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 Health Services Department
Annual PY3 Report
April 1, 2019

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 Health Services Department
Annual PY3 Report
April 1, 2019

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.*

Contra Costa Health Services (CCHS) continues to make significant progress with the CommunityConnect program during PY3. The year included substantial service integration efforts, improved case manager workflows and IT projects focusing on Quality Improvement, and productivity tracking that will **improve the health outcomes for the WPC population.**

One project that demonstrates efforts to continue **increasing integration among county agencies, health plans, providers, and other entities** is the evaluation and expansion of the Community Provider Network (CPN) pilot. This project provides CommunityConnect case management services to patients receiving care from the CPN (Kaiser, La Clinica and Lifelong Medical Center). In PY3, the project increased patient enrollment from 50-120 patients for the La Clinica and Lifelong organizations. The project team also completed a qualitative and quantitative analysis described in section IX(a). PY3 also included projects **increasing coordination and appropriate access to care -** cell phone distribution and housing transition payments. CMCT contracted with Sprint in October 2018 to supply smart phones to patients enrolled in CommunityConnect. The phones were provided at no cost and included a discounted monthly plan payed for by CMCT for 6 months. Intended to encourage engagement with case managers and services providers, the phones have proven to be well-utilized and valued by staff as a successful method to temporarily address communication problems. PY3 also welcomed the development and implementation of FFS Housing Transition funds, supporting patients with security deposits and move-in expenses associated with accessing stable housing. The Housing Fund and ongoing collaboration with Bay Area Legal Aid, a non-profit legal organization providing Health, Safety, and Stability-related services, are helping to **reduce inappropriate emergency and inpatient utilization.**

Other PY3 projects that helped CCHS **achieve quality and administrative improvement benchmarks** include the 'Print and Mail' project, allowing case management staff based in the office or the field to send printed resources to a central office printer. Office-based staff then prepare and mail these resources to patients. This workflow reduces case manager time spent on administrative activities and improves mailing accuracy.

Office staff review addresses prior to mailing to reduce errors with incorrect addresses and apply same-day postage. Another project example includes the development of a case manager training curriculum that standardizes case manager onboarding training to prepare staff to meet the program's deliverables and provide efficient and coordinated services to patients.

PY3 also included **improved data collecting and sharing** projects; the development of manager and caseload management tools to track enrolled patients, contacts, open goals, and other relevant information; a Social Care Summit event sponsored by CCHS convening over 70 local health system IT leaders to explore ways to standardize social needs screening across EHR platforms; a social needs think tank PDSA process and subsequent standardization of the CMCT social needs screening, and; the Mental Health billing interface project bringing MH billing data into the CMCT data warehouse to improve care coordination for clients with MH visits.

The biggest challenges faced in PY3 included the elongated development of a data sharing MOU with the Employment and Human Services Department (EHSD) and the dissolution of the Sobering Center project. The MOU continues to undergo review and editing by individuals within the CCHS and EHSD agencies, and a final version has not yet been developed. In late PY3, CCHS acknowledged that the plan to build a Sobering Center as part of the CMCT program was not viable. After much discussion and financial analysis, a decision was made to stop the project and reallocate funds.

Another challenge identified by program staff is the lack of discretionary funds available to use as needed for patients. Examples of uses for a petty cash fund include: support patients with paying for a Post Office Box, prescription eye glasses, immediate access to food, gas money, car registration fee assistance, no-show appointment fees from outside providers, outstanding non-criminal law enforcement citations, employment fingerprinting, rent, housing application fees, supplies for homeless patients, etc.

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	1816	99	2,540	470	2,759	654	24,939

Item	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12	Annual Unduplicated Total
Unduplicated Enrollees	69	1,036	1,165	1,428	2,259	11	30,907

For **Fee for Service (FFS),** please report your total costs and utilization for each service. These reports should tie to your budget, invoice and utilization report. Add rows as needed.

