information on referral sources, and participant outcomes. Development of ConnectWellSD has continued, and data has been entered into the system. Reports will begin being generated during PY4.

Achieving Quality and Administrative Improvement Benchmarks

San Diego has three overall areas of administrative improvement benchmarks. Status and approaches to achieving them are identified below:

Metric	Status
Proportion of participants with a Comprehensive Care Plan accessible by the entire care team within 30 days of enrollment	58% of the participants had a Comprehensive Care Plan completed within 30 days of enrollment. Access to the Plan by the entire care team is being established through functionality of ConnectWellSD and was made available in December, 2018.
Submission of care coordination and referral policies and procedures submitted to DHCS timely	Completed – June, 2018

Metric	Status
Regular reviews conducted to monitor operationalization of policies and procedures and conduct PDSAs to obtain feedback and learning AND Compile and analyze information and findings from monitoring procedures and modify policies and procedures in a streamlined manner in a reasonable timeframe	During PY3, seven Program Guidance Notices were issued covering issues such as disengagement, use of ACT programs, and documentation requirements (Attachments PG1-PG6). Program Guidance notices clarify specific requirements in identified areas. Bi-monthly meetings are conducted with providers to resolve issues that have arisen and share best practices. The providers are monitored on a continuous basis. Each provider had 2 site visits, one Program Observation around Outreach and Engagement and the other Administrative Sites visit for review of administrative controls and personnel files during PY3. Attached are the detailed Monitoring plans for all contracts providing the details of these activities. (Attachments CPM 1-3)
Submission to DHCS of data and information sharing policies and procedures to streamline care coordination, case management, monitoring and strategic improvements	Completed June, 2018
Regular reviews conducted to monitor operationalization of policies and procedures AND Compile and analyze information and findings from monitoring procedures and modify policies and procedures in a streamlined manner in a reasonable timeframe	Bi-monthly meetings are conducted with providers to resolve issues, including data and information sharing that have arisen and share best practices. The Clinical Review Team routinely addresses data sharing issues as they arise, and a particular concern regarding direct care coordination between the SITs and the MCPs was addressed in PY3 through a revision in the MOAs regarding data sharing.

Increasing Access to Housing and Supportive Services

The incorporation of the Department of Social Services' Housing and Disability Advocacy Program (HDAP) has provided resources to directly increase access to interim housing and access to social security benefits that will support permanent, sustainable housing.

Access to supportive services has been improved through the active engagement with Behavioral Health programs. Additionally, access to supportive services is increased as the community partners want to work with people that are receiving the additional support provided through Whole Person Wellness. The reputation of the program has also assisted in accessing housing resources in the community, as the housing providers and housing authorities are aware of the additional support provided to Whole Person Wellness participants.

Improving Health Outcomes

The following health outcome metrics were improved during the reporting period:

1. 22% Decrease in Emergency Department visits (after exclusion of **single participant** accounting for 37% of all visits)
2. 32% Decrease in inpatient hospitalization days (after exclusion of **a different single participant** who accounted for 34% of all inpatient days)
3. 18% decrease in days spent in psychiatric inpatient units

Conversely, certain metrics demonstrated a decrease in health outcomes. These include:

The decrease in psychiatric hospital days suggest that these individuals are being connected to appropriate mental health services to avoid additional hospitalizations. Additionally, there is a larger percentage of individuals that have a follow up for their mental health at 30 days, demonstrating the need for greater capacity to be seen within 14 days and the support the SITs are providing during this waiting period, all while reducing psychiatric hospital utilization.

Positive outcomes around AOD treatment demonstrate the participants' motivation to change and again, the SITs helping to navigate to the front door of the resource and supporting during the wait.

