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 5]
[April 15, 2021]

## REPORTING CHECKLIST

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

| Component | Attachments |
|---|---|
| **1. Narrative Report**<br>**Submit to:** Whole Person Care Mailbox | ☐ Completed Narrative report<br>☐ List of participant entity and/or stakeholder meetings *(if not written in section VIII of the narrative report template)* |
| **2. Invoice**<br>**Submit to:** Whole Person Care Mailbox | ☐ Customized invoice |
| **3. Variant and Universal Metrics Report**<br>**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.)**<br><br>**Note: If a Policy and Procedures document has been previously submitted and accepted, you do not need to resubmit unless it has been modified.**<br><br>**Submit to:** Whole Person Care Mailbox | ☐ Care coordination, case management, and referral policies and procedures, which may include *protocols and workflows.)*<br>☐ 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**<br>**Submit to:** Whole Person Care Mailbox | ☐ Completed WPC PDSA report<br>☐ Completed PDSA Summary Report |
| **6. Certification of Lead Entity Deliverables**<br>**Submit with associated documents to:** Whole Person Care Mailbox and SFTP Portal | ☐ Certification form |

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

# Whole Person Care

[Alameda County Care Connect]
[Annual Narrative Report, Program Year 5]
[April 15, 2021]

## 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

As reported in prior years, Care Connect continues to work closely with the Alliance and Anthem, the county's Behavioral Health, Social Services, Probation, Alameda Health System, as well as organizations across the housing continuum of care. During this reporting period, COVID-19 continued to bring a new level of intensive cross-departmental work, especially with the Public Health Department, as County departments and agencies were pulled into the emergency operations structures.

The Safer Ground/Operation Comfort hotels demonstrate how Care Connect and our extensive cross sector network were able to collaborate and rapidly respond to the COVID-19 pandemic to launch, operationalize, and significantly expand spaces for unhoused and other high risk populations to shelter, isolate, and quarantine.

Alameda County Health Care Services Agency established the Safer Ground and Operation Comfort hotels program (part of the State's Project RoomKey); the Care

Connect program partnered with the Health Care for the Homeless program and the Office of Homelessness Care and Coordination on this effort. During this reporting period, the number of hotels expanded from two hotels to nine hotels plus three trailer sites located throughout the County. The Safer Ground program brings together community-based housing organizations, health care, social services, mental health and substance use services, emergency services and Care Connect's Peer to Peer Advisor services, and created a unique opportunity to provide whole person care supports and services, including flu vaccinations, on-site COVID-19 testing, connections with IHSS and other services, and support for gathering housing application documents.

In large part because of these efforts, there were no deaths due to COVID-19 among people experiencing homelessness who were housed at the RoomKey hotels in Alameda County. Over 1,400 households isolated and quarantined at the Operation Comfort sites and more than 1,100 households sheltered in place at the Safer Ground sites.

The pandemic led to a delay in implementation of the planned transition to CalAIM; it has been challenging for us and our partners to attend to integrated transition planning when there is little concrete detail about how and when the future programs will be implemented. We are working to keep the conversation going to maintain connection to be ready when it is possible to resume planning.

**Increasing coordination and appropriate access to care**

The Community Health Record (CHR) is one of the main tools we are bringing to bear for increasing coordination and access to whole person care. During this period, Care Connect worked hard to scale up adoption of the CHR for care coordination among the different service sectors across the county, despite the challenges of COVID. Since the inception of the CHR, over 850 people from 27 organizations have been trained as CHR users and have CHR user accounts (as of January 2021).

Another strong collaborative effort is participation in the Governor's 100 Day Challenge and Care Connect's related 100 & Beyond effort, which offered ongoing training to build staff capacity to provide housing support and care coordination within and across the RoomKey hotels. The presence of so many vulnerable people and the wide range of needed services concentrated at Safer Ground / Project RoomKey hotels enabled Alameda County to leverage these resources for housing.

We worked with a number of partners, including PATH Primary Care Clinic sites, housing providers, and CB-CMEs, to shift the model of care when providing case management, outreach, and other services to telephonic; this required significant support and problem-solving.

Finally, in response to the COVID-19 pandemic, AC Care Connect's existing Consumer Engagement program re-organized to address the need to reach communities that are often not effectively reached by mainstream efforts, including certain Black, Mam-speaking and Latino communities. The Peer to Peer Advisors partnered with the County's Case Investigation and Contact Tracing teams to identify and work with community and family supports of persons with suspected or confirmed COVID-19 infection (see section V, Del 75 for more details).

**Reducing inappropriate emergency and inpatient utilization**

Emergency department and inpatient utilization among Care Connect enrollees has continued to drop over the course of the Whole Person Care pilot. The PY5 annual rate for ED visits is 129 per 1000 member months, while the PY4 annual rate was 367.5. Similarly, the rate of inpatient utilization for PY5 is 26.9 discharges per total member months, and the PY4 annual rate was 49.3. The rates of ED and Inpatient utilization dropped so drastically from 2019 to 2020 that it is challenging to identify any influence other than COVID-19. Because of state and federal guidance around sheltering in place, many consumers in our community likely avoided seeking both inpatient and emergency care in an effort to avoid COVID-19 exposure.

To better support people in our community experiencing substance use and behavioral health crises, the Community Assessment and Transport Teams (CATT) launched five teams and Crisis Connect ramped up its services in 2020. This pilot replaces emergency ambulance transport for those coping with behavioral health and substance abuse issue with a low-profile vehicle staffed by an Emergency Medical Technician and a Licensed Clinician. The new program is able to refer clients to more appropriate level of levels of care, rather than the traditional transport of every client to either an emergency room or John George. Of the 372 total calls received by CATT, 82% of the calls were diverted away from a 5150 involuntary hold. Of the 115 consumers who were transported to the hospital, 52% went voluntarily for reasons including detox, medical or psychiatric evaluation, etc.

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. In 2020, despite the challenges of the pandemic, the team was able to reach 2,934 clients and provide 4,079 services.

**Improving data collecting and sharing**

During this period, AC Care Connect continued to secure and ingest new data feeds into the Social Health Information Exchange (SHIE) including: jail census and release, Social Services Agency and Medi-Cal renewal data, refined and improved health plan files (including claims and pharmacy data), real-time hospital encounters, and Public Health mortality data.

The urgency of the COVID-19 pandemic led to a rapid expansion and growth of the CHR and SHIE. Since the Data Governance Committee permitted the expansion of the population that can be disclosed in the CHR from the relatively limited Care Connect eligible population to include most of the Medi-Cal and uninsured populations, we have been able to develop a number of reports for internal and external partners to support program planning and care coordination, particularly in response to COVID. We are continuing to work to expand the reach of the CHR; our Data Governance Committee recently agreed to pilot a program to bring non-HIPAA covered entities into the CHR as users. The DEU also supported the development and expansion of data collection systems, integration with the SHIE, and expanded reporting and analytics at the Safer Ground hotels, which strengthened care coordination between organizations providing services across sectors.

We continue to work to increase the number of Information Sharing Agreements (ISAs), as this enables access to important sensitive data such as mental health and HIV status. Because of the public health emergency and shelter-in-place guidance, many providers transitioned to telehealth services and were not able obtain consent for information sharing with a “wet” signature. Toward the end of 2020, we began integrating the DocuSign e-signature into the CHR so users could get an ISA signed by consumers electronically.

These expansions have significantly increased the capacity and value of the CHR and the SHIE and for the first time since we launched these tools, we have more interested organizations and partners than we have the capacity to onboard.

**Achieving quality and administrative improvement benchmarks**

During this period, Care Connect’s enrollment continued to surpass our initial goal of 17,000. Enrollment as of December 31, 2020 was 24,521.

The transition in early 2020 to the new Social Health Information Exchange platform (Thrasys) to determine eligibility and enrollment and to develop the quarterly enrollment and utilization reports allowed us to more easily integrate COVID-19 related data and populations into our eligibility and enrollment algorithm.

We have learned that early and sustained investment in data and reporting infrastructure does pay off, not only for easier administrative reporting, but also for measuring and communicating impact. In 2020, we launched Care Insights, our internal operational and programmatic dashboard, which allows staff and specific partners to access a range of data on Care Connect populations, programs, and services directly. Using Care Insights, we can more easily use data to evaluate program performance, organizational capacity, and CHR user/organization activity. For instance, we've been looking at our data to assess changes in housing status for individuals enrolled in (and then disenrolled from) Care Connect housing bundles. Analysis of data found that over half of the disenrolled consumers were unsheltered at the time of their (first) enrollment; the share of unsheltered consumers dropped to a fifth at the time of disenrollment, with the majority of this group shifting to Permanent Housing.

**Increasing access to housing and supportive services**

The pandemic has provided opportunities for Care Connect to coordinate and collaborate with a range of housing partners at a much deeper level and has also led to new opportunities to collaborate and support consumers. Additional funding through the CARES Act and FEMA, as well as the additional flexibility in WPC PY5 funding is helpful, however coordinating all these funding sources within short and changing timelines has been challenging.

During this reporting period, much of the housing related work of Care Connect merged into the newly launched Office of Homeless Care and Coordination (OHCC). As described above, the County acted quickly to take advantage of the Project RoomKey opportunity, securing hotels that are not only providing space for sheltering in place during COVID-19, but will add to the housing supply for those who are homeless/at risk of homelessness into the future. In December of 2020, the County purchased two of the RoomKey hotel sites in Oakland, which represent a total of 240 rooms that will ultimately convert to permanent supportive housing.

Our team also worked with partners to redesign the Coordinated Entry System and related processes to focus on equity. The OHCC became the officially designated Management Entity of the Coordinated Entry System. We also worked with our Board of Supervisors (BOS) to prepare for a November 4, 2020 ballot initiative to raise the local sales tax to increase funding available to prevent and end homelessness within Alameda County. The ballot initiative did pass in November; however, it is currently facing a court challenge, and the outcome is uncertain.

In 2020, utilization of Care Connect's Home Stretch Housing Assistance Fund continued to grow, enabling hundreds of people who were without savings, but able to maintain

rent, to obtain and maintain safe and stable housing. The Fund has provided approximately $638,000 in one-time rental assistance and associated move-in costs such as household items, furnishings; for households with disabilities, the Fund can help to get needed equipment or modifications to make their new homes safe and accessible.

The Care Connect capacity development resources have made a real contribution to the emergency response. The Skills Development Unit (SDU) rapidly transitioned to virtual trainings and collaborated with ACBH to conduct trainings on housing and supportive services (e.g., coordinated entry system, document readiness, and housing problem solving) and with congregate shelter and street outreach staff to do trainings on PPE donning and doffing and other COVID-related content. However, training of new hires during COVID-19 continues to be challenging—virtual trainings are limited and do not encourage full engagement and participation.

**Improving health outcomes**

The SHIE now gives us the opportunity to analyze our programs in a way that was not possible in the past.

COVID-19 has had a disproportionate impact on Care Connect's focus population, making connecting people to healthcare and other needed services all the more critical. We recently found that many of the Project RoomKey hotel guests were eligible for Medi-Cal but were not enrolled or had inactive Medi-Cal. Using the SHIE, we generated a list of hotel guests that included their Medi-Cal status and basic identifying information. The Project RoomKey staff were then able to coordinate with Social Services Agency to identify individuals whose Medi-Cal field in the SHIE was blank or inactive and who were eligible to enroll. Hotel staff and RNs connected these guests with Social Services Agency staff who were able to help them complete the Medi-Cal application. In five weeks, half of the 100+ guests who previously did not have active Medi-Cal were enrolled, which allowed these guests to have access to significantly more resources and services than they did previously.

Care Connect's Consumer and Family Engagement Team highlighted a major gap in access to care and knowledge among the local Mam-speaking population. The health system was observing disproportionately high rates of COVID-19 among Mam-speaking populations but were having difficulty effectively reaching this community. Using the SHIE, the Date Exchange Unit created an algorithm based on common Mam last names plus information on race/ethnicity and language (where available) to identify the primary zip codes where the county's Mam-speaking population resides and the top 2-3 clinics the Mam community uses. This algorithm was applied to all individuals in the SHIE

including the expanded population. The work also helped to identify the primary zip codes where the county's Mam-speaking population resides and the top 2-3 clinics the Mam community uses. Turning this information into action, Care Connect identified, hired, and trained trilingual Mam-Spanish-English community members to partner with appropriate clinics and community organizations to design and implement strategies to prevent the spread of COVID-19 and increase wellness in the Mam-speaking community.

## III. ENROLLMENT AND UTILIZATION DATA

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

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

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

| Item | Month 1 | Month 2 | Month 3 | Month 4 | Month 5 | Month 6 | Unduplicated Total |
|---|---|---|---|---|---|---|---|
| Unduplicated Enrollees | 1120 | 734 | 1189 | 3280 | 1347 | 1169 | 8839 |

| Item | Month 7 | Month 8 | Month 9 | Month 10 | Month 11 | Month 12 | Annual Unduplicated Total |
|---|---|---|---|---|---|---|---|
| Unduplicated Enrollees | 936 | 915 | 663 | 660 | 582 | 574 | 4330 |

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

## Costs and Aggregate Utilization for Quarters 1 and 2

| FFS | Month 1 | Month 2 | Month 3 | Month 4 | Month 5 | Month 6 | Total |
|---|---|---|---|---|---|---|---|
| **Category 1 Del #7. Outreach Services-hours - Cost** | 60,185.25 | 48,386.25 | 47,713.50 | 63,942.30 | 64,998.00 | 62,296.65 | $347,521.95 |
| **Category 1 Del #7. Outreach Services-hours** | 1,453.75 | 1,168.75 | 1,152.50 | 1,544.50 | 1,570.00 | 1,504.75 | 8,394.25 |
| **Category 28 Del #7a. Outreach and Engagement encounters - homeless street outreach - Cost** | - | * | * | * | * | 3,450.00 | $6,300.00 |
| **Category 28 Del #7a. Outreach and Engagement encounters - homeless street outreach** | - | * | * | * | * | 23.00 | 42.00 |
| **Category 29 Del #7a. Outreach and Engagement encounters - Home or facility outreach - Cost** | * | * | - | * | * | * | $2,100.00 |
| **Category 29 Del #7a. Outreach and** | * | * | - | * | * | * | 21.00 |

## Costs and Aggregate Utilization for Quarters 1 and 2

| FFS | Month 1 | Month 2 | Month 3 | Month 4 | Month 5 | Month 6 | Total |
|---|---|---|---|---|---|---|---|
| **Engagement encounters - Home or facility outreach** | | | | | | | |
| **Category 30 Del #7a. Outreach and Engagement encounters - In-reach - Cost** | * | * | * | * | - | * | $900.00 |
| **Category 30 Del #7a. Outreach and Engagement encounters - In-reach** | * | * | * | * | - | * | 18.00 |
| **Category 2 Del #8. Housing Education & Legal Assistance--Call Center cases cost** | 10,021.50 | 22,491.00 | 12,393.00 | 9,639.00 | 8,950.50 | 12,699.00 | $76,194.00 |
| **Category 2 Del #8. Housing Education & Legal Assistance--Call Center cases** | 131.00 | 294.00 | 162.00 | 126.00 | 117.00 | 166.00 | 996.00 |
| **Category 3 Del #8. Housing Education & Legal Assistance— Workshops - Cost** | 16,646.30 | 13,946.90 | * | * | - | - | $35,542.10 |
| **Category 3 Del #8. Housing Education &** | 37.00 | 31.00 | * | * | - | - | 79 |

