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

San Mateo County Health
Annual Narrative Report, Program Year 5
April 27, 2021

REPORTING CHECKLIST

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.

Whole Person Care

San Mateo County Health
[Annual Narrative Report, Program Year # 5
April 27, 2021

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

Instructions: 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.

Please limit responses to 500 words. If additional information is needed, please contact your assigned Analyst.

(a) Increasing integration among county agencies, health plans, providers, and other entities;

San Mateo County Health (SMCH) continues to conduct interdivisional meetings to identify and resolve system barriers faced by clients with complex needs. Monthly WPC Operations Committee meetings with representation from all divisions continues to act as a decision-making forum for system problems facing WPC clients. During this period, the Committee made recommendations for identified issues such as: the expansion of the Patient Activation Measure (PAM) implementation to San Mateo Medical Center (SMMC) and Behavioral Health and Recovery Services (BHRS). The Committee also addressed racial disparities amid the COVID-19 pandemic recommending that programs investigate health outcome data for disparities based on race/ethnicity. In preparation for the WPC transition to CalAIM, the Committee identified the need to transition WPC funded limited term positions into permanent positions and recommended further discussion on Interdivisional transitions/Warm Handoffs. Whole Person Care administration meets twice per month to discuss WPC activities and programs as well as to plan for the transition to the California Advancing and Innovating Medi-Cal (CAIAIM) initiative effective January 1, 2022.

(b) Increasing coordination and appropriate access to care;

During this period, SMCH clinicians and healthcare programs reported a substantial increase in youth and young adults with significant mental health issues and increased cases of substance use/abuse. Referrals to behavioral health clinicians embed in primary care increased by 51% by adults, and 100% for youth. We also experienced a 430% increase in over-dose related referrals to the Medication Assisted Treatment outreach/response team. While there is evidence of increased distress as evidenced by

increased calls and referrals, the actual number of people receiving/presenting for services has not increased accordingly. The Integrated Medication Assisted Treatment Team (IMAT) reported approximately 12 client and former client deaths related to increased substance use, lack of social supports and fears of entering treatment due to COVID. Despite this, our data indicates that during the pandemic, WPC programs continued to support clients with behavioral health and substance use related issues:

- 88% of WPC clients with PHQ9 score of 13 or higher seen at the SMMC were either referred to Med-psych or warmly handed off to Behavioral Health.
- A 19% increase in the proportion of unique clients enrolling in Opioid Use Disorder (OUD) treatment services between 2019 (PY4) and 2020 (PY5) compared to the target of 15%.
- A 20% increase in the number of clients given an administration of [redacted] or a [redacted] during the Emergency Department (ED) visit at SMMC between 2019 (PY4) and 2020 (PY5) compared to the target of 10%.
- The data indicates that the number of physicians at SMCH (excluding the ED) prescribing Medicated Assisted Treatment increased by 28%.
- 100% of new referrals were linked to the Medicated Assisted Treatment (MAT) clinic within 30 days of referral.

SMCH continued to provide services while adapting to the safety protocols in response to the COVID-19 pandemic. Telehealth has worked well for some services, but challenges remain where in-person services were required. Nevertheless, WPC programs continued to provide services. Below are some examples of how programs adapted in response to the pandemic.

1 There was an increase demand for additional services to support WPC patient's medical and social needs at San Mateo Medical Center (SMMC). Clients needed additional medical care coordination, financial assistance, food delivery, and access to safe and reliable transportation to help get them to/from medical services. Other services provided include coordinating skilled nursing placement and alternative care/housing for those who needed to safely quarantine (out of their home or off the streets). Patients continue to experience a multitude of stress in the areas of unemployment, economic hardship, housing evictions, homelessness, food insecurity, and social isolation. WPC Social Workers successfully pivoted from working in clinic to working 80% remote, with little to no disruption to patient care. WPC Social Workers also developed strategies to assist WPC patients access accurate and reliable information related to the COVID-19 vaccine.

2 The Collaborative Care Team (CCT) continued to provide support to SMI/co-occurring clients with complex needs placed out of county. The COVID-19 pandemic has resulted in out of county facilities being closed to visitors for several

months. In addition, facilities had COVID -19 outbreaks resulting in admissions/discharges being halted throughout this reporting period. CCT continues to provide client services virtually. With the shelter-in-place restrictions, many clients in community placement expressed frustrations with the limitations resulting in behavioral issues sometimes leading to 30-day notices. CCT held many successful case conferences to help support facilities to keep clients in placement. During the pandemic, there continues to be a need to provide in person support to clients in out of county facilities. Some clients do not have family members that are actively involved in their lives, making the visits from the CCT staff invaluable.

