State of California - Health and Human Services Agency
Department of Health Care Services
Whole Person Care
Alameda County Care Connect
Annual Narrative Report

Reporting Checklist

Alameda County Care Connect
Annual Report Program Year 3
May 7, 2019

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

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

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

Whole Person Care

Alameda County Care Connect

Annual Report Program Year 3

May 7, 2019

I. REPORTING INSTRUCTIONS

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

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

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

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

II. PROGRAM STATUS OVERVIEW

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

Alameda County is privileged to have a large and diverse community of organizations serving high need Medi-Cal members. What has been lacking is communication and coordination. Fragmentation among service providers results in fragmented care. Alameda County Care Connect's (ACCC) challenge is to connect this group of high functioning providers into a system of whole person care. Our approach has been three pronged: investing in new coordinating tables, protocols and agreements; cross-sector training and relationship development; and an electronic collaboration platform.

INCREASING INTEGRATION AMONG COUNTY AGENCIES, HEALTH PLANS, PROVIDERS, AND OTHER ENTITIES

Health Plans: Alameda County's strong partnership with our two managed care health plans continued to evolve during 2018. Both plans sit on the WPC Steering Committee. In 2018 we continued to advance data sharing with the two plans -- both now contribute data to the new Social Health Information Exchange (SHIE), and both plans have representatives on the Data Governance Committee that launched in December 2018.

ACCC's complex case management program for whole person care was designed to mirror the soon-to-launch Health Homes programs. We have contracted with each plan to administer the Bundle and have worked closely with them to build capacity and engage patients, for example, through monthly CB-CME/WPC provider learning sessions hosted by the Alliance and supported with WPC resources. In a practical demonstration of collaboration, the Alliance is also welcoming Anthem CB-CME staff to the monthly learning sessions.

Public Hospital: Another area of work on integration is our partnership with Alameda Health System (AHS) to pilot a program to house homeless AHS clients who are in acute and post-acute care settings. The challenges of discharging patients with housing barriers and complex needs surfaced earlier in 2018 during an Executive Case Conference with HCSA, Alameda Alliance for Health and Alameda Health

System. The effort started small with the goal of better understanding the categories of patients for whom it had been particularly difficult to find post-acute or post-sub-acute care, as well as the system level challenges of coordinating appropriate discharge for patients experiencing homelessness. In support of this project HCSA has allocated $1M of the newly created $5M flexible housing pool. Thirty patients were referred from Sept to December (7 of those Sept, 23 Oct-Dec); 3 patients were placed into Permanent Supportive Housing or a Residential Care Facilities for the Elderly (RCFE).

Cross-Sector Collaboration: Meanwhile, we are leveraging our integrated care sites – Trust Clinic and the Alameda County Behavioral Health (ACBH) Wellness Centers – to improve access to both primary care and mental health services.

- The Health Care for the Homeless program and its Trust Clinic are the foundation for continued work to improve the capacity of homeless and housing providers to connect homeless clients to health care. We are leveraging the skills and expertise of these dedicated personnel to spread best practices to multiple community-based providers, from shelters to health centers.
- Partnership with ACBH's Integrated Behavioral Health program resulted in linkage to primary care for 100 severely mentally ill (SMI) consumers who had not visited a primary provider in over a year. We are continuing to work with them on hard-wiring workflow changes to make this a sustained improvement.

Community Hospitals: SB 1152, the Homeless Patient Discharge bill that became law on January 1, 2019 has increased the incentives for hospitals to work with community providers on whole person care. The Care Connect Housing Team provided training for members of the Northern California Hospital Council to support implementation of the new policy and developed a set of resources for hospital discharge.

Housing Continuum of Care organizations: During this period, the Housing Resource Centers and Coordinated Entry System were fully implemented (see section IV and V). These care coordination hubs represent a major redesign and enhancement of the housing and homeless infrastructure in Alameda County, joining health services to housing resources to benefit the most vulnerable individuals experiencing homelessness. They are a joint effort of Care Connect, Housing and Community Development, cities and local CBOs – a unique collaboration in the county. There is still a lot of work ahead to refine and improve efficiency of the system, which is our focus going forward, but the foundation is in place.

INCREASING COORDINATION AND APPROPRIATE ACCESS TO CARE

Our aim is that all sectors are able to help consumers with the first steps to access needed services in any of the needed sectors.

Care Academies: During 2018, Care Coordination Academies were established; 21 trainings were delivered last year to over 300 unique participants representing more than 85 organizations across Alameda County, in topics such as Housing Problem Solving Skills for Literally Homeless Consumers and Accessing Primary Care. Training Participants documented workflow modifications in addition to describing the impact on consumers utilizing the information from the Academy. We calculate that the care of over 5,700 consumers was affected by the participation of direct service providers and management staff attending the Care Coordination Academy. In addition, mini-collaboratives offered peer learning and practical tool development to CB-CMEs to promote improved outreach, consumer engagement, and retention. Special sessions of the Care Connect Academy, specifically for housing providers, focused on data sharing for whole person care, mental health first aid, and accessing primary care. (See section IV for more detail)

Housing and Health Collaboration: Care Connect's Housing Solutions for Health team is helping HRC leads develop work plans with neighboring community clinics to coordinate care for the highest priority consumers enrolled in the Health, Housing, and Integrated Services Bundle. Plans include points of contact and liaisons between health care and housing, bi-directional referral protocols, and procedures for regional case conferencing participation.

REDUCING INAPPROPRIATE EMERGENCY AND INPATIENT UTILIZATION
An especially productive partnership has evolved with Behavioral Health and Emergency Medical Services (EMS) for creating new approaches to Crisis Services that are aimed at reducing unnecessary costs and increasing options for clients.

Frequent Utilizers of PES: ACCC has hosted a new collaboration between Behavioral Health and Alameda Health System to improve care coordination for the highest utilizers of John George's Psychiatric Emergency Services (PES). Phase I of this pilot focused on 49 individuals with 10 or more visits in 6 months and was primarily aimed at problem identification and exploration of solutions; this phase concluded in March 2018. Phase II launched in Q4 2018 and focuses on approximately 700 consumers with four or more visits to PES in the preceding 12 months. We identified in Phase I the need for additional options for consumers to go to receive support, such as drop-in centers, and are working in Phase II to build effective linkages between PES staff and the consumers with available community resources.

The partnership with Alameda County EMS and Behavioral Health has also led to development of several other system improvements. Three county-wide projects that sprang from this partnership were developed in 2018 and will launch in 2019:

- A program to treat agitation in the field and bridge the gap of access to timely care for people experiencing mental crisis who are picked up by EMS enables delivery of olanzapine while en route to an emergency department. In preparation for the successful January 1, 2019 go-live, more than 2,000 EMTs and 800 paramedics participated in psychiatric crisis training.
- The Community Assessment and Transport Team (CATT) leverages Whole Person Care resources to obtain pilot funding through MHSA and local healthcare tax revenues (Measure A). A mental health clinician and an emergency medical technician (EMT) in a non-ambulance vehicle will be dispatched to 5150 calls for an acute evaluation. This will save expensive and limited EMS resources, and make alternative dispositions possible.
- Crisis Connect is a new post-crisis telephonic follow-up program for High Utilizer and High Risk Patients who have been discharged from Psychiatric Emergency Services (PES) or have had a mobile team contact in the prior 24 hours that we hope will improve our follow-up to mental health hospitalizations or crises.

All of these planned programs are expected to be self-sustaining once established.

IMPROVING DATA COLLECTING AND SHARING

Building a data exchange system is a long-term investment in coordination of care for this complex population. During this reporting period, AC Care Connect has put in place limited small scale data-sharing through the prototype Community Health Record (pCHR), while doing comprehensive planning for the full Social Health Information Exchange / Community Health Record. The limited data exchanges we have implemented have had a positive effect on patient care and providers are enthusiastic about the benefits.

During this reporting period, we achieved a major milestone: Thrasys was selected to provide the permanent data exchange infrastructure that we call a Social Health Information Exchange (SHIE) and the first application, the Community Health Record (CHR). Detailed design and development began immediately after contract execution.

We also launched a Data Governance Committee for decision making and problem resolution. The universal authorization form that will enable consumers to release more of their information to more providers on their care team went through extensive development during this period. The Universal Authorization Workgroup gathered input from counsel, a health literacy specialist, and the Consumer Fellowship group, and then brokered three large stakeholder meetings with representatives of 35 partner organizations and consumers to vet the document and get buy-in for its use.

More than 80 users from seven organizations are now using the pCHR and experiencing the value of shared information. As an example, Tri-City Health Center Health Homes CB-CME uses the pCHR to monitor complex patients and improve

coordination with Washington Hospital providers. ED patient alerts help Tri-City focus on reduction of inappropriate crisis utilization, maintain consistent messaging to consumers, and proactively schedule primary care following hospitalization or ED encounters.

We have run into a significant challenge in rolling out the SHIE; some partners became reluctant to share data, even though, in some cases, data agreements had been signed. Organizational leaders became nervous and required additional legal and technical review. As a result, the go-live date for the first wave of CHR users was delayed. The lesson learned is that sometimes agreement can be superficial until it is tested. It is necessary to make sure that all leaders are fully engaged and understand what is being asked. However, it is important to acknowledge that this is a huge change for multiple large institutions to make at an accelerated pace, and it is understandable that some partners need more time to be ready.

ACHIEVING QUALITY AND ADMINISTRATIVE IMPROVEMENT BENCHMARKS

It is still too early to see change in quantitative metrics. Most of the work so far has gone into creating the critical infrastructure that will support improved performance. The path to improvement is “relentless incrementalism”—and requires the infrastructure to support quality improvement infrastructure and capacity development at a system level. This infrastructure has not existed in Alameda County, and is one of the major transformations that we are slowly building through the Whole Person Care Pilot opportunity.

Working together with partners at the system level provides an opportunity to make significant improvements by smoothing the way through bureaucratic hurdles. One example of this is the innovative Treatment of Agitation in the Field project described above. This project is an example of the impact of the Whole Person Care Pilot program’s investment in quality infrastructure and coordination across systems. The intervention itself cost very little; it was the organizing of change agents and project management support that made it possible to work through the steps to make it happen.

Our Consumer & Family Experience program also contributes to quality improvement; consumer input leads to better engagement and enhanced partnerships between health care providers and consumers and their families. This is based on the principle that those closest to the problem are closest to the solution. Specifically, during this year, nine consumers were appointed to a 12-month fellowship offering leadership and professional development. Fellows have direct lived experience in the public health, criminal justice, housing, and child welfare systems, which helps inform system change. Fellows have participated in planning for services and development of tools such as the universal authorization form. In addition, the Culturally Affirmative Practice Provider Group (CAPPG) is piloting a Patient Wants and Needs Script. This

tool is designed to establish system/provider rapport with consumers, especially when in a crisis; establish a team approach between consumers and providers; and focus a cultural lens on the patient's needs, so that they may be integrated in the treatment plan.