## Costs and Aggregate Utilization for Quarters 1 and 2

| FFS | Month 1 | Month 2 | Month 3 | Month 4 | Month 5 | Month 6 | Total |
|---|---|---|---|---|---|---|---|
| **Legal Assistance--Workshops** | | | | | | | |
| **Category 4 Del #8. Housing Education & Legal Assistance--individual legal assistance - Cost** | 100,035.00 | * | * | * | * | * | $150,930.00 |
| **Category 4 Del #8. Housing Education & Legal Assistance--individual legal assistance** | 57.00 | * | * | * | * | * | 86.00 |
| **Category 5 Del #10. Client Move-In funds - Cost** | - | - | - | - | - | - | $212,256.00 |
| **Category 5 Del #10. Client Move-In funds** | - | - | - | - | - | - | 58.96 |
| **Category 6 Del #10. Housing Locator/Landlord fund - Cost** | - | - | - | - | - | - | $988,537.50 |
| **Category 6 Del #10. Housing Locator/Landlord fund** | - | - | - | - | - | - | 505 |

## 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 - Cost** | - | - | - | - | - | - | $776,883.00 |
| **Category 31 Del #10c. Short-Term Housing Assistance Fund** | 94.00 | 46.00 | 93.00 | 93.00 | 40.00 | 39.00 | 405.00 |
| **Category 7 Del #14. Sobering Center-bed days - Cost** | 90,182.17 | 82,766.66 | 78,460.88 | 51,430.15 | 53,104.62 | 47,363.58 | $403,308.06 |
| **Category 7 Del #14. Sobering Center-bed days** | 377.00 | 346.00 | 328.00 | 215.00 | 222.00 | 198.00 | 1,686.00 |
| **Category 8 Del #15. SUD Diversion - Hours on assessments, - Cost** | 3,210.06 | 2,751.48 | * | * | * | * | $9,630.18 |
| **Category 8 Del #15. SUD Diversion - Hours on assessments,** | 14.00 | 12.00 | * | * | * | * | 42.00 |
| **Category 9 Del #15. SUD Diversion - court visit encounters, - Cost** | 14,215.98 | 11,235.21 | 8,713.02 | - | * | * | $40,813.62 |
| **Category 9 Del #15. SUD Diversion - court visit encounters,** | 62.00 | 49.00 | 38.00 | - | * | * | 178 |

## Costs and Aggregate Utilization for Quarters 1 and 2

| FFS | Month 1 | Month 2 | Month 3 | Month 4 | Month 5 | Month 6 | Total |
|---|---|---|---|---|---|---|---|
| **Category 10 Del #15. SUD Diversion - drug testing w/ Care Manager contact - Cost** | - | 1,203.77 | 1,031.81 | - | - | - | $2,235.58 |
| **Category 10 Del #15. SUD Diversion - drug testing w/ Care Manager contact** | - | 21.00 | 18.00 | - | - | - | 39 |
| **Category 11 Del #16 Portals to Substance Use Disorder Treatment – Linkage - Cost** | 2,014.87 | 3,564.77 | 3,254.79 | * | * | * | $13,174.15 |
| **Category 11 Del #16 Portals to Substance Use Disorder Treatment - Linkage** | 13.00 | 23.00 | 21.00 | * | * | * | 85 |
| **Category 12 Del #16 Portals to Substance Use Disorder Treatment – helpline - Cost** | 8,266.13 | 6,251.26 | 7,026.21 | 5,011.34 | 6,251.26 | 7,181.20 | $39,987.42 |
| **Category 12 Del #16 Portals to Substance Use Disorder Treatment – helpline** | 160.00 | 121.00 | 136.00 | 97.00 | 121.00 | 139.00 | 774.00 |

## Costs and Aggregate Utilization for Quarters 1 and 2

| FFS | Month 1 | Month 2 | Month 3 | Month 4 | Month 5 | Month 6 | Total |
|---|---|---|---|---|---|---|---|
| **Category 13 Del #16 Portals to Substance Use Disorder Treatment - in person assessments - Cost** | - | - | - | - | - | - | $0 |
| **Category 13 Del #16 Portals to Substance Use Disorder Treatment - in person assessments** | - | - | - | - | - | - | 0 |
| **Category 32 Del #16d Portals to SUD Treatment - Care Navigation contacts, hours - cost** | 1,265.75 | 1,653.23 | 1,911.54 | 2,944.81 | 5,424.65 | 6,690.40 | $19,890.38 |
| **Category 32 Del #16d Portals to SUD Treatment - Care Navigation contacts, hours** | 49 | 64 | 74 | 114 | 210 | 259 | 770.00 |
| **Category 14 Del #18b. Psychiatric Consultations for PCPs - curbside consults - Cost** | 15,914.78 | 14,668.00 | 12,321.12 | 16,501.50 | 15,841.44 | 17,161.56 | $92,408.40 |
| **Category 14 Del #18b. Psychiatric Consultations** | 217.00 | 200.00 | 168.00 | 225.00 | 216.00 | 234.00 | 1260.00 |

## Costs and Aggregate Utilization for Quarters 1 and 2

| FFS | Month 1 | Month 2 | Month 3 | Month 4 | Month 5 | Month 6 | Total |
|---|---|---|---|---|---|---|---|
| **for PCPs - curbside consults** | | | | | | | |
| **Category 15 Del #18b. Psychiatric Consultations for PCPs - chart reviews - Cost** | 11,074.34 | 11,734.40 | 10,707.64 | 14,301.30 | 11,074.34 | 8,214.08 | $67,106.10 |
| **Category 15 Del #18b. Psychiatric Consultations for PCPs - chart reviews** | 151.00 | 160.00 | 146.00 | 195.00 | 151.00 | 112.00 | 915 |
| **Category 16 Del #18b. Psychiatric Consultations for PCPs - one-on-one staff meetings - Cost** | 7,535.00 | 8,470.00 | 5,610.00 | 10,285.00 | 10,450.00 | 10,890.00 | $53,240.00 |
| **Category 16 Del #18b. Psychiatric Consultations for PCPs - one-on-one staff meetings** | 137.00 | 154.00 | 102.00 | 187.00 | 190.00 | 198.00 | 968 |
| **Category 17 Del #18b. Psychiatric Consultations for PCPs - elbow support - Cost** | * | * | - | - | * | - | $12,730.23 |
| **Category 17 Del #18b. Psychiatric Consultations for PCPs - elbow support** | * | * | - | - | * | - | 27 |

## 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** | * | * | * | * | * | * | $39,604.80 |
| **Category 18 Del #18b. Psychiatric Consultations for PCPs - training presentations** | * | * | * | * | * | * | 30 |
| **Category 19 Del #19. Completed IBH Care Coordination for patients at FQHC- Cost** | 264,474.26 | 255,870.14 | 335,970.40 | 664,156.12 | 460,013.13 | 450,896.86 | $2,431,380.91 |
| **Category 19 Del #19. Completed IBH Care Coordination for patients at FQHC** | 2,582.00 | 2,498.00 | 3,280.00 | 6,484.00 | 4,491.00 | 4,402.00 | 23,737.00 |
| **Category 20 Del #20b. BH Medical Homes - Nurse Care Coordinators- referrals- Cost** | 9,569.70 | 8,797.95 | 9,569.70 | 6,328.35 | 7,871.85 | 10,187.10 | $52,324.65 |
| **Category 20 Del #20b. BH Medical Homes - Nurse Care Coordinators- referrals** | 62.00 | 57.00 | 62.00 | 41.00 | 51.00 | 66.00 | 339 |

## Costs and Aggregate Utilization for Quarters 1 and 2

| FFS | Month 1 | Month 2 | Month 3 | Month 4 | Month 5 | Month 6 | Total |
|---|---|---|---|---|---|---|---|
| **Category 21 Del #20b. BH Medical Homes - Nurse Care Coordinators- primary care meetings- Cost** | * | * | * | - | - | - | $4,683.58 |
| **Category 21 Del #20b. BH Medical Homes - Nurse Care Coordinators- primary care meetings** | * | * | * | - | - | - | 11 |
| **Category 22 Del #20b. BH Medical Homes - Nurse Care Coordinators- clinic debrief sessions- Cost** | * | * | * | - | - | - | $8,515.60 |
| **Category 22 Del #20b. BH Medical Homes - Nurse Care Coordinators- clinic debrief sessions** | * | * | * | - | - | - | 20 |
| **Category 23 Del #20b. BH Medical Homes - Nurse Care Coordinators- psychiatrist meetings- Cost** | * | * | * | - | - | - | $8,515.60 |
| **Category 23 Del #20b. BH Medical Homes - Nurse** | * | * | * | - | - | - | 20 |

## Costs and Aggregate Utilization for Quarters 1 and 2

| FFS | Month 1 | Month 2 | Month 3 | Month 4 | Month 5 | Month 6 | Total |
|---|---|---|---|---|---|---|---|
| **Care Coordinators- psychiatrist meetings** | | | | | | | |
| **Category 24 Del #20c. BH Medical Homes - Patient Navigators- primary care meetings- Cost** | - | - | - | - | - | - | $0 |
| **Category 24 Del #20c. BH Medical Homes - Patient Navigators- primary care meetings** | - | - | - | - | - | - | 0 |
| **Category 25 Del #20c. BH Medical Homes - Patient transport referrals- Cost** | * | * | - | - | - | - | $3,406.26 |
| **Category 25 Del #20c. BH Medical Homes - Patient transport referrals** | * | * | - | - | - | - | 26.00 |
| **Category 26 Del #20c. BH Medical Homes - Patient Navigators- Wellness Class Coordination- Cost** | - | - | - | - | - | - | $0 |
| **Category 26 Del #20c. BH Medical Homes - Patient Navigators- Wellness Class Coordination** | - | - | - | - | - | - | 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 27 Del #20c. BH Medical Homes - Patient Navigators- psychiatrist meetings- Cost** | - | - | - | - | - | - | $0 |
| **Category 27 Del #20c. BH Medical Homes - Patient Navigators- psychiatrist meetings** | - | - | - | - | - | - | 0 |
| **Category 33 Del #48. Medical Respite Program - bed days cost** | 99,000.00 | 106,500.00 | 105,750.00 | 71,250.00 | 52,000.00 | 47,250.00 | $481,750.00 |
| **Category 33 Del #48. Medical Respite Program - bed days** | 396.00 | 426.00 | 423.00 | 285.00 | 208.00 | 189.00 | 1927 |
| **Category 35 Del #49b. Benefits Enrollment and Advocacy - encounters at accessible locations cost** | * | * | 6,090.00 | 14,500.00 | 13,050.00 | 12,760.00 | $54,810.00 |
| **Category 35 Del #49b. Benefits Enrollment and Advocacy - encounters at accessible locations** | * | * | 21.00 | 50.00 | 45.00 | 44.00 | 189 |

## 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** | - | - | - | 34,020.00 | 4,617.00 | 22,113.00 | $60,750.00 |
| **Del #57. Clinical, technical consultation - individual consultations** | - | - | - | 140.00 | 19.00 | 91.00 | 250 |
| **Del #57. Clinical, technical consultation- organizational meetings cost** | - | - | - | - | - | - | $0 |
| **Del #57. Clinical, technical consultation- organizational meetings** | - | - | - | - | - | - | 0 |
| **Del #57. Clinical, technical consultation - elbow support/coaching cost** | - | - | - | - | - | - | $0 |
| **Del #57. Clinical, technical consultation - elbow support/coaching** | - | - | - | - | - | - | - |
| **Del #57. Clinical, technical consultation- on-site training presentations cost** | - | - | - | 5,832.00 | * | * | $12,636.00 |

## 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- on-site training presentations** | - | - | - | 12.00 | * | * | 26.00 |
| **Category 37 Del#68c Coordinated Entry - assessments cost** | - | - | - | - | 10,000.00 | 5,000.00 | $15,000.00 |
| **Category 37 Del#68c Coordinated Entry - assessments** | - | - | - | - | 50.00 | 25.00 | 75.00 |
| **Category 38 Del#68d Health Assessment Screening and Documentation - assessments cost** | - | - | - | - | 21,200.00 | 12,000.00 | $33,200.00 |
| **Category 38 Del#68d Health Assessment Screening and Documentation - assessments** | - | - | - | - | 53.00 | 30.00 | 83.00 |
| **Category 39 Del#68e Clinical and Technical Consultation for HomeBase sites - document review cost** | - | - | - | - | - | - | $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 39 Del#68e Clinical and Technical Consultation for HomeBase sites - document review** | - | - | - | - | - | - | - |
| **Del 68e Clinical and Technical Consultation for HomeBase sites - organizational meetings cost** | - | - | - | - | - | - | $0 |
| **Del 68e Clinical and Technical Consultation for HomeBase sites - organizational meetings** | - | - | - | - | - | - | - |
| **Del 68e Clinical and Technical Consultation for HomeBase sites - elbow support/coaching cost** | - | - | - | - | - | - | $0 |
| **Del 68e Clinical and Technical Consultation for HomeBase sites - elbow support/coaching** | - | - | - | - | - | - | - |
| **Del 68e Clinical and Technical Consultation** | - | - | - | - | - | - | $0 |

## Costs and Aggregate Utilization for Quarters 1 and 2

| FFS | Month 1 | Month 2 | Month 3 | Month 4 | Month 5 | Month 6 | Total |
|---|---|---|---|---|---|---|---|
| **for HomeBase sites - on-site training presentations cost** | | | | | | | |
| **Del 68e Clinical and Technical Consultation for HomeBase sites - on-site training presentations** | - | - | - | - | - | - | - |
| **Category 40 Del#68f - Benefits Enrollment and Advocacy Services - encounters cost** | - | - | - | - | - | - | $0 |
| **Category 40 Del#68f - Benefits Enrollment and Advocacy Services - encounters** | - | - | - | - | - | - | - |
| **Category 41 COVID Del #69 - Coordinated Entry Assessments cost** | - | - | - | 7,200.00 | 16,400.00 | 13,600.00 | $37,200.00 |
| **Category 41 COVID Del #69 - Coordinated Entry Assessments** | - | - | - | 36.00 | 82.00 | 68.00 | 186.00 |
| **Category 42 COVID Del #70 - Health Assessment** | - | - | * | 138,000.00 | * | 53,200.00 | $246,000.00 |

## Costs and Aggregate Utilization for Quarters 1 and 2

| FFS | Month 1 | Month 2 | Month 3 | Month 4 | Month 5 | Month 6 | Total |
|---|---|---|---|---|---|---|---|
| **Screening and Documentation cost** | | | | | | | |
| **Category 42 COVID Del #70 - Health Assessment Screening and Documentation** | - | - | * | 345.00 | * | 133.00 | 615.00 |

## 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 1 Del #7. Outreach Services-hours - Cost** | 60,526.80 | 58,146.30 | 50,301.00 | 62,648.55 | 58,498.20 | 69,138.00 | $359,258.85 |
| **Category 1 Del #7. Outreach Services-hours** | 1,462.00 | 1,404.50 | 1,215.00 | 1,513.25 | 1,413.00 | 1,670.00 | 8,677.75 |
| **Category 28 Del #7a. Outreach and Engagement encounters - homeless street outreach - Cost** | 10,500.00 | 13,500.00 | 14,550.00 | 18,150.00 | 18,300.00 | 18,300.00 | $93,300.00 |
| **Category 28 Del #7a. Outreach and Engagement encounters - homeless street outreach** | 70.00 | 90.00 | 97.00 | 121.00 | 122.00 | 122.00 | 622.00 |

## 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 - Cost** | * | * | 2,700.00 | * | 1,400.00 | * | $5,900.00 |
| **Category 29 Del #7a. Outreach and Engagement encounters - Home or facility outreach** | * | * | 27.00 | * | 14.00 | * | 59.00 |
| **Category 30 Del #7a. Outreach and Engagement encounters - In-reach - Cost** | - | - | * | * | * | 650.00 | $1,350.00 |
| **Category 30 Del #7a. Outreach and Engagement encounters - In-reach** | - | - | * | * | * | 13.00 | 27.00 |
| **Category 2 Del #8. Housing Education & Legal Assistance--Call Center cases cost** | 12,087.00 | 7,879.50 | 7,267.50 | 7,803.00 | 7,267.50 | 2,295.00 | $44,599.50 |
| **Category 2 Del #8. Housing Education &** | 158.00 | 103.00 | 95.00 | 102.00 | 95.00 | 30.00 | 583.00 |

