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

Alameda County Care Connect
Annual Narrative Report, Program Year 4
Revised July 8, 2020

REPORTING CHECKLIST

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
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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

***Note**, in this section the text in italics is repeated information from past reports, included for context.*

AC Care Connect's aim is to build a sustainable system of Whole Person Care that helps Medi-Cal eligible residents who face the most difficult combination of physical health, mental health, and housing challenges achieve optimal independence and health. The Care Connect program brings together consumers and providers from multiple sectors, including physical and mental health, housing, crisis services, substance use disorder treatment and more to create a system of care. Our primary strategies are:

- *Implementing a new data sharing system (the Social Health Information Exchange/SHIE and Community Health Record/CHR) that allows frictionless, legally vetted sharing of information so that providers from diverse sectors working with a consumer can communicate easily;*
- *Creating a new system of cross-sector care coordination via contract language, establishment of new case conference tables, and supporting cross-sector education;*
- *Supporting meaningful input by consumers and care-givers into critical program designs and forms;*
- *Integrating healthcare and homelessness and housing services; and*
- *Innovative reorganization of the behavioral health crisis response system.*

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

Health Plans and Community-based Care Management Entities (CB-CMEs):
Alameda County's strong partnership with our two managed care health plans, the Alliance and Anthem Blue Cross, continued to evolve during the first half of 2019. Both plans sit on the WPC Steering Committee, both contribute data to the SHIE, and both plans have representatives on the Data Governance Committee that launched in December 2018.

Care Connect's complex case management program for whole person care was designed to mirror the Health Homes program, which launched in Alameda County in July. 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 Alameda Alliance for Health *and supported with WPC resources. The CB-CME workgroup includes the Alliance,* Anthem Blue Cross*, and the CB-CMEs, in addition to Care Connect. Housing entities have participated, providing education for the CB-CMEs.*

In the second half of 2019, this relationship paid off as Care Connect successfully transitioned AC Care Connect consumers enrolled in Care Management Service Bundles to intensive care management services (Health Homes) administered by the Alliance and Anthem. Because of the strong administrative and educational partnership, the new Health Homes program had a strong launch.

Alameda County Behavioral Health (ACBH) and the Alliance worked closely to expand their CB-CME network to include providers that support individuals who have been diagnosed with a serious mental illness, and fostered agreements with two Full Service Partnerships (FSPs) at Bay Area Community Services (BACS) and Abode Services.

Public Hospital: Care Connect continued to work with Alameda Health System (AHS) to improve capacity to house homeless AHS clients who are in acute and post-acute care settings. Care Connect worked with AHS to develop referral guidance and workflows for a new recuperative care program.

The John George multi-disciplinary case conference, a Care Connect pilot project launched in 2018 to promote collaboration between providers working with the highest acuity psychiatric patients in the County, successfully transitioned to a permanent program within ACBH in 2019. Participating providers have said: “It’s like a puzzle that’s becoming more complete” and “Makes me feel hopeful that others are working to change the system.”

Housing Continuum of Care organizations: During this period, we have continued to work with the cities, EveryOne Home (the local HUD Continuum of Care), the County Housing and Community Development department, and many community-based organizations (CBOs). A major focus has been a systematic review of the coordinated entry system to identify ways to improve efficiency and effectiveness.

County Agencies: *The escalating crisis of homelessness (up 43% in Alameda County since 2017) has prompted County entities from the Board of Supervisors on down to dedicate resources to fighting homelessness, and AC Care Connect has helped to facilitate planning, coordination, and action. County Agency leaders have formed a Homelessness Roundtable as a single County leadership body to accelerate progress toward reducing homelessness. It includes Social Services, Health Care Services Agency (HCSA), Community Development and Probation, among others. This body is*

coordinating flexible funding pools across systems and developing health-focused encampment response policies and procedures.

With the establishment of the Office of Homelessness Care and Coordination (OHCC), HCSA has continued stepping up to an expanded leadership role to move our overall system toward increased integration of the housing and health sectors. The OHCC is committed to scaling and aligning HCSA homeless services and strengthen coordination with other County agencies, cities, and community-based organizations.

The Trust Clinic is a powerful example of integration. A partnership of ACBH and HCSA and a local FQHC (LifeLong Medical), with the Health Care for the Homeless Program as home base, the Trust Clinic has emerged as a Center of Excellence. The expertise has been spread through active work with the shelter providers, clinic health care providers, and AHS.

INCREASING COORDINATION AND APPROPRIATE ACCESS TO CARE

Care Connect has a variety of approaches to move the system toward the goals of increasing coordination and appropriate access to care.

Capacity development: In 2019, the **Care Connect Academy** was established by the Care Connect Skills Development Unit (SDU) in partnership with Community Health Center Network and Alameda County HealthPAC to deliver cross-sector trainings on topics such as Strengths-Based Motivational Interviewing and Trauma Informed Care. Forty-one intensive trainings and Train the Trainer sessions were delivered to 557 unique participants from 92 unique health and social service organizations throughout the county, totaling 302 training hours. A database was established that allows the tracking of trainees across sectors and use of a badges program to mark completion of training series. We are especially happy to report increased participation of substance use treatment organizations, from two organizations in 2018 to 31 in 2019.

In the second half of 2019 we implemented a new change mechanism, **Care Communities,** bringing together an ecosystem of providers with a shared set of consumers for capacity development and at-the-elbow technical assistance and support (see section IV Del #32). Care Connect kicked off the first Care Community cohort on July 8-11. Approximately 35 people from 12 organizations received training and resources to enhance consumer engagement and assist their consumers in navigating the system of care. After the first six-month cohort, we conducted a developmental evaluation. We heard both good feedback— “I got a boost of knowledge that would have taken me years to learn since I was new to the area”; “It helped blur the line

between housing and healthcare and helped us bridge the gap so people get what they need – both medical and behavioral health support"—as well as opportunities to improve the next cohort, which were incorporated in the planning for Care Community 2.

Care Connect staff, consumers, and Care Connect evaluator Bright Research Group presented at the annual conference of the National Center for Complex Health and Social Needs, Putting Care at the Center, on the role of the Fellowship in providing input into service delivery design.

Information sharing: Care Connect's instance of **Elemeno** was launched in late 2019 in Care Communities. Elemeno is an online platform that is easily accessible in the field with use of most mobile devices; it contains resources for the CHR, as well as Care Management, Health Plans, Housing, Mental Health, Primary Care and Substance Use Disorder Treatment. Many Care Connect partners contributed subject matter expertise to create practical "how-to" resources for providers, such as how to access behavioral health services, what to do if your client is in jail, how to apply for replacement documents, and much more. Information is specific, local, and kept up to date.

The development of the **Community Health Record** is described below under Data Sharing; it is a major investment of resources that will facilitate access to care across the system.

Housing and Health Collaboration: We are working on a number of fronts to join health services to housing resources to benefit the most vulnerable individuals experiencing homelessness. These are described below.

REDUCING INAPPROPRIATE EMERGENCY AND INPATIENT UTILIZATION

High usage of 5150 holds and frequent Psychiatric Emergency Services (PES) visits are a decades long system problem in Alameda County. We are very pleased to report that Care Connect's performance on the Emergency Department Visits metric shows an 18% reduction in the number of medical or psychiatric emergency visits per 1000 enrolled member months.

There are no doubt multiple causes for this reduction, but these AC Care Connect program components likely contributed:

- The intensive wrap-around services of both our Care Management and Health, Housing and Integrated Services bundles, providing consumers with a viable option to connect to the service they need other than in the Emergency Department or Psychiatric Emergency Service
- The training and relationship-building among providers, enabling them to better refer to other parts of the system

- Active street outreach with psychiatric services by the Trust Street Health Team
- The John George multi-disciplinary case conferencing

IMPROVING DATA COLLECTING AND SHARING

The successful launch of the Social Health Information Exchange / Community Health Record (SHIE/CHR) in the fall of 2019 was a major milestone achieved; this was the

culmination of years of planning, development and partnership, starting with the planning of our whole person care project in 2015.

Wave 1 of the Community Health Record rollout began in September with trainings and onboarding of 116 Care Connect program staff and end users taking place throughout the Fall. Participating organizations in Wave 1 CHR implementation included the public hospital system's Complex Care Program and psychiatric hospital, Alameda County Behavioral Health, both managed care plans, two FQHCs, and several housing and behavioral health organizations.

The Data Governance Committee expanded to include more community participation; this engagement with partners was a significant contributor to the success and sustainability of the SHIE. An agreement with the Social Services Agency was signed, which will be a major contribution to addressing the social determinants of health. The Care Connect Data Exchange Unit successfully executed nine data sharing agreements in 2019 for a total of 28 since program inception.

The crucial step of integrating the Housing Management Information System (HMIS) into the SHIE was achieved, and the system has been set up to track Health, Housing and Integrated Services bundles. Integration of these data sources enables a connection between housing providers and care coordinators that never existed before.

ACHIEVING QUALITY AND ADMINISTRATIVE IMPROVEMENT BENCHMARKS

Data reporting and analysis are foundational to quality improvement, and most of the work so far has gone into creating the critical infrastructure that will support improved performance. 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.

By the end of 2019, we integrated data into the SHIE from 14 different sources, including hospitals, clinics, Social Services Agency, Alameda County Behavioral Health, health plans, and others. The Care Connect Reporting and Analytics team also

developed a data request process, which allows partner agencies to request data from the SHIE (with appropriate compliance and data governance reviews, as needed). In 2019, we also began the development of a Whole Person Care Impacts Dashboard to track the progress and impacts of the services and activities of Care Connect and interactive tools that will support the use of the data for performance improvement.

In collaboration with the county's new Office of Homeless Care and Coordination, we also continue to refine a Homelessness Performance Measure Dashboard for Alameda County that: 1) highlights priority metrics as defined by the Alameda County Homelessness Council and 2) supports multi-agency and system-level planning around homelessness.

Our Consumer & Family Experience program is part of the Care Connect quality improvement program, based on the principle that those closest to the problem are closest to the solution. Consumer input leads to better engagement and enhanced partnerships between health care providers and consumers and their families. The Consumer and Family Fellowship is 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.

During 2019, Consumer and Family Experience group delivered nine culturally affirmative trainings and workshops totaling 28 hours, helping providers understand how to help consumers access public benefits, partner with consumers and their support network, and promote consumer engagement through candid conversations about racial and other dynamics of difference. They provided tools for engaging with consumers' informal support network, such as genogramming and echomapping. 9 focus groups were conducted in 2019 with partners as diverse as Alameda County Probation supervisees, Oakland librarians, and grievance officers from hospitals and clinics

INCREASING ACCESS TO HOUSING AND SUPPORTIVE SERVICES

Reducing barriers to moving into identified housing: The Home Stretch Housing Assistance Fund launched on August 27th. By the end of December, 74 households exiting homelessness had received a total of $251,656 in assistance to pay for various items including security deposits, furniture, household items and unit modifications to make their homes safe and accessible.

A new housing services vendor pool launched in June 2019 to expedite the contract execution time by as much as six months. Forty-eight vendors were added to the pool. Eight contracts and one amendment totaling $4,400,800 were executed.

Growing the availability of interim housing: A new recuperative care site opened in September 2019, providing an immediate placement option for persons who are homeless and being discharged from an inpatient hospital setting. The 27-bed facility includes on-site medical and support services geared toward assisting clients in their recovery and stabilization. By the end of the year it had served 16 unique consumers.

Building up long-term permanent supportive housing: Alameda County was awarded $42,765,680 from the No Place Like Home Program (NPLH) fund to build 175 units of affordable housing—this equaled 24% of the total award amount. The funding supports the development and housing operational costs of permanent supportive housing for

individuals who live with severe mental illness and are experiencing homelessness, chronic homelessness, or are at-risk of chronic homelessness.

IMPROVING HEALTH OUTCOMES

As described in section IV, a number of our universal metrics improved from 2018 to 2019.

- Ambulatory Care - Emergency Department Visits rate reduced by 18.2%
- Follow up within 7 days after PES visit for mental health improved by 8.7%
- Stably Housed at 6 months improved by 5.2%

The Eastmont Collaborative, an initiative led by Care Connect's Consumer Engagement team in partnership with Alameda Health System (AHS) Behavioral Health, launched in November. The pilot focuses on engaging Eastmont clinic's enrollees of African descent identified as having a serious mental illness, who have not been connected to a care manager. By the end of 2019, [redacted] consumers had been assigned to a case manager.

Care Connect partnered with ACBH on a Santa Rita Jail Outpatient SUD Treatment and Medication Assisted Treatment (MAT) pilot. The program started service delivery in November and had served 39 individuals by the end of 2019. The purpose of the pilot is to provide in-custody substance use disorder (SUD) treatment to adults with identified SUDs and to effectively connect participants to an appropriate SUD program and other resources upon release.

Care Connect partnered with Alameda County Behavioral Health and the Community Health Center Network (CHCN) and AHS to link 100 severely mentally ill (SMI) consumers to primary care for the first time in a year or more.