[redacted]The Health Plan of San Mateo (HPSM) continued its efforts to optimize the Community Care Settings Program (CCSP) to support members to transition from Skilled Nursing Facilities (SNF), Long Term Care (LTC) and members at risk of being institutionalized, back into the community. These supports included assisting members with vaccine access, re-location amidst COVID-19 outbreaks, and support to partners working with these members to ensure they had access to relevant vaccine and supply information. HPSM solicited the support of the Wider Circle program to provide additional COVID-19 emergency relief, member screening, and social support. Despite delays in client transitions in the first half of the year, the CCSP was able to transition [redacted]

4 Correctional Health Services (CHS) implemented COVID-19 safety protocols to link the WPC vulnerable population leaving the jail into temporary housing or Residential Treatment programs for substance use disorders. In-person Warm Hand Offs were substituted with taxi vouchers to get clients to residential treatment programs directly after being released. Virtual visits with care teams have helped clients stay connected to the community and improved health outcomes for the WPC population. 90% of clients with planned releases were discharged with medications or a prescription in 2020.

5 The Helping Our Peers Emerge (HOPE) program, which provides peer mentors to clients upon discharge from acute or locked levels of psychiatric care, continues to show positive outcomes. 88% of clients in the program have successfully maintained a lower level of care and have not returned to a long-term locked facility. 91% of clients continue to engage in recovery-based activities consistently.

(c) Reducing inappropriate emergency and inpatient utilization;

Data indicates a * *reduction* in Emergency Department (ED) use and * reduction in-patient utilization (IPU) among WPC clients between 2019 and 2020. The [redacted] (total number of ED visits in 2020) was calculated at * while the [redacted] (the total member months) is *. This places our annual rate at 222.87 ED visits per 1000-member months compared to 252.20 in 2019. The data indicates a decrease in inpatient stays between 2019 and 2020. The [redacted] was calculated at * while the [redacted] was calculated at *. This translates into a rate of * inpatient stays/1000-member months. This is a * decrease from the 2019 rate of *. We hypothesize that the pandemic has led to a decrease in unnecessary visits for both ED and Inpatient visits.

(d) Improving data collecting and Information sharing;

During this period, significant milestones were achieved in overcoming Medi-Cal information sharing barriers between SMCH and the Human Services Agency (HSA). The HSA developed a new system that allows SMCH authorized users (including WPC staff) to conduct simple inquiries on Medi-Cal clients such as coverage status (approved, pending, denied), client's renewal date, and the reason for application denial. This system will greatly aid WPC to track Medi-Cal status thereby reducing Medi-Cal churn once the Governors Order suspending Medi-Cal Redeterminations is lifted.

The implementation of the CHS Electronic Health Record (EHR) has been completed. This EHR provides a platform to support improved coordination of care and services for WPC clients leaving the jail. The WPC Nurse Care Coordinator is now able to electronically schedule follow up behavioral or medical health appointments for the re-entry population. In addition, discharge medication orders can now be pulled into the into the discharge summary and medication history in our Health Information Exchange (HIE) to assist with post release medication reconciliation.

SMCH continued to develop the Enterprise Data Warehouse (EDW), incorporating data for 5 divisions (SMMC, BHRS, CHS, Adult and Aging Services, and Family Health). The Business Intelligence (BI) team also created data marts for individual divisions including WPC. These data marts are currently being utilized for the vaccine roll-out, including tracking and managing the health equity data.

In addition, the Health Information Technology (HIT) team completed stabilization work on the HIE platform to improve the user experience. This stabilization work was implemented to address the low usage of the HIE attributed to slowness and the frequency of being offline. HIE record views among the Bridges to Wellness Team (BWT) increased by 111% between the first half and second half of 2020. Logins also

increased by 56%. Overall HIE logins across SMCH increased by 18% between 2019 and 2020. The WPC administrative team continues to utilize the HIE to triage referrals and to prepare for complex case conferences. HIT is continuing to partner with WPC and others to improve user experience.

(e) Achieving quality and administrative improvement benchmarks

Patient Activation Measure

The implementation of the Patient Activation Measure (PAM) among clients served by the Bridges to Wellness Team (BWT) continued to yield positive results. The PAM is a tool that identifies the level of activation to self-manage on a scale of 1-4, with 1 being the lowest. Data indicates that PAM score changes for those clients at levels 1 and 2 was higher than the common target normally seen for PAM utilizers across the country. BWT continued implementing the PAM as well as piloting the Coaching for Activation (CFA) module. By December 31, 2020 for the clients at levels 1 and *, the mean PAM score increased by 12 and * points respectively. The data shows that clients who scored a 1 at the initial assessment experienced an 86.4% improvement in their score. For clients that scored a 2, there was a 70.3% improvement at time of re-administration.

