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

San Mateo County Health System

Annual Report PY2

4/2/2018

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

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

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

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;
In 2017, the San Mateo County Health System (SMCHS) achieved some level of interdivisional collaboration in addressing the needs of WPC clients. The WPC Operations Committee and its various workgroups continued to act as coordination forums and provided impetus for increased interdivisional communication and collaboration and propelled some initial efforts at care coordination across elements of the Health System. The Health System also witnessed increased discussion and joint problem solving on system barriers and gaps to coordinated and efficient care for complex high utilizing clients. As a result, some teams participating in WPC are now working together to meet the needs of clients. Behavioral Health and Recovery Services (mental health, and addiction services), San Mateo Medical Center, Health Plan of San Mateo now work closely with Bridges to Wellness (BWT) care navigators based in Public Health. The Community Care Setting Pilot (CCSP) intensive transitional case management is working in collaboration with partner agencies such as Adult and Aging Services (AAS), Behavioral Health and Recovery Services (BHRS), the San Mateo County Department of Housing and Housing Authority, the San Mateo Medical Center as well as other community-based primary care providers.

Increasing coordination and appropriate access to care;
A system of complex case conferences was established as a mechanism to identify issues that may have an impact on the system's ability to provide the "right care, at the right time" for WPC clients presenting with complex issues usually related to high medical and high behavioral health needs as well as high social service needs. These conferences bring together medical, behavioral, and other providers of social supports to not only assist the client in receiving the care they need in a coordinated manner but also serve to help us evaluate how the health system can better meet the needs of these complex clients. These complex case conferences have been instrumental in not only identifying barriers such as the lack of communication pathways for providers, service duplication but also have been solution focused and created provider action plans for appropriate individuals involved in the client care. Case conferences have also been established between programs such as Bridges to Wellness and CBOs, as well as within the CCSP program.

A Care Coordination Memorandum of Understanding (MOU) as well as an operational definition of care coordination were developed and approved across all the divisions of the Health System as well as the Health Plan of San Mateo and the Human Service Agency. There has also been general agreement on the use of the Four Quandrant Model as a basis for identifying medical homes and care coordination teams. This set a foundation for the development of WPC policies and procedures for Care Coordination, Referral and Case Management across the Health System.

Reducing inappropriate emergency and inpatient utilization;
Preliminary data is showing aggregate reductions in Emergency Department (ED) and inpatient utilization and a reduction in associated costs between 2016 and 2017. The pilot exceeded targets in relation to reducing ED visits. A key contributing factor to this early success is the implementation of the Bridges to Wellness (BWT) team-a care navigation model providing support to the largely homeless and highest utilizers with the ultimate goal of connecting clients with their primary care or behavioral health home. Data shows that following the engagement of a set of high utilizing clients by care navigators from the BTW team, ED visits and Inpatient utilization among the same group dropped by 32% and 31% respectively.

Improving data collecting and sharing
Some key technology milestones, which in the long run will promote system integration, were achieved. First, the Health Information Exchange (HIE) interface was finalized. The interface is expected to officially launch in 2018. The data from various case management solutions and Electronic Health Records will also be available for the health system, Community Based Partners, Health Plan of San Mateo and other healthcare organizations. A Universal Consent form was finalized and approved and will be implemented with the formal launch of the HIE. The Health System is in final negotiations with a vendor for the common case management solution software. WPC will be one of the initial programs on-boarded onto the new platform in 2018. A key challenge for the Health System is to get all divisions to buy into the use of a common case management solution.

