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, Program Year 5
April 1, 2021

REPORTING CHECKLIST

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

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

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

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, Challenges and Lessons Learned

Increasing integration among county agencies, health plans, providers, and other entities:
Considerable challenges continue as key staff were deployed to the COVID-19 pandemic response. Work towards increasing integration continued via regular WPC-C2H Leadership meetings with representatives from County Clinics and Behavioral Health. The program also held community advisory meetings to keep partners updated on WPC-C2H progress and support ongoing collaborations. The WPC-C2H administrative team met with the new Chief of Psychiatry to discuss current and potential integrations with expanded utilization of the Together We Care (TWC) care coordination platform. The program also advised the newly launched Housing for Health division in the County as to best practices around care coordination. A foundation was set for future program integrations between the Health Services Agency (HSA) and Human Services Division (HSD) both targeting the WPC-C2H population. Plans have been outlined to strengthen and enhance the TWC platform with an eye towards CalAIM and the necessity for more robust integrations.

Increasing coordination and appropriate access to care:
A success this reporting period is the integration of hospital alerts into TWC. The alerts allow for more timely interventions and access to appropriate follow-up care. The WPC-C2H case managers report continued success utilizing TWC for care coordination with the housing navigation and peer coach teams.

A virtual care coordination event occurred on November 10, 2020. Sixty-six registrants from over 20 community organizations participated. The presentation included an overview of data and information sharing and an introduction to the TWC Closed Loop Resource and Referral Directory. There is widespread interest to improve the care coordination infrastructure.

The case management team participates in multiple clinical work groups/case conferences including new groups focused on individuals at the COVID-19 shelters and isolation/quarantine hotels. With many vulnerable, unhoused individuals with complex needs at these temporary shelters, there is an opportunity to assess their linkages to services and eligibility for WPC-C2H.

Improving data collecting and sharing:
The program continues to test the TWC platform for care coordination, data collection and sharing. Successes include coordination of care among WPC-C2H case managers, and the peer support coaches and housing navigation team from community partner, Front St. Inc., Care plans are shared, and communication occurs within the platform, creating more accurate data tracking.

Lessons learned from building a care coordination and social service referrals platform include the need for:

- Governance and management
- Capacity building: support to end-users, committee to advise the Santa Cruz Health Information Organization (SCHIO) board, staff infrastructure to work with vendors.

Challenges in this arena include: establishing documentation standards, duplicate documentation responsibilities for care coordination staff, establishing standards for conducting ongoing assessments to measure program outcomes, and a lack of Release of Information (ROI) infrastructure *within* organizations.

Although WPC-C2H has started outlining a strategy towards improved information sharing across County departments, progress is slowed by competing priorities. These include County response to both the pandemic and the CZU Lightening Complex Fire in August.

Achieving quality and administrative improvement benchmarks:
WPC-C2H administrative team members continue to be deployed to the COVID-19 response, but remain committed to program management, timely submission of reports, and responding to requests form DHCS. No staff turnover occurred during this reporting period.

Increasing access to housing and supportive services; and improving health outcomes for the WPC population:
WPC-C2H continues successfully assisting clients to find and maintain stable housing but is challenged by the notification in September 2020 that the Housing Authority would no longer accept applications for Disabled and Medically Vulnerable (DMV) vouchers, shutting down the primary avenue WPC clients have to permanent housing. WPC-C2H provided housing support services, helping clients achieve and/or maintain stable housing.

Program staff continue to build relationships with community resources and be informed of the status of housing and supportive services.

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	14	*	*	*	12	*	47

Item	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12	Annual Unduplicated Total
Unduplicated Enrollees	*	0	*	*	*	*	72

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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	Rate	Month 1	Month 2	Month 3	Month 4	Month 5	Month 6	Total
FFS 1 - Housing Support	NA	$6,480.42	*	$15,002.58	*	*	*	$49,307.80
Utilization 1		16	*	13	*	*	*	65
FFS 2 - Tenancy Supports	NA	$12,256.45	$9,955.18	$19,299.51	$11,706.07	$18,712.58	$17,640.52	$89,570.31
Utilization 2		19	19	12	25	21	15	111
FFS 3 - Outreach and Referral	$175.00	$4,900.00	$3,500.00	*	*	$2,800.00	$16,800.00	$29,925.00
Utilization 3		28	20	*	*	16	96	171
FFS 4 – Screening/ Assessment	$300.00	$8,400.00	$6,000.00	*	*	$4,800.00	$28,800.00	$51,300.00
Utilization 4		28	20	*	*	16	96	171
FFS 5 - Recuperative Care	$400.00	$24,400.00	$24,800.00	$33,200.00	$26,400.00	$37,200.00	$26,000.00	$172,000.00
Utilization 5		61	62	83	66	93	65	430

