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

Kern Medical
Annual Narrative Report, Program Year 5
April 1, 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.

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I. REPORTING INSTRUCTIONS

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

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

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

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

II. PROGRAM STATUS OVERVIEW

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.

Increasing integration among county agencies, health plans, providers, and other entities:
Kern successfully achieved our initial application's maximum projection of 2,000 members before the end of PY5, finishing out PY5 with over 2,100 unique enrollees. We continue to outreach at both the City and County's low barrier shelters at which we have a consistent presence, providing the medical care multiple times per week at one and daily at another. Our onsite presence at the shelters has afforded us the opportunity to successfully outreach to (and ultimately enroll in many cases) some of the most vulnerable, transient and hard to each beneficiaries of our target population(s). Kern successfully continued to expand services in both the FFS and PMPM categories through the end of PY5, adding COVID-19 related, DHCS approved FFS and PMPM items along with the natural increase in services which comes with increased enrollment. Kern expanded the Care Pods FFS initially launched in Q1 by purchasing an additional Care Pod unit to dedicate to the rural area of Taft in PY6.

Increasing coordination and appropriate access to care:
The COVID-19 Pandemic continued to drastically impact, not only the way we have been able to provide care, but also our ability to properly see and treat our patients, making it almost impossible for us to meet many of our metrics. Kern's WPC Pilot also remained committed to operating the County's COVID-19 Temporary Isolation Units (TIU). In our COVID-19 Alternative Budget proposal, Kern was able to add FFS, PMPM and incentives around the groundbreaking work that we have been doing for the COVID-19 TIUs.

Reducing inappropriate emergency and inpatient utilization:
The paranoia of possible COVID-19 infection drove emergency department (ED) rates up for months post-pandemic. The broad nature of the possible COVID-19 symptoms created enormous influx in the rate of individuals coming to the ED, requiring rule out

testing before discharge. Reagents for the tests were scarce on multiple occasions and the additional burden of testing was placed on the ED was significant. This burden also impacted our WPC population. Our WPC clinic continued to operate and provided face to face encounters throughout the entire pandemic; however, patients often inappropriately gravitate to the ED especially when fear and anxiety about their potential illness possibly required hospitalization.

Improving data collecting and sharing:
Kern launched Cerner HealtheCare in September 2020.This integrated platform for care coordination proved to be a huge success for our care teams, to be able to document and view information very specific to WPC, down to the FFS and PMPM utilization making reporting a much easier process. This also helped us to coordinate better with the county departments and CBOs, when reconciling and providing accurate real-time patient lists for case conferencing almost effortlessly. We are unable to allow other agencies access to our HealtheCare platform to document/view information etc., as HealtheCare is fully integrated within our EMR and therefore there is no way to "lock down" or "restrict" what the outside agency would essentially be able to view. However, we are able to run custom reports that we share with the CBOs which have made care coordination much easier between agencies.

Achieving quality and administrative improvement benchmarks:
The global pandemic and the unavoidable challenges presented early on, making traditional face to face encounters not only less desirable for patients, but challenging for healthcare providers. The pandemic also made a detrimental impact on our ability to successfully achieve our quality and administrative improvement benchmarks. Patients were afraid to leave their residences and see their doctor, where other presumably "sick" people would be and naturally, that paranoia became an even greater deterrent for people to go to their doctor's appointments and be compliant with the testing/etc. that we were desperately trying to urge people to do. Additionally, many places were only booking stat and urgent tests for a period, increasing the burden on the hospitals. These and other challenges made it impossible for pilots to achieve their quality and administrative improvement benchmarks.

Increasing access to housing and supportive services:
Kern's WPC Pilot was asked to be the operator for the County's Temporary Isolation Units (TIU) due to our unique access to housing and other supportive services. We agreed that the alignment was solid and that we had resources at our disposal which could provide necessary linkage for these COVID-19 positive individuals to find placement post isolation with a release from Public Health. We screened and offered all individuals who came to the TIUs enrollment into WPC. We also worked with the housing authority, shelters, local homeless outreach, probation, SLEs and other entities to secure placement upon discharge from the TIU.

