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

Reporting Checklist

Kern Medical Center
Annual PY 4
07/07/2020

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.

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.*

Kern continues to steadily increase enrollment and have continued to exceed enrollment goals we set with DHCS in October 2018 through the PY4 Annual projections. LE continues to expand services in both the FFS and PMPM categories. Kern's WPC Pilot also was responsible for starting the Medication Assisted Treatment (MAT) Re-Entry Program here in Kern County. This is through collaborative efforts with Kern County's Sheriff Office, BHRS and DHS.

The Care Coordinators outreach shifted in the second half of 2019 to focusing more heavily on outreach to existing enrollees rather than potential enrollees since enrolment was steady and we had a long way to go in an effort to meet metrics and performance outcomes. Care coordinators significantly increased the number of acuity calls with the influx in enrollment over the previous year. Kern saw a significant improvement in quality metrics met due to the immense efforts made to proactively engage enrollees to increase compliance.

Kern continues the current data sharing platform and partnership with DHS and Sheriff's Office. DHS workers facilitate services right in the WPC clinic to create more access for our enrollees. This practice continues to be immensely beneficial to our enrollees and has drastically increased access to many services available to our WPC enrollees. Kern is very proud of the positive change this has made and feels that this should be a best practice take away for WPC Pilots.

Data sharing with the Kern County Sheriff's Office has proven to be necessary and essential in both identifying potential WPC enrollees, and locating them upon or immediately after release from incarceration. Kern continues to make efforts to expand data sharing with other CBOs.

Once personal points of contact were established at the various community based organizations and agencies, the WPC team conducted subsequent visits and outreach at those locations to inform staff and potential participants about the program. Ongoing check-in meetings continue to occur to answer questions, enroll participants and troubleshoot and issues with referrals or services.

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	81	58	84	133	69	92	517

Item	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12	Annual Unduplicated Total
Unduplicated Enrollees	106	74	70	81	35	71	437

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
Child Care							
Utilization 1	N/A	N/A	N/A	N/A	N/A	N/A	N/A
In-Home Assessment Training							
Utilization 2	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Benefits Advocacy	$13,199.67	$12,666.35	$13,466.33	$19,866.17	$11,333.05	$13,599.66	$84,131.23
Utilization 3	99	95	101	149	85	102	631
Screening, Assessment, Referral	$2,940.00	$3,381.00	$10,878.00	$5,733.00	$5,586.00	$5,733.00	$34,251.00
Utilization 4	20	23	74	39	38	39	233
Information and Referral	$51,300.00	$44,550.00	$56,880.00	$53,550.00	$57,690.00	$40,950.00	$304,920.00
Utilization 5	570	495	632	595	641	455	3388
Respite Care					[redacted]	$2,550.00	[redacted]
Utilization 6	0	0	0	0	[redacted]	30	[redacted]
Sobering Center							
Utilization 7	0	0	0	0	0	0	0

Whole Person Care

Annual PY

FFS	Costs and Aggregate Utilization for Quarters 3 and 4						
	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12	Annual Total
Child Care							
Utilization 1	N/A	N/A	N/A	N/A	N/A	N/A	N/A
In-Home Assessment Training							
Utilization 2	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Benefits Advocacy	$22,266.11	$9,733.09	$7,333.15	$21,332.80	$21,066.14	$21,066.14	$102,797.43
Utilization 3	167	73	55	160	158	158	771
Screening, Assessment, Referral	$2,205.00	$2,205.00	$3,234.00	$2,499.00	$2,499.00	$2,646.00	$15,288.00
Utilization 4	15	15	22	17	17	18	104
Information and Referral	$25,920.00	$24,030.00	$21,600.00	$18,450.00	$19,440.00	$23,580.00	$133,020.00
Utilization 5	288	267	240	205	216	262	1478
Respite Care	$2,890.00	$2,720.00	$3,485.00	$6,375.00	$2,890.00	$2,635.00	[redacted]
Utilization 6	34	32	41	75	34	31	[redacted]
Sobering Center							
Utilization 7							

