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

County of Santa Cruz Health Services Agency, Whole Person Care – Cruz to Health (WPC – C2H)
Annual Narrative Report PY4
Submitted: April 30, 2020
Revised: July 14, 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.

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.

Successes

Achieving quality and administrative improvement benchmarks: Process Improvement focus - In August 2019, twenty-one Lean Six Sigma team members passed the Green Belt certification exam, including WPC-C2H staff, contractors and stakeholder partners.

Achieving quality and administrative improvement benchmarks: Seven Lean Six Sigma process improvement projects continued towards completion, with the goal of improving care coordination and outcomes for WPC-C2H.

Improving data collecting and sharing: Approximately 70 people attended the October 2019 Data Sharing Convening

Increasing coordination and appropriate access to care: The case management teams hosts regular meetings with housing and peer support partners. This has improved procedures for coordination of referrals and follow-up. Working with its contractors and community partners, the program selected a vendor to build a care coordination platform to be piloted by WPC-C2H and two other community organizations and began implementation steps.

Increasing access to housing and supportive services: Providing housing support services continues to be in demand and one of the primary requests from referrers of enrollees into the pilot. Housing navigators are successfully cultivating relationships with landlords to find the right fit, which in combination with the housing supports (deposit/first month's rent) and tenancy supports (for goods and services) are significantly improving housing outcomes for some of the pilot's hardest to house enrollees.

Delivery infrastructure:
A re-boot occurred in the development and implementation of a care coordination platform with the selection of a new vendor, based on a community-engaged request for proposals process. The community-engaged process allowed for the Whole Person Care (WPC) program to work in collaboration with partners to identify critical care coordination platform functionalities that can improve the care coordination work for the program and the community. As a result, the WPC program and its partners identified a vendor that could rapidly build and deploy a care coordination platform. The care coordination platform has been built and is currently being used.

Challenges

Increasing Integration among county agencies, health plans, providers and other entities: Lack of a shared Electronic Health Record (EHR) and staff vacancies in leadership positions continues to create challenges to integration.

Staffing and program capacity: The program was without one of two housing navigators for three-quarters of the year. The WPC-C2H case managers have full caseloads and the program started a wait list. It is a challenge to meet the long-term case management needs of clients whose access to housing resources is tied to case management.

Lessons Learned

Achieving quality and administrative improvement benchmarks: The Lean Six Sigma approach has been successful in guiding staff to assess program activities, present data and make informed program decisions.

Increasing integration among county agencies, health plans, providers, and other entities: Stakeholder engagement and buy-in is a long process that requires extensive development of trust and continual invitations to participate.

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	11	12	[redacted]	[redacted]	[redacted]	[redacted]	43

Item	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12	Annual Unduplicated Total
Unduplicated Enrollees	[redacted]	[redacted]	[redacted]	21	16	[redacted]	104

Whole Person Care

County of Santa Cruz Health Services Agency, Whole Person Care – Cruz to Health
Annual Narrative Report, Program Year 4
April 29, 2020

*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	**Rate**	**Month 1**	**Month 2**	**Month 3**	**Month 4**	**Month 5**	**Month 6**	**Total**
FFS 1 - Housing Support	NA	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	$27,579.55
Utilization 1		[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	36
FFS 2 - Tenancy Supports	NA	[redacted]	$10,827.55	[redacted]	$9,558.29	[redacted]	[redacted]	$38,973.34
Utilization 2		[redacted]	18	[redacted]	14	[redacted]	[redacted]	66
FFS 3 - Outreach and Referral	$175.00	[redacted]	[redacted]	[redacted]	[redacted]	$3,325.00	$9,625.00	$17,675.00
Utilization 3		[redacted]	[redacted]	[redacted]	[redacted]	19	55	101
FFS 4 – Screening/ Assessment	$300.00	$4,200.00	$5,700.00	[redacted]	[redacted]	$5,700.00	$16,500.00	$38,700.00
Utilization 4		14	19	[redacted]	[redacted]	19	55	129
FFS 5 - Recuperative Care	$400.00	$0.00	$0.00	$0.00	$31,600.00	$24,800.00	$26,800.00	$83,200.00
Utilization 5		0	0	0	79	62	67	208

Whole Person Care

County of Santa Cruz Health Services Agency, Whole Person Care – Cruz to Health
Annual Narrative Report, Program Year 4
April 29, 2020

Costs and Aggregate Utilization for Quarters 3 and 4								
FFS	**Rate**	**Month 7**	**Month 8**	**Month 9**	**Month 10**	**Month 11**	**Month 12**	**Annual Total**
FFS 1 - Housing Support	NA	$11,464.04	[redacted]	$7,005.80	[redacted]	$7,642.69	[redacted]	$69,614.36
Utilization 1		18	[redacted]	11	[redacted]	12	[redacted]	102
FFS 2 - Tenancy Supports	NA	[redacted]	[redacted]	[redacted]	$11,157.90	$12,874.50	$12,016.19	$93,046.23
Utilization 2		[redacted]	[redacted]	[redacted]	13	15	14	129
FFS 3 - Outreach and Referral	$175.00	$2,275.00	$2,275.00	$6,650.00	$6,125.00	$4,725.00	$6,650.00	$46,375.00
Utilization 3		13	13	38	35	27	38	265
FFS 4 – Screening/ Assessment	$300.00	$3,900.00	$3,900.00	$11,400.00	$10,500.00	$8,100.00	$11,400.00	$87,900.00
Utilization 4		13	13	38	35	27	38	293
FFS 5 - Recuperative Care	$400.00	$12,400.00	$4,400.00	$6,800.00	$30,000.00	$49,600.00	$37,600.00	$224,000.00
Utilization 5		31	11	17	75	124	94	560