While some barriers to accessing homelessness data were resolved, access to Medi-Cal eligibility and client level AOD information for purposes of care coordination remain restricted. To increase access to homelessness data, the Health System entered into a Business Associates Agreements with a CBO providing homeless services. However, for some WPC clients, housing information is frequently out of date and changes frequently. Aggravated by the restricted access to Medi-Cal eligibility information from the Human Services Agency, this has affected our ability to effectively manage Medi-Cal Churn. Some workaround processes and additional resources will be put in place to mitigate Medi-Cal churn by locating clients and supporting them to reinstate their benefits.
Increasing access to housing and supportive services;

A Housing Committee was established to receive referrals, make recommendations, and prioritize beneficiaries eligible for housing subsidies paid for by county funding. During this period, the Committee developed policies and procedures for the housing referral process. Six clients were approved for a housing subsidy, two medically fragile clients who have struggled with chronic homelessness were housed. As needed, the clients were provided with moving assistance, housing supplies, and housing case management. However, housing needs remain greater than resources available. The Committee has had to set eligibility criteria for clients accessing these resources so that resources are allocated to those with the greatest need, and demonstrate ability to sustain their housing.

Improving health outcomes for the WPC population.

The pilot has also achieved success with meeting PY2 targets for all ten metrics as explained in section VII. In addition, we are witnessing some remarkable improvements in the lives of clients served by the BWT team. For example, a 40 year old man who has been homeless for 6 years would have died had a BWT Care Navigator not reached out to him and assisted him to connect to medical care. He suffers from end stage renal failure and congestive heart failure and needs to receive dialysis 3 times a week to survive. Thanks to the care he is now receiving, he can spend more time doing the things that he loves, like spending time with his 8-year-old son and listening to his son talk about the things he is learning in school. Similarly, a 47-year old homeless male diagnosed with metastatic cecum cancer, depression, and anxiety is currently receiving chemotherapy twice a month. Before he became a Whole Person Care client, he visited the emergency room 9 times. Since being assigned a Care Navigator in June of 2017, he has not visited the emergency room at all. He was supported to receive a housing subsidy in October 2017 and recently moved into his new home near the San Mateo Medical Center. Living near the medical center allows him to continue his chemotherapy treatments with ease and to have nearby access to other medical and behavioral health care.

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	1996	57	25	54	61	50	*

Item	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12	Annual Unduplicated Total
Unduplicated Enrollees	21	49	44	48	33	16	2454

For **Fee for Service (FFS),** please report your total costs and utilization for each service. These reports should tie to your budget, invoice and utilization report. Add rows as needed.

FFS	**Costs and Aggregate Utilization for Quarters 1 and 2**						
	Month 1	Month 2	Month 3	Month 4	Month 5	Month 6	Total
Service 1							
Utilization 1							
Service 2							
Utilization 2							

FFS	**Costs and Aggregate Utilization for Quarters 3 and 4**						
	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12	Total
Service 1							
Utilization 1							
Service 2							
Utilization 2							

Whole Person Care

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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.

PMPM		**Amount Claimed**						
	Rate	Month 1	Month 2	Month 3	Month 4	Month 5	Month 6	Total
Bundle #1	$636	$103668	$105576	$109393	$91584	$122748	$160908	$693876
MM Counts 1		163	166	172	144	193	253	1091
Bundle #2	$829	$627553	$626724	$620092	$595222	$636672	$753561	$3859824
MM Counts 2		757	756	748	718	768	909	4656

PMPM		**Amount Claimed**						
	Rate	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12	Total
Bundle #1	$636	$129744	$143736	$468732	$445836	$443298	$440748	$2072724
MM Counts 1		204	226	737	701	698	693	3259
Bundle #2	$829	$588590	$589419	$1047027	$1076871	$1079358	$1083503	$5464768
MM Counts 2		710	711	1263	1299	1302	1307	6592

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

No changes have been made to the midyear enrollment and utilization counts. The utilization counts provided here also match the numbers submitted for the Quarterly Enrollment and Utilization reports. We also experienced Medi-Cal churn for some of the months.

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.