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 Counts**						
	Rate	Month 1	Month 2	Month 3	Month 4	Month 5	Month 6	Total
Housing Navigation	$480	$59,040	$75,360	$78,240	$81,120	$74,400	$89,280	$457,440
MM Counts 1		123	157	163	169	155	186	953
Employment Services	$200	$9,200	$5,000	$9,400	$11,000	$13,400	$21,600	$69,600
MM Counts 2		46	25	47	55	67	108	348
WPC Care Coordination	$450	$274,950	$301,050	$337,950	$401,400	$432,450	$473,400	$2,221,200
MM Counts 3		611	669	751	892	961	1052	4936
90-Day Post Incarceration	$1800	$324,000	$311,400	$194,400	$232,200	$205,200	$199,800	$1,467,000
MM Counts 4		180	173	108	129	114	111	815
Moderate Housing Support	$171	$4,275	$4,959	$4,959	$4,104	$4,788	$5,814	$28,899
MM Counts 5		25	29	29	24	28	34	169

Whole Person Care

Annual PY

PMPM		Amount Counts						
	Rate	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12	Total
Housing Navigation	$480	$125,280	$134,880	$159,840	$176,160	$195,360	$204,480	$996,000
MM Counts 1		261	281	333	367	407	426	2075
Employment Services	$200	$14,000	$15,400	$18,400	$12,400	$13,000	$7,600	$80,800
MM Counts 2		70	77	92	62	65	38	404
WPC Care Coordination	$450	$516,150	$549,000	$577,350	$622,350	$636,300	$665,550	$3,566,700
MM Counts 3		1147	1220	1283	1383	1414	1479	7926
90-Day Post Incarceration	$1800	$154,800	$167,400	$136,800	$102,600	$73,800	$37,800	$673,200
MM Counts 4		86	93	76	57	41	21	374
Moderate Housing Support	$171	$8,721	$8,208	$10,773	$4,446	$3,591	$7,866	$43,605
MM Counts 5		51	48	63	26	21	46	255

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

Kern discovered slight discrepancies in one of the PY4 mid-year FFS counts and all of the PMPM counts as there were a few people who were incorrectly reported on at Mid-Year. Discrepancies in the previously reported MY numbers appear in red font and have been adjusted. Kern accounted for both overpayments as well as underpayments in our invoice and adjusted the annual invoice amounts accordingly.

Summary of MY changes:
FFS – Benefits Advocacy: -3
PMPM – Housing Navigation: -1
PMPM – Employment Services: -2
PMPM – WPC Care Coordination: -13
PMPM – 90-Day Post-Incarceration: +321
PMPM – Moderate Housing Support: -2

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.

LE has successfully implemented a Medication Assisted Treatment (MAT) Program hired two additional Medical Assistants to perform the functions of Care Coordination for the expected exponential rise in enrollees throughout the remainder of the pilot. Kern's MAT efforts are not funded through WPC, however, we have found that WPC is a natural fit for nearly all MAT Re-Entry participants. Kern's MAT Re-Entry Program takes place inside the county jails and links qualifying individuals to WPC post-release for continuity and to provide that vital PCP linkage. Kern also added an enrollment specialist and an RN dedicated to WPC in the jail. These additions were very much needed and made it possible to continue the appropriate linkage to WPC for this extremely vulnerable population which we serve in Kern's Pilot.

The pilot has leveraged multiple existing database analyst and information systems specialists in order to develop and write reports, create additional workflows in the medical record and enhance templates in a way that data elements are discreet and able to be captured, and program and enhance our electronic screening tool to capture WPC beneficiary information. These individuals have provided the groundwork for a new template within the current medical record allowing for phone visits, which has greatly enhance the ability for care coordination so that non-face-to-face encounters can be captured. While the number of individuals from Information Systems working on the project was greater than anticipated leading to a higher actual cost, the amount of time spent working on the program was much more than we reported at mid-year due to the launch of Cerner in Q4, while still allowing the total claimed amount to fall within budget.

The Lead Entity is still in the process of implementing an Electronic Data Warehouse, which will house data from various sources and allow for more real time data analysis. This infrastructure will also assist in providing timely and relevant data sharing to CBOs regarding WPC Beneficiaries.

Indirect Costs are used to cover any variable/unknown items, which cannot be predicted in conceptual programs. The lessons learned, research, and possible outcomes for the WPC program are far too important to allow program failure for lack of funding for unknown circumstances.

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.

LE successfully secured an independent WPC clinic in December 2018. LE had another 6 months of WPC Independent Clinic Rent for PY4 Annual totaling $96,201.48.

