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
Whole Person Care – Cruz to Health (WPC – C2H)
Annual Report PY3
Submitted: May 3, 2019

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

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

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

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

- Support and buy-in for improved data sharing, consenting processes, and understanding of care coordination/case management in Santa Cruz County continues to grow and expand in reach through Whole Person Care – Cruz to Health (WPC – C2H). There is strong momentum towards the end of PY3 for events and workgroups pending in early PY4 around these topics.

Increasing coordination and appropriate access to care

- Hiring three WPC – C2H case managers/care coordinators and a case manager supervisor embedded in the Integrated Behavioral Health (IBH) clinic setting to provide specialized case management and complex care coordination services for high utilizers continues to be an area of great success, opportunities for lessons learned and improved integration between behavioral health and clinical health services.

Successfully identifying supported housing for WPC – C2H enrollees

- Through collaborative planning and development with partner agencies and stakeholders, designated supported housing units for WPC – C2H enrollees were secured in PY3. Creative strategies using master leasing and shared housing models proved to ensure these new units were made available to some of our most vulnerable and difficult to house enrollees.

Challenges

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

- Integration between the medical and behavioral health providers continue to be a challenge through the systems of care. The nature of how data is shared in electronic health records as well as the culture of service delivery leads to siloed activities. This is an area that requires additional focus from WPC – C2H, including

systems-wide strategies and innovations that will test how providers can work differently together.

Slow speed of technology infrastructure improvements

- Technological infrastructure activities have taken longer than originally anticipated due to the nature of working towards new and/or innovative technology. WPC – C2H works with multiple electronic health vendors, data sharing vendors, and contractors who have competing deadlines and projects, and who also must find solutions to implementing new concepts to their platforms. Delays are frequent and sometime unavoidable, even with increased resources and focused workplans in place.

Workforce development and retention

- Across partner agencies, including the County of Santa Cruz and contractors, there exist ongoing challenges with recruiting and retaining a workforce with the skills, interest and ability to work with a target population experiencing multiple chronic health and behavioral health conditions. A high cost of living in Santa Cruz, plus a competing marketplace for jobs in the neighboring Silicon Valley confound the problem. Additionally, retaining staff due to burnout, lack of dedicated professional development resources, and other related issues cause turnover, which impacts continuity of service delivery in some cases. These challenges have impacted progress of some infrastructure improvements and service delivery.

Lessons Learned

- ***Communications and clarification of WPC – C2H*** to internal and external stakeholders are critical to the long-term success of the innovations being piloted. Additional communications around the systems change and infrastructure development as part of WPC – C2H will be necessary throughout PY4 and PY5 for lasting impacts.

- ***Supporting the workforce being recruited, hired and retained*** as part of WPC – C2H. A deficiency of resources towards training, retention and building a professional network for staff conducting care coordination, housing navigation, and peer support became apparent in PY3, which is an area for innovation and growth in PY4 and PY5.

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	27	18	19	19	60	16	132

Item	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12	Annual Unduplicated Total
Unduplicated Enrollees	9	1	5	0	21	10	46

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

Costs and Aggregate Utilization for Quarters 1 and 2							
FFS	Month 1	Month 2	Month 3	Month 4	Month 5	Month 6	Total
Housing Support Total Costs	$0	$0	$6,645.51	$1,194.00	$5,003.50	$6,815.00	$19,658.01
Housing Support Utilization	0	0	5	3	5	7	20
Tenancy Supports Total Costs	$0.00	$0.00	$0.00	$0.00	$0.00	$2,139.40	$2,139.40

Costs and Aggregate Utilization for Quarters 1 and 2							
FFS	Month 1	Month 2	Month 3	Month 4	Month 5	Month 6	Total
Tenancy Supports Utilization	0	0	0	0	0	7	7
Outreach and Referrals Costs	0	0	0	0	0	0	0
Outreach and Referrals Utilization	0	0	0	0	0	0	0
Screening, Assessment and Eligibility Costs	0	0	0	0	0	0	0
Screening Assessment and Eligibility Utilization	0	0	0	0	0	0	0

Costs and Aggregate Utilization for Quarters 3 and 4							
FFS	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12	Total
Housing Support Total Costs	$6,146.08	$4,943.00	$3,525.00	$3,600.00	$7,338.50	$1,154.00	$26,706.58
Housing Support Utilization	5	5	3	1	4	1	19
Tenancy Supports Total Costs	$2,139.40	$0.00	$799.03	$615.55	$435.16	$958.04	$4,947.18
Tenancy Supports Utilization	4	0	2	2	1	2	11
Outreach and Referrals Total Costs	$2,800.00	$1,050.00	$1,400.00	$4,900.00	$1,400.00	$1,050.00	$12,600.00

