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

Reporting Checklist

Contra Costa County
Annual PY2
4/2/2018

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

Contra Costa County

Annual PY2

4/2/2018

I. REPORTING INSTRUCTIONS

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

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

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

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

II. PROGRAM STATUS OVERVIEW

Please provide a brief overview of your program's successes and challenges and any lessons learned during the reporting period. Structure your responses in alignment with the WPC program's goals using the following as headers (from STC 112): *increasing integration among county agencies, health plans, providers, and other entities; increasing coordination and appropriate access to care; reducing inappropriate emergency and inpatient utilization; improving data collecting and sharing; achieving quality and administrative improvement benchmarks; increasing access to housing and supportive services; and improving health outcomes for the WPC population.*

Program Status Update

CCHS continued to make substantial progress with the WPC program, CommunityConnect, during the last two quarters of PY2. CCHS is on track for staff hiring and patient enrollment, completed 25 of 28 incentive projects, developed care coordination workflows with Employment and Human Services (EHSD) and continued to refine the data-drive risk model to appropriately identify the highest utilizing Medi-Cal beneficiaries.

Efforts to increase integration among County agencies, health plans, providers and other entities is best demonstrated by the partnership work with EHSD. CCHS worked collaboratively with EHSD to develop workflows and data sharing procedures in anticipation of the pending implementation of a data-sharing MOU. Leveraging the data visualization dashboards and EHR care planning modules, CCHS established preliminary workflows to target Medi-Cal churn and increase data sharing with social services programs, such as SNAP. Data visualization dashboards are a huge step forward in achieving quality and administrative improvement benchmarks, which will greatly support our staff in their daily client management as well as allow our Quality Improvement team to begin tracking internal productivity metrics for program evaluation. CCHS is working closely with EHSD's IT and security department to support the technical components needed to improve data sharing for our enrolled patients. These efforts will greatly improve the coordination of services provided to our patients and will decrease the rate of Medi-Cal churn; increasing the rate of efficacy of our services through expanded continuum of health insurance coverage.

Increased coordination and appropriate access to care and **improved data collection and sharing.** CCHS is maintaining high enrollment rates among enrolled patients, and is actively engaging patients, identifying needs, creating goals and **increasing access to housing and supportive services.** We are leveraging our partnering agencies for these care coordination activities. For example, our case managers work closely with Bay Area Legal to assist clients in addressing housing and benefit related legal needs that if unaddressed would negatively impact a client's stability and increase inappropriate utilization. We have also continued to improve our documentation workflows and standards, embedding our social case management

notes into the patient's EHR. The records are then made available for all CCHS staff, allowing ED, inpatient and outpatient providers access to case management notes, increasing care coordination and the continuum of care for our enrolled population.

CCHS learned in the first half of PY2 the value in partnering with the CCHS 1115 Waiver teams to assess system capacity and redesign through the lens of all Medi-Cal waiver programs. This shared vision has allowed CCHS to look at **reducing inappropriate utilization** and **improving health outcomes**, while reducing duplication, inefficiency and program redundancy. Through the support of CCHS senior staff, all waiver programs are looking at expanding the partnership work in aligning program metrics and missions, in order to meet our program goals of improved health outcomes for enrolled beneficiaries.

The biggest challenge faced continues to be identifying the correct patient populations and evaluating outcomes. Population cohorts continue to change as the data-driven risk model is refined to include newly available data. In PY2 CCHS made strides in patient identification via a new algorithm to identify the characteristics predicting inappropriate ED and inpatient utilization. Thus, the population evaluated in PY4 will vary from PY2.

Other challenges faced are concerns from the larger CCHS system regarding workforce depletion through the large volume of CCHS WPC hiring needs. The CCHS WPC pilot project includes a high hiring volume across multiple disciplines on an aggressive timeline. The civil service hiring process employed by the county allows for incumbent staff to bid into positions, depleting an already resource-strained system.