Our new Safe Parking Program is helping to connect people living in cars and vans to health care services and housing problem-solving. The Safe Parking Program is open 24/7, with overnight security. A total of 36 individuals were served in 2019; [redacted] graduated the program and found housing.

At the end of 2019, Care Connect had enrolled a total of 11,333 beneficiaries, just shy of our goal of 11,500. We are on track to enroll at least 5,500 in 2020, to reach our goal of 17,000 by the end of the project. Through the end of 2019, our reporting has been based on a combination of manual and electronic data collection/compilation from a number of different systems, partners, and spreadsheets. Starting in January 2020, we will be using the new Care Connect Social Health Information Exchange to identify eligible beneficiaries and enrollees and to streamline and automate much of our previous reporting processes. Due to improvements in the algorithm and the additional data available, preliminary data show a significant increase in those identified as Care Connect eligible through the system.

III. ENROLLMENT AND UTILIZATION DATA

Item	Month 1	Month 2	Month 3	Month 4	Month 5	Month 6	Unduplicated Total
Unduplicated Enrollees	343	195	213	226	216	170	1,363

Item	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12	Annual Unduplicated Total
Unduplicated Enrollees	218	165	176	193	125	131	1,008

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	63,965.23	55,063.92	57,465.20	79,200.96	76,054.45	52,662.63	$384,412.39
Category 1 Del #7. Outreach Services-hours	1,545.00	1,330.00	1,388.00	1,913.00	1,837.00	1,272.00	9,285.00
Category 28 Del #7a. Outreach and Engagement encounters - homeless street outreach - Cost	0.00	0.00	0.00	0.00	0.00	0.00	$0.00
Category 28 Del #7a. Outreach and Engagement encounters - homeless street outreach	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Category 29 Del #7a. Outreach and Engagement encounters - Home or facility outreach - Cost	0.00	0.00	0.00	0.00	0.00	[redacted]	[redacted]

Costs and Aggregate Utilization for Quarters 1 and 2							
FFS	**Month 1**	**Month 2**	**Month 3**	**Month 4**	**Month 5**	**Month 6**	**Total**
Category 29 Del #7a. Outreach and Engagement encounters - Home or facility outreach	0.00	0.00	0.00	0.00	0.00	[redacted]	[redacted]
Category 30 Del #7a. Outreach and Engagement encounters - In-reach - Cost	0.00	0.00	0.00	0.00	0.00	[redacted]	[redacted]
Category 30 Del #7a. Outreach and Engagement encounters - In-reach	0.00	0.00	0.00	0.00	0.00	[redacted]	[redacted]
Category 2 Del #8. Housing Education & Legal Assistance--Call Center cases-Cost	13,923.00	12,316.50	13,617.00	13,846.50	14,917.50	13,693.50	$82,314.00

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	182.00	161.00	178.00	181.00	195.00	179.00	1,076
Category 3 Del #8. Housing Education & Legal Assistance—Workshops - Cost	29,243.33	28,793.44	15,746.41	15,296.51	14,846.62	14,846.62	$118,772.92
Category 3 Del #8. Housing Education & Legal Assistance--Workshops	65.00	64.00	35.00	34.00	33.00	33.00	264.00
Category 4 Del #8. Housing Education & Legal Assistance--individual legal assistance - Cost	98,280	[redacted]	[redacted]	21,060.00	[redacted]	[redacted]	$159,705.00

Costs and Aggregate Utilization for Quarters 1 and 2							
FFS	**Month 1**	**Month 2**	**Month 3**	**Month 4**	**Month 5**	**Month 6**	**Total**
Category 4 Del #8. Housing Education & Legal Assistance--individual legal assistance	56.00	[redacted]	[redacted]	12.00	[redacted]	[redacted]	91
Category 5 Del #10. Client Move-In funds - Cost							$184,248.00
Category 5 Del #10. Client Move-In funds							51.18
Category 6 Del #10. Housing Locator/Landlord fund - Cost							$732,105.00
Category 6 Del #10. Housing Locator/Landlord fund							374.00
Category 31 Del #10c. Short-Term Housing Assistance Fund - eligible expenses per client cost							[redacted]

Costs and Aggregate Utilization for Quarters 1 and 2							
FFS	**Month 1**	**Month 2**	**Month 3**	**Month 4**	**Month 5**	**Month 6**	**Total**
Category 31 Del #10c. Short-Term Housing Assistance Fund - eligible expenses per client	0	0	0	[redacted]	[redacted]	[redacted]	[redacted]
Category 7 Del #14. Sobering Center-bed days - Cost	85,158.34	76,307.61	74,872.36	72,241.06	77,742.86	73,676.31	$459,998.53
Category 7 Del #14. Sobering Center-bed days	356.00	319.00	313.00	302.00	325.00	308.00	1,923.00
Category 8 Del #15. SUD Diversion - Hours on assessments, - Cost	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	$9,400.79
Category 8 Del #15. SUD Diversion - Hours on assessments	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	41
Category 9 Del #15. SUD Diversion - court visit encounters - Cost	15,591.61	10,088.69	13,298.73	12,610.86	10,547.27	10,317.98	$72,455.14

Costs and Aggregate Utilization for Quarters 1 and 2							
FFS	**Month 1**	**Month 2**	**Month 3**	**Month 4**	**Month 5**	**Month 6**	**Total**
Category 9 Del #15. SUD Diversion - court visit encounters	68.00	44.00	58.00	55.00	46.00	45.00	316.00
Category 10 Del #15. SUD Diversion - drug testing w/ Care Manager contact - Cost							$30,667.39
Category 10 Del #15. SUD Diversion - drug testing w/ Care Manager contact	88.00	79.00	108.00	74.00	103.00	83.00	535.00
Category 11 Del #16 Portals to Substance Use Disorder Treatment – Linkage - Cost	4,184.80	3,564.83	3,874.81	3,409.84	3,874.81	2,634.87	$21,543.97
Category 11 Del #16 Portals to Substance Use Disorder Treatment - Linkage	27	23	25	22	25	17	139

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 Portals to Substance Use Disorder Treatment – helpline - Cost							$29,552.24
Category 12 Del #16 Portals to Substance Use Disorder Treatment – helpline	86.00	97.00	95.00	94.00	102.00	98.00	572
Category 13 Del #16 Portals to Substance Use Disorder Treatment - in person assessments - Cost	0.00	0.00	0.00	0.00	0.00	0.00	$0.00
Category 13 Del #16 Portals to Substance Use Disorder Treatment - in person assessments	0.00	0.00	0.00	0.00	0.00	0.00	0

Costs and Aggregate Utilization for Quarters 1 and 2							
FFS	**Month 1**	**Month 2**	**Month 3**	**Month 4**	**Month 5**	**Month 6**	**Total**
Category 32 Del #16d. Portals to SUD Treatment - Helpline Care Navigation Contacts – hours- Cost							$6,457.92
Category 32 Del #16d. Portals to SUD Treatment - Helpline Care Navigation Contacts	19	27	42	44	57	61	250
Category 14 Del #18b. Psychiatric Consultations for PCPs - curbside consults - Cost	20,022.49	21,416.00	27,870.14	22,516.14	25,009.78	22,809.51	$139,644.06
Category 14 Del #18b. Psychiatric Consultations for PCPs - curbside consults	273.00	292.00	380.00	307.00	341.00	311.00	1,904
Category 15 Del #18b. Psychiatric Consultations for PCPs - chart reviews - Cost	24,496.38	17,822.22	17,015.45	18,628.99	16,575.40	15,181.89	$109,720.33

Costs and Aggregate Utilization for Quarters 1 and 2							
FFS	**Month 1**	**Month 2**	**Month 3**	**Month 4**	**Month 5**	**Month 6**	**Total**
Category 15 Del #18b. Psychiatric Consultations for PCPs - chart reviews	334.00	243.00	232.00	254.00	226.00	207.00	1,496
Category 16 Del #18b. Psychiatric Consultations for PCPs - one-on-one staff meetings - Cost	9,901.80	8,526.55	8,581.56	9,736.77	8,691.58	7,756.41	$53,194.67
Category 16 Del #18b. Psychiatric Consultations for PCPs - one-on-one staff meetings	180.00	155.00	156.00	177.00	158.00	141.00	967
Category 17 Del #18b. Psychiatric Consultations for PCPs - elbow support - Cost	16,502.03	20,273.92	21,216.89	16,973.51	26,403.24	19,802.43	$121,172.03
Category 17 Del #18b. Psychiatric Consultations for PCPs - elbow support	35.00	43.00	45.00	36.00	56.00	42.00	257

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	40,924.96	27,723.36	23,762.88	23,762.88	21,122.56	17,162.08	$154,458.72
Category 18 Del #18b. Psychiatric Consultations for PCPs - training presentations	31.00	21.00	18.00	18.00	16.00	13.00	117
Category 19 Del #19. Completed IBH Care Coordination for patients at FQHC- Cost	55,002.92	40,355.96	52,954.39	59,202.40	63,709.15	49,062.19	$320,287.01
Category 19 Del #19. Completed IBH Care Coordination for patients at FQHC	537.00	394.00	517.00	578.00	622.00	479.00	3,127
Category 20 Del #20b. BH Medical Homes - Nurse Care Coordinators- referrals- Cost	10,495.55	10,032.51	16,206.36	15,743.32	11,575.97	14,199.86	$78,253.57

Costs and Aggregate Utilization for Quarters 1 and 2							
FFS	**Month 1**	**Month 2**	**Month 3**	**Month 4**	**Month 5**	**Month 6**	**Total**
Category 20 Del #20b. BH Medical Homes - Nurse Care Coordinators- referrals	68.00	65.00	105.00	102.00	75.00	92.00	507.00
Category 21 Del #20b. BH Medical Homes - Nurse Care Coordinators- primary care meetings- Cost	4,683.56	[redacted]	10,218.67	5,960.89	8,089.78	8,941.33	[redacted]
Category 21 Del #20b. BH Medical Homes - Nurse Care Coordinators- primary care meetings	11.00	[redacted]	24.00	14.00	19.00	21.00	[redacted]
Category 22 Del #20b. BH Medical Homes - Nurse Care Coordinators- clinic debrief sessions- Cost	4,683.61	[redacted]	9,367.21	5,960.95	8,515.65	8,515.65	[redacted]

Costs and Aggregate Utilization for Quarters 1 and 2							
FFS	**Month 1**	**Month 2**	**Month 3**	**Month 4**	**Month 5**	**Month 6**	**Total**
Category 22 Del #20b. BH Medical Homes - Nurse Care Coordinators-clinic debrief sessions	11.00	[redacted]	22.00	14.00	20.00	20.00	[redacted]
Category 23 Del #20b. BH Medical Homes - Nurse Care Coordinators-psychiatrist meetings- Cost	[redacted]	[redacted]	6,812.44	[redacted]	7,664.00	5,109.33	$29,804.44
Category 23 Del #20b. BH Medical Homes - Nurse Care Coordinators-psychiatrist meetings	[redacted]	[redacted]	16.00	[redacted]	18.00	12.00	70.00
Category 24 Del #20c. BH Medical Homes - Patient Navigators-primary care meetings- Cost	3,438.98	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	$17,194.91

Costs and Aggregate Utilization for Quarters 1 and 2							
FFS	**Month 1**	**Month 2**	**Month 3**	**Month 4**	**Month 5**	**Month 6**	**Total**
Category 24 Del #20c. BH Medical Homes - Patient Navigators- primary care meetings	10.00	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	50.00
Category 25 Del #20c. BH Medical Homes - Patient transport referrals- Cost	[redacted]	3,537.27	4,716.36	3,537.27	3,144.24	6,157.47	[redacted]
Category 25 Del #20c. BH Medical Homes - Patient transport referrals	[redacted]	27.00	36.00	27.00	24.00	47.00	[redacted]
Category 26 Del #20c. BH Medical Homes - Patient Navigators- Wellness Class Coordination- Cost	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	$6,157.47

Costs and Aggregate Utilization for Quarters 1 and 2							
FFS	**Month 1**	**Month 2**	**Month 3**	**Month 4**	**Month 5**	**Month 6**	**Total**
Category 26 Del #20c. BH Medical Homes - Patient Navigators- Wellness Class Coordination	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	47.00
Category 27 Del #20c. BH Medical Homes - Patient Navigators- psychiatrist meetings- Cost	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	$13,068.48
Category 27 Del #20c. BH Medical Homes - Patient Navigators- psychiatrist meetings	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	38.00
Category 33 Del #48. Medical Respite Program - bed days cost	0.00	0.00	0.00	0.00	0.00	0.00	$0.00
Category 33 Del #48. Medical Respite Program - bed days	0.00	0.00	0.00	0.00	0.00	0.00	0.00

