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 PY3
May 15, 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	X Completed Narrative report X 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	X Customized invoice
3. Variant and Universal Metrics Report **Submit to:** SFTP Portal	X 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	N/A Care coordination, case management, and referral policies and procedures, which may include *protocols and workflows.)* N/A 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	X Completed WPC PDSA report X Completed PDSA Summary Report
6. Certification of Lead Entity Deliverables **Submit with associated documents to:** Whole Person Care Mailbox and SFTP Portal	XCertification 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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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;

San Mateo County Health (SMCH) continued to develop information technology that provides a unified platform to share and store client information thereby promoting integration among divisions, the Health Plan of San Mateo (HPSM) and other partners. This platform is governed by an information governance structure that determines standards of practice, content and workflows. SMC Connected Care, a Health Information Exchange (HIE) went live in 2018. The HIE has been a valuable infrastructure for information sharing among San Mateo Health divisions including, but not limited to the following:

- San Mateo Medical Center (operates the county hospital as well as health clinics throughout the county),
- Aging and Adult Services,
- Behavioral Health and Recovery Services, (provides Specialty Mental Health Services as well as directly operates services for the Mild to Moderate population),
- Correctional Health Services,
- Public Health, Policy and Planning (operates a Mobile Clinic and the Field Medicine team for the homeless population).

The consistent usage the HIE among providers in key departments is necessary to its operational success. Plans are underway to improve the HIE's relevance and usability through enhancements as well as linkage to external providers, including key community-based organizations and the Health Plan of San Mateo. The HIE is, in part, a step along the path to the on-going work of developing an Electronic Health Record (E.H.R) with the goal of providing a single, unified health record across all County Health divisions.

SMCH continued to have interdivisional meetings to identify and resolve system barriers faced by clients with complex needs. Monthly Whole Person Care (WPC) Operations Committee meetings with representation from all divisions continued to act as a decision-making forum for system problems facing WPC clients.

Increasing coordination and appropriate access to care;
During this period, SMCH initiated experiments with the goal of transitioning qualifying clients from high intensity services to lower intensity services. The Bridges to Wellness (BWT) Team and the San Mateo Medical Center (SMMC) primary care clinics, are collaborating to transition clients from intensive care coordination services to lower intensity care coordination services provided by a social worker at the primary care clinic. Eligibility criteria includes: no immediate and acute needs, adherence to medical and behavioral health appointments and stable permanent housing. Three clients were transitioned from the Bridges team to Primary Care in 2018 and an additional 4 clients transitioned in early 2019. We are studying this transition to identify best practices and retention rates. SMCH is seeking to determine the capacity of primary care to coordinate care for clients with both lower level and higher-level needs.

The Helping Our Peers Emerge (HOPE) program was officially launched to support clients transitioning from an acute inpatient psychiatric unit to a lower level of care with the goal of reducing recidivism. The program is proving to be successful in supporting clients with their transitions to their next level of care, connecting them to community resources, and increasing their level of independence. Aspects of the mentoring process, provided by Peer Mentors (PMs) includes benefits support (aiding Peer Participants (PPs) in gaining relevant documentation germane to benefits, such as social security card and California ID card), transportation (supporting PPs in navigating municipal transportation system as well as providing rides), peer recovery coaching (sharing stories of lived experience and recovery in community or inside a facility) and advocacy by interfacing with clinical team members on PP's behalf. Recreational activities such as skateboarding or tossing a football in a park are used by the PMs to establish a personal connection with the PPs. 75% of the program participants have had zero recidivism. Only 3 participants returned to the acute inpatient psychiatric unit.

Using the LEAN framework, San Mateo Medical Center (SMMC) developed an Improvement Charter aimed at increasing access to care for clients who have been identified as having at least one chronic health condition and who had no primary care visit for more than 18 months with some having had no primary care visit in three years. A three-year lack of engagement causes the patient to lose their status as established patients which results in longer wait times for primary care appointments. We anticipate that outreach by a Care Coordinator Nurse who can provide real-time access to triage and appointments will increase the likelihood that these patients will connect with primary care.