Whole Person Care

County of Santa Cruz Health Services Agency, Whole Person Care – Cruz to Health
Annual Narrative Report, Program Year 4
April 29, 2020

*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*

Costs and Aggregate Utilization for Quarters 1 and 2								
PMPM	**Rate**	**Month 1**	**Month 2**	**Month 3**	**Month 4**	**Month 5**	**Month 6**	**Total**
Bundle #1 – Behavioral Health	$ 502.24	$30,636.64	$31,641.12	$29,129.92	$26,618.72	$26,116.48	$25,112.00	$169,254.88
MM Counts 1		61	63	58	53	52	50	337
Bundle #2 – Clinical	$ 501.15	$133,807.05	$135,811.65	$145,834.65	$134,809.35	$135,310.50	$134,308.20	$819,881.40
MM Counts 2		267	271	291	269	270	268	1636
Bundle #3 – Intensive Housing Support	$ 717.50	$21,525.00	$25,112.50	$18,655.00	$15,067.50	$17,220.00	$25,112.50	$122,692.50
MM Counts 3		30	35	26	21	24	35	171
Bundle #4 – Intermediate Housing Support	$ 170.63	$4,607.01	$4,948.27	$4,607.01	$6,313.31	$5,972.05	$5,289.53	$31,737.18
MM Counts 4		27	29	27	37	35	31	186

Costs and Aggregate Utilization for Quarters 3 and 4								
PMPM	**Rate**	**Month 7**	**Month 8**	**Month 9**	**Month 10**	**Month 11**	**Month 12**	**Annual Total**
Bundle #1 – Behavioral Health	$502.24	$29,129.92	$27,623.20	$28,125.44	$28,627.68	$28,627.68	$24,107.52	$335,496.32
MM Counts 1		58	55	56	57	57	48	668
Bundle #2 – Clinical	$501.15	$128,795.55	$130,800.15	$136,813.95	$156,358.80	$167,885.25	$172,395.60	$1,712,930.70
MM Counts 2		257	261	273	312	335	344	3418
Bundle #3 – Intensive Housing Support	$717.50	$30,135.00	$25,112.50	$21,525.00	$24,395.00	$21,525.00	$23,677.50	$269,062.50
MM Counts 3		42	35	30	34	30	33	375
Bundle #4 – Intermediate Housing Support	$170.63	$13,560.48	$14,564.96	$11,551.52	$14,564.96	$10,547.04	$14,564.96	$58,696.72
MM Counts 4		27	29	23	29	21	29	344

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

Referral and Enrollment Process

- 104 total new enrollments during PY4 Year.
- During PY4 Year, 265 referred and 293 checked for eligibility but not everyone was enrolled due to missing criteria (i.e. out of county, no mental health or substance use diagnoses, etc.).
- Began a process improvement project using Lean Six Sigma methodology to streamline referrals, enrollment and linkage to services.

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.

The WPC-C2H Administrative team focused efforts in PY4 on system changes efforts and continued administration of direct services through the pilot. Key achievements included:

- Moving the WPC-C2H Administrative team to offices on the Santa Cruz County Health Services Agency (HSA) Emeline campus. The location provides more efficient access to County staff, programs and community partners.
- On-time reporting of the quarterly enrollment and utilization reports by the Quality Improvement Manager, which has included improving tracking and data collection activities.
- Consolidation of databases, testing and documenting eligibility review processes, and overall improvements to the information gathering and flow of new enrollees.
- Completion of Lean Six Sigma process improvement project to track and share outcomes. Participants include the Program Director, Quality Improvement Manager and key partners. This process improvement helped the pilot develop measures of success to share as sustainability plans advance.
- Continued to utilize updated policies and procedures for eligibility checking.
- Continued successful supervision and project management of contractors, vendors, and staff related to implementing improved data sharing, care coordination and process improvement activities.
- Collaborations between Health Services Agency partners around epidemiological activities, strategic planning, and housing programs as related to the WPC-C2H enrollee population.

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.

Key highlights of activities from Delivery Infrastructure include:

- Hosted a community-wide Data Sharing Convening, titled "Tools Toward Client Centered Information Sharing" on October 25, 2019. 71 attendees from 15 organizations participated. Presentations included findings from WPC-C2H Lean Six Sigma team projects on Data and Information Sharing and Improving Care Coordination. Also shared was overview of the newly developed care coordination platform and an interactive discussion occurred about bridging the gap in information sharing locally. Participant evaluations concluded that they learned more about the Release of Information (ROI) process and the need to improve information sharing for the best interest of clients.
- Completion of the Improving Sharing and Improving Care Coordination Lean Six Sigma projects. Projects informed the pilot in developing mechanisms and processes to better serve enrollees.
- The development and implementation of a care coordination platform made significant progress. With input from community partners and guidance from contractors Health Improvement Partnership (HIP) and Intrepid Ascent, a new vendor was selected and contracted. The build process for Together We Care (TWC) within the Santa Cruz Health Information Exchange (SCHIE) began with the vendor ActMD (now ActivateCare). The platform will launch fully in PY5.
- Continuing to develop strategies towards sustainable data sharing infrastructure and integration, looking at the long-term requirements for the selected care management technology solution, and considering data governance structures in the community.
- The Care Coordination Professional Networking series continued in PY4 with a session in September titled "Improving Care Coordination in Complex Settings". The primary speaker at this well-attended session was the Chief of Psychiatry with Santa Cruz County Health Services, Behavioral Health Division. The focus was developing best practice interventions when caring for patients with complex needs. The sixth session in the series was held in November with a look back at the series and a discussion about continued engagement. An evaluation survey was sent to 160 series participants and a report developed. The report details the

