Reporting Checklist

Contra Costa Health Services Department
Annual PY4 Report
April 2, 2020

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

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

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

Whole Person Care

Contra Costa Health Services Department
Annual PY4 Report
April 2, 2020

I. REPORTING INSTRUCTIONS

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

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

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

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

II. PROGRAM STATUS OVERVIEW

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

Contra Costa Health Services (CCHS) continues to make significant progress with the CommunityConnect program (CMCT) during the second half of PY4.

Further developing the new tier of case management services **targeting high utilizing patients residing in or entering the hospital system of care** saw the introduction of the 'Tier 3' service bundle. This additional funding awarded in early PY4 allowed for **significant coordination and collaboration** between the WPC pilot in Public Health, Emergency Department providers, hospital social workers and clinicians. The program began enrolling patients in Summer 2019 through direct referrals and data mining to identify eligible patients currently admitted to the CCRMC facility with a non-acute bed days status. Working together across divisions, the hospital facility saw the number of 'long stay' patients decrease from a high of 59 to 13 during the latter half of 2019. Concurrently, workflows were established to limit the introduction of new patients by working with the ED to more rapidly identify patients eligible for discharge with additional support from the Tier 3 team.

Continuing to expand our use of technology to support collaboration, coordination, and efficiency, the latter half of 2019 saw the introduction and piloting of **electronic consent forms** and **electronic patient and provider signatures** across the Contra Costa Health Services system. This new workflow removes the burden of handling paper documents and reduces risks associated with scanning into the EHR.

A focused campaign to draw staff awareness to the importance and ease of SBIRT screening saw the **annual SBIRT screening rate** increase 15% from 40% in PY3 to **55% in PY4.**

The innovative idea to **send targeted resource information** to patients based on identified need was presented by a case manager. From this suggestion, the Quality Improvement team developed a workflow using the **PDSA methodology** to identify patients with select social needs and send resources via mail, patient portal, and email. The pilot was successful with 'read' or 'open rates' for messages above industry marketing standards at 32% for patient portal and 42% for email and has been extended across the full program. Qualitative feedback regarding the population

health bulk outreach messages revealed that case managers felt that having important, time-sensitive information (e.g. an open housing waitlist that is due next week, or an upcoming employment fair) was **providing a value-added service that was complimentary to case management**, and reported that these messages **increased client engagement**, specifically with clients that were hard-to-reach. Additional efforts stemming from this initiative include a CCHS system-wide **communications taskforce** aimed at improving and increasing awareness of direct patient communications.

The housing transition fund continues to serve as a **vital resource to securing and sustaining housing for patients**. Through the increase of additional WPC funds in early 2019, CMCT provided 910 units of housing transition funds to enrollees from January through December 2019, helping support patients with essential housing-related expenses.

CommunityConnect's partnership with RoundTrip Health, a transportation booking platform, to **provide electronic ride booking and ridesharing services** to enrolled patients was rolled out to all CMCT staff in summer 2019. Services available include 24x7 call center support, simplified administration, and real-time data on ride volume and completion rates. Since the system launch, CommunityConnect has provided over 4,000 rides using the service, with an **average ride completion rate of 85%.** Additionally, high client rating (average 4.6/5) has encouraged other departments within the health system, including CCHP, to consider a similar approach to transportation services.

The CMCT Quality Improvement team completed an extensive **Mid-Program Evaluation Report** in Fall 2019. The report includes both qualitative and quantitative data detailing the work completed by the pilot to date. Key findings also include the outcomes to date of the randomized clinical trial to evaluate the effectiveness of the program on reducing emergency room (ED) and inpatient (IP) utilization among enrollees. Results from the randomized control trial contains the experience of 37,072 patients (14,467 enrollees and 22,605 controls). During the reporting period through May 2019, patients enrolled in CommunityConnect visited the emergency room 3.3 fewer times per 1,000 months than the control group. This represents a 3.2% reduction in ED utilization. Enrollees were also admitted to inpatient facilities at lower rates: 1.8 fewer admits per 1,000 months (an 11.6% reduction).

