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

Reporting Checklist

Alameda County Care Connect

Annual PY2

4/3/2018

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

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

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

Whole Person Care

Alameda County Care Connect

Annual PY2

4/3/2018

I. REPORTING INSTRUCTIONS

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

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

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

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

II. PROGRAM STATUS OVERVIEW

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

2017 was a year of launch and development for AC Care Connect. We faced many challenges getting a transformation project of such large ambition off the ground, but by the end of the year we felt we were on our way to accomplishing our major objectives.

Increasing integration among county agencies, health plans, providers, and other entities

Care Connect established multiple venues for working with partners on integration; almost all the major stakeholders are involved in problem-solving and improvement across sectors. Examples include the Steering Committee, the Housing Implementation Learning Community, and IT and Data-sharing advisory committees. We are working closely with the managed care organizations' program and executive leadership as well as the provider organizations to develop the CB-CME model and implementation plans.

The Problem-Solving Learning Community (PSLC), described in Section IV, is particularly significant as a venue for communication and relationship-building among sectors that haven't generally worked together in the past. Challenges in this area include ensuring the right people are being reached for these opportunities for learning, and getting beyond learning to actually changing work practices.

A specific example of increasing integration is our collaboration with Social Services Agency on the IHSS Bridge Pilot Project, which is helping recently homeless individuals receive In-Home Support Services, and overcome barriers, e.g., hiring an IHSS caregiver. Key leaders in Social Services and Health Care Services Agencies are collaborating on the project; direct service providers are being trained and coached in how to get these benefits for clients. Challenges include the time it takes to build the trusting relationships that underlie effective collaboration, legal and cultural barriers to sharing information, and understanding complex jurisdictional/agency authority and regulatory conditions.

Increasing coordination and appropriate access to care

In 2017, we focused on improving coordination in care among housing, homeless, and health care providers, and among psychiatric emergency services (PES), primary care,

and case management. There have been positive early results for small-scale interventions; the challenge will be to scale up and systematize these improvements.

PSLC sessions taught health providers about access to housing resources, and in turn raised the need to teach housing providers how to gain access to health services. With this foundation, the Housing Solutions for Health team, working with Health Care for the Homeless and housing partners, and using the coordinated entry system, have been able to respond quickly to get clients in crisis into housing or respite care. Relationships and communication patterns are beginning to change and this alone is changing outcomes.

The PES Highest Utilizers pilot has led to new coordination between providers of psychiatric emergency, primary care and mental health case management services to severely mentally ill and homeless individuals.

In addition, we formed a plan for consumer engagement and integration of their feedback into the standardized system of care coordination, which we believe will help with providing the right care at the right place and time.

Reducing inappropriate emergency and inpatient utilization
The efforts reported above are also directed to this goal.
In the PES Highest Utilizers pilot, all patients who were offered use of the Trust Clinic services showed a decrease in utilization of emergency services. By linking clients to upstream services, early results indicate we can reduce crisis utilization (see PDSA report).

A challenge is that there are limited alternative disposition options in 5150 situations. We began planning a collaborative project with Emergency Medical Services (EMS) to create alternative transports to high cost ambulance transport, that will include behavioral health clinicians and EMTs.

While we don't have strong data yet, we are beginning to hear stories of people getting housed and shifting from crisis to more stable situations that make us think our changes are having an impact.

Improving data collecting and sharing
We completed a Health Data Repository Data Sharing Agreement; it was vetted and approved by Alameda County Counsel and AC Care Connect data governance bodies. All participants will sign the same agreement that will remain in place supporting data sharing beyond the period of the Whole Person Care project.

The Phase I Prototype Community Health Record (pCHR) launched in early October 2017. To date, there are 39 users across 4 organizations utilizing the pCHR, including primary care, complex care, SNF transition, moderate to severe mental health and

housing coordination. With the limited technology and therefore benefits to participants, demonstrating the "value add" for the pCHR is a challenge. However, the experience gained has helped to define detailed requirements for Phase II Social Health Information Exchange (SHIE) and CHR Request for Proposal, which is set to be released at the beginning of March (see PDSA report).

Phase I data collection and report development for the purposes of WPC enrollment and eligibility and State reporting was established. Data sets were expanded from four to ten, including both the data repository and pCHR (See Section IV). As one highlight of the significance of having this data, having HMIS data in the data repository means we can now identify how many homeless individuals do and do not have MediCal and other benefits, whether they are in primary care, etc. This is foundational to improvement on these measures.

Achieving quality and administrative improvement benchmarks
Making data from multiple sectors available for the first time is the most important advance from our project so far. In addition, we are spreading understanding of using data for quality improvement and accountability through the PSLC and PDSA processes. A challenge is inconsistent buy-in across the partnership; a lesson learned is that incentives are powerful.

Results-based accountability (RBA) measures for housing providers were developed through a county-wide collaborative process that included both the County Health Care Services Agency (HCSA) and housing stakeholders. The RBA measures have been included in contracts, and include health-related measures. We have work to do to regularize tracking and reporting.

Increasing access to housing and supportive services
As an example of how Care Connect is leveraging opportunities, Care Connect clients will have dedicated access to a new housing project in downtown Oakland with ten units for formerly homeless people; a provider who is both a CB-CME & a sub-contractor for tenancy-sustaining service bundles will work with the clients who will be prioritized via the coordinated entry system.

The Housing Resource Centers are starting to have an impact—one local city has put hotel vouchers into their budget, and city staff and law enforcement are working with the HRC's staff, using the hotel vouchers and our housing navigation bundles to help transition people to more stable circumstances when they close encampments.

Hiring staff is slower than hoped among contractors, and this is resulting in fewer people being helped; we are dedicating Care Connect resources to assisting with recruitment.

Through the IHSS Bridge pilot and PES High Utilizer Pilot, clients have been connected to housing and supportive services, and we are establishing pathways for existing providers to continue this practice.

Improving health outcomes for the WPC population

We believe the processes described above will lead to improved health outcomes, but it is too early to see measured results for health outcomes.

One activity not yet noted is the formation of a culturally affirmative practice workgroup that is providing a venue to think about what works and how to improve. This group of experienced clinicians is focusing on understanding what consumers perceive to be added value, and how to better engage them as partners in their own care. It has been a challenge to bring a health focus to the housing world, especially since they have such a severe crisis and system transformation to manage.

Overall Lessons Learned

The importance of establishing a common agenda, and developing trusting partners.

Work with legal team on “how to” rather than “can’t do.”

