State of California - Health and Human Services Agency
Department of Health Care Services
Whole Person Care
Lead Entity Mid-Year or Annual Narrative Report

Reporting Checklist

County of Santa Cruz Health Services Agency; WPC - Cruz to Health
PY2 Annual Report
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.*

Successes

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

- Established an organized governance structure made up of the Advisory Council, Management Committee, and four workgroups tackling various areas - Data/IT, Fiscal, Care Coordination, and Clinical.
- Facilitated regularly scheduled meetings in addition to ad hoc meetings, particularly for the Data/IT Workgroup.

Reducing inappropriate emergency and inpatient utilization

- Collaboration with Dominican Hospital (a safety-net hospital) to identify potential referrals and begin developing the pilot's future care coordination infrastructure through their monthly High Utilizer Group (HUGs) meetings to discuss care coordination for the highest ED utilizers at Dominican.

Improving data collecting and sharing

- Santa Cruz Health Information Organization (SCHIO) is one of the oldest health information exchanges (SCHIE), providing the pilot a jump-start in data collection and information sharing.
- SCHIO integrated with CrossTx, a cloud-based HIPAA-compliant care coordination platform to bridge systems, close communication gaps, facilitate closed-loop referrals, improve efficiency in care coordination, and allow for automated, real-time population analytics.

Increasing access to housing and supportive services

- Collaboration with County Human Services Department, Homeless Services Center, Homeless Persons Health Project, County Specialty Mental Health, and other housing stakeholders on various projects that provide new housing opportunities for enrollees.

Improving health outcomes for the WPC population

- Executed two contracts for evidence-based interventions to improve health outcomes in individuals with complex needs: Philips for the purchase and integration of

the telehealth program; Dartmouth University for work related to telehealth program support, Integrated Illness Management and Recovery (I-IMR) training and implementation.

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

- Lack of integration between the County's Clinics' EHR (Epic) and the County's Specialty Mental Health EHR (Avatar), specifically between the County's Crisis Stabilization Program (CSP) and the local psychiatric hospital facility (PHF).
- Fully engaging our internal and external partners for meetings due to reasons including competing priorities, confusion on roles and responsibilities and purposes of meetings, and meeting burn-out.

Increasing coordination and appropriate access to care

- Recruitment for Case Managers took over 6 months which ultimately affects clients' access to key program services and administrative metrics around care planning.

Achieving quality and administrative improvement benchmarks /
Increasing coordination and appropriate access to care

- Several similar case management programs rolling out at the same time as Cruz to Health, leading to confusion and stress for County staff and external partners.

Reducing inappropriate emergency and inpatient utilization

- Timeline to contract and purchase telehealth devices took longer than anticipated and timeline for integration and training appears longer than anticipated.

Improving data collecting and sharing

- Turnaround time for County Counsel and compliance officers to approve the consent/release of information form one of many factors delaying the official consent process for identified enrollees.
- Despite the existing SCHIE in Santa Cruz County, complete data collection remains one of the biggest challenges as data are compiled from various sources besides the SCHIE.

Lessons Learned

- Need for a communication plan to improve understanding within the governance structure to engage stakeholders and clearly explain purpose, goals, and services of the pilot.
- Need for leveraging existing partnership with Health Improvement Partnership to clearly map and align case management programs across the County.
- Need for explicit expectations for data collection and reporting for greater success in PY3.

- Need for systems mapping as Cruz to Health and stakeholders work to articulate the complicated systems that clients with complex needs touch.

III. ENROLLMENT AND UTILIZATION DATA

For the Mid-Year report, provide data for January-June 30 of the Program Year and for the Annual Report, provide data for January-December 31 of the Program Year.

The tables below should reflect enrollment and utilization numbers, consistent with your invoice and quarterly enrollment and utilization reports.

For revisions of enrollment and utilization data submitted during the Mid-Year Report (Months 1-6), changes should be made in bold. Additionally, note explicitly in the additional box at the end of this section if no changes were made to the Mid-Year reported data.