Nine PDSAs were active during this reporting period. Care Connect staff and QI consultants have worked with partners on changing workflows to better support linking clients across systems to services they need (e.g., finding housing for long-stay inpatients and people experiencing homelessness), and improving follow-up to crisis events, among others. These efforts are informing training and capacity development strategies that aim to spread successful changes, design of the Social Health Information Exchange and Community Health Record, as well as leading to scaled-up interventions such as the Crisis Connect program referred to above, and respite beds (planned for PY4).

INCREASING ACCESS TO HOUSING AND SUPPORTIVE SERVICES

Linking housing and homeless services to health care services is a critical goal for Care Connect. Healthcare and housing are two highly complex systems in themselves, and very little structured coordination existed prior to the Whole Person Care effort. Meanwhile, the underlying economic conditions that have so exacerbated homelessness are largely beyond our control. That said, we are determined to build these bridges, and we have made progress this year.

The Housing Resource Centers (HRCs) have been the foundation of our work to connect the housing and homeless system of care to health resources. In 2018, the cities of Oakland and Berkeley and Abode Services began conducting "By Name List" regional case conference meetings with community-based organizations and health care partners that serve those experiencing homelessness. Nearly 5,600 individuals are on the By-Name List generated from the Alameda County Homelessness Management Information System. Cross-sector teams review the list to match the most vulnerable consumers with available services and permanent supportive housing and coordinate services for each client discussed. Care Connect staff attend each of these sessions to facilitate linkage with health and mental health resources and to improve the quality of the cross-sector discussion. We are building on these to add more providers from different parts of the system.

Another highlight of the work to connect people experiencing homelessness to health care and other services is the Trust Clinic's successful Street Psychiatry Outreach program called StreetHealth (Deliverable 46b). The outreach team includes a psychiatrist, a nurse case manager, and a community outreach worker equipped to conduct psychiatric evaluation and administer medication and substance use disorder treatment to people residing in homeless encampments in downtown Oakland. The team works to remove barriers for people who have a hard time coming in to a clinic

by providing quality care where the person is found. The goals are to provide reliable, quality behavioral health care, based on best practices; improve behavioral health and quality of life; and connect patients to a medical home and other social services. This program is part of the Health Care for the Homeless program, which we are leveraging to increase skills in both health care and housing/homeless programs.

IMPROVING HEALTH OUTCOMES FOR THE WHOLE PERSON CARE POPULATION

2018 was again a year of heavy focus on infrastructure. Moving forward we are spreading and embedding new practices and scaling up field interventions and anticipate seeing more movement and improved reporting on outcome measures. During 2018 we saw improvements primarily through our incentive programs:

- Improved colorectal cancer screening
- Reduced times from matching clients to a Permanent Supportive Housing resource to readiness for move-in.
- Continued advances in screening for and treatment of HCV and opioid addiction

CHALLENGES/LESSONS LEARNED

In the second half of PY3, the rubber began hitting the road. Services are being delivered to increasing numbers of clients and we are seeing the predictable challenges as new services and new partnerships move from the drawing board to the real world.

- As the demands of change become more apparent, we have encountered unexpected resistance from some partners. Partners who were on board with data-sharing as a theoretical process are putting brakes on as the details of what will be shared become clearer. In a number of cases this appears to be due to incomplete information getting from one level of the organization to another. This highlights the importance of clear and detailed communication, and the need to get full agreement at multiple levels of the organizations we are seeking to collaborate with.
- Working with our large institutional partners (other County departments, cities, large hospitals) is critical, but it results in more than doubling the time to make change, as each organization works through its processes. We have seen this in working with cities and their subcontractors on housing navigation services. We discovered early that the housing navigation services were being underutilized, but it took 6 months for the contract changes to move from redesign of the model to new contract model to getting new language on the docket for the County BOS and then City Councils. We are moving to embed ACCC staff with the major partners in an effort to reduce the time from identifying a change to accomplishing it. We are also looking at moving to a

model of more direct contracting with providers, involving the cities not as contract intermediaries, but as monitoring and support partners.

- Two of our accomplishments that we believe may be most transformative are not “programmatic” but have to do with resolving bureaucratic barriers – during 2018 we developed a new vendor pool program that has the capacity to speed up and democratize service delivery in the County far beyond the ACCC work, and we patiently worked through data sharing language and agreements that will allow us to share information more widely among County agencies. We will be able to capitalize on these to realize changes in the last two years of the pilot.

I. 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	462	284	302	300	298	309	1955

Item	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12	Annual Unduplicated Total
Unduplicated Enrollees	254	278	233	301	241	3828	5135

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

Costs and Aggregate Utilization for Quarters 1 and 2							
FFS	**Month 1**	**Month 2**	**Month 3**	**Month 4**	**Month 5**	**Month 6**	**Total**
Category 1 Del #7. Outreach Services-hours - Cost	29,146.62	43,968.33	50,012.94	35,108.42	41,649.85	40,656.22	**$ 240,542.38**
Category 1 Del #7. Utilization	704.00	1,062.00	1,208.00	848.00	1,006.00	982.00	**5,810**

Costs and Aggregate Utilization for Quarters 1 and 2							
FFS	**Month 1**	**Month 2**	**Month 3**	**Month 4**	**Month 5**	**Month 6**	**Total**
Category 2 Del #8. Housing Education & Legal Assistance--Call Center cases-Cost	4,590.00	3,519.00	4,972.50	8,644.50	13,005.00	9,256.50	$ 43,987.50
Category 2 Del #8. Utilization	60.00	46.00	65.00	113.00	170.00	121.00	575
Category 3 Del #8. Housing Education & Legal Assistance—Workshops - Cost	5,848.67	5,848.67	5,848.67	5,848.67	5,848.67	5,848.67	**$ 35,092.00**
Category 3 Del #8. Utilization	13.00	13.00	13.00	13.00	13.00	13.00	**78**
Category 4 Del #8. Housing Education & Legal Assistance--individual legal assistance - Cost	24,570.00	10,530.00	15,795.00	12,285.00	21,060.00	10,530.00	**$ 94,770.00**
Category 4 Del #8. Utilization	14.00	6.00	9.00	7.00	12.00	6.00	**54**
Category 5 Del #10. Client Move-In funds - Cost							**$ 41,934.60**
Category 5 Del #10. Utilization	0.00	0.00	0.00	0.00	0.00	0.00	**11.65**
Category 6 Del #10. Housing Locator/Landlord fund - Cost							$ 839,767.50
Category 6 Del #10. Utilization							429
Category 7 Del #14. Sobering Center-bed days – Cost	77,264.44	82,287.83	97,357.98	90,181.72	80,374.16	85,158.34	**$ 512,624.47**

Costs and Aggregate Utilization for Quarters 1 and 2							
FFS	**Month 1**	**Month 2**	**Month 3**	**Month 4**	**Month 5**	**Month 6**	**Total**
Category 7 Del #14. Utilization	323.00	344.00	407.00	377.00	336.00	356.00	**2143**
Category 8 Del #15. SUD Diversion - Hours on assessments, - Cost	687.86	458.58	2,522.16	1,834.30	1,605.01	2,063.59	$ 9,171.50
Category 8 Del #15. Utilization	3.00	2.00	11.00	8.00	7.00	9.00	40
Category 9 Del #15. SUD Diversion - court visit encounters, - Cost	5,732.21	8,942.25	9,171.54	11,005.84	8,483.67	10,776.56	$ 54,112.07
Category 9 Del #15. Utilization	25.00	39.00	40.00	48.00	37.00	47.00	236
Category 10 Del #15. SUD Diversion - drug testing w/ Care Manager contact - Cost	8,483.67	10,547.27	14,445.17	13,298.73	11,005.84	12,381.57	$ 70,162.26
Category 10 Del #15. Utilization	37.00	46.00	63.00	58.00	48.00	54.00	306
Category 11 Del #16 Portals to Substance Use Disorder Treatment – Linkage - Cost	4,649.81	4,494.81	4,184.83	-	2,014.92	309.99	**$ 15,654.35**
Category 11 Del #16 Utilization	30.00	29.00	27.00	0.00	13.00	2.00	**101**
Category 12 Del #16 Portals to Substance Use Disorder Treatment – helpline – Cost	929.96	774.97	619.97	-	-	-	**$ 2,324.90**

Costs and Aggregate Utilization for Quarters 1 and 2							
FFS	**Month 1**	**Month 2**	**Month 3**	**Month 4**	**Month 5**	**Month 6**	**Total**
Category 12 Del #16 Utilization	6.00	5.00	4.00	0.00	0.00	0.00	**15**
Category 13 Del #16 Portals to Substance Use Disorder Treatment - in person assessments - Cost	-	-	-	-	-	-	$ -
Category 13 Del #16 Utilization	0.00	0.00	0.00	0.00	0.00	0.00	0
Category 14 Del #18b. Psychiatric Consultations for PCPs - curbside consults - Cost	15,108.55	17,455.51	16,428.71	18,188.93	22,442.80	19,509.10	**$ 109,133.59**
Category 14 Del #18b. Utilization	206.00	238.00	224.00	248.00	306.00	266.00	**1,488**
Category 15 Del #18b. Psychiatric Consultations for PCPs - chart reviews - Cost	14,521.81	18,702.33	21,709.37	21,782.71	22,662.82	23,469.59	**$ 122,848.64**
Category 15 Del #18b. Utilization	198.00	255.00	296.00	297.00	309.00	320.00	**1,675**
Category 16 Del #18b. Psychiatric Consultations for PCPs - one-on-one staff meetings - Cost	6,105.74	6,545.79	7,755.94	7,205.87	8,636.05	7,810.95	$ 44,060.34
Category 16 Del #18b. Utilization	111.00	119.00	141.00	131.00	157.00	142.00	801
Category 17 Del #18b. Psychiatric Consultations for PCPs - elbow support - Cost	16,502.02	15,559.05	19,330.94	13,673.11	22,159.86	17,916.48	$ 105,141.47
Category 17 Del #18b. Utilization	35.00	33.00	41.00	29.00	47.00	38.00	223

Costs and Aggregate Utilization for Quarters 1 and 2							
FFS	**Month 1**	**Month 2**	**Month 3**	**Month 4**	**Month 5**	**Month 6**	**Total**
Category 18 Del #18b. Psychiatric Consultations for PCPs - training presentations - Cost	29,043.56	30,363.73	34,324.21	27,723.40	34,324.21	38,284.70	$ 194,063.81
Category 18 Del #18b. Utilization	22.00	23.00	26.00	21.00	26.00	29.00	147
Category 19 Del #19. Completed IBH Care Coordination for patients at FQHC-Cost	45,682.13	49,267.05	47,116.09	41,585.07	64,733.42	58,178.13	**$ 306,561.89**
Category 19 Del #19. Utilization	446.00	481.00	460.00	406.00	632.00	568.00	**2,993**
Category 20 Del #20b. BH Medical Homes - Nurse Care Coordinators-referrals- Cost	16,052.01	16,206.36	21,762.83	16,206.36	13,582.47	16,360.71	**$ 100,170.75**
Category 20 Del #20b. Utilization	104.00	105.00	141.00	105.00	88.00	106.00	**649**
Category 21 Del #20b. BH Medical Homes - Nurse Care Coordinators-primary care meetings- Cost	19,160.00	14,902.22	17,456.89	14,476.44	11,921.78	13,624.89	$ 91,542.22
Category 21 Del #20b. Utilization	45.00	35.00	41.00	34.00	28.00	32.00	215
Category 22 Del #20b. BH Medical Homes - Nurse Care Coordinators-clinic debrief sessions- Cost	7,664.08	6,812.52	8,515.65	7,664.08	7,238.30	7,664.08	$ 45,558.73
Category 22 Del #20b. Utilization	18.00	16.00	20.00	18.00	17.00	18.00	107

