Whole Person Care Pilot Application

Application due July 1, 2016

Section 1: WPC Lead Entity and Participating Entity Information

1.1 Whole Person Care Pilot Lead Entity and Contact Person (STC 117.b.i)

Organization Name	Contra Costa Health Services
Type of Entity (from lead entity description above)	County
Contact Person	Patrick Godley, MBA
Contact Person Title	Chief Operating Officer and Chief Financial Officer
Telephone	925-957-5405
Email Address	Patrick.Godley@hsd.cccounty.us
Mailing Address	50 Douglas #310 Martinez, Ca 94553

1.2 Participating Entities

Required Organizations	Organization Name	Contact Name and Title	Entity Description and Role in WPC
1. Medi-Cal managed care health plan	**Contra Costa Health Plan**	**Patricia Tanquary, Chief Exec Officer**	**Contra Costa Health Plan** (CCHP) has been serving the health needs for people in the County for 40 years. CCHP was the first federally qualified, state licensed, county sponsored HMO in the United States. In 1973, CCHP became the first county sponsored health plan in California to offer Medi-cal Managed Care coverage. In 2014 as part of the implementation of the Affordable Care Act, CCHP enrolled over 35,000 newly eligible individuals into Medi-Cal Managed Care and in 2015 over 25,000 more individuals enrolled into CCHP Medi-Cal Managed Care. The Current CCHP Medi-Cal enrollment is over 180,000 individuals. **WPC Role:** CCHP is the Health plan for over 85% of the Medi-Cal population in Contra Costa, therefore they will be an integral partner in data sharing, care coordination, assurance of non-duplication and participation on the governing board

Required Organizations	Organization Name	Contact Name and Title	Entity Description and Role in WPC
2.Health Services Agency/Department	**Contra Costa Health Services**	**William Walker, CEO**	
	☐ **Contra Costa Regional Medical Center and Health Centers (CCRMC)**	☐ **Anna Roth, CEO**	**Contra Costa Regional Medical Center,** located in Martinez, is a full service county hospital and offers a complete array of patient-centered health care services (inpatient, emergency room and specialty service are delivered in throughout the facility Health Centers , located throughout the county, provide many outpatient and specialty t primary health care services. The CCRMC outpatient services provide over 400,000 visits per year. **WPC Role:** CCRMC will provide the Emergency, Specialty and Primary Care services provided to the WPC participants. They will be an integral part of data sharing, care coordination, and a member of the governing board.
	☐ **Public Health**	☐ **Daniel Peddycord, PH Director**	**Contra Costa Public Health** promotes and protects the health and well-being of the individual, family and community in Contra Costa County. **WPC Role:** CommunityConnect will reside in the Public Health division of **CCHS.** PH will provide PHN case management to Tier 1 participants. They will participate in engagement, data sharing, care coordination, quality improvement (PDSA cycles), the administration & management and governing activities of the WPC.
	☐ **Emergency Medical Services**	☐ **Patricia Frost, EMS Director**	**The Emergency Medical Services** division serves the people of Contra Costa County every day. They work with partners and providers to ensure everyone involved in an

Required Organizations	Organization Name	Contact Name and Title	Entity Description and Role in WPC
			emergency response is specially trained and properly equipped. **<u>WPC Role:</u>** The EMS department will benefit from the shared data proposed in the CommunityConnect Program. Ambulance and EMT staff will have access to real-time data on patients being transferred to hospitals or EDs through this Program. Data will allow staff to view hospital records from outside providers and view medication lists, reducing unnecessary medical errors and providing the most appropriate care.
3. Specialty Mental Health Agency/ Department	**Contra Costa Health Services, Behavioral Health**	**Cynthia Belon, Behavioral Health Director**	**<u>Behavioral Health</u>** provides integrated services for mental health, substance abuse, homelessness and other needs that promote wellness, recovery, and resiliency. **<u>WPC Role:</u>** The Behavioral Health department is committed to the CommunityConnect Program and will be an active collaborator throughout this pilot program. This department will provide technical assistance to the Sobering Center functions and provide supervision and oversight to the Mental Health, Substance Abuse and Homeless services providers.
4. Public Agency/ Department	**Housing Authority of Contra Costa County**	**Joseph Villarreal, Executive Director**	**<u>Housing Authority of Contra Costa County</u>** provides rental subsidies and manages and develops affordable housing for low income families, seniors and persons with disabilities in Contra Costa County. **<u>WPC Role:</u>**

Required Organizations	Organization Name	Contact Name and Title	Entity Description and Role in WPC
			HACCC will partner with the WPC pilot in order to serve individuals, who are experiencing, or are at risk of, homelessness or who have a demonstrated a medical need for housing or supportive services and enrolled in WPC. HACCC will participate in planning, care and services coordination and the governing board.
5. Community Partners	**1. La Clinica De La Raza**	**Jane Garcia, CEO**	**La Clinica De La Raza** provides primary health care and other services spread across Alameda, Contra Costa, and Solano Counties. La Clinica delivers health care services in a culturally and linguistically appropriate manner to most effectively address the needs of the diverse populations it serves. La Clinica is a community health center, rooted in the concepts of wellness, prevention and patient-centered care. La Clinica is a contracted partner to Contra Costa Health Plan for the Medi-Cal population. **WPC Role**: La Clinica will provide outreach, engagement, care coordination support, data sharing, and participation in the governing board.
	2.LifeLong Medical Care	**Marty Lynch, CEO**	**LifeLong Medical Care** is a community Health Center that provides high-quality health and social services to underserved people of all ages; creates models of care for the elderly, people with disabilities and families; and advocates for continuous improvements in the health of our communities. LifeLong is a contracted partner to the Contra

Required Organizations	Organization Name	Contact Name and Title	Entity Description and Role in WPC
			Costa Health Plan for the Medi-Cal Population. **WPC Role:** LifeLong Medical Care will provide outreach, engagement, care coordination support, data sharing, and participation in the governing board.
	3.Kaiser Permanente	**Sarita Mohanty, Regional Executive Director, MediCal Strategy and Operations**	**Kaiser Permanente** is an integrated managed care consortium, based in Oakland, California. Kaiser is a contracted Partner for the Contra Costa Health Plan Medi-Cal population. They manage approximately 31,000 CCHP lives. **WPC Role:** Kaiser Permanente will participate in the Program's governing board and data sharing efforts and will provide administrative support to the Program. Kaiser patients will benefit from the enhanced case management services offered through this program.
	4.Health Leads	**Alexandra Quinn,** Managing Principal,	**Health Leads** addresses all patients' basic resource needs as a standard part of quality care. Health Leads works with leading healthcare organizations to tackle social co-morbidities by connecting patients to the community-based resources they need to be healthy – from food to transportation to healthcare benefits. **WPC Role:** Health Leads will provide data support and sharing, tools for care coordination, and participation in the governing board.
	5.NAMI	**Will Taylor, Executive Director**	**NAMI**, the National Alliance on Mental Illness, is a grassroots mental

Required Organizations	Organization Name	Contact Name and Title	Entity Description and Role in WPC
			health organization dedicated to building better lives for people affected by mental illness. NAMI works in the community to raise awareness and provide support and education that was not previously available to those in need. **WPC Role:** NAMI will provide peer support to patients being discharge from Mental Health inpatient or emergency services. NAMI will participate in WPC through peer support, engagement, care coordination, data sharing, and governing board participation.
	6.The Re-entry Success Center	**Nicholas Alexander, Director**	**The Reentry Success Center** is a central gathering space serving formerly incarcerated Contra Costa residents and their families. The Center provides opportunities to learn and develop skills, access to information and critical services, and individualized and responsive support for the continual progress of formerly incarcerated people and their families. **WPC Role:** The Center will provide social support, engagement, links to care coordination, data sharing and participation in the governing board.
	7.Bay Area Legal Aid	**Alex Gulotta Executive Director**	**Bay Area Legal Aid** is committed to providing meaningful access to the civil justice system through quality legal assistance regardless of a client's location, language or disability. **WPC Role:** Bay Area Legal Aid will provide legal

Required Organizations	Organization Name	Contact Name and Title	Entity Description and Role in WPC
			support to the WPC population with housing, disability and any other legal issues that arise. Bay Area Legal Aid will participate in data sharing, services coordination and participate on the governing board.

1.3 Letters of Participation and Support

Please contact Contra Costa Health Services for access to letters:
Rachael Birch
rachael.birch@hsd.cccounty.us
925-313-6167

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See attachments for letters of support.

Section 2: General Information and Target Population

2.1 Geographic Area, Community and Target Population Needs

Contra Costa County has approximately 1.1 million residents living in the urban, suburban and rural communities (2015 U.S. Census). Contra Costa Health Services (CCHS) is a partially integrated government owned and operated health system which includes a hospital; thirteen FQHCs; a Federally Qualified Health Plan (CCHP); Behavioral Health, Environmental Health, Emergency Medical Services; and Public Health.

CCHS is the lead agency for the proposed Whole Person Care pilot, CommunityConnect. CommunityConnect will target Medi-Cal patients that are high-risk, high-utilizers of high acuity medical services and/or across multiple delivery systems. The Program will provide coordination of services through a three-pronged approach: (1) Integrated and Coordinated Data Systems, (2) Enhanced and Coordinated Case Management, and a (3) Sobering Center.

An increase in Medi-Cal eligible residents (274,876 Medi-Cal enrollees in January 2016) has exacerbated problems resulting from fragmented systems, increased appointment wait times and ineffective utilization of the County's emergency departments and hospital systems. The County's low-income and vulnerable residents disproportionately suffer from poor health outcomes that result from unmet social, behavioral and health care needs. In screening for social needs in CCHS clinics, 50% of patients queried had one or more social need, including food, housing, health, utilities, employment, transportation, childcare, and education.

Contra Costa is still recovering from the Great Recession, housing and other costs of living expenses remain high. Overcrowding for low-income renters is 43% above the national average. Approximately 17% of residents live at/below the poverty level, and high housing costs take a significant portion of an individual's income. Income needed to afford average rent is $34/hour yet minimum wage is $9/hour (California Housing Partnership Corporation 2015).

CommunityConnect provides an opportunity for CCHS to bring to scale efforts to implement large system change and redirecting resources to address significant unmet needs of our patients through appropriate, streamlined, non-duplicative, and coordinated care that is prioritized to each patient. CCHS will partner with CCHP, multiple divisions and programs across our health system, and community partners to develop a program that will result in real-time, multi-level patient-centered case management. The program will deliver services to address the social determinants of health that are leading to poor health outcomes. CCHS conducted meetings with all prospective partners on this approach.

CCHS will develop an **integrated and coordinated data system** between partnered agencies and within CCHS divisions to create a system-wide approach to real-time care and coordinated case management. CCHS will also implement real-time integration between the various Health Systems' EHRs, the EMS record system, and integrate new systems, Pre-Manage ED (to receive medical data from outside hospitals), a population management system and social needs database and case management tool. These efforts will improve efficiency and efficacy of involved agencies and will lead to improved health outcomes.

CCHS proposes a County-wide collaborative **Enhanced and Coordinated Case Management** model to provide medical, behavioral health, social services, housing support, public benefits, eligibility and enrollment services and integrated care coordination to reduce unnecessary utilization in its high-risk, high-utilizer population. Coordination will be provided by multidisciplinary teams assigned to enrolled patients. Patients will receive social needs assessments, patient-centered care planning, linkages to social services, outreach and engagement for addiction treatment services, mentorship, health and life-skills education, housing navigation, reentry services, transportation, access to social resources, self-management skill development and other wrap-around services. These services will supplement the work of the patient's Primary Care team to create a more comprehensive approach with a goal of reducing unnecessary utilization of health care services and improve health outcomes

Another important component of the CommunityConnect Program is a **Sobering Center** to provide a safe environment for intoxicated individuals to receive detoxification services.

CommunityConnect also includes **Housing Navigation and Support Services**. Affordable housing in Contra Costa is increasingly difficult to find, landlords frequently evict renters to raise rents. The Program will support the County-wide coordinated entry infrastructure by including vulnerability screenings and housing case management services to people experiencing unstable housing.