## Costs and Aggregate Utilization for Quarters 3 and 4

| FFS | Month 7 | Month 8 | Month 9 | Month 10 | Month 11 | Month 12 | Annual Total |
|---|---|---|---|---|---|---|---|
| **Legal Assistance--Call Center cases** | | | | | | | |
| **Category 3 Del #8. Housing Education & Legal Assistance— Workshops - Cost** | - | * | - | * | * | - | $1,799.60 |
| **Category 3 Del #8. Housing Education & Legal Assistance-- Workshops** | - | * | - | * | * | - | * |
| **Category 4 Del #8. Housing Education & Legal Assistance-- individual legal assistance - Cost** | * | * | * | * | * | * | $59,670.00 |
| **Category 4 Del #8. Housing Education & Legal Assistance-- individual legal assistance** | * | * | * | * | * | * | 34.00 |
| **Category 5 Del #10. Client Move-In funds - Cost** | | | | | | | $425,681.02 |
| **Category 5 Del #10. Client Move-In funds** | | | | | | | 118.24 |

## Costs and Aggregate Utilization for Quarters 3 and 4

| FFS | Month 7 | Month 8 | Month 9 | Month 10 | Month 11 | Month 12 | Annual Total |
|---|---|---|---|---|---|---|---|
| **Category 6 Del #10. Housing Locator/Landlord fund - Cost** | | | | | | | $185,962.50 |
| **Category 6 Del #10. Housing Locator/Landlord fund** | | | | | | | 159 |
| **Category 31 Del #10c. Short-Term Housing Assistance Fund - Cost** | | | | | | | $530,211.00 |
| **Category 31 Del #10c. Short-Term Housing Assistance Fund** | 30.00 | 64.00 | 51.00 | 40.00 | 29.00 | 38.00 | 252 |
| **Category 7 Del #14. Sobering Center-bed days - Cost** | 48,320.42 | 67,457.22 | 67,696.43 | 64,825.91 | 59,563.29 | 37,795.18 | $345,658.45 |
| **Category 7 Del #14. Sobering Center-bed days** | 202.00 | 282.00 | 283.00 | 271.00 | 249.00 | 158.00 | 1445 |
| **Category 8 Del #15. SUD Diversion - Hours on assessments, - Cost** | * | * | * | - | * | - | $3,668.64 |
| **Category 8 Del #15. SUD Diversion - Hours on assessments,** | * | * | * | - | * | - | 16 |

## 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 9 Del #15. SUD Diversion - court visit encounters, - Cost** | 7,107.99 | 7,566.57 | 6,878.70 | - | 12,610.95 | - | $34,164.21 |
| **Category 9 Del #15. SUD Diversion - court visit encounters,** | 31.00 | 33.00 | 30.00 | - | 55.00 | - | 149 |
| **Category 10 Del #15. SUD Diversion - drug testing w/ Care Manager contact - Cost** | - | - | - | - | - | - | $0 |
| **Category 10 Del #15. SUD Diversion - drug testing w/ Care Manager contact** | - | - | - | - | - | - | 0 |
| **Category 11 Del #16 Portals to Substance Use Disorder Treatment – Linkage - Cost** | 2,169.86 | 1,704.89 | 2,789.82 | 3,564.77 | 3,564.77 | 4,804.69 | $18,598.80 |
| **Category 11 Del #16 Portals to Substance Use Disorder Treatment - Linkage** | 14.00 | 11.00 | 18.00 | 23.00 | 23.00 | 31.00 | 120 |
| **Category 12 Del #16 Portals to Substance Use** | 7,646.17 | 9,041.08 | 5,372.99 | 6,044.61 | 6,354.59 | 6,096.27 | $40,555.72 |

## Costs and Aggregate Utilization for Quarters 3 and 4

| FFS | Month 7 | Month 8 | Month 9 | Month 10 | Month 11 | Month 12 | Annual Total |
|---|---|---|---|---|---|---|---|
| **Disorder Treatment – helpline - Cost** | | | | | | | |
| **Category 12 Del #16 Portals to Substance Use Disorder Treatment – helpline** | 148.00 | 175.00 | 104.00 | 117.00 | 123.00 | 118.00 | 785 |
| **Category 13 Del #16 Portals to Substance Use Disorder Treatment - in person assessments - Cost** | - | - | - | - | - | - | $0 |
| **Category 13 Del #16 Portals to Substance Use Disorder Treatment - in person assessments** | - | - | - | - | - | - | 0 |
| **Category 32 Del #16d Portals to SUD Treatment - Care Navigation contacts, hours - cost** | 8,162.81 | 11,805.07 | 8,317.80 | 8,059.48 | 4,675.53 | 4,882.19 | $45,902.87 |
| **Category 32 Del #16d Portals to SUD Treatment - Care Navigation contacts, hours** | 316.00 | 457.00 | 322.00 | 312.00 | 181.00 | 189.00 | 1777 |

## 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 14 Del #18b. Psychiatric Consultations for PCPs - curbside consults - Cost** | 19,875.14 | 17,161.56 | 16,868.20 | 17,381.58 | 17,088.22 | 15,914.78 | $104,289.48 |
| **Category 14 Del #18b. Psychiatric Consultations for PCPs - curbside consults** | 271.00 | 234.00 | 230.00 | 237.00 | 233.00 | 217.00 | 1422 |
| **Category 15 Del #18b. Psychiatric Consultations for PCPs - chart reviews - Cost** | 13,934.60 | 12,321.12 | 12,541.14 | 13,347.88 | 11,587.72 | 13,641.24 | $77,373.70 |
| **Category 15 Del #18b. Psychiatric Consultations for PCPs - chart reviews** | 190.00 | 168.00 | 171.00 | 182.00 | 158.00 | 186.00 | 1055 |
| **Category 16 Del #18b. Psychiatric Consultations for PCPs - one-on-one staff meetings - Cost** | 10,725.00 | 11,550.00 | 12,595.00 | 11,770.00 | 9,405.00 | 8,635.00 | $64,680.00 |
| **Category 16 Del #18b. Psychiatric Consultations for PCPs - one-on-one staff meetings** | 195.00 | 210.00 | 229.00 | 214.00 | 171.00 | 157.00 | 1176 |

## 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 17 Del #18b. Psychiatric Consultations for PCPs - elbow support - Cost** | * | - | * | * | * | * | $7,072.35 |
| **Category 17 Del #18b. Psychiatric Consultations for PCPs - elbow support** | * | - | * | * | * | * | 15 |
| **Category 18 Del #18b. Psychiatric Consultations for PCPs - training presentations - Cost** | 47,525.76 | 29,043.52 | * | * | * | * | $116,174.08 |
| **Category 18 Del #18b. Psychiatric Consultations for PCPs - training presentations** | 36.00 | 22.00 | * | * | * | * | 88 |
| **Category 19 Del #19. Completed IBH Care Coordination for patients at FQHC- Cost** | 780,004.45 | 453,457.61 | 443,829.19 | 442,395.17 | 391,077.74 | 330,848.90 | $2,841,613.06 |
| **Category 19 Del #19. Completed IBH Care Coordination for patients at FQHC** | 7,615.00 | 4,427.00 | 4,333.00 | 4,319.00 | 3,818.00 | 3,230.00 | 27,742.00 |

## 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** | 7,100.10 | 5,247.90 | 8,489.25 | - | - | - | $20,837.25 |
| **Category 20 Del #20b. BH Medical Homes - Nurse Care Coordinators- referrals** | 46.00 | 34.00 | 55.00 | - | - | - | 135 |
| **Category 21 Del #20b. BH Medical Homes - Nurse Care Coordinators- primary care meetings- Cost** | - | - | * | - | - | - | * |
| **Category 21 Del #20b. BH Medical Homes - Nurse Care Coordinators- primary care meetings** | - | - | * | - | - | - | * |
| **Category 22 Del #20b. BH Medical Homes - Nurse Care Coordinators- clinic debrief sessions- Cost** | - | - | * | - | - | - | * |
| **Category 22 Del #20b. BH Medical Homes - Nurse** | - | - | * | - | - | - | * |

## Costs and Aggregate Utilization for Quarters 3 and 4

| FFS | Month 7 | Month 8 | Month 9 | Month 10 | Month 11 | Month 12 | Annual Total |
|---|---|---|---|---|---|---|---|
| **Care Coordinators- clinic debrief sessions** | | | | | | | |
| **Category 23 Del #20b. BH Medical Homes - Nurse Care Coordinators- psychiatrist meetings- Cost** | - | - | * | - | - | - | * |
| **Category 23 Del #20b. BH Medical Homes - Nurse Care Coordinators- psychiatrist meetings** | - | - | * | - | - | - | * |
| **Category 24 Del #20c. BH Medical Homes - Patient Navigators- primary care meetings- Cost** | - | - | - | - | - | - | $0 |
| **Category 24 Del #20c. BH Medical Homes - Patient Navigators- primary care meetings** | - | - | - | - | - | - | 0 |
| **Category 25 Del #20c. BH Medical Homes - Patient transport referrals- Cost** | - | - | - | - | - | - | $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 25 Del #20c. BH Medical Homes - Patient transport referrals** | - | - | - | - | - | - | - |
| **Category 26 Del #20c. BH Medical Homes - Patient Navigators- Wellness Class Coordination- Cost** | - | - | - | - | - | - | $0 |
| **Category 26 Del #20c. BH Medical Homes - Patient Navigators- Wellness Class Coordination** | - | - | - | - | - | - | 0 |
| **Category 27 Del #20c. BH Medical Homes - Patient Navigators- psychiatrist meetings- Cost** | - | - | - | - | - | - | $0 |
| **Category 27 Del #20c. BH Medical Homes - Patient Navigators- psychiatrist meetings** | - | - | - | - | - | - | 0 |
| **Category 33 Del #48. Medical Respite Program - bed days cost** | 85,500.00 | 58,750.00 | 59,000.00 | 68,250.00 | 78,500.00 | 77,000.00 | $427,000.00 |

## 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 33 Del #48. Medical Respite Program - bed days** | 342.00 | 235.00 | 236.00 | 273.00 | 314.00 | 308.00 | 1708 |
| **Category 35 Del #49b. Benefits Enrollment and Advocacy - encounters at accessible locations cost** | 8,120.00 | * | 12,760.00 | 10,440.00 | 9,280.00 | * | $46,690.00 |
| **Category 35 Del #49b. Benefits Enrollment and Advocacy - encounters at accessible locations** | 28.00 | * | 44.00 | 36.00 | 32.00 | * | 161 |
| **Del #57. Clinical, technical consultation - individual consultations cost** | 9,477.00 | $18,346.50 | $13,972.50 - | 6,378.75 | 30,375.00 - | 35,903.25 - | $114,453.00 |
| **Del #57. Clinical, technical consultation - individual consultations** | 39.00 | 75.50 | 57.50 | 26.25 | 125.00 | 147.75 | 471.00 |
| **Del #57. Clinical, technical consultation- organizational meetings cost** | - | * | 7,290.00 | 16,281.00 | 14,337.00 | * | $48,721.50 |
| **Del #57. Clinical, technical consultation- organizational meetings** | | * | 30.00 | 67.00 | 59.00 | * | 200.5 |

## 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 - elbow support/coaching cost** | - | * | - | * | * | * | $40,824.00 |
| **Del #57. Clinical, technical consultation - elbow support/coaching** | - | * | - | * | * | * | 42 |
| **Del #57. Clinical, technical consultation- on-site training presentations cost** | - | - | - | * | - | * | $29,524.50 |
| **Del #57. Clinical, technical consultation- on-site training presentations** | - | - | - | * | - | * | 60.75 |
| **Category 37 Del#68c Coordinated Entry - assessments cost** | 2,400.00 | - | * | * | * | * | $6,200.00 |
| **Category 37 Del#68c Coordinated Entry - assessments** | 12.00 | - | * | * | * | * | 31 |
| **Category 38 Del#68d Health Assessment Screening and Documentation - assessments cost** | 5,200.00 | * | * | * | * | 4,800.00 | $16,400.00 |

## 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 38 Del#68d Health Assessment Screening and Documentation - assessments** | 13.00 | * | * | * | * | 12.00 | 41 |
| **Category 39 Del#68e Clinical and Technical Consultation for HomeBase sites - document review cost** | - | - | - | - | - | - | $0 |
| **Category 39 Del#68e Clinical and Technical Consultation for HomeBase sites - document review** | - | - | - | - | - | - | 0 |
| **Del 68e Clinical and Technical Consultation for HomeBase sites - organizational meetings cost** | - | - | - | - | - | - | $0 |
| **Del 68e Clinical and Technical Consultation for HomeBase sites - organizational meetings** | - | - | - | - | - | - | 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 |
|---|---|---|---|---|---|---|---|
| **Del 68e Clinical and Technical Consultation for HomeBase sites - elbow support/coaching cost** | - | - | - | - | - | - | $0 |
| **Del 68e Clinical and Technical Consultation for HomeBase sites - elbow support/coaching** | - | - | - | - | - | - | 0 |
| **Del 68e Clinical and Technical Consultation for HomeBase sites - on-site training presentations cost** | - | - | - | - | - | - | $0 |
| **Del 68e Clinical and Technical Consultation for HomeBase sites - on-site training presentations** | - | - | - | - | - | - | 0 |
| **Category 40 Del#68f - Benefits Enrollment and Advocacy Services - encounters cost** | - | - | - | - | - | - | $0 |
| **Category 40 Del#68f - Benefits Enrollment and** | - | - | - | - | - | - | 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 |
|---|---|---|---|---|---|---|---|
| **Advocacy Services - encounters** | | | | | | | |
| **Category 41 COVID Del #69 - Coordinated Entry Assessments cost** | 16,000.00 | 7,400.00 | 9,800.00 | 13,600.00 | 18,600.00 | 3,800.00 | $69,200.00 |
| **Category 41 COVID Del #69 - Coordinated Entry Assessments** | 80.00 | 37.00 | 49.00 | 68.00 | 93.00 | 19.00 | 346 |
| **Category 42 COVID Del #70 - Health Assessment Screening and Documentation cost** | 72,800.00 | 103,600.00 | 63,200.00 | 39,600.00 | 32,400.00 | 53,200.00 | $364,800.00 |
| **Category 42 COVID Del #70 - Health Assessment Screening and Documentation** | 182.00 | 259.00 | 158.00 | 99.00 | 81.00 | 133.00 | 912 |

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

### Amount Claimed for Quarters 1 and 2

| PMPM | Rate | Month 1 | Month 2 | Month 3 | Month 4 | Month 5 | Month 6 | Total |
|---|---|---|---|---|---|---|---|---|
| **Category 1 Del #2. Care Management Service Bundle - Tier 1** | $320.95 | 28,564.55 | 27,922.65 | 26,959.80 | 29,206.45 | 27,280.75 | 26,317.90 | $166,252.10 |
| **Category 1 Del #2. Care Management Service Bundle - Tier 1 MM Counts** | | 89.00 | 87.00 | 84.00 | 91.00 | 85.00 | 82.00 | 518 |
| **Category 2 Del #2. Care Management Service Bundle - Tier 2** | $473.96 | 43,130.36 | 44,552.24 | 45,500.16 | 45,500.16 | 46,922.04 | 45,500.16 | $271,105.12 |
| **Category 2 Del #2. Care Management Service Bundle - Tier 2 MM Counts** | | 91.00 | 94.00 | 96.00 | 96.00 | 99.00 | 96.00 | 572 |

