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 4

July 23, 2020

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

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I. REPORTING INSTRUCTIONS

Pursuant to the Whole Person Care Agreement and the Special Terms and Conditions of California's Medi-Cal 2020 §1115 Medicaid Demonstration waiver, each WPC Program Lead Entity ("Lead Entity") shall submit Mid-Year and Annual reports for the duration of the WPC Program. The WPC Reporting and Evaluation guidelines, Attachment GG, provide the requirements for the Mid-year and Annual report.

The Mid-Year Report narrative contains data January-June 30, and is due August 31 for Program Years (PYs) 3-5.

The Annual Report narrative contains data from January 1 through December 31, and is due April 2 each program year. The Annual Report is not meant to be duplicative of narratives provided in the Mid-Year Report, but aims to capture a complete picture of accomplishments and challenges during the Program year.

The Lead Entity is required to submit these reports to the Whole Person Care inbox at: 1115wholepersoncare@dhcs.ca.gov.

II. PROGRAM STATUS OVERVIEW

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

During this period, San Mateo County (SMC) Health expanded access to SMC Connected Care Health Information Exchange (HIE) to the Health Plan of San Mateo (HPSM) and Community Based Organizations (CBOs), Full-Service Partnership (FSP) Telecare and HealthRight360. The HPSM and some community partners now have access to client clinical information shared in HIE.

SMC Health (SMCH) continues to conduct interdivisional meetings to identify and resolve system barriers faced by clients with complex needs. Monthly Whole Person Care (WPC) Operations Committee meetings with representation from all divisions 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 methodology for WPC Evaluation, establishment of Health Department data visualization think tank, and addressing all cause re-admissions among WPC clients.

Increasing coordination and appropriate access to care;
During this period, the number of referrals to the WPC triage line increased by 30% from 153 in the first half to 253 in the second half of 2019 bringing the total number of referrals in 2019 to 436. The majority of the referrals (43%) came from the San Mateo Medical Center (SMMC).

HPSM continues its efforts in implementing the Community Care Settings Program (CCSP) to support member transition from Skilled Nursing Facilities (SNF) and Long-Term Care (LTC) back into the community. Between July and December 2019, the CCSP transitioned 34 individuals from a SNF, LTC or those at risk for institutionalization back into the community bringing the number of individuals transitioning in 2019 to 55. The percentage of residents who maintain their community placement continues to be 98%. A costs analysis indicates that PMPM costs (which include Healthcare and LTC/SNF) showed significant cost savings of 37% or $3,897 per member per month.

The Emergency Department (ED) at SMMC and the Integrated Medicated Assisted Treatment (IMAT) team collaborated to develop protocols for the administration buprenorphine in the ED for individuals in active withdrawal from substance use. During this period, SMCH achieved a 56% increase between the first and second half of 2019 in the number of clients diagnosed with Opioid Use Disorder (OUD) who are either provided an administration of buprenorphine or a prescription during the ED visit at SMMC. The IMAT team also initiated a partnership with a local FQHC, Ravenswood Health Center (RHC), to help support initiation of MAT services and transition clients back to their primary health home at RHC.

SMCH continued to implement the Patient Activation Measure (PAM) among clients served by the Bridges to Wellness Team (BWT) with positive outcomes. 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 the PAM score change for level 1-3 clients to whom the PAM was re-administered in 2019 was higher than the common target. For the least activated clients at levels 1 and 2, the mean PAM score increased by 11.2 and 9.8 points respectively. The data shows that clients who scored a 1 at the initial assessment experienced an 88.2% improvement in their score. For clients that scored a 2, there was a 69.2% improvement at time of re-administration. We will be evaluating the health outcomes for these clients to determine if these changes resulted in improved health.

WPC coordinated various trainings across SMCH to enhance the capacity of staff in various aspects of client care.