Communication is essential to change: messages need to be repeated; we need to identify who we are not yet reaching.

Focus on the list – prioritize based on agreed-upon criteria, work through the list and eventually we will reduce the number of people in our eligible list who are not housed and not in care.

Make use of high level leadership; access to Agency and Department heads and executive CBO leadership makes change more possible.

Please Note: In Alameda’s Invoice, Aggregate Utilization Data, and Enrollment and Utilization Report, there are 27 Fee For Service categories. Of those, categories 6, 14-18, 21-24, and 26-27 are services delivered to staff and not clients in order to improve the capacity, skills, and quality of care provided through the system. Because these services are not client-specific, these categories will be populated in the invoice and Aggregate Utilization section of the Narrative, but not the client-level Enrollment and Utilization Report.

III. ENROLLMENT AND UTILIZATION DATA

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

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

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

Item	Month 1	Month 2	Month 3	Month 4	Month 5	Month 6	Unduplicated Total
Unduplicated Enrollees	159	84	120	89	86	92	*

Item	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12	Annual Unduplicated Total
Unduplicated Enrollees	264	221	254	196	146	161	1242

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

FFS	Costs and Aggregate Utilization for Quarters 1 and 2						
	Month 1	Month 2	Month 3	Month 4	Month 5	Month 6	Total
Category 1 Del #7. Outreach Services-hours - Cost							
Category 1 Del #7. Outreach Services-hours	0	0	0	0	0	0	0

Category 2 Del #8. Housing Education & Legal Assistance--Call Center cases – cost	0	0	0	0	0	0	0
Category 2 Del #8. Housing Education & Legal Assistance--Call Center cases	0	0	0	0	0	0	0
Category 3 Del #8. Housing Education & Legal Assistance—Workshops - cost							
Category 3 Del #8. Housing Education & Legal Assistance--Workshops	0	0	0	0	0	0	0
Category 4 Del #8. Housing Education & Legal Assistance--individual legal assistance - cost							
Category 4 Del #8. Housing Education & Legal Assistance--individual legal assistance	0	0	0	0	0	0	0
Category 5 Del #10. Client Move-In funds - costs							
Category 5 Del #10. Client Move-In funds	0	0	0	0	0	0	0

Category 6 Del #10. Housing Locator/Landlord fund - cost							
Category 6 Del #10. Housing Locator/Landlord fund	0	0	0	0	0	0	0
Category 7 Del #14. Sobering Center-bed days - Cost	59,324.08	43,297.01	59,084.87	48,559.63	61,955.39	54,300.67	326,521.65
Category 7 Del #14. Sobering Center-bed days	248	181	247	203	259	227	1365
Category 8 Del #15. SUD Diversion - Hours on assessments	0	0	0	0	0	0	0
Category 9 Del #15. SUD Diversion - court visit encounters, - Cost							
Category 9 Del #15. SUD Diversion - court visit encounters,	0	0	0	0	0	0	0
Category 10 Del #15. SUD Diversion - drug testing w/ Care Manager contact - Cost							
Category 10 Del #15. SUD Diversion - drug testing w/ Care Manager contact	0	0	0	0	0	0	0
Category 11 Del #16 Portals to Substance Use Disorder							

Treatment – Linkage - Cost							
Category 11 Del #16 Portals to Substance Use Disorder Treatment - Linkage	0	0	0	0	0	0	0
Category 12 Del #16 Portals to Substance Use Disorder Treatment – helpline - Cost							
Category 12 Del #16 Portals to Substance Use Disorder Treatment – helpline	0	0	0	0	0	0	0
Category 13 Del #16 Portals to Substance Use Disorder Treatment - in person assessments - Cost							
Category 13 Del #16 Portals to Substance Use Disorder Treatment - in person assessments	0	0	0	0	0	0	0
Category 14 Del #18b. Psychiatric Consultations for PCPs - curbside consults - Cost				12458.68	11500.32	14227.96	38186.96
Category 14 Del #18b. Psychiatric Consultations for	0	0	0	169	156	193	518

PCPs - curbside consults							
Category 15 Del #18b. Psychiatric Consultations for PCPs - chart reviews - Cost				14670.28	17176.76	13048.44	44895.48
Category 15 Del #18b. Psychiatric Consultations for PCPs - chart reviews	0	0	0	199	233	177	609
Category 16 Del #18b. Psychiatric Consultations for PCPs - one-on-one staff meetings - Cost				4641.25	4700.00	3760.00	13101.25
Category 16 Del #18b. Psychiatric Consultations for PCPs - one-on-one staff meetings	0	0	0	79	80	64	223
Category 17 Del #18b. Psychiatric Consultations for PCPs - elbow support - Cost				15609.74	18127.44	21652.22	55389.40
Category 17 Del #18b. Psychiatric Consultations for PCPs - elbow support	0	0	0	31	36	43	110
Category 18 Del #18b. Psychiatric Consultations for PCPs - training presentations - Cost				52166.30	63445.50	33837.60	149449.40
Category 18 Del #18b. Psychiatric Consultations for	0	0	0	37	45	24	106

PCPs - training presentations							
Category 19 Del #19. Completed IBH Care Coordination for patients at FQHC- Cost							
Category 19 Del #19. Completed IBH Care Coordination for patients at FQHC	0	0	0	0	0	0	0
Category 20 Del #20b. BH Medical Homes - Nurse Care Coordinators- referrals- Cost							
Category 20 Del #20b. BH Medical Homes - Nurse Care Coordinators- referrals	0	0	0	0	0	0	0
Category 21 Del #20b. BH Medical Homes - Nurse Care Coordinators- primary care meetings- Cost							
Category 21 Del #20b. BH Medical Homes - Nurse Care Coordinators- primary care meetings	0	0	0	0	0	0	0
Category 22 Del #20b. BH Medical Homes - Nurse Care							

Coordinators- clinic debrief sessions- Cost							
Category 22 Del #20b. BH Medical Homes - Nurse Care Coordinators- clinic debrief sessions	0	0	0	0	0	0	0
Category 23 Del #20b. BH Medical Homes - Nurse Care Coordinators- psychiatrist meetings- Cost							
Category 23 Del #20b. BH Medical Homes - Nurse Care Coordinators- psychiatrist meetings	0	0	0	0	0	0	0
Category 24 Del #20c. BH Medical Homes - Patient Navigators- primary care meetings- Cost							
Category 24 Del #20c. BH Medical Homes - Patient Navigators- primary care meetings	0	0	0	0	0	0	0
Category 25 Del #20c. BH Medical Homes - Patient transport referrals- Cost							
Category 25 Del #20c. BH Medical	0	0	0	0	0	0	0