## Amount Claimed for Quarters 1 and 2

| PMPM | Rate | Month 1 | Month 2 | Month 3 | Month 4 | Month 5 | Month 6 | Total |
|---|---|---|---|---|---|---|---|---|
| **Category 7 Del #12c. Health, Housing and Integrated Service Bundle - Tier 1 cost** | $300.00 | 39,300.00 | 39,000.00 | 44,100.00 | 48,000.00 | 50,400.00 | 50,700.00 | $271,500.00 |
| **Category 7 Del #12c. Health, Housing and Integrated Service Bundle - Tier 1 MM Counts** | | 131.00 | 130.00 | 147.00 | 160.00 | 168.00 | 169.00 | 905 |
| **Category 8 Del #12c. Health, Housing and Integrated Service Bundle - Tier 2 cost** | $400.00 | 161,200.00 | 138,000.00 | 132,400.00 | 120,400.00 | 123,200.00 | 128,000.00 | $803,200.00 |
| **Category 8 Del #12c. Health, Housing and Integrated Service Bundle - Tier 2 MM Counts** | | 403.00 | 345.00 | 331.00 | 301.00 | 308.00 | 320.00 | 2008 |

## Amount Claimed for Quarters 1 and 2

| PMPM | Rate | Month 1 | Month 2 | Month 3 | Month 4 | Month 5 | Month 6 | Total |
|---|---|---|---|---|---|---|---|---|
| **Category 9 Del #12c. Health, Housing and Integrated Service Bundle - Tier 3 cost** | $575.00 | 168,475.00 | 168,475.00 | 178,250.00 | 194,925.00 | 188,600.00 | 200,100.00 | $1,098,825.00 |
| **Category 9 Del #12c. Health, Housing and Integrated Service Bundle - Tier 3 MM Counts** | | 293.00 | 293.00 | 310.00 | 339.00 | 328.00 | 348.00 | 1911 |
| **Category 6 Del. #46b Trust Health Center Street Psychiatric Team cost** | $1,353.00 | 37,884.00 | 33,825.00 | 24,354.00 | * | * | 73,062.00 | $189,420.00 |
| **Category 6 Del. #46b Trust Health Center Street Psychiatric Team Counts** | | 28.00 | 25.00 | 18.00 | * | * | 54.00 | 140 |

## Amount Claimed for Quarters 1 and 2

| PMPM | Rate | Month 1 | Month 2 | Month 3 | Month 4 | Month 5 | Month 6 | Total |
|---|---|---|---|---|---|---|---|---|
| **Category 10 Del. #68g HomeBase - Health Housing and Integrated Services Bundle - Member Months Cost** | $575.00 | - | - | - | - | - | - | $0 |
| **Category 10 Del. #68g HomeBase - Health Housing and Integrated Services Bundle - Member Months Counts** | | - | - | - | - | - | - | 0 |

## Amount Claimed for Quarters 3 and 4

| PMPM | Rate | Month 7 | Month 8 | Month 9 | Month 10 | Month 11 | Month 12 | Annual Total |
|---|---|---|---|---|---|---|---|---|
| **Category 1 Del #2. Care Management Service Bundle - Tier 1** | $320.95 | 25,996.95 | 25,996.95 | 25,996.95 | 19,577.95 | 18,615.10 | 17,331.30 | $133,515.20 |
| **Category 1 Del #2. Care Management Service Bundle - Tier 1 MM Counts** | | 81.00 | 81.00 | 81.00 | 61.00 | 58.00 | 54.00 | 416 |

## Amount Claimed for Quarters 3 and 4

| PMPM | Rate | Month 7 | Month 8 | Month 9 | Month 10 | Month 11 | Month 12 | Annual Total |
|---|---|---|---|---|---|---|---|---|
| **Category 2 Del #2. Care Management Service Bundle - Tier 2** | $473.96 | 51,187.68 | 52,135.60 | 47,869.96 | 45,974.12 | 48,817.88 | 42,182.44 | $288,167.68 |
| **Category 2 Del #2. Care Management Service Bundle - Tier 2 MM Counts** | | 108.00 | 110.00 | 101.00 | 97.00 | 103.00 | 89.00 | 608 |
| **Category 7 Del #12c. Health, Housing and Integrated Service Bundle - Tier 1 cost** | $300.00 | 49,200.00 | 46,800.00 | 48,000.00 | 46,800.00 | 51,600.00 | 61,500.00 | $303,900.00 |
| **Category 7 Del #12c. Health, Housing and Integrated Service Bundle - Tier 1 MM Counts** | | 164.00 | 156.00 | 160.00 | 156.00 | 172.00 | 205.00 | 1013 |
| **Category 8 Del #12c. Health, Housing and Integrated Service Bundle - Tier 2 cost** | $400.00 | 124,400.00 | 116,400.00 | 118,800.00 | 114,800.00 | 108,000.00 | 79,200.00 | $661,600.00 |

## Amount Claimed for Quarters 3 and 4

| PMPM | Rate | Month 7 | Month 8 | Month 9 | Month 10 | Month 11 | Month 12 | Annual Total |
|---|---|---|---|---|---|---|---|---|
| **Category 8 Del #12c. Health, Housing and Integrated Service Bundle - Tier 2 MM Counts** | | 311.00 | 291.00 | 297.00 | 287.00 | 270.00 | 198.00 | 1654 |
| **Category 9 Del #12c. Health, Housing and Integrated Service Bundle - Tier 3 cost** | $575.00 | 236,325.00 | 270,825.00 | 265,075.00 | 257,600.00 | 302,450.00 | 385,250.00 | $1,717,525.00 |
| **Category 9 Del #12c. Health, Housing and Integrated Service Bundle - Tier 3 MM Counts** | | 411.00 | 471.00 | 461.00 | 448.00 | 526.00 | 670.00 | 2987 |
| **Category 6 Del. #46b Trust Health Center Street Psychiatric Team cost** | $1,353.00 | - | - | * | * | 33,825.00 | 37,884.00 | $87,945.00 |

## Amount Claimed for Quarters 3 and 4

| PMPM | Rate | Month 7 | Month 8 | Month 9 | Month 10 | Month 11 | Month 12 | Annual Total |
|---|---|---|---|---|---|---|---|---|
| **Category 6 Del. #46b Trust Health Center Street Psychiatric Team Counts** | | - | - | * | * | 25.00 | 28.00 | 65 |
| **Category 10 Del. #68g HomeBase - Health Housing and Integrated Services Bundle - Member Months Cost** | $575.00 | - | - | - | - | - | 52,325.00 | $52,325.00 |
| **Category 10 Del. #68g HomeBase - Health Housing and Integrated Services Bundle - Member Months Counts** | | - | - | - | - | - | 91.00 | 91 |

**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 are not 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 hours and total cost matches the invoice.

5. FFS Category #31 (Del #10c. Short-Term Housing Assistance Fund): The total costs represent the total amount of housing assistance funding. The units represent the total number of services clients received.

7. FFS Category #32 (Del #16d. Helpline Care Navigation Contacts – hours): Each contact is 10 minutes each. The units reported are the number of hours and the total cost matches the invoice.

8. FFS Del. #57 Clinical and Technical Consultation for Direct Service Providers; Not client specific. Monthly amounts are not available, so the total claimed for each six-month period is reported

9. Per instructions from DHCS, we have included actual service totals. For one deliverable that exceeds its budget, FFS Category #19 (Del #19 Completed IBH Care Coordination for patients at FQHC), we do not wish to claim the amount over budget. Also indicated on the invoice.

## IV. NARRATIVE – Administrative Infrastructure

**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. During this reporting period, the Housing Solutions for Health Office merged with the Office of Homeless Care and Coordination. OHCC continues to work with other HCSA departments, and coordinate with HCD, Probation, and Social Services to create a better system of care for those experiencing homelessness.

Major projects of the Housing Solutions for Health team and OHCC in 2020 include:

**Street Health Outreach -** a multi-disciplinary model of care providing street outreach and engagement, street health services and triage, collaboration with housing and community organizations to secure housing and benefits for clients, enabling services, short-term case management, laboratory/diagnostic tests, medication formulary, healthcare navigation services, supportive services/referrals. Services are provided to unsheltered homeless on the streets, in encampments, cars, RV's and other places not meant for human habitation.

Key accomplishments of the Street Health Program between July 1-Dec 31, 2020 included:

- 645 individuals were provided outreach and engagement services.
- 374 individuals are actively engaged in services.
- 261 outreach assessments were completed to determine basic needs identified by patients.
- 229 patients were enrolled in medical homes during this period. Fifty-nine percent (59%) of these patients became active users of a brick and mortar clinic, meaning they were seen at least twice by a primary care provider.
- 60 patients were provided field based COVID-19 testing.

**Operation Safer Ground / Operation Comfort** - Non-congregate hotel programs for homeless households were created and operated to provide safe shelter for homeless households exposed or infected with the coronavirus and for those at high-risk for severe COVID-19 disease.

Operation Safer Ground serves people who are homeless and over 65 or otherwise at high risk (medically fragile), or both. During 2020, Alameda County opened seven Safer Ground hotels, with 775 rooms. To date, approximately 1,200 people have been served

by Operation Safer Ground through December 31, 2020. All seven Safer Ground hotel sites remained open through the end of 2020.

In addition, the County secured two Operation Comfort hotels with 198 rooms. Operation Comfort emergency isolation and quarantine housing is for people experiencing homelessness who test positive for COVID-19, or have symptoms and signs consistent with a possible COVID-19 infection, or who have had verified contact with a person with a known COVID-19 infection. Approximately 1,600 people were served by Operation Comfort in 2020. These hotels remained open through the end of 2020.

**Redesign of Coordinated Entry and role as management entity.** The Housing team supported a countywide redesign of our current Coordinated Entry System (CES) based on feedback from service users, providers, and other key stakeholders.

- OHCC became the officially designated management entity of CES.
- The System Modeling and Racial Equity report was finalized at the end of 2020.
- CES redesign was delayed but planning for implementation continued; new roll-out of assessments and HMIS modules will occur in Spring 2021.
- The procurement process for new Access Point/Housing Resource Centers was completed in December.

**Countywide sales tax ballot measure.** Members of the housing team worked closely with our Board of Supervisors (BOS) to prepare for a November 4, 2020 ballot initiative to raise the local sales tax to increase funding available to prevent and end homelessness within Alameda County. The ballot initiative did pass in November; however, it is currently facing a court challenge. This has delayed some of the planning related to roll out of the redesign.

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

During this reporting period, despite the COVID-19 pandemic, AC Care Connect completed its first full calendar year of implementing the permanent Social Health Information Exchange (SHIE)/ Community Health Record (CHR). The primary focus was user expansion, while sustaining ongoing implementation and maintenance work. While the pandemic brought many challenges, it provided a silver lining in Data Governance Committee decisions regarding the CHR/SHIE's direct use to support COVID-19 response efforts.

From July to December 2020, we completed the go-live and onboarding for 208 end-users across 14 programs (which included 2 new organizations to the CHR end-user community) via 18 system training sessions (all webinars); this count includes 19 read-only end-users from organizations providing SUD treatment. This was a culmination of

the full scope of tasks prescribed by our standard and strictly enforced CHR onboarding process.

Over the second half of 2020, the Data Governance Committee (DGC) reviewed and approved a Non-Covered Entity pilot program and amended/restated the Participant Data Sharing Agreement to include a jail mental health scheduling and care coordination program. The DGC also supported Data Exchange Unit (DEU) endeavors such as Information Sharing Authorization (ISA) collection improvement efforts, discussions to make COVID-19 emergency population expansion permanent, and reviewed the first CHR end-user survey.

Continued initiatives were required to adapt to COVID-19. The DEU began integrating the DocuSign e-signature into the CHR so that users can have an ISA signed by consumers electronically. Further, we continued to support Safer Ground hotel-related care via data system analysis, set-up of data collection systems (e.g., Salesforce) and data exchanges (e.g., HMIS), CHR training, and report development (both ad hoc and within the CHR). Critical developments included building an interim Permanent Supportive Housing (PSH) database with reporting capability while we investigate whether the HMIS vendor can supply an adequate replacement.

Data Integration work during the last quarter of the year brought forth: full integration of jail data with an hourly feed (near real-time updates), daily HMIS updates with new fields (i.e., income, benefits, and disability information), as well as EMS data and expanded pharmacy feeds.

**Del #31 Backbone Organization (BBO)**

Throughout 2020, the BBO supported implementation of new services, achievement of incentives and outcomes, and the development of our data system, as described throughout this report. The BBO provides overall structure for Care Connect, including administrative support such as hiring and personnel, as well as planning and project management. We have worked hard to adapt policies and practices to support our staff in continuing the work in the face of the unprecedented challenges of COVID.

**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**

The Skills Development Unit continued to make rapid adjustments to our training offerings to provide new content most urgently needed by staff in the field during the time of COVID-19, and to continue providing critical trainings on skills to engage consumers (especially challenging when interacting remotely) as well as navigating the complex system of care. Please see Del #36 for details.

**Care Communities**

During 2020, the Quality Improvement Unit (QIU) supported the need to pivot and provide support and capacity development, while maintaining connection and cross-sector collaboration to providers in a way that was created during the Care Communities Initiative. This new care coordination, housing coordination, and quality improvement program had a goal to align the efforts of Governor Gavin Newson's 100-day challenge, to create "Safer Ground" hotel sites during the shelter-in-place. These hotels offered space to high-risk individuals experiencing homelessness and emphasized transitioning guest to sustainable housing options. In order to support the effort, we designed a tactical care coordination collaborative that helped navigators learn key resources in the field and share lessons for quick housing solutions.

The 100 and Beyond Initiative began in June 2020 and ended in December 2020. It resulted in 70 participants building relationships and coordinating care for individuals experiencing homeless, workflow and documentation improvement, and that in turn led to 384 guest becoming document ready, 834 clients referred to rapid re-housing or the Permanent Support Housing Target list, and 140 clients exiting to housing.

To accomplish this, 7 organizations, 9 programs and 70 participants worked inter- and intra-program to strategize housing options for hotel guest. During the twice-monthly, 1.5-hour collaborative sessions, participants identified and addressed common knowledge or resource gaps among housing providers and were proactively connected to County staff or additional resources such as training through the Skills Development Unit. Mini-teaches, were organized to provide the needed soft skills that were immediately applicable for housing navigators. Interactive breakout sessions were used to understand resources such as the Community Health Record, and participants problem-solved the best ways to use the tool for care coordination during shelter-in-place. Plan-Do-Check-Act quality improvement projects and targeted coaching from QIU coaches supported enhanced workflows and documentation practices among housing coordinators, leading to positive housing outcomes for guest.

These quality improvement cycles were further supported by the creation of a set of Care Coordination Quick Guides. To build capacity and support front-line staff in providing care coordination and support service for their clients, the Research and Development Unit (RnDU) developed eleven "Quick Guides" on a variety of topics, such as connecting a client to primary care provider and housing problem solving. These

short Quick Guides provided key "how-to" steps and links to resources for providers to use when meeting and supporting their clients. To obtain content for the Quick Guides and better understand the needs of providers, the RnDU attended the 100 and Beyond collaborative and CBC-ME provider meetings, conducted online research and interviews with subject matter experts. They also held two user feedback sessions with providers on the look/feel and content of the first two Quick Guides. Technical assistance was provided to determine how to adapt and disseminate Quick guides on Elemeno so that they could be efficiently located by busy providers in the field – both those focused on the COVID-19hotel work as well as others in the broader care coordination system.

**Del #33 Communications**

The Communications Team increased engagement with stakeholders during the report period. In July, we launched two monthly newsletters through Constant Contact which allows us to track open and click through rates. Readership (open rates) increased over the period and informal feedback from readers is positive. We now have over 1000 subscribers, an increase of about 29% from July through December 2020. The primary audience for the *CHR User Newsletter* includes providers working directly with consumers using the Community Health Record (CHR) for care coordination. The *Partner Update* is targeted to leaders of our partner organizations and provides updates on key accomplishments and activities across all areas of Care Connect's. We also created a database of stories highlighting the impact of whole person care for use in our communications, and we continue to add new stories each month. We update the Care Connect website regularly and push key documents and information available through Elemeno, an online platform housing resources for CHR users.

In October two Care Connect teams presented on "Building a Social Health Information Exchange" and "Care Communities" at the Camden Coalition's *Putting Care at the Center* annual conference.