Costs and Aggregate Utilization for Quarters 1 and 2							
FFS	**Month 1**	**Month 2**	**Month 3**	**Month 4**	**Month 5**	**Month 6**	**Total**
Category 34 Del #49. Benefits Enrollment and Advocacy - encounters at hard-to-access locations cost	0.00	0.00	0.00	0.00	0.00	0.00	$0.00
Category 34 Del #49. Benefits Enrollment and Advocacy - encounters at hard-to-access locations	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Category 35 Del #49. Benefits Enrollment and Advocacy - encounters at accessible locations cost	0.00	0.00	0.00	0.00	0.00	0.00	$0.00
Category 35 Del #49. Benefits Enrollment and Advocacy - encounters at accessible locations	0.00	0.00	0.00	0.00	0.00	0.00	0.00

Costs and Aggregate Utilization for Quarters 1 and 2							
FFS	**Month 1**	**Month 2**	**Month 3**	**Month 4**	**Month 5**	**Month 6**	**Total**
Del #57. Clinical, technical consultation - individual consultations cost							$0.00
Del #57. Clinical, technical consultation - individual consultations							0.00
Del #57. Clinical, technical consultation-organizational meetings cost							$0.00
Del #57. Clinical, technical consultation-organizational meetings							0.00
Del #57. Clinical, technical consultation - elbow support/coaching cost							$0.00

Costs and Aggregate Utilization for Quarters 1 and 2							
FFS	**Month 1**	**Month 2**	**Month 3**	**Month 4**	**Month 5**	**Month 6**	**Total**
Del #57. Clinical, technical consultation - elbow support/coaching							0.00
Del #57. Clinical, technical consultation- on-site training presentations cost							$0.00
Del #57. Clinical, technical consultation- on-site training presentations							0

Costs and Aggregate Utilization for Quarters 3 and 4							
FFS	**Month 7**	**Month 8**	**Month 9**	**Month 10**	**Month 11**	**Month 12**	**Annual Total**
Category 1 Del #7. Outreach Services-hours - Cost	68,974.80	62,371.27	55,954.05	55,353.73	52,869.64	52,455.63	$347,979.12
Category 1 Del #7. Outreach Services-hours	1,666.00	1,506.50	1,351.50	1,337.00	1,277.00	1,267.00	8,405
Category 28 Del #7a. Outreach and Engagement encounters - homeless street outreach - Cost	1,350.00	150.00	150.00	0.00	0.00	0.00	$1,650.00
Category 28 Del #7a. Outreach and Engagement encounters - homeless street outreach	9.00	1.00	1.00	0.00	0.00	0.00	11.00
Category 29 Del #7a. Outreach and Engagement encounters - Home or facility outreach - Cost	[redacted]	[redacted]	0.00	[redacted]	[redacted]	0.00	$1,000.00

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 29 Del #7a. Outreach and Engagement encounters - Home or facility outreach	[redacted]	[redacted]	0.00	[redacted]	[redacted]	0.00	10.00
Category 30 Del #7a. Outreach and Engagement encounters - In-reach - Cost	900.00	1000.00	[redacted]	[redacted]	[redacted]	[redacted]	$2,950.00
Category 30 Del #7a. Outreach and Engagement encounters - In-reach	18.00	20.00	[redacted]	[redacted]	[redacted]	[redacted]	59.00
Category 2 Del #8. Housing Education & Legal Assistance--Call Center cases-Cost	17,059.50	12,240.00	10,021.50	12,393.00	19,431.00	14,994.00	$86,139.00

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 2 Del #8. Housing Education & Legal Assistance--Call Center cases	223.00	160.00	131.00	162.00	254.00	196.00	1,126
Category 3 Del #8. Housing Education & Legal Assistance—Workshops - Cost	15,296.51	14,846.62	14,846.62	14,846.62	15,746.41	14,846.62	$90,429.38
Category 3 Del #8. Housing Education & Legal Assistance--Workshops	34.00	33.00	33.00	33.00	35.00	33.00	201.00
Category 4 Del #8. Housing Education & Legal Assistance--individual legal assistance - Cost	31,590.00	[redacted]	24,570.00	19,305.00	[redacted]	[redacted]	$117,585.00

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 4 Del #8. Housing Education & Legal Assistance--individual legal assistance	18.00	[redacted]	14.00	11.00	[redacted]	[redacted]	67.00
Category 5 Del #10. Client Move-In funds - Cost							$255,357.00
Category 5 Del #10. Client Move-In funds							70.93
Category 6 Del #10. Housing Locator/Landlord fund - Cost							$156,600.00
Category 6 Del #10. Housing Locator/Landlord fund							80

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 31 Del #10c. Short-Term Housing Assistance Fund - eligible expenses per client cost							$239,949.00
Category 31 Del #10c. Short-Term Housing Assistance Fund - eligible expenses per client	[redacted]	[redacted]	[redacted]	16	11	[redacted]	44
Category 7 Del #14. Sobering Center-bed days - Cost	83,244.66	76,786.03	60,759.04	74,633.15	55,018.03	65,064.80	$415,505.70
Category 7 Del #14. Sobering Center-bed days	348.00	321.00	254.00	312.00	230.00	272.00	1,737.00
Category 8 Del #15. SUD Diversion - Hours on assessments, - Cost	[redacted]	2,522.16	2,751.45	2,980.74	3,439.31	[redacted]	$14,445.11

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 8 Del #15. SUD Diversion - Hours on assessments,	[redacted]	11.00	12.00	13.00	15.00	[redacted]	63.00
Category 9 Del #15. SUD Diversion - court visit encounters, - Cost	10,317.98	9,859.40	13,069.44	12,840.15	13,528.02	11,235.13	$70,850.12
Category 9 Del #15. SUD Diversion - court visit encounters,	45.00	43.00	57.00	56.00	59.00	49.00	309.00
Category 10 Del #15. SUD Diversion - drug testing w/ Care Manager contact - Cost							$9,345.52
Category 10 Del #15. SUD Diversion - drug testing w/ Care Manager contact	61.00	66.00	36.00	0.00	0.00	0.00	163.00

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 Portals to Substance Use Disorder Treatment – Linkage - Cost	3,719.82	2,014.90	1,704.92	2,789.87	2,479.88	1,859.91	$14,569.30
Category 11 Del #16 Portals to Substance Use Disorder Treatment - Linkage	24.00	13.00	11.00	18.00	16.00	12.00	94.00
Category 12 Del #16 Portals to Substance Use Disorder Treatment – helpline - Cost							$28,983.93
Category 12 Del #16 Portals to Substance Use Disorder Treatment – helpline	103	89	90	113	95	71	561

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 13 Del #16 Portals to Substance Use Disorder Treatment - in person assessments - Cost	0.00	0.00	0.00	0.00	0.00	0.00	$0.00
Category 13 Del #16 Portals to Substance Use Disorder Treatment - in person assessments	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Category 32 Del #16d. Portals to SUD Treatment - Helpline Care Navigation Contacts – hours - Cost							$8,343.82

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 32 Del #16d. Portals to SUD Treatment - Helpline Care Navigation Contacts – hours - hours	49.00	33.00	65.00	36.00	80.00	60.00	323.00
Category 14 Del #18b. Psychiatric Consultations for PCPs - curbside consults - Cost	16,062.00	12,834.93	17,675.54	16,648.74	14,668.49	13,128.30	$91,018.00
Category 14 Del #18b. Psychiatric Consultations for PCPs - curbside consults	219	175	241	227	200	179	1,241
Category 15 Del #18b. Psychiatric Consultations for PCPs - chart reviews - Cost	18,042.25	19,655.78	14,961.86	18,628.99	13,861.73	10,708.00	$95,858.61
Category 15 Del #18b. Psychiatric Consultations for PCPs - chart reviews	246	268	204	254	189	146	1,307

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. Psychiatric Consultations for PCPs - one-on-one staff meetings - Cost	7,261.32	11,002.00	8,691.58	9,736.77	11,222.04	7,756.41	$55,670.12
Category 16 Del #18b. Psychiatric Consultations for PCPs - one-on-one staff meetings	132	200	158	177	204	141	1,012
Category 17 Del #18b. Psychiatric Consultations for PCPs - elbow support - Cost	[redacted]	0.00	[redacted]	0.00	[redacted]	0.00	$6,129.32
Category 17 Del #18b. Psychiatric Consultations for PCPs - elbow support	[redacted]	0	[redacted]	0	[redacted]	0	13

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 18 Del #18b. Psychiatric Consultations for PCPs - training presentations - Cost	[redacted]	[redacted]	26,403.20	18,482.24	15,841.92	[redacted]	$89,770.88
Category 18 Del #18b. Psychiatric Consultations for PCPs - training presentations	[redacted]	[redacted]	20	14	12	[redacted]	68
Category 19 Del #19. Completed IBH Care Coordination for patients at FQHC- Cost	61,763.05	70,981.42	59,816.95	64,630.99	54,490.79	62,480.04	$374,163.24
Category 19 Del #19. Completed IBH Care Coordination for patients at FQHC	603.00	693.00	584.00	631.00	532.00	610.00	3,653.00

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 20 Del #20b. BH Medical Homes - Nurse Care Coordinators- referrals- Cost	12,965.09	13,736.82	12,347.70	10,495.55	12,502.05	14,045.51	$76,092.72
Category 20 Del #20b. BH Medical Homes - Nurse Care Coordinators- referrals	84.00	89.00	80.00	68.00	81.00	91.00	493.00
Category 21 Del #20b. BH Medical Homes - Nurse Care Coordinators- primary care meetings- Cost	6,386.67	6,386.67	7,664.00	0.00	7,238.22	6,812.44	[redacted]
Category 21 Del #20b. BH Medical Homes - Nurse Care Coordinators- primary care meetings	15.00	15.00	18.00	0.00	17.00	16.00	[redacted]

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 22 Del #20b. BH Medical Homes - Nurse Care Coordinators- clinic debrief sessions- Cost	6,386.74	8,515.65	8,941.43	0.00	7,238.30	6,812.52	[redacted]
Category 22 Del #20b. BH Medical Homes - Nurse Care Coordinators- clinic debrief sessions	15.00	20.00	21.00	0.00	17.00	16.00	[redacted]
Category 23 Del #20b. BH Medical Homes - Nurse Care Coordinators- psychiatrist meetings- Cost	[redacted]	5,109.33	6,386.67	0.00	5,535.11	5,109.33	[redacted]

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 23 Del #20b. BH Medical Homes - Nurse Care Coordinators- psychiatrist meetings	[redacted]	12.00	15.00	0.00	13.00	12.00	[redacted]
Category 24 Del #20c. BH Medical Homes - Patient Navigators- primary care meetings- Cost	[redacted]	0.00	[redacted]	[redacted]	[redacted]	[redacted]	$13,755.93
Category 24 Del #20c. BH Medical Homes - Patient Navigators- primary care meetings	[redacted]	0.00	[redacted]	[redacted]	[redacted]	[redacted]	40.00
Category 25 Del #20c. BH Medical Homes - Patient transport referrals- Cost	6,026.46	[redacted]	[redacted]	3,013.23	3,275.25	2,751.21	$17,031.30

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. BH Medical Homes - Patient transport referrals	46.00	[redacted]	[redacted]	23.00	25.00	21.00	130.00
Category 26 Del #20c. BH Medical Homes - Patient Navigators- Wellness Class Coordination- Cost	[redacted]	0.00	1,572.12	[redacted]	[redacted]	[redacted]	$6,157.47
Category 26 Del #20c. BH Medical Homes - Patient Navigators- Wellness Class Coordination	[redacted]	0.00	12.00	[redacted]	[redacted]	[redacted]	47.00
Category 27 Del #20c. BH Medical Homes - Patient Navigators- psychiatrist meetings- Cost	[redacted]	0.00	[redacted]	[redacted]	[redacted]	[redacted]	$10,317.22

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 27 Del #20c. BH Medical Homes - Patient Navigators-psychiatrist meetings	[redacted]	0.00	[redacted]	[redacted]	[redacted]	[redacted]	30.00
Category 33 Del #48. Medical Respite Program - bed days cost	0.00	0.00	3,500.00	10,250.00	18,250.00	40,500.00	$72,500.00
Category 33 Del #48. Medical Respite Program - bed days	0.00	0.00	14.00	41.00	73.00	162.00	290.00
Category 34 Del #49. Benefits Enrollment and Advocacy - encounters at hard-to-access locations cost	0.00	0.00	0.00	0.00	0.00	0.00	$0.00

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 34 Del #49. Benefits Enrollment and Advocacy - encounters at hard-to-access locations	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Category 35 Del #49. Benefits Enrollment and Advocacy - encounters at accessible locations cost	0.00	0.00	0.00	0.00	[redacted]	0.00	[redacted]
Category 35 Del #49. Benefits Enrollment and Advocacy - encounters at accessible locations	0.00	0.00	0.00	0.00	[redacted]	0.00	[redacted]
Del #57. Clinical, technical consultation - individual consultations cost							$82,620

Costs and Aggregate Utilization for Quarters 3 and 4							
FFS	**Month 7**	**Month 8**	**Month 9**	**Month 10**	**Month 11**	**Month 12**	**Annual Total**
Del #57. Clinical, technical consultation - individual consultations							340
Del #57. Clinical, technical consultation-organizational meetings cost							$34,020.00
Del #57. Clinical, technical consultation-organizational meetings							140
Del #57. Clinical, technical consultation - elbow support/coaching cost							$150,660.00
Del #57. Clinical, technical consultation - elbow support/coaching							155