1. **Trauma Informed Care**
   170 staff at the medical center received training in trauma-informed care practices.
2. **Peer Support**
   30 peer support staff received Intentional Peer Support (IPS) training, an evidence-based practice.
3. **Medicated Assisted Treatment**
   43 physicians, Nurse Practitioners and Dentists received Medicated Assisted Treatment (MAT) training and an additional 449 staff received education on MAT.
4. **ASAM Technical Assistance**
   12 half-day onsite technical assistance sessions on the use and implementation of best practices relevant to the ASAM were provided to community-based organizations that provide Alcohol and Drug treatment and two 2 onsite sessions were provided to 233 County direct service providers and administrative staff. The ASAM establishes clinical guidelines to improve assessment, treatment and recovery services for individuals with substance use disorders (SUD) and co-occurring conditions to enable appropriate level of placement, treatment planning and service provision at all levels.
5. **Feedback Informed Treatment (FIT)**

Trainings were provided to 213 direct care staff and supervisors. FIT is an evidence-based model in which the clinician actively solicits the clients input at each session through use of session rating and outcome rating scales. These scales are used to assure treatment is client directed and strengthens the therapeutic relationship between the provider and client.

Reducing inappropriate emergency and inpatient utilization;
Data indicates a slight reduction in Emergency Department (ED) use and an increase in in-patient utilization (IPU) among WPC clients between 2018 and 2019. During this period, the ED utilization rate for WPC clients improved very slightly. The numerator

(total number of ED visits in 2019) was calculated at 6509 while the denominator (the total member months) came to 26,130. This places our semi-annual rate at 249.10 ED visits per 1000-member months compared to 249.40 in 2018.The data indicates an increase in inpatient stays between 2018 and 2019. The numerator (total number of inpatient stays) was calculated at 1140 while the denominator (total member months) was calculated at 26,130. This translates into a rate of 43.63 inpatient stays/1000-member months. This is a 4% increase from the 2018 rate of 41.38.

Improving data collection and sharing;
During this period, SMCH made strides in enhancing existing and implementing new technologies and tools for information sharing. Some information sharing barriers were also overcome.

In addition to expanding the Health Information Exchange access to the HPSM and CBOs, the Health Department continued the process of optimization and data quality enhancements to our HIE. Providers across SMCH have access to the Emergency Department Information Exchange (EDIE) report and web based portal. There have been improvements on the user interface such as a banner bar that displays a summary of clients' social history. Medication fill history for WPC clients has also been pulled into the HIE. Several trainings on the additional internal and external clinical information found within the HIE were conducted. However, data is showing that HIE usage remained low in 2019. There is still a need for additional behavioral health information in the HIE to improve its usefulness. 42 CFR Part 2 limitations remain a challenge in information sharing across SMCH. In addition, emerging best practices for the use of the information in the HIE need to be identified and spread.

SMCH also worked towards increasing user access to comprehensive WPC cohort and client level data and developed capacity for data visualization. WPC analysts designed and implemented dashboards providing population and client level actionable data to management and providers. In addition, the Business Intelligence (BI) team is designing and developing an Enterprise Data Warehouse (EDW) for SMCH. As a first phase towards building an EDW, specifications were developed and a WPC data mart providing access to WPC universal and variant metrics were developed.

Our Correctional Health Services (CHS) is making steady progress in the development and implementation of technology to coordinate client care for the re-entry population. The process of transitioning CHS from paper charting to an EHR was initiated. However, this process stalled when unanticipated requirements and workflows emerged. The application is now expected to go live in October 2020. Once launched, health records of clients who received services from Correctional Health will be available to providers across SMCH as well as the HPSM through the HIE. The use of secure messaging of Protected Health Information (PHI) from provider to provider has been introduced to CHS. The re-entry staff are now using the secure messaging

application to share information with BWT, IMAT, and Service Connect to enhance coordination and access to care.