positive response of participants. Participants valued the opportunity to network, learn about community agencies, and how to make referrals. Workforce development activities, incorporated throughout the series informed participants about career paths in care case management, and tools such as mindfulness, trauma informed care and motivational interviewing.

- Significant progress was made on the ANSA project to establish a robust data reporting system and tools to effectively inform and continue to improve the service delivery process from Adult Needs and Strengths Assessment (ANSA) for behavioral health engaged clients through data captured in EHR systems.
- Recuperative Care Center (RCC) coordination successfully supported additional outreach and engagement to enrollees within and to utilize the RCC. This coordination included improved collaboration with RCC partner agencies.

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.

Device Utilization Incentive: Based on monthly utilization rates for client participation in the TeleFriend program, a total of $1,725.00 was earned for the second half of PY4. Participation rates are for a total of 23 clients. Payment was made to clients who successfully utilized devices.

Lessons Learned Towards Best Practices: Lessons were tracked and documented by the Quality Improvement Manager across the various activities in WPC-C2H. These lessons learned will be applied through the remainder of the pilot as attention turns toward sustainability and scaling of successful activities. $10,000 was earned per documented lessons learned, with 28 lessons learned in the second half PY4, for a total of $280,000. Payment was made to HSA Behavioral Health Division.

Psychiatry Leadership meetings: Psychiatric leadership were involved in meetings throughout PY4, with 4 meetings achieved in this reporting period. This included attendance and active engagement of psychiatric leadership, including the HSA Chief of Psychiatry. Their participation in Leadership meetings and data sharing discussions increased representation of the complex clinical/psychiatric needs of enrollees. $2,002.84 was earned per documented meeting with involvement of psychiatric leadership, totaling $8,011.36 earned in the second half of PY4. Payment was made to HSA Behavioral Health Division.

Professional Development trainings on process improvements: This objective was completed, and incentive earned during the PY4 Mid-Year reporting period.

Implement Mobile Health Van: While progress was made in the ordering and procurement of the vans, delays from the vendor has resulted in the van delivery and implementation being delayed into PY5, thus this incentive benchmark was not achieved in PY4.

Smoking Cessation Groups: Challenges with identifying staffing and a model for these groups preventing achievement of this incentive benchmark in PY4.

Development and implementation of HIE notification of ED use: Incentive was earned in the second half of PY4. Notifications of ED use of WPC-C2H enrollees began on 11/08/2019 and are fed into the HIE from local EDs, which then flow to the County's EHR. HIE notifications of ED use to the County's EHR is a new integration with potential to actively notify care team members of enrollees' admission and discharge to local emergency departments. This valuable integration will improve how enrollees are coordinated during inpatient stays and upon discharge for a more seamless flow of services by allowing care team members to receive notice more expediently of client ED admission. Amount earned was $40,000. Payment was made to participating county partners.

HIE notifications of ED use: Due to the limited automation of client pairing between the County's EHR (EPIC) records and ED information, there has been a delay in operationalizing the information received through the data integration. This activity was still in progress as the client pairing issue continued through the end of PY4, thus this incentive benchmark was not achieved in PY4.

Implement Population Health reporting tools: Incentive was earned in PY4 Mid-Year reporting period.

Training for Integrated Illness Management and Recovery (I-IMR): A training for new facilitators is planned and scheduled for early PY5. This training will be facilitated by three locally trained facilitators. By leading the training, they will become certified master trainers and able to help sustain I-IMR in Santa Cruz County. This incentive benchmark was not fully attained in PY4 (completed two out of the three trainings).

Barriers identified to secure Supportive Housing: Challenges were encountered with identifying solutions to reduce barriers and secure units for supportive housing, which prevented achievement of this incentive benchmark in PY4.

Contingency Management: Incentive was earned in PY4 Mid-Year reporting period.

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.

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

a. Performance – Not met: The target of 80% or greater WPC-C2H participants would receive a routine follow-up after initial urgent appointment that occurred within 7 days of the patient's recent discharge. In PY4 Mid-Year, 10% was achieved.

b. Challenges – It has been challenging for WPC-C2H and County clinics to develop methods to rapidly engage clients after being discharged from an inpatient setting. This challenge is significantly magnified when inpatient discharge data is not easily accessible to providers within their EHR systems.

c. Lesson Learned – The WPC-C2H program needs to work with SCHIO to establish an ADT connection to the County's EHR systems. Having this connection would allow providers to receive notifications of client's admission, transfers, and discharges.