Costs and Aggregate Utilization for Quarters 3 and 4							
FFS	**Month 7**	**Month 8**	**Month 9**	**Month 10**	**Month 11**	**Month 12**	**Annual Total**
Del #57. Clinical, technical consultation- on-site training presentations cost							$0.00
Del #57. Clinical, technical consultation- on-site training presentations							0

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	60,018.09	60,980.94	70,930.47	79,275.23	86,015.23	88,903.80	446,123.74
Del #2. Care Management Service Bundle - Tier 1 MM Counts		187.00	190.00	221.00	247.00	268.00	277.00	1390.00
Del #2. Care Management Service Bundle - Tier 2	$473.96	69,197.50	68,249.59	80,572.43	84,364.07	10,2848.34	93,843.18	499,075.12
Del #2. Care Management Service Bundle - Tier 2 MM Counts		146.00	144.00	170.00	178.00	217.00	198.00	1053.00
Del #12c: Health, Housing and Integrated Service Bundle - Tier 1	$300.00	30,000.00	28,800.00	29,400.00	35,100.00	34,500.00	36,000.00	193,800.00

Amount Claimed								
PMPM	**Rate**	**Month 1**	**Month 2**	**Month 3**	**Month 4**	**Month 5**	**Month 6**	**Total**
Del #12c: Health, Housing and Integrated Service Bundle - Tier 1		100.00	96.00	98.00	117.00	115.00	120.00	646.00
Del #12c: Health, Housing and Integrated Service Bundle - Tier 2	$400.00	114,400.00	122,800.00	116,000.00	122,000.00	120,400.00	130,400.00	726,000.00
Del #12c: Health, Housing and Integrated Service Bundle - Tier 2		286.00	307.00	290.00	305.00	301.00	326.00	1815.00
Del #12c: Health, Housing and Integrated Service Bundle - Tier 3	$575.00	128,225.00	140,875.00	163,875.00	166,175.00	157,550.00	167,900.00	924,600.00

Amount Claimed								
PMPM	**Rate**	**Month 1**	**Month 2**	**Month 3**	**Month 4**	**Month 5**	**Month 6**	**Total**
Del #12c: Health, Housing and Integrated Service Bundle - Tier 3		223.00	245.00	285.00	289.00	274.00	292.00	1608.00
Del. #46b Trust Health Center Street Psychiatric Team	$1,353.00	74,415.00	81,180.00	89,298.00	89,298.00	48,708.00	52,767.00	435,666.00
Del. #46b Trust Health Center Street Psychiatric Team		55.00	60.00	66.00	66.00	36.00	39.00	322.00

Amount Claimed								
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	25,355.23	24,713.33	25,355.23	28,885.71	27,922.85	25,997.14	158,229.50
Del #2. Care Management Service Bundle - Tier 1 MM Counts		79.00	77.00	79.00	90.00	87.00	81.00	493.00
Del #2. Care Management Service Bundle - Tier 2	$473.96	36,494.57	40,286.22	40,760.17	41,234.13	40,760.17	43,603.90	243,139.16
Del #2. Care Management Service Bundle - Tier 2 MM Counts		77.00	85.00	86.00	87.00	86.00	92.00	513.00
Del #12c: Health, Housing and Integrated Service Bundle - Tier 1	$300.00	40,800.00	40,200.00	40,200.00	40,500.00	40,500.00	39,300.00	241,500.00

Amount Claimed								
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		136.00	134.00	134.00	135.00	135.00	131.00	805.00
Del #12c: Health, Housing and Integrated Service Bundle - Tier 2	$400.00	143,200	149,200	160,400	164,000	162,800	168,000	947,600
Del #12c: Health, Housing and Integrated Service Bundle - Tier 2		358.00	373.00	401.00	410.00	407.00	420.00	2369.00
Del #12c: Health, Housing and Integrated Service Bundle - Tier 3	$575.00	185,725	190,900	188,025	182,850	181,700	177,675	1,106,875
Del #12c: Health, Housing and Integrated		323.00	332.00	327.00	318.00	316.00	309.00	1,925.00

Amount Claimed								
PMPM	**Rate**	**Month 7**	**Month 8**	**Month 9**	**Month 10**	**Month 11**	**Month 12**	**Total**
Service Bundle - Tier 3								
Del. #46b Trust Health Center Street Psychiatric Team	$1,353.00	36,531.00	3,5178.00	33,825.00	18,942.00	[redacted]		148,830.00
Del. #46b Trust Health Center Street Psychiatric Team		27.00	26.00	25.00	14.00	[redacted]	[redacted]	110.00

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

1. Some of Alameda County's Fee for Services are delivered to staff rather than clients in order to improve the capacity, skills, and quality of care provided through the system; others are for clients, but client names are not reported. Because these services are not client-specific, these categories will not appear in the client-level Enrollment and Utilization Report, but are included in the above Aggregate Utilization section of the Narrative and claimed in the Annual invoice. See the WPC_Comments tab in the EU report for details.
2. FFS Category #5 (Del #10 Client Move-In funds) and FFS Category #6 (Del #10 Housing Locator/Landlord funds): Monthly amounts aren't available, so the total claimed for each six-month period is reported. The units are derived by the dividing the total amount by the rate.
3. FFS Category #10 (Del #15. SUD Diversion - Drug testing w/ Care Manager contact, hours): Each testing period is 15 minutes. The units reported are the number of tests, while the cost represents the cost per hour (4 tests/hour) as reflected in the invoice.
4. FFS Category #12 (Del. #16 Portals to Substance Use Disorder Treatment – helpline, hours): Each call is a 20-minute event. The units reported are the number of calls, while the cost is calculated in hours (3 calls/hour) as reflected in the invoice.
5. FFS Category #32 (Del #16d. Helpline Care Navigation Contacts – hours): Each contact is 10 minutes each. The units reported are the number of contacts, while the cost is calculated in hours (6 contacts/hour) as reflected in the invoice.
6. Del #57 Clinical and Technical Consultation for Direct Service Providers; Not client specific.

IV. NARRATIVE – Administrative Infrastructure

Instructions: 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. Please limit your responses to 500 words.

The Alameda County Care Connect Administrative Infrastructure generally funds the Backbone Organization, which is what we call the entity that is driving the project. This includes staff and expenses for overall administrative functions and leadership and management of housing services, care coordination, capacity development, and the development of the data exchange. The BBO is responsible for program management, including reporting, governance, and stakeholder and partner engagement; leads planning; and ensures consumer involvement in program development. The work of the BBO is reflected in the accomplishments reported throughout this report. The Stakeholder engagement table in section VIII illustrates our level of participation from multiple sectors.

DEL #5 Housing Solutions for Health (HS4H)

Housing Solutions for Health, a multi-departmental team of the County Health Care Services Agency, works in partnership with the County's Housing and Community Development Department, EveryOne Home (the County's Continuum of Care entity) and the County's Homelessness Roundtable, to improve the Housing Crisis Response System for all housing and homeless services within the County. The County and cities, HUD and Whole Person Care jointly fund regional Housing Resource Centers (HRCs) and the countywide call center for the Housing Crisis Response System, along with the many services that flow through them (see section V Del #42a).

Through 2019, we have focused on improvement of regional coordination, policies and procedures, workflows, access to health and other social services, as well as data collection and reporting.

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

- **Expanding regional homeless outreach teams across the county.** The Housing Solutions for Health team has been working closely with Alameda County's Health Care for the Homeless program to plan for new multi-disciplinary Street Health

Outreach teams across the county that are regionally-based and comprise an RN, a social worker and 1-2 community outreach workers. This new model will be funded in part with FFS dollars earned in Deliverable 7a, along with state and local funds. The new teams will begin in early 2020.

- **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," meaning they have the documents required to access publicly-funded housing opportunities; and 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).
- **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.
- **Building out the Homelessness Management Information System** (HMIS) in partnership with the County's Oversight committee and the HMIS team. Custom configuration is ongoing and is closely linked with data integration efforts of the Care Connect Social Health Information Exchange/ Community Health Record. Data management has improved, along with storing of documents, and the process for data collection has been revised. During the last quarter of 2019, there was a shift to using HMIS for data entry on AC Care Connect clients. This required a lot of staff training and data entry work, but the result is more complete client data that is easier to track and update.
- **Addressing homelessness in the unincorporated parts of Alameda County**, working with our colleagues at the County Housing and Community Development department. The Safe Parking pilot program is one part of this effort.
- **Launching a re-designed Housing Assistance Fund**. AC Care Connect worked with the Auditor-Controller, the Finance Department, the Consumer Fellows, and AC Housing and Community Development to develop a stream-lined way to utilize online vendors for household items and furnishings, thus removing barriers to stable housing and allowing for consumers to choose the items they want in their home. The full countywide program became available in September, 2019 and served a total of 74 households with a total of $251,656 for furniture, household items, security deposits and first month's rent.

- **Respite / Recuperative Care.** Health Care Services Agency has identified recuperative care for individuals experiencing homelessness as a critical and expensive gap that results in administrative bed days for hospitals, and people being discharged to unsafe locations. This contributes to unnecessary readmissions and emergency department visits. Following months of planning, respite services began in the last quarter of 2019. Thirteen individuals were served in respite beds in 2019 and additional planning for more capacity is being planned.

DEL #26-29 Data Exchange Unit and Community Health Record

During this reporting period, AC Care Connect accelerated the implementation and development of the Social Health Information Exchange / Community Health Record (SHIE/CHR). We completed the Wave 1 go-live and onboarding of 11 organizations,

representing 135 end-users. This work included training material development, hands-on training sessions as well as onsite elbow support. A helpdesk ticket system was set up and helpdesk staff was trained to support end users of the CHR. A monthly Super User Workgroup was established for ongoing education, communications and feedback. Regulatory compliance education associated with the complex data security/consent processes in the CHR is ongoing.

Over the second half of 2019, the Data Governance Committee (DGC) finalized its charter and agreed to expand membership from 11 to 15 voting members, specifically identifying three of the four new members (i.e., Director of Alameda County Public Health, Alameda County Director of Social Services and a housing community-based organization). The DGC made significant edits to evolve the Health Data Repository Data Sharing Agreement from the prototype CHR to the CHR and to accommodate the needs of new participating organizations. The DGC also reviewed and analyzed several data privacy and security documents to ensure compliance with the Data Sharing Agreement. It made final edits to the Information Sharing Authorization and approved the Substance Use Disorder (SUD) Release of Information (ROI). The DGC also approved the SHIE Operational Policies and Procedures, Shared Care Plan Procedures, the Security Audit Plan, and updates the Data Privacy Management Plan.

With the SHIE established, AC Care Connect also launched a new business intelligence and reporting unit to support internal stakeholders in the areas of operations, communications and program management as well as external stakeholders (within compliance guidelines per the DGC). AC Care Connect has already started to receive a few inquiries for this data resource from a variety of organizations, from existing AC Care Connect partners to education and research institutions.

More than 80 users from seven organizations are continuing to use the pCHR and experiencing the value of shared information. We anticipate that these pCHR users will be fully transitioned to the CHR in the 1st quarter of 2020. Best practices from these experiences were applied to the development of user workflows, security and privacy protections, reporting and analytics, and training in the implementation of the CHR.

Del #31 Backbone Organization (BBO)

During the second half of 2019, the BBO continued implementation of new services, including recuperative care/respite beds, outreach and engagement, and a stream-lined housing assistance fund and benefits enrollment. These new services are described in more detail in the appropriate sections. These new services are designed with the intention of permanently changing the way services are delivered to people without homes and other vulnerable people in Alameda County.

Planning for continuity of the successful services and infrastructure changes past the end of the waiver has been a major focus for the BBO. Care Connect has provided analysis and recommendations to senior leadership regarding: 1) effective Care Connect components that should be sustained, 2) costs and benefits, both financial and otherwise, 3) necessary on-going resources, and how they may be obtained, and 4) strategies to develop support from stakeholders to make the system changes last into the future. We are engaging internal and external subject matter experts, county staff, and local leaders to drive this collaborative planning forward.

Del 32 Health Care Systems Planning and Improvement Division

Health Care System Planning and Improvement Division (HCSPI) is the part of the BBO that is responsible for “human infrastructure,” which refers to both skills development and the relationship-building necessary to make changes happen. We work at the system, organizational and individual levels.

Skills Development

On the training side, the Backbone Organization (BBO) with the Skills Development Unit (SDU), maintained and refined the Care Connect Academy (see Del #36, below, and section VII, Del #55). The SDU also focused on sustainability efforts in conjunction with the BBO.

Between July and December 2019, the Skills Development Unit (SDU) continued to scale and maintain training academies and curricula for a wide range of service

providers. The BBO identified a new need to create a "New Hire Academy" in which providers new to their respective organizations would receive an orientation to the landscape of Alameda County and to the front doors of most sectors. The SDU conducted research and put a together a plan that will be implemented in early 2020. With regard to sustainability planning, the SDU created a new training that offers our Training of the Trainers (TOT) cohort to further expand on their training facilitation skills, thereby supporting our newest trainers and also our future workforce.