While evaluating data, we learned that the WPC population experiences a rate of death of at least three times greater than that of the San Mateo County general population. An experiment was designed to prevent early mortality among the WPC population. This experiment brings together all direct treatment and social service providers in a regular bi-weekly Skype meeting as a mechanism to better coordinate care for very complex clients. Our initial data indicates that there is a cohort of individuals who experience life-threatening illnesses, severe substance use disorder, homelessness and who seek care almost exclusively in the emergency room. Often, the emergency department is not the right level of care, however it is the place the client will elect to engage, and/or the client is brought in by ambulance or police. The virtual team meeting seeks to identify the right level of care, an appropriate “care home,” as well as agreement on treatment and social service needs.
SMCH completed at least 37 Complex Case Conferences between September 2017 and December 2018. Of the 13 completed between July and December 2018, 10 had 100% representation from divisions associated with the client’s physical, behavioral, social, and mental health care. During the complex case conferences, barriers that limit access to care were identified and an action plan to address the presenting needs of the client were developed. The Complex Case Conferences have increased cross-divisional discussion and joint problem solving on system barriers and gaps to provide coordinated and efficient care for complex high utilizing clients. They have also revealed a need for system-wide staff training on trauma-informed care, compassion fatigue, person centered care, strength-based practice, motivational interviewing, and the relationship between stigma and care.

Following the development of a Communications Strategy using design thinking and collection of ethnographic data, communication materials aimed at increasing awareness and understanding of the WPC initiative across SMCH were developed and disseminated. A WPC Triage Guide provides information to providers about the criteria for WPC eligibility, enrollment status, and resources available to support WPC clients. Other materials disseminated include a poster that clarifies WPC’s vision, and a Client Highlight that tells a success story of a client’s journey of care.

Reducing inappropriate emergency and inpatient utilization;
Data indicates significant reduction in Emergency Department (ED) use and in-patient utilization (IPU) among WPC clients between 2017 and 2018. Overall, ED utilization reduced by 26%, while IPU decreased by 8%. A contributing factor to this reduction is the intensive case management and care coordination provided by the BWT team. Data shows the top ED utilizers in 2016 (11 clients) assigned to BWT, with continuous enrollment in WPC, had a 60% decrease in ED utilization from 2016 to 2018. In addition, the top utilizers in 2017 (5 clients) had a significant decrease in ED utilization of 48% from 2017 to 2018. Data is also indicating that clients served by the Integrated Medication Assisted Team (IMAT) had significant reduction in ED utilization as measured at six months prior to and six months after engagement in the program. One hundred three new clients served between July 2017 and June 2018, had a 53% reduction in ED utilization. The number of inpatient stays for the same group dropped from 24 to 3—an 87.5% reduction.

Improving data collecting and sharing
SMC Connected Care, a Health Information Exchange (HIE), was evaluated for efficiency and usability in late 2018. This evaluation has helped SMCH understand the current HIE usage, see the opportunities for improvement, and assist in determining the priority of the initiatives to pursue to enhance our HIE. A few of the HIE enhancements currently planned include: Joining CTEN (California Trusted Exchange Network), eHealth Exchange, and EDIE (Emergency Department Information Exchange), adding medication fill history, and customizing the user interface.

During this period, following a thorough analysis, SMCH determined that a new Case Management Platform to connect all of our providers to improve care coordination was not the best solution as it would merely add a new electronic tool to an environment where multiple E.H.R's already exist. Instead, expanding our HIE capability as well as further developing our planned centralized E.H.R will save costs and create a long-term solution. SMCH established an E.H.R project management office (EHR PMO). The purpose of the EHR PMO is articulated in five work streams, two of which kicked off in 2018. First, the San Mateo Medical Center is in the process of extending the use of their current E.H.R., Soarian, to CHS. Additionally, the enterprise master patient index (EMPI) will be enabled to avoid duplicate patients in our disparate systems. Second, the E.H.R. PMO engaged a third-party consulting firm who excels in EHR vendor selections, especially in the public health setting, to assist SMC Health in selecting a new, integrated standalone EHR. The goal of the new E.H.R. will be to provide a single view of the patient's record, regardless of where the patient is being seen within the county.

To increase communication between providers, Health Information Technology (HIT) rolled out SmartText –a communication platform to securely exchange Private Health Information (PHI) via text between providers in SMCH. This tool was piloted with several WPC programs and teams such as Bridges to Wellness, and community-based organization LiveMoves. In the future, it will be expanded to facilitate provider-to-patient communication to satisfy the needs of a patient population that increasingly prefers texting over other means of communication.