Kern executed the contract for the Pre-Manage – EDIE Software in PY3 quarter 4, however, the funds were not due until implementation which did not happen until the first quarter of PY4. LE has continued to develop and implement Pre-Manage – EDIE Software (now Collective Medical) and was able to complete the majority of the IT architecture and design needs by the end of PY4 for the care coordination piece

All other Delivery Infrastructure budget items were not implemented until the third or fourth quarter of 2019.

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.

Kern's eligible incentive payments earned at Annual PY4 report include:

- Bi-weekly Learning Collaborative Calls attendance (Kern Medical Center only) – Met by attending on DHCS Learning Collaborative Calls. Kern Medical achieved 12 incentives at $200 each for a total of $2,400
- DHCS Learning Collaborative Meeting attendance (Kern Medical Center, Kern Health Systems and Kern BHRS only) Met by attending in person Learning Collaborative meeting reimbursed at $1,000 per attendee for each participating organization. Kern Medical Center had 4 individuals in attendance and Kern Health Systems, HealthNet and Kern BHRS each had 1 person.
- Managed Care Plan Referrals – Kern received 8 referrals from Kern Health System and Health Net for $20,000 each. Kern received 6 months of referrals from Kern Health Systems as their referral process is automated and two months of referrals from Health Net.
- 90% in Outreach and Engagement Phase, Enrolled in a Pilot within 3 months of first encounter. Kern has been successfully able to enroll over 99.47% of patients into WPC within 3 months of the first encounter. The total earned for this incentive was $500,300 paid to participating county partners.
- Each WPC enrollee w/primary care clinic appointment scheduled within 7 days discharge from inpatient stay or release from jail Kern had 276 for a total of $82,800
- Proportion of patients with Primary Care follow-up visit within 14 days of hospital discharge 50%, Kern earned $410,600 at a rate of 54.69%
- Proportion of patients with Medication Reconciliation within 14 days of hospital discharge 50%, Kern earned $250,054.28 at a rate of 87.23%
- Active involvement in barrier identification and resolution:

This incentive is reimbursed at $10,000 per meeting to CBOs/County Departments. Role was taken at each meeting to accurately record attendance. A maximum of 6 meeting attendances could be billed by the County Departments/CBOs and LE for the PY4 annual report. Achievement is measured by attendance. In addition to the LE, the County Departments/CBO's who were eligible to bill for this incentive are listed below:

The overall attendance was 90% with 70 of 78 total CBO attendees.

Kern Medical Center – 6 meetings x $10,000 = $60,000

Housing Authority – 6 meetings x $10,000 = $60,000
Probation – 6 meetings x $10,000 = $60,000
Aging and Adult Services – 6 meetings x $10,000 = $60,000
Health Net – 3 meetings x $10,000 = $30,000
KCSO – 6 meetings x $10,000 = $60,000
Kern Health Systems – 6 meetings x $10,000 = $60,000
Golden Empire Gleaners – 6 meetings x $10,000 = $60,000
Public Health – 1 meeting x $10,000 = $10,000
America's Job Center (Formerly E.T.R.) – 6 meetings x $10,000 = $60,000
Kern B.H.R.S. (Formerly Kern County Mental Health) – 6 meetings x $10,000 = $60,000
DHS – 6 meetings x $10,000 = $60,000
Flood Ministries – 6 meetings x $10,000 = $60,000

Mental Health Reporting: Kern BHRS submitted a report in September 2019 and earned $20,000 for PY4 Annual. The trigger for payment is the report must be submitted within 30 days after the previous month. Kern BHRS successfully submitted one report on time during July 2019 and December 2019.

Timely Submission of Data Integrity for social Determinants/Care Coordination: Kern is reporting 24 units of this incentive. Between Kern BHRS, Kern Medical, Kern Health Systems, HealthNet, Kern County Probation and Kern County Sheriff, Kern's Pilot attained 24 of these units. The total per unit is $10,000, earning a total of $240,000.

HEP A Vaccine 30%: Kern could only report 0.46% (6/1305) - The main issue that Kern ran into was not having the HEP A Vaccine in stock at our WPC clinic for several months of the measurement period. Kern is hoping to be able to meet this metric in PY5. – **Not Attained**

Partners with Data Sharing Software: Kern's Pilot has not been successful thus far in implementing the data sharing software. Kern reported zero units for this incentive.

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.