**Del #34 and #37 - Care Coordination System Oversight & Administration**

Enrollment in the Care Management Services Bundle has remained fairly consistent during the second half of 2020. The CB-CME network reported increased time spent for outreach and enrollment due to shelter in place and COVID-19 in-person restrictions. The CB-CME network was required to switch from primarily face-to-face engagement with consumers to a telephonic platform for outreach, enrollment, and continued consumer engagement.

Bay Area Community Services (BACS) joined Alameda Alliance for Health's CB-CME network to increase capacity to serve consumers with serious mental illness. However,

due to COVID-19 response, BACS was not able to begin outreach to enroll members until December 2020.

The capacity of the whole CB-CME network was supported through the monthly work sessions sponsored by Alameda Alliance as part of their role in administering the Care Management Service Bundle (Deliverable 37). The focus was on the following topics, including ongoing support for the seismic workflow shift to primarily telephonic care due to COVID-19 Shelter in Place requirements:

- July – Consumer Engagement & Creative Strategies During COVID-19, Tips for Video Conferencing & Telephonic sessions
- Aug – Opioid Overview Part 1, Opioid Use Disorder & COVID-19
- Sept – Opioid Overview Part 2, SUD Trainings, Health Homes Bundle Reporting & Tip Sheet
- Oct – Board & Care, ACBH Substitute Payee Program, Conservatorship, Independent Living Association Overview
- Nov – cancelled due to holiday.
- Dec – CalAIM, Elemeno Housing 101 Syllabus, Tenant Sustainability, Bay Area Legal Aid & COVID-19 housing protections

AC Care Connect reengaged in planning discussions about the transition of Care Management services under WPC to Enhanced Care Management (ECM) and In Lieu of Services (ILOS) under CalAIM at the end of this reporting period.

**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.

**Skills Development Unit (SDU)**

Between July 2020 to December 2020, a total of **510 unduplicated individuals** participated in the Training Academy in 2020; 36 trainings were offered, across 49 organizations and 11 sectors. To date, from July 2018, 1039 individuals have been trained across 100 orgs and 12 sectors.

The Shelter in Place mandate has made virtual trainings the new norm. These more accessible trainings have allowed SDU to reach more participants and offer training more aligned with the work currently happening. AC Care Connect has built up our selection of online offerings and increased the range of training topics to include mental health and wellness during COVID-19.

New topics included:

- Everyday Mental Health: Coping Strategies for the 2020 Holiday Season
- New Legal Protections for CA Tenants in the Wake of COVID-19
- Leaning into Your Trainings: Consumer Engagement During COVID-19 (CB-CME training)
- Group Facilitation in the Virtual World

As of December 2020, Housing sector participants account for most of the participation in trainings. We continue to see positive indicators in our evaluations and continue to monitor progress to better meet the needs of both our providers and consumers alike.

**Quality Improvement Unit (QIU)**

The Quality Improvement Unit pivoted to support the changing landscape of COVID-19 through a 5-month collaborative “100 and Beyond”. Through supporting cross-sector collaboration, strengthening documentation, developing workflows and sharing best practices for care coordination, better processes rooted in quality improvement principles were established. Please see Del #32 for additional details about the initiative and the outcomes.

**Research and Dissemination Unit (RnDU)**

The RnDU conducted a variety of research studies, documented lessons learned, and outcomes in research briefs and presentations, as well as developed and disseminated tools for providers.

**Research on the capacity, strengths and needs of CB-CME providers to inform program planning.** To learn about the current capacity, reach and needs of CB-CME providers to practice Enhanced Case Management, the RnDU conducted a mixed-method research inquiry. Results of the research were summarized a brief report and presentations.

**Research and technical assistance with Care Connect’s CHR Data Dashboard**. The RnDU provided recommendations on visualizing and communicating data to demonstrate to key stakeholders how systems improve coordination of care, targeting of resources and consumer outcomes.

**COVID-19 Infection Rate among Alameda County homeless.** The RnDU reviewed publicly available data sources and existing literature to determine the feasibility of a research study on whether Whole Person Care infrastructure enabled a collaborative response to COVID-19 and prevented endemic infection rates among the homeless population in Alameda County through Project RoomKey. The brief report included key data and research findings and recommendations for a local outcome evaluation of WPC and Project RoomKey.

**Del #68A HomeBase**

With the help of the Governor's office, the City of Oakland, and the Taube Foundation, a new trailer-based program was established to shelter homeless seniors highly vulnerable to COVID. HomeBase participated in the housing exit weekly meetings with Safer Ground county staff. Trailer housing was established in Berkeley (18 rooms), Alameda (4 rooms) and Oakland (128 rooms). All guests received housing navigation assistance as well as other wrap-around services.

Administrative infrastructure costs include contracted staff salary and benefit costs, plus office supplies, to launch, operate and manage Operation HomeBase in Oakland.

**Del #74 COVID-19 Staff**

In response to the COVID-19 pandemic, AC Care Connect deployed a number of staff to support the county-wide response efforts, specifically initiatives focused on WPC eligible and related populations. These efforts included:

- Launch and operation of seven isolation and quarantine hotels through Governor Newsom’s Project RoomKey Initiative. The hotels provided safe and secure temporary shelter for over 2,500 households to shelter in place and isolate/quarantine. These households primarily included populations at a higher risk for severe COVID-19 illness, including people experiencing homelessness. The Project RoomKey hotel team was also able to create a hotel-based whole person system of care, where providers from a number of sectors, including social services, health care, substance use treatment, housing, and behavioral health, were able to provide services and resources to hotel guests in person and virtually.

Development of a collaborative partnership between Alameda County, local hospitals and health systems, and local long term care facilities, including skilled nursing, assisted living, and residential care facilities, to improve coordination and synergize the collective resources that have mobilized to prevent spread and mitigate COVID-19 outbreaks in long term care facilities. This Long Term Care (LTC) Partnership developed and distributed COVID-19 related guidance for facilities; created a shared

communications hub, where partners could access updated data on outbreaks; provided support and resources for facilities to access testing for their staff and patients; and developed and implemented Fit Testing trainings to build facilities' internal capacity to fit test their own employees (for N95 masks).

## V. 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 a professional association of Community Living Facility operators (the Alameda County Independent Living Association (www.alamedacountyila.org).

Accomplishments to date include:

- The ILA has partnered with the East Bay Rental Housing Association (EBRHA), creating access to an existing pool of property owners in the community who might be interested in operating an independent living home.
- Fourteen operators and 35 independent living homes, totaling 222 beds, are now 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.
- 41 trainings have been held on tenant rights with a variety of trainings including tenant rights, fair housing and Eviction and Retention and ways to maintain healthy ILA homes, for multiple stakeholder groups.
- In 2020, CHIP conducted 22 Policy & Advocacy meetings to support ILA operators with specific concerns including nimbyism and assistance with obtaining business licenses.
- A total of 35 PRAT (Peer Review and Accountability Team) visits have been completed from program launch date through December 2020 and there was an increase from 55% to 87% pass rate (11 PRAT visits passed/20 PRAT visits conducted.)
- Despite some initial setbacks, recruitment of new members is progressing given 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 38.8%.
- Starting in July 2019, the ILA started 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 tenants in more member homes reported their home had a grievance policy and that they signed a rental agreement, compared to non-member homes.

**Del #20a Behavioral Health Medical Homes**
During PY 5 all three Alameda County Behavioral Health (ACBH) primary care medical homes (PATH Clinics) have continued to provide adult SMI Consumers the three key

PATH Clinic services through telehealth virtual visits: 1) nurse care coordination; 2) non-licensed peer support counseling; and 3) health and wellness recovery counseling services.

As a result of AC Care Connect' s focus on improving care coordination services across the Safety Net Systems, the three mental health centers have continued to build and support stronger collaborations among the PATH Clinics' primary care staff and County behavioral health clinicians. During the COVID-19pandemic, the IBH Teams have worked to make sure the patients continue to feel socially connected to the program staff through more frequent wellness check phone calls and telehealth phone conversations with primary care and behavioral health providers. The PATH staff also make home visits to see clients when it is necessary due to their mental and physical health conditions. These high need patients also often require assistance with getting medication refills, and resolving issues related to their Medi-Cal and the public assistance they receive each month from social and community agencies. Program staff help their SMI clients learn to use and become comfortable with telehealth visits with primary care and BH providers using a cell phone, a case manager's laptop at their home, or coming into the mental health center for a telehealth visit with their primary care provider or psychiatrist. The primary care team provides clients new updates on how COVID-19 is transmitted, and reinforces the need to continue wearing a mask, washing their hands frequently, and practicing social distancing.

**Del #21 Training and Workforce Development**

During PY 5, ACBH has continued to support its workforce development and mentoring opportunities for primary care and behavioral health Safety Net providers. The Workforce Development Programs include the UCSF School of Psychiatry one year on-site clinical Fellowship experience at the Trust Primary Care Clinic and the completion of the Sixth Cohort of the UC Davis Primary Care Psychiatry Fellowship Program by four Alameda County FQHC primary care providers (PCP) in December, 2020. This year we added training of Integrated Behavioral Health Care Coordinators (IBHCCs) from eight FQHCs in how to use the Community Health Record (CHR) as a tool to monitor the effectiveness of care coordination referrals to community resources (housing assistance, food banks, social services, emergency rooms, etc.).

During PY5, the IBHCCs provided care coordination services to 2,053 Alameda Care Connect eligible clients. Through Primary Care Psychiatric Consultation Program (PCPCP), ACBH has continued to support the embedding of Psychiatrist and Pharmacy Consultations in eight Alameda County FQHCs and one HIV Specialty Care Health Center to help their PCPs and behavioral health clinicians improve their skills in diagnosing and treating patients with complex psychiatric and substance use disorders

that are often first presented in the primary care clinics. Because the PCPCP consultants are ACBH staff, they are able to improve care coordination by assisting Safety Net PCPs and behavioral health clinicians learn how to properly complete the required screening documents for the ACBH ACCESS Office that will facilitate a patient's approved admission into the County's Specialty Mental Health or SUD Systems of Care.

**Del #41A - Enhancing HMIS and Permanent Supportive Housing applications**

As reported at mid-year, the housing team did extensive work to update the HMIS system to reflect changes to coordinated entry and integrated HMIS more fully into Alameda County's Whole Person Care Social Health Information Exchange (SHIE) and Community Health Record (CHR). This work was completed in the first half of the year and no further expenses are being claimed at this time.

**Del #42a Multi-Sector Care Coordination Hubs**

Care Connect services that were delivered through the Housing Resource Centers in Jan-Dec 2020 include:

- 1790 unique clients received Health, Housing and Integration bundle services.
- The 2-1-1 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 2020, 2-1-1 handled 18,715 calls from 9,411 unduplicated individuals experiencing a housing crisis.
- Over 27,000 street outreach encounters.

Due to COVID-19 restrictions, the HRCs hosted their regional case conferences (By-Name-List meetings) virtually. The platform was a bit challenging at first, but HRC staff became more proficient in using the virtual platform to facilitate effective meetings and overall were able to maintain cross-agency regional collaboration through the end of 2020.

The primary challenges to fully successful implementation of our housing services bundles continue to be Medi-Cal churn, timely monthly reporting by contractors and subcontractors, housing service staffing, and staff development and retention.

- To address Medi-Cal churn with households experiencing homelessness, Care Connect has started to get automated housing data in real time through the CHR so that eventually all providers will have more information on their clients' Medi-Cal status and can help with renewals.

- All housing service provider organizations that are HIPAA covered entities received training and were able to start using the CHR in 2020.
- Medi-Cal status was included in the CHR and allowed housing service providers to help clients stay covered.

The implementation of a Coordinated Entry System in Alameda County, and the availability of Care Connect funds resulted in the addition of an unprecedented number of staff positions added to the system. Care Connect continues to offer skills development and training opportunities to better support the workforce.

**Del #43 – Community Assessment and Transport Team (CATT)**

In July 2020, after several years of planning and work, the first three Community Assessment and Transport Teams rolled out. These teams of one behavioral health clinician and 1 EMT who respond to behavioral health calls that come through our 9-1-1 system are 3 of an eventual 12 teams that will be key to changing how Alameda County responds to individuals experiencing a mental health crisis, and early data indicates they will also be key to reducing our 5150 holds. Two more teams rolled out in September for a total of five teams that operated in 2020; 82% of calls they responded to were able to divert away from a 5150 involuntary hold. The team is working to expand to fill all 12 teams in 2021 and have more robust CATT response available throughout the county.

**Del #47 – Crisis Connect**

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.

The Crisis Connect teams began their work in earnest in February of 2020, and just a few weeks later were sent to work from home as the COVID-19 Pandemic emerged. This caused some early delays in the program, including putting on hold our efforts with the local Psychiatric Emergency Services to get confirmed phone numbers and information to clients to expect a follow-up call. We were able to restart those efforts in October 2020 and saw a fairly immediate uptick in the number of clients the Crisis Connect Teams were able to reach. In 2020, despite the challenges of the pandemic, the team was able to reach 2,934 clients and provide 4,079 services.

One particular case stands out from Dec 24, 2020 in which a Crisis Connect staff member realized the person they were on the line with was still considering self-harm, and had a plan in place to do so. The staff person was able to work with the individual

and other Behavioral Health crisis responders to get the person safely admitted to a Crisis Residential facility.

**Del #60 Open and operate three new Navigation Centers**

Three new navigation centers will serve vulnerable people experiencing homelessness in locations across Alameda County.

As reported mid-year, one navigation center has opened in Mid-County in Hayward. A second navigation center opened in Fremont in September 2020. Fremont's Navigation Center had originally been constructed to offer shelter and housing navigation services for 45 participants; in order to comply with COVID-19 safety measures, this was reduced to up to 25 residents at a time. It will be able to house more residents after the pandemic ends.

Unfortunately, the third navigation center, planned for the Fairmont Campus in Mid-County, experienced construction delays and design changes due to COVID-19, which prevented it from opening in 2020; it is anticipated to open in 2021.

**Del #61 Leveraging Epic for Population Health**

Alameda Health System has leveraged EPIC for Population Heath by conducting 5 connections and improvements. Three connections have been completed which include upgrades to components of EPIC and providing health data in a C-CDA format. Improvements to embed the Community Health Record application link into Epic are in testing, while the incorporation of Information Sharing into AHS's patient portal is pending County Counsel review. 3 activities achieved, 1 activity in-progress, 1 activity pending start.

A) AHS upgraded the behavioral health component of EPIC which includes implementation of IPFQR (Automated CMS Quality Reporting), creation of Suicide Screening Templates and IT infrastructure assessment, and care and treatment planning. Activity achieved.

B) AHS upgraded the EpicCare Link configuration and rollout for eConsults and referrals completed and in production for all CHCN facilities. It is also now available for other community providers. Activity achieved.

C) AHS provided health data in a C-CDA format to Social Health Information Exchange by including language in the DSA agreement aligned with the CHR population expansion. This activity is complete. Interface has been live and operational since December 2020.

D) HCSA and AHS decided together that incorporating HCSA's Information Sharing Authorization (ISA) into AHS Epic's patient portal, MyAlamedaHealth was not a helpful option because it is not used by most AHS patients. In addition, AHS team was concerned about adding the ISA in its current form to AHS's standard intake packet because it added four pages. County Counsel will explore whether components of the ISA could be added to AHS' COA to cover both purposes.

E) AHS's work to embed the Community Health Record application or link into Epic is in testing. Technical difficulties launching the required browser are under review with Epic. Activity in progress.

**Del #65 Street Health Outreach Teams: Mobile Health Vans**

Contracted community-based organizations have purchased and custom outfitted six mobile health vans to provide street health services. Six teams are now in operation serving six different geographical regions of Alameda County.