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

a. Performance – Metric was met: 52 (57%) out of 92 clients currently being served in coordinated case management have received at least 12 months of services. In addition, the percentage of clients receiving at least 12 months of coordinated case management services exceeded the target of 35%. The total amount earned was $37,500.

b. Challenges – Data collected to document the delivery of case management services is not stored within a centralized system that allows for real-time access.

c. Lesson Learned – WPC-C2H needs to identify a system that allows for information to be shared in real time and allows easy access.

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.

PY4 Annual Stakeholder Engagement Activities List

Whole Person Care - Cruz to Health
Stakeholder Engagement Meetings (Program Year 4, Jan - Dec)

DATE	PARTICIPANTS	PURPOSE
1/3/2019	WPC + Dartmouth University	Discuss Integrated Illness Management and Recovery (I-IMR) and TeleFriend device research study
1/8/2019	WPC + WPC Leadership	Discuss WPC program
1/9/2019	WPC + Dartmouth University + County of Santa Cruz Health Services Agency (HSA) Staff + Front St., Inc.	Dartmouth presentation on health homes and health promotion interventions
1/10/2019	WPC + Dartmouth University	Discuss Integrated Illness Management and Recovery (I-IMR) and TeleFriend device research study
1/10/2019	WPC + County of Santa Cruz Clinics Staff	Discussion around monitoring the WPC TeleFriend devices
1/11/2019	WPC + Santa Cruz Health Information Organization (SCHIO) + Intrepid Ascent	Discuss development of the Together We Care care coordination platform
1/14/2019	WPC + Central California Alliance for Health (CCAH) + Health Improvement Partnership (HIP) + multiple community organizations	Convening to discuss best practices in data sharing
1/17/2019	WPC + Dartmouth University	Discuss Integrated Illness Management and Recovery (I-IMR) and TeleFriend device research study
1/22/2019	WPC + WPC Leadership	Discuss WPC program
1/23/2019	WPC + SCHIO + Intrepid Ascent	Discuss development of the Together We Care care coordination platform
1/24/2019	WPC + Dartmouth University	Discuss Integrated Illness Management and Recovery (I-IMR) and TeleFriend device research study

DATE	PARTICIPANTS	PURPOSE
1/28/2019	WPC + WPC Lead Entities + DHCS	Discuss WPC programs with DHCS
1/30/2019	WPC + SCHIO + Intrepid Ascent	Discuss development of the Together We Care care coordination platform
1/31/2019	WPC + Dartmouth University	Discuss Integrated Illness Management and Recovery (I-IMR) and TeleFriend device research study
2/6/2019	WPC + SCHIO + Intrepid Ascent	Discuss development of the Together We Care care coordination platform
2/6/2019	WPC + County of Santa Cruz Clinics Staff + County of Santa Cruz HSA Staff	Discuss Medical Assistant (MA) roles in the integration of services between Behavioral Health and Clinics
2/7/2019	WPC + Dartmouth University	Discuss Integrated Illness Management and Recovery (I-IMR) and TeleFriend device research study
2/14/2019	WPC + Advisory Council	Staffing, program update, Bridging the Care Coordination gap, annual report, communication planning, improving data collection
2/14/2019	WPC + Dartmouth University	Discuss Integrated Illness Management and Recovery (I-IMR) and TeleFriend device research study
2/14/2019	WPC + HIP	Care Coordination Steering Committee
2/20/2019	WPC + SCHIO + Intrepid Ascent	Discuss development of the Together We Care care coordination platform
2/21/2019	WPC + Dartmouth University	Discuss Integrated Illness Management and Recovery (I-IMR) and TeleFriend device research study
2/26/2019	WPC + WPC Leadership	Discuss WPC program
2/26/2019	WPC + HIP + multiple community organizations	Care Coordination Networking Series – networking and learning opportunity for care coordinators
2/27/2019	WPC + SCHIO + Intrepid Ascent	Discuss development of the Together We Care care coordination platform
2/28/2019	WPC + Dartmouth University	Discuss Integrated Illness Management and Recovery (I-IMR) and TeleFriend device research study
3/6/2019	WPC + Data IT	Workgroup planning and governance updates, current projects and responsibilities, workgroup vision
3/6/2019	WPC + WPC Lead Entities + DHCS	Discuss WPC programs with DHCS

DATE	PARTICIPANTS	PURPOSE
3/7/2019	WPC + Dartmouth University	Discuss Integrated Illness Management and Recovery (I-IMR) and TeleFriend device research study
3/12/2019	WPC + WPC Leadership	Discuss WPC program
3/13/2019	WPC + SCHIO + Intrepid Ascent	Discuss development of the Together We Care care coordination platform
3/14/2019	WPC + Dartmouth University	Discuss Integrated Illness Management and Recovery (I-IMR) and TeleFriend device research study
3/15/2019	WPC + SCHIO + CrossTx + Front St., Inc Staff	Together We Care Application Pilot Test/Training
3/20/2019	WPC + SCHIO + Intrepid Ascent	Discuss development of the Together We Care care coordination platform
3/21/2019	WPC + Dartmouth University	Discuss Integrated Illness Management and Recovery (I-IMR) and TeleFriend device research study
3/22/2019	WPC + SCHIO + CrossTx + Front St., Inc Staff	Together We Care Application Feedback session
3/26/2019	WPC + County of Santa Cruz Specialty Mental Health (SMH) Staff	Review list of SMH WPC clients to ensure connections to available services
3/26/2019	WPC + WPC Leadership	Discuss WPC program
3/27/2019	WPC + HIP	Care Coordination Steering Committee
3/28/2019	WPC + HSA Staff	Discuss data sharing governance
4/2-4/2019	WPC + WPC Lead Entities + DHCS	Spring WPC Statewide convening
4/3/2019	WPC + SCHIO + Intrepid Ascent	Discuss development of the Together We Care care coordination platform
4/4/2019	WPC + Dartmouth University	Discuss Integrated Illness Management and Recovery (I-IMR) and TeleFriend device research study
4/8/2019	WPC + HIP	Care Coordination Steering Committee
4/8/2019	WPC + Home Safe Staff	Discuss collaboration between WPC and Home Safe
4/8/2019	WPC + HIP	Discuss Release of Information/Consent
4/9/2019	WPC + multiple community organizations	Together We Care Users Group – to discuss the platform and needs
4/10/2019	WPC + SCHIO + Intrepid Ascent	Discuss development of the Together We Care care coordination platform