SMCH worked on a Memorandum of Understanding (MOU) with the Human Services Agency (HSA) to remove barriers to information sharing on Medi-Cal eligibility. The MOU, which will be implemented in the next reporting cycle, will facilitate some level of information sharing for the purpose of supporting clients to maintain and apply for Medi-Cal. H.S.A staff will now be able to share with select SMCH staff certain data elements such as specific reasons for disenrollment, and verifications needed for supporting paperwork. Although client authorizations will still be required for correspondences, the MOU will enable SMCH to overcome significant barriers that contributed to Medi-Cal churn among the WPC population.

Achieving quality and administrative improvement benchmarks;
During this period, a warm handoff policy for client transitions from intensive case management to primary care social work services was developed. The policy creates practice standards for warm handoffs of clients between the Bridges to Wellness Team (BWT) and SMMC Ambulatory Care Social Workers. The purpose of warm handoffs is to ensure a seamless transition of patient care that respects the unique needs, culture, values, and preferences of the client.

Increasing access to housing and supportive services;
In 2019, 100% of WPC clients referred for housing services received housing services. During this period, our Housing Department received a significant number of Mainstream Vouchers for persons with disabilities who are under the age of 62. Our WPC teams were able to access these vouchers and the Housing Committee was able to assist with housing locations services for many of these voucher recipients. By the end of 2019, 22 mainstream voucher holders had been approved for housing location services and 26 had been approved for housing subsidies. Due to the success of the program, the Housing Authority received an additional 90 vouchers and we expect that a substantial number of recipients will be Whole Person Care clients. Despite these advances in housing, San Mateo County continues to deal with the challenge of the limited stock generally as well as “housing first units” which would provide permanent supportive housing to homeless adults with mental illness and co-occurring substance related disorders.

SMC Health, in partnership with the HPSM, launched recuperative care services in the County. A contract was executed with an established recuperative care provider, Bay Area Community Services (BACS), and the program was stood up as a collaboration between WPC, HPSM, SMMC and BACS in December of 2019. In addition, a WPC care navigator was hired to support members being discharged from recuperative care into the community with the goal of decreasing rates of discharge to the streets. In

addition, Mental Health Association of San Mateo County was contracted to provide supportive housing services to WPC clients. By December 2019, 6 clients had been referred for supportive housing services.

Improving health outcomes for the WPC population.
Data indicates that a majority of clients receiving services from the Bridges to Wellness (BWT) are reporting improved health and self-management skills. In a survey conducted in late 2019 among 61 clients receiving BWT services, 78% of clients included in the results reported both improved health and self-management skills. A number of client stories demonstrate improvements in health outcomes for clients served by the BWT.

Client(s) were addicted for several years. After significant coaching and encouragement by the BWT Care Navigator (CN), they are now sober. With support from the CN, they have been able to achieve steady income, stable housing, and develop healthy personal relationships. They are currently self-managing their recovery and attend meetings at least twice weekly. They are also connected to an outpatient treatment clinic and receive monthly treatment to help decrease cravings.

Client(s) with multiple co-morbidities and other conditions and who experienced homelessness for several years, have not only been housed, but are also now connected to primary, specialty and mental health care. Prior to engaging with BWT, they experienced several barriers including managing medical appointments, getting medication refills when needed, and scheduling any specialty appointments. With support from the CN, they reconnected to primary and specialty care as well as mental health services. They are now housed, stable with medical and mental health care, and continue to move toward self-sufficiency with additional support from a supportive housing services provider.

Client(s), with history of lung diseases and an extensive history of homelessness are now housed and connected to primary care. Prior to engagement with BWT team, they experienced several hospitalizations in Emergency Departments (ED) and admissions to Skilled Nursing Facilities (SNF) in and out of the County. After an ED visit, the BWT CN worked closely with hospital staff and discharge planners for a safe discharge into a board and care placement funded with local housing dollars. They were successfully placed into the board and care from the ED, thereby ending the cycle of homelessness and emergency services. The CN worked with them to connect to back primary care and appropriate social services.