Homes - Patient transport referrals							
Category 26 Del #20c. BH Medical Homes - Patient Navigators-Wellness Class Coordination-Cost							
Category 26 Del #20c. BH Medical Homes - Patient Navigators-Wellness Class Coordination	0	0	0	0	0	0	0
Category 27 Del #20c. BH Medical Homes - Patient Navigators-psychiatrist meetings- Cost							
Category 27 Del #20c. BH Medical Homes - Patient Navigators-psychiatrist meetings	0	0	0	0	0	0	0

FFS	**Costs and Aggregate Utilization for Quarters 3 and 4**						
	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12	Total
Category 1 Del #7. Outreach Services-hours - Cost		1,656.00	9,315.00	$22,852.80	$22,438.80	$19582.20	$75,844.80
Category 1 Del #7. Outreach Services-hours	0	40	225	552	542	473	1832
Category 2 Del #8. Housing Education & Legal Assistance--Call						4140.59	4140.59

Center cases – cost							
Category 2 Del #8. Housing Education & Legal Assistance--Call Center cases	0	0	0	0	0	41	41
Category 3 Del #8. Housing Education & Legal Assistance—Workshops - cost							31493.00
Category 3 Del #8. Housing Education & Legal Assistance--Workshops	0	0	0	0	0	Monthly data n/a	70
Category 4 Del #8. Housing Education & Legal Assistance--individual legal assistance - cost							
Category 4 Del #8. Housing Education & Legal Assistance--individual legal assistance	0	0	0	0	0	0	0
Category 5 Del #10. Client Move-In funds - costs							
Category 5 Del #10. Client Move-In funds	0	0	0	0	0	0	0

Category 6 Del #10. Housing Locator/Landlord fund - cost			7830.00	19575.00	3915.00	13702.50	45022.50
Category 6 Del #10. Housing Locator/Landlord fund	0	0	4	10	2	7	23
Category 7 Del #14. Sobering Center-bed days - Cost	69393.39	97844.68	88129.61	97150.75	87782.64	112417.29	552718.35
Category 7 Del #14. Sobering Center-bed days	200	282	254	280	253	324	1593
Category 8 Del #15. SUD Diversion - Hours on assessments	2292.90	687.87	229.29	2063.61	1375.74	1146.45	7795.86
Category 9 Del #15. SUD Diversion - court visit encounters, - Cost	10	3	1	9	6	5	34
Category 9 Del #15. SUD Diversion - court visit encounters,	16508.88	14674.56	9630.18	5502.96	5732.25	4356.51	56405.34
Category 10 Del #15. SUD Diversion - drug testing w/ Care Manager contact - Cost	72	64	42	24	25	19	246
Category 10 Del #15. SUD Diversion - drug testing w/ Care Manager contact	25221.90	24992.61	12840.24	14445.27	10088.76	7107.99	94696.77
Category 11 Del #16 Portals to Substance Use Disorder	110	109	56	63	44	31	413

Treatment – Linkage - Cost							
Category 11 Del #16 Portals to Substance Use Disorder Treatment - Linkage	930.00	2325.00	1860.00	3255.00	4495.00	775.00	13640.00
Category 12 Del #16 Portals to Substance Use Disorder Treatment – helpline - Cost	6	15	12	21	29	5	88
Category 12 Del #16 Portals to Substance Use Disorder Treatment – helpline	465.00	775.00	1240.00	1860.00	1240.00	310.00	5890.00
Category 13 Del #16 Portals to Substance Use Disorder Treatment - in person assessments - Cost	3	5	8	12	8	2	38
Category 13 Del #16 Portals to Substance Use Disorder Treatment - in person assessments							
Category 14 Del #18b. Psychiatric Consultations for PCPs - curbside consults - Cost	0	0	0	0	0	0	0
Category 14 Del #18b. Psychiatric Consultations for	9731.04	13711.92	12311.24	14965.16	13417.04	5823.88	69960.28

PCPs - curbside consults							
Category 15 Del #18b. Psychiatric Consultations for PCPs - chart reviews - Cost	132	186	167	203	182	79	949
Category 15 Del #18b. Psychiatric Consultations for PCPs - chart reviews	8698.96	14006.80	13343.32	14522.84	15260.04	11574.04	77406.00
Category 16 Del #18b. Psychiatric Consultations for PCPs - one-on-one staff meetings - Cost	118	190	181	197	207	157	1050
Category 16 Del #18b. Psychiatric Consultations for PCPs - one-on-one staff meetings	4230.00	4876.25	3701.25	6403.75	5698.75	4288.75	29198.75
Category 17 Del #18b. Psychiatric Consultations for PCPs - elbow support - Cost	72	83	63	109	97	73	497
Category 17 Del #18b. Psychiatric Consultations for PCPs - elbow support	17120.36	17120.36	16113.29	21148.68	14099.12	11581.42	97183.22
Category 18 Del #18b. Psychiatric Consultations for PCPs - training presentations - Cost	34	34	32	42	28	23	193
Category 18 Del #18b. Psychiatric Consultations for	26788.10	22558.40	36657.40	32427.70	36657.40	31017.80	186106.80

PCPs - training presentations							
Category 19 Del #19. Completed IBH Care Coordination for patients at FQHC- Cost	19	16	26	23	26	22	132
Category 19 Del #19. Completed IBH Care Coordination for patients at FQHC	8808.98	11881.88	13008.61	18949.55	17617.96	18232.54	88499.52
Category 20 Del #20b. BH Medical Homes - Nurse Care Coordinators- referrals- Cost	86	116	127	185	172	178	864
Category 20 Del #20b. BH Medical Homes - Nurse Care Coordinators- referrals	14200.20	18367.65	15589.35	18985.05	12193.65	14663.25	93999.15
Category 21 Del #20b. BH Medical Homes - Nurse Care Coordinators- primary care meetings- Cost	92	119	101	123	79	95	609
Category 21 Del #20b. BH Medical Homes - Nurse Care Coordinators- primary care meetings	5535.14	9792.94	14902.30	15753.86	11921.84	13199.18	71105,26
Category 22 Del #20b. BH Medical Homes - Nurse Care	13	23	35	37	28	31	167