Care Communities

During 2019, we developed the design of a new care coordination promotion strategy that we have named Care Communities, which launched in July 2019. The goal is to have three distinct Care Communities, each running for 6 months with 10-12 provider organizations focused around a shared set of clients (e.g., on the by-name-housing list in Oakland, frequent users of psychiatric emergency, etc.). The purpose is to build relational and process bridges between the participants and organizations, improve processes for working together both with and without electronic data sharing support,

and solve a few prioritized issues to heal some of their greatest pain points in serving the AC Care Connect population.

Care Community 1 took place from July to December 2019. The intervention was designed to establish a foundation to improve and sustain care coordination across sectors by having a diverse group of providers (front line staff and leaders) attend twice-monthly three-hour collaborative sessions; engage in interim check-ins at their organization with their assigned Care Connect advocate to receive county-level insight and problem solving support; and work on PDCA projects at their organization tied to each of the three Care Community focus areas: housing resource centers (HRCs), shared care planning and Medi-Cal. Participants represented ten organizations and three health plans serving consumers with complex needs in Alameda County. Participating organizations – with the exception of the health plans – were financially incentivized to take part. The sectors represented were housing, primary care, community-based care management entities (CB-CME), behavioral health, and SUD.

Key-informant interviews conducted by a third party grouped the value of the Care Community experience to providers into three areas – Knowledge, Feelings, and Attitudes and Beliefs. Providers noted the lack of available training to understand county systems and available resources. Key informants shared that, prior to Care Community, they held unrealistic expectations of other organizations and the county stemming from ignorance around processes and available resources. The Care Community experience shifted attendees to a more solution-oriented, systemic perspective. They reported a

new appreciation for just how hard the system is to navigate, and therefore they believe part of their role is to help set realistic expectations for clients. One participant stated: “It helped blur the line between housing and healthcare and helped us bridge the gap so people get what they need – both medical and behavioral health support.”

Concurrent with implementing Care Community 1, our team began intensive planning for Care Community 2 starting in late October 2019. Care Community 2 is set to launch in January 2020 and will focus on using the Community Health Record, a resource-

sharing tool called Elemeno, and individuals who are frequent utilizers of Psychiatric Emergency Services (PES).

Del #33 Communications

In the second half of Program Year 4, the emphasis continued to be on developing communications resources to support clear, consistent messaging. With the launch of Care Community 1 in July and Wave 1 implementation of the CHR in September, engagement in Care Connect increased and more stakeholder organizations became

involved. The focus was on developing a coordinated communications plan supported by a variety of products tailored to different audiences’ information needs. Selected communications-related activities, products, and highlights during this period include:

Communications materials and tools were developed to support the CHR go-live including the CHR Help Desk launch, in-person training, and web-based video training. In December, in preparation for Wave 2, the training was redesigned to be organization-specific instead of sector-specific

Care Connect staff, consumers, and Care Connect evaluator, Bright Research Group, presented at the annual conference of the National Center for Complex Health and Social Needs, Putting Care at the Center, on the role of the Fellowship in providing input into service delivery design.

Drawing on feedback from Consumer Fellows and stakeholders at Alameda County Behavioral Health, Crisis Connect created a lanyard for consumers to use to keep follow-up and other important information safe, secure, and easily accessible. This addresses the concern that, especially for clients experiencing homelessness, brochures often get wet and lost.

To ensure that consumers in unincorporated areas received information on, and were connected to, services and outreach prior to an abatement by Cal Trans, AC Care

Connect collaborated with county partners on two multi-service pop-up events at a large encampment in Castro Valley.

Del #34 Care Coordination System Oversight & Administration

AC Care Connect has partnered closely with the local Medi-Cal managed care organizations on Health Homes implementation. The focus of the work has been on scaling operations, capacity development of the Community-Based Care Management Entity (CB-CME) network, and expansion of the CB-CME network with the new opportunity to include individuals diagnosed with a serious mental illness (SMI) population beginning in January 2020.

The Care Connect care management bundle model intentionally mirrored the service set and provider network for the upcoming Health Homes Program, offering the same services to two distinct populations, Care Connect and HHP. Our purpose in doing this

was to maximize the sustainability of the services by supporting the Health Homes Program's success. Care Connect has worked closely with the managed care plans in Alameda County to support the development, launch, and improvement of this model after the initial year-long pilot phase. In June 2019, Care Connect and the Managed Care Plans jointly decided that when a client is eligible for and could appropriately be

billed to either program (Care Connect or HHP), they will be assigned to HHP and not billed to Whole Person Care. As a result, we saw a significant decrease in bundle enrollees from 475 in June 2019 to 156 in July 2019.

Throughout the pilot, Care Connect has supported the MCPs in the capacity development and skills-building of providers and CB-CMEs. Once HHP went live in July, Care Connect continued to support the managed care plans in the rollout of monthly trainings for the providers, shifting the focus from topics required for CB-CME certification and the stricter data collection and reporting requirements, to consumer engagement skills and appropriate utilization of systems.

Alameda Alliance also looked to expand their CB-CME network to include providers that support individuals who have been diagnosed with a serious mental illness. The Alliance, with connections from Care Connect, has made pretty significant headway in partnering with two Full Service Partnerships (FSPs) at Bay Area Community Services (BACS) and Abode Services. Both BACS and Abode services are slated to be up and running in early 2020.

The new FFS outreach deliverable (deliverable 7a, b, and c) that will support the CB-CMEs in engaging outreach to Care Connect eligible clients (note, this excludes Health Homes Program enrollees) went live in July 2019. In 2019, $5,750 has been expended.

CB-CMEs actively participated in the implementation of the Community Health Record (CHR). Some went live in our first cohort of organizations in October 2019, while most of the remaining CB-CMEs are scheduled for implementation in early to mid-2020.

With the release of the new proposal for CalAIM, the County began conversations with both Managed Care Plans to discuss collaboration, strategy, and next steps both as part of our sustainability plan and as part of the natural transition into the re-organization of Medi-Cal funding.

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, so this is a significant effort.

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 four sub-units are: Organizational Development and Change Management (ODCM), Quality Improvement Unit (QIU), Skills Development Unit (SDU), and Research and Dissemination Unit (RnDU). Their work is visible throughout the project in training, capacity building and PDSAs.

Organizational Development and Change Management (ODCM)

Alameda County as a whole has accelerated its work to eliminate homelessness, and the ODCM team has been supporting systems alignment and transformation work, as part of the County's homelessness action plan. As an example, the Homelessness Performance Measure Dashboard is a comprehensive tool to track the progress of homelessness projects across the system which aim to improve the housing status of individuals experiencing homelessness. These include street outreach, emergency shelter, transitional housing, rapid re-housing, and permanent supportive housing.

Information on quality of care, utilization, and the impact of Alameda County Homeless System of Care is now available.

In addition, the ODCM team has supported the planning for the Fairmont Campus Navigation Center which is slated to open in 2020. Significant multi-agency planning and strategic coordination has occurred thus far to offer respite, case management, and housing navigation to individuals experiencing homelessness. ODCM has been researching best practices and synthesizing learnings from other Navigation Center launches across the state. A Mobile Hygiene unit will also be incorporated and the ODCM team has been conducting research on program design and implementation.

Skills Development Unit (SDU)

Between July 2019 – December 2019, the Skills Development Unit supported 17 Care Connect Academy trainings with over 198 unique attendees from 61 organizations. The top three sectors represented were: housing (32%), community-based social services (26%), and ambulatory care (24%). Over the entire calendar year of 2019, the Skills Development Unit supported a total of 41 Care Connect Academy trainings with 475 unique attendees from 85 organizations. In 2019 compared to 2018, participant

composition shifted from ambulatory care as the primary sector to housing. Increased participation of substance use treatment organizations was also noted, from two organizations in 2018 to 31 substance use treatment organizations in 2019.

Topics included Accessing Primary Care 101, Accessing Substance Use Disorder Services, Behavioral Health & Medical Crisis Response, Cultural Humility and Affirmative Practices, Housing Coordinated Entry, Mental Health First Aid, among others. Training of Trainers modules included Social Determinants of Health and Trauma Informed Care. Care Connect Academy evaluation found that participants felt

that trainings were extremely helpful and loved having access to subject matter experts. Participants also appreciate the opportunities to network and to learn skills pertinent to their current roles and those to support their colleagues and clients.

From July – December 2019, the SDU developed several new trainings in addition to rolling out with a web-based training to support distance learning (which has become particularly useful in 2020 given shelter-in-place orders to curb the spread of COVID-19). The first online training occurred in October 2019 and was an introduction to the Primary Care landscape in Alameda County. Additionally, a New Hire Academy was developed with a goal of presenting in early-2020. This 3-day training orients providers to a new way of delivering care across the system utilizing the principles of whole

person care to coordinate care across systems. A training of trainers (TOT) curriculum was also developed by SDU on Social Determinants of Health and Trauma Informed Care to support the future workforce in enduring this curriculum.

The SDU has also been engaged in sustainability efforts in preparation for the end of the WPC pilot. The SDU has interviewed key stakeholders to identify future needs for cross-sector training and skills development. As part of these efforts, the SDU is identifying resources needed, potential sources of support, and other entities that could take on training and skills development activities post-2020. In 2019, seven interviews were conducted from experts and/or executives in the housing, health plans, CBOs, safety net health systems and Human Resources departments.

Quality Improvement Unit (QIU)

The Quality Improvement Unit (QIU) served as a strategic planning partner, developed quality improvement curricula and provided coaching for all PDSA cycles for Care Communities from July 2019 - December 2019.

Care Communities (described above, Del #32) provided a bi-weekly forum for organizations supporting similar clients to engage in peer learning to develop improved care coordination practices. Participants learned and applied quality improvement

practices through various exercises including: design thinking, PDSA projects, and provider networking.

Each collaborative session focused on one common challenge for a six-week period (Working with Housing Resource Centers, Shared Care Planning and Preventing Medi-Cal Lapse).

Design thinking activities were facilitated in small groups to help participants think through their everyday processes in new ways. Participants then developed PDSA projects where they tested refined workflows to support increased communication and problem solving among providers and leveraging housing resources for their clients.

QIU coaches provided bi-weekly, on-site coaching to implement PDSA projects and to evaluate data to support workflow modifications.

Some examples include:

Intervention: Developed a Housing Resource Roadmap to inform providers of the housing assessment process, consumer journey through housing navigation.

Result: Decreased phone calls and voicemails from providers seeking information from BACS Housing Resource Center

Intervention: Included housing assessment in standard Full-Service Partnership (FSP) intake processes.

Result: 21 FSP consumers matched to housing in two months

The QIU also supported planning, provided onboarding, and post-go live support for the **Community Health Record** (CHR). From July 2019 - December 2019, the QIU participated in User Acceptance Testing (UAT) and provided feedback on end-user trainings, supported end-users by providing on-site elbow support, and implemented a CHR Super User workgroup.

User Acceptance Testing included using the system at multiple times of day, identifying glitches, and providing feedback on basic functionality and ease of use. Feedback was gathered on CHR end-user training content, length and activities. Eighteen hours of on-site elbow support was provided to end-users; this included troubleshooting common issues such as logging in, how to run reports, how to assign a care team member to a consumer, and how to create a list of consumers. Information gathered was entered into the Help Desk ticketing system and used for future training and enhancements, as applicable. The Super-User workgroup was established as a forum that gathers interested parties and the highest utilizers of the CHR to provide feedback on the tool, learn about enhancements, and share tips and tricks for everyday use.

Research and Dissemination Unit (RnDU)

The RnDU gathered and documented lessons learned and outcomes from Case Conferencing, the Information Sharing Authorization co-development process, Crisis Connect and Care Communities 1 in research briefs. This information has been instrumental for developing and improving each of these processes.

For instance, for the developmental evaluation of the first Care Community, the RnDU observed the bi-weekly convenings and documented key challenges surfaced by providers. At the conclusion of Care Communities 1, the RnDU conducted 15 key informant interviews with participants to gather insights on the implementation and

impact of the Care Communities. The findings from these interviews were used to inform planning for the second Care Community.

A survey to support our Health Care for the Homeless program in improving quality of care at local clinics utilized patient-centered measures of patient experience and

satisfaction at five community clinics. During the reporting period, the RnDU analyzed results from nearly 500 surveys, convened clinic staff and managers in a learning community format, trained clinic staff on constituent feedback, and provided the Health Care for the Homeless program with a toolkit to support the integration of these tools into their ongoing quality and performance management activities.

IV. NARRATIVE – Delivery Infrastructure

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 the Alameda County Independent Living Association (www.alamedacountyila.org), a professional association of Community Living Facility operators. 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 facilities directory with information on housing availability, and maintaining an online portal for community resources and legal regulations. The ILA also provides in-person workshops, trainings, and resources to support operators and residents.

The approach supports operators by providing resources to help modify housing structures and training to help operators engage with residents who have mental health and/or physical health disabilities. Recognizing that the Bay Area's tight housing market incentivizes community living facility owners to sell their properties, the ILA's approach is collaborative rather than punitive 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.