1. **Bridges to Wellness (PHPP)***:* Personnel costs were incurred for program management, data analysis and reporting, accounting and general administration of the program. The WPC Hub hired an Ambulatory Care Nurse who will be coordinating referrals for WPC clients across the health system. Renovations for the new office location for the WPC Hub and the Bridges to Wellness team were initiated. Costs incurred included construction, painting, wiring and carpeting. The WPC Hub and BWT team incurred costs in relation to leasing office space, and purchasing office supplies, furniture and computers for new staff. Other costs incurred were in relation to telephone, information technology services, staff travel and training. A consultant was engaged to start process of developing a WPC communications strategy.
2. **Behavioral Health and Recovery Services (BHRS):** Costs incurred include administrative personnel costs. Programs serving WPC clients incurred costs in relation to leasing office space, and purchasing office supplies, furniture and computers. Indirect costs incurred covered the cost of accounting and administrative support. Other costs incurred were in relation to telephone and information technology services incurred by staff in WPC programs across BHRS.
3. **Correctional Health Services (CHS):** The Director of CHS continued to provide oversight to the WPC re-entry program.
4. **Health Information Technology (HIT):**
   (a) *Health Information Exchange (HIE):* Social determinants data from Aging and Adult Services and Family Health Services have been identified and are now feeding into the HIE/EHR framework. This includes programmatic affiliation as well as specific information on LPS conservatees and the specific status of those clients who are struggling with homelessness. Broad availability to this data is expected to begin in 2018. The data will also be available for consumption/sharing with CBOs, Health Plan of San Mateo and other healthcare organizations.
   (b) *Electronic Health Record (E.H.R).* Planning around the new EHR platform (to include population management, which will specifically benefit WPC) remained on target with all milestones met

(c) *Case management Solution*. HIT developed specifications, and solicited bids for a vendor to provide a Case Management Solution for the Health System. During this period, the process reached the vendor selection milestone.

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 Correctional Health Services (CHS) department continued to coordinate re-entry planning for WPC participants leaving the criminal justice system. Care Coordination was provided by the Nurse, and two clinical services managers (Mental Health and Nursing). Individuals leaving the jail were successfully engaged with a Care Navigator upon release, making the transition from jail to the community smoother. Several clients were able to be connected with primary care services to ensure continuity of care for health conditions.

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.

N/A

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.

(a) *Ambulatory Care-Emergency Department (ED) visits.* The numerator (total number of ED visits in 2017) was calculated at 6779 while the denominator (the total member months) came to 23,459. This places our annual rate at 289 ED visits per 1000 member months. Although we do not have complete baseline information at time of calculating this metric, our internal monitoring efforts indicate that we shall meet the 5% reduction target.

(b) Inpatient Utilization. The numerator (total number of inpatient stays) was calculated at 606 while the denominator (total member months) was calculated at 23,335. This translates into 26 inpatient stays/1000 member months. Although we do not have complete baseline information at time of calculating this metric, our internal monitoring efforts indicate that we shall meet the set target. We anticipate that this metric may need to be thought through from a policy perspective. We have found, consistent with research data that better engagement and care coordination results in treating patients with more serious illnesses due to delayed care. While engaging these patients into care will result in improved health outcomes, it may be the case that this will result in increased inpatient use in the short term.

(c) Follow up after hospitalization for mental illness. In 2017, the total number of patients receiving a follow-up mental health visit within 7 days of discharge was calculated at 69, while the total inpatient discharges for person hospitalized for mental illness was 88 bringing the rate to 78% compared to the annual target of 10%. The total number of patients receiving a mental health follow up visit within 30 days of discharge was 83 compared to the total 88 bringing the rate to 94% compared to the annual target of 10%.