Coordinators- clinic debrief sessions- Cost							
Category 22 Del #20b. BH Medical Homes - Nurse Care Coordinators- clinic debrief sessions	7238.26	8089.82	7664.04	8089.82	4683.58	6812.48	42578.00
Category 23 Del #20b. BH Medical Homes - Nurse Care Coordinators- psychiatrist meetings- Cost	17	19	18	19	11	16	100
Category 23 Del #20b. BH Medical Homes - Nurse Care Coordinators- psychiatrist meetings	9792.94	3832.02	4683.58	9792.94	5960.92	8515.60	42578.00
Category 24 Del #20c. BH Medical Homes - Patient Navigators- primary care meetings- Cost	23	9	11	23	14	20	100
Category 24 Del #20c. BH Medical Homes - Patient Navigators- primary care meetings	1375.60	3439.00	1375.60	5846.30	1375.60	1375.60	14787.70
Category 25 Del #20c. BH Medical Homes - Patient transport referrals- Cost	4	10	4	17	4	4	43
Category 25 Del #20c. BH Medical	6550.50	4323.33	4454.34	2096.16	4978.38	7074.54	29477.25

Homes - Patient transport referrals							
Category 26 Del #20c. BH Medical Homes - Patient Navigators-Wellness Class Coordination-Cost	50	33	34	16	38	54	225
Category 26 Del #20c. BH Medical Homes - Patient Navigators-Wellness Class Coordination	2096.16	2096.16	2096.16	786.06	1310.10	2096.16	10480.80
Category 27 Del #20c. BH Medical Homes - Patient Navigators-psychiatrist meetings- Cost	16	16	16	6	10	16	80
Category 27 Del #20c. BH Medical Homes - Patient Navigators-psychiatrist meetings	3783.01	4126.92	3439.10	3439.10	2063.46	1031.73	17883.32
	11	12	10	10	6	3	52

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

PMPM		**Amount Claimed**						
	Rate	Month 1	Month 2	Month 3	Month 4	Month 5	Month 6	Total
Del #2. Care Management Service Bundle - Tier 1	$							
Del #2. Care Management		0	0	0	0	0	0	0

Service Bundle - Tier 1								
Del #2. Care Management Service Bundle - Tier 2	$							
Del #2. Care Management Service Bundle - Tier 2		0	0	0	0	0	0	0
Del #6. Skilled Nursing Facility Transitions Bundle								
Del #6. Skilled Nursing Facility Transitions Bundle MM Counts		0	0	0	0	0	0	0
Del #12a. Enhanced Housing Transition Service Bundle								
Del #12a. Enhanced Housing Transition Service Bundle MM Counts		0	0	0	0	0	0	0
Del #12b. Housing & Tenancy Sustaining Services Bundle								
Del #12b. Housing & Tenancy Sustaining Services Bundle MM Counts		0	0	0	0	0	0	0

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PMPM		Amount Claimed						
	Rate	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12	Total
Del #2. Care Management Service Bundle - Tier 1	$320.95					320.95	641.90	962.86
Del #2. Care Management Service Bundle - Tier 1		0	0	0	0	1	2	3
Del #2. Care Management Service Bundle - Tier 2	$473.96	7109.33	7583.29	9479.11	8479.11	10427.02	11848.89	55926.76
Del #2. Care Management Service Bundle - Tier 2		15	16	20	20	22	25	118
Del #6. Skilled Nursing Facility Transitions Bundle	$315.39	315.39	630.79	630.78	315.39	315.39	1892.34	4100.07
Del #6. Skilled Nursing Facility Transitions Bundle MM Counts		1	2	2	1	1	6	13
Del #12a. Enhanced Housing Transition Service Bundle	$323.73		6150.87	28488.24	32373.00	32696.73	37552.68	137261.52
Del #12a. Enhanced Housing Transition Service Bundle MM Counts		0	19	88	100	101	116	424
Del #12b. Housing & Tenancy Sustaining Services Bundle	$210.68			1685.44	2949.52	2949.52	2949.52	10534.00

Del #12b. Housing & Tenancy Sustaining Services Bundle MM Counts		0	0	8	14	14	14	50

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

In Alameda's Invoice, Aggregate Utilization Data, and Enrollment and Utilization Report, there are 27 Fee For Service categories. Of those, categories 6, 14-18, 21-24, and 26-27 are services delivered to staff and not clients in order to improve the capacity, skills, and quality of care provided through the system. Because these services are not client-specific, these categories will be populated in the invoice and Aggregate Utilization section of the Narrative, but not the client-level Enrollment and Utilization Report.

After submitting the mid-year claim, we adjusted the number of claimable services based on new information. Since we have been reimbursed for those services, we did not change the mid-year figures in the invoice, and so it shows the same number of claimable services for the first six months. We have made corresponding adjustments to the totals in the second six months of the year to ensure that the total for the year is correct. The narrative shows the correct number of services delivered each month, and the 12 month total matches the invoice and the enrollment and utilization report.

IV. NARRATIVE – Administrative Infrastructure

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

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

Housing Solutions for Health (HS4H) (Del #5)

Housing Solutions for Health worked throughout 2017 in collaboration with the County's Housing and Community Development Department and EveryOne Home, the county's Continuum of Care entity, to redesign housing and homeless services within the county and prepare them to integrate access to healthcare into the system. A Spring RFP process leveraged local, HUD and Whole Person Care dollars, resulting in nearly $27M being awarded to establish the regional Housing Resource Centers (HRCs) and new services that flow through them.

The HRC contracts began in August; HS4H has since focused on launching the HRCs and the Care Connect services that are delivered through them. HS4H supported operators with implementation of tasks such as hiring and training new staff, screening clients, conducting housing problem solving trainings, and preparing for full launch of Coordinated Entry. A newly formed Homelessness Management Information System (HMIS) transition team developed the data migration and system configuration plan in preparation for Spring 2018 launch of the new HMIS system.

Briefly reporting on Care Connect services that were delivered through the HRCs:

• More than 133 unique clients were enrolled in Housing Navigation and Tenancy Sustaining service bundles.

• The 2-1-1 Call Center implemented system improvements to become a Coordinated Entry System entry point, providing 24-hour screening and support for those seeking housing services. From its launch in November through December, 2-1-1 handled 2,475 calls from individuals experiencing a housing crisis.

• Education and Counseling workshops launched in October across the 5 regions, delivering 60 housing education workshops.

• Housing legal workshops began in December with 10 workshops in five cities.

• The Landlord Liaison and Housing Subsidy Management program launched in October; with 23 new units acquired through 2017.

• We have had challenges enrolling in the Skilled Nursing Facilities transition service bundle —only eight clients have been enrolled. However, of these, three (38%) have secured permanent housing.