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	0	**6**	6	**21**	**40**	**20**	**93**

Item	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12	Annual Unduplicated Total
Unduplicated Enrollees	26	23	28	29	32	12	243

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
Outreach & Engagement	**125**	**338**	**610**	**497**	**428**	**406**	**2,404**

	Costs and Aggregate Utilization for Quarters 3 and 4						
FFS	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12	Annual Total
Outreach & Engagement	349	350	272	185	100	68	3,728

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

Amount Claimed								
PMPM	Rate	Month 1	Month 2	Month 3	Month 4	Month 5	Month 6	Total
Phase 2: Stabilization	$851	0	$5,106	$10,212	$27,232	$61,272	$76,590	$180,412
Phase 2: MM	0	0	6	12	32	72	90	212
Phase 3: Maintenance	$681	0	0	0	$681	$681	$2,043	$3,405
Phase 3: MM	0	0	0	0	**1**	1	**3**	**5**
Phase 4: Transition	$511	0	0	0	0	0	0	0
Phase 4: MM	0	0	0	0	0	0	0	0
Phase 5: Aftercare	$340	0	0	0	0	0	0	0
Phase 5: MM	0	0	0	0	0	0	0	0

Amount Counts								
PMPM	Rate	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12	Total
Phase 2: Stabilization	$851	$98,716	$115,736	$136,160	$150,627	$158,286	$164,243	$1,004,180
Phase 2: MM	0	116	136	160	177	186	193	1180
Phase 3: Maintenance	$681	$2,043	$2,724	$4,767	$11,577	$23,154	$25,878	$73,548
Phase 3: MM	0	3	4	7	17	34	38	108
Phase 4: Transition	$515	0	0	0	0	0	0	0
Phase 4: MM	0	0	0	0	0	0	0	0
Phase 5: Aftercare	$340	0	0	0	0	0	0	0
Phase 5: MM	0	0	0	0	0	0	0	0

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

Ongoing data validation has occurred throughout the year. Research analysts use a combination of data coming from information provided by the contractors on a weekly basis, HMIS, invoices, CWSD, MEDs data reports, and direct searches in MEDs to determine Medi-Cal eligibility for enrollment and utilization. This reconciling yielded a decrease of 38 FFS units and an increase in PMPM Phase 2 of 12 units and an increase in PMPM Phase 3 of 2 units.

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.

A Research Analyst and County Retiree were additional resources during the reporting period that were critical in supporting data reporting and working with ConnectWellSD (CWSD), assisting in designing, identifying and resolving issues that arose with system users, and analyzing data. As the WPW population increases and the pilot becomes more developed, we expect to continue to require these resources in providing data for process improvement, community engagement, and ensuring the accuracy of statutory reports. This mirrors feedback from providers who have requested increased administrative support to manage participant data screening and reporting.

In addition to the County's direct administrative support, WPW was able to partner with Third Sector Capital Partners, who worked with The Stanford Center on Poverty and Inequality (CPI), the Social Innovation Fund (SIF), and the Ballmer Group to build an administrative data framework for evaluating the success of social service programs designed to improve life outcomes of the people they serve. For WPW, Third Sector's work was critical in developing a model to inform the County of what would be necessary to meet target enrollment number, the number of teams that would be required, and projected revenue drawdowns. This has proved a critical resource as the County enters its second year of providing direct services.

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.

During this reporting period two new releases were implemented for ConnectWell SD (CWSD):

7/10/18:

1. Implemented the Outcome Plan Report and Owner Summary Reports
2. Produce the Program Success Dashboard
3. Modified the customer portal for participant self-service: add ability for customer to see scheduled appointments, actions from their care plan, and services from their care plan. Also included changes to the 3rd party portal for authorized 3rd party agents to see appointments and care plan actions. While these functions were modified, they have not yet been fully deployed for use.

12/8/18:

1. Screens were modified to capture the monthly phase information.
2. Psycho Social Assessments were added.
3. Functionality so that Care Plan Factors are automatically added at the time the Care Plan is created.
4. A report with the Monthly Phase Log was completed, which assists in validating invoices submitted by providers.
5. Enhanced the ability to add participants to the system.
6. Established Care Plan membership access controls and related notifications.

The Release on 7/10/18 included an upgrade to Cúram version 7.0. This upgrade required an unexpected server upgrade, so enhancements were delayed until the December rollout. The December release was successful, especially around the reporting capabilities namely the Contract Summary, WPW Mental Health Incident Summary, WPW Outcome Plan Owner Summary and WPW Registration and Enhancement Summary. The validity of the new functionality continues to be tested, but shows promise and will help WPW to move closer to having one data system for recording, reporting, and collaborating.