(f) Increasing access to housing and supportive services; and,

- To date 101 clients received some form of housing subsidy funded by local county dollars as well as Mainstream Vouchers. During the reporting period, 70 individuals were supported with either housing location, housing retention, rental and utility subsidies, furniture and move-in support, and/or housing application support.
- 31 individuals were placed into Recuperative Care. During this reporting period, COVID-19 impacted recuperative admissions, however, HPSM worked closely with referral sources to increase awareness about recuperative care eligibility guidelines, workflows, and the site's rules and policies to ensure a positive member experience. The pool of referral sources has widened, with the majority of referrals coming from the San Mateo Medical Center. Other referrals sources included Stanford Medical Center and Sutter Health - Mills Peninsula.
- As of December 31, 2020, 35 clients have been enrolled into supportive housing services provided by Mental Health Association (MHA) of San Mateo County. As part of this service, 17 clients accepted occupational therapy support. All clients enrolled in the program have been referred to the nursing staff, and 22 had completed assessments.

(g) Improving health outcomes for the WPC population.

Data indicates that most clients receiving services from the BWT report improved health and self-management skills. In a survey conducted in late 2020 among 42 clients receiving BWT services, 95% of clients included in the results reported both improved

health and self-management skills. Client stories demonstrate improvements in health outcomes for clients served by the BWT and MHA.

- Clients experiencing homelessness and struggling with substance use addiction, was cycling in and out of jail at the time of referral to a BWT care navigator. Since being assigned a care navigator, clients have not returned to jail or experienced a relapse. The clients has been able to maintain steady employment and housing. They are currently getting ready to participate in on-line courses to receive their GED and is working toward getting their driver's license. They are actively working with a therapist to deal with their trauma and learning to set healthy boundaries to have healthy relationships.

MHA's wraparound supportive housing services have assisted clients with not only maintaining their housing but also improving the quality of their lives.

- WPC clients struggling to maintain their sobriety due to the restrictions set in place by COVID 19 consequently relapsed. Since then the clients worked closely with the Occupational Therapist (OT) to create structure and routines. Their case manager increased the number of visits and check ins to monitor and provide support around sobriety. The case manager also connected the client to resources, to increase socialization. These clients have since been able to maintain sobriety.
- Clients served by MHA and living in a Board and Care (B&C) expressed some frustration with being confined to the house due to COVID restrictions and were experiencing boredom. MHA assigned the clients with Tablets and worked with the clients to download applications for games and entertainment and introduced video chat to clients so that client may video conference with doctors and care team. The clients are extremely happy and reports feeling less bored, and more capable and confident in using new technology.

III. ENROLLMENT AND UTILIZATION DATA

Instructions: 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	51	11	*	15	*	32	122

Item	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12	Annual Unduplicated Total
Unduplicated Enrollees	61	27	21	22	30	24	185

*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
Service 1	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Utilization 1	N/A	N/A	N/A	N/A	N/A	N/A	N/A

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	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Utilization 1	N/A	N/A	N/A	N/A	N/A	N/A	N/A

*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 for Quarters 1 and 2

PMPM	Rate	Month 1	Month 2	Month 3	Month 4	Month 5	Month 6	Total
Bundle #1	$635.58	$487,489.86	$483,676.38	$474,142.68	$486,218.70	$481,769.64	$484,311.96	$2,897,609.22
MM Counts 1		767	761	746	765	758	762	4,559
Bundle #2	$828.63	$1,116,993	$1,103,735	$1,078,876	$1,063,961	$1,058,161	$1,068,933	$6,490,658.79
MM Counts 2		1,348	1,332	1,302	1,284	1,277	1,290	7,833

Amount Claimed for Quarters 3 and 4

PMPM	Rate	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12	Annual Total
Bundle #1	$635.58	$519,904.44	$521,175.60	$523,717.92	$534,522.78	$540,243	$535,158.36	
MM Counts 1		818	820	824	841	850	842	9,554
Bundle #2	$828.63	1,076,390.37	1,091,305.71	1,098,763.38	1,085,505.30	1,087,991.19	1,096,277.49	$6,528,775.77
MM Counts 2		1,299	1,317	1,326	1,310	1,313	1,323	15,721

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

We revised our Quarter 2 enrollment and utilization report. which reduced the member months for PMPM bundle 1 from 4564 to 4559. While we have more people enrolled than budgeted, we will be claiming only to the maximum budgeted amount of **$18,381,234.**

IV. NARRATIVE – Administrative Infrastructure

Instructions: 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. Please limit your responses to 500 words.