Data Exchange Unit and Community Health Record (Del #26-29)

We developed the implementation strategy and work plan for the data exchange in the first part of 2017. Our approach is to develop the Community Health Record2 (CHR) and the supporting Social Health Information Exchange3 (SHIE) in two phases:

1. First establish a prototype CHR (pCHR) built on the existing systems in use, to enable a small group of early users to test workflow processes and identify needs.
2. Then implement a permanent SHIE/CHR based on the prototype experience and extensive input from Care Connect partners.

A Health Data Repository Data Sharing Agreement was developed during Summer/Fall 2017 by expert legal consultants. It was vetted and approved by the Data Sharing Advisory Sub-Committee. All participants will sign the same agreement. To date, six organizations have executed the data sharing agreement.
The pCHR was launched in early October, with 4 user organizations. Meanwhile, the Request for Proposal for Phase II Social Health Information Exchange (SHIE) and CHR was developed, incorporating technical and functional requirements from community partners and lessons learned from the pCHR implementation and established, successful Health Information Exchanges around the country.
The Data Exchange unit also supported our housing partners in the selection and initial implementation of a new Homeless Management Information System (HMIS), an essential element in the establishment of the Coordinated Entry System and the Housing Resource Centers.
Data Reporting and Analysis. The growing data repository is based on an existing data warehouse housed in Behavioral Health Care Services (BHCS), and the staff's access to and expertise with sensitive data sets (e.g., Criminal Justice & Substance Use Disorders). Care Connect resources were added to the existing team to increase internal capacity. Between the data repository and the pCHR, Care Connect is now making use of ten datasets, including the County Housing and Community Development's HMIS, BHCS' Mental Health, Substance Use Disorder and Criminal Justice Mental Health, MEDS, and data from both managed care health plans.
We refined our data dictionary and are continuing to refine the logic for identifying eligible clients from the multiple datasets. Over 11,000 clients who meet eligibility requirements based on their service use patterns and medical and social needs are currently identified. We are balancing the impetus to grow the enrolled population quickly against the need to test new processes with a small number of users and clients.
Backbone Organization (Del #31)
AC Care Connect has successfully created a backbone organization (BBO) with a diverse staff and the capacity to drive our system to attain AC Care Connect goals. Section VIII, Stakeholder engagement illustrates our work in pulling together participation from multiple sectors.
In addition to the program management and development described in other sections, we have begun developing a Sustainability Plan that will provide analysis and recommendations regarding: 1)
effective Care Connect components that should be sustained, 2) costs and benefits, both financial and otherwise, 3) what on-going resources are required, and how they may be obtained, and 4) strategies to develop support from stakeholders to make the system changes last into the future.
Health Care System Planning and Improvement Division (Del #32)

Our growing AC Care Connect staff has been deeply engaged in program development in 2017. The Care Management Service Bundle has been live since July, serving as a testing ground for new care management strategies such as engagement of healthcare with housing providers (See Del #34). In parallel, the framework for a Standardized System for Care Coordination is being developed and tested in two ways:
1) Thirty-nine individuals across four organizations were piloting the use of our **data infrastructure** by using our prototype Community Health Record, as of the end of the year. Our staff is at the elbow of providers learning what data elements and attributes of such a record are needed to effectively support improvements in care coordination. Key lessons we have learned include a. the value of both psychiatric and medical emergency department admissions,
b. for maximum uptake, the tool must be integrated with other tools that providers are already using,
c. providers want the tool to work for a majority of their client load instead of small subset, and
d. to demystify HIPAA and build confidence about what data can legally be shared across a care team, we need to work through concrete scenarios with our providers.

2) The development of **human infrastructure** is progressing via the inter-agency Problem Solving Learning Community (PSLC). The purpose of PSLC is to build relationships across sectors, learn about each other's systems of care, and identify where improved connections and workflows could enable multi-sector care teams to operate more effectively for whole person care. Five sessions were held as of December, bringing together 89 staff people from 37 organizations including hospitals, clinics, mental health providers, housing providers, criminal justice organizations, and others. Relationships were seeded, common issues needing improvement were identified, and a culture of quality improvement was fostered.

As one illustration, the gathering learned from Behavioral Health Care Services about a bridge psychiatry program that can provide psychotropic medications before a more permanent psychiatrist relationship can be established. This is not a new program, but it was not well known in the community previously. Now this community of providers knows that the program exists, how to access it, what clients are the best candidates for
it, and what the clients can and should expect. The challenge for us is to make such information sharing routine.
The content for these sessions was guided by the Backbone Organization, quality improvement and PDSA planning support was handled by the Quality Improvement Unit (contracted), and the container of this training and learning setting was managed by the Skilled Development Unit (contracted).
Finally, we began piloting improvement projects in the BH Crisis System, aiming to link people who are frequent users of crisis services to stable, consistent, non-crisis care, and to shift services to be tailored to a behavioral health crisis event rather than a general medical crisis. One exciting mini-pilot reaches out to the 49 most frequent users

of the Psychiatric Emergency Service to offer them connection to lower-cost primary care and wrap around services (see PDSA report). Care planning shifts dramatically when there is more time to explore the consumer's needs outside of the crisis episode. Instead of seeing each crisis as an isolated incident, the provider can see the larger picture, which can help prioritize getting the right services to meet the needs of the whole person.

Communications (Del #33)

In Program Year 2, we set up communication tools such as trackable communications through Constant Contact, newsletters/ updates, and began work on the AC Care Connect website. We completed a branding exercise that allowed us to develop consistent templates for more streamlined communications with our partners. The Communications Manager position was hard to fill, but we were finally successful and the new hire started in January 2018.

Care Coordination System Oversight (Del #34)

The Care Management Service Bundles began to be offered in July 2017 after AC Care Connect executed a contract with Alameda Alliance for Health (the Alliance) to administer the bundles. In total, 118 member months of service were provided to 34 consumers via four Community-Based Care Management Entities (CB-CMEs). Contract negotiations were underway with several more CB-CMEs, which will expand the provider network and increase capacity.

Care Connect and Alliance personnel have held weekly huddles, monthly strategic program implementation meetings, and monthly work sessions with the CB-CMEs to work through program design and implementation. Different CB-CMEs have different strengths and needs. One may have extensive expertise in complex case management, but going beyond the clinic walls is a new experience; another may have excellent capacity working with a particular population subset such as the elderly or persons with disabilities, but the level of case management record keeping is a new challenge. Now that the basic workflows and reporting requirements are mostly in place, the CB-CMEs are eager to develop their capacity for housing navigation and housing problem solving, which Care Connect is ready and willing to provide. Our goal is to bring up capacity to support housing needs across the system of care, and we will be rolling out training on these topics throughout 2018.