In addition, work began to develop an interface between the San Diego Health Connect's system (the region's Health Information Exchange) and ConnectWellSD. The interface activities included meetings between San Diego Health Connect and the ConnectWellSD team, development of required documentation, identifying appropriate methods to receive data, and initial work on the screen designs. This work accounts for the $131,000.00 incurred this reporting period.

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.

The County of San Diego has not claimed any Incentive Payments during this reporting period. During San Diego's inaugural year of providing WPW services, to the County learned a great deal about our inclusion criteria. The Pilot overcame challenges with too small of a population from older vetted data to an overwhelming number of referrals requesting services for anyone who is experiencing homelessness. The SITs were diligent in vetting each individual and ensuring if someone was not appropriate for the pilot, they were connected directly with an appropriate service provider. Of those who were enrolled 56% were enrolled within 90 days. This calculation is much more representative of the efforts of the SITs rather than anyone ever touched of which 25% were enrolled within 90 days. San Diego has taken what we have learned regarding the referral process and the level of service provided in the Outreach and Engagement Phase to revise this incentive for PY4 to "50% of enrollees will have been enrolled within 1 month of their first outreach and engagement encounter."

During this reporting period, the SITs self-reported that 58% of the WPW participants had a comprehensive care plan (CCP) addressing 9 factors: Housing, Income, Legal Issus, Mental Health, Physical Health, Quality of Life, Substance Abuse, and Transportation rated using the 2-1-1 San Diego Vulnerability Scale ranging from Crisis, Critical, Vulnerable, Stable, Safe, and Thriving, that takes into account barriers and supports, knowledge and utilization of resources, and immediately of need. At the end of this reporting period, many of the technical issues around connectivity and functionality have been resolved, allowing for completion of the Bio Psycho Social and CCP in CWSD as well as some reporting capabilities. With these improvements and acknowledgement of the level of case management effort that is being put forth by the SITs in the field during Outreach and Engagement the expectation has been adjusted accordingly to 50% of enrollees will have a comprehensive care plan within 30 days of enrollment.

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 County of San Diego is claiming $450,000.00 for exceeding Measure 5.
Measure #5: Decrease number of hospital days spent in psychiatric inpatient units in the County by new WPW clients during their first 6 months of enrollment by 5% compared to 6 months immediately prior to pilot enrollment (Variant Metric #19 from Section 4.1.b)
Result: Decreased days by 18%.

Detail: The decrease in psychiatric hospital days suggest that strong referrals to WPW are coming from our psychiatric inpatient units and that these individuals are being connected to appropriate outpatient services. Success can also be attributed to the support the SITs are providing navigating to alternative resources.

Measure #1: Decrease number of days spent in the hospital by new WPW clients during their first 6 months of enrollment by 5% compared to the 6 months immediately prior to pilot enrollment (Universal Health Outcome Metric #3 from Section 4.1.a)
Result: 67% increase in utilization.
Detail: A single participant accounted for 34% of all hospital days. If utilization by this individual is excluded, there was a 32% decrease in hospital days.

Measure #3: Decrease number of ED visits for new WPW clients during their first 6 months of enrollment by 5% compared to 6 months immediately prior to pilot enrollment (Universal Health Outcome Metric #1 from Section 4.1.a)
Result: 20% increase.
Detail: There are many reasons for these results, including that one individual accounted for 37% of all Emergency Department visits, and an intervention time of 6 months for health stabilization. If the utilization by the individual accounting for over a third of the visits is excluded, there was a 22% decrease in the number of ED visits, suggesting that people are being effectively linked to primary care resources and receive attention for health concerns prior to them becoming emergent.

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.

In addition to the regularly meeting Clinical Review Team, Data Work Group, and Management Committee, WPW held a community update event on July 31st with over 100 attendees, representing a broad array of community partners in the initiative, including Medi-Cal Managed Care Plans, Hospitals, the Sheriff's Department, Public Safety Group, Homeless Service Providers, and Behavioral Health Providers. At this meeting, the community was updated on the status of the overall program, including data on enrollments, the development of CWSD, and referral process improvements.