Client(s), with several chronic illnesses, history of substance abuse, and history of homelessness successfully graduated from intensive case management to a lower level of care. With support from BWT CN and housing location services, a unit was located and they moved into scattered site housing. They are also now

connected to primary care and behavioral health services. They are also re-engaging in vocational goals and potentially inheriting a business. By the end of 2019, they were closed to BWT through a warm hand off to our supported housing provider.

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	164	18	*	*	55	30	275

Item	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12	Annual Unduplicated Total
Unduplicated Enrollees	41	0	69	*	45	*	179

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*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							
Utilization 1							
Service 2							
Utilization 2							

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

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*For **Per Member Per Month (PMPM),** please report your rate, amount claimed and member months by PMPM type. These reports should tie to your budget, invoice and utilization reports. For "Bundle #" below, use the category number as reported in your submitted Quarterly Enrollment and Utilization Report. Add rows as needed*

Amount Claimed								
PMPM	Rate	Month 1	Month 2	Month 3	Month 4	Month 5	Month 6	Total
Bundle #1 Bridges to Wellness	$ 635.58	$643,206.96	$635,580	$626,046	$585,369	$587,378	$566,302	$3,643,881.96
MM Counts 1		1012	1000	985	921	910	891	5719
Bundle #2 Behavioral Health and Recovery Services	$ 828.63	$1,027,501	$1,029,598	$,1,020,044	$1,053,189	$1,078,876	$1,087,991	$6,438,602
MM Counts 2		1240	1242	1231	1271	1302	1313	7599

Amount Claimed								
PMPM	Rate	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12	Total
Bundle #1 Bridges to Wellness	$635.58	$572,657.58	$567,572.94	$562,488	$504,650.52	$490,032	$470,329	$3,167,730.04
MM Counts 1		901	893	885	794	771	740	4,984
Bundle #2 Behavioral Health and Recovery Services	828.63	$1,112,021.46	$1,086,333.93	$1,110,364.20	$1,145,167	$1,121,965	$1,093,792	$6,669,643.59
MM Counts 2		1342	1311	1340	1382	1354	1320	8049

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

We made some minor changes to and resubmitted our Enrollment and Utilization reports for Qtr 1 and 2 of 2019.

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 costs in relation to leasing office space and purchasing office supplies. Other costs incurred were in relation to license for the Patient Activation Measure (PAM), purchase of a passenger van, vehicle maintenance, telephone, information technology services, staff travel and training.
2. *Behavioral Health and Recovery Services (BHRS):* Costs incurred include administrative personnel costs. Programs serving WPC clients incurred costs in relation to leasing office space, and purchasing office supplies, furniture and computers. Indirect costs incurred covered the cost of accounting and administrative support. Other costs incurred were in relation to 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 of the Health Information Exchange, as well as planning activities in relation to enhancing the HIE by linkage to the Emergency Department Information Exchange (EDIE) and expanding access to HPSM, CBOS and FQHCs. Expenses were incurred in extending EHR Sorian from San Mateo Medical Center to Correctional Health Services.

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.
2. *Process Improvement software:* During this period, SMCH finalized the contracting process for the software that will assist us to improve our continuous improvement efforts. The software has been procured and is in the process of being configured for use by SMCH.
3. *Recuperative Care: A* contractor was selected and Recuperative Care services were officially launched as a collaboration between HPSM, SMC Health, SMMC and Bay Area Community Services (BACS). A site was located, sanitized, and furnished. Staff were engaged/or hired, workflows and procedures were developed. Clients were referred for services by the end of PY4.
4. *Learning Collaborative on Individualized Treatment:* SMCH contracted with California Institute for Behavioral Health Solutions (CIBHS) to assist with the implementation of the Feedback Informed Treatment (FIT) Model. During this period, FIT trainings were provided to direct care staff and supervisors. Provider teams from four Substance Use Disorder (SUD) treatment agencies, representing multiple facilities and levels are care also attended the training. Follow-up FIT webinars provided support to each agency in the pre-implementation preparation phases including an agency self-assessment, to preview the software for support, clarify FIT best practices. To support implementation of FIT, SMCH purchased a platform by which the FIT data could be uploaded and analyzed to provide feedback to the counselors regarding the effectiveness of their individual and group counseling sessions with clients. In addition, ASAM support materials were purchased for use by contract providers and county staff when implementing ASAM practices.