Access to Medi-Cal eligibility, Homeless Management Information System (HMIS) and client-level Substance Use Disorder (SUD) information for purposes of care coordination remains restricted. This data sharing difficulty has affected our ability to effectively manage Medi-Cal Churn. Despite these difficulties, communication efforts with our HSA department remain on-going and productive. In addition, through the implementation of a Business Associate Agreement (BAA) with a Community-Based Organization (CBO) providing services to homeless--LifeMoves, the BWT team has successfully located and engaged 50% of clients that have been hard to reach. LifeMoves Community Health Outreach Workers (CHOWs) have placed a flag for WPC clients who are hard to reach in the HMIS so that providers can identify and connect them to the CHOWs for services.

Achieving quality and administrative improvement benchmarks;
LEAN work on a Complex Client Enterprise Value Stream continued as an effort to improve the care coordination process for complex adult clients. With participation from all divisions within the health system, a shared care plan for both clinical and social services needs was developed, and an experiment conducted with 3 clients was initiated. There is a long-term plan to scale up the use of the shared care plan across the health system.

Policies and Procedures were developed to guide the conduct and follow up of actions items from Complex Case Conferences (CCC). The Policy requires providers to make an effort to resolve client's barriers with other providers and exhausting all options prior to requesting a CCC. This will ensure that CCC are conducted when system barriers and roadblocks prevent providers and care coordinators from supporting their clients to access care.

Behavioral Health and Recovery Services (BHRS) successfully implemented and evaluated the use of the Columbia Suicide Risk Assessment tool in all county-operated clinics and specialty programs. Clinicians are now completing the Columbia using the ICD-10 code when clients are initially assessed or are diagnosed with recurrence of Major Depressive Disorder. In addition to implementation across all county behavioral health clinics, BHRS will require all contract providers to utilize this standardized tool in 2019.

Increasing access to housing and supportive services;
SMCH continued to increase access to housing for WPC clients who experience homelessness, or are at risk of imminent homelessness, through local county dollars and other funding. Through local tax dollars, 17 individuals received housing support and rental subsidies in the reporting period. A total of 26 homeless individuals received housing supports and subsidies in 2018. Clients approved for housing have an assigned Care Coordinator who ensures that supportive housing services are provided either by the Coordinator or other providers.

We are also able to support homeless individuals who are at risk of a worsening medical condition due to homelessness to secure a hotel room for short term respite. In 2018, a total of 20 clients had access to motel vouchers for a total of 199 bed nights as an interim respite care solution.

The Health Plan of San Mateo (HPSM) conducted a recuperative care feasibility study, released a Request for Proposal (RFP), and selected a housing intermediary to implement a 6-bed recuperative care facility. It is anticipated that this program will open in 2019. HPSM also Implemented two pilots (Permanent Supportive Housing (PSH) Moving Up and PBAP Flow) to create housing flow into the community through scattered site housing as well as communal living with onsite case management. This effort supports the Collaborative Care Team (CCT) to move clients from higher levels of care back into the community. Despite these promising efforts, San Mateo County continues to experience a serious housing crisis due to low stock and exorbitant pricing.

Improving health outcomes for the WPC population;
In a survey among clients served by Bridges to Wellness (BWT), the majority of clients expressed high levels of satisfaction with the services they received. Additionally, the majority of clients reported that their health has improved 79% and quality of life has improved 82%, due to the services received from the BWT Care Navigator. Clients that received housing subsidies reported higher rates of improvement with 92% stating that both their health and quality of life had improved due to the services received. Examples of client stories in 2018 include:

- A 71-year-old male with a history of alcohol abuse, depression and multiple chronic diseases, was engaged by a BWT care navigator. The Care Navigator assisted the client to attend his medical appointments and provided care coordination among various providers. The client is now sober and independent.
- A client who had been street homeless for over 10 years, has a heart condition, was non-adherent with medications and did not show up to appointments, was supported to have his medications refilled and attend appointments. Client was referred to and received emergency housing which enabled him to become more adherent to medications and improved his ability to manage his heart condition

- A 70-year-old male with a history of homelessness was diagnosed with dementia and metastatic cancer to the bone. With support from the Care Navigator, the client was reconnected to care and was successfully able to connect with neurology, oncology, primary care, and psychiatric services. The client was transferred to a skilled nursing facility where he continues to reside and receive care. Client continues to receive specialty care at SMMC and to follow-through with outpatient medical treatment for his medical conditions. The client has responded very positively to the cancer treatment (Lupron) and has been able to stop the spread and growth of cancer.