CommunityConnect will strengthen relationships between community entities by allowing programs to access shared data, provide coordinated case management, and streamline the identification of social needs and prioritization of service needs. CommunityConnect will be implemented by the CCHS Public Health division to leverage existing community partnerships and program managers with ties to consumer groups, agencies, school districts and other CBOs.

Learnings for potential future local efforts beyond the term of the waiver will be explored during implementation through evaluation, analysis and PDSA cycles. Evaluation efforts will include developing a data dashboard to track data progress in all measurement categories.

The backbone of CommunityConnect will be the administrative and technology infrastructure, which are designed to be sustainable beyond the pilot period and will help shape the transformation of existing delivery systems. The technology integration project consists of large initial costs for the development of integrated systems that will accommodate information flow across multiple systems, identify unique patient markers and allow for more robust and efficient decision making. This project will enable providers and case managers to reduce service duplication, provide care coordination, and communicate effectively to support appropriate and timely care across the spectrum of service delivery. Administrative infrastructure, including the program management, service provision and evaluation staff, as well as the program guidelines, protocols and workflows are designed to be embedded in the existing CCHS departments. Throughout the waiver, CCHS will be required to adapt to and utilize the enhanced service model; ultimately resulting in a more cohesive system that is systematically coordinated to best meet the patient's needs and reduce barriers to care. With reduced ED visits and improved service utilization, CCHS will see cost savings that will be applied towards other areas of the CCHS system of care, including ongoing support for the Program's infrastructure and other services.

2.2 Communication Plan

The CommunityConnect Program includes a multi-level, collaborative governing structure involving representatives from participating entities and stakeholders.

The Program Director will chair a **Governing Board** consisting of representatives from all participating entities that will meet monthly to review implementation, assess metrics, provide evaluation guidance, and inform entities of new state requirements. CCHS Board members will include the Chief Financial Officer, Chief Executive Officer of CCRMC, Chief of Information Technology, Chief Quality Officer of CCRMC, Public Health Director, Substance Abuse Director, Mental Health Director, Homeless Program Director, EMS Director and Contra Costa Health Plan Chief Executive Officer. Partner agency representatives will include Kaiser, Lifelong Medical Services, La Clinica de la Raza, The Reentry Success Center, Bay Area Legal Aid, the Housing Authority, National Alliance of Mental Illness and Health Leads. During Year 1, the Board will develop a stakeholder engagement plan to align partnering agencies and identify stakeholders to participate on Working Committees. The plan will include a client-centered approach to stakeholder involvement to enhance communication, build relationships, and increase integration efforts.

Working Committees will provide project input and report to the Board monthly. Committee members will include the Program Director, Project Manager, Quality Improvement Manager, selected service managers and other 'best fit' stakeholders from all participating entities, as identified through the stakeholder engagement plan. Committees will be multidisciplinary to help minimize silos. Committees will review program sustainability as part of their standing agenda.

The **Engagement and Communication Committee** will address consumer engagement efforts, which are paramount to program success and overall Program enrollment/retention. The Committee will also monitor Program communication and be responsible for developing communication standards, ensuring Program transparency and monitoring Program visibility.

The **Care Coordination Committee** will address cross-sector care coordination services with a focus on improving coordination of services provided by entities and identifying service gaps and best practices for service alignment. This Committee will also be an advisory board to the CCHS delivery system to identify new outpatient services to help sustain the Program past the funding cycle and increase efficiency and system capacity. This Committee will also be responsible for reviewing corrective action plans for participating entities.

The **Information Technology (IT) Committee** will focus on the Program's data sharing project. Data collection, security, confidentiality, and metric monitoring will be key topics. This committee will ensure the integrity, quality, security, availability, and awareness of data created, stored, and used by the Program, and will be a subcommittee to the CCHS Data Governance Board, which manages CCHS data and information assets.

The **Quality Improvement Committee** will monitor Program outcome measures and Program integrity. This Committee will ensure compliance with state requirements and will monitor and advise on infrastructure and service sustainability beyond the funding period.

Program decisions will be addressed at committee meetings with significant issues brought to the Governing Board by the Program Director. Adjustments to interventions or services may be proposed at the Governing Board meetings and implemented through the committees, as well as through quality improvement efforts including PDSA cycles. The Program Director will be the main point of contact for participating entities.

2.3 Target Population(s)

In preparation for this proposal, CCHS and partnered agencies reviewed various databases to understand the high-risk, high-need populations that were utilizing high-acuity medical services and/or multiple systems within Contra Costa. Our report incorporated claims data from the Contra Costa Health Plan (CCHP), CCRMC/HC charge data and available utilization data. Although limited in patient identifier specificity, we used CY2015 data dumps from: CCRMC/HCs, CCHS Substance Abuse, Mental Health and Homeless Programs, and CCHP Medi-Cal data (including services provided at Lifelong, La Clinica and Kaiser) to quantify the CommunityConnect target populations.

The data analysis was based on CMS' hierarchy of chronic conditions risk adjustment model, so the financial team could appropriately assign a PMPM rate based on the health of our target population. Data was filtered to exclude non-Medi-Cal participants, patients with elective inpatient admissions and other appropriate markers of hospital and system utilization, and patients with no system activity during CY2015. The end result included 106,219 patients to construct a 'snapshot' of our high-risk, high-cost patients accessing services across all four health sectors; Homeless, Mental Health, Substance Abuse and Medical systems.

After identifying common characteristics within various percentiles of Medi-Cal high-utilizers, we also identified overlapping subpopulations, including the homeless, patients with more than two chronic diseases, recently incarcerated, patients with substance abuse and/or mental health diagnoses, foster children and long-term hospital stay patients. Due to the high level of complex needs, dual diagnoses, and comorbidities among all high-utilizers and the common need for care coordination and social support management, we decided that CommunityConnect would target the highest utilizers based on claims data costs. According to a 2011 DHCS report on high-cost Medi-Cal patients, the top 5% of users in the CCHS system represented 49.3% of total costs and the top 15% represented 78.9% of total costs. We found a similar correlation with our CY2015 data analysis. Projecting similar methodologies on the current CY2016 patient population, CCHS is proposing to target 15,600 patients in the CommunityConnect Program once fully operational, representing roughly the top 15% of high-utilizers. Some high-need Medi-Cal patients may not be identified within our current data systems due to lack of available charges or claims data. The DHCS report demonstrated that the top 1% cost cohort of Medi-Cal beneficiaries was disproportionately FFS only. If funded, CCHS will develop a more robust and inclusive report for baseline data based on the State's Global Payment Program's point value system logic, by the end of 2016. Of these patients, we expect 4,000 to represent the highest need tier with complex medical, behavioral and social health needs, requiring the highest level of intensive, multi-disciplinary, nurse-led case management. The remaining 11,600 will require a slightly less-robust, socially-driven case management team.

Using our CY2015 data, the design team analyzed the top 15% of the 106,219 Medi-Cal beneficiaries found in our initial report who are receiving services at CCHS, Lifelong Medical Center, La Clinica de la Raza and Kaiser. Of the initial 106,219 Medi-Cal beneficiaries, this 15% includes:

- 96.9% of the Skilled Nursing Facility patients
- 78.5% of the patients with > 6 ED visits in either the County or Kaiser Richmond ED
- 100% of the patients with > 6 inpatient days in the County hospital
- 100% of the patients with > 2 inpatient admissions in the County hospital

These target population patients are Medi-Cal recipients who are primarily and repeatedly accessing health care services in high-acuity settings due to the complexity of their unmet medical, behavioral health and social needs. These are patients who are facing extreme social and economic issues such as lack of housing/housing instability, unemployment, food insecurity, transportation and dominant language competency, and lack of other social support systems.

The Program's enrollment plan includes the development of a data-driven, real-time report to identify the target population and an interfaced, electronic intake application. Eligible patients will be electronically identified and assessed by the Program's intake unit. The intake unit will have a multidisciplinary team with access to the Program's data warehouse. Intake staff will contact patients to encourage Program enrollment. If enrollment is accepted, the intake unit will perform additional screening, obtain necessary consents and review the patient's data and service history to determine and assign the appropriate case management tier.

Ongoing identification will occur through two strategies: (1) monthly data runs to identify patients who are entering the target population based on utilization and claim charges; and (2) opt-in referrals for high-need patients as identified by CCHS or partner providers but which are not identified by data due to service utilization outside our current data capture and reporting capabilities.

Section 3: Services, Interventions, Care Coordination, and Data Sharing

3.1 Services, Interventions, and Care Coordination

The CommunityConnect Program will provide team-based services designed to meet complex individual needs of our target population. To effectively provide these services, CCHS must integrate the Program's administrative and IT infrastructure into the system of care and ensure alignment and de-duplication with existing system initiatives: PRIME, GPP, Drug Medi-Cal waiver, DTI, PCMH, Public Health Accreditation, TCM, HRSA and MHSA funding. CCHS is poised to facilitate the Program's delivery of proposed services and interventions, integrate services, coordinate program design across multiple sectors, and lead data-sharing efforts to improve communication, care coordination and service delivery. CCHS will leverage existing resources within our system, including executive management, finance department and quality improvement staff, to successfully implement and centrally administer the Program's services.

A two-step process will tailor services to the individual enrollee. Patients will be identified as eligible through a data-driven algorithm that will be implemented by March, 2017. Each potential enrollee identified, will receive a structured chart review and an individualized assessment through a centralized intake unit, comprised of Nurses, Community Health Workers and Care Coordinators. If criteria met, an outreach, enrollment and assessment procedure will occur. This process will identify service duplication and existing case management services, and will include initial screening tools to assess: unmet social needs; housing stability; legal/financial stability; medical care/access stability; mental health and addiction service needs. This assessment will guide initial tier designation and case manager assignments.

The Case Manager will coordinate care between patient, existing services and new services available through the CommunityConnect Program. Patients receiving case management through other programs will receive coordination for services not currently being provided.

Case Management

High utilizing patients have numerous and complex physical, mental and social service needs. These patients frequent the Emergency Departments, becoming high utilizers of a care setting that isn't designed to address long-term, deeply complex health issues. These patients have difficulty navigating the complex and fragmented care system, become frustrated with the barriers to receiving appropriate and timely care and resort to ineffective methods to meet their needs.

The CommunityConnect model of case management aims to divert high utilizers away from the ED and Detention facilities towards care that addresses their complex needs and promotes long-term health. The model uses case management focused on cross-sector care coordination to address the underlying behavioral health and socioeconomic needs that influence health outcomes and utilization. Services include coordination of primary, specialty, mental health, addiction services, physical rehabilitation and palliative care, homeless services, financial management services, legal services, transportation, patient advocacy, food and housing supports, reentry-focused and other supporting services.

CommunityConnect Case Managers will be hired by CCHS. The Program's Governing Committee will collaboratively establish policies/procedures for communication between case managers and agency providers and maintain data sharing efforts.

CCHS currently provides Targeted Case Management (TCM) services through Public Health Nurses (PHN).

Our proposed CommunityConnect PHN case management productivity is based on an algorithm of current TCM productivity, the type of services covered by TCM, the type of services required by our highest utilizing patients and the variation in populations served by both case management programs. Based on the algorithm CCHS was able to estimate that approximately 80% of all services would be WPC eligible and 20% of the services were TCM related. The 20% overlap of TCM services has been carved out of our application.

CCHS utilized these algorithm service estimate distinctions in developing our CommunityConnect application. **Accordingly, the CommunityConnect application excludes all TCM case management related services and costs. The application includes only the WPC component of the case management functions.** Based on this methodology, all services that are billable to Medi-Cal (inclusive of TCM) have been eliminated from the program proposal.

The activities of the care coordination teams will not duplicate the Medi-Cal targeted case management (TCM) benefit. Specifically, CommunityConnect will provide services that compliment TCM but are not reimbursable by TCM. The hallmark of TCM is performing a comprehensive assessment of the client by which a care plan is developed that guides referrals and linkages for the client into needed services and resources, and assessing whether those services met the needs of the client. TCM defines the resources and services needed by the client, **but does not reimburse for the provision of those needed services**. Unlike TCM, CommunityConnect will provide services such as patient education, direct patient care, patient counseling, behavior modification, medication reconciliation, substance abuse counseling, tenancy support, motivational support, trust building activities, preventative care, etc. Care coordination teams will have Public Health Nurses and Social Workers who will assess clients, then direct, collaborate and coordinate with the CommunityConnect team members to effectively deliver needed services.