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	*	*	*	$11,192.55	$10,331.59	$14,636.42	$104,409.60
Utilization 1		*	*	*	13	12	17	129
FFS 2 - Tenancy Supports	NA	$21,495.29	$16,534.84	$12,401.13	$11,574.39	$13,227.87	$13,227.87	$178,031.70
Utilization 2		26	20	15	14	16	16	218
FFS 3 - Outreach and Referral	$175.00	*	*	*	*	*	*	$34,825.00
Utilization 3		*	*	*	*	*	*	199
FFS 4 – Screening/ Assessment	$300.00	*	*	*	*	*	*	$59,700.00
Utilization 4		*	*	*	*	*	*	199
FFS 5 - Recuperative Care	$400.00	$12,400.00	*	*	$12,400.00	$12,000.00	$20,800.00	$241,600.00
Utilization 5		31	*	*	31	30	52	604

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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*

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	$33,650.08	$29,632.16	$31,138.88	$30,134.40	$25,112.00	$24,107.52	$173,775.04
MM Counts 1		67	59	62	60	50	48	346
Bundle #2 – Clinical	$501.15	$152,850.75	$159.866.85	$160,368.00	$160,368.00	$166,381.80	$173,899.05	$973,734.45
MM Counts 2		305	319	320	320	332	347	1943
Bundle #3 – Intensive Housing Support	$717.50	$22,242.50	$20,090.00	$17,937.50	$17,220.00	$22,242.50	$22,242.50	$121,975.00
MM Counts 3		31	28	25	24	31	31	170
Bundle #4 – Intermediate Housing Support	$170.63	$5,460.16	$6,313.31	$4,436.38	$6,483.94	$6,825.20	$4,777.64	$34,296.63
MM Counts 4		32	37	26	38	40	28	201

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	$27,120.96	$25,112.00	$17,578.40	$16,573.92	$16,573.92	$305,864.16
MM Counts 1		58	54	50	35	33	33	609
Bundle #2 – Clinical	$501.15	$162,873.75	$168,887.55	$162,372.60	$187,931.25	$193,945.05	$191,439.30	$2,041,183.95
MM Counts 2		325	337	324	375	387	382	4073
Bundle #3 – Intensive Housing Support	$717.50	$30,135.00	$23,677.50	$28,700.00	$16,502.50	$16,502.50	$15,785.00	$253,277.50
MM Counts 3		42	33	40	23	23	22	353
Bundle #4 – Intermediate Housing Support	$170.63	$6,654.57	$6,142.68	$8,019.61	$2,730.08	$2,730.08	$4,607.01	$65,180.66
MM Counts 4		39	36	47	16	16	27	382

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

- 72 total new enrollments during PY5.
- During PY5, 199 individuals were referred and 199 were 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.).

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.

Key Administrative Infrastructure achievements:

- The WPC-C2H Administrative team continue their deployment to the COVID-19 public health response while maintaining WPC-C2H activities.
- No staffing changes within the Administrative Team.
- Adjustments made to eligibility screening and enrollment procedures as the program expanded its target population to includes individuals who are homeless, at risk for homelessness and vulnerable to COVID-19.
- Reports and requests from DHCS are met in a timely manner.
- Continued successful supervision and project management of contractors, vendors, and staff related to implementing improved data sharing, care coordination and process improvement activities.
- Ongoing and regular communication with Health Services Agency leadership.

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.

Santa Cruz Health Information Organization (SCHIO):
Together We Care (TWC) data sharing and care coordination platform. Program highlights:

- 158 individuals have a shared care plan in TWC.
- Working towards eliminating double data entry between TWC and Electronic Health Record (EHR) systems.
- UniteUs was selected through a community engaged selection process (TWC Steering Committee) as a vendor for the social service directory and closed loop referrals.
- TWC Steering Committee has become an advisory body to the SCHIO board, made up of several local health and social service organizations.
- Contracted UniteUs in late 2020.
- Working on implementation of the social service/closed loop referral platform.
- Dec 15, 2020 – TWC Steering Committee met and heard updates about the pilot.
- Advising programs on technical tips and tricks.
- Working with SCHIO and Activate Care to clarify how changes in the platform affect existing users.
- Developing content for end user meetups, user group and other recurring meetings.
- Developing a new program onboarding plan.