The WPC program continues to face the following challenges in the second half of PY2: county council approval on the EHSD data-sharing MOU, limited housing inventory, privacy restrictions mandated through 42 CFR Part 2, evaluating our program's impact and impacted primary care clinics. 42 CFR Part 2 specifically creates an enormous barrier for reaching our WPC goals of improved care coordination and therefore improved patient well-being by requiring patient consent to share Substance Abuse treatment information.

Our lessons learned have included that in order to develop a centralized communication system (an EHR) that allows for all members of a patient's care team to work collaboratively and effectively, challenges related to data sharing, interoperability and confidentiality must be addressed and overcome. This work takes substantial time, and it requires the support of local, state and federal agencies.

III. ENROLLMENT AND UTILIZATION DATA

For the Mid-Year report, provide data for January-June 30 of the Program Year and for the Annual Report, provide data for January-December 31 of the Program Year.

The tables below should reflect enrollment and utilization numbers, consistent with your invoice and quarterly enrollment and utilization reports.

For revisions of enrollment and utilization data submitted during the Mid-Year Report (Months 1-6), changes should be made in bold. Additionally, note explicitly in the additional box at the end of this section if no changes were made to the Mid-Year reported data.

Item	Month 1	Month 2	Month 3	Month 4	Month 5	Month 6	Unduplicated Total
Unduplicated Enrollees	162	*	0	3003	2002	2122	*

Item	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12	Annual Unduplicated Total
Unduplicated Enrollees	1610	2020	4312	1290	25	*	16601

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.

FFS	Costs and Aggregate Utilization for Quarters 1 and 2						
	Month 1	Month 2	Month 3	Month 4	Month 5	Month 6	Total
Service 1	0	0	0	0	0	0	0
Utilization 1	0	0	0	0	0	0	0
Service 2	0	0	0	0	0	0	0
Utilization 2	0	0	0	0	0	0	0

Whole Person Care

Contra Costa County

Annual PY2

4/2/2018

FFS	Costs and Aggregate Utilization for Quarters 3 and 4						
	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12	Total
Service 1	0	0	0	0	0	0	0
Utilization 1	0	0	0	0	0	0	0
Service 2	0	0	0	0	0	0	0
Utilization 2	0	0	0	0	0	0	0

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

PMPM		Amount Claimed						
	Rate	Month 1	Month 2	Month 3	Month 4	Month 5	Month 6	Total
Bundle #1	$326	$52,812	$63,244	$63,244	$64,222	$716,874	$759,254	$1,719,650
MM Counts 1		162	194	194	197	2199	2329	5275
Bundle #2	$146	$0	$0	$0	$438,000	$438,000	$727,810	$1,603,810
MM Counts 2		0	0	0	3000	3000	4985	10985

PMPM		Amount Claimed						
	Rate	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12	Total
Bundle #1	$326	$1,282,810	$1,270,748	$1,168,384	$1,161,212	$1,111,986	$1,046,786	$7,041,926
MM Counts 1		3935	3898	3584	3562	3411	3211	26876
Bundle #2	$146	$719,780	$998,932	$1,580,158	$1,694,476	$1,612,278	$1,538,110	$8,143,734
MM Counts 2		4930	6842	10823	11606	11043	10535	66764

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

CCHS has experienced delays in opening our Sobering Center, the FFS bundle included in our original approved application. Due to this delay, we are not reporting any FFS services in PY2. CCHS has requested roll-over of the $861,000 associated with this FFS bundle in our roll-over request. Therefore, we are reporting 0 FFS units in PY1.

CCHS is reporting a higher number of PMPM enrollees than budgeted in our original, approved application. In PY 2 CCHS provided 2,876 more member months for XX and 4,364 more member months for XX than included in the WPC application and budget. With DHCS approval CCHS was able to use $1,574,720 in unspent PY 2 funds to cover this increased cost.

IV. NARRATIVE – Administrative Infrastructure

Please describe the administrative infrastructure that has been developed specifically for the WPC program and how it relates to achievement of program goals. Reimbursement will be based on actual costs expended and employees hired/employed for the WPC pilot, and only up to the limit of the funding request in the approved budget.