Tier A – **Intensive Case Management**.

Public Health Nurses will lead case management teams. Patients have complex medical, behavioral health and housing needs that require long-term intensive and comprehensive case management services. This tier will include any enrollee who requires housing for medical stability and/or enhanced support services to maintain independence in the community.

Tier B – **Social Case Management**.
Patients in Tier B also have complex medical needs; however, the drivers for inappropriate system utilization are social in nature and therefore will be address by the appropriate social case manager and supporting team members. Social Workers lead case management teams. Patients will receive in person and telephone case management services.

Overall care coordination activities in both Tiers may include:

- Identification/prioritization of needs and barriers to achieving targeted goals
- Development/documentation of comprehensive care plans that including a social needs assessment
- Patient-centered care through integrated data systems
- Coordination of appointments and transportation arrangements
- Health education and medication management
- Self-management health skills and other life skills
- Patient-level advocacy, engagement and referral or linkage to appropriate services

The following is a detailed list of additional services and programs for patients enrolled in the CommunityConnect Program:

Sobering Center
The CommunityConnect program includes a 24/7 sobering center that will divert uncomplicated acute intoxication and serial inebriates from the County's EDs and criminal justice system. The Center will provide sobering services including detoxification and offer comprehensive care to clients including: basic hygiene; identifying and management of urgent care needs; transportation; housing navigation and support; linkages to primary care, mental health and detoxification and Substance Use Disorder treatment programs. The Center will also include an advanced electronic education system, including tablet education stations available to patients with remotely controlled educational applications, videos and learning exercises. The main sources of referrals will be the ED, police and EMS system. All patients will go through an intake process and be enrolled in CommunityConnect during their stay.

NAMI Mentor on Discharge
Mentor on Discharge (MoD) is a program of National Alliance on Mental Illness (NAMI). The program has shown to reduce re-hospitalizations by more than 70% within a critical 60 day period following discharge. The MoD program provides peer mentors, whose goal is to serve marginalized and often disadvantaged patients being discharged from a hospital, thereby making the peer mentor/participant relationship a seamless transition from hospital to the community.

Post-Incarceration
Post-Incarceration services will be available to patients through two organizations: The CCHS Reducing Health Disparities Initiative and the Reentry Success Center, an outside contracted agency. Services will include support groups, appointment scheduling and referral monitoring, and general care coordination for social and health services. The CCHS Transitions Clinic (targeting formerly incarcerated individuals)

will serve as the primary care site for coordination of services, interpersonal skill development, life skills coaching, social services linkages and money management. Staff will be trained in motivational interviewing, anger management and cultural competency. Services will be gender-responsive and tailored to support clients' ability to make positive, healthy future choices.

Housing Navigation and Case Management
Housing services provided to homeless patients or patients at risk of losing their housing will include vulnerability assessments using the VI-SPDAT tool, landlord and property management engagement and relationship development, assistance with rental applications, resources for paying utility bills and moving expenses, eviction avoidance assistance, and continued support to recently housed patients.

Payee Services
Contracted payee services will be available to Tier A patients, helping caregivers and beneficiaries successfully manage finances and benefits.

SNF & Board and Care Coordination
The Program includes staffing to provide care coordination at Skilled Nursing Facilities and Board and Care facilities that do not accept Medi-Cal and when patients cannot afford the monthly rate. This will enable the hospital system to successfully transition longer term hospital stay patients into long-term housing placements, and provide care coordination services needed by patients residing in these facilities. Facilities often turn patients away due to their high-acuity needs and lack of supporting services from the referring agency. Board and Care patients receiving this service are expected to be enrolled in Tier A.

Other Services
- Life skills – Psychosocial and interpersonal skill development
- Translation – Bilingual staff will assist with translation and medical interpretation outside of the clinic or hospital setting.
- Education – Vocational training resources, school application assistance
- Money Management – Banking assistance, budgeting and matched-savings programs
- Eligibility Services - Application assistance for County and State assistance Programs will occur outside of the clinic or hospital setting.
- Transportation – Vouchers for enrollees to go to scheduled social, medical or behavioral health agencies
- Mobile communication devices – Temporary phones will be provided to patients while waiting for long-term, low-income cell phone program enrollment.

Legal Support
Legal support will be provided through the participation of Bay Area Legal Aid (BayLegal). Legal support is an identified need for many patients, especially those requiring advocacy for public benefits; housing and conservatorship. BayLegal will provide enrolled patients with meaningful access to the civil justice system through free legal assistance, including advice and counsel, brief services and full legal representation, outreach and education, and systemic advocacy.

Social Services
The Program includes the development of a social needs call center and patient-facing mobile application for social need interventions using the Health Leads organization and their REACH database.

The call center will receive inbound referrals and provide resource connections. The mobile app will provide a lower-touch, easily accessible resource for patients seeking community resources. Both services will identify needs and find resources based on location, eligibility, and desirability.

The proposed case management and listed services and interventions will ultimately result in cost savings for the CCHS and CCHP system of care. These savings will be redirected back into the CCHS system to help support sustainability of the Program.

3.2 Data Sharing

The CommunityConnect program requires a comprehensive technology infrastructure to support integrated data sharing for the efficient delivery of services. CCHS is structured to support, implement, and sustain the goals of data sharing between the CommunityConnect participating entities. As a partially integrated, comprehensive health system, we are able to quickly build and upgrade current data collection systems across multiple programs/ divisions. We currently provide IT support for the CCHP, County Hospital and Health Centers, Public Health, Behavioral Health (including Mental Health, Alcohol/Other Drugs and Homeless Program) and Emergency Management System (EMS). We have a longstanding relationship with all participating entities and have the technical capacity/capability to interface with their electronic systems utilizing agreed upon information sharing protocols.

The CommunityConnect design team identified a number of data sharing components that would be necessary to implement the large-scale, streamlined case management system to increase provider efficiency/ efficacy and reduce unnecessary utilization of health care services.

1. Develop a data warehouse to capture data from multiple software platforms and use CorePoint to convert and send data from one system to another in real-time.

2. Implement/ integrate new software, system components and communication tools into CCHS' existing EHR (Epic) to enhance patient-to-provider and provider-to-provider communication, care coordination, population management, and track social determinants of health.

3. Develop a data governance structure to provide project guidance, data validation, security and confidentiality. Structure must be integrated into existing CCHS system for sustainability and cohesion.

Security and Data Governance – Security/Governance for CommunityConnect will be provided by the Data Committee, under the umbrella of the CCHS Data Governance Committee. Data governance is a crucial role for data collected, shared internally or through our community. The data governance structure includes our privacy officer, CMIO, CISO, Counsel, and Assistant Director of Business Analytics. Our governance structure delivers on their charter of getting right data, to right person, with most appropriate security.

Incentive Payments - Data Sharing Projects:

In support of the agencies who will serve the target population, the data sharing and infrastructure build will require technology that is necessary for identifying and referring the patient population to the CommunityConnect intake group.

We have grouped the technology and sharing "Incentive Payments" into the following groups: **Data Migration and Communication System, Data Capture and Sharing, Enable e-Prescribing for Behavioral**

Health Providers, HMIS replacement, Patient Population Management, Social Case Management, and CommunityConnect Intake Unit.

Data Migration and Communication System

The **Data Migration and Communication System** outcome will reduce duplication and improve communication across the care teams and CommunityConnect population. This work will include the following system implementations and improvements; Implement Behavioral Health documentation and scheduling in Epic; Reduce data duplication by connecting 3rd party systems; Implement additional communication modalities, such as SMS messaging to coordinate care for the CommunityConnect providers; migration of our Public Health workflows from current system with limited sharing capabilities to Epic; Implement systems to improve image and data collection within clinics.

Purchase and distribute temporary communication devices for education and communication. The Program will supply temporary phones to eligible participants and will implement Sobering Center Education stations. Stations will include tablet technology for education, resource navigation and communication for patients utilizing Sobering services. Project will include implementation of mobile device management interface to remotely manage devices and install educational components.

> **Incentive Measurement:** By 12/31/2017, provide documentation that mobile communication devices have been purchased and Education stations have been installed, provide documentation that a Mobile Device Management interface has been purchased and implemented and used to remotely install educational material and resource database updates on WPC devices and provide project completion certification for installation of Sobering Center Wi-Fi access points.

Migrate Public Health CommunityConnect workflows to Epic – Develop case management documentation system in Epic to track Program services rendered to enrolled patients. Case Management documentation is currently done in a separate Public Health system.

> **Incentive Measurement**: By 12/31/2017, Provide documentation that Case Management workflows and navigators have been built and implemented into Epic.

Coordinated SMS communication between providers – Deploy smart phone application that allows Secure Messaging System (SMS) communication between Program staff to securely communicate Protected Health Information for enrolled patients.

> **Incentive Measurement**: By 12/31/2017, Provide documentation that at least 50% of the hired CommunityConnect team members have been trained and have access to the secure SMS communication system.

Receive eligibility data from Employment and Human Services Department (EHSD) – Data will include eligibility information for Medi-Cal from the State and will enable the CommunityConnect Program to rapidly identify and enroll Medi-Cal eligible patients.

> **Incentive Measurement**: By 12/31/2017, Provide documentation that we have received and imported into the data warehouse first batch of client data from EHSD.

Improve data structures for CommunityConnect population - Complete the architecture, configuration and implementation of the data warehouse that will be the data repository for the CommunityConnect program. Data warehouse will include data from systems that do not currently connect to Epic.

> **Incentive Measurement**: By 12/31/2017, Produce initial data report showing verified and de-duplicated patients from the data warehouse and show project completion documentation.

Increase communication with patient through smartphone and web-based patient engagement tools – Enabling patients to access their medical record through mobile application (Epic's MyChart) and website, improving communication and patient engagement and reducing inappropriate system utilization.

> **Incentive Measurement**: By 12/31/2017, Provide documentation that enrolled beneficiaries have access to smartphone apps and websites to view their medical chart, schedule appointments, review lab results and contact their provider.

Implement Patient messaging system – Using automated telephone and SMS system to contact patients with appointment reminders and pre-appointment testing.

> **Incentive Measurement**: By 12/31/2017, Provide documentation that at least 50% of enrolled beneficiaries are configured to receive automated telephone appointment reminders and the corresponding response rate for the reminders.

Implement Behavioral Health Documentation with Epic – Allows Mental Health Clinical Specialists and Substance Abuse Counselors, and other Behavioral Health providers to document in the Epic system. This requires Epic workflow development and navigator builds to support documentation and streamline workflow for staff providing these services. Current CCHS Behavioral Health staff do not use Epic for clinical documentation. Current system in use is no longer supported by vendor.

> **Incentive Measurement**: By 12/31/2017, Provide documentation of Epic workflow and charting navigators for Behavioral Health visits.

Scheduling for Behavioral Health population in Epic – Allows staff to schedule Behavioral Health appointments in Epic. Current CCHS Behavioral Health staff do not use Epic for scheduling, this measure will allow appointments to be captured in Epic.

> **Incentive Measurement**: By 12/31/2017, Provide documentation that CCHS-provided behavioral health appointments for enrolled beneficiaries can be seen in Epic.

Data Capture and Data Sharing

Data Capture and Sharing are critical components for the success of the CommunityConnect project. With our CommunityConnect program, we will be connecting our agency with other ED hospitals to see other ED visit data for this population. Our Homeless Information Management System's data will be collected into a central data warehouse and then shared in a meaningful way to the providers. Another outcome is to increase our cross agency data sharing capabilities by implementing a curated and structured way to share data through open standards. The data will then be displayed in the clinician's or CommunityConnect support staff's native application. Security tools and additional staff will be necessary to govern the data, protect the privacy and security of the data, and reduce the risk associate with the data sharing.