**Del #66 Expand support services for homeless transition age youth (TAY)**

The Hayward TAY shelter program operated by Covenant House of California provides emergency housing resources for individuals 18-24 years old who are experiencing homelessness. The County Office of Homelessness Care and Coordination has been working on opening six trailers as emergency housing with on-site support services for youth in northern Alameda County. Unfortunately, various obstacles prevented the site from opening in 2020; however, progress has been made, and we plan to open the site in 2021.

**Del #68A HomeBase**

With the help of the Governor's office, the City of Oakland, and the Taube Foundation, a new trailer-based program was established to shelter homeless seniors highly vulnerable to COVID. HomeBase participated in the housing exit weekly meetings with Safer Ground county staff. Trailer housing was established in Berkeley, Alameda and Oakland. All guests received housing navigation assistance as well as other wrap-around services.

Delivery infrastructure costs include one-time and ongoing construction to establish residences, security systems, and other expenses.

**Del #75 Peer to Peer Program Start Up and Operations**

In 2020, the Consumer Engagement Program launched and rapidly expanded the Peer to Peer (P2P) Advisors Program in response to the COVID-19 pandemic. This effort addresses the need to reach and engage with communities that are often not effectively reached by mainstream efforts, including guests at RoomKey hotels and certain Black, Mam-Mayan and Latino communities. The Peer to Peer Advisors are individuals with life experience similar to that of the population to be reached and provide a unique resource that is particularly capable of providing support and education to communities that are insular. Due to previous experiences, these communities are often wary of outsiders, and may be reluctant to participate in public health activities like testing and contact tracing that are so essential to preventing the spread of COVID. The support of the Peer Advisors resulted in better adherence to isolation practices, repeat testing, and other public health recommendations.

In 2020, the Consumer Engagement Program hired and trained Peer to Peer Advisors to provide services and support in the following areas:

- Project RoomKey Hotels: Because guests are asked to shelter in place in their rooms at the isolation and quarantine hotels, the Peer Advisors serve as both a social contact, as well as a conduit for resources. They conduct regular calls to hotel guests to check in, assess if they have needs or concerns, and provide connections and referrals to resources, such as clothing, benefits, food, among other things.
- Mam Community Outreach Team (MCOT): This team includes three trilingual (Mam-Mayan, Spanish, and English) staff. The objective of this team is to ensure that Mam speaking residents have information and resources to protect and improve their health. They also provide education, training, and other resources to Mam-speaking populations in Alameda County. This team works in coordination with the Public Health Department's regular case investigation/contact tracing (CI/CT) program.
- Eastmont Collaborative: Using Care Connect's data, the Consumer Engagement Program found that a number of Black Care Connect enrollees with severe mental illness who are assigned to the AHS Eastmont Wellness Center do not have case management support. The Eastmont Collaborative aims to improve health outcomes of these individuals by a) creating transdisciplinary teaming and strategies that partner medical, behavioral health, social services, library, and other providers particularly those at Eastmont, b) facilitating knowledge and understanding needed for collaboration between the consumer's formal and informal circles of care and c) familiarizing both providers and consumers with the services and resources within the Eastmont Town Center and the surrounding community.

## VI. NARRATIVE – Incentive Payments

| Triggering deliverable | Level of achievement | $$ / Receiving entities |
|---|---|---|
| **Del #1 Timely Adoption of AC Care Connect System**<br><br>1) At least one representative from each provider organization and/or site or program will attend each monthly meeting throughout PY5 to develop standard care management definitions, outcomes, models as part of the care coordination system; includes gathering feedback at their home organization between meetings and bringing fruitful content to each discussion.<br><br>2) Provider organization and/or site or program to secure time and complete training of at least two of their designated employees involved in care coordination to operationalize | **% Target Achieved July-Dec: 25%**<br>**Total Target Achieved Jan-Dec: 66%**<br><br>1) AC Care Connect convened a new Care Community called 100 & Beyond from August-December 2020; it brought together housing navigators and provider organizations serving individuals experiencing homelessness who are high risk for COVID-19. Representatives of 7 CBOs participated. The purpose was to help new providers access trainings, understand the unique system of care they were working within in Alameda County, as well as to network together for shared problem solving and best practices for coordinating care for this special population.<br><br>In addition, during this program year eight Federally-Qualified Health Centers (FQHCs) sent at least two representatives to the Alameda County Care Connect Super User Workgroup to develop standard care management definitions, outcome objectives, and models as part of the CHR care coordination system. This included regular participation in the monthly Workgroup meetings, gathering feedback at their organization between meetings, and bringing back content to each Workgroup discussion.<br><br>2) Seven provider organizations secured time for 3-18 staff to participate in regular collaborative training sessions and 1:1 coaching sessions to enhance their understanding of the care coordination system and how to navigate services needed by the consumers they served. At the closing | Total Claim Del 1: $573,800<br><br>Del 1. Total Budget 2020: $2,300,000.00<br><br>1.1 Claim: 15 community-based organizations x $12,751 (average) = $191,266<br><br>1.2 Claim: Claim: 15 community-based organizations x $12,751 (average) = $191,267<br><br>1.3 Claim: Claim: 15 community-based organizations x $12,751 (average) = $191,267<br><br>*Note: the exact number of provider organizations, providers per organization, and/or sites, and the dollars per site, will reflect actual participants and incentives set to be appropriate to the organization.* |

| Triggering deliverable | Level of achievement | $$ / Receiving entities |
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| the new standardized care coordination system, including webinar participation, creating and searching for care plans with test patients, sending issues encountered to the appropriate BBO staff, etc. | session, many providers recounted how valuable the experience of being networked together with other providers who shared common goals and clients was. Several others talked about how it gave them a new vision for how to provide true "whole person care" for clients that they would take with them well beyond the COVID-19 response.<br><br>All 8 FQHCs completed training of their designated employees, including the IBHCCs, involved in care coordination to operationalize the new standard CHR care coordination system. | |
| 3) Provider organization and/or site or program to provide evidence of adoption and use of the tools of the new standardized care coordination system including written workflow, 5 written anecdotes about the experience of using the system for patient care, and reported number of clients each month for six months whose care was shaped by the new system. | 3) Seven provider organizations provided written workflows specific to their site, 10 anecdotes of work with individual consumers whose care was impacted because of the understanding the providers had of the care coordination system and strategies in Alameda County, and a count of consumers whose care was enhanced by that system.<br><br>All 8 FQHCs submitted one written CHR care coordination workflow each and ten written anecdotes each about the experience of using CHR for patient care. All 8 FQHCs reported the number of patients each month whose care coordination was provided by using the CHR system through the submission of the Quarterly IBHCC Report. | |
| **Del #17 Opioid Dependence Treatment**<br><br>**17.2** Increase volume of patients screened and treated for opioid dependence by reducing the gap between the goal negotiated with each | **% Target Achieved July-Dec: 53%**<br>**Total Target Achieved Jan-Dec: 100%**<br><br>17.2 One CBO and the public hospital met their targets for increasing opioid dependence screening and treatment through the implementation of improved processes and institutionalized protocols. | Total Claim Del 17: $3,008,776<br><br>17.2 Budget: $5,658,321<br><br>Claim: 1 Community Primary Care Site at $224,924 and |

| Triggering deliverable | Level of achievement | $$ / Receiving entities |
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| provider agency and current screening and treatment levels by at least 10%. Payments will be paid on a pro-rated basis for each Program Year as long as at least 50% of the improvement target is accomplished. Payments will be paid on a pro-rated basis for each Program Year as long as at least 50% of the improvement target is accomplished. | | the Public Hospital at $2,783,852 |
| **Del #22 Hepatitis Screening and Treatment**<br><br>**22-2.** Incentive funds will be paid to Community Primary Care sites that show a 10% decrease in PY5 of the gap between target treatment rate negotiated with each provider agency during PY2 (and revised annually if needed) and that clinic site's performance in PY4.<br><br>Incentive funds will be paid to the Public Hospital System for initiating a new program of Hepatitis C screening at two community hospital emergency rooms. As documentation of successful launch, the public hospital will report on the percent of patients screened at each location. | **% Target Achieved July-Dec: 11%**<br>**Total Target Achieved Jan-Dec: 100%**<br><br>3 CBO's increased Hep C screening and or treatment rates, and improved protocols and quality reports for Hep C tracking and documentation focusing on no-show, retention, and adherence processes. | Total Claim Del 22: $517,263<br>22 Budget: $4,763,218.80<br><br>Claim: 3 Community Primary Care Sites x $172,421 average |

| Triggering deliverable | Level of achievement | $$ / Receiving entities |
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| **Del #23 Capacity Development Incentives for Physical Health Providers – HEDIS**<br><br>**CBOs** - Improve performance on a growing set of HEDIS measures (or other nationally recognized improvement metrics) selected in partnership with the Managed Care Plans, measured by reducing the gap between the PRIME specifications and 90th percentile targets (for the Public Hospital and Clinic System) and 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. One measure will be selected for improvement during PY3, a second will be added for PY4, and a third will be added for PY5. Payments will be paid on a prorated basis for each Program Year as long as at least 50% of the improvement target is accomplished. | **% Target Achieved July-Dec: 11%**<br>**Total Target Achieved Jan-Dec: 97%**<br><br>Metric #1 – Between July 1 – Dec 31, 2020, 1 additional CBO met the performance goal for the first HEDIS measure.<br><br>Metric #3 - Between July 1 – Dec 31, 2020, the remaining 6 of 8 CBOs met their performance goals for a third HEDIS measure. | Total Claim Del 23: $635,649<br><br>Budget: $5,763,219<br><br>23.1 Claim: 1 Community Primary Care Site met the metric<br><br>23.3 6 Community Primary Care Sites met the metric.<br><br>7 x $90,807 average |
| **Del #24 Capacity Development Incentives for Physical Health Providers – Access**<br><br>**24.1** - Performance incentive to improve primary care | **% Target Achieved July-Dec: 8%**<br>**Total Target Achieved Jan-Dec: 100%**<br><br>The remaining two CBO's achieved their Provider Recruitment and Retention goals by fostering partnerships with other community-based organizations, academic | Total Claim Del 24: $429,687<br><br>24.1 Budget: $1,718,748<br><br>Claim: 2 Community Primary Care Sites x $214,883.50 average |

| Triggering deliverable | Level of achievement | $$ / Receiving entities |
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| access through Provider (primary care and behavioral health) recruitment and retention activities. Community based Primary Care Organizations will implement 2-3 Provider Recruitment and Retention activities in each program year. These activities include Nurse Practitioner onboarding/residencies, professional development, teaching opportunities and loan repayments. Each organization will report on the number and types of providers engaged in each activity. Organizations that implement retention activities must show at least 50% of providers involved in the retention-related activities indicate an increase in job satisfaction or at least 50% of providers who participate in retention-related activities are retained. Organizations that implement recruitment activities must show that at least 1 provider is recruited due to the selected recruitment activities or at least 75% of slots in their Nurse Practitioner Residency are filled. Payments will be paid on a prorated basis for each Program Year as long as at least 50% of the improvement target is accomplished. | institutions, and medical residency programs to raise awareness of the clinics' primary care, behavioral health, and dental career opportunities. The CBO's also exchanged best practices for provider recruitment and retention to create a pipeline of future providers. | |

| Triggering deliverable | Level of achievement | $$ / Receiving entities |
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| **Del #30 Capacity Development Incentives for Physical Health Providers - Data Quality Improvements**<br><br>**30.1 -** Timely data submission (monthly, unless frequency determined to be otherwise through data sharing system planning)<br><br>**30.4** - Provide evidence of successful implementation of new electronic health record module for patient portal by reporting the number of patients who have activated their patient portal account.<br><br>**30.5** – Provide evidence of successful implementation of new electronic health record module for collection of social determinants of health data by reporting patient responses to social determinant of health questions. | **% Target Achieved July-Dec: 100%**<br>**Total Target Achieved Jan-Dec: 100%**<br><br>30.1 The Public Hospital continued to provide timely data as required.<br><br>30.4 In addition, AHS worked with its electronic health record partner (Epic) to develop the appropriate activation rate metric (i.e., the percentage of patients who have AHS as their assigned medical home who activated or have an active MyChart account). According to baseline data and quarterly improvements, the percentage had increased to 11.9%.<br><br>30.5 Social determinants of health data are collected from patients during registration in inpatient and outpatient settings and recorded in the electronic health record. AHS continue to promote the benefits of MyAlamedaHealth to patients and clinicians to increase signup and utilization. | Total Claim Del 30: $1,481,926<br>30 – Budget $1,481,926<br><br>30.1 - Claim: Public hospital = $481,926<br><br>30.4 - Claim: Public hospital = $500,000<br><br>30.5 – Claim: Public hospital = $500,000 |
| **Del #43 Community Assessment and Transport Team (CATT)**<br><br>**43.4** - Contracts in place with EMS contractor to provide EMTs and a completed RFP process and contract in place with a Community Based | **% Target Achieved July-Dec: 33%**<br>**Total Target Achieved Jan-Dec: 100%**<br><br>**Contracts were completed.**<br>In July 2020, after several years of planning and work, the first three Community Assessment and Transport Teams rolled out. Two more teams rolled out in September for **a** | Total Claim Del 43: $250,000<br><br>43.4 Budget: $250,000<br>Claim: $250,000 to County partners |

| Triggering deliverable | Level of achievement | $$ / Receiving entities |
|---|---|---|
| Organization to provide Behavioral Health clinicians. | **total of five teams that operated in 2020.** The team is now working to expand to fill all 12 teams in 2021 and have a robust CATT response available throughout the county.<br>In July 2020, after several years of planning and work, the first three Community Assessment and Transport Teams rolled out. These teams of one behavioral health clinician and 1 EMT who respond to behavioral health calls that come through our 9-1-1 system are key to changing how Alameda County responds to individuals experiencing a mental health crisis, and early data indicates they will also be key to reducing our 5150 holds. Two more teams rolled out in September for **a total of five teams that operated in 2020.** In 82% of calls they responded to they were able to divert away from a 5150 involuntary hold. The team is now working to expand to fill all 12 teams in 2021 and have a robust CATT response available throughout the county. | |
| **Del #44 Consumer and Family Experience**<br><br>**44a.3** - Develop a curriculum aimed at enhancing trusting provider/consumer relationships and strengthening the dialogue among consumers, their networks, and providers, in order to improve the ability to effectively engage consumers in care, and deliver services that consumers value<br><br>**44a.4** - Produce a Culturally Affirmative Practice Guide that includes principles and practice recommendations. | **% Target Achieved July-Dec: 100%**<br>**Total Target Achieved Jan-Dec: 100%**<br><br>The Consumer Family Experience program has completed and continues to refine the planned curriculum and culturally affirmative practice guide. Because our curriculum development plan required conducting in vivo workshops to test out our pedagogy, the pandemic upended this work for a time. Nevertheless, we were able to make a considerable move forward by conducting teleconferences and updating our content to address the consumer needs that were emerging from the pandemic.<br><br>A core principle of our work is that the relationship between the consumer and a provider is a partnership. How we | Total Claim Del 44: $200,000<br>Budget: $200,000<br><br>44a.3 - Claim: $100,000 to the public hospital and clinic system<br><br>44a.4 - Claim: $100,000 to the public hospital and clinic system |

| Triggering deliverable | Level of achievement | $$ / Receiving entities |
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| | define and demonstrate the value of this is through our providers' trainings which include: how to assist consumers in receiving the highest level of their public and work-related entitlements, understanding how migration influences the functioning of family and the individuals in it, training peers in helping our unsheltered neighbors during the COVID-19era, as well as training seasoned and new providers in how culturally affirmative strategies align with clinical case management.<br><br>We have also launched our cultural assessment tool. We are monitoring feedback and expect to revise the tool over 2021. | |
| **Del #48 Medical Respite Program Incentives (48 a-e)**<br><br>**48c.** Create and adopt Toolkit for Referrals into County-funded Respite. Earn $100,000 for demonstrated adoption.<br><br>**48e.** Training and cross-system learning for respite providers and managed care | **% Target Achieved July-Dec: 11%**<br>**Total Target Achieved Jan-Dec: 11%**<br><br>48c. In addition to a toolkit and protocols that were previously developed for referrals from hospital inpatient settings into medical respite, a toolkit and protocols were developed and adopted so that Street Health Teams could refer into respite. Trainings were provided in December 2020 Regional street health teams now have the capacity to refer clients who are unsheltered and at high risk for hospitalization based on their medical conditions into medical respite.<br><br>48e) Alameda County Health Care Services held four medical respite coordination and learning meetings with Alameda County medical respite providers, the two managed care health plans, and county staff. Meetings were held on January 8, May 6, July 1, and October 7, 2020. Topics included: sharing goals and information between | Total Claim Del 48: $250,000<br>Budget = $2,290,000<br><br>48c - Claim: $50,000 to Lead Entity<br><br>48e - Claim: $200,000 to Lead Entity |