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. *Attendance at Complex Case Conferences.* Triggering Deliverable: 75% (18 of 24) of WPC bi-monthly complex case conferences will have 100% attendance. Out of the 18 Complex case conferences, budgeted for PY4, 10 of the 12 were held between July-December 2019 had 100% representation. SMC Health is claiming for 9 earning $20,000.
2. *Management recommendations for addressing system barriers and strategies for service improvements*. Triggering Deliverable: 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 PY4, 6 are claimed mid-year, and 3 are being claimed between July-December 2019. SMC Health earned $ 13,333.33. At each meeting, issues and/or system barriers were brought forward, and the following recommendations were proposed by the committee:
    - Recognizing that various programs were conducting specific evaluations, the committee endorsed the constitution of a WPC Workgroup to guide the process of the evaluation of all WPC participating programs.
    - In noting that there were parallel efforts in understanding and addressing all cause re-admissions, the committee recommended a joint effort between WPC Administrative Hub and the medical center.
    - In view of the various data visualization initiatives across SMCH, the Committee recommended the formation of a data group to enable sharing of resources across SMCH.
    - Recommended a pilot to reduce social isolation for WPC clients served by the Community Care Settings Pilot.
3. *Capacity development activities for providers completed*. 12 half-day onsite technical assistance sessions on the use and implementation of best practices relevant to the ASAM were provided to community-based organizations that provide Alcohol and Drug treatment and two 2 onsite sessions were provided to 233 County direct service providers and administrative staff. SMC Health earned $160,000.
4. *Integration of HIE technology with CBOS by December 31, 2019.* HIE technology has been successfully integrated with Telecare Corporation and HealthRight360. HIT earned $500,000.

5. *Integration of HIE technology with business partners and FQHC clinics by December 31, 2019.* HIE Technology has been extended to the Health Plan of San Mateo (HPSM) as well as Fair Oaks Health Center, Daly City Clinic and South San Francisco Clinic. HIT earned $500,000
6. *Provide documentation that Data Mart specifications have been designed to improve ease of access to WPC metrics*. The Business Intelligence team has designed data mart specifications, reviewed the metric logic, and created metric code. WPC data marts providing access to WPC metrics have been built. HIT has earned $213,681.25
7. *Ensure that care coordinators and physicians will be able to view medication fill history in the HIE September 30, 2019*. Care Coordinators and physicians can view medication fill history in the HIE. HIT earned $588,000.
8. *Ensure that the care team can utilize Diameter Health software to improve support to complex clients who typically have multiple medications and treatment needs by December 31, 2019.* Diameter Health software has been purchased and implemented. This software has allowed us to better analyze the data available, and to identify where we have opportunities for improvement. HIT has earned $700,000.
9. *Report on quality enhancements made to the HIE environment that improve usability by December 31, 2019*. A report of the recommendations of the quality enhancements to the HIE needed to optimize functionality and reliability was produced by Zen Health. HIT earned $1,125,000.
10. *Completion of 10 trainings to staff across the health system on HIE enhancements by December 31, 2019*. During this period, HIT conducted 6 trainings on the quality enhancements to the HIE including topics such as the EDIE report and portal, the new Banner Bar, and the Zen Health report. HIT earned $150,000.
11. *10% 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.* SMCH saw a 56% increase in the number of clients diagnosed with Opioid Use Disorder (OUD) who are given an administration of buprenorphine or prescription during the ED visit at SMMC between the first half and second half of 2019. SMCH earned $160,000.

VI. NARRATIVE – Pay for Outcome/Reporting

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 knowledge and learnings in 2019, we needed to re-run our metric rates for 2018 in addition to 2019. We have found some new data sources previously unavailable and have learned new methods of collating the data from various sources.

