State of California - Health and Human Services Agency

Department of Health Care Services

Whole Person Care

Lead Entity Narrative Report

Contra Costa Health Services Department

Annual Narrative Report, Program Year 5

April 9, 2021

REPORTING CHECKLIST

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

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

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

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

Instructions: 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.

Please limit responses to 500 words. If additional information is needed, please contact your assigned Analyst.

During PY5, Contra Costa Health Services (CCHS) continued to make progress in reaching program goals focused on multi-agency collaboration and data sharing, increasing partnerships with social services, evaluating, and communicating results with partners, and leveraging program infrastructure to best respond to the COVID-19 pandemic for program recipients.

CCHS continued **increasing integration among county agencies, health plans, providers, and other entities.** Initial planning activities to support the transition to CalAIM and the implementation of a system-wide case management documentation platform within the EHR brought together the Contra Costa Health Plan, behavioral health services, and social services on projects to improve services for shared clients. This project will pave the way for greater alignment in documentation and workflows to set standards across case management programs. Additionally, all departments now utilize a single resource directory, Aunt Bertha, fully integrated into the EHR, further enabling alignment between the health plan, providers, and other entities. This tool will allow for **increased access to housing and supportive services** by centralizing resources within the EHR. Expanded integration with the Employment and Human Services Department (EHSD) has resulted in the introduction of In-Home Support Services social workers to the multidisciplinary Whole Person Care teams along with expanding data sharing.

The program has been able to **increase coordination and appropriate access to care** during the COVID pandemic by implementing a vulnerability index that identifies patients most at risk for poor outcomes if they were to contract COVID and proactively outreach to these persons to assist them during shelter in place activities. The use of mobile communication technologies introduced through WELL Health has allowed for greater patient contact in a secure fashion. The infrastructure established through WPC allowed the entire health system to pivot to pandemic response and was highlighted in a Health Affairs article in 2020.

The internal program evaluation has demonstrated a **reduction in inappropriate emergency and inpatient utilization**. Findings from the randomized clinical trial have shown that WPC enrollees in Contra Costa are 25% less likely to be admitted to the hospital after one year of services and 14% less likely to use the emergency department. CCHS has parted with UC Berkeley to publish this study and share findings more widely. Additionally, CCHS has begun working on better communicating findings to non-academic audiences by working with a local communications partner, Full Court Press, to **improve data collection and sharing** of key findings.

The quality team conducted a Housing Fund evaluation in early 2020, where all recipients received follow-up 6 months after receiving security deposit assistance to assess program success. Over 78% of clients remained housed in the same location 6-months after the initial security deposit assistance. In addition, 53% of respondents reported an increase in their physical health (from baseline enrollment measurement) and 64% reported an increase in their emotional health. These results demonstrate the success of the FFS housing bundle at **improving health outcomes for the WPC population.**

The program was able to **achieve quality and administrative improvement benchmarks** by continued use of program dashboards accessible by all staff, managers, and leadership. The COVID pandemic brought challenges with achieving the Pay for Outcome measure, SBIRT Screening, due to a decrease in in-person services and clinical visits. Despite this setback, the program was able to thrive and continue to provide vital services to patients because of the strong infrastructure developed in the earlier years of the pilot.

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	701	1,504	988	1,075	688	692	47,250

Item	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12	Annual Unduplicated Total
Unduplicated Enrollees	898	923	687	725	840	655	51,978

*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
Service 1	$688,500	$679,500	$742,500	$396,000	$261,000	$364,500	$3,132,000
Utilization 1	153	151	165	88	58	81	696
Service 2							
Utilization 2							

Costs and Aggregate Utilization for Quarters 3 and 4

FFS	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12	Annual Total
Service 1	$346,500	$337,500	$387,000	$346,500	$243,000	$364,500	$2,025,000
Utilization 1	77	75	86	77	54	81	1146
Service 2							
Utilization 2							

*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
Bundle #1	$326	$2,047,606	$1,993,490	$1,956,652	$1,943,938	$1,926,334	$1,919,488	$11,787,508
MM Counts 1		6,281	6,115	6,002	5,963	5,909	5,888	36,158
Bundle #2	$146	$1,037,768	$1,019,226	$1,000,684	$997,034	$978,930	$976,010	$6,009,652
MM Counts 2		7,108	6,981	6,854	6,829	6,705	6,685	41,162
Bundle #3	$2133.66	$364,855.86	$324,316.32	$305,113.38	$354,187.56	$348,786.58	$324,316.32	$2,020,576.02
MM Counts 3		171	152	143	166	163	152	947

Amount Claimed for Quarters 3 and 4

PMPM	Rate	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12	Annual Total
Bundle #1	$326	$1,913,294	$1,905,796	$1,902,862	$1,896,668	$1,895,364	$1,903,840	$11,417,824
MM Counts 1		5,869	5,846	5,837	5,818	5,814	5,840	35,024
Bundle #2	$146	$972,944	$976,156	$974,404	$973,236	$976,448	$976,156	$5,849,344
MM Counts 2		6664	6,686	6,674	6,666	6,688	6,686	40,064
Bundle #3	$2133.66	$356,321.22	$352,053.90	$349,920.24	$330,717.30	$330,717.30	$332,850.96	$2,052,580.92
MM Counts 3		167	165	164	155	155	156	962

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

IV. NARRATIVE – Administrative Infrastructure

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

Please note the narrative submitted during the Mid-Year report will be considered part of the Annual report and will not need to be resubmitted. Include updates, notable trends, and highlights of achievements/progress as well as any changes since the report. Please limit your responses to 500 words.