Costs and Aggregate Utilization for Quarters 1 and 2							
FFS	**Month 1**	**Month 2**	**Month 3**	**Month 4**	**Month 5**	**Month 6**	**Total**
Category 23 Del #20b. BH Medical Homes - Nurse Care Coordinators-psychiatrist meetings- Cost	6,812.44	10,218.67	9,792.89	10,218.67	9,367.11	9,367.11	$ 55,776.89
Category 23 Del #20b. Utilization	16.00	24.00	23.00	24.00	22.00	22.00	131
Category 24 Del #20c. BH Medical Homes - Patient Navigators-primary care meetings- Cost	2,063.39	-	-	-	-	-	$ 2,063.39
Category 24 Del #20c. Utilization	6.00	0.00	0.00	0.00	0.00	0.00	6
Category 25 Del #20c. BH Medical Homes - Patient transport referrals-Cost	-	-	-	-	-	-	$ -
Category 25 Del #20c. Utilization	0.00	0.00	0.00	0.00	0.00	0.00	0
Category 26 Del #20c. BH Medical Homes - Patient Navigators-Wellness Class Coordination- Cost	2,620.20	-	-	-	-	-	$ 2,620.20
Category 26 Del #20c. Utilization	20.00	0.00	0.00	0.00	0.00	0.00	20
Category 27 Del #20c. BH Medical Homes - Patient Navigators-psychiatrist meetings- Cost	1,375.63	-	-	-	-	-	$ 1,375.63
Category 27 Del #20c. Utilization	4.00	0.00	0.00	0.00	0.00	0.00	4

Costs and Aggregate Utilization for Quarters 3 and 4							
FFS	**Month 7**	**Month 8**	**Month 9**	**Month 10**	**Month 11**	**Month 12**	**Annual Total**
Category 1 Del #7. Outreach Services-hours - Cost	41,774.06	47,942.87	52,538.43	65,290.07	65,704.09	23,516.02	$ 296,765.54
Category 1 Del #7. Utilization	1,009.00	1,158.00	1,269.00	1,577.00	1,587.00	568.00	7,168.00
Category 2 Del #8. Housing Education & Legal Assistance--Call Center cases-Cost	9,639.00	9,868.50	8,797.50	12,699.00	11,781.00	7,573.50	$ 60,358.50
Category 2 Del #8. Utilization	126.00	129.00	115.00	166.00	154.00	99.00	789
Category 3 Del #8. Housing Education & Legal Assistance—Workshops - Cost	5,848.67	5,848.67	5,848.67	5,848.67	5,848.67	5,848.67	$ 35,092.00
Category 3 Del #8. Utilization	13.00	13.00	13.00	13.00	13.00	13.00	78
Category 4 Del #8. Housing Education & Legal Assistance--individual legal assistance - Cost	17,550.00	17,550.00	8,775.00	28,080.00	10,530.00	-	$ 82,485.00
Category 4 Del #8. Utilization	10.00	10.00	5.00	16.00	6.00	0.00	47
Category 5 Del #10. Client Move-In funds - Cost							$ 110,403.72
Category 5 Del #10. Utilization	0.00	0.00	0.00	0.00	0.00	0.00	30.67

Costs and Aggregate Utilization for Quarters 3 and 4							
FFS	**Month 7**	**Month 8**	**Month 9**	**Month 10**	**Month 11**	**Month 12**	**Annual Total**
Category 6 Del #10. Housing Locator/Landlord fund - Cost							$ 189,877.50
Category 6 Del #10. Utilization							97
Category 7 Del #14. Sobering Center-bed days - Cost	85,397.54	73,915.52	60,998.25	72,001.85	66,739.26	73,915.52	$ 432,967.94
Category 7 Del #14. Utilization	357.00	309.00	255.00	301.00	279.00	309.00	1,810
Category 8 Del #15. SUD Diversion - Hours on assessments, - Cost	1,375.73	1,375.73	1,605.01	917.15	687.86	1,146.44	$ 7,107.91
Category 8 Del #15. Utilization	6.00	6.00	7.00	4.00	3.00	5.00	31
Category 9 Del #15. SUD Diversion - court visit encounters, - Cost	11,923.00	12,610.86	14,445.17	7,107.94	13,298.73	11,693.71	$ 71,079.41
Category 9 Del #15. Utilization	52.00	55.00	63.00	31.00	58.00	51.00	310
Category 10 Del #15. SUD Diversion - drug testing w/ Care Manager contact - Cost	15,362.32	14,445.17	20,177.38	16,508.77	16,967.34	17,425.92	$ 100,886.90
Category 10 Del #15. Utilization	67.00	63.00	88.00	72.00	74.00	76.00	440
Category 11 Del #16 Portals to Substance Use Disorder Treatment – Linkage - Cost	9,919.59	13,019.46	12,709.47	10,074.58	2,789.88	13,019.46	$ 61,532.45

Costs and Aggregate Utilization for Quarters 3 and 4							
FFS	**Month 7**	**Month 8**	**Month 9**	**Month 10**	**Month 11**	**Month 12**	**Annual Total**
Category 11 Del #16 Utilization	64.00	84.00	82.00	65.00	18.00	84.00	397
Category 12 Del #16 Portals to Substance Use Disorder Treatment – helpline - Cost	-	-	-	-	-	-	$ -
Category 12 Del #16 Utilization	0.00	0.00	0.00	0.00	0.00	0.00	0
Category 13 Del #16 Portals to Substance Use Disorder Treatment - in person assessments - Cost	-	-	-	-	-	-	$ -
Category 13 Del #16 Utilization	0.00	0.00	0.00	0.00	0.00	0.00	0
Category 14 Del #18b. Psychiatric Consultations for PCPs - curbside consults - Cost	17,015.45	16,722.08	18,482.30	23,176.22	19,289.07	16,795.43	$ 111,480.55
Category 14 Del #18b. Utilization	232.00	228.00	252.00	316.00	263.00	229.00	1,520
Category 15 Del #18b. Psychiatric Consultations for PCPs - chart reviews - Cost	22,076.08	22,296.11	20,022.49	28,896.93	20,829.26	17,162.14	$ 131,283.02
Category 15 Del #18b. Utilization	301.00	304.00	273.00	394.00	284.00	234.00	1,790
Category 16 Del #18b. Psychiatric Consultations for PCPs - one-on-one staff meetings - Cost	6,765.82	7,920.96	9,076.10	9,736.18	6,325.77	5,335.65	$ 45,160.47

Costs and Aggregate Utilization for Quarters 3 and 4							
FFS	**Month 7**	**Month 8**	**Month 9**	**Month 10**	**Month 11**	**Month 12**	**Annual Total**
Category 16 Del #18b. Utilization	123.00	144.00	165.00	177.00	115.00	97.00	821
Category 17 Del #18b. Psychiatric Consultations for PCPs - elbow support - Cost	25,460.27	20,273.92	14,144.59	21,688.38	17,445.00	24,517.29	$ 123,529.44
Category 17 Del #18b. Psychiatric Consultations for PCPs - chart reviews - Cost	22,076.08	22,296.11	20,022.49	28,896.93	20,829.26	17,162.14	$ 131,283.02
Category 17 Del #18b. Utilization	54.00	43.00	30.00	46.00	37.00	52.00	262
Category 18 Del #18b. Psychiatric Consultations for PCPs - training presentations - Cost	31,683.89	27,723.40	33,004.05	26,403.24	25,083.08	18,482.27	$ 162,379.92
Category 18 Del #18b. Utilization	24.00	21.00	25.00	20.00	19.00	14.00	123
Category 19 Del #19. Completed IBH Care Coordination for patients at FQHC-Cost	61,660.63	73,644.50	51,520.42	51,213.14	44,862.71	44,248.16	$ 327,149.57
Category 19 Del #19. Utilization	602.00	719.00	503.00	500.00	438.00	432.00	3,194
Category 20 Del #20b. BH Medical Homes - Nurse Care Coordinators-referrals- Cost	17,749.82	15,434.63	16,823.75	13,428.13	12,656.40	8,643.39	$ 84,736.12
Category 20 Del #20b. Utilization	115.00	100.00	109.00	87.00	82.00	56.00	549

Costs and Aggregate Utilization for Quarters 3 and 4							
FFS	**Month 7**	**Month 8**	**Month 9**	**Month 10**	**Month 11**	**Month 12**	**Annual Total**
Category 21 Del #20b. BH Medical Homes - Nurse Care Coordinators- primary care meetings- Cost	12,773.33	8,941.33	8,089.78	7,664.00	7,664.00	3,832.00	$ 48,964.44
Category 21 Del #20b. Utilization	30.00	21.00	19.00	18.00	18.00	9.00	115
Category 22 Del #20b. BH Medical Homes - Nurse Care Coordinators- clinic debrief sessions- Cost	8,089.87	5,960.95	5,535.17	4,683.61	5,109.39	3,832.04	$ 33,211.03
Category 22 Del #20b. Utilization	19.00	14.00	13.00	11.00	12.00	9.00	78
Category 23 Del #20b. BH Medical Homes - Nurse Care Coordinators- psychiatrist meetings- Cost	9,792.89	6,812.44	9,367.11	7,664.00	6,386.67	1,703.11	$ 41,726.22
Category 23 Del #20b. Utilization	23.00	16.00	22.00	18.00	15.00	4.00	98
Category 24 Del #20c. BH Medical Homes - Patient Navigators- primary care meetings- Cost	3,782.88	3,438.98	3,438.98	4,126.78	4,126.78	3,438.98	$ 22,353.38
Category 24 Del #20c. Utilization	11.00	10.00	10.00	12.00	12.00	10.00	65
Category 25 Del #20c. BH Medical Homes - Patient transport referrals- Cost	-	5,502.42	8,646.66	2,489.19	13,101.00	7,336.56	$ 37,075.83

Costs and Aggregate Utilization for Quarters 3 and 4							
FFS	**Month 7**	**Month 8**	**Month 9**	**Month 10**	**Month 11**	**Month 12**	**Annual Total**
Category 25 Del #20c. Utilization	0.00	42.00	66.00	19.00	100.00	56.00	283
Category 26 Del #20c. BH Medical Homes - Patient Navigators- Wellness Class Coordination- Cost	-	393.03	1,703.13	1,965.15	1,965.15	1,965.15	$ 7,991.61
Category 26 Del #20c. Utilization	0.00	3.00	13.00	15.00	15.00	15.00	61
Category 27 Del #20c. BH Medical Homes - Patient Navigators- psychiatrist meetings- Cost	3,095.17	2,751.26	2,751.26	3,439.07	3,439.07	2,751.26	$ 18,227.09
Category 27 Del #20c. Utilization	9.00	8.00	8.00	10.00	10.00	8.00	53