(a) *Ambulatory Care-Emergency Department (ED) visits.* Data is indicating that the ED utilization rate for WPC clients improved very slightly between 2018 and 2019. The numerator (total number of ED visits in 2019) was calculated at 6509 while the denominator (the total member months) came to 26,130. This places our semi-annual rate at 249.10 ED visits per 1000-member months compared to 249.40 in 2018.

(b) Inpatient Utilization. Data shows an increase in patient stays between 2018 and 2019. The numerator (total number of inpatient stays) was calculated at 1140 while the denominator (total member months) was calculated at 26,130. This translates into a rate of 43.63 inpatient stays/1000-member months. This is a 5% increase.

(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 2018 and 2019. The total number of suicide risk assessments in 2019 was calculated at 32, while the count of clients with major depressive disorder is 480 bringing the rate to 6.67% compared to 15.1% in 2018. The decline can be attributed to a change SMCH made in calculating the numerator. SMCH introduced a practice change in the completion of suicide risk assessments in 2018 and determined that one of the previously used sources of data did not meet the technical specifications. We remain pleased with the practice change that was implemented to introduce an evidenced based tool that will be used across SMCH. We realize that this practice change will require time for better adoption.

(d) Comprehensive Diabetes Care. Data shows a slight decline in the rate for diabetes (HbA1c) control between 2018 and 2019. 53.75% of clients diagnosed with diabetes

had HbA1c below 8 in 2019 compared to 52.86% in 2018.*Follow up after hospitalization for mental illness.* SMCH has seen some improvement on this metric. In 2019, the total number of patients receiving a follow-up mental health visit within 7 days of discharge was calculated at 92, while the total inpatient discharges for person hospitalized for mental illness was 195 bringing the rate to 47.18% compared to 36.22% in 2018. The total number of patients receiving a mental health follow up visit within 30 days of discharge was 136 compared to the total 195 bringing the rate to 69.74% compared to 56.12% in 2018. 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 discover the hospitalizations after the 7 days.

(e) *Initiation and engagement of AOD dependence treatment*
In 2019, the total number of clients who initiated AOD dependence treatment within 14 days of diagnosis was calculated at 254, and the total number of clients with a new episode of AOD diagnosis is 613 bringing the rate to 41.44%. The total number of WPC clients who initiated treatment and had two or more additional services within 30 days of diagnosis was calculated at 137, and the total number of clients who initiated treatment within 14 days was 245 bringing the rate to 53.93% When calculated as a percentage of the total number of clients with a new episode of AOD diagnosis (613), the rate comes to 22.35%

(f) *30 Day All Cause Readmissions.* The rate of All Cause Readmissions increased from 20.28% in 2018 to 26.42% in 2019. The count of 30 day all cause re-admissions in 2018 was 256 and compared to the count of index hospital stays for the eligible population of 969, bringing the rate to 26.42%

(g) *Percentage of homeless clients receiving housing services after being referred for housing services*. In 2019, we achieved 100% with all clients receiving housing services after referral. WPC clients were referred for housing services, and all received housing services. The number of clients served increased * in 2019.

(h) *Percentage of clients with a comprehensive care plan accessible by the entire care team within 30 days.* In 2019, 41.63% of new enrollees had a comprehensive care plan compared to 41.59% in 2018. In addition, 44.01% of WPC continuing enrollees have a comprehensive care plan.

(i) *Assignment of Care Coordinator.* In 2019, 59.41% of WPC participants had a care coordinator assigned, compared to 60.53% in 2018. The number of WPC clients

engaged in some form of care coordination program was calculated at 1585, compared to the total number of enrollees in 2019 which was 2579.