Accomplishments to date include:

- In August 2019, the ILA began distributing the Operation Course flyer to Alameda County's Housing Services mass email distribution list, which includes approximately 3,400 contacts, and also developed flyers marketed to the general public;
- The ILA partnered with the East Bay Rental Housing Association (EBRHA) to create access to an existing pool of property owners in the community who might be interested in operating an independent living home;
- Seven operators and 17 independent living homes are members of the ILA and meet ILA Quality Standards;
- The Alameda County Healthy Homes Department continues to identify independent living homes in the County, address complaints and issues raised by the public and public officials related to these homes, and expand educational efforts about the critical value of these homes for providing housing options to individuals living on extremely low-incomes;

- A total of 20 Peer Review Accountability Team (PRAT) visits have been completed from program launch date through December 2019, with a 55% pass rate.
- Despite some initial setbacks, recruitment of new members is progressing, due to additional support from key partners in the community;
- A total of 130 individuals have attended the ILA operator trainings. Based on the pre- and post-tests administered to each attendee, knowledge of the course content increased by an average of 39%;
- Four trainings were held on tenant rights for a variety of stakeholder groups;
- Starting in July 2019, the ILA began conducting surveys with tenants who live in independent living homes (both ILA member homes and non-ILA member homes) in order to track quality metrics. Initial survey results show that more tenants in member homes reported their home had a grievance policy and that they had signed a rental agreement, compared to non-member homes.

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. As of December 31, 2019, there were two Promoting Access to Health (PATH) Primary Care satellite clinics that participate in Care Connect activities in county operated mental health centers (an additional PATH Clinic opened in February 2020). 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.

During January – December 2019, the PATH Nurse Care Coordinators participated in 492 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. Over the same period, the Nurse Care Coordinators served 243 unique Care Connect clients. Furthermore, PATH Peer Navigators conducted 94 Health and Wellness Classes and Activities for consumers at the two PATH clinics.

The Integrated Behavioral Health Care Coordinators, located in eight community-based FQHCs, help to improve the care coordination and support of integrated behavioral health. Technical assistance was provided to the FQHCs to strengthen their workflows and Result-Based Accountability (RBA) measures of their integrated behavioral health

services. The goal is to improve linkages to health care services by strengthening the County's safety net system for all clients.

Here is a case study that highlights the work of the IBHCCs at the Native American Health Center (NAHC) in Alameda County, and illustrates how connections are being made across systems as a result of the Care Connect program:

The IBHCCs at NAHC have worked closely with [redacted] member(s) over the past two years. When we first started working together, they were sleeping on the streets and was only receiving Primary Care services through NAHC, which also included their [redacted] medication [redacted] They expressed hesitation at connecting to any other services or agencies for support. Through rapport building, we have more recently been able to connect them to social support services. As we saw a decline in their [redacted] health [redacted], we reached out to the Alameda County Behavioral Health's Mobile Crisis Response Team, who met with the client in the community, and connected them to a specialty [redacted] service with case management and [redacted] support for individuals with dual diagnoses. Our team of Care Coordinators also connected them to the Coordinated Entry Housing Resource Center, and they recently moved into their own apartment [redacted]. The NAHC IBHCCs are continuing to work to keep the client engaged with primary care services, [redacted] They continue to benefit from appointment reminders and assistance with scheduling transportation services.

Del #21 Training and Workforce Development

Building the skill set of the Alameda County 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 in Alameda County.

The following types of on-site workforce development trainings and mentoring opportunities for primary care and behavioral health safety net providers continue illustrate the commitment to providing quality care services to underserved and low-income residents:

- Continued funding of a yearlong on-site clinical Fellowship experience for a selected UCSF School of Psychiatry student at the Trust Clinic located in downtown Oakland;

- Embedding of Primary Care Psychiatric Consultation Program (PCPCP) ACBH psychiatrist in each of the 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;
- Funding of the fifth cohort of FQHC primary care providers to attend the University of California, Davis School of Psychiatry and Primary Care Psychiatry Fellowship Program began January 2, 2019.

Del #42a Multi-Sector Care Coordination Hubs

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. HRCs also provide housing problem solving, flexible funding, and referrals to other mainstream resources.

In 2019, the HRCs continued to work to sustain and improve their effectiveness. Care Connect services that were delivered through the HRCs in Jan-Dec 2019 include:

- 898 unique clients received Health, Housing and Integration bundle services;
- The 211 Call Center, operating as a Coordinated Entry System primary access point, provided 24-hour screening and support for those seeking housing services. From January through December, 211 handled 22,828 calls from 12,438 unduplicated individuals experiencing a housing crisis;
- Over 27,790 street outreach encounters were delivered;
- Housing Education and Counseling (HEC) workshops continued across the 5 regions. In 2019, 465 HEC workshops have been offered (these workshops also offer access to CES and connect participants to individual legal representation, workshops and counseling).

Care Connect has started to get automated data in real time through the CHR so that eventually all providers have more information on their clients' Medi-Cal status and can help with renewals. CHR information has become available to housing service providers in the second half of 2019, however, Medi-Cal renewal dates were not yet available on the system. When this change goes into effect and all housing service providers use the CHR regularly, we expect to see a decrease in the number of clients falling off Medi-Cal.

In our original design, housing service bundles were embedded in larger contracts for operating regional Housing Resource Centers and include many subcontractors partnering in the region to provide the services. To address the challenge of compiling reports on service bundle enrollment, Care Connect created a way to collect the reporting information in HMIS. Implementation with contractors and subcontractors was completed in the last quarter of 2019 and has resulted in better data collection and client tracking. A lesson learned is that multi-level contracting is not efficient, and we are moving to more direct contracting.

Care Connect continues to offer skills development and training opportunities to better support the workforce. In May 2019, Housing Solutions for Health assisted the City of Oakland HRC to run a training for all housing services subcontractor staff on housing problem solving, and during this period another more robust training was planned for January 2020.

Hiring and retaining staff is very challenging for the HRCs and their subcontractors, and we are very concerned about losing staff as the end of the waiver approaches. Quarterly meetings with all the HRC leads have been used to discuss sustainability efforts and challenges.

Del #47 Crisis Connect – Post-Discharge Follow-Up for Behavioral Health Crisis

Crisis Connect is a pilot program that provides short-term telephonic follow-up, coordination and linkage by licensed clinicians and peers to help transition identified patients to services, with the goal of demonstrating that these types of post-crisis follow-up phone calls can improve outcomes for patients who have had a mental health crisis.

A request for proposal was completed and vendor was chosen to begin work on an automated patient engagement platform that will help triage and track calls and other follow-up needs. The contract was signed at the end of July, 2019 and work on building out the system began in fall. While post-discharge follow-up calls are common in the medical sector, it's new territory to create scripts and call rhythms for behavioral health clients so the design process continued through the end of 2019.

Crisis Connect operates 5 days a week, Monday-Friday, 8 AM to 6 PM. Starting in October, the Crisis Connect program began follow-up calls with clients within 24-48 hours after a Behavioral Health Mobile Team interaction. By December, we added follow-up calls to Care Connect Eligible patients being discharged from Psychiatric Emergency Services (PES). We look forward to growing and refining the program in 2020.

V. NARRATIVE – Incentive Payments

Triggering deliverable	Level of achievement	$$ / Receiving entities
Del #1 Timely Adoption of AC Care Connect System 1) At least one representative from each provider organization and/or site will attend each monthly meeting throughout PY4 to develop standard care management definitions, outcomes, models as part of the care coordination system 2) Provider organization and/or sites to secure time and complete training of at least two of their designated employees involved in care coordination to operationalize the new standardized care coordination system 3) Provider organization and/or sites to provide evidence of adoption and use of the tools of the new standardized care coordination system	1) The first Care Community cohort brought together 33 people from 10 provider organizations and three health plans serving consumers with complex needs in Alameda County over the six-month period of July 1, 2019 – December 31, 2019. The members of the Care Community participated in 13 collaborative sessions, nine case conferences involving 25 unique clients, seven homelessness problem-solving/care coordination meetings, as well as weekly check-in meetings at the participating organizations' sites. The objectives of the cohort were to foster a shared understanding of current best practices across sectors in Alameda county, test and implement innovative ideas via small scale quality improvement projects to refine population specific workflows, and propose cross-sector specific processes to be adopted as coordinated	$4,183,333 / the public hospital and clinic system, the community-based Federally Qualified Health Centers, and several community-based organizations

Triggering deliverable	Level of achievement	$$ / Receiving entities
	practices. Three topics were focused on during the six-month period: working with Housing Resources Centers, shared care planning, and Medi-Cal lapse prevention. The group utilized a new web-based platform called Elemeno to provide in-context micro-learning content such as a Housing Resource Guide for Health Providers, information on helping your client be "document ready," How to Apply for Replacement Identification Documents, and What to Do If Your Client Is in A Mental Health Crisis. 2) The public hospital secured time for two designated employees who participated in a total of four training and planning sessions to identify and strategize successful implementation of care coordination practices, data exchange, supervisor and staff support, and use of external resources. The public hospital also committed staff to attend Universal Authorization Workgroup meetings, of	

Triggering deliverable	Level of achievement	$$ / Receiving entities
	which three were held in 2019. 3) Eight FQHC's and the public hospital have submitted Quarterly Adoption reports that demonstrate standardizing care coordination through written work flows that incorporates information and resources attained at the Care Coordination meetings, five anecdotes illustrating consumer cases and scenarios utilizing information, and the total number of consumers that were impacted. Eight FQHC's and the public hospital have met this deliverable.	
Del #11 IHSS Rapid Intake [redacted] recently homeless AC3 patients have received expedited IHSS services through this process, as defined by an average 3-5 day processing time upon referral to the IHSS unit & determination of services	We are reversing the claim made on this deliverable at midyear. While the statement made in the report is accurate, we felt, on further reflection, that the trigger was not met, because no IHSS unit was created, which was really the goal of the deliverable.	-$200,000 / County partners

Triggering deliverable	Level of achievement	$$ / Receiving entities
Del #17 Capacity Development Incentives for Physical Health Providers - Opioid 2) Increase rate of patients receiving chronic opioids who are treated for opioid dependence. Incentive funds will be paid to provider organization sites that show a 10% decrease in the gap between target treatment rate negotiated with each provider agency during PY2 and that clinic site's performance the prior year.	At midyear, we reported that eight community-based Federally Qualified Health Centers attained this deliverable. On review of the evidence, we found that one of the clinics did not make the target, so we are reversing the claim for that clinic.	-$224,924 / One community-based Federally Qualified Health Center
Del #22 Hepatitis Screening and Treatment **22-2.** Community primary care sites will be paid to maintain treatment rate achieved during PY3.	All 8 FQHC's continued to increase Hep C screening and treatment rates, improve protocols and quality reports for Hep C tracking and documentation, and focusing on no-show, retention and adherence processes. One additional FQHC met the deliverable.	$47,421 / One community-based Federally Qualified Health Center

Triggering deliverable	Level of achievement	$$ / Receiving entities
Del #23 Capacity Development Incentives for Physical Health Providers – HEDIS **23.1 CBOs** - 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 the Community Primary Care Sites) for our Region IX and performance for AC3 beneficiaries the prior year by at least 10% each year PY3-5. **23.1 – Public Hospital -** Improve performance on a growing set of HEDIS measures selected in partnership with the Managed Care Plans, measured by reducing the gap between the PRIME specifications and targets (for the Public Hospital and Clinic System) the prior year by at least 10% each year PY3-5.	**23.1 Colorectal Cancer Screening** Seven out of eight CBOs and the public hospital met their performance goals. **23.1 Controlling High Blood Pressure**. In 2018, 7 out of 8 clinics and the public hospital had exceeded the NCQA benchmark, and therefore could not “reduce the gap” as defined in the approved deliverable. For these providers, we measured whether they had improved by at least 5% over the prior year. If they achieved at least 50% (2.5%) of the 5% target, we pro-rated the claim accordingly. Two **CBOs** met their performance goals in full; two CBOs exceeded the NCQA benchmark and achieved an improvement between 2.5% and 5% over the prior year. The **public hospital** exceeded their PRIME benchmark and improved performance over the prior year by 5%.	$4,955,108 / eight provider organizations, including one hospital and clinic system including seven community-based Federally Qualified Health Centers

Triggering deliverable	Level of achievement	$$ / Receiving entities
Del #24 Capacity Development Incentives for Physical Health Providers – Access **24.2 – Public Hospital -** Performance incentive to increase non-traditional visits by 10% (relative) over FY 2016-17 baseline in PY3, and an additional increase of 10% over the prior year's performance for PY4 and PY5. Public Hospital will actively invest in alternate visit types to expand team-based care and improve primary care access. These visit types include, but are not limited to, pharmacist visits, nurse visits, telephone visits and e-consults.	The public hospital chose to work on e-consults, and increased their e-consult visits by 26% over the prior year.	$3,583,852 / the public hospital and clinic system