Frequent care coordination with a CSW in addition to their regular care coordinator also proved to be a huge benefit to the patient from a behavioral health standpoint. SBIRT screenings were preformed typically every 90 days unless a higher frequency was necessary and our in house (mild to moderate) behavioral health therapy was also available at every clinic visit as well as scheduled appointments.

Due to the transient nature of the population that we were enrolling into WPC, it was often a challenge to successfully contact enrollees who are in desperate need of the care coordination services we provide. This makes it difficult to build the relationships mentioned above which have proven to be so successful in impacting the overall health for these individuals.

Housing Authority has proven to be instrumental in locating our homeless population, keeping them current with physician appointments, and assisting with housing navigation services. Aggregated data from the PY4 Mid-Year report indicate that Housing Authority has assisted with 957 months of services on a PMPM basis.

5% Improvement over previous PY of ER Utilization Kern's pilot had a baseline of 41% and a PY4 annual rate of 38.82% - **Attained**

- This metric is paid based on DHCS run data, the trigger for payment was not achieved. DHCS data showed no reduction from PY3 to PY4. – **Not Attained**

5% Improvement over previous PY of Inpatient Utilization Kern's pilot had a baseline of 34.09% and a PY4 annual rate of 26.5% - **Attained**

- This metric is paid based on DHCS run data, the trigger for payment was achieved. DHCS data showed a reduction from PY3 to PY4 that surpassed 5%. – **Attained $300,000**

5% Improvement over previous PY for Follow-up after hospitalization for Mental Illness Kern's pilot had no hospitalizations for mental illness in the baseline year. PY3 Annual rate 0% within 7 days and 57.14% within 30 days. At PY4 annual, the reported rate was 62.5% within 7 days of discharge and 87.5% within 30 days of discharge – **Attained $600,000**

5% Improvement over previous PY Initiation and engagement of ETOH and other dependence Kern's pilot had a baseline of 0. PY3 Annual rate 96% within 30 days. At PY4 annual, the reported rate was 80% within 30 days of initiation visit – **Not Attained**

5% Improvement over previous PY for PHQ-9 depression remission at 12 months - Kern's pilot had a baseline of 0%, PY2 rate of 0%, PY3 rate of 0%, and a PY4 annual rate of 1.39% **- Not Attained.**

This metric looks back one year for the PHQ score, so this population was screened prior to enrollment in the program. Now when enrolled, individuals are being screened for depression and work immediately with social workers in the event the score greater than 9.

2% Improvement over previous PY of Hba1C Control <8% Kern's pilot had a baseline of 66.0%, PY3 annual rate of 60.56%, and a PY4 annual rate of 62.32% - **Attained $500,000**

As populations increase, variation and volatility in this metric should decrease.

5% Improvement over previous PY for preventative care measures of WPC beneficiaries – Kern's pilot was excellent ? at achieving this metric and were able to attain this for the first time and ended PY4 annual with a rate of 60.74% (229/377). Of the 377 total eligible clients, 229 was able to meet this measure. This measured colorectal cancer screening, breast cancer screening, cervical cancer screening. – **Attained** $500,000

40% Post-incarceration primary care visit within 60 days of release – Kern's pilot had [redacted] post-incarcerated beneficiaries who had a primary care visit within 60 days of release – **Attained $250,000**

5% Improvement over previous PY 30 day all cause readmission - Kern's pilot had a baseline of 20%, an PY3 rate of 8.16% and a PY4 annual rate of 20.31%. DHCS runs this metric on an Annual basis. - **Not Attained.**

- This metric is paid based on DHCS run data, the trigger for payment was not achieved. DHCS data showed no reduction from PY3 to PY4. – Not Attained

5% Improvement over previous PY Mental Health Reporting: Screening, Brief intervention and referral to treatment (SBIRT) Kern's pilot had a baseline of 68.4%, PY3 annual rate of 59.26%, and a PY4 annual rate of 76.46% - **Attained. $500,000**

5% Improvement over previous PY: Overall Beneficiary Health – Kern's pilot was not capturing this survey before PY4 Mid-Year. The PY3 Annual rate was 0%. At the end of PY4 annual we had data reporting [redacted] eligible clients met this measure) for the overall health question and [redacted] eligible clients met this measure) for the mental and emotional health question. – **Attained 250,000.**

5% Improvement over previous PY: Controlling High Blood Pressure Kern's pilot had a baseline of 65.63%, PY3 rate of 70.75% and a PY4 annual rate of 73.64% - **Partially Attained. $408,000**