Financial Oversight and Contracting (Del #35)

The BBO and Health Care Services Agency (HCSA) have put in place the necessary resources to conduct the functions of contracting and financial oversight systems. Over 30 contracts were

procured in 2017. Most contracts include RBA measures, and we are continuing to develop RBA measures for most aspects of our program.

Skills Development and Quality Improvement SDQI (Del #36)

Contracts for four organizations that collectively make up the Skills Development and Quality Improvement (SDQI) unit were approved. The SDQI units—Skills Development, Quality Improvement, Organizational Development and Change Management, and Research and Dissemination—completed assessment activities and began work in the areas of training, quality improvement PDSA cycles, and research. PDSA opportunities

were identified and improvement work began in several areas including reducing high utilization of psychiatric emergency services, improving follow up after mental health hospitalization, and improving primary care attendance for severely mentally ill Care Connect clients. Priority training topics identified were Whole Person Care 101, Housing Problem Solving, Data Sharing and Confidentiality, and Motivational Interviewing. Monthly trainings started in September for a multi-sector audience with topics including Mental Health system access and Successful Application to IHSS.

V. NARRATIVE – Delivery Infrastructure

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

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Community Living Facilities (Del # 9)
To improve the quality and number of Community Living Facilities (CLFs) in order to provide more safe, affordable housing for vulnerable County residents, AC Care Connect is creating a professional association of CLF operators. This new organization will conduct activities such as creating an online directory of facilities and quality standards, an online portal for community resources and legal regulations, and in-person workshops for operators and residents.
Following the spring release of an RFP and the solidification of a CLF planning committee for program development, fall negotiations for the new Alameda County Independent Living Association contract resulted in an approved final contract in December. Other accomplishments in 2017 include:
• Establishing an MOU with Alameda County Healthy Homes Department, part of the Community Development Agency, which was nearly finalized as of December 2017.
• Holding focus groups with tenants, service providers, and housing operators.
• Finalizing and approving quality standards for homes.
• Planning for a website to be launched by summer 2018.

Behavioral Health Medical Homes (Del 20a)
Care Connect is supporting BHCS expansion of delivery infrastructure to improve and expand behavioral health-based medical homes. The new Promoting Access To Health (PATH) Primary Care Clinic at Eden Adult Community Support Center that was scheduled to open in November 2017 was not ready for operation due to delays related to building and renovations (not funded by WPC). However, we have continued to prepare for the expansion by completing the Memorandum of Understanding between BHCS and the Federally Qualified Health Center (FQHC) provider and submitting the request for approval of a new satellite FQHC at the county mental health facility to HRSA.
Meanwhile, the existing PATH clinics are participating actively in Care Connect activities, and their service delivery is reported in Section III, including nurse care coordination, peer coordinators and behavioral health care coordination support from non-licensed staff at the FQHCs. The team is participating in a PDSA designed to increase the percentage of clients with severe and persistent mental illness enrolled in the county's Community Support Centers who are accessing primary care, by providing

data and systematizing referrals and communications between them and local FQHCs or the PATH clinics.

Training and Workforce Development (Del #21)

Building the skill set of the behavioral health and primary care workforce to deliver high quality and culturally responsive care management services to complex and high need patients is essential to sustaining whole person care. Training and workforce development opportunities in 2017 have included:

• Providing clinical education and experience to a selected UCSF School of Psychiatry Fellow at the Trust Primary Care Clinic;

• The Primary Care Psychiatric Consultation team worked with primary care and behavioral health clinicians at eight Alameda County, FQHCs to improve their skills in treating and diagnosing psychiatric conditions that are often presented in the primary care setting;

• The sponsorship of ten primary care providers to attend the University of California Davis Primary Care Psychiatry Fellowship Program so that they can receive advanced training in primary care based psychiatry. Ten Fellows were supported in Year 2017, and ten have enrolled in the 2018 Fellowship Program. All of the Primary Care Fellows are from the FQHCs that serve the AC Care Connect population.

VI. NARRATIVE – Incentive Payments

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

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Timely Adoption of the AC Care Connect System (Del #1)

1. At least one representative from each provider organization will attend each monthly meeting throughout PY2 to develop standard care management definitions, outcomes, models as part of the care coordination system; includes gathering feedback at their home organization between meetings and bringing fruitful content to each discussion.

Monthly Problem Solving Learning Community meetings began in August 2017 to provide a venue for prioritizing care coordination system elements for improvement and for cross-sector learning. $900,000 was paid across nine organizations for attending 100% of these foundational monthly meetings held in 2017, bringing learning and problem solving mindset to each. The remainder of the incentive dollars in the PY2 budget are being requested to rollover to PY3 to support similar participation in this ongoing forum for additional providers who have not yet taken part.

$900,000 / nine provider organizations, including one hospital and clinic system and eight community-based Federally Qualified Health Centers

Capacity Development Incentives for Physical Health Providers (Del #25)

1. Implement population health management system
2. Evidence of management reports
3. Identification and implementation of 3 population initiatives

Deliverables 1 and 2 were achieved and paid by the Mid-year 2017 report. Alameda Health System has now achieved the remaining two components.

3. Using the population health management system, three outreach programs were prioritized for implementation: breast cancer, cervical cancer screening, and colon cancer screenings. The data on an initial population was stratified into risk categories using eligibility, medical claim, pharmacy claim, and lab data. Alameda Health System has confirmed that they have
implemented comprehensive team-based programs for the three conditions across all AHS ambulatory care sites to improve screening rates for these three conditions including empowering their medical assistants to order and schedule mammograms and FIT tests, implemented standard work and standing orders to routinize broader

screening practices, and data dashboard and alert systems to encourage adherence to new practices.
$2,000,000 / Alameda Health System

4. Evidence of improvement on at least two of those Population Initiatives by at least 10% over baseline
4. Evidence of improvement
Breast Cancer Screening:
Baseline: 68.98%
Benchmark: PRIME 90th Percentile: 71.44%
Gap: 2.46%
Goal: 10% reduction in gap between baseline and benchmark.
68.98% + 0.25% = 69.23%
Achieved by August 2017: 72.75%
Exceeded goal AND benchmark
Colon Cancer Screening
Baseline: 55.80%
Benchmark: PRIME 90th percentile: 65.71%
Gap: 9.91%
Goal: 10% reduction in gap between baseline and benchmark.
55.80% + 0.99% = 56.79%
Achieved by August 2017: 59.59%
Reduced gap between baseline and benchmark of 9.91 percentage points by 3.79 points, exceeding the 10% improvement target.