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

	Costs and Aggregate Utilization for Quarters 3 and 4						
FFS	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12	Annual Total
Service 1	0	0	0	0	0	4,500	94,500
Utilization 1	0	0	0	0	0	21	21

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

		Amount Claimed						
PMPM	Rate	Month 1	Month 2	Month 3	Month 4	Month 5	Month 6	Total
Bundle #1	$326	$1,583,056	$1,574,254	$1,533,830	$1,627,718	$1,489,820	$1,393,650	$9,202,328
MM Counts 1	NA	4856	4829	4705	4993	4570	4275	28228
Bundle #2	$146	$1,473,578	$1,414,594	$1,724,406	$1,603,080	$1,828,504	$1,753,314	$9,797,476
MM Counts 2	NA	10093	9689	11811	10980	12524	12009	67106

		Amount Counts						
PMPM	Rate	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12	Total
Bundle #1	$326	$1,305,630.00	$1,225,434.00	$1,192,508.00	$1,910,686.00	$2,059,994.00	$1,913,294.00	$18,809,874.00
MM Counts 1	NA	4005	3759	3658	5861	6319	5869	57,699
Bundle #2	$146	$1,654,180.00	$1,612,278.00	$1,612,278.00	$1,287,574.00	$1,295,166.00	$1,198,514.00	$18,457,466.00
MM Counts 2	NA	11330	11043	11043	8819	8871	8209	126,421

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

CCHS received a budget adjustment approval in PY3 to adjust Tier assignment for some of the highest utilizing patients. Numerous patients were assigned to Tier 2 but were receiving Tier 1 services. (i.e. CMCT was providing Tier 1-level case management services but receiving Tier 2 reimbursement rate for these patients). CCHS requested a shift in member months from Tier 2 to Tier 1, so that the program was accurately reimbursed for services rendered.

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.

There are no changes to report from the final PY2 Administrative Infrastructure narrative. Prior narrative is below:

The CommunityConnect administrative infrastructure consists of five positions that support some of 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.

All Administrative staff members were hired in the early years of the project, and while the focus has shifted from implementation to program maintenance and improvement, roles and responsibilities remain applicable.

It is important to note that the above staffing profile does not truly represent the administrative support required to administer a program this large. Some administrative staff are included in the PMPM bundle and report to the administrative leads listed above.

V.

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 make many improvements to enhance the delivery of case management services to high utilizing patients. During 2018, CommunityConnect staff contacted 23,940 patients. Over 230,000 contacts attempts were made to enrolled patients, through in-person visits, phone visits, letters, texts, or other contact attempts. CommunityConnect completed 45,000 phone visits and nearly 20,000 home visits. In 2018, case managers addressed nearly 50,000 goals as part of patients' care plan, resolving and closing nearly 17,000 goals.

The program reached several milestones in 2018, as mentioned in Section II above, including the roll-out of free cell phones to eligible patients and distribution of housing transition funds. The housing fund directly supports patients with expenses related to moving and has enabled several enrolled patients to transition from temporary to permanent living situations. The standardization of the social needs screening questionnaire was also completed, and updates made to documentation goal templates used by case managers to identify and track patient needs. This standardization will aid the evaluation team by providing clean data on identified needs while also improving workflows for staff. Other workflow enhancements implemented in PY3 include the 'Print and Mail' project that centralized all resource printing for case management staff; including both field and telephone-based. The project reduces the amount of time case managers spend mailing resources to patients and improves the rate of delivered mail by verifying addresses prior to mailing.

Other PY3 highlights related to the CommunityConnect delivery infrastructure include a tier reassignment project, completion of case load management tool and the completion of IT incentive deliverables.

The Tier Reassignment project is a PDSA included in this annual report and involved a review of the patients assigned to Tier 2, the telephonic-based model, who had an increased risk score after enrollment. Patients identified in this PDSA were reassigned to a field-based case manager, ensuring they had the appropriate services available based on increased need. This PDSA helped to prepare the mid-year budget adjustment request to modify PMPM bundles and move patients to more appropriate levels of service.

The Caseload management tool was developed to assist case managers in tracking their assigned patients, upcoming milestones, open goals, and completed tasks. The tool is embedded in the EHR and helps staff to manage their daily activities and closely monitor 'difficult to engage' patients. The tool has greatly improved staff and manager communications, allowing supervisors to track productivity and support case managers in a very targeted manner during one-on-one supervision.