(d) *Initiation and engagement of AOD dependence treatment.* In 2017, the total number of clients who initiated AOD dependence treatment within 14 days of diagnosis was calculated at 97, and the total number of clients with a new episode of AOD diagnosis is 269 bringing the rate to 36% compared to the annual target of 8.75%. The total number of WPC clients who initiated treatment and had two or more additional services within 30 days of diagnosis was calculated at 18, and the total

number of clients who initiated treatment within 14 days was 97 bringing the rate to 19% compared to the annual target of 12.5%.
Of concern is that our detox services aren't being captured because our detox provider does not code for diagnosis. If we could modify our specifications, we would probably eliminate some people who do not meet the negative diagnosis history thereby capturing more AOD services.

(e) *30 day all cause readmissions.* The pilot has successfully reduced the rate of All Cause Readmissions to 21%. The count of 30 day all cause re-admissions in 2017 was 77 and compared to the count of index hospital stays for the eligible population of 359, the rate is calculated at 21% which exceeds the 2017 target of 30%.

(f) Adult Major Depressive Disorder: Completion of Suicide Risk Assessment. In 2017, the rate for completion of suicide risk assessments was calculated at 17%. The total number of suicide risk assessments in 2017 was calculated at 48, while the count of clients with major depressive disorder is 281. A major challenge with this metric is that only some divisions in our health system document suicide risk assessments in a systematic way, so while the practice is to provide a suicide risk assessment it is not reported in a way that can be captured. Additionally, in our Behavioral Health Division, the typical practice is to meet with the patient several times before formulating a diagnosis. Thus, the suicide risk assessment may take place at a visit prior to the date of diagnosis. We have counted any suicide risk assessment completed in the month prior to or on the day of diagnosis. In addition, while providers conduct a suicide risk assessment, they were not using a standardized tool. An additional challenge is that it has not been standard practice to code to remission and/or recurrent episode. This division has not only adopted a standardized tool (Columbia) but is also implementing policy change to ensure that practitioners are providing a remission and recurrent episode diagnoses.

(g) *Percentage of diabetic clients with HbA1c less than 8.* In 2017, the percentage of WPC participants with diabetes with HbA1c less than 8 was greatly reduced. The rate was calculated at 56% compared to the 2017 target of 20%.

(h) *Percentage of homeless clients receiving housing services after being referred for housing services.* In 2017, we achieved 100% with all clients receiving housing services after referral. A total of 6 clients were referred for housing services, and all 6 received housing services. However 2 were excluded from the calculation because they exceeded the allowable gap in enrollment of one month. Currently, we are including only housing services provided through our Whole Person Care housing fund. We would like to broaden this to include services provided through our new Coordinated Entry System.

(i) Percentage of clients with a comprehensive care plan accessible by the entire care team within 30 days. 34% of WPC participants have a comprehensive care plan

compared to the annual target of 16%. A significant challenge is to develop a comprehensive care plan within 30 days of enrollment as it may take a considerable amount of time to locate the client on a consistent basis in order to develop a care plan. A better metric would be to develop a care plan within 30 days of active engagement with the client.

(j) *Assignment of Care Coordinator.* In 2017, 56% of WPC participants had a care coordinator assigned, compared to the annual target of 50%. The number of WPC clients engaged in some form of care coordination program was calculated at 1370, compared to the total number of enrollees in 2017 which was 2454.

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.

Attachment I: San Mateo County-WPC Stakeholder Engagement

Stakeholders	Meeting Title	Meeting Purpose
SMC Departments	Operating Committee Meeting	This meeting is held monthly and is responsible for assisting the supporting workgroups (Care Coordination and Quality) to remove barriers and make executive decisions around policies and system changes recommended by the Care Coordination and Quality workgroups. Topics discussed include: staffing updates, PDSAs, Risk Stratification, Case Management Solution, WPC Communications Strategy development, Universal Consent form, Care Coordination MOU, WPC Metrics and ED Utilization analysis, Budget Adjustment and Rollover, clients with no monthly services, WPC FAQs, WPC Day of Partnering.
Public Health, Policy, and Planning		
Health Administration		
Behavioral Health & Recovery Services		
BHRS-IMAT		
San Mateo Medical Center		
Aging Adult Services		
Human Services Agency		
Health Information Technology		
Correctional Health Services		
Health Care for the Homeless		
Health Communications		
Community Based Organizations		
Heart and Soul Voices of Recovery The California Clubhouse		
Health Plan Partner		
Health Plan of San Mateo		