Attached is a list of meeting dates during CY2018 for each of the regularly meeting groups: Clinical Review Team (CRT), Data Work Group, and Management Committee. (1B)

IX. PROGRAM ACTIVITIES

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

(1) The SITs have persisted in learning how to navigate to the front doors of resources and established best practices of including Releases of Information for CWSD, San Diego's Community Information Exchange, HMIS, and their Primary Care Providers at time of enrollment. Using these systems and establishing bi-directional referral and communication processes with physical health, behavioral health, and housing providers has assisted the SITs in improving access to services. For example, the Community Information Exchange is used to identify prior service providers who have worked with an individual, and record current providers. Information on prior service utilization assists the SITs in coordinating care with current providers.

(2) During this reporting period, a Contractor has brought in a Family Nurse Practitioner with a background in Health Care for the Homeless and a motivated RN. Their expertise have been able to break down barriers and provide a continuum of medical care across systems, providers, and very critically while waiting to access higher levels of care.

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

(1) Many of the processes in place for services, such as In Home Support Services (IHSS) and In Home Health Care, meet the needs of the broader population, but need to be tailored to Whole Person Wellness participants, given their isolation from other support systems while waiting for services to begin. The County is developing processes with the Service Integration teams to meet the needs of the WPW population by expediting requests for IHSS.

(2) A large diverse, network of care, large caseloads and rotating staff cause challenges in following up in care coordination. The Service Integration Teams continue to learn ways to streamline communication such as specifying the most appropriate link within the hospital. The need to continually build relationships across service providers and systems is critical to the ongoing success and effectiveness of the project.

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

(1) We have experienced improvements with our partners in sharing information by continuing the discussion around HIPAA, updating MOA's as needed with minor changes, and sharing the work provided by the WPC Learning collaborative on legislation supporting data sharing for serving WPW participants to ensure they get the services they need.

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

(1) Monthly files will begin to be sent in PY4 to each Plan listing their specific members who are involved in WPW to assist in data coordination efforts.

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

(1) The weekly dashboard template includes detailed information regarding outreach and enrollment, broken out by each individual Managed Care Plan, as well as the number of people referred from different sources.

(2) (2) One of the contractors already had a mature Access Database in place for documentation and reporting. During this reporting period the other contractor implemented a management information system, Vertical Change, to record their work and report outcomes.

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

(1) Access to information on Medi-Cal eligibility is obtained through two distinct systems (CalWIN and MEDS), and the service providers do not have direct access to either system. This causes delays in preventing lapses in Medi-Cal coverage. In PY4, this challenge is being addressed through regular data validation in our Office of Business Intelligence (OBI) and Eligibility and Operations (E&O). Invoices from the contractors will be run against the MEDS database by OBI to validate Medi-Cal Enrollment, Aide Code, and Managed Care Plan. OBI then provides the list of participants to E&O, each MCP the list of their WPW participants, and let the SITs and WPW Coordinator know of any lapses in coverage or other disqualifying findings. E&O runs the validated list from OBI to provide re-certification dates and returns the list to the WPW Coordination. This list is then provided to the SITs so they can plan and support the patients in avoiding lapses in Medi-Cal coverage.

g.) Looking ahead, what do you foresee as the biggest barriers to success for the WPC Program overall?
(1) Housing continues to be the biggest barrier to success for the WPW Program overall. Additionally, the acuity of the population being served is increasingly apparent. Many participants have undiagnosed mental health and/or substance use disorders which create significant challenges in accessing housing. Of those housed in WPW, the average length of time from enrollment to becoming housed is 4.66 months, of those housed. This is similar to other pilots such as SAMHSA's Home to Health (H2H), that report 4.33 months enrolled in H2H prior to becoming housed. In 2018, the region's largest Public Housing Authority, the San Diego Housing Commission, reported that of the 3,222 individuals housed in the Temporary Bridge Shelter Programs throughout the year, there were only9.8% permanently housed.

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
5A COSD WPC Pilot PDA Summary

1. 5B WPW Eligibility Criteria
2. 5C WPW Transfer of Care
3. 5D WPW ED Communication
4. 5E WPW ID Card
5. 5F WPW CCP Integration
6. 5G WPW CCP Monitoring
7. 5H WPW CCP Screening Tool
8. 5I WPW Care Coordination
9. 5J WPW ConnectWell SD Data
10. 5K WPW Early Enrollee Cohort