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. The WPC Hub and BWT team incurred costs for recurrent expenses in relation to leasing office space and purchasing office supplies. Other costs incurred were vehicle maintenance, telephone, information technology services, staff travel and training. During this period, the PAM license was also renewed. Some line items such as Office space, vehicle maintenance, technology service charges, office expenses and human resources charges exceeded the budgeted amount, a total of about $52,375.99. SMCH would like to claim the overages of these items are the costs were unanticipated but necessary for the operation of the pilot.
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 relating to providing WPC services were incurred covered the cost of accounting and administrative support. Other costs incurred were in relation to 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) Programs:* Costs were incurred in relation to maintenance, enhancing and stabilizing of the Health Information Exchange, assessing the various Electronic Health Records (Avatar, eCW, Soarian) from the lens of WPC data and client needs. The HIT team also continued developing the WPC data marts and enhancing the MPI.

IV. NARRATIVE – Delivery Infrastructure

Instructions: 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. Please limit your responses to 500 words.

1. *Correctional Health Services (CHS) Staffing:* A Medical Office Assistant (MOA) continued to support the WPC Care Coordination Nurse in identifying WPC clients and providing information needed for re-entry planning. While the personnel costs in this department exceeded the budgeted amount, SMCH would like to claim up to the budgeted amount.
2. *Process Improvement software:* During this period, the software KaiNexus was customized and tested to assist with the tracking and visibility of the process improvement activities underway for our WPC clients. KaiNexus has become the critical incident reporting platform for SMMC, the largest direct service division within Health. Unlike previous platforms, contracted staff can access this application allowing for ease of visibility for all staff. As more divisions adopt KaiNexus, this visibility – and therefore collective problem solving – will be even more seamless throughout the Health Department.
3. *Care Coordination Hub:* WPC contracted with a local non-profit, We HOPE, to provide mobile restroom and handwashing stations in East Palo Alto for the homeless and unsheltered in response to the COVID-19 pandemic. During this period, these services have been expanded to two additional cities.
4. *Medication Monitoring Service.* 100 electronic pill dispensers with 16 bin capacity were procured, and workflows developed for rolling out the medication monitoring services to select WPC programs such CCSP, as well as clinics within the San Mateo Medical Center.
5. *Learning Collaborative on Individualized Treatment:* During this period, BHRS extended the Feedback Informed Treatment (FIT) Learning Collaborative to a community-based organization. The FIT training, held in December 2020, was provided virtually due to the COVID-19 pandemic. The Transition Oversight Group (TOG), which meets twice a month to monitor implementation, provides a space to discuss and resolve obstacles to implementation.
6. *Learning Collaborative on Trauma-informed Care*: During this period, SMCH developed a strategy for cross-departmental trauma resilience efforts. Social

workers from SMMC attended an intensive trauma course on how trauma impacts the brain; internalizes/manifests in the body; and affects one's response and ability to process information.

V. NARRATIVE – Incentive Payments

Instructions: 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. Please limit your responses to 500 words.

1. *75% of (18 of 24) of WPC bi-monthly complex case conferences will have 100% attendance.* In 2020, SMCH held at least 24 complex cases conferences. Out of the 18 Complex case conferences budgeted for PY5, SMC Health claimed 12 at mid-year. 12 case conferences held between July-December 2020, had 100% representation. SMCH is claiming for 6 in this reporting period, earning $13,333.32
2. *75% (9 out of 12) of WPC Operations Committee meetings held will result in recommendations/solutions for addressing system barriers and gaps and/or strategies for service improvements.* Out of the 9 Operations Committee recommendations budgeted for PY5, 5 are claimed mid-year. Between July-December 2020, at least 5 recommendations emerged from the Operations Committee meeting. SMCH is claiming for 4 in the reporting period, earning $17,777.76. At each meeting, issues and/or system barriers were brought forward, and recommendations were proposed by the committee. These include:

(i) *Expansion of the Patient Activation Measure (PAM) implementation to SMMC and BHRS.* Data is showing positive results from PAM implementation including decreases in ED and IP utilization for BWT clients with an improvement in PAM scores. *The WPC Hub will explore the expansion of this tool to other divisions serving WPC clients.*

(ii) *Racial justice initiatives amidst the COVID-19 pandemic*. It was noted that app. 45% of the Medi-Cal population in San Mateo County identifies as Latinx or Hispanic, however, access by race/ethnicity reveals that 27% of those served are Latinx or Hispanic. In recognition that Covid-19 disproportionately affects the Latinx population*, it was recommended that programs investigate their health outcome data for disparities based on race/ethnicity. SMCH should develop outreach and engagement strategies that ensure equitable access to care.*

(iii) *WPC sustainability/Transition to CALAIM.* There is a need to move WPC funded limited term positions into permanent positions as we transition into CALAIM. SMCH may need to use savings to cover some of the funding gaps that may occur during the transition period.