Increase the use of and create data mappings between multiple sources and connect data sources into a data warehouse. Once data warehouse is built, this phase will connect various clinical systems to the warehouse to enable data sharing.

> **Incentive Measurement**: By 3/31/2017, Provide documentation of completed data interface between social needs system (Health Leads) and the data warehouse.

Develop a tracking, enrolling and analytic interface for CommunityConnect Sobering Program. Interface will be used to identify patients utilizing Sobering Program services, track them after discharge and transfer data to CommunityConnect data warehouse. Interface project will include purchase of QLIK, a data visualization and analytics tool that will enable CommunityConnect evaluators to manage Sobering Center patients and develop patient registries.

Incentive Measurement: By 12/31/2017, provide documentation that Sobering Center interface has been implemented, and enterprise licenses for QLIK have been purchased.

Capture data from the Homeless Management Information System (HMIS) – Phase 1 of HMIS project: Capture and dump data from the current CCHS HMIS into the data warehouse for the CommunityConnect data sharing project. HMIS system is no longer supported and this measure will capture data in preparation for data sharing and eventual system replacement.

Incentive Measurement: By 3/31/2017, Provide documentation of completed data interface between the current HMIS database and the data warehouse.

Pre-Manage Emergency Department (ED) Software – Pre-mange ED would allow ED providers to view outside care plans and prior ED visit history to improve patient care and track utilization patterns.

Incentive Measurement: By 6/31/2017, Provide documentation of a contract with Emergency Department High Utilizer sharing system and provide documentation of implementation.

Pre-Manage Community – Pre-Manage Community allows free standing clinics to access ED visits for their patient population. In addition, case managers are notified when their patients enter EDs to create and share follow-up care plans.

Incentive Measurement: By 12/31/2017, Provide documentation of completed data sharing with Pre-Manage Community.

Share data from the HMIS system – Phase 2 of HMIS project: Enable bi-directional querying between HMIS and data warehouse for on demand data flow between two systems. This will enable providers to view data on Homeless services (including housing situation) from the data warehouse until the new HMIS system is implemented.

Incentive Measurement: By 12/31/2017, Provide documentation of active bi-directional querying between data warehouse and HMIS system.

Create a bi-directional interface between PHN Case Management System and Epic. – Phase 2 of PHN Case Management system migration. This allows specific data from PHN Case Management System (Persimmony) to be displayed in Epic, and Epic data to be displayed in Persimmony. Bi-directional support will allow for enhanced care coordination between existing case management systems to reduce duplication of services and provide appropriate care. This will also support care coordination on patients that may disengage in CommunityConnect services but be seen in other Case Management Programs.

Incentive Measurement: By 12/31/2017, Provide documentation of completed bi-directional interface between Public Health Nurse (PHN) Case Management system and Epic.

Implement data and system security tools - Security components necessary to securely support the increase in interconnectivity and number of users and vendors as a result of our CommunityConnect data sharing project.

Incentive Measurement: By 12/31/2017, Provide documentation of implementation of FairWarning (Access Management Logging and Analytics) for Epic. Provide documentation

showing use of administrative and vendor access control for privileged accounts (critical administrator accounts which can be used to decrypt or transfer large datasets). Provide documentation for implementation of Structured Query Language (SQL) data exfiltration technology for data warehouse.

Implement bi-directional sharing capabilities with our Social Determinants application – Viewing documentation of social services provided by Community Based Organizations in Epic.

Incentive Measurement: By 12/31/2017, Provide documentation (screenshots and data schemas) of bi-directional sharing capabilities between social determinants application and the data warehouse.

Enable e-Prescribing for Behavioral Health Providers

Allow access for Behavioral Health providers to e-prescribe through Epic, which will capture all prescribed medications for the CommunityConnect patient. This outcome will address high risk medication, medication adherence, and reduce adverse drug interactions.

Incentive Measurement: By 6/31/2017, Provide documentation that case managers can view e-prescriptions in Epic.

Incentive Measurement: By 6/31/2017, Provide documentation that behavioral health providers can place e-prescribing orders through Epic.

Incentive Measurement: By 6/31/2017, Provide documentation that appropriate security has been implemented to ePrescribe controlled substances.

Homeless Management Information System (HMIS) replacement

The current HMIS system is not supported. CommunityConnect is a significant user of this application and the data is critical for the participating agencies to have access when working towards better outcomes.

The current HMIS system is no longer support and must be replaced. The new system will allow CCHS to share homeless service data and homeless vulnerability screenings with the Epic platform and will allow CommunityConnect providers to track, update and streamline services for homeless patients.

Incentive Measurement: By 12/31/2017, Provide documentation of new HMIS contract and provide documentation that system implementation is complete.

Patient Population Management

An essential component of the CommunityConnect data sharing project includes the development of a **patient population management** system that will access data from the CommunityConnect data warehouse and enable Program staff to create, view and report on Program registries to manage clinical, financial and social needs. This system will also allow for comprehensive program evaluation and sustainability planning, contributing to utilization and fiscal analysis.

Capture the CCHS Public Health Nurse (PHN) Case Management system (Persimmony) data into the CommunityConnect data warehouse – Initial phase of PHN case management data system migration to Epic. This phase includes the initial data load from Persimmony into the data warehouse.

Incentive Measurement: By 6/30/2017, Provide documentation of completed data interface between the PHN Case Management system into the data warehouse.

Purchase and implement a Population Health Case Management system – Purchase system named ENLI to manage population health within CommunityConnect Program.

Incentive Measurement: By 12/31/2017, Provide documentation of contract for population management system and provide documentation of completed implementation and use by CommunityConnect staff.

Enable population management system to allow Program providers to create registries of their CommunityConnect population in Epic – Using ENLI, develop registries to manage and monitor CommunityConnect population health.

Incentive Measurement: By 12/31/2017, Provide documentation of clinical registries of CommunityConnect enrolled beneficiaries within Epic

Social Case Management

Social determinants systems can extend a lifeline to our CommunityConnect participants. The clinicians will be able to place an order for the patient to take to the Community Health Workers, who can then connect the patient to the appropriate community resource. Given that not all patients may be able to immediately seek help within the participating agencies, we will implement a smartphone app, which will act as a "211" type service to connect the population to the appropriate social services resources.

Expand Social Case Management System into Epic, to be used by all case managers to track resources and linkages to resources – Deploy social case management system to appropriate CommunityConnect sites. Current social determinate system has been developed specifically for a single location, this measure will expand reach of application and increase access to local CBOs.

Incentive Measurement: By 12/31/2017, Provide documentation of Epic charts that include social case management data.

Develop a social needs application for smartphones for CommunityConnect – Implement smartphone application to identify socials needs and connect patients to local providers.

Incentive Measurement: By 12/31/2017, Provide documentation that social needs resources database application for smart phones is available on appropriate "App" website (Google Play, Apple, or CCHS site).

CommunityConnect Intake Unit

Develop CommunityConnect eligibility screening and flagging system in Epic that will identify and enroll patients. Screening will be data-driven based on system utilization, coverage status, disease identification and other factors. Once enrolled, patients will be flagged in Epic so all CCHS system providers are aware of enrollment and case management assignment.

Develop and implement an application to support and share CommunityConnect eligibility and intake.

Incentive Measurement: By 12/31/2017, Provide documentation of completed report that identifies eligible beneficiaries and tracks intake process.

With the completion of the proposed data projects, CCHS will have developed a stream-lined data capturing and sharing system that incorporates multiple health sectors. This will result in increasing efficiency within the health system and create cost savings for sustainable change. Efficiencies and

improved outcomes will substantiate the extensive collaboration efforts and technology coordination that will be needed to support true care across agency coordination.

Section 4: Performance Measures, Data Collection, Quality Improvement and Ongoing Monitoring

4.1 Performance Measures

We are positioning CommunityConnect at CCHS Services to coordinate in real-time the extensive work our lead and participating entities will do to serve our large and diverse target population. Once identified as eligible for CommunityConnect via utilization tier designation, an individualized assessment and outreach to enroll patients in our CommunityConnect program will occur through intake unit. Our intake process will allow us to appropriately identify the level and specificity of services needed for a particular patient and the level of coordinated case management needed to address the patient's needs and assure appropriate tier designation. This work will become increasingly coordinated and scoped within a comprehensive care plan tailored to each individual enrolled in our CommunityConnect pilot across the life of the pilot as we grow greater data integration. In PY2, we will develop the system for collecting and monitoring our specified metrics with our participating entities including developing timelines and processes of accountability for: performance measures, data collection, quality improvement and monitoring that are appropriate to the scope, level of engagement and capability of each respective entity and the subpopulations they will be serving. There will be variation on the levels of measurement that each participating entity is responsible for given their engagement and integration to our data system that we develop across the lifetime of the project. We will expect that CommunityConnect participating entities that will be providing specialty services to enrolled CommunityConnect patients within a larger coordinated care plan (e.g. legal services, housing navigation, health systems navigation, etc.) will develop processes and protocols to track and monitor CommunityConnect clients served and types of services provided. Our ability to bring our partners into a coordinated data system(s), will inform our ability to develop our data metrics, performance improvement and outcome measures. We have set out our metrics, at present, to represent the systems we have in place to collect and measure within available systems. However, we anticipate that the work of the CommunityConnect Program, will increase our capacity for metrics across systems that we plan to integrate in the context of CommunityConnect work. Given the diverse levels and scope of service delivery across our partners, we propose to have a tiered-system of metrics and deliverables across our partners. We propose that for our partners that are within our CCHS lead entity system: Public Hospital and Health Systems (CCRMC/HCs); Public Health; Behavioral Health (Mental Health; AODS; Homeless Services); and our County Health Plan (CCHP): we will expect to have metrics and deliverables that further the goal of real-time coordinated case management across these systems by implementing data systems and workflows that facilitate optimal communication around the care of any individual patient and their needs as assessed and prioritized. This includes assessments and measurements of our referrals and enrollments into mental health and addiction services that will not violate the current CFR 42 regulations. For patients who enroll in CommunityConnect pilot program, we propose to use a standardized intake tool to screen and provide brief intervention and referral to treatments (SBIRT) for those identified to have substance use disorders and/or mental health disorders.

We will leverage our enhanced primary care team members including: health coaches; community health workers and alcohol and drug counselors to optimize and measure the services provided in the context of our CommunityConnect pilot delivery settings. We will obtain a voluntary consent to allow communication and sharing of information across our service delivery agencies as part of standardized intake and enrollment. This will facilitate adequate tracking and measurement of services received via inpatient and outpatient rehabilitation services as related to addiction health and mental health services. We will continue to work with our internal partners to develop a universal case management platform that will allow us to perform the day-to-day work and to ensure that communication is being optimized between the providers delivering services to patients at point of care. For our participating entities external to CCHS, we propose that we will develop with each entity an appropriate set of data metrics and process measures through a collaborative implementation process that utilizes PDSA methodology.

4.1.a Universal Metrics

X Health Outcomes Measures
X Administrative Measures

See table below for goals.