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

We have no changes to report from our mid-year Administrative Infrastructure narrative. Prior narrative is below:

The CommunityConnect administrative infrastructure consists of five positions that support the fiscal, administrative and quality improvement needs of the program. Staff are tasked with the responsibility of achieving program goals, reviewing program sustainability and embedding new workflows and services into the larger Contra Costa Health Services' system.

Staff include:

Quality Improvement Manager – Oversees all Quality Improvement efforts and manages workgroups aimed at improving deliverable outcomes and achieving program goals of reducing inappropriate utilization of Emergency and Inpatient services.

Program Director – Oversee management of Program deliverables and assists Quality Improvement Manager in assigning priority to projects. The Program Director liaisons with the larger CCHS system to ensure program transparency and avoid duplication of services. The Director supervises service delivery managers and develops the team-based models of service provision.

Financial Managers – Responsible for all CommunityConnect billing activities, staff payroll and Program budgeting. Financial Managers also oversee MOUs and contracts, and direct hiring activities.

Project Manager – Provide project management guidance for incentive and other reporting projects. The Project Managers lead all communication efforts and are the main point of contact for care coordination activities within and among all participating entities.

We were able to quickly hire administrative staff for the CommunityConnect Program early in PY2 and are on target to meet and exceed the budget proposal amounts in the administrative infrastructure category.

V. NARRATIVE – Delivery Infrastructure

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

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

CommunityConnect continues to implement a two-tiered case management model which aims to divert high utilizers away from unnecessary emergency department visits and inpatient facilities, and towards appropriate care that addresses their complex needs and promotes long-term health and improved quality of life.

Case management services in both tiers are provided by an interdisciplinary team, including: Mental Health Staff, Substance Abuse Staff, Public Health Nurses, Community Health Workers, Social Workers and Housing Specialists. The aim of our team model is to have different specialty providers available to address the variety of patient needs.

CCHS' successes over PY2 come from the sustainable models of care coordination that have been implemented across our larger delivery system. The CommunityConnect program championed the expansion of identifying care team members within the EHR to encourage system-wide care coordination. CommunityConnect continues to grow our case management documentation within the HER, making social risk factors identifiable to the patient's care team. This screening of risk factors has identified that the most prevalent needs among enrolled patients include, dental, food, transportation and housing.

CCHS made great strides in the partnership with our local social service agency, the Employment and Human Services, since the mid-year report. CCHS has since hired our Employment and Human Services Division Manager, social workers and eligibility workers. Having these positions onboard to support service delivery has allowed for an increased depth of services offered to clients. Working closely with EHSD as technical experts and preparing scopes of work in advance allowed for a smoother transition of the social work staff.

The introduction of the eligibility worker has allowed for the development of proactive workflows targeting clients impacted by Medi-Cal churn. As with most counties, Contra Costa experiences approximately a 10% to 20% churn in Medi-Cal eligibility each month. Many clients are unaware of their lapse in Medi-Cal coverage, therefore this change is often not communicated to their case manager. CCHS is currently working with the EHSD to notify case managers in a timely manner when a client's coverage

lapses. These individuals work directly with the case manager and client to reestablish coverage as soon as possible. Once CCHS has implemented the new universal consent form with EHSD, CommunityConnect will be able to identify the enrollee's Medi-Cal redetermination date sixty days in advance. This will allow case managers to proactively engage with clients and work toward avoiding any lapse in coverage.

CCHS wrapped up project year two targeting the concerns of disparate workflows among specialty case management staff that developed over the last two quarters of the project year. Over multiple days, project leadership and management staff collaboratively developed a core service map depicting the bundle of services provided to all enrolled patients. Next steps are to work with management staff to ensure workflow alignment and collaboration, working with Quality Improvement to measure implementation and identify potential PDSAs as needed.

Our lessons learned have included that the mapping and clear identification of existing and potentially overlapping case management services/programs/staff is an integral component of developing an integrated, multidisciplinary case management program such as Whole Person Care.