Med Reconciliation completed within 30 days of enrollment – 70% Kern's pilot had 76.87% of med reconciliations completed within 30 days of enrollment – **Attained $239,300**

70% of participating beneficiaries with a comprehensive care plan, accessible by the entire care team within 30 days Kern's pilot achieved 100% compliance – **Attained $250,000**

Screening for clinical depression and follow-up plan – 10% improvement over prior year Kern's pilot had a baseline of 0%, PY3 annual rate [redacted] and a PY4 annual rate of [redacted] eligible clients met this measure) **– Partially Attained** $206,000

Percent of homeless receiving housing services in PY that were referred for housing services – 75% Kern's pilot had an annual rate of 95.58% - **Attained $250,000**

Completion of Universal Assessment Tool with Homeless individuals – 80% Kern's pilot achieved [redacted] eligible clients met this measure) – **Attained $282,516.75**

Percentage of participants who have obtained TB clearance – 75% - Kern's pilot achieved [redacted] eligible clients met this measure) – **Attained $527,200**

Alternate Metrics:

For Program Year 2 and 3, Kern County was permitted to propose recoup metrics for Inpatient Hospital Stay not met in PY2 as well as All Cause Readmission and Emergency Department Visits metrics not met in PY3. The total possible recoup is $2,498,400 after the 10% withhold. These recoup metrics had to be pay for outcomes and had to be achieved at the PY4 annual invoice.
A detailed breakdown of the recoup request can be found below:

Cerner Millennium EHR Implementation Completion by November 1, 2019: Kern successfully implemented Cerner Millennium Electronic Health Record (EHR) on November 1, 2019. Prior to the Cerner implementation, Kern utilized an antiquated Electronic Medical Record (EMR) called CareVue or OpenVista, a McKesson product that was extremely difficult to report out of and poorly documented both clinical and non-clinical information in a way that was easily digestible for clinicians. Our Cerner Millennium implementation included PowerChart, iView Assessments, ePrescribe, Cerner's HealtheIntent platform which includes HealtheAnalytics and an Electronic

Data Warehouse (EDW), and other modules which allow for a sole-source, cohesive and thorough documentation experience for providers and medical staff which improves patient experience and quality of care. This was a tremendous undertaking which began in February of 2018 and took a total of twenty months to complete and launch. Kern is requesting $500,000 for this Pay for Outcome as an alternate metric for our recoup.

Kern Housing Authority (KHA) Housing Partnership and Coordination Improvement LE Will Provide Warm Handoff within 10 days of referral to KHA: Over the development of WPC, we have witness a staggering increase in the sheer volume of referrals made to Kern County Housing Authority, on behalf of WPC patients. In order to effectively manage the increase in the number of referrals, we have had to reimagine and refine our processes and allocate additional time and resources to accommodate our patient's housing needs. Cumulatively in both PY2 and PY3 Kern only produced a volume of 581 PMPM month for Housing Navigation utilization. For volumes that low, Kern's WPC Pilot would simply forward referrals to KHA for assessment and navigation. As of PY4, that volume increased nearly six-fold totaling 3,028 PMPM months for the program year. That tremendous growth demanded that we reevaluate our initial workflow. The primary and most substantial change was that a warm hand off to KHA was the new requirement for making a referral to Housing Navigation. During that warm handoff the process now involves:

1. Coordinating schedules between WPC Care Coordination Staff and KHA staff
2. WPC staff assisting patients (when necessary) to obtain the required documentation before their scheduled KHA assessment
3. Collaborating with KHA by assisting patients in completing their housing plans as assigned by KHA
4. Bi-weekly case conference calls with KHA and the WPC care coordinators

All of this is managed through weekly meetings between WPC and KHA to discuss individual cases, process improvements, sharing of program developments and coordination of other services. With this more hands-on approach, we are trying to ensure that WPC patients are not falling through the cracks and improve the likelihood of placement into permanent supportive housing. Kern is requesting $500,000 for this Pay for Outcome as an alternate metric for our recoup.