III. ENROLLMENT AND UTILIZATION DATA

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

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

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

Item	Month 1	Month 2	Month 3	Month 4	Month 5	Month 6	Unduplicated Total
Unduplicated Enrollees	755	562	903	1039	1019	904	36,098

Item	Month 7	Month 8	Month 9	Month 10	Month 11	Mont 12	Annual Unduplicated Total
Unduplicated Enrollees	1047	969	1043	914	43	1489	41,602

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

FFS	Costs and Aggregate Utilization for Quarters 1 and 2						
	Month 1	Month 2	Month 3	Month 4	Month 5	Month 6	Total
Service 1	$90,000	$180,000	$279,000	$355,500	$279,000	$58,500	$1,242,000
Utilization 1	20	40	62	79	62	13	276

FFS	Costs and Aggregate Utilization for Quarters 3 and 4						
	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12	Annual Total
Service 1	$292,500	499,500	$459,000	$571,500	585,000	$445,500	$4,095,000

FFS	Costs and Aggregate Utilization for Quarters 3 and 4						
	Month 7	**Month 8**	**Month 9**	**Month 10**	**Month 11**	**Month 12**	**Annual Total**
Utilization 1	65	111	102	127	130	99	910

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

PMPM		Amount Claimed						
	Rate	**Month 1**	**Month 2**	**Month 3**	**Month 4**	**Month 5**	**Month 6**	**Total**
Bundle #1	$326	$2,065,862	$2,074,338	$2,055,104	$2,070,100	$2,068,144	$2,064,232	$12,397,780
MM Counts 1		6337	6363	6304	6350	6344	6332	38,030
Bundle #2	$146	$1,115,586	$1,032,950	$1,020,394	$1,014,116	$1,019,372	$1,019,518	$6,221,936
MM Counts 2		7641	7075	6989	6946	6982	6983	42,616
Bundle #3	$2,133.66	-	-	-	-	-	$83,212.74	$83,212.74
MM Counts 3		-	-	-	-	-	39	39

PMPM		Amount Counts						
	Rate	**Month 7**	**Month 8**	**Month 9**	**Month 10**	**Month 11**	**Month 12**	**Total**
Bundle #1	$326	$2,092,920	$2,096,180	$2,091,942	$2,101,722	$1,981,754	$2,098,462	$24,860,760
MM Counts 1		6420	6430	6417	6447	6079	6437	76,260

PMPM		Amount Counts						
	Rate	**Month 7**	**Month 8**	**Month 9**	**Month 10**	**Month 11**	**Month 12**	**Total**
Bundle #2	$146	$1,022,146	$1,022,876	$1,024,336	$1,023,022	$941,116	$1,028,570	$12,284,002
MM Counts 2		7001	7006	7016	7007	6446	7045	84,137
Bundle #3	$2,133.66	$168,559.14	$277,375.80	$362,722.20	$360,588.54	$337,118.28	$279,509.46	$1,869,086.16
MM Counts 3		79	130	170	169	158	131	876

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

Tier 3 added in June 2019 with additional funding

IV. NARRATIVE – Administrative Infrastructure

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

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

There are no changes to report from the previous PY4 Administrative Infrastructure narrative. Prior narrative is below:

The CommunityConnect administrative infrastructure consists of five positions that support some of the fiscal, administrative and quality improvement needs of the program. Staff are tasked with the responsibility of achieving program goals, reviewing program sustainability and embedding new workflows and services into the larger Contra Costa Health Services' system.

Staff include:
Quality Improvement Manager – Oversees all Quality Improvement efforts and manages workgroups aimed at improving deliverable outcomes and achieving program goals of reducing inappropriate utilization of Emergency and Inpatient services.

Program Director – Oversee management of Program deliverables and assists Quality Improvement Manager in assigning priority to projects. The Program Director liaisons with the larger CCHS system to ensure program transparency and avoid duplication of services. The Director supervises service delivery managers and develops the team-based models of service provision.

Financial Managers – Responsible for all CommunityConnect billing activities, staff payroll and Program budgeting. Financial Managers also oversee MOUs and contracts, and direct hiring activities.

Project Manager – Provide project management guidance for incentive and other reporting projects. The Project Managers lead all communication efforts and are the main point of contact for care coordination activities within and among all participating entities.

All Administrative staff members were hired in the early years of the project, and while the focus has shifted from implementation to program maintenance and improvement, roles and responsibilities remain applicable.

It is important to note that the above staffing profile does not truly represent the administrative support required to administer a program this large. Some administrative staff are included in the PMPM bundle and report to the administrative leads listed above.