The completion of two IT incentive projects in Q3 and Q4 was another notable achievement – one being the development of an interface between the Health System's Mental Health billing system and the EHR, allowing staff to view information from prior Mental Health visits within the patient's chart. This increases the ability to provide comprehensive care coordination to patients with a history of receiving services from the Mental Health system. The other key project included the implementation of Caboodle, a data warehouse platform allowing for the organization of data into a more flexible structure able to be consumed by reports and dashboards. Caboodle will support the development of process measure reports able to be sliced and diced per specific data elements. The program will be able to use data displayed through Caboodle to help focus QI projects and ultimately make program improvements.

CCHS made significant program improvements in PY3 and has developed a robust data-driven delivery infrastructure within the WPC program and expanded these tools and systems to the larger CCHS network where possible. As the pilot has unfolded, a number of additional opportunities to build on this infrastructure have been identified that were previously unknown at the time of submitting the original WPC application. While CCHS is confident that the accomplishments realized through the WPC project to date are positively contributing to the success of the pilot, additional funding and IT tools and systems will be required to attempt to reach the full potential of the pilot and spread its learnings to the larger system.

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 the attachments below for supporting documentation of incentive payments and deliverables.

1. PY3 Incentive Measures Tracker_02.26.19.xlsx
2. 4_Caboodle.pdf
3. 5_MH Billing Interface.pdf
4. 26_27_Improvement Conference Attendance.pdf
5. 29_Waiver Integration Team Meetings.pdf

CCHS completed 28 of the 29 incentives approved for PY3. The outstanding item was rolled over to a new incentive deliverable to be completed in PY4.

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: Increase adult patients in WPC screened for Substance Abuse and Mental Health (depression) using the SBIRT tool at least once by 3% from PY2.

CCHS has met this deliverable. PY2 reported SBIRT completion rate of 36% and PY3 reported completion rate of 40%, reflecting a 4% increase from PY2.

This rate reflects the total number of WPC enrollees who were screened for Substance Abuse and Mental Health using the SBIRT tool at least once during the reporting year.

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 limit responses to 500 words*

Please see attachment 'Stakeholder Engagement Meeting Log_PY3_Annual.xlsx' for stakeholder meetings during the reporting period.

IX. PROGRAM ACTIVITIES

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

(1) Expanding CommunityConnect Services to Community Partners Organizations. Working with Community Partners, LifeLong, La Clinica, and Kaiser Permanente, CommunityConnect completed a six-month pilot to enroll eligible patients from these organizations and provide case management services. In the Summer of 2018, a pilot evaluation was prepared and presented to leadership from CommunityConnect, Contra Costa Health Plan, and the Community Partner organizations. Analysis of quantitative and qualitative results showed that established workflows supported the delivery of care coordination services to pilot enrollees. Specifically, monthly service planning meetings and documented materials supported CommunityConnect case managers in coordinating patients into appropriate care by increasing their knowledge of existing clinic services and pathways to access those services. Additionally, the establishment of onsite partner contacts improved patient care communication between case managers and clinic staff. Based on the pilot findings, a spread plan was proposed that included: increasing the number of enrollees, adding additional CommunityConnect staff to the case management team assigned to the partners, and aligning the enrollment and assignment of Community Partner patients to CommunityConnect's standard processes. Next steps include implementation of the proposed spread plan and exploring opportunities to improve communication between case managers and clinic providers through the EHR.

(2) Waiver Integration Team. CCHS developed a Waiver Integration Team (WIT) to convene representatives from redesign and incentive projects (PRIME, GPP, QIP and WPC) to identify opportunities for system coordination and alignment. The team meetings have provided space for waiver program's leadership staff to map services and coordinate efforts for overlapping priorities. A number of opportunities have been identified for workflow improvements and standardized approaches for care coordination, targeting shared Medi-Cal patients. This collaboration has also identified several technological improvements that could be implemented to streamline patients' access to care and reduce barriers to services.

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

(1) Limited capacity of system providers to learn about CommunityConnect services. One of CommunityConnect's PY3 goals was to increase the awareness and understanding of services provided through the program to the Health System's internal and external provider network. This has proven challenging as providers have limited availability to attend presentations or otherwise dedicate time to learn how CommunityConnect services are reflected in the EHR, how services can support providers' care plan or be best utilized by care coordinators. Coordinating events that would allow providers to participate in learning activities has been very difficult and therefore provider proficiency is less than desired.