(iv) *WPC performance on Completion of Suicide Risk assessments.* SMCH is seeing a slight declining trend in the rate of completion and will increase efforts to engage staff in the completion of the Columbia Suicide Risk Assessment.

(v) *Interdivisional transitions.* The pathways for interdivisional client transitions were identified. Some barriers identified include the lack of storage facilities for Buprenorphine in primary care clinics as well as multiple EHRs being used across the system, *and it was recommended that a specific meeting be organized to identify and find solutions to the barriers to effective client transitions.*

3. *60% of clients served by BWT show an improvement in the PAM score over the previous year at 12 months*. Data indicates that 58% of clients served by a BWT showed an improvement in the PAM score over the previous year. SMCH did not earn this incentive payment.

4. *Scaling up the use of PAM to other divisions (San Mateo Medical Center Clinics, Aging and Adult Services, Behavioral Health Mental Health Clinics) in the Health System serving WPC clients by December 2020.* Due to the COVID-19 pandemic, several programs in SMCH had to adjust their focus include pandemic response. The expansion of PAM implementation was put on halt to address challenges and changes created by the pandemic. SMCH did not earn this incentive payment and rolled the funds over to PY6.

5. *Correctional Health Services will move from paper charting to an existing E.H.R, Sorian, within the Health Department as a first step toward full integration into the E.H.R. 2.0* The implementation of the CHS Electronic Health Record (EHR) has been completed. The “Go Live” of the Soarian Clinicals was October 19, 2020, with the full Bar Code Administration module completed and “live” as of November 2, 2020. SMCH earned $404,161.67.

6. *Provide documentation of WPC Sustainability meetings between the WPC Administrative Hub and the Health Plan of San Mateo.* The WPC administrative HUB has held 4 meeting between January and June 2020 to discuss WPC sustainability. Another 8 meeting were held between July-December 2020. SMCH earned $41,236.48 Topics discussed in the meetings include:
   - Scenarios for funding the BWT post-WPC. BWT will be funded by HPSM either through CALAIM or otherwise.
   - The differences between delegate and provider functions under ECM.
   - A centralized hub for Enhanced Care Management (ECM) based on capacity for data analytics, utilization reporting, and enrollment developed by WPC.

- Target populations under ECM and risk score tools being utilized by HPSM.
- Quality Management and metrics. It was pointed out that the HEDIS metrics may not be suitable for the population that WPC currently serves. There is a need to carefully consider appropriate metrics for this population.
- In Lieu of Services (ILOS) and existing provider capacity.
- Data interoperability: There is a need that SMCH and HPSM technology is interoperable so that SMCH can push data to the HPSM.
  Developing a roadmap for WPC sustainability touching on topics such as provider/delegate functions, target populations, enrollment, and performance metrics.

7. *Provide documentation that a roadmap for the transition from WPC to CalAIM has been developed by December 31, 2020 earnable by SMCH.* SMCH has developed a roadmap identifying strategies and activities that will guide the WPC transition to CALAIM. SMCH earned $401,939.21

8. *25% increase in the number of physicians prescribing Medication Assisted Treatment.* The data indicates that the number of physicians prescribing Medicated Assisted Treatment with SMCH increased from 60 in 2019 to 77 in 2020. This is a 28% improvement compared to the goal of 25%. SMCH earned $160,000

VI. NARRATIVE – Pay for Outcome

Instructions: 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. Please limit your responses to 500 words.

Universal and Variant Metrics

Based on new learnings in 2020 we needed to re-run our metric rates for 2019 in addition to 2020. We have found some new data sources previously unavailable, we have had to limit the data sources for metrics such as completion of suicide risk assessments and have learned new methods of collating the data from various sources.

(a) *Ambulatory Care-Emergency Department (ED) visits.* Data shows that the ED utilization rate for WPC clients decreased by 12% between 2019 and 2020. The numerator (total number of ED visits in 2020) was calculated at 5571 while the denominator (the total member months) came to 24,997. This places our annual rate at 222.87 ED visits per 1000-member months compared to 252.20 in 2019.

(b) Inpatient Utilization. Data shows a 9% decrease in in-patient stays between 2019 and 2020. The numerator (total number of inpatient stays) was calculated at 1083 while the denominator (total member months) was calculated at 24997. This translates into a rate of 43.33 inpatient stays/1000-member months compared to 47.53 in 2019.