4.1.b Variant Metrics

All variant metrics were developed through the standardized process set forth in attachment MM: and align with CCHS PRIME and HRSA UDS metrics. WPCP=CommunityConnect

Variant Metric	PY 1	PY 2	PY 3	PY 4	PY 5
Administrative Metric	Establish governing board: Develop monthly meetings schedule, identify attendees from each entity.	Develop governing board agendas and sign-in sheets, and maintain partner participation at 75% average attendance in second year.	Develop a WPC staff and partner training curriculum for implementation over course of pilot.	Implement staff and partner training as indicated by curriculum developed in PY3. Ensure at least 50% of staff and/or partners have completed training by end of PY4.	Ensure at least 90% of staff and/or partners have completed training by end of PY5.
Improve self-reported health status and reported quality of life at prior	Establish baseline.	Maintain baseline.	Improve baseline by 5% from PY2.	Improve baseline by 5% from PY3	Improve baseline by 5% from PY4

Variant Metric	PY 1	PY 2	PY 3	PY 4	PY 5
assessment					
Depression Remission at Twelve Months (NQF 0710) This is an indicator of improved beneficiary health outcomes	Develop baseline data for WPCP eligible adult patients age 18 and older with major depression or dysthymia and an initial PHQ-9 score > 9 who demonstrate remission at twelve months (defined as PHQ-9 score < 5)	Maintain baseline.	Improve baseline by 5% from PY2.	Improve baseline by 5% from PY3	Improve baseline by 5% from PY4
Adult Major Depression Disorder (MDD): Suicide Risk Assessment (NQF 0104)Metric This is an indicator of improved beneficiary health outcomes	Develop baseline data for WPCP eligible patients age 18 and older with MDD who had a Suicide Risk Assessment Performed at appropriate visit	Maintain baseline	Improve baseline by 5% from PY2	Improve baseline by 5% from PY3	Improve baseline by 5% from PY4
Housing-Specific Metric (if applicable)	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable
SBIRT Substance Abuse and Mental Health (depression)	Develop baseline data on adult patients in WPC screened	Maintain baseline	Increase adult patients in WPC screened for Substance Abuse and	Increase adult patients in WPC screened for Substance Abuse and	Increase adult patients in WPC screened for Substance Abuse and

Variant Metric	PY 1	PY 2	PY 3	PY 4	PY 5
Universal Screening This indicator improves coordination and information sharing; improves beneficiary health outcomes.	for Substance Abuse and Mental Health (depression) using the SBIRT tool at least once during the reporting year.		Mental Health (depression) using the SBIRT tool at least once by 3% from PY2.	Mental Health (depression) using the SBIRT tool at least once by 3% from PY3.	Mental Health (depression) using the SBIRT tool at least once by 3% from PY4.

Universal Metric	PY 1	PY 2	PY 3	PY 4	PY 5
i. **Health Outcomes: Ambulatory Care – Emergency Department Visits**	Reduce the gap between observed and expected ED Visits for all WPCP enrolled target populations by 20% by end of project duration.	Reduce the gap between observed and expected ED Visits for all WPCP enrolled target populations by 2% by end of PY2.	Reduce the gap between observed and expected ED Visits for all WPCP enrolled target populations by 7% by end of PY3.	Reduce the gap between observed and expected ED Visits for all WPCP enrolled target populations by 14% by end of PY4%.	Reduce the gap between observed and expected ED Visits for all WPCP enrolled target populations by 20% by end of project duration (PY5).
ii. **Health Outcomes: Inpatient Hospital Utilization-General Hospital/Acute Care**	Reduce the gap between observed and expected acute inpatient hospitalizations for all WPCP enrolled target populations by 7% by end of project period.	Reduce the gap between observed and expected acute inpatient hospitalizations for all WPCP enrolled target populations by 1% by end of PY2.	Reduce the gap between observed and expected acute inpatient hospitalizations for all WPCP enrolled target populations by 1% by end of PY3.	Reduce the gap between observed and expected acute inpatient hospitalizations for all WPCP enrolled target populations by 2% by end of PY4.	Reduce the gap between observed and expected acute inpatient hospitalizations for all WPCP enrolled target populations by 3% by end of project period (PY5).
iii. **Health Outcomes: Follow-up After Hospitalization for Mental Illness**	Establish the gap between baseline and benchmark (2015 Medicaid 90th Percentile =70%) of FUH visits within 7 days for enrolled members 6 years and older.	Reduce the gap between baseline and benchmark (2015 Medicaid 90th Percentile =70%) of FUH visits within 7 days for enrolled members 6 years and older, with mental health hospitalization, by 1% by end of PY2.	Reduce the gap between baseline and benchmark (2015 Medicaid 90th Percentile =70%) of FUH visits within 7 days for enrolled members 6 years and older, with mental health hospitalization, by 1% by end of PY3.	Reduce the gap between baseline and benchmark (2015 Medicaid 90th Percentile =70%) of FUH visits within 7 days for enrolled members 6 years and older, with mental health hospitalization, by 2% by end of PY4.	Reduce the gap between baseline and benchmark (2015 Medicaid 90th Percentile =70%) of FUH visits within 7 days for enrolled members 6 years and older, with mental health hospitalization, by 3% by end of project period (PY5).

Universal Metric	PY 1	PY 2	PY 3	PY 4	PY 5
iv. **Health Outcomes: Initiation and Engagement of Alcohol and Other Drug Dependence Treatment**	Establish the gap between baseline and benchmark (2015 Medicaid 90th Percentile= 19%) for initiation and engagement in AOD services for enrolled patients with identified alcohol or drug dependency issues.	Reduce the gap between baseline and benchmark (2015 Medicaid 90th Percentile= 19%) by 1% by end of PY2 for initiation and engagement in AOD services for enrolled patients with identified alcohol or drug dependency issues.	Reduce the gap between baseline and benchmark (2015 Medicaid 90th Percentile= 19%) by 1% by end of PY3 for initiation and engagement in AOD services for enrolled patients with identified alcohol or drug dependency issues.	Reduce the gap between baseline and benchmark (2015 Medicaid 90th Percentile= 19%) by 2% by end of PY4 for initiation and engagement in AOD services for enrolled patients with identified alcohol or drug dependency issues.	Reduce the gap between baseline and benchmark (2015 Medicaid 90th Percentile= 19%) by 3% by end of project period (PY5) for initiation and engagement in AOD services for enrolled patients with identified alcohol or drug dependency issues.
v. **Administrative- Comprehensive Care Plan**	Collect data to establish comprehensive care plans, accessible by the entire care team within 30 days of enrollment and at anniversary of participation in the pilot.	50% of WPC enrolled beneficiaries will have a comprehensive care plan, accessible by the entire care team within 30 days of enrollment and at anniversary of participation in the pilot.	50% of WPC enrolled beneficiaries will have a comprehensive care plan, accessible by the entire care team within 30 days of enrollment and at anniversary of participation in the pilot.	60% of WPC enrolled beneficiaries will have a comprehensive care plan, accessible by the entire care team within 30 days of enrollment and at anniversary of participation in the pilot.	75% of WPC enrolled beneficiaries will have a comprehensive care plan, accessible by the entire care team within 30 days of enrollment and at anniversary of participation in the pilot.
vi. **Administrative Care Coordination, case management, and referral infrastructure**	Submit documentation demonstrating established policies and procedures related to care coordination,	Submit at least 60% of documentation demonstrating established policies and procedures related to care	Submit at least 60% of documentation demonstrating established policies and procedures related to care	Submit at least 70% of documentation demonstrating established policies and procedures related to care	Submit at least 80% of documentation demonstrating established policies and procedures related to care

Universal Metric	PY 1	PY 2	PY 3	PY 4	PY 5
	case management and referral infrastructure across WPC pilot within timeframe established by State; Monitor procedures for oversight of how policies and procedures are being operationalized, including regular review to determine modifications and use the PDSA methodology; Develop method to compile and analyze information and findings from the monitoring procedures, including process to modify as needed.	coordination, case management and referral infrastructure across WPC pilot within timeframe established by State; Monitor procedures for oversight of how policies and procedures are being operationalized, including regular review to determine modifications and use the PDSA methodology; Develop method to compile and analyze information and findings from the monitoring procedures, including process to modify as needed.	coordination, case management and referral infrastructure across WPC pilot within timeframe established by State; Monitor procedures for oversight of how policies and procedures are being operationalized, including regular review to determine modifications and use the PDSA methodology; Develop method to compile and analyze information and findings from the monitoring procedures, including process to modify as needed.	coordination, case management and referral infrastructure across WPC pilot within timeframe established by State; Monitor procedures for oversight of how policies and procedures are being operationalized, including regular review to determine modifications and use the PDSA methodology; Develop method to compile and analyze information and findings from the monitoring procedures, including process to modify as needed.	coordination, case management and referral infrastructure across WPC pilot within timeframe established by State; Monitor procedures for oversight of how policies and procedures are being operationalized, including regular review to determine modifications and use the PDSA methodology; Develop method to compile and analyze information and findings from the monitoring procedures, including process to modify as needed.
vii. **Data and information sharing infrastructure**	Submit required documentation demonstrating established policies and	Submit required documentation demonstrating established policies and	Submit required documentation demonstrating established policies and	Submit required documentation demonstrating established policies and	Submit required documentation demonstrating established policies and

Universal Metric	PY 1	PY 2	PY 3	PY 4	PY 5
	procedures related to data and information sharing across the WPC to the extent permitted by applicable state and federal law, within timeframe established by State; CCHS will be the lead agency and all participating entities will have access; Monitor procedures for oversight of how the policies and procedures are being operationalized, including regular review to determine modifications and utilization of the PDSA methodology; Develop method to compile and analyze information and findings from the monitoring procedures, including	procedures related to data and information sharing across the WPC to the extent permitted by applicable state and federal law, within timeframe established by State; CCHS will be the lead agency and all participating entities will have access; Monitor procedures for oversight of how the policies and procedures are being operationalized, including regular review to determine modifications and utilization of the PDSA methodology; Develop method to compile and analyze information and findings from the monitoring procedures, including	procedures related to data and information sharing across the WPC to the extent permitted by applicable state and federal law, within timeframe established by State; CCHS will be the lead agency and all participating entities will have access; Monitor procedures for oversight of how the policies and procedures are being operationalized, including regular review to determine modifications and utilization of the PDSA methodology; Develop method to compile and analyze information and findings from the monitoring procedures, including	procedures related to data and information sharing across the WPC to the extent permitted by applicable state and federal law, within timeframe established by State; CCHS will be the lead agency and all participating entities will have access; Monitor procedures for oversight of how the policies and procedures are being operationalized, including regular review to determine modifications and utilization of the PDSA methodology; Develop method to compile and analyze information and findings from the monitoring procedures, including	procedures related to data and information sharing across the WPC to the extent permitted by applicable state and federal law, within timeframe established by State; CCHS will be the lead agency and all participating entities will have access; Monitor procedures for oversight of how the policies and procedures are being operationalized, including regular review to determine modifications and utilization of the PDSA methodology; Develop method to compile and analyze information and findings from the monitoring procedures, including

Universal Metric	PY 1	PY 2	PY 3	PY 4	PY 5
	process to modify as needed.	process to modify as needed.	process to modify as needed.	process to modify as needed.	process to modify as needed.

4.2 Data Analysis, Reporting and Quality Improvement

The CommunityConnect Program will provide support and incentive to direct resources towards the continued integration of a CCHS data system that includes feeds from current and future electronic systems used by many of our participating entities. We will continue to work towards an IT system with the capability to work with partner systems for data collection, tracking, reporting and monitoring. The CommunityConnect proposal includes the consolidation of legacy data systems that include many case management and behavioral health data systems into our data warehouse. This consolidation will break down data silos as well as integrate data from exterior systems with whom we are partnering to build an accurate narrative of both the diversity and specificity of needs for our high-utilizer Medi-Cal population.

Through the technology integration efforts proposed in this application, data collected by all CommunityConnect staff will be available in their natural workflows regardless of the underlying data source. Staff across participating entities will be trained in standardized workflows to improve data accuracy with the ability to optimize real-time care coordination for the patient interfacing with care team members.

Quality improvement (QI) efforts will be facilitated by the CommunityConnect QI Manager through the Program's Quality Improvement Committee, with input from the Program's IT Committee. Both Committees will report to the Program's Governance Board monthly. QI Activities will be conducted in collaboration with community partners and will be reported quarterly to the CCHS Data Governance committee, a multidisciplinary team with stakeholders from all CCHS divisions. The Quality Improvement Committee will include the QI Manager, Chief Medical Informatics Officer, Data Scientist and Project Manager and other program managers as appropriate. Using Statistical Process Control methodology the Committee will be responsible for data integrity and data analysis and will determine if strategies and interventions have been successful in meeting our goals. The Data Committee will institute regular data quality checks, review workflows on a regular basis to ensure data accuracy, provide input on standardizing workflow to capture more complete and relevant data, and identify and address barriers to data capture. QI efforts will involve ongoing PDSA methodologies for Program metrics. Metrics will be reported to the State on a semi-annual basis. Reporting and all supporting documentation on metrics will be provided using templates provided by the State.