Costs and Aggregate Utilization for Quarters 3 and 4							
FFS	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12	Total
Outreach and Referrals Utilization	16	6	8	28	8	6	72
Screening, Assessment and Eligibility Total Costs	$4,800.00	$1,800.00	$2,400.00	$8,400.00	$2,400.00	$1,800.00	$21,600.00
Screening, Assessment and Eligibility Utilization	16	6	8	28	8	6	72

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 - Behavioral Health	$502.24	$40,179.09	$43,694.76	$44,699.24	$28,125.37	$28,627.60	$29,129.84	$214,455.91
MM Counts 1		80	87	89	56	57	58	427
Bundle 2 – Clinical	$501.15	$74,169.79	$83,190.44	$92,211.09	$82,689.29	$112,758.12	$120,275.33	$565,294.07
MM Counts 2		148	166	184	165	225	240	1,128
Bundle 3 - Intensive Housing Support	$717.50	$2,152.50	$3,587.50	$7,892.50	$17,220.00	$21,525.00	$21,525.00	$73,902.50
MM Counts 3		3	5	11	24	30	30	103

Amount Claimed								
PMPM	Rate	Month 1	Month 2	Month 3	Month 4	Month 5	Month 6	Total
Bundle 4 - Intermediate Housing Support	$170.63	$1,194.38	$1,194.38	$1,023.75	$2,388.75	$3,412.50	$3,753.75	$12,967.50
MM Counts 4		7	7	6	14	20	22	76

Amount Counts								
PMPM	Rate	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12	Total
Bundle 1 - Behavioral Health	$502.24	$17,578.35	$19,587.31	$19,587.31	$35,156.71	$32,143.27	$31,138.80	$155,191.75
MM Counts 1		35	39	39	70	64	62	309
Bundle 2 - Clinical	$501.15	$124,284.51	$123,282.22	$127,291.39	$114,261.57	$124,785.66	$131,801.72	$745,707.07
MM Counts 2		248	246	254	228	249	263	1,488
Bundle 3 - Intensive Housing Support	$717.50	$14,350.00	$14,350.00	$10,762.50	$11,480.00	$10,762.50	$7,175.00	$68,880.00
MM Counts 3		20	20	15	16	15	10	96
Bundle 4 Intermediate Housing Support	$170.63	$6,825.00	$7,678.13	$6,995.63	$6,313.13	$7,336.88	$8,190.00	$43,338.75

Amount Counts								
PMPM	Rate	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12	Total
MM Counts 4		40	45	41	37	43	48	254

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

Referral and Enrollment Process

- 205 total new enrollments during PY3
- During PY3, 62 referred and checked for eligibility but not enrolled due to missing criteria (i.e. out of county, no mental health or substance use diagnoses, etc.)
- WPC Administrative Aide gained access to HMIS system to verify clients' information and look up VI-SPDAT scores (September 2018)
- Completed checking eligibility for waitlisted individuals (December 2018)
- Developed and began testing an Internal Data Collection Tool to ensure collection of the most accurate data from multiple systems to facilitate referral processing and eligibility screening (December 2018)
- WPC Administrative team developed and began testing standard operating procedures to streamline and focus the referral processing across multiple electronic record systems.

Program PMPM and FFS Utilization

- **Intensive and Intermediate Housing Supports Bundles**

The utilization of these bundles that began in PY3, including housing navigation and peer support coach services, increased in popularity and need with the enrolled population. However, challenges were encountered during PY3 as the full staffing of housing navigators was not fulfilled during the year due to difficulties in recruiting and retaining housing navigators by the contract agency. Additionally, peer support coaches experienced a staffing shortage due to an extended leave by one peer support coach. These bundles continue to be requested and needed by care coordinating staff on behalf of enrollees. WPC – C2H is committed to working with the contract agency to support the workforce in order to maintain staffing to meet PMPM reach in PY4.

- **Behavioral Health Bundle**

Delays in recruitment of the full staff for case management led to a reduced utilization of this PMPM bundle during PY3. Caseloads have been in flux due to these staffing challenges, which are likely to impact utilization in PY4.

- **Housing Support and Tenancy Support Fee For Service**

Enrollees were able to access these new FFS items in PY3. However, utilization of these services were lower than anticipated, due in part to the difficulties in successfully housing enrollees. Also, the FFS rates approved were higher than the actual cost utilization per enrollees using the FFS items.

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.

WPC – C2H continued to solidify the administrative infrastructure to ensure successful implementation of the pilot. The Admin Team is the core staffing of WPC – C2H, which supports the operations, implementation, reporting, and quality improvement activities for the pilot. During this reporting period, the Administrative Infrastructure staff were successfully hired, which included a smooth transition of the Quality Improvement Manager role to a new hire in September. The Program Support role has seen an increase in workload related to referrals and supporting direct service administration, thus a request to increase the FTE to 0.85 FTE was approved in the PY3 Mid-Year budget adjustment. The Fiscal Manager role saw a lower workload required than 1.0 FTE, and a request to reduce 0.40 FTE was approved.