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

Amount Claimed								
PMPM	**Rate**	**Month 1**	**Month 2**	**Month 3**	**Month 4**	**Month 5**	**Month 6**	**Total**
Del #2. Care Management Service Bundle - Tier 1	$320.95	2,246.67	3,209.52	3,530.48	3,851.43	4,493.33	7,060.95	**24,392.38**
Del #2. Tier 1 MM Counts		7.00	10.00	11.00	12.00	14.00	22.00	**76.00**

Amount Claimed								
PMPM	**Rate**	**Month 1**	**Month 2**	**Month 3**	**Month 4**	**Month 5**	**Month 6**	**Total**
Del #2. Care Management Service Bundle - Tier 2	$473.96	14,218.67	12,796.80	14,218.67	13,270.76	17,062.40	19,906.13	**91,473.42**
Del #2. Tier 2 MM Counts		30.00	27.00	30.00	28.00	36.00	42.00	**193.00**
Del #6. Skilled Nursing Facility Transitions Bundle	$315.39	1,261.56	2,838.51	5,046.24	5,992.41	5,677.02	5,361.63	**26,177.35**
Del #6. MM Counts		4.00	9.00	16.00	19.00	18.00	17.00	**83.00**
Del #12a. Enhanced Housing Transition Service Bundle	$323.73	41,437.44	51,149.34	43,379.82	77,695.20	100,032.57	126,578.43	**440,272.80**
Del #12a. MM Counts		128.00	158.00	134.00	240.00	309.00	391.00	**1,360.00**
Del #12b. Housing & Tenancy Sustaining Services Bundle	$210.68	4,845.64	7,795.16	12,219.44	13,483.52	16,222.36	18,329.16	**72,895.28**
Del #12b. MM Counts		23.00	37.00	58.00	64.00	77.00	87.00	**346.00**

Amount Claimed								
PMPM	**Rate**	**Month 1**	**Month 2**	**Month 3**	**Month 4**	**Month 5**	**Month 6**	**Total**
Del. #46b Trust Health Center Street Psychiatric Team	$1,353.00	0.00	0.00	1,353.00	4,059.00	5,412.00	5,412.00	**16,236.00**
Del. #46b MM Counts		0.00	0.00	1.00	3.00	4.00	4.00	**12.00**

Amount Counts								
PMPM	**Rate**	**Month 7**	**Month 8**	**Month 9**	**Month 10**	**Month 11**	**Month 12**	**Total**
Del #2. Care Management Service Bundle - Tier 1	$320.95	9,949.52	11,233.33	9,307.62	12,196.19	16,368.57	18,615.24	77,670.48
Del #2. Tier 1 MM Counts		31.00	35.00	29.00	38.00	51.00	58.00	242.00
Del #2. Care Management Service Bundle - Tier 2	$473.96	24,645.69	24,171.73	25,119.64	28,911.29	34,124.80	36,968.53	173,941.69
Del #2. Tier 2 MM Counts		52.00	51.00	53.00	61.00	72.00	78.00	367.00

Amount Counts								
PMPM	**Rate**	**Month 7**	**Month 8**	**Month 9**	**Month 10**	**Month 11**	**Month 12**	**Total**
Del #6. Skilled Nursing Facility Transitions Bundle	$315.39	4,100.07	4,100.07	6,623.19	9,146.30	7,569.35	9,777.08	41,316.06
Del #6. MM Counts		13.00	13.00	21.00	29.00	24.00	31.00	131.00
Del #12a. Enhanced Housing Transition Service Bundle	$323.73	112,981.77	121,398.75	125,607.24	0.00	0.00	0.00	359,987.76
Del #12a. MM Counts		349.00	375.00	388.00	0.00	0.00	0.00	1,112.00
Del #12b. Housing & Tenancy Sustaining Services Bundle	$210.68	21,489.36	21,910.72	22,332.08	0.00	0.00	0.00	65,732.16
Del #12b. MM Counts		102.00	104.00	106.00	0.00	0.00	0.00	312.00
Del. #46b Trust Health Center Street Psychiatric Team	$1,353.00	8,118.00	20,295.00	31,119.00	67,650.00	75,768.00	77,121.00	280,071.00
Del. #46b MM Counts		6.00	15.00	23.00	50.00	56.00	57.00	207.00

Amount Counts								
PMPM	**Rate**	**Month 7**	**Month 8**	**Month 9**	**Month 10**	**Month 11**	**Month 12**	**Total**
Del #12c: Health, Housing and Integrated Service Bundle - Tier 1	$300.00	0.00	0.00	0.00	37,200.00	33,600.00	36,300.00	107,100.00
Del #12c: Tier 1 MM Counts		0.00	0.00	0.00	124.00	112.00	121.00	357.00
Del #12c: Health, Housing and Integrated Service Bundle - Tier 2	$400.00	0.00	0.00	0.00	155,200.00	130,400.00	134,400.00	420,000.00
Del #12c: Tier 2 MM Counts		0.00	0.00	0.00	388.00	326.00	336.00	1,050.00
Del #12c: Health, Housing and Integrated Service Bundle - Tier 3	$575.00	0.00	0.00	0.00	37,375.00	68,425.00	80,500.00	186,300.00
Del #12c: Tier 3 MM Counts		0.00	0.00	0.00	65.00	119.00	140.00	324.00

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

There are some changes in the numbers reported for some of the service categories in Jan-Jun in this Annual Report, compared to what was reported in our Mid-Year Report. This is due to a number of factors.

- In December 2018, a total of 3,924 clients were administratively enrolled (made “active”) in Care Connect. These clients were made active due to the benefit they were receiving through their coordinated care in the prototype Community Health Record. As we reviewed the Care Connect services and bundles for 2018, many of these clients who were administratively enrolled, also received services in 2018, and are now included in the enrollment and utilization report.
- Additionally, we recently were able to integrate our Coordinated Entry “By-Name” List (list of persons experiencing homelessness assessed as part of the U.S. Department of Housing and Urban Development (HUD) requirements) from HMIS into the Care Connect data repository. This allowed us to get a more accurate list of eligible persons for our program, thus making it easier to enroll them in our services and bundles.
- Finally, we audited and corrected some of the data from the Mid-Year Report to conform with contractual requirements and reconciliation of Medi-Cal enrollment dates.

As a result of these changes, there may be significant differences between some of the enrollment and utilization numbers we listed in our Mid-Year report compared to the Annual Report. The invoice has been corrected accordingly.

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.

DEL #5 HOUSING SOLUTIONS FOR HEALTH (HS4H)

The Housing Solutions for Health team continues to work in partnership with the County's Housing and Community Development Department, EveryOne Home (the County's Continuum of Care entity) and the County's newly formed Homelessness Council, to continue implementation and quality improvement of the Housing Crisis Response System for all housing and homeless services within the County. Integrating access to health care into the housing system is a top priority. Funding from the County and cities, HUD and Whole Person Care jointly funds regional Housing Resource Centers (HRCs) and the countywide call center for the Housing Crisis Response System, along with new and ongoing services that flow through them. Throughout 2018 we have focused on implementation and improvement of policies and procedures, workflows, and access to health and other social services.

The HS4H team is a key engine for the following efforts, in addition to many others:

- Coordinating regional outreach teams across the county
- Streamlining access to Permanent Supportive Housing (PSH) and decreasing the time it takes to fill PSH units through two key strategies: 1) ensuring our highest priority homeless residents are document-ready to access publicly-funded housing opportunities 2) using data systems to track up-to-date contact information for clients so that they can be quickly located and engaged when housing opportunities arise (see PDSA Results)
- Ensuring the most vulnerable, highest need Alameda County residents are prioritized for services and housing resources through the Coordinated Entry System
- Supporting workflow development and ongoing training for housing provider staff, including conducting outreach and engagement activities, screening and assessing clients, supporting housing problem-solving as an intervention, and bringing more resources into the system
- Continuing work in partnership with the County's Homelessness Management Information System (HMIS) team to implement a new HMIS vendor in Alameda County. Custom configuration is ongoing and the buildout of HMIS is also closely linked with data integration efforts of the Care Connect Social Health Information Exchange/Community Health Record.

There are many barriers to housing vulnerable and low-income people. Obviously the appalling cost of housing in the Bay Area is a fundamental challenge. In addition, one of the most significant barriers is that the people prioritized for permanent supportive housing lack the required documentation to move into housing. This is a problem that our data-sharing and collaborations can help with.

We have faced capacity challenges in implementing some of the advanced features of the new HMIS. We are working with HUD Continuum of Care and HCD on

resolving these issues in 2019. Data management has improved, but interoperability is not complete, and providers still have to track housing placement data both within the HMIS and on monthly spreadsheets, which is a burden for them and also makes timely reporting difficult. Reconciliation processes for this data are being revised Q1-2019 to develop workflows that afford more timely reporting.

DEL #26-29 DATA EXCHANGE UNIT AND COMMUNITY HEALTH RECORD

In October, Thrasys was selected to provide the permanent data exchange infrastructure for the Social Health Information Exchange (SHIE) and the design and development of the first application, the Community Health Record (CHR). Infrastructure and implementation work included:

- Established implementation roadmap (implementation strategy/schedule)
- Completed DEU strategy presentation formulating CHR/SHIE value proposition; this will be refined as conversations continue with both internal and external partners
- Built and defined first iteration of data dictionaries
- Engaged with Thrasys to educate and onboard their team, and to structure workplans
- Began transition plan from pCHR to CHR

A key element of proper data exchange is patient consent. The Data Exchange Unit (DEU) drafted a Universal Authorization that was vetted through community participants in anticipation of a more sophisticated integrated data exchange infrastructure.

The County executed six additional Health Repository Data Sharing Agreements, adding a substance use disorder behavioral health care services organization, a medical/dental/ and behavioral non-profit health provider, and four additional community based providers in preparation for the use of the new SHIE/CHR.

The DEU continued to support the pCHR which by December was supporting approximately 16,000 active eligible consumers (now including Anthem and Alliance members). The pCHR will continue to be actively used until the permanent CHR is active in mid-2019 and now has approximately 80 total end users, seven organizations and approximately 19,000 Care Connect total client records available to end users. Users include Lifelong Medical Center Trust Clinic (physical health), East Bay Innovations (SNF transition service bundle provider), Alameda Health System (physical health and psychiatric emergency), Alameda Alliance (managed care organization), Tri-City Health Center (physical health), Pathways to Wellness (behavioral health outpatient), and Abode (housing). This small group of providers represents a cross-disciplinary microcosm of the system and has helped identify and resolve issues that will need to be addressed when implementing the full system.

Even though the pCHR has limited functionality, it has been invaluable to the pioneering users:

- Housing providers use information from pCHR to advise in case conferencing for clients experiencing homelessness
- Care Connect utilized the pCHR to facilitate data sharing between Alameda Health System (AHS) and East Bay Innovations (EBI) for patients who needed extra support to transition out of inpatient care into a home
- Tri-City Health Center used the system to better coordinate care for shared clients with Washington Hospital
- In 2018, five partner organizations using the pCHR received a total of 807 emergency or inpatient admission alerts, a critical function that allows Care Team members to better facilitate follow-up care and care coordination.