Data Quality Improvements- Capacity Development Incentives for Physical Health Providers
Data Quality Improvements (Del #30-1) The Public Hospital and Clinic System provided data regularly to our prototype Community Health Record throughout the fall of 2017. Their real-time ADT data allowed the community-based outpatient providers participating as test users to receive immediate notifications when consumers in their care arrive at the Emergency Department.

(Del #30 - 1)
1. Timely data submission (monthly, unless frequency determined to be otherwise through data sharing system planning)
$481,926 / Alameda Health System

Data Quality Improvements- Capacity Development Incentives for Physical Health Providers
(Del #30-2)
2. Provide evidence of improvement in collection and electronic documentation of housing status by reducing the percentage of patients seen with housing status as

"unknown" by at least 20% over the prior year in PY2 for the psychiatric hospital, and then by all four ambulatory sites for PY3-5 by at least 10% over the prior year.

Data Quality Improvements (Del #30-2)

Through the implementation of improved processes and institutionalized protocols, the public hospital has made tremendous strides to improve data quality related to the collection and electronic documentation of housing status by reducing the percentage of patients seen with housing status as "unknown" at the County's Psychiatric Facility, JGPH. System-level changes were made to disallow Unknown or blank responses to registration requests related to housing status, pushing all staff to determine a meaningful answer to the question of homelessness when working with a client. This work was done across the entire population served by the public hospital, instigated by focus on the Care Connect enrolled population but benefiting and adding capacity to the entire system. The numbers below reflect all clients served.

$1,000,000 / Alameda Health System

Additional work on incentives since mid-year report

The FQHCs and Public Hospital are on a July to June fiscal year, so some PY2 incentive payments were earned and paid in the first half of PY2; these were included in the PY2 mid-year report. The FQHCs and public hospital are now working on a new set of deliverables and incentives described below. Payments for these incentives are in the PY3 budget.

Opioid Treatment (Del #17)

The 8 FQHCs and the public hospital continue to improve opioid dependence screening and treatment through the implementation of improved processes and institutionalized protocols. They are working on increasing the volume of Care Connect patients receiving chronic opioids who are treated for opioid dependence, with an increased focus on providing **non-opioid (non-medication)** therapies to treat pain and avoid or mitigate opioid dependence.

Hepatitis C (Del #22)

The 8 FQHCs and Public Hospital continue to improve Hepatitis C screening and treatment through the implementation of improved processes and institutionalized protocols that focus on no-show, retention and adherence processes. They are working on increasing the volume of Care Connect patients who are treated for Hepatitis C.

Access to Care (Del #24)

The FQHCs continue to work on improving access to care by offering Convenient Care appointment slots and closely monitoring their Third Next Available Appointment data. In PY3 improving access to care incentive expands to include the remaining 3 FQHCs and the public hospital.

Data on these efforts are reported to ACHCSA on a quarterly basis, and once reviewed and approved, it serves as a trigger for releasing payment.

VII. NARRATIVE – Pay for Outcome

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

Follow-up After Mental Health Hospitalization (Del #4)

Method

The method for measuring improvement that AC Care Connect set for this metric was to show a 10% decrease in the gap between performance and benchmark; the benchmark selected was the Medicaid Average—43.9% for 7 day and 63.0% for 30 day follow-up. At the time of our application submission, we did not have the data infrastructure in place to enable us to run this metric using data from multiple sources. With more integrated data available thanks to the work of the Data Exchange unit and many partners, we learned that current performance was better than expected, and it became clear that we needed a higher benchmark. The new benchmark, approved for PY3, is the 2014 commercial HMO rates.

Medicaid Average (PY2 benchmark)	43.9%	63.0%
All Medi-Cal Clients, all relevant discharging facilities and follow- up providers	44.0%	63.1%
AC Care Connect enrolled consumers	40.3%	67.9%.
2014 commercial HMO rates (PY3 benchmark)	*53%*	*71%*

Performance improvement work in 2017

In PY2 we actively engaged with partners to improve follow-up to hospitalization for mental health. We have identified both "low-hanging fruit" and more difficult-to-achieve challenges, providing more than enough improvement opportunities to last until 2020 and beyond.

Being able to obtain the required data from the full continuum of potential follow-up providers (primary care, outpatient specialty mental health, and psychiatric inpatient services) has been a significant accomplishment of 2017, demonstrating advances in system-level integration and problem solving. Before AC Care Connect and the BHCS team broadened the data repository, this was not possible. IT and data staff from mental health and physical health have had to learn each other's coding schemes for diagnoses, procedures, and billing, in order to get a system view of a client's utilization. Though we understand that Care Connect will be held to the performance across all facilities, we began our work by engaging with John George Psychiatric Hospital (part of Alameda Health System-JGPH), which is our largest discharging provider. JGPH, BHCS, and a large outpatient provider

(Pathways to Wellness) have been holding constructive discussions to improve transitions of consumers from acute psychiatric services to lower-cost outpatient services (see PDSA).

The follow-up rate for AC Care Connect clients discharged from John George Psychiatric Hospital is as follows.

John George Discharges	7 day Follow-up Rate	30 day Follow-up Rate
Benchmark: Medicaid Average	43.90%	63.00%
Baseline: Calendar Year 2016 for AC Care Connect Eligibles	40.31%	62.88%
2017 Follow-up Rates Among AC Care Connect Eligibles	42.70%	62.92%
2017 Follow-up Rates Among AC Care Connect Enrolled	39.02%	65.04%

In this reporting year, after our improvement work began, referrals from the John George to Pathways to Wellness increased from an average of 1.1 new referrals per month to an average of 8 per month. This success was due to improved workflows and clear expectations for client outcomes. Although the rate of referrals made through this project greatly increased, half of the clients (14 out of 28) did not attend their follow-up appointment; of new referrals, only 81% attended their follow-up appointment. Our focus for PY3 is clear: maintenance of those improved referral rates and reducing no-shows for follow-up appointments.

Stably Housed at 6 months (Del #13)

No payments have yet been made on this metric. In September 2017, Alameda County's Coordinated Entry System started its phased launch across five regional housing resource centers throughout the county, along with the housing navigation and tenancy sustaining service bundles and outreach services that will help us to achieve this outcome. As the very first clients served by housing navigation will not have been in their permanent housing for six months by the end of 2017, we have requested rollover of these funds to continue the incentive for high quality navigation services.