Pay for Outcome Metrics

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 a very slight change in the rate of ED utilization between 2018 and 2019.
   a. Achieved: This metric is paid based on DHCS run data; the trigger for payment was achieved. DHCS data showed a reduction from PY3 to PY4 that surpassed 5%. $372,290.38

(b) *Completion of Suicide Risk Assessment.* Data is showing that the rate for completion of suicide risk assessments decreased from 17.7 to 6.67% compared to the target of 22%.

(c) *Proportion of clients served by the Bridges to Wellness team (BWT) with a primary care visit within the measurement year.* 67% of clients served by BWT had a primary care visit in 2019 compared to the target of 55%. $269,478.52

(d) *Proportion of clients served by Bridges to Wellness (BWT) surveyed reporting improved health and self-management skills.* 78% of clients served surveyed reported improved health and self-management skills compared to the target of 60%. $269,478.52

(e) *Proportion of WPC clients with PHQ9 score 13 or higher referred to med-psych or warmly handed off to Behavioral Health.* 80% 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 50%. $269,478.52

(f) *Proportion of justice involved who receive a two-week supply of medications upon re-entry.* 54% 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 50%.$269,478.52

(g) *Proportion of San Mateo Medical Center (SMMC) Clinics whose staff receive training in trauma informed care.* SMMC staff in 80% of the Clinics attended trainings in trauma informed care compared to the target of 75%.$269,478.52

(h) *Proportion of clients served by the HOPE program with zero recidivism that transition to a lower level of care successfully for 6 months.* 79% of clients served by the HOPE program in 2019 transitioned to a lower level of care successfully for 6 months compared to the target of 65%. $269,478.52

(i) *Proportion of peer participants who engage in peer recovery activities every month for 6 months.* 83% of participants enrolled in the HOPE services engaged in recovery related activities for 6 consecutive months. $158,969.55

(j) *Number of health system staff educated on Medication Assisted Treatment (MAT).* 449 staff across SMCH were educated on MAT compared to the target of 300. $269,478.52

(k) *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. $269,478.52

(l) *Proportion of clients served by the CCT team with monthly visits by social workers within the measurement year.* 90% of clients served by CCT team received monthly visits from social workers compared to the target of 70%. $269,478.52

(m) *Number of CCSP clients transitioning into community.* 55 CCSP clients were transitioned into the community in 2019 meeting the set target. $134,739.26

(n) *Average number of days it takes to transition a CCSP client into community.* The average number of days it takes to transition the 55 CCSP clients into care was 90 days. This is lower than the target of 100 days. $134,739.26

(o) *Proportion of transitioned CCSP members still in the Community at six months.* Data shows that 90% of CCSP clients are still in the community at six months after the transition. This exceeds the 65% target we set. $134,739.26

(p) *Proportion of CCSP clients that successfully remain in community for twelve (12) months in measurement year.* Data shows that 100% of CCSP clients were in the community for 12 months in 2019. This exceeds the 65% target we set. $245,248.23

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.

Attachment I: San Mateo County-WPC Stakeholder Engagement

Stakeholders	Meeting Title	Meeting Purpose
SMC Departments	Operating Committee Meeting	This meeting is held monthly and is responsible for assisting the supporting workgroups (Care Coordination and Quality) to remove barriers and make executive decisions around policies and system changes recommended by the Care Coordination and Quality workgroups. Topics discussed include: WPC Evaluation; providing actionable data to managers and providers using data visualization tools; Addressing 30-Day All Cause Re-admissions; Social Isolation program; Recuperative Care start-up in San Mateo.
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 is held bi-weekly and is intended to identify the health system gaps and barriers that limit care coordination for WPC clients with the goal of developing solutions that provide a more coordinated health care delivery approach. Topics
Public Health, Policy, and Planning		
Health Administration		
Behavioral Health & Recovery Services		
BHRS-IMAT		
San Mateo Medical Center		