Jail EHR Integration via SCHIO:
No progress made on this objective.

HMIS Integration with SCHIO:
No progress made on this objective but discussions with key partners indicate this is an objective planned for 2021.

Program Enrollment Registry and Data Quality Monitoring Tool:
These two deliverables combined are part of the WPC-C2H Data Management and Analytics project. The program completed a needs assessment of the County's data management and analytics capacity and infrastructure to identify areas of needs and strengths. The findings of the assessment will be used to develop recommendations and strategies for leveraging existing resources to improve the County's data management and analytics capacity and infrastructure in preparation for the CalAIM initiative.

211.org Enhancements for Community and Social Referrals:
Progress made in developing a community-wide approach to referrals with selection of a vendor to set up the platform. Activities include:

- Conversations with key stakeholders to build commitment for the Unite Us implementation.
- Establishment of the TWC Steering Committee as an official advisory committee to the SCHIO board.
- Goals for the TWC Steering Committee:
    - Data sharing agreements for cross organizational collaboration and reporting
    - Reporting and data access needs for care coordination programs
    - Implementation of the referral and directory tool, including development of a community network that serves equity goals
    - Integration between the Santa Cruz Health Information Exchange (SCHIE), the care coordination tool, the referral and directory tool, and other key data sources and tools identified by the committee members
    - Long-term funding and staffing model for both care coordination and referral functionality

Recuperative Care Center (RCC) coordination:
The program supported 7 WPC-C2H clients utilizing the RCC this reporting period. In addition, the program worked with RCC to identify and enroll clients eligible for WPC-C2H services.

ANSA System Project Management:
Work completed and reported at the mid-year reporting period.

Implement Mobile Health Van (Behavioral Health):
The van was purchased and delivered, one of the two staff was hired for the new program, and a safe enclosure was constructed for it to be parked in Watsonville next to County Behavioral Health Offices. The van is formally in use.

Opening a Navigation Center:
No progress made on this objective due to delays and competing priorities with the COVID-19 pandemic response, although meetings were held with the County's new Director for Housing for Health. Several options for creating a Navigation Center are being pursued with input from multiple county divisions for 2021.

Together We Care Program Coordination:
Progress completed on this activity. The project coordinator engaged organizational users in the design, implementation, and use of TWC. The project coordinator supported teams with decisions around integration with electronic health records, data collection goals and strategies, and the need for training materials and capacity building. The project coordinator assisted with the development of a formalized SCHIO Board advisory TWC Steering Committee with an updated and signed Project Charter, and regularly attending members from key community-based organizations across the County.

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.

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 19 lessons learned in the second half of PY5, for a total of $190,000. Payment was made to HSA Behavioral Health Division.

Psychiatry Leadership Capacity:
Psychiatric leadership involvement in meetings continued in PY5 once the new HSA Chief of Psychiatry was onboarded. His participation in WPC-C2H Leadership meetings and data sharing discussions increased representation of the complex clinical/psychiatric needs of enrollees. Incentive was partially achieved with Psychiatric Leadership attendance at three meetings. A total of $6008.52 was earned in the second half of PY5. Payment was made to HSA Behavioral Health Division

Professional Development trainings on process improvements:
No progress achieved this reporting period, primarily due to the COVID-19 pandemic and move to remote work.

Implement Mobile Health Van (Clinics):
The program has met with Health Services Agency Clinics to plan for the implementation of the mobile health van early in PY6 (moved to Delivery in PY6).

Development and implementation of HIE notification of ED use:
Objective completed last reporting period.

HIE notifications of ED use:
The Santa Cruz Health Information Exchange organization (SCHIO) transmitted 580 admission, discharge, and transfer (ADT) Emergency Department (ED) notifications to the County's electronic health record (EHR) system, which were received and integrated into the patients' medical records. A total of 300 units were earned in the

second half of PY5 for a total of $45,000. Payment was made to participating county partners.

Implement Population Health reporting tools:
Objective completed last reporting period.