The Administrative Infrastructure expenditures primarily supported the staffing of the core WPC – C2H Admin Team. The Admin Team devoted significant time on launching the FFS and PMPM services during PY3, ensuring contracts were secured and operational, staffing was hired for the required roles, as well as supporting developing policies, procedures and implementation strategies. Additionally, the Admin Team were instrumental in leading, facilitating and cultivating the stakeholder groups in WPC – C2H, including the Advisory Council, Leadership Team, and Data and Care Coordination Workgroups.

With the launch of direct services, the Admin Team were able to focus significant energies towards the systems changes required for success in WPC – C2H, such as efforts towards improved data sharing and integrations in technology, as well as strategies towards improved care coordination and integration across county providers.

Process Improvement activities increased in PY3, with the Quality Improvement Manager documenting and tracking numerous lessons learned and best practices that have resulted from early activities in WPC – C2H, which will be invaluable as the pilot moves towards sustainable and scalable efforts. Admin Team staff attended process improvement trainings and began planning for an intensive Lean Six Sigma Green Belt process improvement training for early PY4.

Additional expenditures included miscellaneous office supplies to support the program and goals. The WPC – C2H team also utilized travel expenses to attend the two WPC Statewide Convenings in April and September.

V. NARRATIVE – Delivery Infrastructure

Please describe the delivery infrastructure that has been developed as a result of these funds and how it relates to achievement of pilot goals. Reimbursement will be based on actual pilot expenditure for the final deliverable or outcomes, up to the limit projected or estimated costs in the approved budget.

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

During PY3, WPC – C2H began development of Together We Care (TWC) with Santa Cruz Health Information Organization (SCHIO). TWC will become WPC – C2H's key portal for care coordination, shared care plans, referrals and management of eligibility of consented patients. While progress was made, with discovery sessions, demos of the platform, pilot testing of training modules for users and intensive improvement planning sessions, TWC is still in development. The delays led to a requested reduction in this line item for PY3.

During this reporting period, WPC – C2H hired a new program coordinator to oversee implementation of electronic health record (EHR) integration projects and activities, including telehealth monitoring data interfaces with EHRs. Interfaces with the EHRs and telehealth monitoring devices are underway, plus the telehealth monitoring devices were deployed in a small pilot, with plans to scale up in PY4.

Additionally, WPC – C2H engaged in contract services with Health Improvement Partnership (HIP), a key stakeholder and partner in the community, that serves as a convener and facilitator of strategic activities. HIP led the design and planning of the data sharing convenings scheduled in PY4 through collaborative meetings with stakeholders, focused on increased buy-in for bi-directional data sharing and universal consent processes in the County for WPC – C2H.

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.

Primary Care Physician (PCP) Follow-Up Appointments and Behavioral Health Follow-Up Appointments
Due to difficulties of maintaining clinic staffing and provider shortages, reductions in these incentive payments were requested and approved in PY3.

Primary Care Clinic Follow-up Incentive: Santa Cruz County's Health Services Agency's (HSA) primary care clinics successfully scheduled a follow-up appointment for 107 participants in PY3 within 7 days of 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 $32,100 for PY3. Payment made to HSA Clinics Division.

- Office visits completed by physician, PA, NP, RN
- Hospital discharges collected from HIE (Dominican Hospital and Watsonville Community Hospital only)

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 107 participants in PY3 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 $32,100 for PY3. Payment made to HSA Behavioral Health Division

- Appointments completed by mental health clinician (Psychiatrist, NP, LCSW, Licensed Clinical Psychologist)
- Hospital discharges collected from Avatar, including out-of-county facilities

Device Utilization Incentive: The Device Utilization launched in October 2018 with a small test of users. Due to the small pilot and delayed start, only one month of one participant met the 85%-100% benchmark in PY3, earning $75.00. Payment made to WPC-C2H enrollee.

Additional incentives were approved in the PY3 Mid-Year Adjustment and Rollover, with the following highlights:

- Collaborative Discovery and Planning Meetings were held throughout PY3 that helped WPC – C2H focus on key infrastructure improvements, innovations, and strategies. These meetings included stakeholders from throughout the county and have improved buy-in for the pilot. $10,000 was earned per meeting, totaling 20 meetings in PY3. Payment made to HSA.
- Psychiatry Leadership were involved in meetings throughout PY3, with more than 5 meetings achieved in this reporting period. This included attendance and active engagement of psychiatric leadership, including the HSA Chief of Psychiatry and lead psychiatrist from Integrated Behavioral Health. Their participation in Leadership meetings, workflow planning meetings for the Health Monitoring Devices and data sharing discussions increased representation of the complex clinical/psychiatric needs of enrollees. $2,002.84 was earned per documented meeting involvement of psychiatric leadership, totaling 5 meetings. Payment made to HSA Behavioral Health Division.
- Identify Data Sharing Infrastructure Expert Consultation was an important activity to ensure progress in the data sharing application development with the SCHIE. Intrepid Ascent was identified as the vendor for this consultation. Intrepid Ascent works with multiple Whole Person Care pilots across the state and provides a broad and extensive expertise with data sharing application development, project management and state policies. $55,000 was earned with this deliverable. Payment made to HSA.
- Lessons Learned Towards Best Practices were tracked and documented by the Quality Improvement Manager across the various activities in WPC – C2H. These lessons learned will be applied through PY4 and PY5 as attention turns toward sustainability and scaling of successful activities. $10,000 was earned per documented lessons learned, totaling 41 lessons learned. Payment made to HSA Behavioral Health Division.
- Design and Plan for Health Monitoring Device Interfaces with EHRs were key activities towards integrating the flow of information entered by patients on the new health monitoring devices to two EHRs. Extensive development time was committed to ensure implementation of this innovation would be successful for use through the pilot. $50,000 was earned with this deliverable. Payment made to HSA.
- Professional Development trainings on process improvements were completed to enhance staff ability to support PDSAs. $40,000 was earned for this deliverable. Payment made to HSA
- Identification of a Peer-Based Day Program Vendor was completed in PY3 (Community Connections) to operate a peer-based program for homeless and co-occurring clients. $50,000 was earned for this deliverable. Payment made to HSA Behavioral Health Division.

- Participation in Smart Path for Housing as part of the county's new coordinated entry system was an important integration step related to successfully housing WPC – C2H enrollees. WPC – C2H staff and contractors were trained in the assessment implementation and actively participate in Smart Path to ensure enrollees have access to the array of housing opportunities. $15,000 per staff trained, totaling 10 staff completing the training and participating. Payment made to HSA
- Barriers identified to secure Supportive Housing dedicated to WPC – C2H enrollees is a new and promising activity begun in PY3. 10 supportive housing units were identified, secured and made available to enrollees, due to collaborations with partner agencies to identify and reduce barriers. These units increase access to housing for some of the most vulnerable enrollees that would otherwise not have housing options in the community. $17,500 was earned per barrier reduced/unit secured, totaling 10 units. Payment made to HSA Behavioral Health Division.
- Development and implementation of HIE notification of ED use in PY3 within Epic EHR is a new integration with potential to actively notify care team members of enrollees' admission and discharge to local emergency departments. This valuable integration will improve how enrollees are coordinated during inpatient and upon discharge for a more seamless flow of services. $40,000 was earned for this deliverable. Payment made to HSA.
- HIE notifications of ED use incentives were not earned in PY3 due to technical difficulties with the system sending messages to users directly. Fixes and tests to repair the issue began at the end of PY3.
- Design and planning of population health reporting tools were completed, including comparing/contrasting softwares and technologies most appropriate for WPC – C2H activities. $22,751.45 was earned for this deliverable. Payment made to HSA

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.

PY3 outcomes were tracked throughout the year, with the metrics reported summarized below:

Health Outcomes: Follow-up After Urgent Appt (Metric 16 - Timely Care Management and Enrollment)

a. Performance – Not met: target of 80% or greater WPC – C2H participants would receive a routine follow-up after initial urgent appointment that occurred within 7 days of the patient's recent discharge. In PY3, 27% was achieved.
b. Challenges – Information sharing between the WPC program and SCHIO has been difficult, which makes it difficult for the program to actively monitor progress towards achieving the outcome. In addition, the lack of information sharing negatively affects the timely follow up of providers after discharge.
c. Lesson Learned – The WPC program needs to work with SCHIO to build better reporting templates that allow for weekly and/or monthly reporting. In addition, the WPC program needs to communicate information found through reporting with providers in order to effectively engage clients after discharge.

Health Outcomes: 12 Months Coordinated Case Management (Metric 17 - 12 Months Coordinated Case Management)

a. Performance – Metric was not met because clients being served in case management have not been in the program long enough to receive the services for 12 months in order to meet the 25% or more achievement.
b. Challenges – Due to WPC – C2H operational delays in PY3 specific to staffing and hiring within the County of Santa Cruz, the program is unable to report data for this outcome. Reporting specifications outlined for this outcome require for the program to report the number of WPC – C2H clients who have received 12 months of case management services. As a result of the delays mentioned, the program was unable to hire qualified case managers to deliver at least 12 months of case management services. Case management services were not launched until April 2018. Based on this information, no client meets the reporting guidelines outlined in this outcome.
c. Lesson Learned – Launching new services that include hiring additional County staff often takes longer than anticipated. Starting the hiring process sooner, working more closely with Personnel and looking for alternative ways to provide services were all lessons learned from this process.