V. NARRATIVE – Delivery Infrastructure

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

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

CommunityConnect continues to make many improvements to enhance the delivery of case management services to high utilizing patients. Between January 1, 2019 – December 31, 2019, CommunityConnect staff completed 28,543 in-person field visits and 49,976 phone visits for 13,898 unique patients. Nearly 300,000 total patient contacts were made, including field visits, phone visits, letters, texts, calls, and other contact attempts. In 2019, case managers addressed over 77,000 goals as part of patients' care plan, resolving and closing over 23,000 goals.

The program reached several milestones in 2019, including new patient services/service expansion and the expansion of resources. The below examples highlight projects that directly relate to the WPC goals of reducing inappropriate ED/IP utilization and improving the health outcomes of the Medi-Cal population.

New services/expansion of services

- With new WPC funds, CMCT was able to add a new tier of case management services focusing on high utilizing patients residing in or entering our hospital delivery system. This high-touch bundle of services is helping patients transition out of the hospital and into more appropriate, community-based levels of care. Over the course of the summer/fall, CommunityConnect ramped up enrollment and established new workflows for high risk Medi-Cal patients entering the hospital system to be linked with a multi-disciplinary team of case managers. Through improved workflows and support, the program was able to reduce the number of sub-acute long-term stay patients in the hospital from 54 to 24 by year end.
- CommunityConnect established referral-based enrollment for patients transitioning into and out of substance use residential treatment. The program enrolled 332 patients during 2019, providing critical support and linkages to patients as they move back into the community. Nearly half of patients coming out of residential treatment were able to utilize the transitional fund, being housed in sober living environments.
- After finalizing a data sharing MOU with the County's social services agency, CommunityConnect's redetermination PDSA expanded to all patients by year

end. The program alerts patients of upcoming renewal dates through flyers and electronic health record messages. Additionally, case managers reach out and provide assistance on completing renewal forms. The program has seen a 10-15% reduction in Medi-Cal churn since this outreach began.

- Field-based case managers were all trained administration of Narcan and began distributing Narcan to patients and family members that may be at risk of overdose. Two reversals have been reported back to the program since this began.
- Through collaboration with the Employment and Human Services Department, CommunityConnect arranged for dedicated IHSS social workers to work on case redeterminations and approval of new IHSS cases. These IHSS workers were granted access to the electronic health record at CCHS to more efficiently make case redeterminations for CommunityConnect patients. These IHSS social workers also have dedicated time at the CommunityConnect office to coordinate with case managers.
- CommunityConnect expanded the population health outreach efforts in the fall and winter to send regular community resources to patients with specific identified social needs. Patients are immediately alerted via email, electronic health record messaging, or mail of upcoming job fairs, open subsidized housing properties, or holiday resources. In 2019, 37,000 messages went out to CommunityConnect patients.

Expansion of Resources

- CommunityConnect expanded the use of its transportation platform, RoundTrip, which is interfaced within the EHR and allows case managers to dispatch transportation via taxi's and rideshare for enrolled patients. The ease of administration has taken notice by other departments within CCHS, who are looking to expand usage.
- CommunityConnect continues to provide free cell phones to enrollees. Working with Sprint, CommunityConnect is receiving low-cost smart phones that are deployed to clients who are identifying as lacking income and resources to purchase their own phone. The phones are kept active for 6 months, while case managers work with client on sustainable communication plans. A recent evaluation of the cell phone project showed case manager engagements rates among cell phone receipts increased from 61% to 86% percent.
- CommunityConnect continued to provide support to patients with the transitional housing fund. In mid-2019, CommunityConnect changed criteria to access the fund into order to curb utilization. The housing fund has been a valued resource by case managers to assist patients with housing transition. It has especially been instrumental in transitioning patients out of substance use residential treatment into sober living environments.

VI. NARRATIVE – Incentive Payments

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

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

Please see the attachments listed below for supporting documentation of incentive payments and deliverables.

1. PY4 Incentive Measures Tracker.xlsx
2. 2_eConsent.pdf
3. 8-9_Case Mgmt Services Map.pdf

CCHS completed 9 approved PY4 incentives. Six were reported with the PY4 Mid-Year Report and the remaining three are reported in this PY4 Annual Report.

VII. NARRATIVE – Pay for Outcome

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

CCHS had one pay for outcome deliverable: Increase adult patients in WPC screened for Substance Abuse and Mental Health (depression) using the SBIRT tool at least once by 4% from PY3.

CCHS has met this deliverable. PY3 reported SBIRT completion rate of 40% and PY4 reported completion rate of 55%, reflecting a 15% increase from PY3.

This rate reflects the total number of WPC enrollees who were screened for Substance Abuse and Mental Health using the SBIRT tool at least once during the reporting year.