Implement HIE and EMS data integration:
This activity is complete. All elements were in place to go “live” at the end of 2020. This integration allows for electronic patient lookup for emergency ambulance providers and establishes a secure, bidirectional movement of electronic patient health information with hospitals for daily emergency medical services and allows for more rapid identification of high utilizer clients using Emergency Medical Services (EMS) to ensure better care coordination and lead to avoidance of hospitalizations. An incentive payment of $90,000 was earned this reporting period. Payment made to County HSA EMS.

Transition Planning Meetings with Health Plan:
The WPC-C2H director participated in two sustainability planning meetings regarding CalAIM with local managed care health plan, Central California Alliance for Health (CCAH). Due to the delay in implementing CalAIM, meetings were limited and delayed until 2021. A $20,000 incentive was earned in the second half of PY5. Payment was made to HSA Behavioral Health.

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

a. Performance – Metric was met: 88.57% of 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 50%. 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.

Whole Person Care - Cruz to Health Stakeholder Engagement Meetings (Program Year 5, July - Dec)		
DATE	**PARTICIPANTS**	**PURPOSE**
7/1/2020	WPC + HIP	WPC Steering Committee meeting
7/7/2020	WPC + multiple community organizations	TWC Steering Committee
7/8/2020	WPC + HIP	WPC Steering Committee meeting
7/9/2020	WPC + multiple community organizations	Discussion of TWC and Expansion of Use
7/13/2020	WPC + HSA Behavioral Health	WPC-C2H Overview
7/14/2020	WPC + WPC Leadership	Discuss WPC program
7/15/2020	WPC + HIP	WPC Steering Committee meeting
7/22/2020	WPC + SCHIO	TWC Progress
7/22/2020	WPC + HIP	WPC Steering Committee
7/28/2020	WPC + WPC Leadership	Discuss WPC program
8/4/2020	WPC + multiple community organizations	TWC Steering Committee
8/5/2020	WPC + HIP	WPC Steering Committee
8/10/2020	WPC + multiple community organizations	TWC User Group
8/13/2020	WPC + multiple community organizations	WPC Advisory Council
8/18/2020	WPC + multiple community organizations	TWC Steering Committee
8/19/2020	WPC + HIP	WPC Steering Committee
8/26/2020	WPC + HSD	WPC and COVID Homeless Response
9/2/2020	WPC + HIP	WPC Steering Committee
9/15/2020	WPC + multiple community organizations	TWC Steering Committee
9/16/2020	WPC + HIP	WPC Steering Committee
9/17/2020	WPC + CCAH	CalAIM Local Stakeholder Meeting

9/21/2020	WPC + multiple community organizations	TWC User Group
9/29/2020	WPC + multiple community organizations	TWC Steering Committee
9/30/2020	WPC + HIP	WPC Steering Committee
10/2/2020	WPC + IBH	Future Direction Discussion
10/5/2020	WPC + multiple community organizations	TWC User Group
10/14/2020	WPC + HIP	WPC Steering Committee
10/15/2020	WPC + Psychiatry	WPC Program Overview
10/19/2020	WPC + multiple community organizations	TWC User Group
10/27/2020	WPC + multiple community organizations	TWC Steering Committee
10/28/2020	WPC + HIP	WPC Steering Committee
10/29/2020	WPC + multiple community organizations	Introduction to TWC
11/3/2020	WPC + CCAH	CalAIM Local Stakeholder Meeting
11/10/2020	WPC + multiple community organizations	Bridging the Care Coordination Gap: Implementation of a Community-wide Resource and Referral Directory
11/16/2020	WPC + Intrepid Ascent	Analytics and Data Collection
11/17/2020	WPC + multiple community organizations	TWC Steering Committee
11/18/2020	WPC + HIP	WPC Steering Committee
11/19/2020	WPC + Clinics	Discuss WPC, Shelter+Care and Union St.
11/30/2020	WPC + Intrepid Ascent	2021 Planning
12/1/2020	WPC + multiple community organizations	TWC Steering Committee
12/2/2020	WPC + HIP	WPC Steering Committee
12/8/2020	WPC + WPC Leadership	Discuss WPC program
12/16/2020	WPC + Housing for Health	Discussion of budget and housing
12/17/2020	WPC + HIP	WPC Steering Committee
12/18/2020	WPC + Clinics	WPC Budget and funding for Clinics program
12/18/2020	WPC + HSA Behavioral Health	TWC Demo
12/22/2020	WPC + Clinics	TWC Demo
12/23/2020	WPC + Housing for Health	Planning