Item	Month 1	Month 2	Month 3	Month 4	Month 5	Month 6	Unduplicated Total
Unduplicated Enrollees	0	0	0	0	0	0	*

Item	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12	Annual Unduplicated Total
Unduplicated Enrollees	178	0	*	*	*	16	202

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	0	0	0	0	0	0	0
Service 2							
Utilization 2	0	0	0	0	0	0	0

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	0	0	0	0	0	0	0
Service 2							
Utilization 2	0	0	0	0	0	0	0

Whole Person Care

County of Santa Cruz Health Services Agency; WPC - Cruz to Health

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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	$							
MM Counts 1		0	0	0	0	0	0	0
Bundle #2	$							
MM Counts 2		0	0	0	0	0	0	0

PMPM		Amount Claimed						
	Rate	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12	Total
Bundle #1	$502.24	$55245.96	$55245.96	$55748.20	$57254.90	$57254.90	$57757.14	$338507.06
MM Counts 1		110	110	111	114	114	115	674
Bundle #2	$501.15	$89205.41	$89205.41	$89706.57	$91711.18	$92212.34	$100230.80	$552271.71
MM Counts 2		178	178	179	183	184	200	1102
Bundle #3	$717.53	$33723.91	$35158.97	$33723.91	$*	$*	$*	$107629.50
MM Counts 3		47	49	47	*	*	*	160
Bundle #4	$170.63	0	0	0	$6825.0	$6995.63	$7166.25	$20986.88
		0	0	0	40	41	42	123

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

Referral and Enrollment Process

Program referrals during PY2 were collected from multiple sources including reports from the lead entity's electronic health record systems (Epic – Clinics, Avatar – Behavioral Health), Dignity Health's Dominican Hospital's High Utilizer Group (HUGs) list, various internal referrals (Homeless Persons Health Project, Integrated Behavioral Health program, Specialty Mental Health treatment teams, Emergency Medical Services), and other sources (e.g. family, self, community partners). Our program's initial enrollment process involved a 2-step approach:

1) Administrative Enrollment: The Administrative Team screens a referral for eligibility and documents each screening outcome by enrollment status and date.

2) Consent to Release of Information & Agreement to Participate: The Administrative Team and/or existing case managers/providers facilitate an official onboarding process, including required documents (Consent Form/ROI and Agreement to Participate).

Once enrollees are officially consented into the program's enhanced data-sharing, the Admin team plans to tag the enrollee in each EHR system as a WPC participant. For the first cohort identified in Quarter 3, notification letters were mailed out to individuals announcing their eligibility for the WPC's and new services.

Several factors delayed the official onboarding/consenting process for our PY2 enrollees, including a slower than anticipated turnaround time for County Counsel to approve the program's consent form, in addition to a long recruitment process for the new case management positions with the Integrated Behavioral Health program. These new hires will be tasked with assisting the WPC Admin Team in consenting the enrollees.

Program PMPM and FFS Utilization

No FFS services were utilized in PY2 but the pilot anticipates the FFS for Housing Assistance will be used in PY3 as there are many homeless enrollees who will be referred to Housing Navigation services following their official consent process.

Revisions were made to the PY2 Quarter 3 and Quarter 4 Enrollment and Utilization Reports which included correcting enrollment dates and bundle utilization for participants who had been receiving program services earlier than previously noted.

- Clinical Bundle utilization was expanded to all WPC enrollees as more clinical oversight and support from the primary care clinics is necessary to help manage our target population, particularly the dually diagnosed (mental Illness and chronic disease). Furthermore, the referral and enrollment process for all enrollees requires significant program support, data management, and planning for enhancement to existing IT infrastructure. Such bundle utilization was applied to the PY2 Quarter 4 report and will be applied to future reports.

- Intensive and Intermediate Housing Supports Bundles were adjusted to account for additional information from the contractor providing the services.
- Utilization in the Intensive Housing Support bundle exceeded the maximum approved members months of 150 for PY 2 by 10 member months. The utilization reported is 160 member months, however, the total amount claimed does not exceed the maximum member months of 150, per contract requirements.

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.

Administrative Infrastructure

WPC – Cruz to Health was able to expand administrative infrastructure to assist with the initial implementation of the pilot. The Admin Team is the core staffing to support the operations, implementation, reporting, and quality improvement activities for the pilot.