DATE	PARTICIPANTS	PURPOSE
4/11/2019	WPC + Advisory Council	Staffing, workforce development "Bridging the Care Coordination gap," data sharing TWC, Lean Six Sigma Green Belt Training, state pilot updates
4/11/2019	WPC + Dartmouth University	Discuss Integrated Illness Management and Recovery (I-IMR) and TeleFriend device research study
4/16/2019	WPC + HIP + multiple community organizations	Release of Information/Consent to Share workgroup to identify, develop and disseminate tools, training materials, and templates for release of information/consent to share forms to support data sharing among all organizations that coordinate care for common patients/clients in Santa Cruz County
4/17/2019	WPC + SCHIO + Intrepid Ascent	Discuss development of the Together We Care care coordination platform
4/18/2019	WPC + Dartmouth University	Discuss Integrated Illness Management and Recovery (I-IMR) and TeleFriend device research study
4/23-25/2019	WPC + multiple community organizations	Lean Six Sigma training
4/26/2019	WPC + Intrepid Ascent + SCHIO + CrossTX	Together We Care walkthrough
4/30/2019	WPC + WPC Leadership	Discuss WPC program
5/2/2019	WPC + Dartmouth University	Discuss Integrated Illness Management and Recovery (I-IMR) and TeleFriend device research study
5/2/2019	WPC + SCHIO + Intrepid Ascent	Together We Care users group functionalities
5/2/2019	WPC + Philips + Netsmart	Discuss TeleFriend project
5/3/2019	WPC + Front St., Inc.	Front street contract
5/6/2019	WPC + Leadership	Lean Six Sigma proposals
5/8/2019	WPC + HSA Staff	Dominican Hospital Endocarditis Review
5/8/2019	WPC + HIP	Care Coordination Steering Committee
5/8/2019	WPC + Front St., Inc.	Discuss flex funds, FSI amendment, FSI 19/20 contract

DATE	PARTICIPANTS	PURPOSE
5/9/2019	WPC + Dartmouth University	Discuss Integrated Illness Management and Recovery (I-IMR) and TeleFriend device research study
5/15/2019	WPC + Front St. Inc. Housing Support Team	Discuss updates and supporting landlords
5/16/2019	WPC + Dartmouth University	Discuss Integrated Illness Management and Recovery (I-IMR) and TeleFriend device research study
5/16/2019	WPC + Intrepid Ascent	Unite Us Demo
5/21/2019	WPC + HIP	Discuss Release of Information/Consent
5/22/2019	WPC + HSC	HSC presentation and tour of services
5/23/2019	WPC + HIP	Care Coordination Steering Committee
5/23/2019	WPC + Dartmouth University	Discuss Integrated Illness Management and Recovery (I-IMR) and TeleFriend device research study
5/24/2019	WPC + multiple community organizations	Integrated Behavioral Health Action Coalition (IBHAC)
5/28/2019	WPC + HSA Staff	Strategic Planning Workshop
5/29/2019	WPC + HIP + multiple community organizations	Care coordination networking series “Bridging the Care Coordination Gap”
5/30/2019	WPC + Dartmouth University	Discuss Integrated Illness Management and Recovery (I-IMR) and TeleFriend device research study
5/30/2019	WPC + Philips	Discuss eCC connection with Epic interface
5/30/2019	WPC + HIP	WPC Steering Committee
6/3/2019	WPC + County of Santa Cruz SMH + Dartmouth University	Discuss Integrated Illness Management and Recovery (I-IMR), review session recordings, answer questions and give guidance
6/4-6/2019	WPC + multiple community organizations	Lean Six Sigma training
6/4/2019	WPC + multiple community organizations	Children’s Behavioral Health program event
6/6/2019	WPC + multiple community organizations	MHSA community stakeholder committee
6/7/2019	WPC + Home Safe Staff	Discuss collaboration between WPC and Home Safe