(c) Adult Major Depressive Disorder: Completion of Suicide Risk Assessment. There has been a decline in the rate for completion of suicide risk assessments between 2019 and 2020. While our previously submitted data placed our 2019 rate at 9%, our current data run places the rate at 18.12%. The improvement in rate can be attributed to a change SMCH made in calculating the denominator. SMCH introduced a practice change in the completion of suicide risk assessments in 2018 for behavioral health clinicians. Therefore, a decision was made to limit the data to behavioral health. The total number of suicide risk assessments in 2020 was calculated at 32, while the count of clients with major depressive disorder is 192 bringing the rate to 16.67% compared to 18.12% in 2019. Although we did not meet

the 5% improvement, leadership remains committed to ensuring that this practice change will become standard practice throughout SMCH.

(d) Comprehensive Diabetes Care. Data shows a decline in the rate for diabetes (HbA1c) control between 2019 and 2020. 44.42% of clients diagnosed with diabetes had HbA1c below 8 in 2020 compared to 53.05% in 2019. This decline can be attributed to the COVID-19 pandemic as some clients were reluctant to have lab visits for safety reasons and the absence of a level is counted as a negative value.

(e) Follow up after hospitalization for mental illness. SMCH has seen some improvement on this metric. In 2020, the total number of patients receiving a follow-up mental health visit within 7 days of discharge was calculated at 98, while the total inpatient discharges for person hospitalized for mental illness was 155 bringing the rate to 63.23% compared to 60.53% in 2019. The total number of patients receiving a mental health follow up visit within 30 days of discharge was 112 compared to the total 155 bringing the rate to 72.26% compared to 76.32% in 2019. 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 become aware of the hospitalization after the 7-day follow-up period has elapsed.

(f) *Initiation and engagement of AOD dependence treatment*
In 2020, the total number of clients who initiated AOD dependence treatment within 14 days of diagnosis was calculated at 171, and the total number of clients with a new episode of AOD diagnosis is 588 bringing the rate to 29.08%. The total number of WPC clients who initiated treatment and had two or more additional services within 30 days of diagnosis was calculated at 106, and the total number of clients who initiated treatment within 14 days was 171 bringing the rate to 61.98% When calculated as a percentage of the total number of clients with a new episode of AOD diagnosis (588), the rate comes to 18.03%. At the time of the submission of this report, the data for calculating this metric is incomplete. We are requesting to resubmit at a future date.

(g) 30 Day All Cause Readmissions. The rate of All Cause Readmissions decreased from 26.61% in 2019 to 25.44% in 2020. The count of 30 day all cause re-admissions in 2020 was 259 and compared to the count of index hospital stays for the eligible population of 1018, bringing the rate to 25.44%.

(h) Percentage of homeless clients receiving housing services after being referred for housing services. In 2020, we achieved 100% with all clients receiving housing

services after referral. A total of 55 WPC clients were referred for housing services during this reporting period, and all 55 received housing services. The number of clients served increased from * in 2017 to 26 in 2018 to 39 in 2019 to 55 in 2020.

(i) *Percentage of clients with a comprehensive care plan accessible by the entire care team within 30 days.* In 2020, 54.97% of new enrollees had a comprehensive care plan compared to 42.07% in 2019. In addition, 45.43% (924) of WPC continuing enrollees (2034) have a comprehensive care plan.

(j) Assignment of Care Coordinator. In 2020, 58.54% of WPC participants had a care coordinator assigned, compared to 58.85% in 2019. The number of WPC clients engaged in some form of care coordination program was calculated at 1415, compared to the total number of enrollees in 2020 which was 2417.

Pay for Outcome Metrics

SMCH elects to use the COVID-19 Alternative Payment method for Pay for Outcome payments in Program Year 5. SMCH achieved 91% of our Pay for Outcomes in Program Year 4. SMCH will receive 91% payment in Program year 5, in the total amount of $3,483,902.23.

Based on SMCH data, 14 out of 16 targets are met for pay for 2019 outcome metrics listed below:

(a) *Ambulatory Care - Emergency Department Visits*. We saw an improvement in the rate of ED utilization between 2019 and 2020. Data indicates that the ED utilization rate for WPC clients decreased by 12% between 2019 and 2020 compared to the target of 5%. The numerator (total number of ED visits in 2020) was calculated at 5571 while the denominator (the total member months) came to 24,997 This places our annual rate at 222.87 ED visits per 1000-member months compared to 252.20 in 2019.
(b) *Completion of Suicide Risk Assessment.* Data is showing that the rate for completion of suicide risk assessments decreased from 18.12 to 16.67% compared to the target of 22.12%.
(c) *Proportion of clients served by the Bridges to Wellness team (BWT) with a primary care visit within the measurement year.* 75.3% of clients served by BWT had a primary care visit in 2019 compared to the target of 60%.
(d) *Proportion of clients served by Bridges to Wellness (BWT) surveyed reporting improved health and self-management skills.* 90% of clients surveyed reported improved health and self-management skills compared to the target of 65%.