Strengthen community partnership and increase WPC enrollment by Providing Medical Support for SLEs and Halfway Houses within 7-10 days of new residence – Kern will secure referrals from a minimum of 10 facilities by 12/31/2019: Local Sober Living Environments (SLEs), treatment facilities, and halfway houses are required to obtain medical clearances for new residents within 7 – 10 days of receiving a new client. Traditionally, these facilities have relied on local providers for such medical clearances. A number of facilities have reported to WPC frustrations that their regular providers have had significant challenges meeting their requirements for thorough and timely exams. WPC took this opportunity to develop a provider relationship with these facilities which not only resulted in improved regulatory outcomes for the facilities, but also increased our WPC enrollments. As new residents move in, they are sent to the WPC Clinic for medical clearance and in turn, WPC gains

a new enrollee. As these referred patients go through their treatment program, WPC provides additional support within our programmatic resources and services, which greatly improves the likelihood for patient recovery and decreased recidivism. Kern's Pilot did not have any SLE providers who referred their new residents to WPC prior to Q1 2019. By December 31, 2019 we had developed referral relationships with the following facilities:

1. Jason's Retreat Residential Treatment (Men) 30 Beds
2. Jason's Retreat/Capistrano Residential Treatment (Female) 24 Beds
3. Jason's Retreat/Perinatal Residential Treatment (Female) 14 Beds
4. Jason's Retreat Sober Living (Male) 26 Beds
5. Jason's Retreat Sober Living (Female) 25 Beds
6. Freedom House Sober Living (Male) 35 Beds
7. Tara Lynn's Sober Living (Female) 25 Beds
8. New Life Recovery (Male) 40 Beds
9. Turning Point/Kennemer Residential/Reentry (Male/Residential) 125 Beds
10. Salvation Army Residential Treatment (Male) 60 Beds
11. Teen Challenge - Bakersfield (Female) 45 Beds
12. Teen Challenge – Shafter (Male) 75 Beds

Kern was able to receive referrals from a total of twelve different SLEs by 12/31/2019, meeting our goal. Kern is requesting $500,000 for this Pay for Outcome as an alternate metric for our recoup.

Pre-Manage – EDIE Software (Collective Medical) Implementation Completion by June 2019: In PY4 Kern was able to successfully launch and implement the Pre-Manage – EDIE Software, now known as Collective Medical. EDIE stands for Emergency Department Information Exchange and is a platform which allows all hospitals who participate to view emergency visit data on all patients who present to the participating emergency departments. This software was purchased with the intent to give the ability for care coordinators to be notified when WPC beneficiaries present at community hospitals, allow the care coordinators to provide care notes, visible to the treating providers, enhance the overall care provided to the beneficiaries, and allow the care coordinators the instant ability to follow-up and provide information to the WPC Primary Care Physician. This was huge for the identified WPC population which we paid a PMPM to track within EDIE, however, there was another population surfacing out of our EDIE implementation which was not initially accounted for. Kern noticed that there were individuals we thought would have already been linked to WPC who were showing up on our EDIE reports that clearly needed vital linkage. Kern started a bi-monthly case conference meeting with our Emergency Department Director, Inpatient Case Management Director, Senior Director of Whole Person Care, Manager of Whole Person Care, Chief Nursing Officer, and VP of Ambulatory Services where we discussed the top ten emergency department offenders and discussed what their linkage was (if any) and identified who would benefit from Whole Person Care. This case conference process utilizing the EDIE report data directed dozens of high utilizers of the ED to be effectively linked to Whole Person Care through our process improvement of holding our bi-monthly case conference meetings. Kern is requesting $500,000 for this Pay for Outcome as an alternate metric for our recoup.