The Quality Improvement Committee will be aligned with CCHS's existing Performance Improvement Program and be kept informed on other QI activities taking place in the CCHS delivery system. The CCHS Performance Improvement Program uses the Institute for Healthcare Improvement's Triple Aim and LEAN methodologies to implement process changes and redesign. The QI processes use standardized, evidence-based models for all improvement work. There are five key steps employed within these models:

Assess – what are we trying to accomplish
Identify – what changes can we make that will result in improvement
Test – how will we know that a change is an improvement (Using PDSA cycles)
Spread – what change will we scale and spread
Sustain – how will we sustain improvement

CommunityConnect will develop a reporting dashboard, accessible to all Program partners, and aligned with other initiatives and QI efforts, showing the status of our Universal and Variant metrics. A major focus in our reporting efforts is to invest in self-service analytics. This means that teams can analyze and assess real-time data in control charts themselves for targeted improvement efforts without requiring a report writer. Not only will this make data more accessible and flexible for team members, it will require fewer resources from our analytics team. Self-service analytics will also enable the Quality Improvement Manager and Quality Improvement Committee to analyze services and strategies for sustainability planning. Services and interventions that result in appropriate resource allocation and/or reduced costs will be presented to the governance team and CCHS executive staff with strategic recommendations on adjustments to current health center functions and allocations.

An important component of data analysis, particularly as it pertains to sustainability planning, is monitoring and reporting on cost efficiencies. Services and interventions will be evaluated using the selected universal and variant metrics. The CommunityConnect data scientist will be responsible for tracking the success of the cost avoidance strategies. CCHS will divert cost savings towards health center and partner infrastructure, service enrichment and staffing changes to support the Program past the life of the pilot.

4.3 Participant Entity Monitoring

CCHS will provide all monitoring activities for participating entities to ensure CommunityConnect Program fidelity. Representatives from each agency will be identified as main points of contacts for the Program and will participate as active members on the Governing Board. The partners that benefit the most from the Program are Lifelong Medical, La Clinica de la Raza and Kaiser. These entities are members of the CCHP provider network and will have patients enrolled in the CommunityConnect Program, but they will not be providing any direct services. Monitoring for these agencies will be limited to attendance at Board meetings and adherence to Program guidelines and protocols that will include providing regular feedback on service deliver and the collection of patient satisfaction surveys.

Agencies that will be contracted with CCHS for the Program for direct services will be technically monitored through in-kind support of the CCHS Contracts and Grants division. Contracted agencies will receive HIPAA training and be required to provide electronic documentation of provided services using their native clients. As appropriate, consents will be collected and any necessary screening tools will be used to assess need and provide appropriate services. Data will be collected through the proposed data sharing projects and deposited into the data warehouse.

Ongoing monitoring will be conducted by the Program's Health Planner/Evaluator. The Planner/Evaluator will develop a method to receive feedback from delivery staff and patient satisfaction survey's to monitor services delivery from all Program entities.

All agencies will participate on the governing board and working committees, where progress towards outcome measures will be monitored and service adjustments will be recommended. Entities that are non-compliant or are failing to provide the contracted services will receive a corrective action and/or technical assistance within 30 days of report. These will be provided by the Program Director when appropriate. Corrective action plans and results will be reviewed by the Care Coordination Committee if further action is required and if termination is considered.

5.1 Financing Structure

Contra Costa Health Services (CCHS) is the lead agency for the CommunityConnect Program. CCHS will provide the non-federal share matching component of the CommunityConnect funding through an Intergovernmental transfer (IGT). The funds used for the IGT will be those identified as federally allowable under the Special Terms and Conditions.

The CCHS Finance Division will be responsible for all aspects of the CommunityConnect accounting and financial reporting. The CCHS Finance Division has a well-developed infra-structure and a high functioning operational system with state and national-level reporting, capitated payment disbursement, expenditure reporting and budgeting capabilities. No new systems are anticipated to be needed for the Program.

The CommunityConnect budget was developed with input and agreement from all major partners in the pilot (Public Health, Behavioral Health (including Mental Health, Alcohol and Other Drugs Services and Homeless Services), Health Plan, Contra Costa Regional Medical Center and Health Centers, EMS and outside partners). The jointly developed budget revenues will be sufficient for the proposed service delivery.

The Program envisions program payments from the State based on a combination of (a) performance target achievements for service delivery functions (b) cost based reimbursement for certain new start-up programs, (c) bundled service payments based upon a capitated per member per month model and (d) fee for service payments.

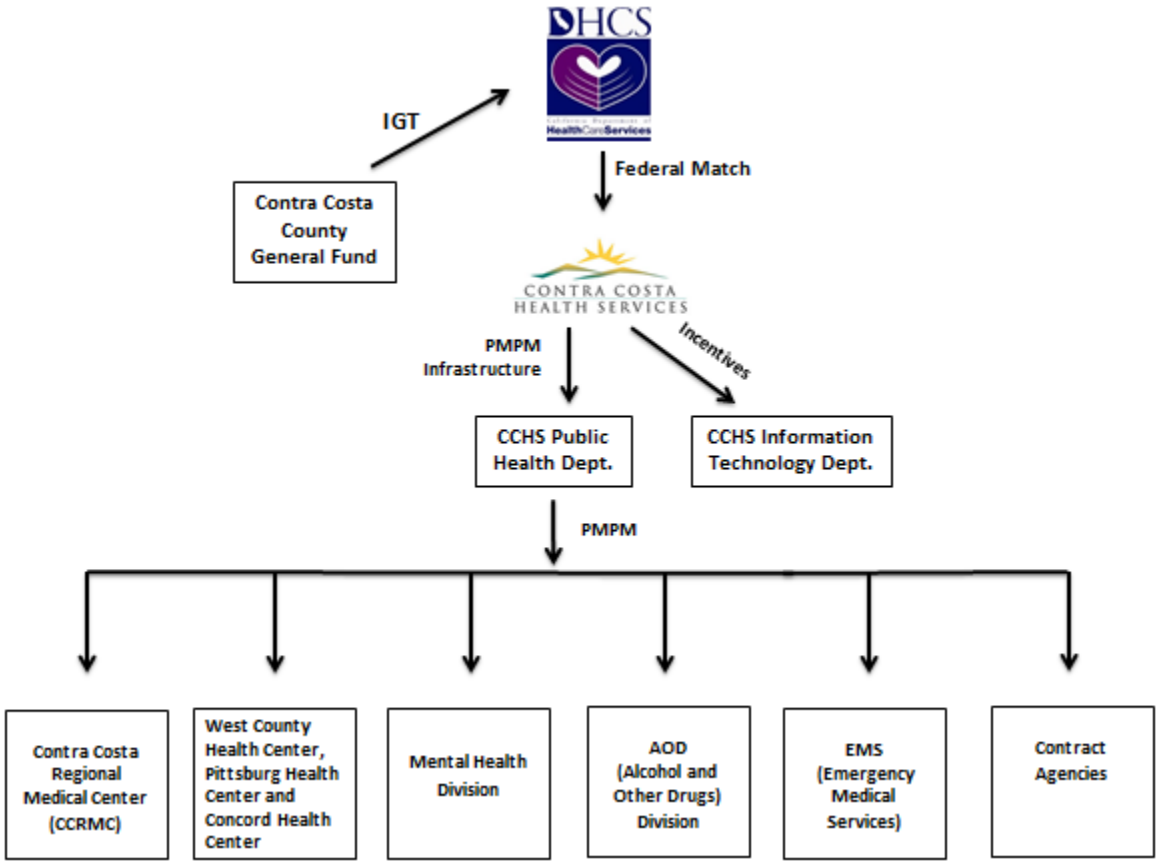
Billing to the State will be done by the CCHS Finance Division. The billing will have full documentation available related to the particular service claimed eg. bundled payments will have full linkage to patient specific data. Program costs will be incurred prior to receiving reimbursement from the State.

Once payment has been received from the State the CCHS Finance Division will disburse the funds to the impacted partners based on the type of payment deliverable and service component cost (cost based functions will be disbursed to the entity incurring the cost; pmpm payments will be disbursed based on the budgeted contribution; performance payments will be made to the responsible party). Full traceable documentation of the payment disbursements will be maintained in the Finance office. Costs incurred by participating entities will be paid prior to receiving reimbursement from the State. Payment will be made to the partners within 20 calendar days of receiving funds from State.

Additionally, the Finance Division reviews and approves all payroll and accounts payable transaction requests to ensure their compliance with a comprehensive set of both Health Services and County-wide policies and procedures. Once approved by Finance, all payroll and expenditure requests are submitted

to the County Auditor-Controller's Office for final review, approval and payment processing. Copies of the financial policies and procedures are available upon request. As a public entity, the accounting policies and procedures are dictated by the State of California Controllers Office. The elected County Auditor-Controller ensures compliance with these policies and procedures, including periodic reviews of CCHS separation of duties and internal controls by the Auditors Internal Audit department. All transactions are recorded according to either GAAP or GASB pronouncements as appropriate.

5.2 Funding Diagram



5.3 Non-Federal Share

Contra Costa Health Services (a Department of Contra Costa County) will be the sole entity providing the non-federal share to be used for payments under the WPC pilot.

5.4 Non-Duplication of Payments and Allowable Use of Federal Financial Participation

The CommunityConnect Program will only serve Medi-Cal patients; therefore the federal financial participation will be received only for services provided to Medi-Cal beneficiaries. The Program supports (1) infrastructure to integrate data and deliver services across a large target population; (2) services that are not covered or reimbursed by Medi-Cal; and (3) other interventions that will reduce unnecessary utilization of the County's health services, improve health outcomes for our target population and improve integration among a currently fragmented system.

Pilot payments shall support 1) infrastructure to integrate services among local entities that serve the target population; 2) services not otherwise covered or directly reimbursed by Medi-Cal to improve care for the target population such as housing navigation; and 3) other strategies to improve integration, reduce unnecessary utilization of health care services, and improve health outcomes

The total Program funding represents five categories; Administrative Infrastructure, Pay for Outcomes, Pay for Reporting, Incentive Payments, Fee For Service and PMPM Service Bundles. This pilot will result in a large technological overhaul, increasing the ability of service providers to provide appropriate, timely and coordinated care to a population that general experiences negative health outcomes due to a complex and fragmented system. This provides CCHS the opportunity to achieve the Triple Aim of Better Care, Improved Health and Lower Costs for a large portion of our high-utilizer population. The Program also encourages the CCHS system of care to redirect resources towards a new model of care, one that supports enabling integrated social services and high-level care coordination rather than emergency, fragmented and siloed behavioral and primary care. The Program will result in a new, enhanced delivery system that is easier to navigate, provides a more comprehensive array of social services, includes an advanced communication and data sharing network and offers a more holistic approach to health care delivery with an emphasis on the social determinants of health.

CommunityConnect intake and enrollment will assure that only Medi-Cal beneficiaries will receive the services offered through the WPC pilot. Intake will have a real-time eligibility component.

CCHS currently provides Targeted Case Management (TCM) services through Public Health Nurses (PHN).

Our proposed CommunityConnect PHN case management productivity is based on an algorithm of current TCM productivity, the type of services covered by TCM, the type of services required by our highest utilizing patients and the variation in populations served by both case management programs. Based on the algorithm CCHS was able to estimate that approximately 80% of all services would be WPC eligible and 20% of the services were TCM related. The 20% overlap of TCM services has been carved out of our application.

CCHS utilized these algorithm service estimate distinctions in developing our CommunityConnect application. **Accordingly, the CommunityConnect application excludes all TCM case management related services and costs. The application includes only the WPC component of the case management functions.** Based on this methodology, all services that are billable to Medi-Cal (inclusive of TCM) have been eliminated from the program proposal.