DATA REPORTING AND ANALYSIS

One of the data repositories which supports Care Connect is an existing data warehouse housed in Alameda County Behavioral Health Care Services (ACBH), and their staff's access to and expertise with sensitive data sets such as criminal justice and substance use disorder information are being leveraged. Care Connect resources are adding to the existing team to increase internal capacity. Between the ACBH data repository and the pCHR, Care Connect is now making use of ten datasets.

The data dictionary and the logic for identifying eligible clients from multiple datasets continues to be refined. The approximately 19,000 clients who meet eligibility requirements are derived from their service use patterns as well as medical and social needs. Initial dashboards and self-service reporting tools have been developed to support monitoring and management of program enrollment and associated state reporting.

DEL #31 BACKBONE ORGANIZATION (BBO)

The BBO is overall responsible for program management, including reporting, governance, and stakeholder and partner engagement. The BBO leads planning, and ensures consumer involvement at a high level. AC Care Connect has successfully created a backbone organization with a diverse staff and the capacity to drive our system to attain AC Care Connect goals. The work of the BBO is reflected in the accomplishments reported throughout. The Stakeholder engagement table in Section VIII illustrates our level of participation from multiple sectors.

Planning a complex and ambitious transformation like Care Connect is a constantly evolving task, as we listen to and learn from participants, pilots and PDSAs. During 2018, an overall project roadmap was developed, as well as specific project plans for components such as the SHIE/CHR. Input from program components and partners fed into planning for several new services that are proposed for PY4, including respite beds, outreach and engagement, and benefits enrollment.

In addition, the BBO is leading development of 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.

DEL #32 HEALTH CARE SYSTEM PLANNING AND IMPROVEMENT DIVISION
The second six months of 2018 has been a time of ongoing refinement of strategy and process for making culture and practice change across the community of providers, creating an evolving care coordination network design. We aim to establish a consistent level of competency in meeting whole person care needs across the system through these efforts.

On the training front, the Care Coordination Academy and Comprehensive Care Management Academy were combined into one unified Care Connect Academy. This includes a set of core competencies focused on accessing and navigating services for consumers with complex needs, and foundational engagement strategies. Once all these modules are tested and established, additional streams of trainings specifically designed for CB-CME providers of Health-Homes-like services in the Care Management Service Bundle, and for the housing navigation staff will be added.

The monthly Care Connect Academy training forum has continued to develop and test those core competencies modules, bringing far-ranging providers into the same room to meet one another, to learn new information on care coordination practices, and to discuss the differences of implementation in their varied circumstances to broaden understanding across siloed sectors. The Care Connect Academy trainings from July-December 2018 included: Accessing Primary Care, introduction to Motivational Interviewing, Mental Health First Aid, Trauma Informed Care, Cultural Humility, and a return to Motivational Interviewing from a strengths-based perspective. Those trainings ranged in attendance between 60 and 80 individuals from 30 organizations across seven sectors. This has been a terrific format to hone training goals and test the packaging of trainings across these topics.

Introductions to these topics in the two-hour monthly gathering is educational, but many of these topics need more time in smaller groups to wrestle with the realities of implementation, spend time practicing the skills they are learning, and to have more time for questions and discussion. More topics will be initiated in the existing structure in 2019, and then the training schedule will be restructured to allow the time necessary for each training module. The goal is to have these trainings regularly available and repeated to educate new staff as they enter the care coordination workforce across organizations in the system of care.

Outside of training, AC Care Connect staff have also considered and tested how to implement system connection and integration practices across sectors. A few significant challenges have been encountered. One is that a wide range of providers with different levels of capacity and operations are being asked to adopt the practices being promoted, but those practices cannot be applied as a one-size-fits-all package. And, Care Connect may wish that all providers screen for medical, mental health, addiction, housing, and social support needs, but it's up to each entity to promote that change, and there are significant system-level challenges and barriers these providers confront daily in their effort to provide care coordination to the clients they serve. Even with incentive dollars available, the lack of bandwidth is the limiting factor.

We have learned that it is necessary to get elbow-to-elbow with providers, learning the nuances of the challenges they face, and partnering with them to actually solve some of them, to get the buy-in necessary to implement other system changes. Therefore, the engagement strategy is shifting for 2019 to go deeper with a smaller number of organizations at one time, focusing first on becoming problem-solving partners at their side.

DEL #33 COMMUNICATIONS

Investment in communications resources is essential, as we see every day how important communication is to change.

At the end of Program Year 3, the first phase of the Strategic Marketing Communications Plan was implemented with the specific purpose of maintaining message consistency across all levels of the agency to reduce confusion, alleviate anxiety, and distill and deliver complex content in a coherent and concise manner to facilitate comprehension, ensure consumption, and prompt advocacy. By implementing a consistent structure to monthly communications and leveraging communication toolkits, we were able to make great strides on consistency around what was being communicated, how and when.

Accomplishments during this period include:

- Reorganized AC Care Connect website (www.accareconnect.org) to better respond to the needs of the primary audience, partner providers, to improve access to tools and resources to foster shared practices for whole person care and improve outcomes for consumers in Alameda County
- Published and distributed 5 newsletter articles to highlight and provide program updates and promote new available tools so internal and external audiences are informed of work across programs within AC Care Connect
- Internal audience communications initiatives continued to be refined, particularly in the monthly Director's Report, to focus on milestones in the

strategic roadmap and set expectations for the work to be accomplished in the following month
- Increased the open rate of the primary mode of communication to the broader internal audience, the monthly newsletter, from 21.43% at the mid-year reporting period for Year 3 to nearly 36% by the end of the year, bringing the overall average open rate for the newsletter to nearly 41%
- Completed an "About Us" toolkit to orient staff and partners around what AC Care Connect is, what it does, and who it serves, and includes a one page flyer, a Frequently Asked Questions document, and a master PowerPoint template. Similar toolkits for the Social Health Information Exchange and Community Health Record and Housing Solutions for Health have been created.

DEL #34 CARE COORDINATION SYSTEM OVERSIGHT

AC Care Connect Care Management services have continued to grow through the latter half of 2018. We especially value the strong relationship we have developed with the Alliance and Anthem.

The number of CB-CMEs providing the services remained at 15 through the reporting period, and the enrollment totals have grown from 80 in June 2018 to 134 slots filled in December. Anthem Blue Cross was added as a second administrator of this service in 2018. Though this second plan has had a slow start in the County, the capacity they have developed from their contracting work should lead to higher numbers in 2019.

The CB-CME teams offer a wide range of expertise on the care of individuals who are elderly; and/or have serious mental illness, complex chronic medical conditions, or disabilities; and/or are experiencing homelessness. However, the teams do have gaps in other necessary skills. Developing capacity in the CB-CMEs to work with the Care Connect population has been a strong focus during 2018. Two rounds of a mini-collaborative series were provided to the CB-CMEs and were focused on outreach, engagement, and retention strategies. The plans assessed that actively outreaching to clients on a list is new to many of the CB-CMEs, in contrast to their normal practice of seeing clients who come to them by appointment. These mini-collaboratives primarily focused on peer learning and strategy sharing, identifying specific new processes to try back at their organizations, and testing out those small changes with feedback from their peers. This process led to the development of a new outreach and engagement service proposed for PY4. (See Deliverable #36 below for more detail.)

Care Connect staff regularly attended the monthly CB-CME work sessions led by the Alliance and now Anthem, listening for system-level connection issues that the County is best positioned to address. Care Connect facilitated a joint work session

between the CB-CMEs and the operators of the regional Housing Resource Centers so that they could meet one another, exchange contact information, learn the processes for accessing each other's services for potential clients, and begin to see each other as co-care team members for some shared clients. The chasm between the health and housing systems is one of the more severe in the County, and this bridge building is a critical step towards resolving barriers.

Care Connect also brokered trainings and discussions with the CB-CMEs and Alameda County Behavioral Health department, which provides crisis and outpatient care for clients with serious mental illness. The experience of accessing these services by CB-CMEs has been at times confusing and inconsistent, so Care Connect has facilitated education about what is and is not available and how those services are best accessed.

DEL #35 FINANCIAL OVERSIGHT AND CONTRACTING

The BBO and Health Care Services Agency (HCSA) continue to allocate necessary resources to conduct the essential functions of contracting and financial oversight systems. Unlike many other counties, Alameda contracts out most direct services. In 2018, six new contracts were established and 18 existing contracts were amended, most of which include results-based accountability (RBA) measures. Total contract expenditures totaled $11.2 million in 2018.

In addition, the contracting team is working to remove barriers to housing for clients who are homeless or at risk of homelessness. In partnership with the County Auditor's Office and the General Services Agency, Care Connect expects to receive Board of Supervisors' approval in Spring 2019 to waive existing County procurement policies for the new Housing Assistance Fund (Del #10c). The proposal would allow many new vendors, including landlords, to be brought into the County financial system and issued payments within 24 hours, thereby reducing the waiting time for clients to move into housing. We are similarly planning for a new alternative method that will streamline procurement, using a vendor pool approach. Making these kinds of bureaucratic changes seems mundane, but actually can have a major impact on effectiveness in responding to community needs. WPC is the engine making such change possible.

DEL #36 SKILLS DEVELOPMENT AND QUALITY IMPROVEMENT (SDQI)

The Skills Development and Quality Improvement (SDQI) Unit works closely with the BBO, especially Health Care System Planning and Improvement. It comprises five sub-units geared towards addressing transformation in stakeholder groups at three levels: system-wide, organizational, and individual. The five sub-units are: Organizational Development and Change Management (ODCM), Quality Improvement Unit (QIU), Skills Development Unit (SDU), Research and

Dissemination Unit (RDU), and Sustainability. Their work is visible throughout the project in training, capacity building and PDSAs.

The Research and Dissemination Unit supported the Consumer and Family Fellowship and Culturally Affirmative Practice Provider Champion Group (CAPPCG) described above.

Over the course of the year, the Skills Development Unit supported 21 Care Coordination Academy trainings with over 730 (304 unique) attendees from more than 85 organizations.

Topics included:

- Accessing the Coordinated Entry System
- Housing Problem Solving Skills for Literally Homeless Consumers
- Motivational Interviewing
- Trauma Informed Systems of Care
- Mental Health First Aid
- Drug Medi-Cal Organized Delivery System
- Accessing Primary Care
- Cultural Humility

Care Coordination Academy evaluation found participants appreciate the networking and learned skills pertinent to their current roles. Thirty-one percent of organizations reported that they regularly exchange and review information received from the trainings with staff via weekly huddles and monthly meetings. Between July and September 2018, 16 organizations provided feedback and anecdotal evidence of how these learnings are being implemented and disseminated throughout their programs and organizations; 5,700 unduplicated consumers have been positively impacted by the 16 organizations' use and incorporation of the information presented in trainings.

The Quality Improvement Unit led 2 mini-collaboratives in 2018. The mini-collaboratives provide a monthly forum across three months where organizations engaging in similar work supporting complex clients can learn about national best practices in care management and apply lessons learned through PDSA projects facilitated through the duration of the mini-collaborative.

Participants were provided coaching in design thinking and quality improvement to examine their organization's enrollment, client engagement and client retention strategies to identify service delivery improvement opportunities to test through PDSA projects. In between meetings, quality improvement coaches offered one-on-one support through regular calls and site visits to help the participants plan and implement their projects.