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	**306**	**48**	**29**	**31**	**29**	**39**	**482**

Item	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12	Annual Unduplicated Total
Unduplicated Enrollees	20	40	47	36	9	8	642

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. San Mateo does not have FFS line items.

	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							
Utilization 1							

	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							
Utilization 1							

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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	$635.58	**$592,360.56**	**$598,080.78**	**$598,080.78**	**$563,759.46**	**$552,319.02**	**$541,514.16**	**$3,446,114.76**
MM Counts 1		**932**	**941**	**941**	**887**	**869**	**852**	**5,422**
Bundle #2	$828.63	**$1,017,557.64**	**998,499.15**	**1,000,156.41**	**1,045,731.06**	**1,061,475.03**	**1,078,876.26**	**$6,202,295.55**
MM Counts 2		1228	1205	1207	1262	1281	1302	7,485

		Amount Counts						
PMPM	Rate	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12	Total
Bundle #1	$635.58	$524,989.08	$517,362.12	$510,370.74	$500,837.04	$488,761.02	482,405.22	$3,024,725.22
MM Counts 1		826	814	803	788	769	759	4759
Bundle #2	$828.63	$1,097,934.75	$1,107,049.68	$1,119,479.13	$1,149,309.81	$1,148,481.18	$1,132,737.21	$6,754,991.76
MM Counts 2		1325	1336	1351	1387	1386	1367	8152

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

We revised our Enrollment and Utilization reporting for Quarter 1 and 2 because the initial submission had a cap of 2000 clients. Based on a discussion with our Analyst, we revised it to reflect the actual number of clients receiving services.

IV. NARRATIVE – Administrative Infrastructure

Please describe the administrative infrastructure that has been developed specifically for the WPC program and how it relates to achievement of program goals. Reimbursement will be based on actual costs expended and employees hired/employed for the WPC pilot, and only up to the limit of the funding request in the approved budget.

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

1. **Bridges to Wellness (PHPP)***:* Personnel costs were incurred for program management, data analysis and reporting, accounting, quality assurance and general administration of the program. Office space and furnishings for the new office location for the WPC Hub and the Bridges to Wellness team (BWT) were completed. Furniture was installed, and staff moved into the new space. Three vehicles for the BWT were purchased. The WPC Hub and BWT team incurred recurrent costs in relation to leasing office space, and purchasing office supplies, furniture, and computers for new staff. Other costs incurred were in relation to vehicle maintenance, telephone, information technology services, staff travel and training. An annual license for the Patient Activation Measure was purchased.
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 purchase of two vehicles, cell phones, and 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):* Costs were incurred in relation to maintenance of the Health Information Exchange, as well as planning activities in relation to connecting to statewide and national networks.
   (b) *Electronic Health Record (E.H.R).* A Project Management Office was set up and a vendor who excels in E.H.R. vendor selections, especially in the public health setting, to assist SMC Health in selecting a new, integrated single E.H.R. Planning around the new E.H.R. platform (to include population management which will specifically benefit WPC) remained on target with all milestones met. Support was also provided for Correctional Health Services (CHS) in planning the transition from a paper-based to an Electronic Health Record.

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 increased its staff capacity to coordinate re-entry planning for WPC participants leaving the jail. A Bridges to Wellness Care Navigator was brought on board to engage individuals leaving the jail, to ensure a smooth transition into living in the community. A Medical Office Assistant was hired to support the Nurse Care Coordinator to gather client's information for re-entry planning. A daily report of WPC clients incarcerated is generated to facilitate quick identification of WPC clients in the absence of an electronic health record. CHS supported by the Health Information Technology (HIT) in the planning phase of migrating to an electronic health record.

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.

In addition to the Incentives earned between January-June 2018, which were reported at midyear, between July-December 2018, the following milestones were achieved:

1. *Attendance at Complex Case Conferences.* Out of the 18 budgeted complex case conferences with 100% representation for PY3, 14 were claimed at mid-year, and although San Mateo held 10 case conferences that met the payment trigger, only 4 are claimed during this period. Between July-December, 13 Complex case conferences were completed and 10 out of 13 had 100% representation from providers associated with the client's care. These conferences brought together medical, behavioral, and other providers of social supports to not only coordinate client care, but also serve to evaluate how the Health System can better meet the needs of these complex clients. The Health System earned $8,888.89.
2. *Management recommendations for addressing system barriers and strategies for service improvements*. Out of the 9 Operations Committee recommendations budgeted for PY3, 5 were claimed at the mid-year, and 4 are being claimed during this period. The Health System earned $17,777.78. Although San Mateo held 5 Operating Committee meetings that resulted in a recommendation between July-December 2018, only 4 are being claimed. At each meeting, issues and/or system barriers were brought forward, and recommendations were proposed by the committee. These include:
   (a) The increasing aging homeless population. Our Aging and Adult Services division is developing an Improvement Charter that will address the issue of the growing population of older adults who homeless. This charter will include an evaluation of the existing data and propose solutions that address prevention and best practices for service provision.
   (b) Stigma and complex clients in the health system. A concern was raised that complex clients with substance use issues may experience stigma when interacting with the health system which may lead to health disparities. This issue was raised in a number of complex case conferences. An Improvement Charter is under development to identify root causes and propose solutions.