The following outcomes were requested and approved to be removed from WPC – C2H's reporting requirements:

- The Comprehensive Care Plan
- SBIRT Assessment
- Tobacco Assessment and Counseling

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 activities continued and grew extensively throughout PY3. Adjustments to regular workgroup and governance meetings were made to maximize the use of stakeholder time and resources. The Advisory Council and Data Workgroup moved to every other month meetings. The Care Coordination Workgroup shifted to smaller adhoc groups, including a steering committee, to focus on activities and deliverables that would result from smaller group-based work. The WPC – C2H Leadership group shifted to meeting every other week. These changes have not reduced, but in some manners have improved engagement and interest through more concentrated use of time and working with stakeholders in more intimate settings for higher productivity and results. Stakeholders remain positive and encouraging about the pilot, including showing strong support for the innovative, systems-wide, and process improvement focused activities. Support for convening and facilitation of stakeholders and partners was supported through a new contract with Health Improvement Partnership (HIP), a local nonprofit coalition of public and private health care leaders dedicated to increasing access to health care and building stronger local health care systems.

PY3 Annual Stakeholder Engagement Activities List

See pages 21-25 “Whole Person Care - Cruz to Health
Stakeholder Engagement Meetings (Program Year 3 Annual, July - Dec)”

IX. PROGRAM ACTIVITIES

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

(1) **Continued improved integration with providers:** Care coordination continues to use "step-ins" with clients for their medical and psychiatric appointments, which supports speedy referrals, recommendations, and follow-up on medical and behavioral health appointments. WPC – C2H case managers have increased documentation in Epic EHR, which allows for increased communication and care coordination planning with providers.
(2) **Care coordination meetings:** Case managers frequently meet with care coordination teams which include but are not limited to meetings with PCP, psychiatrist, PNP, therapists, housing support and peer support coaches. Establishment of weekly meetings with the Peer Support Coach team has also improved care coordination efforts.

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

(1) **Limited Services for Specialized Patients:** A major challenge in care coordination continues to be the availability of services for the level of care that some of the most vulnerable clients need with certain complex needs, such as assisted living, skilled nursing facilities (SNFs), and long-term inpatient treatment services. WPC – C2H is highly sensitive to supporting and encouraging expansion of these services in the county, as well as working towards solutions to ensure enrollees are in the right level of care.
(2) **Availability of shelters/transitional or bridge housing:** The city and county of Santa Cruz is experiencing a housing emergency of unsheltered homeless individuals. There are insufficient shelter beds throughout the community, which directly impacts WPC – C2H enrollees seeking transitional housing during their path to wellness. Care coordination staff experience significant difficulties in stabilizing enrollees who cannot find bridge housing, especially for persons with mild to moderate diagnoses.

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

(1) **SCHIO to EHR ADT Notifications**: WPC – C2H staff in collaboration with the Santa Cruz Health Information Exchange Organization (SCHIO) established an ADT (Admission, Discharge, and Transfer) link between SCHIO's database and the County's Epic EHR. The link allows for real-time information sharing between SCHIO

to Epic via a notification, which is triggered when a tagged WPC – C2H client is admitted, discharged, or transferred. WPC – C2H staff is monitoring the notifications in order understand the level of information provided and develop a workflow for processing and response. This level of information sharing has a potential for improving follow up with clients and better coordination of care.

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

(1) **Developing a new data sharing application**: Embarking on a new data sharing application has taken extensive planning, coordination of partners and understanding of the key information that would be useful for a shared view of client information. Specifically, it has been difficult to identify an application that is able to provide multiple features (referral tracking, case management, team communication, clinical data sharing, dashboards, and reporting) within one system.
(2) **Consolidating multiple patient data sources**: Consolidating information for Medi-Cal and WPC – C2H eligibility checks and care coordination meetings (like Post HUGS) has been a significant and time-consuming challenge. Many data sources do not capture overlapping information which would allow for merging of datasets. As a result, it has been challenging to gain a clear picture for each client at a large scale and automating processes.

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

(1) **Housing Navigation and Peer Support data**: The WPC – C2H Admin Team successfully received reports from Front St, our contract provider of the intermediate and intensive housing support bundles for the new sets of services for housing navigation and peer supports, despite the provider having no EHR system or database to document such non-billable services. The processes used to effectively exchange information are continuously modified and improved over time.
(2) **SCHIE and EHR data**: The WPC – C2H Admin Team successfully acquired complex and extensive data from the Santa Cruz Health Information Exchange (SCHIE), operated by SCHIO, and EHRs, despite many challenges around different data sources, reporting mechanisms, and dataset formats. The processes used to effectively exchange information are continuously modified and improved over time.