A major challenge we face is the increasingly 'out of reach' housing market in the Bay Area. The time it is taking housing navigators to find housing is growing, and when a housing opportunity does present itself, navigators and clients often have to seize it even if it may not be the best situation for the client and their housing needs. This may result in less stable housing situations that might impact the number of clients staying stably housed at 6 and 24 months.

VIII. STAKEHOLDER ENGAGEMENT

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

Attachment included in report is not available.

IX. PROGRAM ACTIVITIES

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

(1) Input from multiple venues fed the development of a standardized system of care coordination: The community-based care management entities (CB-CMEs) sessions provided focused testing space for improvements in referral and linkage to other service providers in other parts of the system. More than ten organizations participated in three Community Health Record Listening Sessions to share their information needs to improve care coordination, and four organizations are testing the pCHR; these stakeholders are shaping the technology that will support the future care coordination system. Monthly Problem Solving Learning Community sessions brought together providers from across the system to hear each other's perspectives on care coordination issues.

(2) The John George PES Highest Utilizers Pilot advanced our understanding of the needs of the highest crisis system utilizers and demonstrated effectiveness of case conferencing with providers involved in the patient's care, system experts, and consumer experts. A total of 34 of the 49 identified high-utilizing patients visited the psychiatric emergency facility 151 times. Eleven agreed to the pilot and arrived at the Trust Clinic. All patients who accepted the pilot had an initial decrease in their average PES utilization.

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

(1) The concept of a standardized system of care coordination is generally welcomed by our provider community, but the bandwidth to prioritize participation in its development is challenging. Other organizations are simultaneously focused on new electronic health record implementations, other waiver programs such as Drug-Medi-Cal and PRIME, as well as many other operational and quality improvement initiatives. Communicating to partners how the work of Care Connect will support these other activities and not a distraction is critical. Communications staff need to be involved early and often for program success.

(2) Understanding what leads people to utilize the Crisis System as their primary source of care will be an ongoing process; early exploration indicates the reasons are much more varied than expected. We are developing approaches to talk with consumers and families to better understand their needs so we can better work with them to design the crisis continuum of care and interventions that are optimized to meet their needs.

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

(1) Adopted health data repository data sharing agreement with the following benefits:
• All participants sign the same agreement, eliminating need to track many different arrangements
• Participants are allowed to both provide and receive data to/from the HCSA health data repository
(2) We stood up the prototype community health record (pCHR) during Fall '17. Enrollment/eligibility files are being generated from the data repository and our pCHR vendor processes encounter files from four participating organizations on a regular basis. There were 39 end users in 2017.

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

(1) Use and disclosure of data from a data repository is very complex. We have learned the importance in analyzing data requests from all angles. Examples of questions to ask include (but are not limited to): Who is requesting data? Are they a covered entity? What data are they requesting? What is the purpose? Who are the recipients? Are they business associates, and are agreements in place? We have learned the importance having a pre-determined data request process with a built in compliance toolset which requires Privacy Officer sign-off. This internal process is currently under development.

(2) Communicating the benefits of the Care Connect project is an ongoing challenge both internally and externally. Communications specifically tailored to prospective data providers are needed, so they will be willing to dedicate resources towards the exchange project.

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

(1) Live dashboards have been expanded and improved significantly since the mid-year report. In addition to supporting reporting needs, these dashboards may be used as communication tools with providers and key stakeholders and to provide data for PDSAs.

(2) We have built an algorithm and user interface to improve person matching across the Care Connect Data Sets to reduce duplication. Plans are in progress to develop

dashboards to further streamline management of AC Care Connect enrollees including reporting on services.

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

(1) Data collection and reporting on data across multiple disciplines continue to be extremely resource intensive. The County hiring processes are slow, and getting these resources trained to understand external datasets has been a challenge. We continue to invest time and resources in stakeholder engagement, establishment of data terminology definitions, surveillance of the existing landscape of available data, and phased implementation and prioritizing, all while demonstrating collaboration, consensus-based decision making and sensitivity to potentially limited resources and competing priorities of partner entities.

(2) In some programs there is a culture of concern about information-sharing, privacy and confidentiality restrictions that goes beyond the actual law, and can inhibit willingness to be collaborative and innovative to solve care coordination issues. Sometimes this is more rooted in a fear of doing something wrong than actual legal restrictions. We have begun providing education and training on HIPAA and soon on 42CFR, as well as the consumer benefits of providers sharing data. We have made good progress, but we need to continue to understand the concerns that participants have and address them.

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

(1) Competing priorities – in particular, major stakeholders will be implementing a new electronic health record (Epic) during the same period as we are launching the Social Health Information Exchange/Community Health Record.

(2) Increasing Medi-Cal enrollment among the high utilizers, many of whom do not have or do not maintain benefits that can help them avoid health crises. This is one reason we are reporting lower numbers than anticipated. Medi-Cal “churn” is also an issue.

(3) Balancing the tension between the benefits of data-sharing and respecting privacy. We need to obtain buy-in from organizations and staff that are skeptical about data-sharing and concerned about protecting clients' privacy by demonstrating the benefits of coordinating care and ensuring that we are setting up a system that protects clients. Sectors such as law enforcement, city and public works are a particular challenge to integrate.

(4) Making our own and others' institutional processes move more quickly (contracting, payment of invoices, approval of agreement, etc.). In some cases we have contracted with large institutional partners such as cities and the managed care organizations. Our rationale for this approach is that working with these partners will make sustained change more likely. However, it has meant a slower start, as there is an added layer of bureaucracy, and creating subcontracts with community providers added months to the launch. It also makes data-sharing more complicated.

(5) Hiring front-line staff is difficult both at the County and for subcontractors; the high cost of housing in the Bay Area is a barrier for staff as well as clients, and CBO and public service salaries are not competitive in this market.

(6) "Pilotitis" – the tendency to continually start new programs, rather than enhance and scale up existing programs. We are striving to avoid this by identifying existing programs and partners that we can work with to transform the system for whole person care.

X. PLAN-DO-STUDY-ACT

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

List PDSA attachments
- Accessible Comprehensive Care Plan
- Care coordination infrastructure
- Initial Test of Data Sharing Across Partners
- Reducing Recidivism Amongst High Utilizers of Psychiatric Emergency Service (PES)
- Increasing Mental Health Consumers Accessing Primary Care
- Increase housing placement for Care Connect eligible clients housed in skilled nursing facilities (SNF)
- Increase post-hospitalization follow up visits