(c) WPC Pay for Outcome Metrics. A review of the data revealed that for some of the universal and variant metrics, San Mateo County is achieving rates that are at or above national averages for the Medi-Caid population. Concerns were raised that achieving 5% increments of improvement would be unrealistic for metrics where performance is already relatively high. It was proposed that monies tied to Pay for Outcomes for the universal and variant metrics be replaced with process metrics that support the goals of the WPC pilot.

(d) Diabetes Control and the Care4Life program. The Care4Life program was presented as an evidenced based text messaging program that has proved successful as a tool for managing diabetes among the Medi-Caid population. A concern was raised that clients may not adopt to a text messaging program especially if they are homeless and have developmental/behavioral challenges. It was proposed that a test of acceptability of the tool with 10 clients be conducted to learn if full implementation is feasible.

(e) Patient Activation Measure (PAM). The PAM was presented as a tool for measuring level of client self-management to be piloted with the Bridges to Wellness team. It was proposed that this tool could be scaled up to other divisions within Health. The WebEx training on the PAM will be made available to all divisions interested in learning more about the tool.

3. *Health Information Exchange (HIE*). An evaluation of the HIE, SMC Connect, was completed in November 2018. The Evaluation revealed that the although the HIE is very relevant to care coordination and patient care, its relevance could be improved by enhancing its features, improving data quality and connecting SMCH to statewide and national HIE networks. The Health System earned $250,000.00.
4. *Secure Text Messaging platform*. The Health Information Technology (HIT) department completed the rollout of the Secure Text messaging platform. The Health System earned $664,591.67. A contract was executed with the vendor TelMedIQ to make the application/software (SmartText) available to users in SMCH and to provide education and technical assistance to users. The application was configured and integrated into County of San Mateo applications. The following milestones were achieved:
    a) *Implementation of the provider secure messaging system:* The application was initially rolled out to several programs as 60-day pilot. This included Bridges to Wellness and LifeMoves, a CBO working with clients experiencing homelessness.
        - The application has allowed for securing instant sharing of Protected Health Information (PHI) between the BWT Care Navigators, the Registered Nurse as other Care Team members. Through this portal, the BWT Care Navigators also receive alerts when assigned clients register at San Mateo Medical Center (SMMC) emergency department.

- The WPC Community Health Outreach Workers (CHOWS) at LiveMoves are also using this SmartText application to communicate to BWT Care Navigators in real time when hard to reach clients have been located.

b) *On-going technical assistance and training on the use of the secure messaging platform:* Through a series of educational sessions and technical assistance sessions, the vendor increased the capacity of County staff to use the application as administrators, on-call schedulers, call center users, power users and champions.

c) A workgroup was established to explore use of secure text messaging for provider to patient communication.

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.

In 2018, SMCH submitted a budget adjustment request to substitute 6 out of 9 pay for Outcome metrics for PY3 with process metrics. The first three 3 Universal and Variant metrics reported below are tied to payment. Payment is earned upon 5% improvement from the previous program year.

Universal and Variant Metrics

(a) *Ambulatory Care-Emergency Department (ED) visits.* We have had significant success in reducing ED utilization. The numerator (total number of ED visits in 2018) was calculated at 5455 while the denominator (the total member months) came to 25,210. This places our semi-annual rate at 210.51 ED visits per 1000-member months compared to 284.87 in 2017. This is a 26.1% reduction.

(b) *Inpatient Utilization.* Data is indicating a reduction in patient stays between 2017 and 2018. The numerator (total number of inpatient stays) was calculated at 685 while the denominator (total member months) was calculated at 25,210. This translates into a rate of 27.17 inpatient stays/1000-member months. This is an 8.2% reduction.