Stakeholders	Meeting Title	Meeting Purpose
SMC Departments	Care Coordination Workgroup	This meeting is held bi-weekly and is intended to identify the health system gaps and barriers that limit care coordination for WPC clients with the goal of developing solutions that provide
Public Health, Policy, and Planning		
Health Administration		
Behavioral Health & Recovery Services		
BHRS-IMAT		

San Mateo Medical Center Aging Adult Services Human Services Agency Health Information Technology Correctional Health Services Health Plan of San Mateo **Community Based Organizations** Brilliant Corners Life Moves **Health Plan Partner** Health Plan of San Mateo		a more coordinated health care delivery approach. Topics discussed included WPC Consent form, WPC referral policy for new clients, WPC referral process in mental health, AOD, Four Quadrant Model, Health Homes, Warm Hand-offs.
Stakeholders	**Meeting Title**	**Meeting Purpose**
SMC Departments Public Health, Policy, and Planning Health Administration Behavioral Health & Recovery Services BHRS-IMAT San Mateo Medical Center Health Information Technology Healthcare for the Homeless **Health Plan Partner** Health Plan of San Mateo	Quality Workgroup	This meeting is held monthly for the purpose of discussing metric calculations and identifying data challenges and barriers. Topics discussed include progress with WPC metrics, suicide risk assessment metric application in mental health and primary care clinics; data quality
Stakeholders	**Meeting Title**	**Meeting purpose**
SMC Departments Public Health, Policy, and Planning **Health Plan Partner** Health Plan of San Mateo **Community Based Organizations** Brilliant Corners	Housing Committee	This meeting is held twice a month for the purpose of developing and monitoring P&P for providing housing services, and housing subsidies. Topics discussed policies and procedures for housing referrals, review of housing referral applications, review of implementation of approved housing applications.

IX. PROGRAM ACTIVITIES

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

(1) A Care Coordination Memorandum of Understanding (MoU) was executed across all the divisions of the Health System, the Health Plan of San Mateo and the Human Services Agency. All parties came to a common agreement that outlined care coordination at the individual and cohort level. Additionally, an operational definition of care coordination was adopted by the Operating Committee for use across the Health System. Previously, there was no consistent understanding across SMCHS of the definition and purpose of Care Coordination. This MOU and definition has set a foundation for the development of policies and procedures for Care Coordination, Referral and Case Management across the Health System.

(2) The Integrated Medication Assistance Treatment (IMAT) team formally opened the referral base to include treating those who struggle with Opioid Use Disorder (OUD). IMAT also reported a 27% increase in the number of referrals over the same period in 2016, a 29% increase in the number of referrals from the SMMC Emergency Department. The Community Care Settings Pilot transitioned 30 individuals from Skilled Nursing Facilities or institutions into the community. The average time to transition decreased from 80 days to 60.6 days over the course of the reporting period.

(3) A WPC comprehensive assessment and care plan were developed and tested with the Bridges to Wellness Team.

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

(1) The systems of care across the health system are still using various EHRs and case management systems, sometimes for the same clients with no clear communication pathways. A common case management solution software used in conjunction with defined communication pathways will foster care coordination across divisions.
(2) Provider stigma and limited expertise in prescribing medications for addiction treatment means that clients with substance use disorder may have limited access to a health home in a primary care clinic. A very limited number of providers in our primary care and behavioral health clinics are willing to prescribe buprenorphine for SUD. We are hopeful that with additional education, training, and support, this number will increase.
(3) Limited Housing resources compared to needs. The Coordinated Entry System (CES) has made one central point of access for shelters which may cause delays for

WPC clients. There is need to monitor implementation of the CES and propose solutions that will address the needs of the WPC clients. There is an effort underway to create "flow" in Permanent Supportive Housing (PSH) to ensure that the very limited supply can be accessed by those that need the intensive support. We are attempting to initiate a voluntary pathway for those in these units who no longer need the support to access other units with subsidies.