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

(1) **Medi-Cal coverage dates:** Historical and valid Medi-Cal coverage dates have been difficult to obtain, which creates a significant challenge to successfully analyzing the many required WPC metrics. This challenge significantly affects the program's ability to automate the checking of client Medi-Cal coverage status in real time.

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

(1) **Housing:** The housing crisis and number of unsheltered homeless in the county of Santa Cruz remain a key barrier towards ensuring enrollees' path to wellness. The inability to safely shelter enrollees, due to lack of housing stock and funds to direct housing expenses, will continue to prevent true WPC – C2H program success.
(2) **Siloed resources:** With the focus on integration of care and services, WPC – C2H is seeking opportunities to collaborate, leverage, and coordinate throughout the system. However, the siloed resources and funding is a significant barrier that prevents or even discourages some of the integration efforts. Carve-outs and information sharing regulations are examples of barriers that will continue to hamper system-wide change and incentives towards integration.

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:

- WPC Santa Cruz PDSA Summary PY3 Annual Report
- WPC Santa Cruz PDSA Report - PY3 Q1 Ambulatory Care
- WPC Santa Cruz PDSA Report - PY3 Q2 Ambulatory Care
- WPC Santa Cruz PDSA Report - PY3 Q3 Ambulatory Care
- WPC Santa Cruz PDSA Report - PY3 Q4 Ambulatory Care
- WPC Santa Cruz PDSA Report - PY3 Q1 Inpatient Utilization
- WPC Santa Cruz PDSA Report - PY3 Q2 Inpatient Utilization
- WPC Santa Cruz PDSA Report - PY3 Q3 Inpatient Utilization
- WPC Santa Cruz PDSA Report - PY3 Q4 Inpatient Utilization
- WPC Santa Cruz PDSA Report - PY3 Q1 Comprehensive Care Plan
- WPC Santa Cruz PDSA Report - PY3 Q2 Comprehensive Care Plan
- WPC Santa Cruz PDSA Report - PY3 Q3 Comprehensive Care Plan
- WPC Santa Cruz PDSA Report - PY3 Q4 Comprehensive Care Plan
- WPC Santa Cruz PDSA Report - PY3 Q1 Care Coordination
- WPC Santa Cruz PDSA Report - PY3 Q2 Care Coordination
- WPC Santa Cruz PDSA Report - PY3 Q3 Care Coordination
- WPC Santa Cruz PDSA Report - PY3 Q4 Care Coordination
- WPC Santa Cruz PDSA Report - PY3 Q1 Data
- WPC Santa Cruz PDSA Report - PY3 Q2 Data
- WPC Santa Cruz PDSA Report - PY3 Q3 Data
- WPC Santa Cruz PDSA Report - PY3 Q4 Data

Whole Person Care - Cruz to Health
Stakeholder Engagement Meetings (Program Year 3 Annual, July - Dec)

DATE	PARTICIPANTS	PURPOSE
7/2/2018	WPC + Front St. Inc.	Discuss FY18-19 Budget
7/3/2018	WPC + WPC Lead Entities + DHCS	Discuss WPC programs with DHCS
7/5/2018	WPC + Philips	Discuss TeleFriend project
7/5/2018	WPC + Dartmouth University	Discuss Integrated Illness Management and Recovery (I-IMR) and TeleFriend device research study
7/9/2018	WPC + Care Coordination Steering Committee	Discuss planning for WPC Care Coordination Workgroup
7/10/2018	WPC + WPC Leadership	Discuss WPC program updates
7/11/2018	WPC + Philips	Discuss TeleFriend project
7/11/2018	WPC + Data IT	Discuss WPC Referral & Enrollment, metrics, Together We Care use for data-sharing
7/11/2018	WPC + County of Santa Cruz Clinics and Case Mgmt Staff	Post-High Utilizer Group (HUG) case conference
7/12/2018	WPC + WPC Lead Entities + DHCS	Discuss rollovers and budget adjustments
7/12/2018	WPC + Philips	TeleFriend deployment pre-planning
7/16/2018	WPC + WPC Lead Entities + DHCS	Discuss Technical Specifications
7/16/2018	WPC + 180/2020 Staff	Discuss 180/2020 program and Disabled and Medically Vulnerable Vouchers
7/17/2018	WPC + Philips	TeleFriend deployment pre-planning
7/17/2018	WPC + Insure the Uninsured Project (ITUP)	Discuss expanded coverage for mental health and SUD treatment and the advancement of integration of health, mental health, and SUD services.
7/18/2018	WPC + Philips	Discuss TeleFriend project
7/18/2018	WPC + Care Coordination Steering Committee	Discuss planning for WPC Care Coordination Workgroup
7/18/2018	WPC + County of Santa Cruz Fiscal Staff	Discuss WPC finances
7/18/2018	WPC + Intensive Case Management (ICM) Staff	Discuss care coordination between WPC and ICM
7/19/2018	WPC + County of Santa Cruz IT Staff	Discuss IT work around WPC w/focus on TeleFriend devices