(c) *Adult Major Depressive Disorder: Completion of Suicide Risk Assessment*. There has been improvement in the rate for completion of suicide risk assessments between 2017 and 2018. The total number of suicide risk assessments in 2018 was calculated at 70, while the count of clients with major depressive disorder is 338 bringing the rate to 20.71% compared to 12.80% in 2017. This an improvement of the rate by 7.9% compared to the target of 5%.

(d) *Comprehensive Diabetes Care.* Data is showing an increase in the rate for Diabetes (HbA1c) control between 2017 and 2018. 56.04% of clients diagnosed with diabetes had HbA1c below 8 in 2018 compared to 54.91% in 2017-an improvement of 2%.

(e) *Follow up after hospitalization for mental illness.* SMCH has seen some improvement on this metric. In 2018, the total number of patients receiving a follow-up mental health visit within 7 days of discharge was calculated at 46, while the total inpatient discharges for person hospitalized for mental illness was 94 bringing the rate to 48.9% compared to 44.87% in 2017. The total number of patients receiving a mental health follow up visit within 30 days of discharge was 62 compared to the total 94 bringing the rate to 65.95% compared to 64.10% in 2017. The rate for 7-day follow-up is lower than the 30-day follow-up because some clients are hospitalized outside the county in a facility that has no direct communication pathway with SMCH. Our clinicians will therefore find out about the hospitalizations after the 7 days.

(f) Initiation and engagement of AOD dependence treatment
In 2018, the total number of clients who initiated AOD dependence treatment within 14 days of diagnosis was calculated at 211, and the total number of clients with a new episode of AOD diagnosis is 478 bringing the rate to 44%. The total number of WPC clients who initiated treatment and had two or more additional services within 30 days of diagnosis was calculated at 117, and the total number of clients who initiated treatment within 14 days was 211 bringing the rate to 55.45% When calculated as a percentage of the total number of clients with a new episode of AOD diagnosis (478), the rate comes to 24.4%

(g) *30 Day All Cause Readmissions.* SMCH reduced the rate of All Cause Readmissions from 18.74% in 2017 to 17.83% in 2018. The count of 30 day all cause re-admissions in 2018 was 84 and compared to the count of index hospital stays for the eligible population of 471, bringing the rate to 17.83%

(h) *Percentage of homeless clients receiving housing services after being referred for housing services*. In 2018, we achieved 100% with all clients receiving housing services after referral. A total of 26 clients were referred for housing services, and all 26 received housing services. Although the number of clients served increased from 6 in 2017 to 26 in 2018, there can be no further improvement as the rate is 100%.

(i) *Percentage of clients with a comprehensive care plan accessible by the entire care team within 30 days.* In 2018, 38.41% of new enrollees had a comprehensive care plan compared to 34% in 2017. In addition, 35.9% (685) of WPC continuing enrollees (1907) have a comprehensive care plan.

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. For the BWT team, we are working towards developing a care plan within 30 days of enrollment with the understanding that an addendum can be added after the client has been actively engaged.

(j) *Assignment of Care Coordinator.* In 2018, 56% of WPC participants had a care coordinator assigned, compared to 51.1% in 2017. The number of WPC clients engaged in some form of care coordination program was calculated at 1455, compared to the total number of enrollees in 2018 which was 2571.

We have used encounter data and claims data when encounter data is not available to calculate these metrics. Because some claims data may take at least 3 months to trickle in, we may not have all the data we need at this point to accurately calculate these metrics. The overall trends may remain the same but actual percentages will change when all claims data becomes available.

New Pay for Outcome Metrics

SMCH met all targets for new process pay for 2018 outcome metrics listed below:

(a) *Ambulatory Care - Emergency Department Visits*. We achieved a 26.1% reduction compared to the 5 % target as reported above.
(b) *Inpatient Utilization-General Hospital/Acute Care (IPU).* We achieved an 8.2% reduction compared to the 5% target as reported above.
(c) *Completion of Suicide Risk Assessment.* Data is showing that the rate for completion of suicide risk assessments increased from 12.8% to 20.7%, an improvement of 7.9% compared to the target of 5% as reported above.
(d) *Assignment of Care Coordinator.* In 2018, 57% of WPC participants had a care coordinator assigned, compared to 51.1% in 2017, an improvement of 5.43%. The number of WPC clients engaged in some form of care coordination program was calculated at 1455, compared to the total number of enrollees in 2018 which was 2571.
(e) *Proportion of clients served by the Bridges to Wellness team (BWT) with a primary care visit within the measurement year.* 65% of clients served by BWT had a primary care visit in 2018 compared to the target of 50%
(f) *Proportion of clients served by Bridges to Wellness (BWT) surveyed reporting improved health and self-management skills.* 79% of clients served surveyed reported improved health and self-management skills compared to the target of 50%.
(g) *Proportion of Peer Mentors trained in Intentional Peer Support*. 67% of Peer Mentors received training in Intentional Peer Support in 2018 compared to the target of 60%.