DATE	PARTICIPANTS	PURPOSE
6/13/2019	WPC + Advisory Council	PRIMO! Cohort Lean Six Sigma Overview, interactive activity with PRIMO! Cohort 2 project, pilot program updates, state pilot updates, direct services, reporting and metrics
6/13/2019	WPC + Dartmouth University	Discuss Integrated Illness Management and Recovery (I-IMR) and TeleFriend device research study
6/17/2019	WPC + Front St. Inc. Housing Support Team	Discuss WPC program and services, and processes for referral/enrollment
6/17/2019	WPC + Watsonville Community Hospital	Presentation and discussion on WPC
6/17/2019	WPC + HIP	Care Coordination Steering Committee
6/18/2019	WPC + County of Santa Cruz Children's Specialty Mental Health	Presentation on WPC and discussion on HIE
6/18/2019	WPC + Dartmouth University	Discuss Integrated Illness Management and Recovery (I-IMR) and TeleFriend device research study
6/20/2019	WPC + Dartmouth University	Discuss Integrated Illness Management and Recovery (I-IMR) and TeleFriend device research study
6/25/2019	WPC + WPC Leadership Meeting	Discuss WPC program
6/27/2019	WPC + Care Coordination Workgroup	Discuss high-utilizers and Internal Endocarditis in local hospital and what workgroup can produce to assist care coordination
7/4/2019	WPC + Intrepid Ascent	Discuss development of the Together We Care care coordination platform (weekly updates)
7/8/2019	WPC + Recuperative Care Center	WPC additional approved funding
7/9/2019	WPC + WPC Leadership Meeting	Discuss WPC program
7/9 - 10/2019	WPC + multiple community organizations	Lean Six Sigma training
7/10/2019	WPC + Intrepid Ascent	Discuss development of the Together We Care care coordination platform (bi-weekly updates)
7/11/2019	WPC + Dartmouth University	Discuss Integrated Illness Management and Recovery (I-IMR) and TeleFriend device research study
7/15/2019	WPC + IBHAC Steering Committee	Strategic Planning Session #1

DATE	PARTICIPANTS	PURPOSE
7/18/2019	WPC + Dartmouth University	Discuss Integrated Illness Management and Recovery (I-IMR) and TeleFriend device research study
7/22/2019	WPC + multiple community organizations	Lean Six Sigma Project Demonstration to HSA
7/23-25/2019	WPC + HIP + SCHIO	RFP Vendor Demo – UniteUS/Eccovia/ACT MD/Safety Net Connect
7/23/2019	WPC + Santa Cruz County	Countywide analytic tools
7/29/2019	WPC + SCHIO	Discuss development of the Together We Care care coordination platform (weekly updates)
7/30/2019	WPC + WPC Leadership Meeting	Discuss/update WPC program
7/31/2019	WPC + SCHIO + Care Management	RFP Review Committee
8/8/2019	WPC + Advisory Council	Together We Care relaunch progress update, discussion of WPC one-time funding for housing from State, lessons learned from process improvement initiatives, programmatic updates.
8/8/2019	WPC + SCHIO	Funding Model
8/13/2019	WPC + WPC Leadership Meeting	Discuss/update WPC program
8/15/2019	WPC + Dartmouth University	Discuss Integrated Illness Management and Recovery (I-IMR) and TeleFriend device research study
8/21/2019	WPC + SCHIO + Intrepid Ascent	Together We Care + updates
8/22/2019	WPC + Dartmouth University	Discuss Integrated Illness Management and Recovery (I-IMR) and TeleFriend device research study
8/23/2019	WPC + HIP + multiple community organizations	August IBHAC (Integrated Behavioral Health Coalition)
8/27/2019	WPC + WPC Leadership Meeting	Discuss/update WPC program
8/28/2019	WPC + SCHIO + Intrepid Ascent	Together We Care + updates
8/29/2019	WPC + Dartmouth University	Discuss Integrated Illness Management and Recovery (I-IMR) and TeleFriend device research study
9/4/2019	WPC + SCHIO + Intrepid Ascent	Together We Care + updates
9/11/2019	WPC + SCHIO + Intrepid Ascent	Together We Care + updates
9/11/2019	WPC + HIP	WPC Steering Committee
9/12/2019	WPC + Dartmouth University	Discuss Integrated Illness Management and Recovery (I-IMR) and TeleFriend device research study

DATE	PARTICIPANTS	PURPOSE
9/16/2019	WPC + CHW	WPC Advisory Planning Group Meeting
9/18/2019	WPC + SCHIO + Intrepid Ascent	Together We Care + updates
9/19/2019	WPC + multiple community organizations	WPC Care Coordination Networking Series #5
9/24/2019	WPC + WPC Leadership Meeting	Discuss/update WPC program
9/24/2019	WPC + HIP	WPC Steering Committee
9/26/2019	WPC + Dartmouth University	Discuss Integrated Illness Management and Recovery (I-IMR) and TeleFriend device research study
10/2/2019	WPC + SCHIO + Intrepid Ascent	Together We Care + updates
10/9/2019	WPC + SCHIO + Intrepid Ascent	Together We Care + updates
10/17/2019	WPC + Dartmouth University	Discuss Integrated Illness Management and Recovery (I-IMR) and TeleFriend device research study
10/22/2019	WPC + WPC Leadership Meeting	Discuss/update WPC program
10/24/2019	WPC + Dartmouth University	Discuss Integrated Illness Management and Recovery (I-IMR) and TeleFriend device research study
10/25/2019	WPC + multiple community organizations	Tools toward client centered information sharing
10/29/2019	WPC + DHCS	BH stakeholder meeting
11/1/2019	WPC + CHW	Peer advisory group
11/4/2019	WPC + WPC Leadership Meeting	CALAIM Proposal
11/6/2019	WPC + HIP	WPC Steering Committee
11/6/2019	WPC + multiple community organizations	Bridging the Care Coordination Gap
11/7/2019	WPC + Dartmouth University	Discuss Integrated Illness Management and Recovery (I-IMR) and TeleFriend device research study
11/8/2019	WPC + Front St.	Front St services/housing
11/12/2019	WPC + WPC Leadership Meeting	Discuss WPC program
11/14 - 15/2019	WPC + Health Service Agency	Strategic Planning
11/15/2019	WPC + UCSC	Discuss research/evaluation opportunities
11/19/2019	WPC + multiple community organizations	Together We Care Implementation
11/21/2019	WPC + DHCS	WPC Learning Collaborative: CalAIM Overview