In addition to the previous PY4 Administrative Infrastructure narrative, pasted below, the WPC Administrative unit was responsible for CalAIM transition planning in early 2020 and COVID program adaptions beginning in March 2020.

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.

IV. NARRATIVE – Delivery Infrastructure

Instructions: 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. Please limit your responses to 500 words.

During PY5, CCHS WPC provided 7,600 in-person visits and over 75,000 phone visits to more than 15,000 patients. Throughout the year, in-person case managers pivoted their work to phone visits due to the COVID-19 pandemic. Patient needs changed during the pandemic and case managers worked to provide services to address those unique needs, identifying over 96,000 goals with patients and addressing 68,000 needs.

The CCHS WPC program **expanded collaboration with the social services agency, Employment and Human Services Department (EHSD),** by co-locating In-Home Support Services social workers at the WPC office and adding these staff members to the multidisciplinary care teams. Existing **data sharing agreements with EHSD** allowed for unique patient matching, identification, and assignment of WPC enrollees to designated IHSS social workers. IHSS social workers were provided access to the EHR, allowing for expanded IHSS hours and expedited processing of cases.

The implementation of a new social case management platform within the EHR during the second half of 2020 will allow for **increased coordination and standardization of social determinants** documentation across CCHS. Aligning all case management programs to standardized documentation tools will allow for greater coordination and less duplication of services. Staffing and design was completed in Q1 and Q2, with the first case management programs began using the system during Q4. Additional case management programs will continue to transition throughout 2021. The implementation of these new tools will prepare the system to transition to CalAIM. The **implementation of a comprehensive social resource directory**, Aunt Bertha, has provided an essential replacement for the previous system, Health Leads, as the vendor exited the space. The new directory is fully integrated into the EHR and also has a client-facing version, a necessary aid in assisting with self-sufficiency.

The program continued scaling PDSAs to improve **No-Show rates in ambulatory care** and **screening for social risk during COVID**. While the No-Show PDSA ended at the beginning of the COVID-19 response and will be implemented more fully as the health system emerges from the pandemic, the COVID social risk screening was successfully implemented. The PDSA of **providing social needs population health outreach** has been an important way to disseminate vital information to clients during COVID, when

they may not be able to receive in-person flyers from case managers. The program has quickly been able to disseminate open housing voucher programs to eligible clients.

As CalAIM activities were put on hold during 2020, there was uncertainty regarding the future of WPC services. This introduced added stress and concerns for staff during the pandemic regarding the sustainability of the program. With this uncertainty, the CCHS pilot focused on **maintaining services** and working on **projects and infrastructure that were system focused**. The extension of the 1115 waiver at the end of the year, along with the announcement of a relaunch of CalAIM, has allowed for greater vision to the future in terms of the program preparing for CalAIM implementation.

V. NARRATIVE – Incentive Payments

Instructions: 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 limit your responses to 500 words.

Please see the attached documents for documentation of PY5 Annual Incentive Payments:

- *PY5 Incentive Measures Tracker_Annual.xls*
- *PY5 Incentives_Annual.pdf*

CCHS completed 12 of 12 approved incentives for PY5.

VI. NARRATIVE – Pay for Outcome

Instructions: 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. Please limit your responses to 500 words.

CCHS WPC will opt to use the COVID-19 Alternative Payment method for the Pay for Outcome, utilizing our competition rate from PY4. CCHC achieved 100% of our Pay for Outcomes in Program Year 4. In PY3, the program had 40% of WPC enrollees screened, and this increased to 55% in PY4 (a 15% increase). CCHS will receive 100% payment in Program year 5, in the total amount of $250,000.

In PY5, increase adult patients in WPC screened for Substance Abuse and Mental Health (depression) using the SBIRT tool had a goal of achieving at least 5% improvement over PY4. In PY5, due to the COVID-19 pandemic, SBIRT screening decreased due to less in-person visits by both case managers and less interactions with the health system due to shelter in place. In PY5, 38% of patients received SBIRT screening. As such, CCHS is opting to use the alternative payment method. The quality team is developing a system to increase SBIRT competition for PY6.