VI. NARRATIVE – Incentive Payments

Please provide a detailed explanation of incentive payments earned during the Reporting Period. Elaborate on what milestones were achieved to allow the payment, the amount of each payment, and to whom the payment was made. The lead entity will only be permitted to invoice for actual incentive payments made.

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

Please see attached spreadsheet and folder containing all supporting documents. All incentive payments are made directly to Contra Costa Health Services' Information Technology division.

CCHS completed 25 incentives of the 28 submitted in our approved application. The total incentive paid for PY 2 = $16,873,762 ($10,191,433 in Mid-year report and $6,682,329 in annual report).

CCHS was unable to complete 3 incentive projects. These three projects have been addressed in our Budget Roll-Over submission to DHCS, and CCHS is anticipating approval of our request to roll-over $3,360,486 into PY3.

VII. NARRATIVE – Pay for Outcome

Referencing the Whole Person Care Universal and Variant Metrics Technical Specifications, please provide a detailed explanation of the status of your program's performance on the pay-for-outcome metric(s). For the Mid-year report, only report those measures that are reported semi-annually; for the Annual report, please report all. Provide details that demonstrate what was achieved for each outcome, any challenges, and any lessons learned. Reimbursement will occur for achieved outcomes based on proposed annual target and methodology.

CCHS had one pay for outcome deliverable: Maintain metric baseline and provide documentation of: process and procedures for ensuring the spread of SBIRT to the WPC participating entities by the end of PY2; provide training for WPC staff in SBIRT and motivational interviewing within 3 months of hiring new staff.

CCHS has met this deliverable.

1) CCHS has developed the processes and procedures for ensuring the spread of SBIRT and has completed training for all CMCT staff.

2) CCHS tracks the completion rate for SBIRT screening among enrolled patients and are confident that baseline will be maintained in PY2. Our current data shows that baseline data (2016) is 31% and PY2 data (2017) is 36%. This data will be validated and reported in our Variant and Universal Metric report.

CCHS has implemented the SBIRT screening for patients enrolled in CommunityConnect, as part of the core package of services provided to our patients. All staff have been trained on how to deliver the SBIRT screening(s), provide appropriate follow-up services and/or interventions and document outcomes in the EHR. Workflows are aligned with other system SBIRT workflows to ensure non-duplication of screenings and interventions, and to promote a continuum of care for patients.

CCHS schedules Motivational Interviewing training during the onboarding process for all new CommunityConnect employees. Transcripts are available if requested. We have also implemented motivational interviewing principles into the development and provision of core services provided through the CMCT program.

Lesson learned: CCHS has surprised by the amount of training time required by staff to prepare them to deliver the screenings and follow-up services. Due to the large number of new staff hired for the CommunityConnect program, staff already had a steep learning curve with many trainings scheduled during their onboarding process. Staff came into our program with varying degrees of experience and education, which required the SBIRT trainings to be adapted to this diverse workforce.

VIII. STAKEHOLDER ENGAGEMENT

Stakeholder Engagement - In the text below or as an attachment to this report, please provide a complete list of all program policy meetings you have held with participating entity/ies and/or stakeholders during the reporting period, and a brief summary, with topics and decisions, of the proceedings. The list of meetings will not count against your word limit. Please Note: Do not include meetings held as part of providing WPC services (e.g. care planning, MDT meetings). Meeting information provided in the Mid-Year Report does not need to be resubmitted.

Please see attached spreadsheet which includes a list of all stakeholder and participating entity meetings. The attached spreadsheet includes a list of topics covered, attendees, meeting dates and meeting names.

IX. PROGRAM ACTIVITIES

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

(1) **EHSD Workforce.** CCHS has had success partnering with the local social service agency, the Employment and Human Services Division (EHSD) of Contra Costa County to merge workforces and develop an integrated eligibility and case management system for the CommunityConnect Program. EHSD staff are co-located with CommunityConnect staff and workflows have been defined to address Medi-Cal churn for enrolled patients. EHSD Eligibility Workers manage a workqueue of patients identified as having lapsed Medi-Cal coverage. Workers contact patients and work with them directly to determine what is needed to continue coverage. Currently, only EHSD staff have access to view eligibility information (per DHCS Medi-Cal mandate), therefore their presence on the CommunityConnect team has greatly aided efforts to address patients falling off coverage and therefore out of the program.