Improved Partnership and Coordination of Services with County Department of Human Services (DHS) to Provide a DHS Analyst Onsite 3 days Per Week to Assist WPC Enrollees In-Clinic by June 2019: One of the main barriers that Kern's WPC Pilot identified for our target populations was the difficulty in accessing and coordinating services at the local DHS facilities. It was not uncommon at the impacted DHS sites for clients to wait over three hours to be called back to meet with an eligibility worker and have an assessment. Couple with the high behavioral health needs, post-incarceration circumstances, and stressors associated with homelessness many of our patients suffer from, it is not uncommon for applicants to be discouraged prior to completing the process of seeking assistance and accessing resources. Additional hurdles due to the highly transient nature of our populations, compounded by their chronic lack of transportation made visits to DHS challenging, but also hampered follow-up visits. These factors drastically decreased crucial access to resources and even Medi-Cal enrollment. The chronicity facing the most vulnerable target populations enrolled by Kern's WPC Pilot required innovation and strategic planning with our partners at DHS. Kern had a vision to add a DHS worker to our interdisciplinary team, onsite in the clinic, advancing the notion of true Whole Person Care delivery.
Kern began discussions with DHS in Q1 2019 with a target of implementing an onsite DHS worker embedded in the WPC clinic by June 2019. Many planning sessions went into selecting services that could be accessed by WPC enrollees at the Q Street Clinic, how frequent DHS staff should be onsite, what priority was given to WPC applications and what internal DHS processes were going to be adjusted for this new pilot effort. Ultimately, DHS agreed to place a designated analyst onsite three days per week and we were shooting for June 2019 for implementation. Once DHS was available onsite, WPC enrollees were able to take care of Medi-Cal Enrollment Applications, CalFresh Applications, CalWorks Applications, Passport to Services, Emergency Shelter Funds, and General Assistance support all from our WPC Clinic with drastically decreased wait times and priority processing. DHS transitioned an assigned analyst three days per week to work at our WPC Clinic on June 19, 2019. WPC beneficiaries have tremendously benefited from this enhancement to our program. Kern is requesting $498,000 for this Pay for Outcome as an alternate metric for our recoup.

Pay for Reporting
Below is a summary of all pay for reporting items:

Proportion of participating beneficiaries with a comprehensive care plan, accessible by the entire care team, within 30 days of enrollment

- Kern's pilot achieved 100% compliance

Care Coordination, Case management and referral infrastructure

- Reported

Data and information sharing infrastructure

- Reported

WPC Meeting Effectiveness measured by attendance

- 70/78 = 90%

PHQ 9 Depression Remission at 12 months

- PY4 annual rate of 1.39%

  This metric looks back one year for the PHQ score, so this population was screened prior to enrollment in the program. Now when enrolled, individuals are being screened for depression and work immediately with social workers in the event the score greater than 9.

Percent of Homeless receiving housing services in PY that were referred to housing services

- Kern's pilot had an annual rate of 95.58%

Mental Health Reporting: SBIRT

- PY4 annual rate of 76.46%

Ambulatory Care – Emergency Department visits

- PY4 annual rate of 38.82%

Ambulatory Care – General Hospital/Acute Care

- PY4 annual rate of 26.5%

Follow-up after hospitalization for mental illness

- In PY4 annual there were four, one had a follow-up within 30 days, one that had a follow-up within 7 days and 2 had no follow-up.

Initiation and engagement of Alcohol and other drug dependence treatment

- 80% (77/81) in PY4

Adult BMI assessment

- 99.41% PY4 annual

Controlling High Blood Pressure

- PY4 annual rate of 73.64%

Hba1C <8%

- PY4 annual rate of 57.97%

Wellness/Lifestyle Class Attendance

Of the various wellness/lifestyle classes, there were 1019 patient contacts made through education classes attended by WPC beneficiaries for January-December 2019.

Number of WPC Enrollees Inducted in MAT Re-Entry Program – During 2019 Kern was able to successfully induct a total of 24 WPC beneficiaries from April to December into our MAT Re-Entry Program. Many of these inductees came from our county jails.

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.

- Kern Behavioral Health & Recovery Services
- Kern County Sheriff's Office
- Kern County DHS

We have met with the Sheriff's, BHRS and DHS to implement a Medication Assisted Treatment (MAT) Re-Entry Program in Kern utilizing our strategic alliance with both the jails and WPC to create a comprehensive release program with structured continuity for inmates with SUD issues who are willing to follow-up with WPC post-release. We have worked with Alkermes to participate in their Vivitrol sample program for the initial induction dose and then once released, they follow-up with Whole Person Care.

LE has also spent a considerable amount of time meeting with Kern County DHS to make process improvements in the way that the Medi-Cal eligibility and aid codes are reported to LE for both the general population as well as the incarcerated and recently post-incarcerated populations. We have been working with a DHS MCIEP assigned worker to more efficiently track and assist the transition from incarceration to release. Additionally, we have been working closely to reduce Medi-Cal churn amongst this pilot population. LE has also partnered with DHS to be a potential referral source for Kern's WPC Pilot. We have developed a screening tool that General Assistance workers can use to send potential referrals for individuals applying for General Assistance. DHS has also set WPC up as a "CBO Assistor" which allows WPC affiliates to assist beneficiaries and check the status of applications, etc. This has greatly helped LE to better manage the application process for our WPC beneficiaries.