(e) *Proportion of WPC clients with PHQ9 score 13 or higher referred to med-psych or warmly handed off to Behavioral Health.* 88% of WPC clients with PHQ9 score of 13 or higher were either referred to Med-psych or warmly handed off to Behavioral Health compared to the target of 55%.

(f) *Proportion of justice involved who receive a two-week supply of medications upon re-entry.* 90% of clients with planned discharges and need medication received either a two-week supply or a prescription upon leaving the jail compared to the target of 55%.

(g) *Proportion of clients served by the HOPE program with zero recidivism that transition to a lower level of care successfully for 6 months.* 88% of clients served by the HOPE program in 2020 transitioned to a lower level of care successfully for 6 months compared to the target of 70%.

(h) *Proportion of peer participants who engage in peer recovery activities every month for 6 months.* 91% of participants enrolled in the HOPE services engaged in recovery related activities for 6 consecutive months compared to the target of 75%.

(i) *Number of health system staff educated on Medication Assisted Treatment (MAT).* 407 staff across SMCH were educated on MAT compared to the target of 350.

(j) *Proportion of new SUD clients linked to MAT within 30 days of referral.* 100% of new referrals were linked to the MAT clinic within 30 days of referral compared to the target of 80%.

(k) *Proportion of clients served by the CCT team with monthly visits by social workers within the measurement year.* 100% of clients served by CCT team received monthly visits from social workers compared to the target of 75%.

(l) *Number of CCSP clients transitioning into community.* 27 CCSP clients were transitioned into the community in 2020. SMCH did not meet the targeted 55. The transition rate for this metric was affected by safety protocols put in place in response to COVID-19.

(m) *Average number of days it takes to transition a CCSP client into community.* The average number of days it took to transition the 27 CCSP clients into the community was 136 days. This is higher than the target of 100 days. The transition rate for this metric were affected by safety protocols put in place in response to COVID-19.

(n) *Proportion of transitioned CCSP members still in the Community at six months.* Data shows that 91% of CCSP clients that transitioned in 2020 are still in the community at six months after the transition. This exceeds the 65% target we set.

(o) *Proportion of CCSP clients that successfully remain in community for twelve (12) months in measurement year.* Data shows that 91% of CCSP clients were in the community for 12 months in 2020. This exceeds the 70% target we set.

(p) Percentage increase in proportion of clients enrolling in Opioid Use Disorder (OUD) treatment services between 2019 (PY4) and 2020 (PY5). There was a 19% increase

in proportion of unique clients enrolling in Opioid Use Disorder (OUD) treatment services between 2019 (PY4) and 2020 (PY5) compared to the target of 15%.

(q) *Percentage increase in the number of clients diagnosed with OUD and who are given an administration of buprenorphine or a prescription for buprenorphine during the ED visit at San Mateo Medical Center between 2019 (PY4) and 2020 (PY5).* There was a 20% increase in the number of clients given an administration of buprenorphine or a prescription for buprenorphine during the ED visit at San Mateo Medical Center between 2019 (PY4) and 2020 (PY5) compared to the target of 10%.

VII. STAKEHOLDER ENGAGEMENT

Instructions: 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. An attachment to this report is also acceptable, please note below if this option is being used. 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.

Stakeholders	Meeting Title	Meeting Purpose
SMC Departments	Operating Committee Meeting	This meeting is held monthly and is responsible for assisting the supporting workgroups (Care Coordination and Quality) to remove barriers and make executive decisions around policies and system changes recommended by the Care Coordination and Quality workgroups. Topics discussed include: expansion of the PAM; racial disparities amid COVID-19 pandemic; the WPC transition to CALAIM, the Committee identified the need to move WPC funded limited term positions into permanent positions; Interdivisional transitions/Warm Handoffs
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 LifeMoves		
Health Plan Partner		
Health Plan of San Mateo		

Stakeholders	Meeting Title	Meeting Purpose
SMC Departments	Care Coordination Workgroup	*This meeting has been suspended during the pandemic.* 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
Public Health, Policy, and Planning		
Health Administration		
Behavioral Health & Recovery Services		
BHRS-IMAT		
San Mateo Medical Center		