VIII. PROGRAM ACTIVITIES

Care Coordination:

A. Briefly describe 1-2 successes you have had with care coordination.
   1. **Ongoing success in connecting clients to primary and specialty health care.** Staff have built relationships within County Clinics and with local medical providers and developed processes to support continuity of care coordination.
   2. **Building relationships with local service providers such as the Housing Authority and General Assistance.** These relationships support the ability to assist clients more efficiently by navigating through complex systems more easily.

B. Briefly describe 1-2 challenges you have faced with care coordination, and lessons learned from those challenges.
   1. **Limitations in moving a client to a higher level of care.** Case managers are challenged to keep clients housed when the level of required support is greater than they can provide. These are clients who don't qualify for supports though County Behavioral Health with a diagnosis of serious mental illness (SMI). Without higher level of supports to maintain housing, WPC-C2H program often must support clients to relocate and/or avoid an eviction. Lessons Learned: The need for case management does not necessarily end when a client is housed. It is important for clients to stay connected with a service provider for support and care coordination.
   2. **High staff turnover at partner agencies.** WPC-C2H desires to maximize resources through partnerships. With inconsistencies in staffing, clients may feel their care is fragmented and they have expressed desire to just work with one care coordinator. Lessons Learned: A single point of contact (or "quarterback") is optimal for care coordination.

Data Sharing

A. Briefly describe 1-2 successes you have had with data and information sharing.
   1. **Utilization of TWC:** WPC-C2H partner, Front St, Inc. has increased communication among care providers and created efficiencies in care management. And Unite Us as a social service referral platform had its initial launch.
   2. **Use of ED Notifications Through EHR (EPIC):** WPC-C2H case managers have been successful in accessing ED notifications through the County's medical EHR (EPIC). Access to the ED notifications allows staff to know when WPC-C2H clients have been admitted, transferred, or discharged from the ED Department.

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

1. **Delays in Information Sharing:** Technical and programmatic issues which have slowed or stopped the process of information sharing. A lesson learned from this challenge is that it is critical for the program to have a centralized location where client data (Service and Clinical Data) can be accessed by professionals working with the client.

2. **Aggregate Reporting of ED Notifications:** WPC-C2H staff have been unable to generate an aggregate report of ED notification. Not being able to generate this report limits the team's ability to understand how many clients may have been admitted, transferred, or discharged from the ED Department. A lesson learned from this is that there is a need to engage more with the County's medical EHR (EPIC) system administrator (OCHIN). The system administrator can work with the WPC-C2H staff to create reporting templates.

Data Collection

A. Briefly describe 1-2 successes you have had with data collection and/or reporting.
    1. **Reporting Through Together We Care Platform:** Since WPC-C2H staff and program partners have been using the TWC platform to document services provided, generating and reviewing general administrative reports has been easier. This is because the platform has built-in reports that allow managers to monitor utilization of the program and caseloads.
    2. **Data Collection Through Together We Care Platform:** WPC-C2H staff has transitioned to using the newly deployed TWC platform to document services provided. The transition in data collection provides the opportunity for information to be stored in one location that can be securely accessed by other service providers. Ultimately this allows for more efficient service collaboration.

B. Briefly describe 1-2 challenges you have faced with data collection and/or reporting.
    1. **Reporting Through Together We Care Platform:** Although the platform does contain general pre-loaded administrative reports, the reporting tool within the platform is not flexible enough to be customized by individual users. As a result, if more in-depth analysis or reporting needs to be done, data extracts need to be requested and manipulated using 3rd party tools.
    2. **Data Collection Through Together We Care Platform:** WPC-C2H staff has transitioned to use the newly deployed TWC platform to document services provided, but the new data collection process is currently not perfect. Additionally, onboarding more care coordination partners into the new platform is a slow adoption process, which potentially increases the double data entry process.