The first mini-collaborative brought together the CB-CMEs to problem-solve and share effective practices in outreach, engagement and retention of consumers enrolled in the bundled services. Four organizations and sixteen individuals participated. A second round focused on peer learning and practical tool development to promote improved outreach, consumer engagement, and retention. Four different organizations and fourteen individuals participated.

Some of the administrative improvements that were tested by CB-CMEs during the mini-collaborative, and their measured outcomes, include:

Project Focus	Intervention	Outcomes
Engagement	Created patient goal-setting procedures for Community Health Outreach Workers (CHOWs)	All CHOWs completed patient goal-setting 83% surveyed felt setting a goal increased the patients' engagement 50% reported clients made "a moderate amount" of progress toward set goal
Outreach	Integrated Health Homes eligibility screening questions in existing workflows to identify and enroll eligible clients	7 clients identified 5 clients enrolled
Outreach	Implemented in-reach workflows with primary care team to increase in-person referrals	8 eligible patients identified 2 patients enrolled
Outreach and Enrollment	Modified procedure to respond to inpatient alerts. Called the emergency department and contacted potential client the day before going to emergency room to establish trust and provide awareness.	Outreached to potential clients within 48 hours of receiving notice 100% successful enrollment rate to clients who were outreached to
Health Action Plan (HAP)	Instituted workflow and timelines to ensure HAP discussions were taking place in both individual and group supervision settings.	HAP completion and tracking done via Excel available to the team via shared drive Developed and/or reviewed 9 HAPs over the course of 5 weeks

Project Focus	Intervention	Outcomes
Enrollment	Coordinate with Health Homes Social Worker to receive direct referrals from Alameda Alliance. Identify other Health Homes Programs and coordinate to increase enrollment	Received 5 referrals from Alameda Alliance and enrolled one client in services In the process of developing a partnership with the TRUST Clinic to enroll clients identified as having Severe Mental Illness (SMI)

V. NARRATIVE – Delivery Infrastructure

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

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

DEL # 9 COMMUNITY LIVING FACILITIES

To improve the quality and stock of shared housing in order to provide safer, affordable housing options for vulnerable County residents, AC Care Connect created a professional association of Community Living Facility operators (the Alameda County Independent Living Association (www.alamedacountyila.org). The Independent Living Association (ILA) utilizes a 'Better Business Bureau'-type model, evaluating Community Living Facilities and supporting operators in meeting quality standards, managing an online directory of facilities with information on housing availability and whether quality standards have been met and an online portal for community resources and legal regulations, and providing in-person workshops, trainings, and resources to support operators and residents.

The approach supports operators by connecting them with resources to help modify housing structures as needed, and training to help operators engage with residents who have mental health and/or physical health disabilities. Recognizing that with the Bay Area's tight housing market, many community living facility owners are cashing out on their properties and leaving the business altogether, the Independent Living Association approach is collaborative in nature and aims to preserve the limited shared housing opportunities that these facilities provide, while increasing the quality of living conditions and overall habitability for residents.

AC Care Connect has contracted with Community Health Improvement Partners to support the County's implementation of the ILA. The following implementation benchmarks have been reached:

- The ILA Steering Committee membership was finalized earlier in the year, and the Steering Committee meets monthly. They provide oversight of the association with approximately 15 members from multiple sectors.
- Written guidelines are in place for the Steering Committee, governing all ILA operations.
- The website for the Alameda County ILA is online at www.alamedacountyila.org
- Training plans and curricula have been implemented for both residents and operators, and the schedule of trainings can be found online.
- The ILA:
  - Has produced and implemented standards and a membership guide for Independent Living operators.
  - Has developed a grievance process for operators who apply for membership.
  - Continues to receive new applications from housing providers to become members of the association and has currently approved membership for 4 CLF homes.
  - Coaches and provides technical assistance for operators to meet quality standards.

- Has assembled an assessment team that conducts onsite assessments of independent living facilities to determine if they meet quality standards.

DEL #20A BEHAVIORAL HEALTH MEDICAL HOMES

AC Care Connect supports the Alameda County Behavioral Health (ACBH) Integrated Health Care Services' initiative to improve timely access to primary care services for consumers with serious mental illness (SMI) in Alameda County's eight Federally Qualified Health Centers (FQHC) and two county operated mental health centers. Currently, there are two operational Promoting Access to Health (PATH) Primary Care satellite clinics that participate in Care Connect activities in the county operated mental health centers. Each PATH Clinic provides three significant services to SMI consumers: 1) nurse care coordination, 2) non-licensed peer support counseling, and 3) health and wellness recovery counseling services.

Care Connect anticipates another Alameda County PATH Clinic to open in the near future. This new satellite primary care clinic was scheduled to open in November 2017 but has been delayed due to project contracting and construction challenges. Once the project renovations are scheduled and completed, ACBH will contract with a local FQHC to provide services in the new PATH Clinic.

As a result of AC Care Connect's focus on improving care coordination services across systems, the mental health centers staff have continued to support more collaboration among the PATH Nurse Care Coordinators, Clinic Coordinators, and Peer Navigators, and the medical and psychiatric providers. During Jul-Dec 2018, the PATH Nurse Care Coordinators participated in 356 care coordination and other clinical care meetings with the primary care providers, behavioral health clinicians, and the psychiatrists of the consumers enrolled at the mental health facility, and PATH Peer Navigators conducted 61 Health and Wellness Classes and Activities for consumers at the two PATH clinics.

The integrated behavioral health (IBH) Mental Health Centers' Services team has also participated in a Care Connect supported PDSA project to increase the percentage of SMI clients accessing primary care on a regular and timely basis. In this PDSA, in the baseline month primary care providers made 150 referrals to behavioral health that resulted in 64 warm connections (42%) where an intake with a BHCC was completed. After implementing the warm connections protocol and revised intake forms for four months, the team saw an average of 75% completed warm connections. Staff members were surveyed to provide input to the effectiveness of the warm connection process and future improvements. A new PDSA is underway to improve the care integration practices throughout ACBH's infrastructure so that primary care assessment and integration is embedded within the reporting and service delivery practices across the department.

During the 2018 Annual State of California's External Quality Review Organization (EQRO) site visit, members of the Review Team visited the Oakland Adult Community Support Center's PATH Clinic. The Team was so impressed with how the clinic provides access to primary care services and wellness activities that they reported that the PATH model primary care clinic should be adopted and available in every California county that provides services to SMI consumers.

Despite the success of PATH clinics, there have been staffing challenges that have impacted both clinics; key vacancies have been difficult to fill. It has taken a long time to find another primary care provider who is not only competent but has a strong desire to work with specialty mental health clients.

DEL #21 TRAINING AND WORKFORCE DEVELOPMENT
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 clients is essential to sustaining whole person care.

Training and workforce development opportunities continued to include the following types of workshops and trainings:

- Providing clinical education and work experience for a selected UCSF School of Psychiatry Fellow at the Trust Primary Care Clinic located in downtown Oakland, California. The Primary Care Psychiatric Consultation Program (PCPCP) team embeds ACBH psychiatrists in eight Alameda County FQHCs to help primary care providers and behavioral health clinicians improve their skills in treating and diagnosing psychiatric conditions that are often presented in the primary care setting. Because they are ACBH staff, the psychiatrists have access to and understanding of the behavioral healthcare system and are able to be a bridge for care coordination for the primary care providers. This program is building capacity in the Alameda County FQHC primary care clinics by helping their medical and behavioral health providers improve their skills and comfort level diagnosing and start treatment for primary care patients with complex behavioral health conditions.
- The fourth cohort of nine FQHC primary care providers to attend the University of California, Davis, School of Psychiatry, and Primary Care Psychiatry Fellowship Program began January 2, 2019.
- In December 2018, ACBH and Alameda Health Consortium started collaborating in the development of a Care Connections Process Model. The goal of the model is to improve communications among the three Safety Net Systems of Care providers (primary care, specialty mental health, and SUD programs) so that clients who are able can transition to lower levels of care in the primary care system. All of the primary care and behavioral health

providers will receive training as part of the Care Connections Process Model's implementation process once it is approved by the executive leadership of the various Safety Net organizations.

DEL #42A MULTI-SECTOR CARE COORDINATION HUBS

Care coordination hubs (also known as Housing Resource Centers) represent a major redesign and enhancement of the housing and homeless infrastructure in Alameda County, joining health services to housing resources to benefit the most vulnerable individuals experiencing homelessness. They are a joint effort of Care Connect, cities and local CBOs – a unique collaboration in the county. Five regional Housing Resource Centers (HRCs) cover all of Alameda County and serve as access points for people experiencing homelessness in each region. Access to all HUD and other publicly funded services and resources for people experiencing literal homelessness are managed by the HRCs, through universal assessment and matching to openings from a prioritized by-name list.

In addition to coordinating housing resources, the HRCs also provide housing problem solving and referrals to other mainstream resources. As new access points to a new system of access, prioritization, resource matching, and coordination of care, the HRCs underwent rapid infrastructure building in 2018.

The following implementation benchmarks have been reached or are underway:

- All 5 primary sites (or 'hubs') were launched and fully operational
- All 5 hubs are fully staffed and are physically open for weekly drop-in hours.
- Training of hub staff and development of policies and procedures, affirmative marketing practices and so on, are ongoing and led by AC Care Connect in partnership with our County's Continuum of Care Council, EveryOne Home.

Care Connect services that were delivered through the HRCs in Jan-Dec 2018 include:

- 843 unique clients were enrolled in housing navigation and tenancy sustaining bundles.
- The 211 Call Center implemented system improvements to become a Coordinated Entry System primary access point, providing 24-hour screening and support for those seeking housing services. From January through December, 211 handled 23,650 calls from individuals experiencing a housing crisis. A housing problem-solving website and referral listing of available affordable housing opportunities were created.
- Over 14,095 street outreach encounters were delivered
- Housing Education and Counseling (HEC) workshops continued across the 5 regions, currently facilitating 40 housing education workshops each month. In

2018, HEC workshops (these workshops also offer access to CES and connect participants to individual legal representation, workshops and counseling)

The Landlord Liaison and Housing Subsidy Management program engaged landlords to both acquire new units and preserve existing ones for tenancies with our most vulnerable clients. As of December 2018, landlord liaisons are managing 322 units made available to our clients through this program, of which 145 are new units acquired through our efforts. Housing legal workshops continue in all 5 regions in the County, with at least one workshop in each region every month, for a total of 60 workshops during 2018. Over one hundred unique clients have received individual housing legal services and representation from January through December 2018.

An increasingly tight housing market has resulted in a major decline of available units in the private market that can be utilized by clients with vouchers. This, and a lack of affordable housing in general, means that there are very limited opportunities for households to exit homelessness and move into permanent, safe, and affordable housing. Landlord liaison services are tied to finding landlords and units in the private market willing to accept subsidies for clients with tenant-based rental assistance vouchers through some of the County's Permanent Supportive Housing (PSH) programs. With the slow trickle of PSH openings, this limits the number of units that providers of this service can obtain and maintain, as it is directly tied to the county's PSH inventory. However, these services are necessary to make sure that we keep the units that are dedicated to the system through ongoing support and relationship-building with private market landlords, and so we can continue to engage prospective landlords to add units to the system. Many housing authorities in the Bay Area are starting to pilot similar initiatives, and we believe these efforts will soon become a local best practice for supporting PSH. We are also using the new Flexible Housing Subsidy Pool to obtain commitments from developers to make new units available to the AC Care Connect population.