Lesson Learned – Providing information to staff in a large, complex organizational structure should be done in a coordinated manner utilizing existing methods of communication, provided they exist. Attempting to coordinate presentations and disseminate information through other channels requires time that many providers do not have.

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

(1) Continuation of IT projects to further goals of connection and collaboration – During the reporting period CCHS completed an interface between the Mental Health billing system, ShareCare, to the EHR, Epic. This interface allows all EHR users to view MH services provided by contracted Mental Health clinicians in the community. The unique episode of care, provider, provider contact information, and dates are service are now visible in the patient chart for users with appropriate security. The contracted MH clinicians who provide these services are most often small private practices who do not use an EHR (or a small EHR) but do submit billing claims through a centralized billing platform required for California's unique Medi-Cal mental health billing requirements. Interfacing from the shared billing system is an efficient and effective solution to support information sharing in light of the challenges faced by service delivery situations where clinical providers are not able to use the same EHR and limitations exist in integrating to multiple systems**.**

(2) Share learnings and begin conversation regarding data sharing with broader community network – Building on the success of IT infrastructure developed through the WPC pilot the CCHS IT and Public Health Divisions began a concerted effort to share this information with neighboring healthcare organizations in the Bay Area. By using the same EHR, Epic, and its integrated patient record sharing functionality, Care Everywhere, many healthcare systems can share data in real time at the point of care. With this sharing, remote relationships are immediately developed across the United States, building a collaborative data sharing environment with minimal configuration required. As organizations have matured in their use of the EHR over time and patient continue to utilize multiple systems, the desire to share more information has naturally grown. With the support of the EHR vendor, Epic, Contra Costa Health Services hosted a 'Bay Area Social Care Summit' in December 2018. The Summit was attended by over 70 representatives from more than 9 different Bay Area healthcare organizations, some other public systems participating in WPC, some large not-for-profit systems, and others as community partners. During the day-long meeting CCHS shared the progress made in building tools and technology to support social needs in the EHR through the WPC program, all organizations discussed challenges and lessons learned, Epic shared future functionality developments, and all organizations were able to provide feedback and guidance to Epic.

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

(1) Completion of data sharing MOU with Social Services Agency – During the reporting period, Contra Costa continued to be challenged with the completion of a Memorandum of Understanding for data sharing between the Health Services Department (CCHS) and the county social services department, Employment and Human Services Department (EHSD). The two departments have been working on the agreement since January 2017, remaining at a continued standstill. Differing perspectives on the amount of patient consent required and a revolving door of involved parties led to the engagement of legal counsel from the Foley Law Firm based in Los Angeles and multiple conversations with policy advising organizations. The advice received from these outside parties has contributed to a new approach to the data sharing agreement and both CCHS and EHSD look forward to finalizing the MOU in early 2019.

Lessons learned – It is essential to have decision makers for contractual agreements meet consistently to clarify areas of concern and develop structured timelines for moving forward while respecting the varied cultural identities of unique organizations which may hinder linear progress.

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

(1) Developing operational infrastructure to support technical data processes – The CCHS WPC pilot developed an internal 'Think Tank' structure to encourage front-line staff input in optimizing case manager workflows and overhauling data collection processes. A workgroup was formed in Summer 2018 to support the Quality Improvement team's PDSA efforts to improve the Social Needs Screening Tool developed earlier in the program. The Think Tank was staffed with representatives from all case management disciplines and met weekly with support of program leadership. Team members were highly engaged, and champions of the tests and modifications identified through the process. A key outcome was the development of more discrete tools for tracking the outcomes of services provided and streamlining the number of 'goal templates' available for documentation. In the absence of discrete tools and standards, case manager documentation was widely varied with some case managers charting quite verbose statements and others barely including information to follow the case. The Think Tank designed, tested, and implemented new standardized templates to consistently document services provided, allowing for more consistent data collection to support reporting.

(2) Implementing new data warehouse analytics tools – Building on the internal Evaluation Committee formed in April 2018, the CCHS WPC pilot began an implementation of Epic's data warehouse tool, Caboodle, to better support the evaluation. This tool is built on the integrated EHR and allows for data to be more easily identified, evaluated, and analyzed. With Caboodle, CCHS is now able to collate clinical, financial, and operational data together from multiple sources – both within and outside the CCHS organization to support the cutting-edge analytics utilized in the WPC program operations and evaluation.