Triggering deliverable	Level of achievement	$$ / Receiving entities
Del #30 - Capacity Development Incentives for Physical Health Providers - Data Quality Improvements **30.2 –** Provide evidence of improvement in collection and electronic documentation of housing status by reducing the percentage of patients seen with housing status as "unknown" by at least 20% over the prior year in PY2 for the psychiatric hospital, and then by all four ambulatory sites for PY3-5 by at least 10% over the prior year **30.3 -** 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.	**30.2** - The public hospital improved in their collection and electronic documentation of housing status, and reduced the percentage of patients seen with housing status as “unknown” to 0.01%. **30.3** - The public hospital improved in their 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 "unknown" to 0.65%.	$1,000,000 / the public hospital and clinic system
Del #39C Community Health Record (CHR)/Data Exchange Infrastructure--Permissions Monitoring System	AC Care Connect has completed the primary implementation of the SHIE and Community Health Record in 2019. Thrasys, a contracted vendor, in conjunction with the	$2,000,000 / County partners

Triggering deliverable	Level of achievement	$$ / Receiving entities
1) Provide documentation that AC Care Connect initial phase CHR platform launched. 2) Provide documentation that at least 50% of the Wave 1 prototype CHR (pCHR) end users have accessed the long-term CHR or data exchanged through AC Care Connect. 3) Provide documentation of clinical registries of AC Care Connect enrolled beneficiaries within the CHR. 4) Provide documentation that behavioral health appointments for enrolled beneficiaries can be seen in the CHR. 5) Provide documentation that CHR has an operating Consent Management function 6) Provide documentation that CHR has an operating Record Locator service 7) Provide documentation that CHR has an operating Messaging service 8) Provide documentation that CHR has an operating Integration service	Data Exchange Unit, delivered the first Wave of the project in May of 2019 which leveraged the integration services by implementing 12 data streams from partner organizations. 100% of the 134 users trained in this 1st wave logged onto the Community Health Record in 2019. The Community Health Record has successfully integrated a variety of clinical registries from our partners. We have been able to track behavioral health scheduled appointments for the purpose of tracking follow up. Most significant has been the implementation of a consent management infrastructure which integrates patients in the sharing of their information. Additionally, this phase of the development included a messaging system that allows care managers to communicate securely to coordinate care. Lastly, while the Record locator services function has been implemented and tested, we anticipate that we will use this in 2020.	
Del #42C Capacity Development in multi-	**42C.1** – In 2019, more than 45 countywide case conferencing	$360,000 / County partners

Triggering deliverable	Level of achievement	$$ / Receiving entities
sector care coordination hubs **#42C.1** - Each Housing Resource Coordination entity will expand its multi-sector participation in regional case conferencing for AC Care Connect members experiencing homelessness, including at a minimum, an increase of at least one behavioral and one physical health agency currently not participating in each region. **#42C.2** - Each Housing Resource Coordination entity will increase its percentage of homeless clients who have complete housing documentation ready in order to be matched to publicly-funded permanent housing by at least 10%.	meetings were held with housing navigators, case managers, outreach teams, shelter services and other key Housing Resource Center (HRC) staff across five HRC sites. North County (Berkeley) HRC and City of Oakland HRC holds case conference meetings bi-monthly and East, South and Mid-County meet monthly to review the By-Name-List with regional partners and focus on coordinating care. Three of the five HRCs had new attendance from physical health agencies; all five of the HRCs had additional attendance from behavioral health agencies. **42C.2** - In September 2018, 3,656 people were on the By Name List (BNL), of which 2,973 were homeless and disabled and therefore eligible for Permanent Supportive Housing. Of the top 50 on the BNL, only 22 percent had all of their housing portfolio documents and the projected estimate was that only 10 percent of the overall BNL had documents. As a follow-up to the initial inquiry to determine the portion	

Triggering deliverable	Level of achievement	$$ / Receiving entities
	of individuals ranking within the top 50 on the By Name List with all housing portfolio documents, partners associated with each Housing Resource Coordination entity conducted a document readiness campaign during March and April 2019. This time, the number of individuals ranking at the top of the BNL expanded from 50 to 150. As a result of this targeted effort, partners succeeded in preparing 61 percent of clients or 91 of 150 people on the BNL to apply for Permanent Supportive Housing. This is well above the 10 percent improvement target as defined by the deliverable. Tools and lessons learned from the campaign will be incorporated into housing workflows moving forward such as a new function in the Homeless Management Information System (HMIS) to upload documents so that they can be stored electronically.	
Del #43 Community Assessment and Transport Team (CATT) **43.1 –** Add Behavioral Health System to the available hospital beds software used	Despite delays, the Community Assessment and Transport Team program has continued to make progress toward rolling out. Milestone 1, adding Behavioral Health Crisis	$250,000 / County partners

Triggering deliverable	Level of achievement	$$ / Receiving entities
by EMS (ReddiNet). This will allow the CATT team to know which disposition options are open so they can take a client directly to a disposition with availability.	Residentials, Crisis Stabilization Units, and other behavioral health dispositions to Emergency Medical Services ReddiNet software, has been met. A new tab has been created in which all Behavioral Health dispositions can be seen and are updated regularly. In addition, a successful RFP process took place to select the community-based organization (CBO) that will provide the mental health clinicians for the teams, and contracts are in place with both the EMS provider and the CBO. There have been delays in acquiring the vehicles, in part due to the large General Motors strike that came at the same time our teams placed an order for 15 vehicles, and also due to the difficulties of hiring in such a competitive market. The vehicle order is now on track to be delivered in the spring of 2020 and new recruitment strategies and incentives are in place for hiring. The program expects to roll out its first teams in the summer of 2020.	

Triggering deliverable	Level of achievement	$$ / Receiving entities
Del #44 - Consumer and Family Experience **#44A.1**- Gather input from two sets of consumers; (1) caregivers, family members, and others in their informal support network across multiple sectors, reflective of the population, and (2) direct service providers to inform development of the culturally affirmative practice care model, conducting at least 21 focus groups with at least 200 participants **#44A.5** - Deliver at least 12 workshop hours to local and/or state providers aspiring to deliver whole person care to populations similar to Care Connect's at various venues	**#44A.1** From July -Dec 2019, we conducted nine additional focus groups ($8,000/each x 9 workshops = $72,000), for a total of 15 since the beginning of this project. All of these increased the depth of our understanding of consumer experiences. We reached out to stakeholders who are rarely engaged, on topics that are not often considered. We learned we need to partner with Oakland's librarians in their success in addressing the social and health concerns of their unsheltered patrons. Through Probation's supervisees our attention to informal support networks was validated. We also learned that we need to not only engage with consumers' support system but help consumers develop the network of support they want. Grievance officers from hospitals and clinics from around the County, in noting the preponderance of complaints of racism, affirmed the importance of culturally affirmative skill development. The other most frequent and vexing issue they manage is	$205,333 / County partners

Triggering deliverable	Level of achievement	$$ / Receiving entities
	consumer complaints regarding access to needed pharmacy prescriptions. **#44A.5** In July 2019, we commenced a 6-part series of workshops (Provider Connect) which contained candid conversations about racial and other dynamics of difference; the first step in building insight between provider and consumer and how they can become partners for health and dismantle barriers to positive health outcomes for our clientele. We focused on skill building that results in navigating through candid conversation in interracial settings including "pushing beyond anxiety, grief, fear, distrust, anger", "how providers' perceptions of Black consumers can interfere with high quality care" and" how to identify, assess and engage consumer friend/kin support network". The workshops are well attended and the reviews highly positive. $200,000 x 8/12 workshop hours = $133,333	
Del #46C Dissemination of Best Practices in Outreach	**#46C1** - 10 trainings were completed in 2019, five of which were completed between	$350,000 / County partners

Triggering deliverable	Level of achievement	$$ / Receiving entities
and Care for Unsheltered Individuals **#46C1** - Facilitate 10 trainings to expand the knowledge and skills of front line homeless outreach service providers, focusing on improving the success and speed of engagement with clients to move them into making meaningful connections and use of healthcare, mental health services and more advanced housing services. **#46C2** - Expand the network of community based health and social service organizations working effectively with highly vulnerable homeless individuals by providing technical assistance to at least 6 medical, housing, or human services organizations that do not currently have programs, expertise, or a stated mission to serve people experiencing homelessness. **#46C3** - Establish an MOU to establish standard practices for continuity of healthcare for unsheltered individuals, that includes at least 6	July-December. Subjects included: emergency response system, compassion fatigue and burn-out prevention, motivational interviewing in the outreach setting, trauma informed care, substance use and harm reduction, culturally affirmative practice, benefits advocacy and immigration, and NARCAN training. **#46C2** - The network of organizations working with homeless individuals was expanded by providing technical assistance to 7 organizations. All of these organizations are well-established to serve low-income residents of Alameda County but previously had limited or no capacity to implement a street health outreach service model with the goal of linking unsheltered homeless people to primary medical care. Four formal trainings were provided, in addition to technical assistance follow up meetings with each organization. Areas of training and technical assistance covered: team roles, team huddle, engagement and connecting	

Triggering deliverable	Level of achievement	$$ / Receiving entities
organizations providing care for unsheltered people. **#46C4** - Facilitate successful launch of Respite Services: Produce a written protocol and a training module for referring organizations and respite providers to facilitate successful launch of new Respite Services.	with clients, safety, de-escalation, core RN protocols and services, collaboration with primary care providers, best practices in health care during outreach, common conditions among unsheltered homeless, mental health and substance use disorders in the field with a focus on harm reduction, MAT, and anti-psychotic medications. **#46C3** – MOUs were completed with 10 organizations to establish health care services for people experiencing homelessness served by those organizations. **#46C4** - Respite services were established and began accepting referrals in September 2019; by the end of the year, it had served 16 unique consumers. Written protocols and a training module for referring organizations and respite providers were created.	
Del #48 Medical Respite Program **#48a** - Expand county-wide respite capacity by 27 beds in 2019. Payment of $30,000 per bed created. **#48c** - Create and adopt Toolkit for Referrals into County-funded Respite –	**#48a** – The Adeline Street Recuperative Care began accepting patients in September 2019. The program maintains 27 beds. **#48c** – The program has completed referral protocols from hospitals and street	$1,060,000 / County partners

Triggering deliverable	Level of achievement	$$ / Receiving entities
a) Earn $100,000 to complete protocols for coordinated referrals from hospitals b) Earn $100,000 to complete protocols for coordinated referrals from street medicine **#48d** - Create and adopt Toolkit for Exits from Respite – a) Earn $100,000 for protocols for coordinated exits from respite (connection to family, coordinated entry, and other housing programs). **#48e** - Training for respite providers and cross-system learning (1 training in 2019). The objective of the training will be to: 1) have providers share challenges with the county to help guide future trainings; 2) provide information to providers on specific resources; and 3) establish a learning community and commitment to future collaboration.	medicine and actively accepts patients from both sites. **#48d** – Not achieved **#48e** – Alameda County Health Care for the Homeless convened a respite coordination meeting in October 2019 for all county staff and providers involved in respite services to discuss challenges, provide information on available resources and to establish the group as a learning community moving forward. The group will meet 2-4 times a year for on-going learning and problem solving.	

VI. NARRATIVE – Pay for Outcome

Del #3 Ambulatory Care - Emergency Department Visits

This metric is a HEDIS measure modified for WPC to count the number of medical or psychiatric emergency visits (numerator) per 1000 enrolled member months. Our performance benchmark is tied to the DHCS Medi-Cal Managed Care Performance Dashboard, March 2016 release at the Seniors and Persons with Disabilities Rate which is 91 ER Visits/1,000 member months**.**

Payment Trigger Language: a 10% decrease in the gap between benchmark/goal and performance on the metric during the prior year.

Results:

- Benchmark: [redacted]/1000 member months.
- Performance PY3: [redacted] per 1000 member months.
- Gap: [redacted] per 1000 member months.
- Ten percent of that gap: [redacted] per 1000 member months.
- PY4 goal: [redacted] per 1000 member months.
- PY4 performance: [redacted] per 1000 member months.

The reduction in the rate of ED visits far exceeds the goal, [redacted]

ACHIEVED in full = $900,000

Discussion

ED visits for the Care Connect enrolled population went down significantly. At the same time, such a large change warrants further investigation, and we will be looking to identify if there are any environmental factors that may be influencing this outcome.

AC Care Connect's program includes a number of initiatives that we anticipated would reduce the ED visit rate of our enrolled population:

- The intensive wrap-around services of both our Care Management and Health, Housing and Integrated Services bundles, providing consumers with a viable option to connect to the service they need other than in the Emergency Department or Psychiatric Emergency Service
- The training and relationship-building among providers, enabling them to better refer to other parts of the system

- Connecting severely mentally ill consumers to primary care through integrated behavioral health program and the housing navigation services
- Active street outreach with psychiatric services by the Trust Street Health Team
- The Psychiatric Emergency Services (PES) Frequent Utilizers Pilot which has led to on-going case-conferencing to connect consumers to needed services, and also yielded practice and workflow improvements such as updated discharge protocols.