The activities of the care coordination teams will not duplicate the Medi-Cal targeted case management (TCM) benefit. Specifically, CommunityConnect will provide services that compliment TCM but are not reimbursable by TCM. The hallmark of TCM is performing a comprehensive assessment of the client by which a care plan is developed that guides referrals and linkages for the client into needed services and resources, and assessing whether those services met the needs of the client. TCM defines the resources and services needed by the client, **but does not reimburse for the provision of those needed services**. Unlike TCM, CommunityConnect will provide services such as patient education, direct patient care, patient counseling, behavior modification, medication reconciliation, substance abuse counseling,

tenancy support, motivational support, trust building activities, preventative care, etc. Care coordination teams will have Public Health Nurses and Social Workers who will assess clients, then direct, collaborate and coordinate with the CommunityConnect team members to effectively deliver needed services.

5.5 Funding Request

The budget for Year 1 of the CommunityConnect Program is for the submission of the application and baseline data.

Administrative Infrastructure

The administrative infrastructure represents staff from the CommunityConnect Program Management team. Management staff include the Quality Improvement Manager, Program Director, Financial Managers and Project Manager. Staff will be 100% dedicated to the CommunityConnect Program and will oversee all Tier A and B direct services, the Sobering Center, deliverables and pilot reporting.

Quality Improvement Manager – Oversee all Quality Improvement efforts, Chair the Quality Improvement Committee and be responsible for PDSA cycle implementation and review.

Program Director – Oversee management of Program deliverables, act as liaison with DHCS, provide program guidance to all direct service staff and be responsible for reporting requirements.

Financial Managers – Be responsible for all CommunityConnect billing activities, staff payroll and Program budgeting. Managers will also oversee hiring of service providers and conduct other administrative duties.

Project Manager – Provide project management guidance to all IT activities, be responsible for ensuring IT incentives are delivered and data sharing activities are meeting expected deadlines.

Hiring will begin in late PY1 and early PY2. Years 3-5 will be fully staffed at 5.0 FTEs. Costs include fringe benefits at 55% of Salaries and Wages, Travel for all staff, Building Rent, Computers and Printers.

	Year 2			Years 3-5		
	FTE	Annual Salary	Total Amount	FTE	Annual Salary	Total Amount
SALARIES & WAGES						
Quality Improvement Manager	1	$92,331	$92,331	1	$96,947	$96,947
Program Director	1	$140,568	$140,568	1	$147,596	$147,596
Financial Manager	2	$65,640	$131,280	2	$68,922	$137,844
Project Manager	1	$104,856	$104,856	1	$110,099	$110,099
TOTAL SALARIES & WAGES	5.00		$469,035	5.00		$492,486
FRINGE BENEFITS @55% of Salaries & Wages			$257,969			$270,866
TOTAL PERSONNEL COST			$727,004			$763,352
SERVICES & SUPPLIES						
Rent ($1.6/sq ft * 25,000 per month)			$480,000			$480,000
Travel (200 miles/mo/FTE @ $.54/mile)			$6,480			$6,480
Computers (5 @ $1,800)			$9,000			$0
Printers (3 @ $500)			$1,500			$0
TOTAL SERVICES & SUPPLIES			$496,980			$486,480
TOTAL COSTS Administrative Infrastructure			**$1,223,984**			**$1,249,832**

Fee For Service

The **Sobering Center** includes professional and paraprofessional staff to keep the facility open and operational 24 hours a day, 7 days a week. Staff include medical providers, Mental Health and Substance Abuse counselors, a security guard for night hours, a patient transport driver, a consultation doctor and program supervisors. Costs also include rent for the facility and other services. Some staff, services and supplies will be provided in-kind by CCHS. Sobering Center costs will begin in Year 2. FFS amount of $246 was derived from 40% of actual program cost estimates as projected below for 3,500 visits in PY2 and 7,000 visits in PY3-5.

	Year 2			Year 3 - 5		
	FTE	Annual Salary	Total Amount	FTE	Annual Salary	Total Amount
SALARIES & WAGES						
Medical Doctor	0.50	$199,844	$99,922	1.00	$209,836	$209,836
Registered Nurse	3.00	$110,288	$330,864	6.00	$115,802	$694,814
Licensed Vocational Nurse	3.00	$63,882	$191,646	6.00	$67,076	$402,457
Driver/Clerk	1.00	$47,074	$47,074	2.00	$49,428	$98,855
Mental Health Clinical Specialist	2.00	$84,441	$168,882	4.00	$88,663	$354,652
Community Support Worker	2.00	$44,453	$88,906	4.00	$46,676	$186,703
Security	1.00	$66,120	$66,120	2.00	$69,426	$138,852
Substance Abuse Counselor	2.00	$70,648	$141,296	4.00	$74,180	$296,722
Program Coordinator/Supervisor	1.00	$96,415	$96,415	2.00	$101,236	$202,472
	15.50		$1,231,125	31.00		$2,585,363
FRINGE BENEFITS @55% of Salaries & Wages			$677,119			$1,421,949
TOTAL PERSONNEL COST			**$1,908,244**			**$4,007,312**
SERVICES & SUPPLIES						
Travel (200 miles per FTE/mo @ $.54/mile)			$20,088			$40,176
Transportation Vouchers			$7,500			$7,500
Cell Phones (@ $200 each)			$7,200			$0
Cell Phone Usage ($50/month for each phone)			$12,000			$21,600
Laptops/Desktops (@ 1,800 each)			$32,400			$32,400
Printers (4 @ $500 each)			$0			$2,000
Rent (8,000 sq ft @ $1.6/sqft/month)			$153,600			$153,600
Linens (130/year @ $52.5)			$6,825			$6,825
Gas/Van Maintenance			$0			$30,000
TOTAL SERVICES & SUPPLIES			$239,613			$294,101
TOTAL COSTS SOBERING CENTER			**$2,147,857**			**$4,301,413**
Encounters			3,500			7,000
FFS based on 40% of actual Sobering Center Costs = **$246**						

Bundled PMPM Services: Complex Case Management

Our Complex Care Management program focuses on patient-centered care coordination in two bundled tiers, Tier A and Tier B. Staff for tiers will be hired in Year 2, with roughly 50% of staff on board before July 1, 2017.

The Complex Case Management Bundles also include costs associated with the CommunityConnect Intake Unit. The Intake unit will be responsible for providing screenings on patients identified for enrollment, assigning case management tier level and case manager, and enrolling patient into the Program.

Patients in Tier A and B are expected to be enrolled for the entire project year (12 months). Duration is based on complexity of patient needs, implementation timeline for expected behavioral changes and

monitoring/demonstrating proper system and resource utilization. The program will include patient redetermination for eligibility and tier assignment on an annual basis. At this time, patients may be removed from the Program or re-enrolled in appropriate Tier.

Patients will be identified for eligibility in each Tier through an acuity system that uses point value assignment to each patient based on system utilization as reported through claims data. The point value system will be developed using the State's Global Payment Program's weighted system with logic modifications to identify Medi-Cal high utilizers of multiple systems and inappropriate Inpatient and Emergency Department utilization. The Program will identify the top 20% of eligible patients based on point value score, with estimation that roughly 25% of these patients will not be enrolled in the Program. Tier A will include 4,000 patients based on the weighted system while Tier B will include 10,400 patients. Patients identified through this electronic system will be assigned to an appropriate Tier during the intake process which will include a review of client history, direct patient screenings and pertinent social and medical system reviews. Additional patients will be identified on a monthly basis to fill gaps for patients with discontinued services or who refuse enrollment services.

Service bundles will be discontinued:

- Per patient request
- When patients are lost to follow-up/move out of area
- Death of patient
- During redetermination if patient does not meet program benchmark

The CommunityConnect Program may include patients who receive both a FFS and PMPM service if they are enrolled in Program and seek services at the Program's Sobering Center. Patients will never be assigned to more than one PMPM bundle due to the structure of the CommunityConect pilot

Tier A – **Intensive Case Management** (4,000 patients)
Patients in Tier A will be managed by robust case management teams led by a Public Health Nurse. Patients in this tier have complex medical, behavioral health and housing needs that require long-term intensive and comprehensive case management services. This tier will include any enrollee who is assessed to require housing for medical stability and enhanced support services to maintain independence in the community. PMPM for this tier is based on a caseload of 90 patients per case manager per year. Patients may be managed directly by a Substance Abuse Counselor, Public Health Nurse, Community Health Worker, Housing Case Manager, Nurse Practitioner or Mental Health Clinical Specialist depending on need. The Nurse Practitioner will be dedicated to managing patients placed in Skilled Nursing Facilities or Board and Care Facilities. The Lawyer and Medical Doctor will provide consultation for these patients.

PMPM for this tier is $326 in PY2-5.

CCHS currently provides Targeted Case Management (TCM) services through Public Health Nurses (PHN).

Our proposed CommunityConnect PHN case management productivity is based on an algorithm of current TCM productivity, the type of services covered by TCM, the type of services required by our highest utilizing patients and the variation in populations served by both case management programs. Based on the algorithm CCHS was able to estimate that approximately 80% of all services would be WPC

eligible and 20% of the services were TCM related. The 20% overlap of TCM services has been carved out of our application.

CCHS utilized these algorithm service estimate distinctions in developing our CommunityConnect application. **Accordingly, the CommunityConnect application excludes all TCM case management related services and costs. The application includes only the WPC component of the case management functions.** Based on this methodology, all services that are billable to Medi-Cal (inclusive of TCM) have been eliminated from the program proposal.

The activities of the care coordination teams will not duplicate the Medi-Cal targeted case management (TCM) benefit. Specifically, CommunityConnect will provide services that compliment TCM but are not reimbursable by TCM. The hallmark of TCM is performing a comprehensive assessment of the client by which a care plan is developed that guides referrals and linkages for the client into needed services and resources, and assessing whether those services met the needs of the client. TCM defines the resources and services needed by the client, **but does not reimburse for the provision of those needed services**. Unlike TCM, CommunityConnect will provide services such as patient education, direct patient care, patient counseling, behavior modification, medication reconciliation, substance abuse counseling, tenancy support, motivational support, trust building activities, preventative care, etc. Care coordination teams will have Public Health Nurses and Social Workers who will assess clients, then direct, collaborate and coordinate with the CommunityConnect team members to effectively deliver needed services.

Other expenses in this tier include Patch funding (a contract for care coordination services provided to Board and Care patients), Payee funding for contracted financial management services, transportation vouchers, rent, cell phones and laptops.

	Year 2			Years 3-5		
	FTE	Annual Salary	Total Amount	FTE	Annual Salary	Total Amount
SALARIES & WAGES						
Data Scientist	1.00	$150,000	$150,000	1.00	$157,500	$157,500
Health Planner/Evaluator	1.00	$91,200	$91,200	1.00	$95,760	$95,760
Program Manager	2.00	$97,201	$194,402	2.00	$102,061	$204,122
Care Coordinator	2.00	$41,601	$83,202	2.00	$43,681	$87,362
Registered Nurse	1.00	$105,036	$105,036	1.00	$110,288	$110,288
Licensed Vocational Nurse	1.00	$60,840	$60,840	1.00	$63,882	$63,882
Substance Abuse Coordinator	1.50	$91,824	$137,736	1.50	$96,415	$144,623
Mental Health Coordinator	1.50	$87,300	$130,950	1.50	$91,665	$137,498
Public Health Nurse Program Manager	3.00	$123,672	$371,016	4.00	$129,856	$519,424
Substance Abuse Counselor	3.00	$67,284	$201,852	6.00	$70,648	$423,888
Social Worker	3.00	$78,375	$235,125	5.00	$82,294	$411,470
Public Health Nurse	18.00	$120,060	$2,161,080	34.00	$126,063	$4,286,142
Community Health Worker II	10.00	$45,600	$456,000	19.00	$47,880	$909,720
Housing Case Manager/Navigator	4.00	$45,000	$180,000	7.00	$47,250	$330,750
Lawyer (Legal Aid)	0.50	$152,088	$76,044	1.50	$159,692	$239,538
Nurse Practitioner	0.50	$131,616	$65,808	1.00	$138,197	$138,197
Mental Health Clinical Specialist	2.00	$80,420	$160,840	7.00	$84,441	$591,087
Patient Financial Services Specialist	0.50	$54,504	$27,252	3.00	$57,229	$171,687
Medical Doctor	0.50	$187,286	$93,643	1.50	$196,650	$294,975
TOTAL SALARIES & WAGES	56.00		$4,982,026	100.00		$9,317,912
FRINGE BENEFITS @55% of Salaries & Wages			$2,740,114			$5,124,852
SERVICES & SUPPLIES						
Patch for Services			$0			$500,000
PAYEE Contract			$0			$33,500
Travel (200 miles per FTE/mo @ $.54/mile)			$72,576			$129,600
Transportation Vouchers			$0			$220,000
Cell Phones (@ $200 each)			$0			$24,400
Cell Phone Usage ($50/month)			$33,600			$60,000
Laptops (@ 1,800 each)			$0			$228,600
Printers (@ $500 each)			$0			$5,000
TOTAL SERVICES & SUPPLIES			$106,176			$1,201,100
TOTAL COSTS TIER A			**$7,828,316**			**$15,643,864**
Member Months			24,000			48,000
P.M.P.M			$326			$326

Tier B – **Social Case Management** (10,400 patients)
Patients in Tier B also have complex medical needs; however, the drivers for increased inappropriate system utilization are social in nature and therefore will be address by the appropriate social case manager and supporting team members.