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

(1) Meaningful discrete data collection in qualitative nature of social case management work. The Contra Costa EHR, Epic, has been one of the greatest assets in our program infrastructure, allowing for a centralized repository of patient information, mechanisms to communicate across care team members, connect to partnering community organizations through the shared record, and much more. However, as is standard with most technology systems, data reporting is only as good as data entry. Most data collection and reporting tools are reliant on discrete data entry, often inherent in quantitative and/or binary operations. Social Case Management is inherently more of a qualitative activity, with services based on the development of an underlying relationship between patient and case manager. As services and patient interactions grow, the CCHS IT build has been stretched, modified, and tested beyond its original expectations to support the full scope of patient services and situations encountered through the WPC pilot. To continue to collect meaningful data on services provided, the vast number of patient outcomes encountered, and scale to other programs supporting our shared clients, CCHS will need to modify the social case management tools built in the EHR. Working with the EHR vendor directly, CCHS has begun to discuss future tools and modifications should funding be available to support this transition.

(2) **Delay in capturing outcomes due to long-term nature of social services and enrollment period.** The CCHS WPC pilot program is anxious to have outcomes data analyzing the impact of WPC services and receives frequent requests both internally and externally for this information. This is logical recognizing the large investment in the program as well as the desire to make a difference in the lives of these high need enrollees. However, due to the longer-term enrollment period of 1 year in the CCH pilot, the program is just now beginning to be able to collect outcomes data from the first cohort of patients who received services. Coupled with the expected and realized frequent workflow changes through PDSA improvement cycles, the initial enrollees may not be the 'best' group to study for true program outcomes. It is concerning to many individuals that this delay in gathering and analyzing outcomes may be 'too late' for the decision timelines required for waiver renewal.

Lessons Learned: As the pilot has progressed, CCHS has learned more about the qualitative nature of services provided and been required to modify IT tools and configuration to support these needs in a discrete data entry environment. Employing technology that is capable of being responsive to these needs is essential to learning through the PDSA processes.

While a five-year pilot timeframe can feel and appear lengthy, outcome results take a significant amount of time to collect due to varying enrollment timeframes and the development and modification of workflows which result in changes in data entry procedures. While less than ideal, information may not be available in time to best inform future waiver planning.

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

As previously reported in the PY3 Mid-Year Narrative, the CommunityConnect program still believes the uncertainty of the future of the 1115 waiver is a key area of concern. As stated, the development of a program of this size and scope takes a significant amount of time and planning with committed partners and expertise. While the Contra Costa Whole Person Care pilot has been tremendously successful in building on past success in the Public Health Clinic Services department to create a large-scale social care management program, staff and system anxiety has grown as the program years have progressed. This anxiety is fueled by the recognition that waiver negotiations will be required to occur prior to the finalization and true realization of outcomes data.

The impacts of changes to social needs and services are proven to take a significant amount of time to be realized and are unlikely to be demonstrated through the formal WPC program metrics selected by DHCS. The significant variances across pilot entities in target populations, enrollment timeframes, and interventions are likely to result in varied outcomes that may not be necessarily indicative of program success or social case management services.

Relying too heavily on the DHCS WPC formal metrics and preliminary outcomes to design a future waiver may result in a misinterpretation of the benefits of social case management in improving health outcomes. The early communication of initial outcomes to the media and public by some WPC pilots has set unrealistic timeframes to realize success and overall gains.

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.

See PDSA attachments:

1. PDSA Summary PY3 Annual Report.xlsx
2. PDSA -Inpatient Utilization_2018_Q3.doc
3. PDSA - Inpatient Utilization_2018_Q4.doc
4. PDSA - Data_2018_Q34.doc
5. PDSA - ComprehensiveCarePlan_2018_Q3.doc
6. PDSA - ComprehensiveCarePlan_2018_Q4.docx
7. PDSA - Care_Coordination_2018_Q34.doc
8. PDSA - Ambulatory_2018_Q3.doc
9. PDSA - Ambulatory_2018_Q4.doc