| Triggering deliverable | Level of achievement | $$ / Receiving entities |
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| plans. Earn $50,000 each for up to four trainings in 2020. | respite providers and health plans, training on accessing the substance use disorder system, best practices and policy changes due to COVID-19, and data sharing. | |
| **Del # 59 Information Technology – Utilize Population Health IT to improve Complex Care at AHS**<br><br>Multiple departments across the AHS system will use the new EPIC population health tool in concert with the new CHR to improve care for the complex care population. To achieve a wide impact across the system, at least eight specific projects will be conducted, with measurable goals for each. | **% Target Achieved July-Dec: 100%**<br>**Total Target Achieved Jan-Dec: 100%**<br><br>Alameda Health System is now using the new EPIC population health tool in concert with the new CHR to improve care for the complex population across multiple departments. 8 specific projects were developed and conducted, all of which have measurable goals. Projects include the development of new protocols for collaboration with internal and external partners: using new IT tools; and weekly huddles for staff to engage and collaborate on projects. All 8 projects are currently ongoing and being integrated into standard workflow processes to effectively utilize the EPIC tool and CHR concurrently. Activity achieved. | Total Claim Del 59: $800,000<br>Budget: $800,000<br><br>Claim: $800,000 to the public hospital and clinic system |
| **Del #63 Sustainability Readiness**<br><br>**63a.1** - Convene Safety Net planning meetings at least monthly, that will include executive leadership of the four major safety net healthcare systems in Alameda County, to coordinate planning for transition at the close of Whole Person Care | **% Target Achieved July-Dec: 40%**<br>**Total Target Achieved Jan-Dec: 40%**<br><br>63a) During 2020 (PY5), AC Care Connect completed the following activities to meet the payment triggers for the Sustainability Readiness incentive at the System Level for a total of $100,000:<br>1. The executive leaders of Health Care Services Agency (Office of the Agency Director, Behavioral Health, and Public Health), the two health plans (Alameda Alliance and Anthem Blue Cross), and the two large safety net provider organizations (Alameda Health System and | Total Claim Del 63: $400,000<br>Budget: $1,000,000<br><br>63a - Claim: $100,000 to Lead Entity<br><br>63d - Claim: $300,000 to Lead Entity |

| Triggering deliverable | Level of achievement | $$ / Receiving entities |
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| | Community Health Center Network) met on a monthly basis throughout the year. The group discussed evolving plans for transition of services and infrastructure at the end of Whole Person Care, and how to stay in coordination as those timelines changed due to COVID-19. This regular cadence created a reliable space for communication, problem solving, collaboration, and coordination, primarily for sustainability planning through this evolving landscape, but also for COVID-19 testing and response work as well. The group of executives has gelled in a friendly and supportive way that will serve the safety net care system well into the future. | |
| **63a.2** - Convene two cross-sector and multi-level Planning Forums that will bring together executive leaders, program managers and front-line providers. | 2. Two Planning Forums were held in December 2020 to walk participants through the landscape of how whole person care services, connections, and infrastructure will be sustained into the future. The two forums had 50 and 30 participants, respectively, across 32 organizations. | |
| **63a.3** - Conduct financial, risk, and organizational capacity analyses to inform decision-making. | 3. The AC Care Connect, Alameda Alliance, and Anthem Blue Cross teams worked together on a monthly basis throughout the year to track changes to the opportunities to sustain whole person care services. Ultimately, together the parties analyzed the alignment of services, the capacity of the current and possible provider networks, the transition processes, and the financial opportunities and risk to lay the foundation for ongoing decision-making for sustaining as many of the AC Care Connect services as possible once the program would come to an end. This was all mutually documented in a complex spreadsheet with each health plan, proving the | |

| Triggering deliverable | Level of achievement | $$ / Receiving entities |
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| | foundation for ongoing transition planning and implementation. | |
| **63a.4** - Convene a planning group to include relevant parties such as SSA, ACCC, ACBH, CHCN, Sheriff and Probation and the MCPs to begin discussions regarding re-entry re-enrollment in Medi-Cal, warm hand-offs to care, and improvement in Medi-Cal enrollment practices. | 4. AC Care Connect team convened a planning group in December 2020 to begin discussions about the history and future opportunities to support Medi-Cal enrollment and transitions in care for those re-entering the community from incarceration. The convening was preceded by 10 one-on-one interviews with a majority of the participants to document their experience in the space, hear about the challenges they had come up against in improving these processes in the past, and also what each saw as opportunities moving forward. The convening itself included 29 participants from across medical, behavioral health, probation, sheriff, Medi-Cal managed care plans, social services, Board of Supervisors, and a consumer representative. The group talked through many challenges, opportunities, and potential solutions across this broad and complex space. Out of this rich discussion, the area that AC Care Connect identified as its highest value-add is in the area of data exchange and sharing between medical and mental health providers in the jail and the community to promote more effective and supportive transitions in care. Though there are many barriers to overcome even with the robust data exchange launched through AC Care Connect, the potential to better connect these providers for their shared consumers is great. AC Care Connect looks forward to pursing these opportunities further in 2021. | |

| Triggering deliverable | Level of achievement | $$ / Receiving entities |
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| **63d.1** - Develop collaborative governance structure for post-WPC-related data exchange.<br><br>**63d.5** - Develop added outcome reporting capacity for both population health and SDOHs | 63d) AC Care Connect completed the following activities to meet the payment triggers for the Sustainability Readiness incentive at the Information System level for $100,000 for each item, a total of $300,000:<br>1. AC Care Connect has solidified a permanent Data Governance Committee structure to advise Alameda County Health Care Services Agency on evolving strategies, objectives, and policies to further improve the data exchange that supports the needs of safety net providers and vulnerable Alameda County residents. The committee has 15 seats across various data contributing sectors. The Committee convenes monthly to review recent implementation accomplishments for the Social Health Information Exchange and Community Health Record and upcoming goals, and then to discuss, express concerns, and/or bless developments such as sharing mental health data according to relevant laws and regulations and bringing non-HIPAA-covered organizations into the system where consumers provide consent. Though the discussion topics may shift after the close of AC Care Connect, the collaborative governance structure is routinized for the long term.<br><br>5. The Social Health Information Exchange (SHIE) is now equipped with the capacity to provide outcomes reporting at the population level related to social determinants of health. This is most clearly shown by the development of our analytics dashboard we call Care Insights. An example of the capacity is shown below, considering the change in housing status over time among those consumers served in the AC Care Connect housing | |

| Triggering deliverable | Level of achievement | $$ / Receiving entities |
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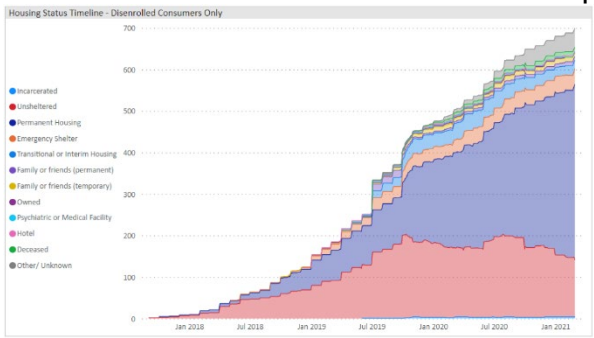
| **63d.7** Training for providers on IT functionality for new and existing services, including creating materials, in-person trainings and elbow support | services bundle. This is brand new reporting capacity that did not exist before the SHIE was in place.<br>  <br>7. Providers from across 25 organizations, including more than 100 programs, have been trained to navigate the IT functionality of the Community Health Record (CHR) and make use of the data and collaborative functionality in their day-to-day work serving vulnerable consumers. The materials to shepherd providers through this process are readiness assessments, workflow analyses, technical training, and follow up elbow support coaching. These materials have been refined and improved through the experience training so many different types of providers. | |
| **Del #64 New Street Health Outreach Teams**<br><br>Launch four new Street Health Outreach Teams.<br>• Each team that is launched by July 31 will earn $100,000 incentive. | **% Target Achieved July-Dec: 100%**<br>**Total Target Achieved Jan-Dec: 100%**<br><br>Street Health Team Launch Dates:<br><br>Zone 4 June 2020 = $100,000<br>Zone 5 June 2020 = $100,000 | Total Claim Del 64: $400,000<br>Budget: $400,000<br><br>Claim: $400,000 paid to county partners |

| Triggering deliverable | Level of achievement | $$ / Receiving entities |
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| • After that, the incentive will be reduced by 20,000 each month | Zone 13 June 2020 = $100,000<br>Zone 14 June 2020 = $100,000<br>Zone 12 October 2020 = $60,000<br>Zone 1 December 2020 = $20,000<br><br>In the midst of the COVID-19 pandemic, Health Care for the Homeless was able to support the successful launch of six new Street Health teams. While providing core Street Health services the teams have adapted their services in response to the needs of the unsheltered population during COVID-19 crisis including outreach, education, supply distribution, ongoing and frequent wellness checks, field-based COVID-19 testing and referrals to Project RoomKey for isolation and quarantine. Notably, the first referral into Project Comfort in Alameda County came from a Street Health Team. | |
| **Del #67 Community Health Worker Learning Community at AHS**<br><br>Hold at least 20 CHW training sessions with an average of 15 or more participants.<br>•Incentive of $10,000 per training session up to 20 total training sessions. | **% Target Achieved July-Dec: 50%**<br>**Total Target Achieved Jan-Dec: 50%**<br><br>AHS held a total of 10 CHW training sessions with an average of 20-25 participants per session with 200-250 participants total. Training included topics on Strategies for patient outreach in setting of COVID-19, Substance Use Disorder Services, COVID-19vaccine 411, and Palliative Care. | Total Claim Del 67: $100,000<br>Budget: $200,000<br><br>Claim: $100,000 to public hospital and clinic system |
| **Del #68 Operation HomeBase**<br><br>**68h.** Incentive will be earned upon successful opening of new trailer-based transitional housing programs (HomeBase) by July 31, 2020 | **% Target Achieved July-Dec: 24%**<br>**Total Target Achieved Jan-Dec: 24%**<br><br>**68h -** HomeBase and Alameda trailers both opened up the week of May 3rd. The Berkeley trailers opened up the week of June 21. | Total Claim Del 68h-k: $201,000<br>Total budget 68h-k = $845,000<br><br>68h - Budget: $150,000 |

| Triggering deliverable | Level of achievement | $$ / Receiving entities |
|---|---|---|
| **68i.** Incentive will be earned upon successful enrollment in any of these VA services: Veteran's Administration (VA) health services, Supportive Services for Veterans and their Families (SSVF), and VA Supportive Housing (VASH) programs.<br><br>**68j.** Incentive will be earned based on [HomeBase] client having four core documents on file and registered in the Homeless Management Information System (HMIS). The four core documents include a government issued photo identification, social security card, disability verification, and homelessness verification.<br><br>**68k.** This incentive links Operation HomeBase guests with specific permanent supportive housing, affordable housing, bridge housing subsidies, and other housing opportunities: successful program completion, measured by linkage to a | **68i – 5 HomeBase clients were linked to VA services.** Alameda County has worked closely with the Veteran's Affairs (VA) Northern California Healthcare System to ensure all veterans entering the Project RoomKey sites were identified and assessed for benefits and gained access to veteran-specific resources. Alameda County and the VA corresponded regularly via collaborative spreadsheets that identified veterans in the Project RoomKey sites. We partnered to connect veterans to resources while also filling in gaps in information needed to appropriately serve our homeless veterans.<br><br>**68j - 26 HomeBase clients became document ready.** HomeBase shelter staff participated in collaborative meetings with other Project RoomKey shelter staff to provide support to staff who worked directly with trailer occupants on getting them "document ready," meaning that each guest would have all four core documents on file and up-to-date in HMIS. Weekly meetings with county staff were held to go over the status of each guest's document readiness and troubleshoot as needed to obtain the required documents.<br><br>**68k - 4 HomeBase clients were linked to permanent or affordable housing slots.** HomeBase housing navigation staff participated in weekly collaborative meetings designed to share information about housing placement opportunities and remove barriers that prevent clients from being able to access identified housing opportunities. The HomeBase staff gained skills around housing problem solving and having difficult conversations with clients around expectations and available opportunities. | Claim: $150,000 to downstream providers<br><br>68i - Budget: $1,000/per successful connection or reconnection of each Veteran with a VA resource for a total claim amount up to $40,000<br>Claim: $5,000 to downstream providers<br><br>68j - Budget: $1,000 one-time for each HomeBase guest that meets the document readiness standard for a total claim amount up to $40,000<br>Claim: $26,000 to downstream providers<br><br>68k - Budget: $5,000/successful program completion, measured by linkage to a housing subsidy program or opportunity and exit to permanent housing for a total claim amount up to $615,000.<br>Claim: $20,000 to downstream providers |

| Triggering deliverable | Level of achievement | $$ / Receiving entities |
|---|---|---|
| housing subsidy program or opportunity and exit to permanent housing. | Additionally, HomeBase staff met weekly with county staff to go over the application status of each trailer occupant and troubleshoot any outstanding issues or problems. Staff were able to work with clients to match clients to appropriate housing opportunities and support those clients through the application process. | |
| **Del #71 PSH Target List Document Readiness**<br>Incentive will be earned based on client having four core documents on file and registered in the Homeless Management Information System (HMIS). The four core documents include a government issued photo identification, social security card, disability verification, and homelessness verification. | **% Target Achieved July-Dec: N/A**<br>**Total Target Achieved Jan-Dec: N/A**<br><br>**297 guests became document ready.**<br><br>For the time period July 1, 2020 through December 31, 2020, additional support was provided to all Project RoomKey Operation Safer Ground shelter operators to support success in getting all Safer Ground guests "document ready" meaning that each guest would have all four core documents on file and up-to-date in HMIS. Weekly meetings with county staff were held to go over the status of each guest's document readiness and troubleshoot as needed to obtain the required documents. The opportunity to work with guests staying at the hotels allowed for great progress to be made as it was significantly easier to locate and meet with guests as needed. | Claim: $297,000 to Lead Entity<br><br>Budget: $1,000 one-time for each Operation Comfort and Safer Ground guest that meets the document readiness standard. |
| **Del #72 Complete program and exit to Permanent Housing or Affordable Housing Slots**<br><br>This incentive links Operation Comfort and Safer Ground guests with specific permanent supportive housing, | **% Target Achieved July-Dec: N/A**<br>**Total Target Achieved Jan-Dec: N/A**<br><br>**307 guests were linked to permanent or affordable housing slots.** | Claim: $1,535,000 to Lead Entity<br><br>Budget: $5,000/successful program completion, measured by linkage to a housing subsidy program or |

| Triggering deliverable | Level of achievement | $$ / Receiving entities |
|---|---|---|
| affordable housing, bridge housing subsidies, and other housing opportunities. | Between July 1, 2020 and December 31, 2020, Alameda County operated nine Project RoomKey Hotel sites: seven Operation Safer Ground sites and two Operation Comfort sites. The shelter operators at each of the PRK hotels participated in weekly collaborative meetings as part of the 100-Day Challenge. The collaboratives enabled hotel staff to support each other, learn about housing resources and application processes, and gain new skills such as motivational interviewing and housing problem solving.<br><br>In addition to the collaborative meetings, county staff met weekly with shelter operators at Safer Ground sites to review each guest's housing status, ensure that coordinated entry assessments were completed, and guests were document ready. The county sought to ensure that each Safer Ground guest received at least one viable exit option. The county, along with its partners including cities and community-based organizations, was able to identify enough housing options to be able to offer at least one option to each guest. The matching process was complex and deciphering the various housing option requirements, as well as understanding when specific units were to come online, was another focus of the weekly check-in meetings. | opportunity and exit to permanent housing |
| **Del #73 Average Occupancy**<br><br>Payment is earned if the Safer Ground hotels achieve an average occupancy (total # of households enrolled in given week/maximum # of household slots at hotels) of 80% or greater at year-end. | **% Target Achieved July-Dec: 100%**<br>**Total Target Achieved Jan-Dec: 100%**<br><br>**The Safer Ground hotels achieved an average occupancy of 83.1%.**<br>For the time period July 1, 2020 through December 31, 2020, Alameda County operated seven Project RoomKey Operation Safer Ground hotel sites throughout the county. On July 29, 2020, the Safer Ground Days Hotel site in | Claim: $360,000 to Lead Entity<br><br>Budget: $360,000 |

| Triggering deliverable | Level of achievement | $$ / Receiving entities |
|---|---|---|
| | Oakland was opened; on August 3, 2020, the county added two Safer Ground hotel sites in Berkeley; and on August 24, 2020, the Safer Ground Livermore site opened. Prior to opening each of the Safer Ground hotels sites, the county developed a referral process, and provided outreach and training to community-based referral agencies so that referrals could begin on the opening day. Each site had a ramp up period where guests were accepted into the hotel in a safe and controlled way. The ramp up period ranged from a couple weeks to approximately one month before reaching 80% occupancy or greater. Once filled, a wait list was created to facilitate continued maximum occupancy as guests left the hotel. Beginning November 1, 2020, in anticipation of the end of CARES Act funding, the county halted new referrals and planned to ramp down occupancy at the hotels. The smallest hotel site, one of the Safer Ground Berkeley hotels, closed on December 30, 2020, while all the others remained open into the new year. | |