DATE	PARTICIPANTS	PURPOSE
7/19/2018	WPC + Dartmouth University	Discuss Integrated Illness Management and Recovery (I-IMR) and TeleFriend device research study
7/19/2018	WPC + County of Santa Cruz Clinics Staff	Discuss test cases to determine procedures for TeleFriend devices
7/20/2018	WPC + WPC Lead Entities + DHCS	Discuss Technical Specifications
7/20/2018	WPC + Philips	Discuss TeleFriend project
7/23/2018	WPC + Dartmouth University	Discuss data collection for research study
7/24/2018	WPC + WPC Leadership	Discuss WPC program updates
7/25/2018	WPC + Front St., Inc.	WPC TeleFriend device initial meeting
7/26/2018	WPC + Care Coordination Workgroup	Discuss care coordinator role, activities, challenges, difference between care coordination and case management, what CC workgroup can produce to assist care coordination in Santa Cruz County
7/27/2018	WPC + County of Santa Cruz Maintaining Ongoing Stability through Treatment (MOST) Team	Discuss WPC + MOST collaboration
7/27/2018	WPC + County of Santa Cruz Fiscal staff	WPC fiscal review
7/30/2018	WPC + Care Coordination Steering Committee	Discuss planning for WPC Care Coordination Workgroup
7/30/2018	WPC + Health Improvement Partnership (HIP) + Central California Alliance for Health (CCAH)	Discuss Care Coordination and Case Management
7/31/2018	WPC + Santa Cruz Homeless Services Center	Discuss housing data available and placement tracking
8/1/2018	WPC + WPC Lead Entities + DHCS	Discuss WPC programs with DHCS
8/2/2018	WPC + Dartmouth University	Discuss Integrated Illness Management and Recovery (I-IMR) and TeleFriend device research study
8/7/2018	WPC + WPC Lead Entities	WPC Care Coordination & Data Sharing Affinity Group
8/8/2018	WPC + Philips	Discuss TeleFriend project planning
8/9/2018	WPC + HIP Council	Presentation on WPC program

DATE	PARTICIPANTS	PURPOSE
8/9/2018	WPC + Advisory Council	Discuss WPC – C2H goals and successes, updates on WPC – C2H services and workgroups, Data Sharing Convening, enrollment and utilization, statistics and reports
8/9/2018	WPC + Dartmouth University	Discuss Integrated Illness Management and Recovery (I-IMR) and TeleFriend device research study
8/13/2018	WPC + Front St., Inc.	Discuss WPC Housing Navigation services
8/14/2018	WPC + WPC Leadership	Discuss WPC program
8/15/2018	WPC + Santa Cruz Health Information Organization (SCHIO) + CrossTx + Front St., Inc.	Together We Care care coordination platform demonstration
8/15/2018	WPC + County of Santa Cruz Clinics and Case Mgmt Staff	Post-HUGs case conference
8/16/2018	WPC + Front St., Inc.	Discussion about new master-leased housing and including WPC clients
8/17/2018	WPC + WPC Lead Entities	WPC Sustainability Affinity Group
8/21/2018	WPC + Philips	Discuss TeleFriend project planning
8/22/2018	WPC + DHCS	DHCS Care Coordination Advisory Committee
8/23/2018	WPC + MOST	Discuss WPC + MOST coordinating care for WPC clients
8/23/2018	WPC + Dartmouth University	Discuss Integrated Illness Management and Recovery (I-IMR) and TeleFriend device research study
9/7/2018	WPC + Care Coordination Steering Committee	Discuss planning for WPC Care Coordination Workgroup
9/11/2018	WPC + Philips	Discuss TeleFriend project planning
9/11/2018	WPC + WPC Leadership	Discuss WPC program updates
9/12/2018	WPC + County of Santa Cruz HSA IT	Discuss updates/issues related to current IT/WPC projects
9/12/2018	WPC + County of Santa Cruz Clinics and Case Mgmt Staff	Post-HUGs case conference
9/13/2018	WPC + Dartmouth University	Discuss Integrated Illness Management and Recovery (I-IMR) and TeleFriend device research study
9/18/2018	WPC + Philips	Discuss TeleFriend project planning