(h) *Proportion of Peer Mentors utilizing software Sage Surfer*. In 2018, the software sage surfer was set up to track mentoring engagements, coordinate care and provide data for program evaluation. 100% of peer mentors are utilizing Sage Surfer by December 2018 compared to the target of 60%.

(i) *Proportion of clients served by the HOPE program with zero recidivism within the measurement year.* 80% of clients served by the HOPE program in 2018 did not return to a higher level of care compared to the target of 60%.

(j) Number of health system staff educated on Medication Assisted Treatment (MAT). 354 staff across SMCH were educated on MAT compared to the target of 250.

(k) *Number of new SUD referrals linked to Medication Assisted Treatment (MAT) clinic*. 138 new referrals were linked to the MAT clinic compared to the target of 120.

(l) *Number of CCSP clients transitioning into community.* 52 CCSP clients were transitioned into the community in 2018 compared to the target of 50.

(m) *Average number of days it takes to transition a CCSP client into community.* The average number of days it takes to transition the 52 CCSP clients into care was 97 days. This is lower than the target of 100 days.

(n) *Proportion of transitioned CCSP members still in the Community at six months.* Data is indicating that 76% of CCSP clients are still in the community at six months after the transition. This exceeds the 60% target we set.

(o) Proportion of CCSP clients that successfully remain in community for twelve (12) months in measurement year. Data is indicating that 64% of CCSP clients were in the community for 12 months in 2018 This exceeds the 60% target we set.

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.

(See Attachment I)

IX. PROGRAM ACTIVITIES

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

In addition to the successes reported at the midyear:

(1) There have been successful experiments to transition clients from one care team to another, generally from a higher level of service to a lower level of service, without a break in care.

(a) The Bridges to Wellness Team (BWT) successfully transitioned 3 clients from an intensive care coordination program to primary care social workers. The initial set of clients were fairly stable and able to keep their primary care and behavioral health appointments with minimal support from Care Navigators and were transitioned by an electronic referral. Another set of clients required a physical warm-handoff with the care navigator, social worker and client meeting at the primary care clinic. The BWT also transitioned one client to the Health Plan of San Mateo (HPSM) care coordination team. We are studying the experiments for best practices and outcomes with the goal of firming up policies and procedures and scaling up implementation.

(b) The Helping Our Peers Emerge (HOPE) Program has supported 12 clients transitioning from an acute inpatient psychiatric unit to a lower level of care in the community. The 7 Peer Mentors (PMs) are now mentoring 12 Peer Participants (PP's). 75% of the program participants have had zero recidivism. Only 3 returned to the acute inpatient psychiatric unit.

(c) The Correctional Health Re-entry team, working with the Integrated Medicated Assistance Team (IMAT), has successfully transitioned one client from an in-custody Vivitrol Pilot to a primary care clinic providing medication assisted treatment. The client received a Vivitrol injection in custody, and IMAT coordinated care to provide timely services and subsequent injections following his release from custody.

(2) In order to ensure access to medication assisted treatment for those with addiction disorders, the Public Health Officer has written a standing order for Suboxone to assist clients experiencing opiate withdrawal symptoms. This standing order has enabled the IMAT team to assist clients to manage withdrawal symptoms so that they can transition into addiction treatment with the medication assisted treatment clinic provided by a participating CBO, HealthRight 360.

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

In addition to the challenges reported at the midyear:
(1) Limited housing stock continues to be a major barrier for our homeless clients. While some clients can be placed into scattered site housing, a significant number of clients, especially those with mental health and co-occurring disorders, need a supported housing environment to be successful. Additionally, a number of clients approved for a housing subsidy have been placed into extended-stay motels while we identify a level of housing and services that can meet their long-term needs. We have learned that most clients receiving a housing subsidy either through local tax dollars or a voucher program through the Housing Authority require traditional wrap-around supported housing services to be successful in a housing placement. We plan to engage a not-for-profit Supported Housing provider to provide these services to clients.