VIII. STAKEHOLDER ENGAGEMENT

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

**Please limit responses to 500 words*

Please see attachment 'Stakeholder Engagement Meeting Log_PY4 Annual.xlsx' for stakeholder meetings during the reporting period.

IX. PROGRAM ACTIVITIES

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

1. **Reduction of hospital long-stay patients due to introduction of new 'social admission' diversion PMPM service bundle.** Summer 2019 saw the development of a new PMPM bundle, Tier 3, aimed at preventing non-acute admissions. This would be done by providing a high level of case management, coordination with the ED, and skilled nursing beds. The core project goal was to initiate coordinated case management efforts with T3 team, hospital services and partnering agencies to focus on three target population groups: Patient frequently presents to ED with non-medical needs, Medically fragile patient presents to ED and discharge disposition unclear, and Acute admission with potential of becoming non-acute long term stay patient. Bringing together ED Providers, ED Social Workers, hospital providers, hospital social workers, and discharge planners for multiple design sessions proved to be a fruitful experience and resulted in workflows to refer patients to CMCT Tier 3. Patients at risk for non-acute admissions are offered same-day evaluation and enrollment into the program where they are supported by an interdisciplinary team, including Social Workers, Nurses, Community Health Worker, Physician, Nurse Practitioner, Homeless Services Specialist and Support staff. The first six months of the service have seen the number of long-stay patients at the Contra Costa Regional Medical Center decrease by over 400% from 54 to 13. This decrease can be directly attributed to the heightened awareness, improved workflows, and collaboration among team members.

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

1. **Systemic culture and infrastructure within hospital delivery system to prevent non-acute hospitalizations.** Through the introduction of the 'Tier 3' PMPM service bundle to support social needs identification and divert non-acute hospital admissions a handful of new challenges were identified. Of these, it was quickly identified that there was a lack of clear 'rules of engagement' between hospital services, homeless services, and public health clinic services to support patients with significant social needs presenting at the Emergency Department. Staffing shortfalls and limited working hours had resulted in needed resources only being available 25% of the time. In response, ED providers had relied on direct admissions to the hospital in lieu of discharging with social supports. This inadequate infrastructure and inefficient processes resulted in delays, inappropriate admissions and longer lengths of stay than needed. With the introduction of dedicated resources to identify and highlight these challenges, together the Tier 3, ED, and hospital-based teams

began to solve each challenge to develop new workflows to reduce non-acute admissions and discharge 'long stay' patients.

Lessons learned: in the absence of dedicated resources and clearly defined communication pathways, chaos can become normalized and lead to less-than-ideal workflows and process. Taking the time to step back and identify the root cause of each challenge can allow true and sustainable resolutions to be presented.

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

1. **Transition of paper consent forms to electronic versions and allow electronic patient and provider signatures –** Like all health systems, Contra Costa Health Services is reliant on patient consent in order to provide services. This is true in both the WPC pilot as well as the larger health system. Historically, patient consent has always been obtained through traditionally paper and 'wet' signature processes and then scanned into the electronic health record (EHR) afterwards. Using WPC incentive payments, CCHS was able to successfully build and pilot the transitioning of two paper consent forms to versions. In addition, patients and providers are able to sign these electronic consent forms using either their finger on a laptop trackpad or with a mouse. The collection of authorization via electronic forms and signature removes the burden of handling paper documents as well as reduces the risks associated with scanning into the EHR. Building on this successful pilot, CCHS is working to transition additional consent forms and workflows to electronic versions in 2020 as well.

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

1. **Finding and retaining a reliable social resource database vendor.** At pilot onset, CommunityConnect contracted with Health Leads REACH to provide a social resource database that case managers could use to provide community resources to clients. In 2019, case managers reported that the database was not maintained with high quality standards, and CommunityConnect worked with the vendor to update resources and restore data integrity. In late 2019, CommunityConnect was informed that Health Leads REACH would be exiting the business of maintaining a social resource database but would honor the contract through the end of the pilot. CommunityConnect is actively looking for another vendor, ideally one that can integrate more directly into the electronic health record with a high-quality control protocol for ensuring updated resources.

Lessons learned: Even when contracting with an outside vendor, it is important to have a robust internal quality assurance and audit process to ensure quality of materials for clients.