DATE	PARTICIPANTS	PURPOSE
9/20/2018	WPC + Santa Cruz Health Information Organization (SCHIO) + CrossTx + Front St., Inc.	Together We Care care coordination platform training
9/25/2018	WPC + Philips	Discuss TeleFriend project planning
9/25/2018	WPC + CrossTx	Discuss Together We Care care coordination platform development
9/26/2018	WPC + WPC Leadership	Discuss WPC program updates
9/27/2018	WPC + Care Coordination Workgroup	Discuss TeleFriend project, Together We Care development, developing a case manager peer network and brown bag event, Data Sharing Convening
9/27/2018	WPC + Dartmouth University	Discuss Integrated Illness Management and Recovery (I-IMR) and TeleFriend device research study
9/28/2018	WPC + Philips	Discuss EHR interface for TeleFriend project planning
10/1/2018	WPC + WPC Lead Entities + DHCS	WPC Statewide Convening
10/2/2018	WPC + Philips	Discuss TeleFriend project planning
10/2/2018	WPC + Care Coordination Steering Committee	Discuss planning for WPC Care Coordination Workgroup
10/2/2018	WPC + HSA IT Staff	Discuss TeleFriend Device management and workflows
10/3/2018	WPC + HSA Fiscal Staff	Discuss WPC – C2H Fiscal updates, review scope of WPC – C2H program, discuss current structure and HSA division financial expectations
10/3/2018	WPC + WPC Lead Entities + DHCS	Discuss WPC programs with DHCS
10/5/2018	WPC + DHCS	DHCS Care Coordination Advisory Committee
10/15/2018	WPC + County of Santa Cruz Clinics and Case Mgmt Staff	Post-HUGs case conference
10/16/2018	WPC + Philips	Discuss TeleFriend project planning
10/23/2018	WPC + WPC Leadership	Discuss WPC program updates
10/24/2018	WPC + Care Coordination Steering Committee	Discuss planning for WPC Care Coordination Workgroup
10/25/2018	WPC + HIP	View Together We Care demo
10/26/2018	WPC + HSA Specialty Mental Health (SMH) Staff	Discuss WPC – C2H and SMH services planning
10/29/2018	WPC + DHCS	DHCS Care Coordination Advisory Committee

DATE	PARTICIPANTS	PURPOSE
10/30/2018	WPC + Philips	TeleFriend activation: clinical application training
10/31/2018	WPC + Philips	TeleFriend activation: administrative application training
11/1/2018	WPC + Philips	TeleFriend activation: onboarding patients
11/2/2018	WPC + Philips	TeleFriend activation: debrief and technical support
11/8/2018	WPC + Dartmouth University	Discuss Integrated Illness Management and Recovery (I-IMR) and TeleFriend device research study
11/9/2018	WPC + HPHP Staff	Review the Passport to Health (P2H) caseload and who may be transitioning to WPC – C2H
11/9/2018	WPC + Care Coordination Steering Committee	Discuss planning for WPC Care Coordination Workgroup
11/13/2018	WPC + WPC Leadership	Discuss WPC program updates
11/15/2018	WPC + County of Santa Cruz Clinics and Case Mgmt Staff	Post-HUGs case conference
11/15/2018	WPC + Dartmouth University	Discuss Integrated Illness Management and Recovery (I-IMR) and TeleFriend device research study
11/16/2018	WPC + Care Coordination Steering Committee	Discuss planning for WPC Care Coordination Workgroup
11/19/2018	WPC + Front St. Inc.	Discuss Housing Navigation and Supports
11/26/2018	WPC + Front St. Inc.	Discuss Peer Support Coaches
11/26/2018	WPC + Front St. Inc.	Discuss TeleFriend project
11/27/2018	WPC + Care Coordination Steering Committee	Discuss planning for WPC Care Coordination Workgroup
11/27/2018	WPC + WPC Leadership	Discuss WPC program updates
11/29/2018	WPC + Dartmouth University	Discuss Integrated Illness Management and Recovery (I-IMR) and TeleFriend device research study
11/30/2018	WPC + Philips	TeleFriend Protocol review
12/6/2018	WPC + Dartmouth University	Discuss Integrated Illness Management and Recovery (I-IMR) and TeleFriend device research study
12/7/2018	WPC + SCHIO	Overview of Together We Care platform
12/10/2018	WPC + HIP	Planning for Data Sharing Convening

DATE	PARTICIPANTS	PURPOSE
12/11/2018	WPC + Care Coordination Steering Committee	Discuss planning for WPC Care Coordination Workgroup
12/12/2018	WPC + Data/IT Workgroup	Discuss updates on referral & enrollment, TeleFriend project, Together We Care development, reports submitted, and 2019 plans for workgroup
12/12/2018	WPC + Care Coordination Providers	Updates from local programs, best practices in care coordination, networking
12/13/2018	WPC + Advisory Council	Discuss WPC – C2H goals, services and staffing updates, 2018 achievements and lessons learned, and 2019 activities
12/20/2018	WPC + Dartmouth University	Discuss Integrated Illness Management and Recovery (I-IMR) and TeleFriend device research study
12/27/2018	WPC + HSA Fiscal Staff	Programmatic Budget discussion