The Administrative Infrastructure includes a Program Director, Program Support (Administrative Aide), Quality Improvement Manager, and a Fiscal Manager. Although not all Administrative positions were fully staffed for the entirety of PY2, these positions proved vital for the coordination and implementation of the grant. The Admin Team developed an initial referral and enrollment tracking process making it possible to more efficiently determine eligibility criteria and administratively enroll eligible referrals. The Admin Team continuously made improvements in the referral and enrollment process throughout PY2.

The WPC Admin Team established the organized governance structure and began facilitating planning and governance meetings related to pilot implementation. The Admin Team provided presentations to stakeholders and partners, developed program materials, facilitated planning meetings. Additionally, the Admin Team provided monthly data reports and project updates, created a preliminary Consent Form (release of information), Agreement to Participate form, and continuously developed administrative policies and procedures related to the framework for referral and enrollment as well as the data sharing and care coordination infrastructure.

In July 2017, the Quality Improvement Manager t was hired on a part-time extra-help basis while the limited-term, full-time position was later filled on December 30¬, 2017. The Program Director was hired on a part-time extra help basis in early August while the limited-term full-time Program Director position was recruited and selected for by the end of 2017 and filled in early PY3. The Administrative Aide position was filled on November 29, 2017. The Fiscal Manager position was filled in September 2017.

WPC – Cruz to Health computer equipment, hybrid vehicle, and miscellaneous office supplies were expensed during PY2, expanding administrative infrastructure needed to support the program and its goals.

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.

Delivery Infrastructure
During PY2, the WPC Admin team was able to identify enrollees through the lead entity's existing EHR databases and IT infrastructure (Epic, Avatar, and Santa Cruz HIE). Coordination and collaboration with the IT teams working on the existing Epic and Avatar integration efforts began in PY2. During PY2, several telecommunication devices (smartphones) were purchased and deployed for the WPC – Cruz to Health Program Director and Quality Manager.

WPC – Cruz to Health began building its Delivery Infrastructure through procurement of 100 telehealth devices to help manage chronic co-occurring medical and psychiatric conditions in clients' homes and/or non-medical residential settings. The devices were contracted and invoiced for, but delivery is not expected until Quarter 2 of PY3 due to preparing the devices for technical specifications. Some telehealth device costs from the PY2 Delivery Infrastructure budget were not expensed in PY2 as planned (e.g. device monitoring fees). The purchase of these devices will assist WPC - Cruz to Health enrollees with improved care management of chronic co-occurring conditions and will allow clients to live outside of unnecessary medical settings.

Since Quarter 4 of PY2, Santa Cruz Health Information Organization (SCHIO) has taken the lead on identifying and designing a data-sharing and care coordination solution for the WPC – Cruz to Health program and broader community. During PY2, the SCHIO and the Data/IT Workgroup designed a survey to learn about the various data-sharing gaps in the community related to care coordination for our target populations. From the initial survey and preliminary planning meetings, the SCHIO and Data/IT Workgroup planned to more fully understand the needs through individual "discovery" sessions with partners and providers in early PY3. SCHIO's Health Information Exchange (SCHIE) is already integrated with CrossTx, a cloud-based, HIPAA-compliant care coordination and referral management platform. The WPC Admin Team and SCHIO have been fully engaged in identifying specific data-sharing needs across the community to design the ideal application for the program's Admin Team, providers, contractors, and WPC – Cruz to Health community partners. However, the pilot experienced contracting delays as the Scope of Work and SCHIO contract amendment was not fully negotiated during PY2, thus the funds were unspent in PY2 (requested for rollover into PY3).

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.

Incentive Payments

During PY2, the system for reporting and payment was being developed so that metrics and milestones could be tracked for Primary Care Physician (PCP) Follow-Up Appointments, Behavioral Health Follow-Up Appointments, and Telehealth Device Utilization.

Primary Care Clinic Follow-up Incentive: Santa Cruz County's Health Services Agency's primary care clinics successfully scheduled a follow-up appointment for 90 participants within 7 days of or discharge from hospital or release from jail, triggering the payment of $300 per program participant scheduled within 7 days post discharge or release. Primary Care Clinic Follow-Up incentive payments totaled $27,000 for PY2.