2. **Lack of experience in data evaluation activities in Social Services leads to delays in technical understanding of data sharing -** While the partnership between the Health and Social Services departments successfully moved forward with the execution of the data sharing MOU in Spring 2019, there are continued challenges in understanding and operationalizing social services datasets. Social services IT staff have had difficulty translating the datasets into operational terms so that the program can best identify fields to use for evaluation. Data quality issues stemmed from data entry raise further questions for usage. Both Health Services and Human Services are actively working to identify the correct fields to best evaluate the partnership. While this will likely be resolved in the near future, there has been significant time spent trying to clarify human services evaluation metrics.

   Lessons Learned: It is important to identify both technical and operational analysts when working to define new data elements for quality metrics, especially when looking to unfamiliar data sources.

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

1. **Completing an Interim Evaluation Report.** At the end of 2019, Contra Costa completed its Interim Evaluation Report, an internal evaluation aimed at assessing the services provided at the mid-point of the pilot. The report covers pilot background, an assessment of services provided, a look at special populations and unique service bundles, an outcomes evaluation through a randomized control trial, and an assessment of infrastructure development. Report findings of the randomized control trial showed a 14% reduction in ED usage and a 24% reduction in inpatient admissions after one year of services. Contra Costa is currently working on sharing best practices and key findings, looking for ways to disseminate findings more broadly.

2. **Developing a Program Quality Dashboard** – CommunityConnect developed an interactive program quality dashboard that tracks key program metrics and provides simple ways to stratify results by population groups. In developing this dashboard, the program also identified case management quality metrics. Quality improvement staff trained program leadership and managers on using the dashboard. Program leadership and direct service staff use these quality measures to identify future quality improvement projects and improve quality of care.

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

(1) **Difficulty in partnering with outside partners for data sharing.** CommunityConnect has been exploring collaboration with academic institutions to share data and further evaluate the program. While there is great interest with academic partners on partnering and collaborating on joint research and reporting projects, there are multiple hurdles with sharing PHI with academic institutions. CommunityConnect has been working to establish data sharing agreements on specific research projects; however, the length of time to get these approved both through local county council and through academic institutions has delayed this collaboration. Contra Costa has recently developed an internal research and evaluation team to oversee relationships with outside academics.

Lessons learned: Developing an internal knowledge base on how to collaborate with outside research institutions will make future collaborations more streamlined.

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

As previously reported in narrative reports from previous years, the future of the Whole Person Care pilot remains an area of concern. The recent CalAIM proposal outlines support to continue many of the core principles piloted in Whole Person Care. While this is greatly encouraging, Contra Costa has many open questions as to the volume of patients that will be eligible for the newly established 'Enhanced Care Management' service bundle as well as the amount of funding to be provided. As one of the largest Whole Person Care pilots, CCHS has been providing services to 15-25% of the county Medi-Cal population and seen very positive outcomes. It has been mentioned that ECM may only be able to cover 1-3% of the high risk population – successful outcomes with this smaller population are unknown and untested.

A select number of services that have been provided through the CCHS Whole Person Care pilot such as smartphones and transportation to non-medical locations will no longer be included. The CCHS WPC pilot has found these to be essential services to engage and connect with patients to advance the pilot goals. In addition to the loss of services, the CCHS pilot has found that FFS patients often have very high support needs with high gaps in care, and often mistrust or misunderstand the health delivery system more than managed care patients. While the CalAIM proposal includes initiatives to move a greater number of patients to Managed Care Medi-Cal, the FFS

model does remain in place while excluding FFS patients from the population health and ECM services.

In addition to the structural and service uncertainly, staff members providing services continue to feel uncertainly as well. As previously reported, program staff and leadership feel fear and anxiety with an increase in staff turnover during 2019. Filling open positions in 2020 will continue to be a challenge and may impact services for enrolled patients.

X. PLAN-DO-STUDY-ACT

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

See PDSA attachments:

1. PDSA Summary PY4 Annual Report.xlsx
2. PDSA - Ambulatory_2019_Q3_Complete.doc
3. PDSA - Ambulatory_2019_Q4_Complete.doc
4. PDSA -Inpatient Utilization_2019_Q3_Complete.doc
5. PDSA -Inpatient Utilization_2019_Q4_Complete.doc
6. PDSA_Comprehensive_Care_Plan_2019_Q3_Complete.docx
7. PDSA_Comprehensive_Care_Plan_2019_Q4_Complete.docx
8. PDSA_Care_Coordination_2019_Q3_Q4_Complete.docx
9. PDSA_Data_Q3_Q4_Complete.docx