CCHS and EHSD are also working to finalize an MOU to share Medi-Cal redetermination data for enrolled patients, allowing CommunityConnect case managers to proactively assist patients with Medi-Cal enrollments.

(2) **Eliminate Duplication of Case Management Services.** CCHS has eliminated the duplication of case management services by developing an electronic system to identify patients currently assigned to a case manager through the Contra Costa Health Plan (CCHP), Ryan White HIV Program and Persimmony Home Visiting Program. This system checks for an assigned case manager before determining eligibility for the CommunityConnect Program. Once a patient leaves other case management, they may become eligible again for CommunityConnect if their risk meets program requirements. This coordination reduces duplicated services and creates a continuum of care for patients who meet eligibility requirements for both programs. The Program has also developed a way to identify case manager assignment within the EHR. The name and contact information of case managers are displayed as a member of the patient's care team which is visible to all staff accessing the patient record. Case Managers, Care Coordinators and PCPs can now identify each other through the Care Team listing for improved communication.

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

(1) **42 CFR Part 2**. CCHS has invested a lot of time and resources into understanding 42 CFR Part 2 requirements as it relates to CommunityConnect. Program staff includes

Substance Abuse Counselors, who provide support to patients who may suffer from Substance Use Disorder and who may be seeking treatment. CCHS has received conflicting guidance on whether CommunityConnect is a Part 2 Program. In general, 42 CFR Part 2 completely contradicts the purpose of a program like Whole Person Care, and care coordination efforts. Blocking information in a patient's chart that relates to the treatment of SUDs would inhibit the work of our case managers to support the patient through their recovery efforts. Many WPC patients have a current substance use disorder diagnosis, as this is a common cause for inappropriate usage of ED and IP visits. The CCHS WPC Program recently consulted with legal representation to provide guidance in determining how to balance the requirements of Part 2 while also meeting the WPC goal of providing integrated care coordination services.

Lesson(s) Learned: In retrospect, we were unprepared for the 42 CFR Part 2 implementation and its implications on our care coordination activities using a shared electronic health record system. We continue to proactively and purposely involving our CommunityConnect administration team in 42 CFR Part 2 workgroups and planning sessions.

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

(1) **High Risk Notifications**. CCHS has recently completed Phase 1 of a High-Risk Notification report. This report notifies case managers of external and internal high-risk events through an in-basket message (in EHR alert). Such events include any Inpatient or Emergency Department admission and discharge. The in-basket message includes a full visit summary that includes diagnoses, prescription information and visit notes. Following phases will streamline the notification process so that case managers get in-line alerts on patients with high risk events inside the Electronic Health Record. Additional high-risk events will include detention entry and release, and lapse of insurance coverage.

High risk event notification is a crucial component of providing supporting services to the highest risk patients, especially those that are using the hospital and ED inappropriately. Catching patients upon entry or exit will ensure contact with patients who can be hard to track down. It can also provide patients with the support they need during psychologically stressful events, increasing the likelihood of engagement in services. CCHS is incredibly excited by this notification system and believes it will improve the health of enrolled patients. CCHS will continue to conduct PDSA cycles for this project to continue improvement and usability of the notification system.

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

(1) **EHSD MOU**. As mentioned above in section a), CCHS and the local social service agency (EHSD) have been working on an MOU to allow data sharing for CommunityConnect patients. The data would include Medi-Cal redetermination dates for enrolled patients. This MOU has been under development and review for almost one year now. It is currently with CCHS County Council for final review and approval. However, until final approval is received, EHSD staff cannot share Medi-Cal determination data with the WPC CommunityConnect Case managers, inhibiting the services able to be provided to patients who have lapsed coverage.

Lesson learned: Federal and State statutes regarding the sharing of specific patient information in regard to Medi-Cal and WPC can be interpreted in conflicting ways. Asking each program to interpret laws for incorporation into the MOU has caused delays. Involving an outside legal party who is knowledge in theses specific laws would have sped up this process.