VII. STAKEHOLDER ENGAGEMENT

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

Please see the attached documents for documentation of stakeholder meetings during Q3-Q4 2020:

- *PY5 Stakeholder Engagement Meeting Log_Annual.xls*

VIII. PROGRAM ACTIVITIES

Care Coordination

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

1. **Expanded Relationships with Employment and Human Services Department (EHSD).** During 2020, CCHS expanded upon the partnership with Social Services, specifically with the In-Home Support Services program. In 2020, four IHSS social workers were relocated to WPC offices to increase collaboration across teams. Caseloads assigned to these social workers were exclusively WPC clients. Through data sharing agreements, CCHS WPC was able to identify which patients were receiving IHSS benefits and these patients were all assigned to the IHSS social workers dedicated to WPC clients. IHSS social workers were given access to the EHR which allowed the social work team to perform initial assessments more easily and reassess the number of hours. Additionally, the IHSS workers became part of the monthly multidisciplinary care teams and were able to be part of case conferencing. As case managers often assist their clients applying for IHSS, the program developed a more streamlined and integrated process, as the case manager and IHSS social worker could conduct assessments together and the IHSS social worker was a part of the joint care plan. Having IHSS social workers as part of the program has allowed for great care coordination across departments.

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

1. **Remote work among care team.** The Covid-19 pandemic has changed the way in which care teams have interacted and been able to coordinate care for patients. With staff moving to remote work, the amount of informal hallway coordination has decreased, resulting in a need for more formal and planned pathways for coordination amongst care team members.

   Lesson Learned: Having technology systems and planned case conferencing meetings have been an important component to ensure case conferencing with various members of the care team. Having integrated technology within the electronic health record has been an important component as care team members have been able to securely message each other for advice and counsel regarding patients.

Data Sharing

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

1. **IHSS Data Sharing.** In 2020, CCHS and EHSD were able to operationalize their data sharing agreement specifically for IHSS recipients. On a monthly basis, CCHS sends EHSD a list of WPC enrollees to match against IHSS recipients. IHSS provides back a list of WPC enrollees that have receiving IHSS services, along with that person's IHSS social worker and direct contact information. This data match has been used to assign WPC patients specifically to the IHSS workers dedicated to WPC.

2. **Social Resource Database.** In the second half of 2020, Contra Costa Health Services completed contracting with Aunt Bertha, a social resource directory that is integrated into the EHR. In previous years, CCHS used a resource database called Health Leads, which informed the county that they would no longer provide resource directory services past 2020. The change to Aunt Bertha has been positive as the database is integrated into the EHR, which has allowed greater visibility of social resources to the entire health system, as well as greater accessibility.

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

1. **Transitioning to new Resource Directory.** The transition to the Aunt Bertha database was challenging, as social resources from the previous system had to be transitioned to the new directory. The implementation team planned a virtual go-live, which did not provide as much hands-on training that is typical.

   Lessons Learned. Providing trainings and tip sheets for virtual go-lives can be a good way to train a largely remote workforce. Having these reinforced during team meetings and virtual super users that are available to assist with screen share was important for successful transition.

Data Collection

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

1. COVID Vulnerability Index. Our program data scientist was able to adapt our WPC risk model to create a COVID Vulnerability Index (CVI) to identify patients

that are at risk for poor outcomes for COVID. An assessment was created and WPC case managers were able to contact these patients to provide services and resources to assist patients with shelter in place. The infrastructure of WPC was able to be quickly leveraged to meet the needs of the pandemic.

2. **Collaboration with UC Berkeley.** CCHS signed a data sharing agreement with UC Berkeley to study CCHS response to COVID and how WPC was leveraged for the greater pandemic response. This study has allowed researchers access to the program and look at the ways in which WPC may be having broader impacts on the system of care during crisis. Some of this was shared in a Health Affairs piece, and a more in-depth qualitative and quantitative study is in progress.

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

1. **Contracting for Evaluation.** It took nine months for a data use agreement to be approved by both Contra Costa and UC Berkeley so that the program could share patient-level data with researchers in order to study the program. CCHS did not have prior experience in sharing patient level data with academic institutions and many items had to be addressed with county counsel in order to move the data use agreement along.

   Lessons Learned. Creating data sharing agreements with external researchers should be done at a system level so that these agreements can be leveraged for multiple projects at CCHS given the length of contracting.

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

The transition to CalAIM and the uncertainty of the future remains a concern. CCHS WPC program is one of the largest pilots in terms of proportion of Medi-Cal beneficiaries receiving services. CCHS Tier 2 bundle is not an ECM bundle, as those services are directed at the rising risk population and are telephonic services. It is not clear who will be providing these services to this population come 2022. CCHS spent five years developing infrastructure not only for ECM but also for Basic and Complex case management. These services have been vital for these “lower risk” patients, but they are not being discussed in the CalAIM transition process.

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 Attachments:

PDSA Attachments:

- Please see the attached PDSA documents for Q3-4Q4 2020:

PDSA-Ambulatory_2020_Q3_Complete.doc
PDSA-Ambulatory_2020_Q4_Complete.doc
PDSA-Care_Coordination_2020_Q3_Q4_Complete.doc
PDSA-Comprehensive_Care_Plan_2020_Q3_Complete.doc
PDSA-Comprehensive_Care_Plan_2020_Q4_Complete.doc
PDSA-Data_2020_Q3_Q4_Complete.doc
PDSA-Inpatient_2020_Q3_Complete.doc
PDSA-Inpatient_2020_Q4_Complete.doc
WPC Pilot PDSA Summary 2020.xlsx