It is also possible that the passage of Senate Bill 1152 that requires better hospital discharge planning for consumers experiencing homelessness may have improved these rates as well, deterring a rapid return to the emergency department by ensuring housing and other service connections are offered at the time of discharge.

#4 Pay for Outcome: Follow up within 7 days after PES visit for mental health (FUM)

Payment Trigger Language:

- 5% improvement over the prior year for the 7-day follow up rate = $450,000
- >5%-10% improvement over the prior year for the 7-day follow up rate = additional $450,000

Results:

- Performance PY3: 31.4%
- Performance PY4: 34.1%, an 8.7% improvement
- Goal 1 for PY4: 31.4% x 5% improvement = 33%
  ACHIEVED in full = $450,000
- Goal 2 for PY4: 31.4% x 10% = 34.5%

Proration analysis:

- Our deliverable specifies that payments will be paid on a prorated basis for improvement over 5%.
- With an overall improvement of 8.7%, we achieved a 3.7% improvement, less than the 10%, but still greater than the 5% of goal 1.
- 3.7/5=an achievement rate of 74.2%; 74.2% of $450,000
  ACHIEVED in PART = $333,900

Discussion:

Care Connect is aligning its resources with significant changes happening in Alameda County's Behavioral Health Crisis system, focused on diversion from and follow-up after PES visits. Care Connect has been engaging in multiple efforts to wrap services around the population that are frequent visitors to PES, including work to get them connected to follow-up care. We are pleased with the initial improvement we see in the follow-up rates, and we anticipate these collective efforts and new collaborations with partner organizations will continue to result in measurable improvement in follow-up for individuals experiencing a psychiatric crisis moving forward.

Some of the programs we anticipate continuing to bring improvement in this area are:

- Crisis Connect phone calls to consumers after Psychiatric Emergency Service visit to connect to care – this program soft launched at the end of 2019;
- Community Assessment and Transport Teams (CATT) to offer other appropriate disposition options for an ambulance other than the Emergency Department or Psychiatric Emergency Service, set to launch summer 2020;
- Care Communities (described in section IV) and
- The implementation of a permanent Community Health Record to better link care providers across to respond efficiently to the needs of their consumers, drawing them to engage in the outpatient setting rather than the Emergency Department or Psychiatric Emergency Service.

In addition, our partner Alameda County Behavioral Health changed the contracts of their Full-Service Partnership (FSP) and Service Team providers to require timelier follow-up to clients in their care. They also have started several new Crisis intervention programs that we suspect had an impact on this change, most notably, Familiar Faces, a post-crisis follow-up program focused on the highest users of Psychiatric Emergency Services.

#13 Pay for Outcome: Stably Housed at 6 months

Payment Trigger Language: Improve performance in variant metric permanent housing by 5% compared to prior year's performance.

This outcome is 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.

Results:

- Performance PY3: [redacted] were in permanent housing for at least six months, and [redacted] were in housing for greater than six months (measured at the seventh month mark.
- Performance PY4: [redacted] were in permanent housing for at least six months, and [redacted] were in housing for greater than six months, a [redacted] improvement
[redacted]

ACHIEVED in full = $120,000

#52 Pay for Outcome: Quality Improvement of Housing Education & Counseling Program

Payment Trigger Language: Increase the number of participants who obtain tenancy within 3 months of receiving housing education and counseling services by 50% over the prior year.

Results:

- Performance PY3: [redacted] participants obtained tenancy within 3 months of receiving housing education and counseling services
- Performance PY4: [redacted] participants obtained tenancy within 3 months of receiving housing education and counseling services = [redacted] improvement
- [redacted]

ACHIEVED in full = $250,000

Discussion:

Housing Education and Counseling services are provided in partnership with regional Housing Resource Coordination entities to serve homeless and at-risk of homeless members through group workshops and individual counseling sessions that focus on topics such as the housing search process; understanding tenant rights and responsibilities; addressing barriers to obtaining/maintaining housing; and orienting members to the provision of online resources that support the process of finding housing.

This is an important low-barrier resource available to any member, including those who may not be highest priority for receiving more intensive housing services. In 2019, the quality of offerings and housing outcomes for participants was strengthened to ensure maximum utility of this resource.

#55 Pay for Outcome: Achieve cross-sector competency in coordination and access to care skills

There are two parts to this deliverable:

a) At least 300 unduplicated individuals will participate in the Academy over 2019.
b) 30% of participants in the Care Connect Academy will have completed (earned badges for) at least 10 trainings on multi-sector care.

For the purposes of this metric, we are defining Academy participants as individuals who have attended at least two trainings in 2019.

Results:

- A total of [redacted] unduplicated individuals have participated in the Academy in 2019 [redacted]

  ACHIEVED in part = $74,000- $53,000 claimed at midyear = $21,000

- Of the [redacted] individuals who attended at least two trainings, [redacted] have completed at least 10 trainings [redacted]. We expect to reach the 30% goal by the end of 2020, as planned.

Discussion:

This metric is designed as a measure of success of our capacity development work.

Before Care Connect began, providers in one sector knew very little about how to help consumers access services in another sector, and didn't know providers in the other services. The Care Connect Academy is a series of trainings tailored to the needs of Alameda County primary care, behavioral health, housing staff and other providers working with the Care Connect population (see section IV Del #36).

#58 Pay for Outcome: Follow up within 30 days after PES visit for mental health (FUM)

Payment Trigger Language:

- 5% improvement over the prior year for the 30-day follow up rate = $450,000

Results:

- Performance PY3: 59%
- Performance PY4: 62.7%, a 6.3% improvement

- Goal 1 for PY4: 59% x 5% improvement = 62%
  ACHIEVED in full = $450,000

Discussion:
Care Connect is aligning its resources with significant changes happening in Alameda County's Behavioral Health Crisis system, focused on diversion from and follow-up after PES visits. Care Connect has been engaging in multiple efforts to wrap services around the population that are frequent visitors to PES, including work to get them connected to follow-up care. We are pleased with the initial improvement we see in the follow-up rates, and we anticipate these collective efforts and new collaborations with partner organizations will continue to result in measurable improvement in follow-up for individuals experiencing a psychiatric crisis moving forward.

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- Crisis Connect phone calls to consumers after Psychiatric Emergency Service visit to connect to care – this program soft launched at the end of 2019;
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In addition, our partner Alameda County Behavioral Health changed the contracts of their Full-Service Partnership (FSP) and Service Team providers to require timelier follow-up to clients in their care. They also have started several new Crisis intervention programs that we suspect had an impact on this change, most notably, Familiar Faces, a post-crisis follow-up program focused on the highest users of Psychiatric Emergency Services.

VII. STAKEHOLDER ENGAGEMENT

Instructions: 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. An attachment to this report is also acceptable, please note below if this option is being used. 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 Stakeholder Engagement Chart attached

VIII. PROGRAM ACTIVITIES

Briefly describe 1-2 successes you have had with care coordination.
One of the more exciting efforts in our Care Communities was the impact for clients when their providers learned how to access a much broader set of services available in the county for their clients. In Care Community 1, the providers participated in an activity in which they shared their go-to resources for a wide variety of issues. Then, all of the other providers did a gallery walk around the room and added additional information. The resources were typed up, organized by category and sent out to them. The next day, one of the behavioral health providers had a client come in for their regular appointment in significant pain from a dental issue they didn't think they could afford to address. The provider remembered a free, walk-in dental clinic for Medi-Cal clients from the day before, looked up the resource, arranged a referral and was able to connect the client that day. The provider was so encouraged that there was a concrete, immediately available resource that could address his client's need.

Briefly describe 1-2 challenges you have faced with care coordination, and lessons learned from those challenges.
One unintended consequence of defragmenting services, and more specifically having two service bundles—Care Management and Health and Housing Integrated Services—is that some consumers are eligible for both. This has created an administrative challenge when billing because both CB-CMEs and housing providers attempt to claim for reimbursement, but only one entity can be reimbursed. Care Connect convened leaders and program staff from the Health Plans, Alameda County Housing Services Office, and CB-CMEs to discuss a policy for the times when a consumer is dually eligible. We learned that while we are attempting to de-silo systems of care, it's imperative to provide infrastructure at the administrative level as well so challenges like this are not overlooked in the process of restructuring the current service delivery model.

Briefly describe 1-2 successes you have had with data and information sharing.
1. The successful launch of the Social Health Information Exchange / Community Health Record (SHIE/CHR) was the culmination of years of work, starting with the planning of our whole person care project in 2015. It was an intensive rollout—eleven organizations were on-boarded, and all the processes associated with a product launch: creation of training materials, a helpdesk system and elbow 2. The Substance Use Disorder (SUD) release of information (ROI) form was drafted by an SUD Workgroup comprising members from Alameda County Behavioral Healthcare, County Counsel, and HCSA Care Connect

management. The form was vetted by the Care Connect Consumer Fellows for understandability/comprehension and then approved by the Data Governance Committee. Reaching agreement on the final form was a tedious process, given the sensitivity of the information and complexity of 42 CFR Part 2 regulation.

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

1. Developing policies and procedures for the CHR Shared Care Plan (SCP) proved to be difficult, given the lack of control in a "free text" environment. We were not able to apply the same system controls utilized in the core system. Managing special permissions to share HIV and mental health information can only be controlled by end-user training/system prompts. Also, given the SCP usage in a multi-sector environment, 42 CFR Part 2 programs were limited to view-only access. We have learned that frequent training of end users of the CHR to remind them of best practices for SCP usage has been the most effective to-date.
2. The nature of the Whole Person Care Program focuses on care management of high need consumers. The Community Health Record has been a valuable tool to care managers who are coordinating care across sectors for those individuals. However, while we thought giving care managers access to the limited Whole Person Care eligible and enrolled population would be sufficient in a pilot, users want to see patients who are in their broader caseload. They want a unified case management workflow that they can use for all clients in need of case management. Thus planning for transitioning to a broader based population is a new focus as the end of the Whole Person Care program approaches. This is a challenge but is critical for the widescale adoption of a tool like the CHR.

Briefly describe 1-2 successes you have had with data collection and/or reporting.
1. Care Connect hired a management analyst devoted to developing an interim reporting strategy as we begin the gradual transition from the ACBH Data Warehouse to the Thrasys analytics platform. She has transitioned the team to a new dashboarding tool and is producing some reports from the new platform supporting both internal and external partners as well as CHR onboarding efforts 2. Successful engagement with the community based clinics has allowed HCSA to collect historical encounters back to 2014 for three of the eight FQHCs. This data is more robust than the prototype Community Health Record dataset, and we hope to provide insight for future analytics. We have also formed a successful engagement with the Community Health Care Network (CHCN) office to have a partnered process going forward to collect data from all eight FQHCs to support variant metrics state reporting.

Briefly describe 1-2 challenges you have faced with data collection and/or reporting.
1. Understanding ACBH data format and relationships as well as complying with their requirements, is difficult. Behavioral Health encounter data are organized in a different manner than physical health data obtained from clinics or hospitals. The technical team spent several weeks to extract the data in the format that can be ingested and connected within the SHIE. Data Quality and Data Privacy were also issues and a considerable amount of effort was spent in clarifying rules with privacy officials and subsequently cleansing and loading that data. 2. For most of this reporting period, the Data Exchange Unit was limited in its ability to support robust operations for the program staff, such as the rapid production of custom reports. This can be attributed to the slow hiring processes as well as the need to focus resources on standing up the permanent Community Health Record with Thrasys. During Q4 2019, the data team has grown by three people and the completion of the first wave of CHR implementation has stabilized, allowing for more focus on reporting development.

Looking ahead, what do you foresee as the biggest barriers to success for the WPC Program overall?
• 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. • Staff turnover among our community partners is a big challenge – they are constantly recruiting and training. This is becoming more of a challenge as the end of the WPC funding is approaching – CBOs don't want to hire people if they don't know how they will be paid after December 2020. • The COVID-19 pandemic will have long-lasting negative effects on the health and well-being of consumers that are hard to foresee. It is likely the need for whole person care services will be even greater than was already the case. The associated financial crisis will make it harder to provide essential services. • The uncertainty of the future, budgetary and otherwise, makes it difficult to plan.

IX. PLAN-DO-STUDY-ACT

Instructions: 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 are listed for Quarters 3 and 4:

- Community Assessment Transport Team Pilot
- Improving Recuperative Care (Medical Respite) Utilization
- Accessible Comprehensive Care Plan
- Improving Care Transitions to a Higher Level of Care (Healthcare for the Homeless and Community Based Organization)
- Increasing Information Sharing Agreement Collection to Improve Care Coordination
- Initial Test of Data Sharing Across Partners

The following PDSAs are listed for Quarters 1 and 2:

- John George PES Frequent Utilizers Case Conference
- Health Care Services Agency and Alameda Health Systems Housing Placement Pilot
- Accessible Comprehensive Care Plan
- Care Communities
- Community Collaboration for Housing Readiness Documents
- Improving warm hand off process between specialty mental health (PTW) and primary care providers (Trust)
- Initial Test of Data Sharing Across Partners