(2) An evaluation of the HIE revealed that among a sample of service and treatment providers across SMCH, 98% had heard of the HIE while approximately 30% use the HIE on a consistent basis. Providers continue to use source EMRs to access patient information as they reported that the HIE was not detailed enough. Understanding the user's experience has been critical in identifying the next enhancements to be completed within the HIE to increase usage. Plans are underway to connect the HIE to the CTEN (California Trusted Exchange Network), eHealth Exchange, and EDIE (Emergency Department Information Exchange). Additional enhancements include adding medication fill history and improving the user interface.

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

In addition to the successes reported at the midyear:
(1) Health Information Technology (HIT) rolled out a communication tool, SmartText to securely exchange Private Health Information (PHI) via text between providers in San Mateo County Health. This tool was piloted with several WPC programs and teams such Bridges to Wellness (BWT) and LifeMoves. It also provides alerts to BWT care navigators when clients register at the Emergency department. This application will be expanded in future to facilitate provider to patient communication to satisfy the needs of a patient population that increasingly prefers texting over other means of communication.

(2) A Business Associate Agreement (BAA) with LifeMoves, a CBO providing services to homeless individuals, has allowed for information sharing with the BWT team. This information sharing has allowed LifeMoves to locate 50% of hard to locate homeless individuals in 2018. Once located the BWT team begins the engagement process to bring these individuals into care. Additionally, LifeMoves has placed a flag for WPC clients who are hard to reach in the HMIS so that providers can identify and connect them to LifeMoves for location services.

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 and during this period, the Human Services Agency (HSA) restricted access to the MEDS system for benefit verification. This has further limited our ability to effectively deal with Medi-Cal churn. We continue to pilot work around processes as the Health System and Human Services Agency continue to work to remove barriers to information sharing.

(2) Access to client level AOD data for purposes of care coordination remains restricted due to 42CFR restrictions.

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 the universal and variant metrics.
(2) Our strong relationship with the Health Plan of San Mateo (HPSM) allows us ready access to data that supports analytics and data-driven decision making. The HPSM will be providing cost data for all WPC clients to SMCH for purposes of analytics and evaluating cost information.

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

1. The pilot uses both encounter and claims data to calculate metrics and performance, and where encounter data is not available we are restricted to using claims data. Unfortunately, there is often up to a 3-month lag in claims data and some claims may be submitted after the 3-month period. As the semi-annual and annual report is due to DHCS 60 days after period in question, there are concerns as about the completeness of the data.
2. SMCH's access to Homeless Information Management System (HMIS) remains restricted. The homeless data available to us is self-reported at points of service and may vary among the numerous electronic health records in our system.

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

(1) Overcoming barriers to share AOD information across providers within the same department.
(2) Acceptance of technology, tools, and processes across and within divisions.
(3) Ability to fund and adopt 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 BWT Qtr3
   - (b) Ambulatory Care – Emergency Department Visits BWT Qtr4
   - (c) Ambulatory Care – Emergency Department Visits Housing Qtr3
   - (d) Ambulatory Care – Emergency Department Visits Housing Qtr4
   - (e) Inpatient Utilization BWT Qtr 3
   - (f) Inpatient Utilization BWT Qtr 4
   - (g) Comprehensive Care Plan Qtr 3
   - (h) Comprehensive Care Plan Qtr 4
   - (i) Care coordination CCC semi-annual 2
   - (j) Care coordination WHOs semi-annual 2
   - (k) Data and information sharing: semi-annual -HIE
   - (l) Data and information sharing: semi-annual -Location Services
   - (m) Other: Medi-Cal churn- semi-annual

Attachment I: San Mateo County-WPC Stakeholder Engagement

Stakeholders	Meeting Title	Meeting Purpose
• **SMC Departments** • 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 • LiveMoves • **Health Plan Partner** • Health Plan of San Mateo	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: Stigma in Healthcare, WPC Pay for Outcome Metric Changes, Diabetes Management tools-Care4Life; Patient Activation Measure (PAM), Aging Homeless Adults Improvement Charter.

Stakeholders	Meeting Title	Meeting Purpose
• **SMC Departments** • 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	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 a more coordinated health care delivery approach. Topics discussed included Warm Hand- Offs, Shared Care Plan, and Care Coordination across divisions
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 discussing metric calculations and identifying data challenges and barriers. Topics discussed include progress with WPC metrics, PDSAs and 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.