Ongoing challenges with implementation of housing services are many. Medi-Cal churn with households experiencing homelessness continues to be an issue in identifying, enrolling, and continuing enrollment for housing navigation and tenancy sustaining service bundles. Care Connect is working on ways to automate data in real time so that our providers have more information on someone's Medi-Cal status and can help to keep it active.

Housing service bundles are embedded in larger contracts for operating regional Housing Resource Centers, and include many subcontractors partnering in the region to provide the services. While the range of providers and network of partners can be beneficial, it has also resulted in significant delays in compiling reporting on service bundle enrollment, impeding the availability of real-time data. Care Connect is working with its providers to streamline reporting efforts and utilize HMIS where possible.

The implementation of a Coordinated Entry System in Alameda County, and the availability of Care Connect funds have resulted in the addition of an unprecedented number of positions added to the system. However, delays in hiring and retaining a stable workforce contributed to a slow ramp-up of providers able to enroll and serve clients across all our housing-related deliverables. Care Connect continues to offer skills development and training opportunities to better support the workforce.

VI. NARRATIVE – Incentive Payments

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

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

Triggering deliverable	Level of achievement	$$ / Receiving entities
Del #23 Capacity Development Incentives for Physical Health Providers – HEDIS 1. Improve performance on a growing set of HEDIS measures selected in partnership with the Managed Care Plans, measured by reducing the gap between the NCQA benchmark for our Region IX and performance for AC3 beneficiaries the prior year by at least 10% each year PY3-5. **One measure will be selected for improvement during PY3,** a second will be added for PY4, and a third will be added for PY5. Payments will be paid on a prorated basis for each Program Year as long as at least 50% of the improvement target is accomplished.	To increase the value of care received by AC3 patients, the community based clinics and public hospital worked to improve their performance on the colorectal cancer screening HEDIS measure. This work was done across the entire population and required the FQHCs to improve their clinic processes, workflows and reporting systems. At the mid-year report, the public hospital had met and exceeded their colorectal cancer screening target performance rate at two out of the four ambulatory sites. By December 31, one additional site made their target, and one site didn't. We received quarterly reports from public hospital, which serves as a trigger for payment.	$ 895,963/ Alameda Health System, the public hospital system *(one of two remaining targets, remainder requested to rollover)*

Triggering deliverable	Level of achievement	$$ / Receiving entities
Del #30-3 Data Quality Improvements- Capacity Development Incentives for Physical Health Providers 3. Provide evidence of improvement in collection and electronic documentation of Primary Care Provider and Primary Care Medical home, whether inside or outside of the public hospital and clinic system, by reducing the percentage of those patients seen with these EHR fields that are blank or "unknown" by at least 10% compared to the prior year. Payments will be paid on a prorated basis for each Program Year as long as at least 50% of the improvement target is accomplished.	The public hospital has made progress to improve quality of data related to the collection and electronic documentation of the Primary Care Medical Homes for those patients inside and outside the public hospital system. This work was done across the entire population served by the public hospital, initiated by focus on the Care Connect enrolled population. At mid-year report, the public hospital exceeded the 10% relative improvement goal at two out of the three inpatient sites. By December 31, 2018, the goal was met at the third inpatient site, San Leandro Hospital. We received quarterly reports from the public hospital, which serves as a trigger for payment.	$166,667/ Alameda Health System, the public hospital system
Del #39b Community Health Record (CHR)/Data Exchange Infrastructure- - Permissions Monitoring System Provide documentation of an implemented enrollment, opt-out and eligibility system to support deliverables.	Clients are identified as eligible through administrative data in our system. Eligible clients are enrolled in the program once they receive a discrete service or are enrolled in one of the service bundles. All clients enrolled in the program receive a Notice of Rights and Services, which includes instructions for clients who wish to opt out of the program. The Notice contains the phone line and email that have been set up specifically to manage incoming calls and questions from clients, including requests to be opted out of the program.	$300,000 / Lead Entity *(milestones 39 c, d, and e are requested rollover)*

Triggering deliverable	Level of achievement	$$ / Receiving entities
Del #39b (cont.)	AC Care Connect created a workflow process to ensure that calls from clients, including opt out requests, are tracked and responded to in a timely manner.	
Del #40 Behavioral Health IS Infrastructure Enhancement **40a. Procurement and implementation of an automated Contract Lifecycle Management (CLM) System** 5) Develop provider portal for exchange of provider information for use in contract development and inventory of provider services.	A contract with the selected vendor, Apttus, was executed and work began to develop the Contract Lifecycle Management System in 2018. The Salesforce Community Portal for CLM and other information look-up has been developed and pilot usage is in place.	$50,000 / Lead Entity *(3 milestones were claimed at mid-year; #6 is requested rollover)*
Del #40b Behavioral Health Care Services (BHCS) Data System Expansion 1) Conduct assessment of data system expansion needs. 2) Upgrade the network infrastructure to enhance system performance to meet expanded requirements due to the CHR, data exchange, more data feeds and more users, as well as system expansion for the Drug Medi-Cal Waiver increase in service delivery. 3) Based on the assessment, provide the necessary technology resources and hardware to provide the user with technology tools that will enhance our ability to provide direct services	Behavioral Health Information Systems department conducted a comprehensive assessment of the underlying infrastructure of its data systems. The assessment included server infrastructure, client hardware and software, storage performance and utilization. We determined that we had deficiencies around compute, memory, and storage in our Hyper V and Citrix environments. We also needed to replace older PCs that were not capable of running Windows 10 operating system. Networking infrastructure was also monitored to identify network saturation points. Upgrades were completed and hardware and software that was then purchased to fill these gaps.	40b = $1,000,000 / Lead Entity *(3/3 milestones)*

Triggering deliverable	Level of achievement	$$ / Receiving entities
Del #40d Training for BHIS personnel to introduce new technologies to upgrade and maintain capacity 1) Provide training for information systems staff in order to develop advanced program configuration capacity for Salesforce applications. 4) Trainings and conferences to maintain employee skills and keep up with current industry standards and current technologies.	1) Training to develop advanced program configuration capacity for Salesforce applications was completed by BHIS personnel. 4) BHIS staff attended Citrix Synergy conference with a focus on the future of work and how Citrix enables a competitive advantage in changing climates. BHIS staff also received monthly training beginning in September 2018 from a consultant to strengthen management effectiveness, provide strategy and change leadership.	40d $50,000 / Lead Entity *(2/4 milestones; #2 & #3 are requested rollover)*
Del #42b Capacity Development in multi-sector care coordination hubs 1) Each Housing Resource Coordination entity will establish regular case conferencing that is geographically and target-population-informed, with multiple sectors represented, to assist high complexity AC Care Connect members with resolving housing and health barriers. Emphasis will be placed on developing the capacity of housing providers to link effectively with medical care providers (e.g., CB-CMEs, primary care centers, and hospitals). At least 26 case conferences will occur during the program year.	1) In 2018, 31 countywide case conferencing meetings were held with housing navigators and other key Housing Resource Center (HRC) staff across four HRC sites. Each HRC entity holds case conference meetings bi-monthly to review the By-Name-List with regional partners and coordinate care.	**$600,000 total/ Lead Entity** *(½ of #3, and #4 are requested rollover)* *$300,000 for milestone 1* *$150,000 for milestone 2 (claimed half at mid-year, claiming rest now)*

Triggering deliverable	Level of achievement	$$ / Receiving entities
Del #42b (cont.) 2) AC Care Connect, in partnership with the Housing Resource Coordination entities, will train HRC staff, including outreach workers, assessors and navigators to ensure they have skills for medical and behavioral health referrals and care collaboration.	2) Members of Care Connect's Housing Solutions for Health team conducted countywide trainings during 2018 with outreach workers, housing navigators, and other key Housing Resource Center (HRC) staff: • There were 3 trainings offered in partnership with AC Health Care for the Homeless between July and December 2018 that included skills development in coordination of care in the following areas: Primary Care Linkage and In-Home Supportive Services, Core Components of Outreach, Extreme Weather Planning and Voter Registration. • Eight additional trainings for Housing Navigators were conducted by the County's Home Stretch program (which is coordinating access to Permanent Supportive Housing) between July-December 2018 and included topics on addressing legal barriers, accessing primary care, and spotting and addressing barriers to housing navigation. • HMIS User Training continues on a monthly basis at about four each month or 22 for the reporting period.	*$150,000 for milestone 3 (half completed; remainder of #3 requested rollover; requested rollover for #4)*

Triggering deliverable	Level of achievement	$$ / Receiving entities
Del #42b (cont.) 3) Each Housing Resource Coordination entity will host a service evaluation for their geographic area and target population(s) that incorporates AC Care Connect consumer feedback and that informs 2019 service planning.	These trainings are in addition to the training provided by Care Connect's Skills Development and Quality Improvement team. 3) Surveys were developed by consumer fellows to evaluate the performance of Housing Resource Centers. Consumer fellows received three trainings on the topics of: Principles of Evaluation/Results-Based Accountability, Survey Design & Data Collection, Housing Navigation Orientation, HRC Survey Design. Surveys will be distributed to the HRCs in 2019 and feedback will inform 2019 and 2020 service planning.	
Del #44 Consumer & Family Member Experience 1) Gather input from consumers, caregivers and family members across multiple sectors, reflective of the population, to inform development of the culturally affirmative practice care model, conducting at least 25 focus groups with at least 200 participants	Due to staff vacancies, the focus groups have been slower than anticipated. One additional focus group was held August 20th, 2018. A total of four groups have been held in 3 different cities throughout Alameda County; Oakland, Hayward and Fremont. Participants included seniors, adults with mental health and co-occurring disorders, and homeless family service providers. Focus group insights have been utilized in the Culturally Affirmative Practice Provider Group as well as the Care Connect Executive Management, Steering Committee and Data Governance processes.	$8,000 / Lead Entity (1/25 for milestone #1) *(#2 was claimed at mid-year; remainder of #1 and milestones #3, #4, & #5 are requested rollover)*