Aging Adult Services		more coordinated health care delivery approach.
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		
Stakeholders	**Meeting Title**	**Meeting Purpose**
SMC Departments	Quality Workgroup	This meeting is held quarterly for discussing metric calculations and identifying data challenges and barriers. Topics discussed include progress with WPC Pay for Reporting and Pay for Outcome metrics, PDSAs and data quality
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		
Stakeholders	**Meeting Title**	**Meeting purpose**
SMC Departments	Housing Committee	This meeting is held four times per 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.
Public Health, Policy, and Planning		
Health Plan Partner		
Health Plan of San Mateo		
Community Based Organizations		
Brilliant Corners		
Mental Health Association of San Mateo County		

VIII. PROGRAM ACTIVITIES

Care Coordination

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

1. SMMC Social workers successfully built partnerships to address social issues resulting from the COVID-19 pandemic. WPC Social Workers now work in close partnership with programs such as Bridges to Wellness (BWT), Integrated Medication Assisted Treatment (IMAT), Brilliant Corners, and Mental Health Association (MHA) to identify community resources such as shelter, rental assistance, food donations, clothing donations, and employment/job training services.

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

1. The Recuperative Care facility saw an inconsistent flow of referrals at the beginning of the COVID-19 pandemic. Due to a number of variables such as low hospital census, additional housing support for homeless individuals including Project RoomKey, and time spent on COVID-19 response, uptake for recuperative care was low in the first half of 2020. HPSM and Bay Area Community Services (BACS) had to think creatively on how to optimize this resource and as a result of the efforts, the site was fully occupied for 5 out of the 6-month time period starting in August 2020. The COVID-19 pandemic highlighted the importance of working together and learning to actively and thoughtfully modify our process' in order to best support those in our community
2. Transitions to lower levels of care from intensive care management remains a service gap. In our current systems of care there is very limited funding for mid-level service needs thereby making graduation from high intensity to lower intensity very difficult. Clients are often transitioned away from high intensity services after they have stabilized only to end up with very limited supports which then leads to new crises necessitating higher levels of care.

Data and Information Sharing

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

1. BWT care navigators have made optimal use of jail booking and release alerts created by the BI team to find hard to reach clients. For example, clients who has been difficult to engage was located in jail through an alert. This provided the ability to visit with them through telehealth to better develop plans as well as link them to partnering Service providers upon re-entry.

B. Briefly describe 1-2 challenges you have faced with data sharing, and lessons learned from those challenges.
    1. SMCH continues to use multiple EHRs for case management. SMMC social workers document their services in SMMC's EHR which has limited the ability to capture care coordination services in a structured manner. Care coordination services are still documented in client notes which are not in "structured" fields that can easily be pulled for data analysis. SMCH Information Technology is working towards utilizing Diameter Health software to structure unstructured data in our EHRs so that we can pull data from clinical notes.

Data Collection

A. Briefly describe 1-2 successes you have had with data collection and/or reporting.
    1. WPC has successfully used Data Marts to run the Universal and Variant Metrics.
    2. During this period, HIT worked to improve the matching for homeless clients and migrant farm workers. This data was incorporated into our EDW to facilitate pulling together records from multiple electronic health records. Our EMPI also contains basic demographic information that facilitates SMCH health equity efforts.
B. Briefly describe 1-2 challenges you have faced with data collection and/or reporting.
    1. SMCH continues to have inaccurate homelessness data, with no direct access to the Homeless Management Information System (HMIS). It emerged in the matching of WPC data, that there is a need for additional data elements, such as Social Security numbers, to improve the accuracy of the matching considering the gaps in the homelessness status data.
    2. WPC has transitioned to using Data Marts to run the Universal and Variant Metrics. Based on new knowledge and learnings in 2020, we needed to re-run our metric rates for 2018, and 2019 in addition to 2020. We have found some new data sources previously unavailable and have learned new methods of collating the data from various sources.

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

Data sharing between Health and Social Services will remain a barrier unless a statewide regulatory solution is developed. Data sharing restrictions due to 42CFR

remains a significant barrier to provided effective care coordination for persons with substance use disorders. Limited funding for adequately addressing poverty and racial inequities will continue to affect our ability to reach some of the most vulnerable and at-risk individuals.

IX. PLAN-DO-STUDY-ACT

Instructions: 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.

PDSA Attachments:

1. Ambulatory Care – Emergency Department Visits BWT Qtr3
2. Ambulatory Care – Emergency Department Visits BWT Qtr4
3. Inpatient Utilization BWT Qtr 3
4. Inpatient Utilization BWT Qtr 4
5. Comprehensive Care Plan Qtr3
6. Comprehensive Care Plan Qtr 4
7. Care Coordination WHOs Semi-annual 2
8. Data and information sharing: Semi- annual -HIE
9. Data and information sharing: Semi-annual -Location Services
10. Other: Medi-Cal churn- Semi-annual
11. Other: Patient Activation Measure (PAM)- Semi-annual