DATE	PARTICIPANTS	PURPOSE
11/21/2019	WPC + CHW	Peer advisory group
11/22/2019	WPC + Encompass	Homeless Outreach Coordination
11/25/2019	WPC + PRIMO	PRIMO project support coordination
11/26/2019	WPC + CHW	Peer convening/sustainability session
12/3/2019	WPC + WPC Leadership	Discuss WPC program
12/5/2019	WPC + Dartmouth University	Discuss Integrated Illness Management and Recovery (I-IMR) and TeleFriend device research study
12/6/2019	WPC + HIP + multiple community organizations	December IBHAC (Integrated Behavioral Health Coalition)
12/6/2019	WPC + multiple community organizations	HIV stakeholder planning
12/9/2019	WPC + HIP	TWC Implementation
12/12/2019	WPC + Advisory Council	Discuss WPC-C2H case management updates, Together We Care Kickoff success, I-IMR updates, CalAIM proposal overview, in lieu of services proposal, update on WPC One-Time Housing Funds, and next steps
12/16/2019	WPC + HIP	TWC Implementation
12/19/2019	WPC + Dartmouth University	Discuss Integrated Illness Management and Recovery (I-IMR) and TeleFriend device research study
12/23/2019	WPC + TWC Leadership	Discuss ACTMD platform/check in

VIII. PROGRAM ACTIVITIES

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

1. **Increased Collaboration:** WPC-C2H staff continue an ongoing and consistent presence at internal meetings, such as morning rounds in the HSA clinic and external meetings, such as the high utilizers discussion group at Dominican Hospital. The result is a better understanding of client needs and an increase in linkages to services.

2. **Standardizing Processes:** WPC-C2H staff participate in regular team meetings, clinical supervision, and meetings with WPC-C2H partners delivering housing support and peer coaching. Consistent meetings have been valuable in sorting out client needs and improving the delivery of services. The case management team began utilizing a three-tiered service delivery system, developed during the previous reporting period. The systems set clear parameters for service delivery, varying levels of service depending on need, and a common language for both staff and participants to use when discussing care options. The system allows for a more objective method to manage and distribute caseloads.

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

1. **Lack of Universal Electronic Care Coordination System:** One of the main challenges faced with care coordination is the lack of a universal electronic care coordination system, which would allow care providers to share data and information in real time. This would allow for providers to work from a single treatment plan, communicate more effectively/efficiently and ultimately improve care for patients. What has been learned from these challenges is the need for clear protocols and a systemized approach to care coordination service delivery. Clear protocols ensure that treatment plans are shared in a standardized manner and communication happens consistently and timely.

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

1. **Data Integration of ED and EHR (EPIC):** WPC-C2H successfully completed the development and implementation of the HIE notification of ED use data integration to the County Medical EHR (EPIC). This integration allows for client hospitalization information (admission, transfer, and discharges) to be sent to the client's EHR record, which can be accessed by the client's care team.

2. **Together We Care (TWC) Platform:** The selection of a platform that allows for documentation and tracking of care management services was completed. After selection of the platform, the WPC-C2H team rapidly moved into building the platform with the developer to meet the needs of the program. The platform is expected to be piloted and deployed during PY5.

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

1. **Partial Automation of ED and EHR (EPIC) Data Integration:** WPC-C2H successfully implemented a data integration of ED and EHR (EPIC) data, but the integration had limited automation. In many instances, the EHR (EPIC) system was unable to properly pair client information with the client's ED information. As a result, a report is generated by the County's EHR (EPIC) listing clients who were unable to properly pair. The pairing of clients requires a staff member to review client information and manually make the link between the County's EHR (EPIC) system and the ED information. This presents an issue as new clients are enrolled in the WPC-C2H, whose information is not paired if a staff member is not available to review the report daily. It would be crucial for the success of this data integration to have standard procedures for regularly reviewing the report.

2. **Multiple Databases:** The Together We Care (TWC) platform will serve as an excellent tool for documenting and tracking client data related to case management and care coordination. Unfortunately, there are program activities, such as referrals to the WPC-C2H program, that are not able to be documented in the TWC platform. Therefore, these activities will continue to be recorded and tracked outside the TWC platform. As a result, multiple databases will need to be monitored, maintained, and used for reporting. This adds an additional level of complexity when it comes to data sharing relating to identifying a single source of truth. Policies will need to be adopted to avoid confusion and potential double entry.

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

1. **Improvement in WPC-C2H Internal Referral Screening Process:** WPC-C2H staff enhanced the screening data collection process by identifying a master list of ICD-10 Behavioral and Medical chronic diagnosis codes. Having this master list of ICD-10 codes has allowed WPC-C2H staff to identify client diagnoses more accurately.