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

The WPC-C2H team has identified several issues that could be barriers to success in the coming program year and as the program transitions to CalAIM:

- Lack of housing supports (vouchers) and housing inventory, which has been exacerbated by the COVID-19 pandemic.
- Lack of data sharing agreements going forward (after the WPC pilot and possible sunsetting of the current ROI), for continuity of care.
- Capacity/staffing of community-based organizations and County to support ongoing ECM and ILOS activities.
- Uncertainty around negotiating with the local managed care plan (MPC) and the challenges to successfully transition clients.
- Uncertainty if TWC (care coordination and data sharing platform) will be adopted by the MCP or other agencies, and whether CalAIM will incentive or pay the MCP to adopt such a platform.

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 PY5 Annual Report
2. WPC Santa Cruz PDSA Report - PY5 Q1 Ambulatory Care 1
3. WPC Santa Cruz PDSA Report - PY5 Q2 Ambulatory Care 1
4. WPC Santa Cruz PDSA Report - PY5 Q3 Ambulatory Care 1
5. WPC Santa Cruz PDSA Report - PY5 Q4 Ambulatory Care 1
6. WPC Santa Cruz PDSA Report - PY5 Q1 Inpatient Utilization 1
7. WPC Santa Cruz PDSA Report - PY5 Q2 Inpatient Utilization 1
8. WPC Santa Cruz PDSA Report - PY5 Q3 Inpatient Utilization 1
9. WPC Santa Cruz PDSA Report - PY5 Q4 Inpatient Utilization 1
10. WPC Santa Cruz PDSA Report - PY5 Q1 Comprehensive Care Plan 1
11. WPC Santa Cruz PDSA Report - PY5 Q2 Comprehensive Care Plan 1
12. WPC Santa Cruz PDSA Report - PY5 Q3 Comprehensive Care Plan 1
13. WPC Santa Cruz PDSA Report - PY5 Q4 Comprehensive Care Plan 1
14. WPC Santa Cruz PDSA Report - PY5 Q1 Care Coordination 1
15. WPC Santa Cruz PDSA Report - PY5 Q2 Care Coordination 1
16. WPC Santa Cruz PDSA Report - PY5 Q3 Care Coordination 1
17. WPC Santa Cruz PDSA Report - PY5 Q4 Care Coordination 1
18. WPC Santa Cruz PDSA Report - PY5 Q1 Care Coordination 2
19. WPC Santa Cruz PDSA Report - PY5 Q2 Care Coordination 2
20. WPC Santa Cruz PDSA Report - PY5 Q3 Care Coordination 2
21. WPC Santa Cruz PDSA Report - PY5 Q4 Care Coordination 2
22. WPC Santa Cruz PDSA Report - PY5 Q1 Care Coordination 3
23. WPC Santa Cruz PDSA Report - PY5 Q2 Care Coordination 3
24. WPC Santa Cruz PDSA Report - PY5 Q3 Care Coordination 3
25. WPC Santa Cruz PDSA Report - PY5 Q4 Care Coordination 3
26. WPC Santa Cruz PDSA Report - PY5 Q1 Data 1
27. WPC Santa Cruz PDSA Report - PY5 Q2 Data 1
28. WPC Santa Cruz PDSA Report - PY5 Q3 Data 1
29. WPC Santa Cruz PDSA Report - PY5 Q4 Data 1
30. WPC Santa Cruz PDSA Report - PY5 Q1 Data 2
31. WPC Santa Cruz PDSA Report - PY5 Q2 Data 2
32. WPC Santa Cruz PDSA Report - PY5 Q3 Data 2

33. WPC Santa Cruz PDSA Report - PY5 Q4 Data 2
34. WPC Santa Cruz PDSA Report - PY5 Q1 Data 3
35. WPC Santa Cruz PDSA Report - PY5 Q2 Data 3
36. WPC Santa Cruz PDSA Report - PY5 Q3 Data 3
37. WPC Santa Cruz PDSA Report - PY5 Q4 Data 3
38. WPC Santa Cruz PDSA Report - PY5 Q1 Other 1
39. WPC Santa Cruz PDSA Report - PY5 Q2 Other 1
40. WPC Santa Cruz PDSA Report - PY5 Q3 Other 1
41. WPC Santa Cruz PDSA Report - PY5 Q4 Other 1
42. WPC Santa Cruz PDSA Report - PY5 Q1 Other 2
43. WPC Santa Cruz PDSA Report - PY5 Q2 Other 2
44. WPC Santa Cruz PDSA Report - PY5 Q3 Other 2
45. WPC Santa Cruz PDSA Report - PY5 Q4 Other 2