Stakeholders	Meeting Title	Meeting Purpose
Aging Adult Services		discussed included WPC patients with chronic conditions who need primary care; Electronic Pill dispensers; Care4Life application for diabetes management, Emergency Department Information Exchange (EDIE) report and portal, Stigma Improvement Charter, Warm Handoff Policy, Risk Assessment tools, and Complex Case Conferences.
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 monthly 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 twice a month for the purpose of developing and monitoring P&P for providing housing services, and housing subsidies. Topics discussed policies and procedures for housing referrals, review of housing referral applications, review of implementation of approved housing applications.
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

Briefly describe 1-2 successes you have had with care coordination.
1. SMCH in partnership with the HPSM and Bay Area Community Services launched recuperative care services during this period. This provides a safe place for discharge of clients experiencing homelessness transitioning from hospitalization and yet not well enough to be discharged to the streets. 2. As a result of the collaboration between the Emergency Department (ED) at SMMC and the Integrated Medicated Assisted Treatment (IMAT) team, clients diagnosed with Opioid Use Disorder (OUD) can receive Medicated Assisted Treatment (MAT) in the ED when they need it. This has led to increased engagement and linkage to services. SMC Health saw a 56% increase in the administration of MAT during the ED visit at SMMC between the first half and second half of 2019.

Briefly describe 1-2 challenges you have faced with care coordination, and lessons learned from those challenges.
1. SMCH continues to deal with the challenge of the limited stock of “housing first units” which would provide permanent supportive housing (PSH) to homeless adults with mental illness and co-occurring substance related disorders. 2. Barriers set forth by 42 CFR Part 2 regulations protecting Substance Use information limit the sharing of SU for care coordination without specific client consents.

Briefly describe 1-2 successes you have had with data and information sharing.
1. Our Health Information Exchange has now been extended to the Health Plan of San Mateo (HPSM) and two CBOs - Telecare and HealthRight360. 2. WPC designed and implemented dashboards providing population and client level actionable data to management and providers. WPC metrics and other actionable administrative data can be accessed by users using dashboards.

Briefly describe 1-2 challenges you have faced with data sharing, and lessons learned from those challenges.
1. HIE use remained low in 2019 as providers continued to use source EHRs. There is still a need for additional behavioral health information in the HIE to improve its usefulness. In addition, emerging best practices for the use of the information in the HIE needs to be identified and spread. 2. The implementation of dashboards providing actionable client level data for providers went through several iterations to meet the needs of users. The implementation of data sharing tools for end-users requires a participatory approach with providers identifying their data needs.

Briefly describe 1-2 successes you have had with data collection and/or reporting.
1. SMCH has been able to put together data from various sources including claims, internal behavioral health and medical data for running the WPC metrics. 2. SMCH has increased staff capacity for claims data analysis after a claims in-service training with the HPSM. In addition, HPSM has now automated the process for data sharing with HPSM through a Secure File Transfer Portal.

Briefly describe 1-2 challenges you have faced with data collection and/or reporting.
1. Data from various sources can be challenging to collate due to variation in variables and identifiers. There is a need to standardize identifiers and variables for data collected across from E.H.Rs across SMC Health.

Looking ahead, what do you foresee as the biggest barriers to success for the WPC Program overall?
(1) Overcoming barriers to share AOD information across providers within the same department. (2) Acceptance of technology, tools, and processes across and within divisions. (3) Ability to fund and adopt models that address the need for flexible, on-demand services.

3. 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. PDSA Summary sheet
2. PDSA summary reports:
   (a) Ambulatory Care – Emergency Department Visits BWT Qtr3
   (b) Ambulatory Care – Emergency Department Visits BWT Qtr4
   (c) Inpatient Utilization BWT Qtr 3
   (d) Inpatient Utilization BWT Qtr 4
   (e) Comprehensive Care Plan Qtr 3
   (f) Comprehensive Care Plan Qtr 4
   (g) Care coordination CCC Annual 2
   (h) Care coordination WHOs Annual 2
   (i) Data and information sharing: Annual -HIE
   (j) Data and information sharing: Annual -Location Services
   (k) Other: Medi-Cal churn- Annual
   (l) Other: Patient Activation Measure (PAM)-Annual