Behavioral Health Clinic Follow-up Incentive: Santa Cruz County's Health Services Agency's Behavioral Health Services successfully scheduled and completed follow-up appointments for 12 participants within 7 days post hospital discharge or jail release, triggering the payment of $300 per program participant scheduled and participation in follow-up appointment. Behavioral Health Clinic Follow-Up incentive payments totaled $3,600 in PY2.

Telehealth Device Utilization Incentive: PY2 Telehealth Device Utilization incentive payments are tied to individuals' consistent use of the telehealth devices (75% or greater and 85% or greater use). The Philips telehealth device contract was not fully executed until PY3 so devices were not deployed to enrollees during PY2 resulting in zero incentive payments for Telehealth Device Utilization. The device procurement date is projected to be 8-10 weeks after execution of the contract (determined by Philips). Although no incentive payments were made, the Admin Team identified a need to amend a contract with an existing service contractor to provide this incentive for their clients' consistent use of telehealth devices going forward.

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.

WPC - Cruz to Health's approved contract does not include Pay for Outcome metrics for PY2. Pay for Outcomes become earnable in PY3.

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.

Stakeholder Engagement

During PY2, the WPC – Cruz to Health Admin Team established the program's governance structure comprised primarily of program managers and community stakeholders. The development of this structure included the scheduling, coordination, and facilitation of routine stakeholder meetings for the Management Committee, WPC – Cruz to Health Leadership team meeting, the Advisory Council, and four workgroups

The Management Committee and the subgroup WPC – Cruz to Health Leadership Team are comprised of individuals in leadership roles within the lead entity, County of Santa Cruz's Health Services Agency. Members include division leaders, supervisors, analysts, and fiscal managers from the Behavioral Health Division, Clinics Division, and Public Health Division. The program's Leadership Team is a core planning group made up of the WPC – Cruz to Health Admin Team, Director of Behavioral Health Services, Director of Adult Mental Health Services, Chief of Psychiatry, and the Integrated Behavioral Health Directors.

The Advisory Council is comprised of County department and program staff, community service providers, service contractors, and peer and advocacy organizations who work with the WPC - Cruz to Health target populations. The Advisory Council includes four workgroups charged with developing infrastructure, outlining policies and procedures, and trouble-shooting pilot challenges related to Clinical Care, Care Coordination, Fiscal, and Data/IT needs.

WPC – Cruz to Health's key partners include: County of Santa Cruz Health Services Agency, Central California Alliance for Health, Santa Cruz Health Information Organization, Dignity Health Dominican Hospital, Watsonville Community Hospital, Housing Authority of the County of Santa Cruz, Human Services Department, Homeless Services Center, Santa Cruz County Sheriff's Department (Probation), Janus of Santa Cruz, Telecare (PHF), Front Street Inc., Encompass Community Services, National Alliance on Mental Illness (NAMI), Health Improvement Partnership of Santa Cruz County (HIP), Dartmouth University, Philips North America, OCHIN, and NetSmart.

PY2 Stakeholder Engagement Activities List - See attachment "Whole Person Care - Cruz to Health Stakeholder Engagement Meetings (Program Year 2)"

IX. PROGRAM ACTIVITIES

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

(1) High Utilizer Meetings: One of the two local safety-net hospitals, Dominican Hospital, hosts monthly High Utilizer Group (HUGs) meetings to discuss care coordination for recent high utilizers of Dominican's ED. The Admin team and partners attend these meetings which serve as a starting point for program referrals and will eventually be a model and catalyst for case conferencing and quality improvement projects related to the pilot.

(2) SC Health Information Exchange: Santa Cruz Health Information Organization (SCHIO) runs one of the country's oldest health information exchanges, Santa Cruz Health Information Exchange (SCHIE) giving WPC - Cruz to Health's data-sharing infrastructure an immediate jump start. Prior to the implementation of the pilot, the SCHIE was already integrated with a care coordination/case management/referral management application called CrossTx. Much work remains in building the application to suit the specific needs for the pilot, but this provides a foundation from which to build a data-sharing solution.