2. **Improvement in SCHIO and County IT Data Reporting:** WPC-C2H staff has been able to gather data more accurately and efficiently from the Santa Cruz Health Information Exchange Organization (SCHIO) and the County's internal IT Department. This increase in accuracy and efficiency has allowed WPC-C2H to gather data for reporting purposes within days instead of weeks.

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

1. **Identifying Data Single Source of Truth:** WPC-C2H staff have had difficulties with identifying data points single source of truth. A data point single source of truth is defined as a trusted data source that gives a complete and most accurate picture of the data point. One specific data point WPC-C2H has struggled with is homeless status. This is a data point that is collected across multiple data systems at different points in time. As a result, when merging information from multiple systems there may be various responses for the same data point.

2. **System that Integrates Data Collected Across Sectors:** WPC-C2H has been unable to fully integrate data collected across multiple sectors. This is an area of difficulty due to the data being collected through different tools and/or methods. In addition to data being collected through different tools and/or methods, the County of Santa Cruz does not have a single system that integrates the information.

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

Determining Overall Impact to System Changes and Enrollee Outcomes: Such a complex, interdisciplinary pilot is proving to be difficult to define, explain and evaluate in a way can show direct correlation of the pilot activities to the successes that are beginning to emerge, both in the systems and enrollee outcomes. This includes the qualitative community engagement progress that is layered and multi-pronged.

Prioritizing Large Number of Projects and Initiatives: The pilot has ambitious goals and activities, and in the year remaining, focusing and prioritizing to ensure the most lasting impacts may be a significant barrier, while also seeking sustainability for potentially successful activities.

Rapidly changing and uncertain community environment: At the time of writing this report, Santa Cruz County and the WPC-C2H program are adapting in response to the COVID-19 crisis. It is apparent that several program components may not be achieved due to social distancing restrictions. In addition, Administrative staff, as part of Public Health, are being reassigned to COVID-19 response teams.

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. WPC Santa Cruz PDSA Summary PY4 Annual Report
2. WPC Santa Cruz PDSA Report - PY4 Q1 Ambulatory Care 1
3. WPC Santa Cruz PDSA Report - PY4 Q2 Ambulatory Care 1
4. WPC Santa Cruz PDSA Report - PY4 Q3 Ambulatory Care 1
5. WPC Santa Cruz PDSA Report - PY4 Q4 Ambulatory Care 1
6. WPC Santa Cruz PDSA Report - PY4 Q1 Inpatient Utilization 1
7. WPC Santa Cruz PDSA Report - PY4 Q2 Inpatient Utilization 1
8. WPC Santa Cruz PDSA Report - PY4 Q3 Inpatient Utilization 1
9. WPC Santa Cruz PDSA Report - PY4 Q4 Inpatient Utilization 1
10. WPC Santa Cruz PDSA Report - PY4 Q1 Comprehensive Care Plan 1
11. WPC Santa Cruz PDSA Report - PY4 Q2 Comprehensive Care Plan 1
12. WPC Santa Cruz PDSA Report - PY4 Q3 Comprehensive Care Plan 1
13. WPC Santa Cruz PDSA Report - PY4 Q4 Comprehensive Care Plan 1
14. WPC Santa Cruz PDSA Report - PY4 Q1 Care Coordination 1
15. WPC Santa Cruz PDSA Report - PY4 Q2 Care Coordination 1
16. WPC Santa Cruz PDSA Report - PY4 Q3 Care Coordination 1
17. WPC Santa Cruz PDSA Report - PY4 Q4 Care Coordination 1
18. WPC Santa Cruz PDSA Report - PY4 Q2 Care Coordination 2
19. WPC Santa Cruz PDSA Report - PY4 Q3 Care Coordination 2
20. WPC Santa Cruz PDSA Report - PY4 Q4 Care Coordination 2
21. WPC Santa Cruz PDSA Report - PY4 Q2 Care Coordination 3
22. WPC Santa Cruz PDSA Report - PY4 Q3 Care Coordination 3
23. WPC Santa Cruz PDSA Report - PY4 Q4 Care Coordination 3
24. WPC Santa Cruz PDSA Report - PY4 Q1 Data 1
25. WPC Santa Cruz PDSA Report - PY4 Q2 Data 1
26. WPC Santa Cruz PDSA Report - PY4 Q3 Data 1
27. WPC Santa Cruz PDSA Report - PY4 Q4 Data 1
28. WPC Santa Cruz PDSA Report - PY4 Q2 Data 2

29. WPC Santa Cruz PDSA Report - PY4 Q3 Data 2
30. WPC Santa Cruz PDSA Report - PY4 Q4 Data 2
31. WPC Santa Cruz PDSA Report - PY4 Q2 Data 3
32. WPC Santa Cruz PDSA Report - PY4 Q3 Data 3
33. WPC Santa Cruz PDSA Report - PY4 Q4 Data 3
34. WPC Santa Cruz PDSA Report - PY4 Q2 Other 1
35. WPC Santa Cruz PDSA Report - PY4 Q3 Other 1
36. WPC Santa Cruz PDSA Report - PY4 Q4 Other 1
37. WPC Santa Cruz PDSA Report - PY4 Q2 Other 2
38. WPC Santa Cruz PDSA Report - PY4 Q3 Other 2
39. WPC Santa Cruz PDSA Report - PY4 Q4 Other 2