Patients will receive in person and telephone case management services. Duration of case management services is estimated to be 12 months. PMPM for this tier is based on a caseload of 120 patients per case manager per year. Patients may be managed directly by Substance Abuse Counselor, Social Workers, Registered Nurses, Financial Counselors, Community Health Worker, Housing Case Manager, Nurse Practitioner or Mental Health Clinical Specialist depending on need. The Nurse Practitioner will be dedicated to managing patients placed in Skilled Nursing Facilities or Board and Care Facilities. The Lawyers will provide legal consultation. The Health Leads staff will provide Social linkages through a Call Center.

PMPM for this tier is $146 in PY2-5.

	Year 2			Year 3 - 5		
	FTE	Annual Salary	Total Amount	FTE	Annual Salary	Total Amount
SALARIES & WAGES						
Data Scientist	1.00	$150,000	$150,000	1.00	$157,500	$157,500
Health Planner/Evaluator	1.00	$91,200	$91,200	1.00	$95,760	$95,760
Program Manager	4.00	$97,201	$388,804	4.00	$102,061	$408,244
Care Coordinator	2.00	$41,601	$83,202	3.00	$43,681	$131,043
Licensed Vocational Nurse	1.00	$60,840	$60,840	1.00	$63,882	$63,882
Medical Doctor	0.50	$187,286	$93,643	1.00	$196,650	$196,650
Public Health Nurse	3.00	$120,060	$360,180	5.00	$126,063	$630,315
Mental Health Coordinator	1.50	$87,300	$130,950	1.50	$91,665	$137,498
Substance Abuse Coordinator	1.50	$91,824	$137,736	1.50	$96,415	$144,623
Lawyer (Legal Aid)	1.00	$152,088	$152,088	1.50	$159,692	$239,538
Social Worker	15.00	$78,375	$1,175,625	31.00	$82,294	$2,551,114
Substance Abuse Counselor	4.00	$67,284	$269,136	8.00	$70,648	$565,184
Mental Health Clinical Specialist	7.00	$80,420	$562,940	13.00	$84,441	$1,097,733
Nurse Practitioner	1.00	$131,616	$131,616	1.50	$138,197	$207,296
Registered Nurse Experienced Lvl	5.00	$105,036	$525,180	9.00	$110,288	$992,592
Reentry Coordinator	3.00	$45,600	$136,800	7.00	$47,880	$335,160
Health Leads Navigator	4.00	$54,504	$218,016	7.00	$57,229	$400,603
Community Health Worker II	19.00	$45,600	$866,400	42.00	$47,880	$2,010,960
Patient Financial Services Specialist	3.00	$54,504	$163,512	5.00	$57,229	$286,145
Housing Navigators	1.00	$45,000	$45,000	2.00	$47,250	$94,500
TOTAL SALARIES & WAGES	78.50		$5,742,868	146.00		$10,746,339
FRINGE BENEFITS @55% of Salaries & Wages			$3,158,577			$5,910,486
TOTAL PERSONNEL COST			$8,901,445			$16,656,825
SERVICES & SUPPLIES						
NAMI Contract			$0			$500,000
Travel (# FTE * 200 miles/mo @ $.54/mile)			$101,736			$189,216
Transportation Vouchers						$400,000
Cell Phones (@ $200 each)			$0			$34,600
Cell Phone Usage ($50/month for # cell phones)			$47,100			$87,600
Printers (@ $500 each)			$0			$5,000
Laptops/Computers (@ $1,800 each)			$0			$288,000
TOTAL SERVICES & SUPPLIES			$148,836			$1,504,416
TOTAL COSTS TIER B			**$9,050,281**			**$18,161,241**
Member Months			62,000			124,800
P.M.P.M			$146			$146

Pay for Outcomes

CommunityConnect Program will receive pay for outcome funding when the following metric outcomes areachieved for each project yer as indicated in Budget Summary form and Veriant Metric Table, Section 4.1. Funding will be provided directly to the lead entity, CCHS, at $250,000 for PY2 and $250,000 for PY3 – PY5 if outcome is achieved.

- SBIRT Substance Abuse and Mental Health (depression) Universal Screening. This indicator improves coordination and information sharing; improves beneficiary health outcomes.

Pay for Reporting

CommunityConnect Program will receive pay for reporting funding when the following Variant Metric reports are successfully submitted:

Project Year 2

- Administrative Metric – Governing Board @$322,000
- Overall Beneficiary Health Variant Metric @ $322,000
- PHQ-9/Depression Remission Metric @ $322,000
- Suicide Risk Assessment Metric @ $322,000

Project Year 3-5

- Administrative Metric – Governing Board @$322,000
- Overall Beneficiary Health Variant Metric @ $322,000
- PHQ-9/Depression Remission Metric @ $322,000
- Suicide Risk Assessment Metric @ $322,000
- Health Outcomes: Ambulatory Care - Emergency Department Visits @ $322,000
- Health Outcomes: Inpatient Hospital Utilization - General Hospital/Acute Care Metric @ $322,000
- Health Outcomes: Follow-up After Hospitalization for Mental Illness Metric @ $322,000
- Health Outcomes: Initiation and Engagement of Alcohol and Other Drug Dependence Treatment Metric @ $322,000

Incentive Payments

In support of the agencies who will serve the target population, the data sharing and infrastructure build will require technology that is necessary for identifying and referring the patient population to the CommunityConnect intake group. The costs below account for, and were reduced by 40% of actual costs, to reflect our projections that 60% of the data sharing and technology infrastructure will be used by the target population

We have grouped the technology and sharing “Incentive Payments” into the following groups: **Data Migration and Communication System, Data Capture and Sharing, Enable e-Prescribing for Behavioral Health Providers, HMIS replacement, Patient Population Management, Social Case Management, and CommunityConnect Intake Unit.**

The **Data Migration and Communication System** outcome will reduce duplication and improve communication across the care teams and CommunityConnect population. This work will include the following system implementations and improvements. Implement Behavioral Health documentation and

scheduling in Epic. Reduce data duplication by connecting 3rd party systems. Implement for the CommunityConnect providers additional communication modalities such as SMS messaging to coordinate care. Our Public Health workflows affecting the CommunityConnect population, which is on a platform with limited data sharing capabilities, will be migrated to Epic. Implement systems to improve image and data collection within clinics. Measures include purchase and distribution of temporary communication and education devices for use in Sobering Center and to Tier A/B patients.

Data Capture and Sharing are critical components for the success of the CommunityConnect project. With our CommunityConnect program, we will be connecting our agency with other ED hospitals to see other ED visit data for this population. Our Homeless Information Management System's data will be collected into a central data warehouse and then shared in a meaningful way to the providers. Another outcome is to increase our cross agency data sharing capabilities by implementing a curated and structured way to share data through open standards. The data will then be displayed in the clinician's or CommunityConnect support staff's native application. Security tools and additional staff will be necessary to govern the data, protect the privacy and security of the data, and reduce the risk associate with the data sharing.

Allowing BH providers to **ePrescribe** will improve the CommunityConnect population health through better coordination of medications, improve medication adherence, and reduce adverse drug reactions.

The Homeless Information Management System (**HMIS)** does not support full bi-directional data sharing. CommunityConnect is a significant user of this application and the data is critical for the participating agencies to have access when working towards better outcomes. The replacement system will support bi-directional sharing.

An essential component of the CommunityConnect data sharing project includes the development of a **patient population management** system that will access data from the CommunityConnect data warehouse and enable Program staff to create, view and report on Program registries to manage clinical, financial and social needs. This system will also allow for comprehensive program evaluation and sustainability planning, contributing to utilization and fiscal analysis.

Social determinants systems can extend a lifeline to our CommunityConnect participants. The clinicians will be able to place an order for the patient to take to the Community Health Workers, who can then connect the patient to the appropriate community resource. Given that not all patients may be able to immediately seek help within the participating agencies, we will implement a smartphone app, which will act as a "211" type service to connect the population to the appropriate social services resources.

Lastly, to enroll members and track eligibility, Contra Costa will develop and implement an application to create an **electronic intake process**.

Year 2

Incentive outcomes are listed in Data Sharing 3.2 included above and are specific to each of the below.

Incentive Category	Funding Amount
Data Migration and Communication System	$7,142,687
Data Capture and Sharing	$5,933,800
Enable e-Prescribing for Behavioral Health Providers	$1,661,481

Incentive Category	Funding Amount
Homeless Information Management System (HMIS) replacement	$854,300
Patient Population Management	$2,130,580
Social Case Management	$1,623,800
CommunityConnect Intake Unit	$887,600
Total	$ 20,234,248

Year 3-5

The ongoing costs to support the WPC systems are $2,250,000 per year. These costs include personnel and software updates necessary to support the data sharing interfaces.

Data interchange interface support and maintenance (2.0 FTE): $400,000
Analyst support for implemented systems (3.5 FTE): $654,500
Report writers and data verifiers for system integrity (2.0 FTE): $510,000
Software to maintain patches, security updates, enhancements to interface and other changes to ensure compliance with underlying operating systems: $685,500

WPC will cover 50% of these total costs = $1,125,000

Section 6: Attestations and Certification

6.1 Attestation

This attestation is superseded by the revised attestation included in the agreement.

WPC Budget Template: Summary and Top Sheet

WPC Applicant Name:	Contra Costa Health Services

	Federal Funds *(Not to exceed 90M)*	IGT	Total Funds
Annual Budget Amount Requested	20,395,816	20,395,816	40,791,632

PY 1 Budget Allocation (Note PY 1 Allocation is predetermined)	
PY 1 Total Budget	40,791,632
Approved Application (75%)	30,593,724
Submission of Baseline Data (25%)	10,197,908
PY 1 Total Check	OK

PY 2 Budget Allocation	
PY 2 Total Budget	40,791,632
Administrative Infrastructure	1,223,984
Delivery Infrastructure	0
Incentive Payments	20,234,248
FFS Services	861,000
PMPM Bundle	16,934,400
Pay For Reporting	1,288,000
Pay for Outomes	250,000
PY 2 Total Check	OK

PY 3 Budget Allocation	
PY 3 Total Budget	40,791,632
Administrative Infrastructure	1,249,832
Delivery Infrastructure	
Incentive Payments	1,125,000
FFS Services	1,722,000
PMPM Bundle	33,868,800
Pay For Reporting	2,576,000
Pay for Outomes	250,000
PY 3 Total Check	OK

PY 4 Budget Allocation	
PY 4 Total Budget	40,791,632
Administrative Infrastructure	1,249,832
Delivery Infrastructure	0
Incentive Payments	1,125,000
FFS Services	1,722,000
PMPM Bundle	33,868,800
Pay For Reporting	2,576,000
Pay for Outomes	250,000
PY 4 Total Check	OK

PY 5 Budget Allocation	
PY 5 Total Budget	40,791,632
Administrative Infrastructure	1,249,832
Delivery Infrastructure	0
Incentive Payments	1,125,000
FFS Services	1,722,000
PMPM Bundle	33,868,800
Pay For Reporting	2,576,000
Pay for Outomes	250,000
PY 5 Total Check	OK