Triggering deliverable	Level of achievement	$$ / Receiving entities
Del #45a – Hepatitis Registry 1) Develop SOW & RFP for creation of Chronic Hepatitis Registry database.	A draft statement of work and request for proposal for a consultant to develop the chronic hepatitis registry was prepared. Upon consulting with internal and external information systems experts, it was concluded that joining the planned Alameda County Public Health Department client database procurement process will be a more efficient long-term solution than revising and releasing the request for proposal. Milestones 2-4 have been included the PY4 rollover request.	$250,000 / Lead Entity *(milestones #2, #3, & #4 are requested rollover)*
Del #45b – Hepatitis Linkage to Care 1) Develop data sharing agreement(s) with at least 1 key major health system provider.	Alameda County Public Health Department (ACPHD) has been confirmed to be included within Alameda County Health Care Services Agency in the current Health Care Data Repository Data Sharing Agreement. Therefore, ACPHD is included in data sharing agreements with participating major health system providers. Subdeliverables 2-4 have been included in the PY4 rollover request.	$125,000 / Lead Entity *(milestones #2, #3, & #4 are requested rollover)*
Del #46a - Trust Health Ramp-up and Dissemination 1) Trust staff will work with Behavioral Health Care Services to expand the network of behavioral health organizations partnering with Trust for coordinated physical and behavioral health care of high utilizing patients. A minimum of 6 organizational partnerships will be initiated.	1) During January 1 through December 31, 2018, Health Care for the Homeless and Care Connect outreached to 8 behavioral health providers and formalized MOUs with 5 providers to refer clients to the TRUST clinic in Oakland.	$1,011,110 / Lead Entity *(milestone #1 = $361,111, 5/6 completed)*

Triggering deliverable	Level of achievement	$$ / Receiving entities
Del #46a (cont.) 2) Trust program staff will participate in at least one PDSA and one pilot program directed to identifying better practices to reduce utilization of crisis services among frequent users of psychiatric emergency services. 3) Trust staff will participate in at least 10 community meetings and trainings to support new shelter standards for shelters to support mentally and physically ill clients residing in shelters, to spread best practices regarding basic triage and problem-solving protocols, as well as expedited referral and warm handoff work flows.	2) LifeLong's Trust Health center participated with Care Connect in the John George Frequent Utilizer Pilot Phase 2 which began October 1, 2018 and is currently ongoing. The efforts included frequent collaborations between the John George Social Work team and the Trust Clinic staff, and Trust sent regular representative to the monthly case conferencing connected to the pilot. A PDSA was not completed and will be done in PY4. 3.) Eighteen meetings and trainings were held. Nine meetings were conducted at shelter providers throughout the county and an additional nine trainings were held for outreach staff, including shelter staff. Training and technical assistance was site specific depending on need/current challenges regarding health-related topics that included accessing primary care; health insurance benefits including transportation support for appointments, dental and optometry benefits; substance use and mental health service providers and access points, and Hepatitis A outbreak prevention.	*(milestone 2 = 216,666, half completed); remainder request rollover)* *(milestone 3= $433,333)*

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.

DEL #4 FOLLOW-UP AFTER HOSPITALIZATION FOR MENTAL HEALTH

As a part of the budget revision approved for PY3, AC Care Connect is now using the 2014 commercial HMO average rates as the benchmark for the Follow-up After Hospitalization for Mental Health metric, up from the national Medicaid average. We chose to increase the benchmark because the prior targets were not a challenge. The measurement methodology is a reduction in the gap between the prior year's performance and the benchmark by 10%. The measurements through the end of PY3 are as follows:

2018 Status	7 day follow-up	30 day follow-up
National Commercial HMO Average (PY3 benchmark)	53.0%	71.0%
AC Care Connect enrolled consumers, 2017 (PY2)	48.7%	73.8%
Gap between benchmark and prior year performance	4.3%	No Gap
10% of Gap	0.4%	0%
Target for PY3: 2017 Performance + 10% of Gap	49.1%	71.0% (benchmark)
Rate as of end of December 2018*	47.0%	68.3%

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Unfortunately, the new, increased Pay for Outcome target for PY3 was not achieved.

There is a fair amount of rate fluctuation month to month and efforts are being made to routinize follow-up to achieve a more consistent outcome.

AC Care Connect, along with partners at John George Psychiatric Hospital (JGPH) and the county's designated Psychiatric Medication Clinics – Pathways to Wellness – have been working collaboratively to improve the rates on this metric. After successfully reaching the benchmark at the end of December 2017, a lot of the original momentum the group shared was lost. Combined with attention focused on other areas needing improvement, and a number of staffing changes at JGPH in 2018, efforts to continue improving the metric stalled. This is a common pitfall of performance-based incentive programs, and we need to find ways to standardize improvements.

As PY4 nears with a new target in place and incentive dollars available for additional partners if that target is met (as proposed in our rollover budget request), we anticipate that the original energy for this work will pick back up.

DEL #4 FOLLOW-UP AFTER HOSPITALIZATION FOR MENTAL HEALTH (cont.)
We plan to implement a collaborative impact incentive model that will engage additional discharging and follow-up provider partners in this effort. By strengthening processes and relationships with additional key organizations and engaging new participants with fresh eyes on the issue to identify innovative solutions, the goal is to increase follow-up rates in a routinized way.

DEL #13 STABLY HOUSED AT 6 MONTHS
The funding under this deliverable was structured as a downstream payment to providers as an incentive. However, due to difficulty in tracking payments to a large network of providers through regional subcontracting mechanisms, we have not made any downstream payments, and therefore are not claiming at this time.

This outcome is also one of Alameda County's variant metrics for all housing bundle-enrolled clients, as housing stability at 6 months remains an important milestone for long-term housing stability. In 2018, out of all clients in permanent housing for at least six months (109), 84% (92) were in housing for greater than six months (measured at the seventh month mark).

Variant Metric: Permanent Housing
Reporting Year: 2018
Numerator: Longer than six consecutive months of permanent housing = 92
Denominator: Permanent housing with six months = 109
Rate: 84%

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.

See attachment

IX. PROGRAM ACTIVITIES

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

(1) In 2018, five partner organizations who were users of the prototype Community Health Record received a total of 807 alerts that indicated clients they were serving came to the emergency department or were admitted to the inpatient setting. By receiving this alert, Care Team members are better able facilitate follow-up care and care coordination.

Care coordination after hospital visits is critical in preventing readmissions and stabilizing patients through ongoing outpatient and preventative care. Due to these alerts, the pCHR users reported that they communicated with the hospital about transportation to the next level of care, proactively scheduled hospital follow-up visits sooner with the client's primary care provider, altered care plans in real time as they tracked their crisis utilization, and maintained consistent messaging with each client across the care team.

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

(1) Competing priorities continue to challenge the level of engagement of some key partners. It has been critical to continuously clarify how the infrastructure work of AC Care Connect can support and propel partners towards success in their own objectives. Targeted messaging continues to be critical, not just at kick off but constantly throughout the arc of each piece of the work.

(2) While the client-facing users of the prototype Community Health Record find the benefits of the pCHR quite clear, there is often no clear path for communication up to higher level leadership within those organizations to develop that same understanding of commitment to use and improvement of this tool at the higher levels. Many executives are understandably focused on their highest priority implementation goals, but it is a challenge when those priorities don't align with what client-facing staff say is needed.

Ensuring positive and transparent partnership development throughout the organization requires navigating communication and decision-making structures that are unique to each organization. A new Communications Manager at Care Connect will help with more strategic and effective communication to ensure all levels of the partner organizations understand what is being done and to facilitate escalation of issues where they are currently getting stuck.

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

(1) The Care Connect Data Exchange Unit engaged with the vendor selected from the Request for Proposal for Phase 2 Community Health Record (CHR) and Social Health Information Exchange (SHIE) at the beginning of November. Necessary design and implementation workgroups were established to define the technology infrastructure to support the permanent solution.

(2) The Universal Authorization (UA) form was drafted and went through a comprehensive vetting process. This included review by County and outside Counsel, two separate consumer focus groups, health literacy consultant review and three county-wide stakeholder workgroup meetings with approximately 50 representatives. The final approval of the UA form, prior to technical implementation, sits with the SHIE Data Governance Committee.

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

(1) Communicating and educating current and prospective stakeholders on the "value-add" of the Phase 2 CHR/SHIE has been and remains a challenging issue as we roll into a later stage of our implementation. The public hospital system and the large network of community based clinics continue to express concern about sharing broader data sets (e.g., expansive Medi-Cal population). Additionally, stakeholders are concerned about being penalized for performance level. These challenges in communication have impacted our ability to get data in a timely fashion (see f. below).

(2) The SHIE potentially introduces the issue of re-disclosing data to non-covered entities which are then not held to the HIPAA rules. This concept, in particular with the justice system, has brought forth fear amongst health stakeholder organizations that PHI will be used in a punitive way toward the consumer (e.g., ICE, warrants for arrest). As a result, Care Connect leadership has removed the Sheriff's Office and Probation Department from the list of organizations participating in the CHR/SHIE, for the time being.

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

(1) The HMIS system launched in May 2018 and over 40 agencies are active users. The data is being used to produce By-Name lists of clients who have been prioritized for supportive housing, and to track outcomes.

(2) The homeless Coordinated Entry System By-Name List is now reporting over 5,600 persons who have been assessed for vulnerability.

The regional Housing Resource Center staff are actively making resource placements from the prioritized By-Name List. The Housing Resource Centers use the HMIS data in regular multi-sector case conferencing to connect people experiencing homelessness to health care and other support services.

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

(1) Intense work has gone into pursuing data streams for the SHIE, to make sure that the CHR provides the kind of data that providers need and are currently missing. Unfortunately, in some cases, even though data agreements were signed, organizational leaders became nervous and have required additional legal and technical review.

The ability to obtain robust data streams from source systems in a timely fashion has impacted the implementation of the technical infrastructure. It was hoped that all data streams to the newly acquired solution would be established by December 2018. These data streams and development of associated reports and CHR dashboards have been delayed until summer of 2019.

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

- 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.
- An increasingly tight housing market has resulted in a major decline of available units in the private market that can be utilized by clients with vouchers. This, and a lack of affordable housing in general, mean that there are very limited opportunities for households to exit homelessness and move into permanent, safe, and affordable housing. This slows down the flow of all services in the system.
- Balancing the tension between the benefits and risks of data-sharing. CEOs and IT directors are focused on the risks, while program staff who are experiencing the benefits of the prototype community health record are not in the room when negotiations occur regarding which data about whom should be shared.
- Housing providers are struggling with the PMPM design. Our cohort of providers believes that they are losing money on providing housing bundle services as a result of this design. It is an unfamiliar model for them and Medi-Cal is a new funding source; they are not used to doing anything like claiming. Staying in touch with and locating unsheltered clients ongoing is difficult, and that makes PMPM a challenging payment model.
- Bandwidth challenges for our project staff and our partners as we simultaneously support implementation of the pilot and planning for sustainability. Many of the same people are involved in both efforts.

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.

The following PDSAs listed are from Q3 and Q4

- Accessible Comprehensive Care Plan
- Care Coordination Infrastructure
- Decrease time to fill permanent supportive housing units
- Improve referrals from primary care to behavioral health team at Tri-City Health Center
- Increase housing placement for Care Connect eligible clients housed in skilled nursing facilities (SNF)
- Increase post-hospitalization follow-up visits
- Increasing Mental Health Consumers Accessing Primary Care
- Initial Test of Data Sharing Across Partners
- Restructuring mental health resources within shelter providers

The following PDSAs listed are for Q1 and Q2

- Accessible Comprehensive Care Plan
- Care coordination infrastructure
- Initial Test of Data Sharing Across Partners
- John George PES Highest Utilizers Pilot
- 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
- Decrease time to fill permanent supportive housing units
- Improve internal referrals from primary care to behavioral health team at Tri-City Health Center
- Restructuring mental health resources within shelter providers