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

1) The Health System entered into a Business Associates Agreements with a CBO working on homelessness (LiveMoves) a subcontractor with the Human Services Agency that has access to the Homeless Information Management System. LiveMoves is now working with the Health System to locate clients for purposes of engagement, as well as to facilitate the reinstatement of Medi-Cal coverage.
2) The Bridges to Wellness team was approved for migration from the use of excel spreadsheets in SharePoint as a case management solution to a software system- Avatar E.H.R. This means that information from the BWT team will now be visible to other providers through the HIE.

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

(1) The Health system's access to Medi-Cal eligibility data remains restricted. This has limited our ability to effectively deal with Medi-Cal churn. A work around process with the Health Coverage Unit reveals that there is need for a field based effort at reaching out to homeless clients to get them to submit the required paperwork's and verifications for renewals.

(2) Access to client level AOD data for purposes of care coordination still remains restricted. 42 CFR concerns are still applied somewhat stringently. The use of a Universal Consent form that includes release and sharing of AOD information will increase information sharing for purposes of care coordination.

e.) Briefly describe 1-2 successes you have had with data collection and/or reporting.
(1) The Health Information Technology team was able to create business requirements and code for all of the metrics. (2) Our strong relationship with the Health Plan of San Mateo allows us ready access to data that supports analytics and data driven decision making.

f.) Briefly describe 1-2 challenges you have faced with data collection and/or reporting.
1. *Multiple data sources in various formats*. The various divisions in the health system and CBO partners are using different case management systems, sometimes while serving the same clients. Some data is stored in spreadsheets instead of EHRs. The pilot has also had to collate information from multiple data sources in various formats. Matching client data from many of the various sources, which can be challenging and time-consuming because many of the record systems use different client identification numbers, the systems may have partial overlap or conflicting information, and many do not contain complete client data for all WPC clients. 2. *Incomplete Housing data*: Housing data on WPC clients is being collected from multiple sources, and not all sources of data contain information on the client's housing status. The housing status of many of our clients is frequently changing, and it is difficult to know if the data we have reflects the most up to data housing status of each of our clients. 3. *Medi-Cal eligibility churn*. Some clients continue to drop off the enrollment list when their Medi-Cal eligibility expires. The pilot has had to enroll new members to maintain the eligible list at 2000 while retaining those who have dropped off. 4. *Claims data delays*: The pilot uses claims data to measure metrics performance. The WPC Hub has decided to allow for 3 months after date of service to utilize this data. However, some claims may be submitted after the 3 month period. Moreover, the semi-annual and annual report is due to DHCS 60 and 90 days after period in question, which raises concerns as to the completeness of the data.

g.) Looking ahead, what do you foresee as the biggest barriers to success for the WPC Program overall?
(1) The success of this pilot will depend on the willingness of all stakeholders in the Health System to embrace and adopt common care coordination, case management and referral processes. (2) Overcoming barriers to share AOD information across providers within the same department. (3) Acceptance of integration across and within divisions. Adopting models that address the need for flexible, on demand services.

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 1. PDSA summary sheet 2. PDSA summary reports: (a) Ambulatory Care – Emergency Department Visits Qtr3 (b) Ambulatory Care – Emergency Department Visits Qtr4 (c) Inpatient Utilization Qtr 3 (d) Inpatient Utilization Qtr 4 (e) Comprehensive Care Plan Qtr 3 (f) Comprehensive Care Plan Qtr 4 (g) Care coordination semi-annual 2 (h) Data and information sharing semi-annual 2 (i) Other: Medi-Cal churn semi-annual 2