(2) **HMIS vendor.** CCHS was unable to complete one of the approved incentive projects due to complications working with the vendor for the HMIS system. The unmet incentive has been requested to roll-over to PY3 with a due date of June 30, 2018. CCHS hopes to have all problems resolved with this vendor to ensure the new incentive due date is able to be met. One of the biggest challenges faced includes the limitation for adding new custom data fields in the new HMIS product. Due to vendor limitations, CCHS was unable to import CommunityConnect Case Manager data into the HMIS system. This import will greatly aid HMIS users in connecting with case managers assigned to patients for improved care coordination.

Lesson learned: Giving this specific project a longer due date would have given us the extra time needed to work with the HMIS vendor to develop the new custom data fields.

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

(1) **Metric Dashboard**. CCHS has recently completed Phase 1 of our CommunityConnect Manager dashboard, an electronic visualization of metrics for managers to use to track staff productivity and outcomes. The dashboard was a product of regular meetings between the CCHS Business Intelligence department, the CommunityConnect Quality Improvement team and CommunityConnect direct services

managers. During these meetings, information was gathered from the managers to identify specific metrics that would assist them in supporting staff, providing staff supervision and ensuring accountability for the Program metrics and productivity standards. Process measures were developed after extensive mapping of the program's core services, state metrics and other program sustainability metrics.

The information displayed in the dashboards have allowed CommunityConnect management staff to develop productivity standards and identify Key Performance Indicators that will help guide future planning and quality improvement work.

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

(1) **Starting from scratch**. The CommunityConnect project has required CCHS to develop a home-grown case management system embedded into our system's EHR for documentation and tracking purposes. As exciting and impressive as this home-grown system is, it has required significant effort to ensure that it meets the needs of multi-disciplinary team members and that it is transparent to the larger CCHS system of care. The case management documentation system is socially-focused and includes assessments, screenings, and the creation, tracking and resolution of identified goals. One of the biggest struggles faced is the inclusion of management staff in the development of our documentation platform. CommunityConnect staffs come from a variety of different disciplinary backgrounds, each with their own prior experience working in siloed systems that were dictated by distinct funding steams and documentation expectations. Developing a new system that is inclusive of the perceived needs of all staff has been frustrating and time-consuming. CommunityConnect is a new program with new workflows and expectations that are being developed and refined as the program progresses. The process has been an evolving balance of mapping services, needs, goals, workflows and outcomes while ensuring that services are aligned with DHCS guidance and are supporting the larger medical and behavioral health system of care. Although this is identified as a challenged, we want to stress the added benefit this process and the outcome has provided to our entire program. The process has illuminated the complexity of compiling a multi-disciplinary team to conduct a set of core services, and although the process is recognized as challenge, it was also a necessary component to the program design.

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

(1) CCHS is struggling to understand the correct approach to begin planning for sustainability. CCHS believes that tracking the fiscal impact of services provided is the best way to internally report success and encourage continued funding for these services. However, it is complicated to track financial impact data for enrolled patients and be able to directly credit the work done by CommunityConnect to fiscal changes. There are numerous other 1115 waiver efforts being conducted in the CCHS system of care, and it's challenging to isolate specific outcomes and connect them to specific efforts. Many efforts overlap, and although it is known that combined, 1115 waiver programs WILL show decreased costs and improved health outcomes, and CCHS continues to try to understand how to prove success through financial outcomes.

X. PLAN-DO-STUDY-ACT

PDSA is a required component of the WPC program. The WPC PDSA Report template will be used for each PDSA that the LE is conducting. Summary and status reports are required components of your Mid-Year and Annual reports. Please attach all required PDSA documents and completed template demonstrating your progress in relation to the infrastructure, services, and other strategies as described in the approved WPC LE application and WPC STCs. Note: For the Mid-Year Report, submit information from January – June 30. For the Annual Report, submit information inclusive of all PDSAs that started, are ongoing, or were completed during the Program Year.

Please refer to PDSA summary report and related PDSA status reports.