Additionally, we are also pleased to report that we have successfully secured an onsite DHS worker in clinic Monday, Wednesday and Fridays to directly assist WPC enrollees apply for Medi-Cal as well as a variety of other services. This enhancement has been a tremendous success and patients are so grateful to be able to take care of everything at their clinic appointment and not have to go down to the DHS office to take care of their enrollment needs. Many of our enrollees have no transportation, so it is a huge benefit for them to be able to have transportation provided for them to their medical appointment and be able to take care of their DHS enrollment(s) as well.

IX. PROGRAM ACTIVITIES

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

(1) The Care Coordinators were able to assist a patient who was homeless, had substance abuse issues, medical conditions that caused seizures, that was in an abusive relationship. The provider noticed the signs of abuse and the team coordinated help for her. She broke free from the abuser, stopped the substance abuse and is now living back with family in a safe environment.

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

(1) We continue to struggle linking the patients to affordable housing. There is a greater need for housing than there are locations that match the limited incomes of our patients. This is a difficult task for our care coordination team.
(2) Contacting our patients is another area that often proves difficult. Due to the transient nature of the majority of our enrollees, making sure they have a phone and that the number stays consistent is an ongoing issue. We make additional efforts to obtain phone numbers at each visit or call so that we have multiple contact options should a phone number change.

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

(1) The lead entity has experienced continued success in data sharing with DHS. LE has partnered with DHS to allow a DHS worker to come onsite three days per week to facilitate services right in our WPC clinic to create more access for our enrollees.
(2) Data sharing with the Kern County Sheriff's Office has proven to be necessary and essential in both identifying potential WPC enrollees, and locating them upon or immediately after release from incarceration. In addition, The Kern County Sheriff's Office has been instrumental in helping us identify MAT candidates as well.

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

(1) Kern is still not live with our HealtheIntent data-sharing platform. We were still utilizing i2i Tracks for WPC tracking and much of our reporting through October 31, 2019, however, it did not have the ability to restrict certain sensitive identifiers, so at this time we are unable to do an automatic feed to CBOs. Data sharing is still a much more manual process where a CBO requests something and then we tailor a report to meet their needs and send it over. We have worked with several CBOs to refine these monthly manual reports; however, the current process is both time and labor intensive.

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

(1) We have been receiving reports from Probation which has assisted us in our Post-Incarcerated enrollment utilization. Post-incarcerated data has been the most difficult to collect-so having this additional report to reference monthly has been instrumental in helping us identify releases-real time, so that we can provide timely outreach and hopefully increase our ability to maximize post-incarcerated PMPMs for those individuals.

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

(1) Post-incarcerated data continues to be difficult to collect. In October, we were granted permission by DHCS to also be able to include state and federal releases in our post-incarcerated PMPM bundle and although we were happy to be able to capture additional PMPMs for the PI bundle, we soon realized how difficult this information was to obtain with our current MOUs. We still do not have a contract with CDCR for WPC and so we have no one to call to request data from. We have resorted to utilizing probation data; however, they will only have information on those individuals released on probation. We have since began asking for more specifics regarding release when individuals are identified as post-incarcerated. We ask where they were released from (facility/institution), when they were released (day/month) and we also ask for proof of release if they have it.

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

Identification and engagement of this typically transient and non-compliant patient population continues to be one of the largest barriers we face in WPC. Once you engage and even enroll a patient, it is so difficult to maintain contact, engagement, and compliance with the program. Additionally, substance abuse continues to be a tremendous barrier and until we can be more successful at reducing substance abuse among this population, proper linkage, participation and compliance will remain difficult. Kern is hopeful that our newly implemented MAT efforts will provide some success for our enrollees who suffer from substance abuse.

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.

List PDSA attachments:

- **Ambulatory Care**: Health Outcomes: Ambulatory Care – Emergency Department Visits
- **Impatient Utilization**: Health Outcomes: Inpatient Utilization – General Hospital/Acute Care
- **Comprehensive Care Plan**: Administrative: Proportion of participating beneficiaries with a comprehensive care plan, accessible by the entire care team, within 30 days
- **Care Coordination**: Administrative: Care coordination, case management, and referral infrastructure
- **Data**: Administrative: Data and information sharing infrastructure

Other: Post-Incarceration Enrollment and Retention