## VII. NARRATIVE – Pay for Outcome

AC Care Connect elects to use the COVID-19 Alternative Payment method for Pay for Outcome payments in Program Year 5. AC Care Connect achieved 91.4% of our Pay for Outcomes in Program Year 4. AC Care Connect will receive 91.4% payment in Program year 5, in the total amount of $4,081,675. The narrative below and the invoice show actual performance for PY5

**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:** The PY5 Care Connect improvement target is to reduce the gap between our performance in PY4 and that benchmark by 10% by the end of PY5.

**Results:**

- Benchmark: 91/1000 member months.
- Performance PY4: 368 per 1000 member months.
- Gap: 277 per 1000 member months.
- Ten percent of that gap: 28 per 1000 member months.
- PY5 goal: 368-28 = 340 per 1000 member months
- PY5 performance: 129 per 1000 member months.

**The reduction in the rate of ED visits far exceeds the goal and represents a reduction of 65% year over year.**

- **ACHIEVED in full**

**Discussion**
The rate of ED utilization dropped so drastically from 2019 to 2020 that it is challenging to identify any influence other than COVID-19. Many consumers in our community avoided the medical system if at all possible to avoid COVID-19 exposure, likely to the detriment of valid health concerns. This behavior change likely caused this big change in rate. It is also true that many of our most vulnerable consumers experiencing homelessness were housed in the Project RoomKey Hotels with wraparound services that may have help avoid what would have been unnecessary ED visits.

**Del #4 Follow up within 7 days after PES visit for mental health (FUM)**
**Payment Trigger Language:** Pay for Outcome funds will be earned by showing improvement over the prior year for the 7-day after PES visit for mental health. Trigger for payment will be:

- 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 PY4: 34.14%
- Goal 1 for PY5: 34.1% x 5% improvement = 35.8%
- Performance PY5: 37.15%, an 8.8% improvement
    - **ACHIEVED in full**

- Goal 2 for PY5: 34.1% x 10% = 37.6% (an additional 5% improvement)
    - **PARTIAL ACHIEVEMENT = 76%**

**Proration analysis:**

- Our deliverable specifies that payments will be paid on a prorated basis for improvement over 5%.
- With an overall improvement of 8.8%, we achieved 3.8 percentage points improvement toward Goal 2;
- 3.8/5=an achievement rate of 76%.

**Discussion:**
In light of the alignment of AC Care Connect's resources with the many changes occurring in Alameda County's Behavioral Health Crisis system, we are glad to see continued steady improvement in follow-up for individuals experiencing a psychiatric crisis moving forward, even through the chaos of the COVID-19 pandemic. These ongoing improvements may be due to:

- Improvements to the Crisis Connect phone call program to contact consumers after Psychiatric Emergency Service visit to connect to care, especially the implementation of improved collection and sharing of the consumer's current contact phone numbers to increase connection rate;
- Launched Community Assessment and Transport Teams (CATT) to offer other appropriate disposition options for an ambulance other than the Emergency Department or Psychiatric Emergency Service;
- The Community Health Record to support care providers across sectors 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.

**Del #13 - 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 PY4: 88.8%
- Goal for PY5: 88.8 x 5% improvement = 93.24%
- Performance PY5: 95% - Numerator: 480 in housing for greater than six months (measured at the seventh month mark. Denominator: 503 clients were in permanent housing for at least six months
    - **ACHIEVED in full**

**#48F - Completed housing assessments and HMIS documents**
**Payment Trigger Language:** 90% of clients will have completed housing assessments and have copies of documents in HMIS (Housing Management Information System) when exiting respite. Measurement based on average of four quarterly reports.

**Results:**

- Performance PY5: 38 of 97 people had at least one document reviewed and a completed housing assessment when exiting respite.
    - **Partially ACHIEVED = 39.18%**

**Discussion:**
While it is a standard practice to complete housing assessments and documents for respite clients, staff was not always consistent in uploading documents to HMIS and will be more thorough in this regard in the future.

**Del #48H - Perform primary care visit within 1 month of hospital discharge**
**Payment Trigger Language:** Clients will receive a post-hospital discharge primary care visit within 1 month of hospital discharge on more than 80% of clients who are admitted to recuperative care from inpatient. Primary care visits will be performed either by a respite provider or the client's medical home.
**Results:**

- Performance PY5: 15 of 27 people referred to respite from a hospital inpatient setting received medical appointment within 1 month of hospital discharge.
    - **Partially ACHIEVED = 55.65%**

**Discussion:**
All respite clients regardless of referral source obtain a primary care visit in respite through one of the following ways: on-site visits, in person visit with a preferred provider, via telehealth (alone or with RN or case manager if preferred). This data is reflected in RBA reports showing 100% of all respite clients receive a primary care visit while in respite. We determined that of the 27 clients who had been referred to respite from a hospital inpatient setting, 15 had a length of stay less than 30 days and had thus met the deliverable.

**Del #50 - Reduce LOS in sub-acute psychiatric facilities**
This project was dropped due to COVID. No claim.

**Del #56A - Tele-psych for Street Health Outreach Teams**
**Payment Trigger Language:** Expand availability of psychiatry to teams providing street medicine by making tele-psychiatry available to 10 street health outreach teams by year end. These metrics are a measure of the successful utilization of the purchased equipment.

1) Connect at least 10 clients per team to tele-psychiatry services by year end
2) Achieve a tele-psychiatry service utilization rate of 75% of available tele-psychiatry time per team by year end

**Results:**
- County Information Technology Department (ITD) placed order for 5 iPads on 1/5/2021. Alameda County Health Care for the Homeless has not yet received the equipment and the deliverable has not been attained.
    - **Outcome not achieved.**

**Del #58 - Follow up within 30 days after PES visit for mental health (FUM)**
**Payment Trigger Language:** Pay for Outcome funds will be earned by showing improvement over the prior year for the 30-day after PES visit for mental health (FUM). Trigger for payment will be:
- 10% improvement over the prior year for the 30-day follow up rate = $450,000

**Results:**
- Performance PY4: 62.7%
- Goal for PY5: 62.7% x 10% improvement = 69.0%
- Performance PY5: 53%, a 16% **reduction**, not an improvement
    - **Outcome not achieved.**

**Del #68I - HomeBase Average Weekly Occupancy at 80% or greater**

**Payment Trigger Language:** Payment is earned if trailer sites achieve an average occupancy (total # of households enrolled in given week/maximum # of household slots at site) of 80% or greater at end of the year.

**Results:**

- Average weekly occupancy between 5/6/2020 – 12/31/2020 across all trailers = 85.3%
    - **ACHIEVED in full = $360,000**

**Discussion:**

Occupancy rates across three trailer sites increased greatly from the first week they were opened on May 5, 2020 to greater than 90% in the beginning of July 2020. These rates held steady throughout the rest of the year. Occupancy rates at the Berkeley site were affected by sporadic infrastructure issues, such as electricity connections and sewer hookups that required units to be unoccupied for periods when the city's public works staff needed access to the trailers to complete work. However, once the work was completed referrals into the trailers resumed and trailer slots were filled. In total 215 people were served.

## VIII. STAKEHOLDER ENGAGEMENT

See Stakeholder engagement chart, attached.

## IX. PROGRAM ACTIVITIES

### Care Coordination

A. **Briefly describe 1-2 successes you have had with care coordination.**

1. One of the most notable care coordination successes in our Project RoomKey program began with the problem of incomplete disability verifications. Many clients had clearly documented disabilities, but in the early days of a pandemic, reaching providers, accessing records, and getting paperwork signed for so many clients felt insurmountable to housing navigators. The Interim Medical Directors of the Project RoomKey hotels had recently been given access to the Community Health Record (CHR) and realized that between their knowledge of patients regularly seen, and the extensive documentation they could find in the CHR, they had enough information to sign-off on most of the needed disability verifications. With only a few people at each hotel remaining who needed appointments with providers or records to be tracked down, staff were able to complete most of the remaining applications. An issue we thought would take months to resolve was solved in a matter of days thanks to teamwork and the access to centralized data provided by Care Connect.

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

1. While Project RoomKey was not a WPC service, our efforts to stand up Project RoomKey hotels highlighted the extremely varied nature of the trainings new staff receive. Because so many of our housing services are contracted to CBOs who do their own staff orientations and trainings, basic “101” level information -- how to access services, what the system of care in our county is like, etc. – was not consistently provided. This reinforced the importance of Care Connect’s New Hire Academy, but it had not fully rolled out as the hotels were launching.

### Data Sharing

A. **Briefly describe 1-2 successes you have had with data and information sharing.**

1. Our sharing of jail census, booking, and discharge information has allowed care managers to become more familiar with a crisis system that is typically hard to navigate. The sharing of jail information helps to reestablish care with recently released inmates. While associating jail data records has been a challenge due to data quality issues, we match approximately 50% to existing clinical and housing data. Experimentation with an established, off-the-shelf matching tool, Verato, was the primary mechanism for achieving this match rate.

Via a multi-month presentation process, we attained approval from the Data Governance Committee to pilot end-users from non-covered entities (NCE's) in the CHR/SHIE—an advance that is cutting-edge for HIEs. This effort included an industry scan, an Alameda County NCE needs assessment, and a phased pilot implementation proposal. The proposal contained but was not limited to a data-sharing agreement attestation and strict IT constraints.

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

1. A major challenge has been obtaining consensus on how best to integrate the "Social" partners in the use of CHR and SHIE. Some leaders of participating organizations believe the Epic EHR system covers all users' needs for patient/consumer information, when in reality it is missing most of the social information that makes such a difference in people's lives. Many of the members of the Data Governance group are used to working with HIPAA covered entities and they are most concerned about whether NCEs will handle their data with appropriate attention to privacy. We are in the early stages of trust-building with Alameda County NCEs via the pilot program referenced above (See Success #2).

2. Sign-off on the Sheriff's Office Health Services department's data sharing agreement continues to be an arduous process. Despite follow-up and escalation, we were not able to get the agreement executed as of year-end. We are working to establish a project sponsor within the Sheriff's Office to prioritize this project. Understandably, the Sheriff's need to address COVID-19 testing, isolation, and vaccination has contributed to the delay.

**Data Collection**

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

1. Data quality clean-up improved medical home assignments of consumers. The immediate benefit was increased care coordination and outreach during the COVID-19 pandemic. The deeper level of detail around medical home assignments resulted in higher accuracy of reporting and the capability to support more targeted outreach to shared care team members of specific populations in the community (e.g., Mam language speakers).

2. John's Hopkins ACG algorithm within the SHIE was implemented for the expanded population for risk stratification. This algorithmic tool is used to identify "at-risk/ vulnerable" clients and has been valuable during the pandemic. For example, Care

Connect utilized the ACG risk score/frailty indicator coupled with a customized list of Ambulatory Care sensitive conditions to identify high-risk clients currently housed in FEMA shelter hotels. Client risks of hospitalization were reduced through either preventive care measures, controlling an acute episodic illness, or aiding in managing a chronic disease.

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

1. Our expanded population has identified a delicate balance between data quality and report usability. Large clinical datasets with data quality issues, like the Medical Home assignment, showed us that users became concerned when the data was absent or incorrect. While we can explain away that the data is "only as good as the sources that provide it," it is clear that we have to lean into data clean-up and more accurate mapping to keep user engagement on the reporting side. We plan to expand our quality assurance process and work with partners to ensure better data accuracy.

2. Alameda County's Homeless Management Information System (HMIS) is in a constant flux state with HUD re-design requirements. Early in 2020, HUD audited Alameda County's HMIS. It resulted in a 12-15 months-long community re-evaluation of the Coordinated Entry System and a re-design of the prioritization of Permanent Supportive Housing and CES assessment in HMIS, creating uncertainty in the data structure and data exchange within the SHIE. We have been receiving data in the interim, but changes are frequent and timely notification of changes is absent. We find ourselves using significant resources keeping track of these changes and building plans for how this will impact the ingestion process and subsequent disclosure in CHR.

**Overall**

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

COVID-19 has presented a whole new set of barriers, in addition to those that already existed:

- Maintaining momentum and our focus on long term goals is difficult in the face of ongoing crises on many fronts. COVID-19 continues to divert resources and attention from the efforts needed for system change.
- Limited provider attention and bandwidth to work on system improvements because of the overwhelming need for service provision during COVID-19, and the stress that puts on providers, particularly providers who have been disproportionately bearing the brunt of consumer care during the pandemic.

- Ongoing uncertainty regarding the short- and long-term consequences of COVID-19, including people not accessing or delaying access to care, increased numbers of people relying on the safety net for support, increasing numbers of people becoming unsheltered, etc.

Other barriers include:

- On-going challenge of creating a data-sharing positive culture.
- Transitioning our data sharing governance and infrastructure from Care Connect to the County.
- Administrative, operational, and service challenges related to transitioning from County-based services to health plan-based services in CalAIM.
- Transitioning whole person care work and efforts to various partners without the associated funding for people and resources to champion the work.
- Organizations, partners, and sectors continuing to work in silos.

## X. 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.*

**PDSA Projects: January to June 2020, Quarters 1-2**

1. Community Assessment Transport Team Pilot
2. Improving Recuperative Care (Medical Respite) Utilization
3. Accessible Comprehensive Care Plan
4. Developing and Testing CHR Workflow at Cherry Hill Detoxification Services
5. Collection of Information Sharing Authorization (ISA) to Improve Care Coordination Efforts
6. Data Sharing Across Partners

**PDSA Projects: July to December 2020, Quarters 3-4**

1. Community Assessment Transport Team Pilot
2. Improving Recuperative Care (Medical Respite) Utilization
3. Accessible Comprehensive Care Plan
4. Connecting Clients to Health and Home Services through Operation Safer Ground – 100 & Beyond
5. Data Sharing Across Partners