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

(1) Staffing: The program was not fully staffed with the Integrated Behavioral Health Case Managers and Case Management Supervisor to provide all the case management services that are key to the program. These new Case Managers will assist in efficiently consenting enrollees to the expanded information-sharing aspect of the program. The Admin Team has identified alternative ways to consent individuals in the absence of program Case Managers.

(2) Other case management programs: HSA and other partner organizations received funding to launch similar case management programs around the same time as WPC – Cruz to Health's implementation. Understandably, HSA staff and community partners have been confused on which program provides what, for whom, and for how long. The Admin Team identified a need to provide system maps, crosswalk materials, and opportunities to align the various programs through community collaboration. Health Improvement Partnership (HIP) of Santa Cruz has been a key partner in bridging the programs and partners and will continue to move forward in that work by coordinating care coordination collaboration meetings, learning opportunities, and evidence-based case management trainings.

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

(1) SC Health Information Exchange: The County of Santa Cruz has a culture already interested and motivated to share data to streamline services to improve client care and outcomes. Leveraging these existing resources and beliefs are key to supporting the expansion and enhancements of data sharing through WPC - Cruz to Health.

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

(1) Avatar data: The County of Santa Cruz, Health Services Agency (HSA), Behavioral Health Division's version of Avatar is not the same as the local psychiatric hospital's version of Avatar. Both versions of Avatar do not already integrate with the current HIE. This challenge has been identified and solutions are being considered, but it exemplifies the need for coordination of data platforms throughout the County and its partner/contractor agencies. This could lead to larger systems level discussions around best practices in selecting EHRs and data packages.

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

(1) Central California Alliance for Health (CCAH): A previous agreement between CCAH and Monterey County's WPC pilot program allowed for a quicker process for WPC - Cruz to Health to start conversations around data-sharing with CCAH.
(2) Emergency Medical Services (EMS): Despite not being a required grant metric, it was important to the WPC - Cruz to Health pilot to collect and monitor EMS utilization data on enrollees and to receive referrals. The County of Santa Cruz's EMS program operates out of HSA's Public Health Division, which allows for efficient data reporting of EMS utilization.

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

(1) Variant EHRs: Having different EHR systems between HSA's Clinics and Behavioral Health Division (Epic and Avatar, respectively) has historically made care coordination and data sharing very challenging. This continues to be a challenge that WPC - Cruz to Health will face and seeks to find solutions and innovations to overcome.
(2) Delays in data collection: Despite having an existing SCHIO in Santa Cruz County, there have been unexpected delays in data collection and reporting from the SCHIO, which is a key source of WPC - Cruz to Health participant data. The pilot also experienced other delays in data reporting from other sources.

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

(1) Housing: Affordable housing stock is extremely limited in Santa Cruz County. Lack of resources for enrollees to pay for housing rent even once identified, may also be a barrier for many of our participants.
(2) Data-sharing: Navigating the regulations around information sharing, particularly around substance use data, will remain a challenge for our WPC Admin Team and partners. Communicating and interpreting the regulations to stakeholders will also be a critical for the pilot.
(3) Related programs: Managing the interactions of the various case management programs situated in our community and specifically in the Health Services Agency will become a barrier due to confusion, fear of duplication and competing for scarce resources.

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.

- WPC.Cruz to Health_PDSA Summary Report_PY2
- WPC.Cruz to Health_PDSA Report_PY2 Q3_Ambulatory ED Care
- WPC.Cruz to Health_PDSA Report_PY2 Q4_Ambulatory ED Care
- WPC.Cruz to Health_PDSA Report_PY2 Q3_Inpatient Hospitalization
- WPC.Cruz to Health_PDSA Report_PY2 Q4_Inpatient Hospitalization
- WPC.Cruz to Health_PDSA Report_PY2 Q3_Comprehensive Care Plan
- WPC.Cruz to Health_PDSA Report_PY2 Q4_Comprehensive Care Plan
- WPC.Cruz to Health_PDSA Report_PY2 Q3_Care Coordination_HIO Application
- WPC.Cruz to Health_PDSA Report_PY2 Q4_Care Coordination_HIO Application
- WPC.Cruz to Health_PDSA Report_PY2 Q4_Data_Consent Form