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	60	64	51	38	38	72	323

Item	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12	Annual Unduplicated Total
Unduplicated Enrollees	59	51	46	66	54	70	346

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

Costs and Aggregate Utilization for Quarters 1 and 2

FFS	Month 1	Month 2	Month 3	Month 4	Month 5	Month 6	Total
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	$13,466.33	$21,999.45	$26,399.34	$13,866.32	$13,599.66	$22,799.43	$112,130.53
Utilization 3	101	165	198	104	102	171	841
Screening, Assessment and Referral	$2,646.00	$2,646.00	$2,352.00	*	*	*	$9,702.00
Utilization 4	18	18	16	*	*	*	66
Information and Referral	$31,500.00	$35,460.00	$27,540.00	$22,590.00	$17,820.00	$25,830.00	$160,740.00
Utilization 5	350	394	306	251	198	287	1786
Respite Care	$4,420.00	$6,120.00	$5,780.00	$2,550.00	$2,635.00	$2,210.00	$23,715.00
Utilization 6	52	72	68	30	31	26	279

Costs and Aggregate Utilization for Quarters 1 and 2

FFS	Month 1	Month 2	Month 3	Month 4	Month 5	Month 6	Total
Sobering Center	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Utilization 7	0	0	0	0	0	0	0
Care Pods	$0.00	$0.00	$3,900.00	$0.00	$0.00	$54,300.00	$58,200.00
Utilization 8	0	0	13	0	0	181	194
Community Integration Treatment	$1,918.25	$3,376.12	$1,688.06	$0.00	$1,994.98	$1,457.87	$10,435.28
Utilization 9	25	44	22	0	26	19	136
COVID-19 Warm Call Screening	$0.00	$0.00	$31,800.00	$32,100.00	$35,500.00	$42,300.00	$141,700.00
Utilization 10	0	0	318	321	355	423	1417
COVID-19 TIU Screening	$0.00	$0.00	$0.00	*	*	$6,300.00	$9,900.00
Utilization 11	0	0	0	*	*	21	33

Costs and Aggregate Utilization for Quarters 3 and 4

FFS	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	$18,799.53	$15,999.60	$11,733.04	$12,933.01	$17,066.24	$16,932.91	$93,464.33
Utilization 3	141	120	88	97	128	127	701
Screening, Assessment and Referral	$3,822.00	$3,528.00	$2,940.00	$2,205.00	$4,704.00	$4,704.00	$21,903.00
Utilization 4	26	24	20	15	32	32	149
Information and Referral	$15,840.00	$15,390.00	$11,700.00	$0.00	$0.00	$0.00	$42,930.00
Utilization 5	176	171	130	0	0	0	477
Respite Care	$5,270.00	$6,800.00	$9,095.00	$8,840.00	$12,665.00	$10,540.00	$53,210.00
Utilization 6	62	80	107	104	149	124	626

Costs and Aggregate Utilization for Quarters 3 and 4

FFS	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12	Annual Total
Sobering Center	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Utilization 7	0	0	0	0	0	0	0
Care Pods	$63,000.00	$129,600.00	$99,300.00	$123,300.00	$70,800.00	$26,400.00	$512,400
Utilization 8	210	432	331	411	236	88	1708
Community Integration Treatment	*	$844.03	*	*	*	*	$1,841.52
Utilization 9	*	11	*	*	*	*	24
COVID-19 Warm Call Screening	$37,700.00	$30,600.00	$27,100.00	$43,500.00	$41,000.00	$43,700.00	$223,600.00
Utilization 10	377	306	271	435	410	437	2236
COVID-19 TIU Screening	*	*	*	*	*	*	$6,300.00
Utilization 11	*	*	*	*	*	*	21

*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
Housing Navigation	$480	$121,920	$125,280	$132,480	$218,400	$220,800	$233,760	$1,052,640
MM Counts 1		254	261	276	455	460	487	2193
Employment Services	$200	$7,600	$10,000	$6,200	$23,000	$23,600	$37,200	$107,600
MM Counts 2		38	50	31	115	118	186	538
WPC Care Coordination	$450	$598,050	$626,850	$649,800	$746,100	$763,200	$795,600	$4,179,600
MM Counts 3		1329	1393	1444	1658	1696	1768	9288
90-Day Post Incarceration	$1,800	$36,000	$66,600	$73,800	$66,600	$52,200	$72,000	$367,200
MM Counts 4		20	37	41	37	29	40	204
Moderate Housing Support	$171	$8,379	*	*	$9,405	$10,431	$15,219	$50,103
MM Counts 5		49	*	*	55	61	89	293

Amount Claimed for Quarters 1 and 2

PMPM	Rate	Month 1	Month 2	Month 3	Month 4	Month 5	Month 6	Total
COVID-19 Care Management Expansion	$500	$0.00	$0.00	$0.00	*	*	*	$9,500
MM Counts 6		0	0	0	*	*	*	19

Amount Claimed for Quarters 3 and 4

PMPM	Rate	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12	Annual Total
Housing Navigation	$480	$245,280	$252,000	$239,040	$245,280	$240,960	$240,960	$1,463,520
MM Counts 1		511	525	498	511	502	502	3049
Employment Services	$200	$39,200	$43,400	$41,800	$44,200	$44,800	$45,800	$259,200
MM Counts 2		196	217	209	221	224	229	1296
WPC Care Coordination	$450	$831,600	$855,000	$875,700	$897,750	$922,050	$953,550	$5,335,650
MM Counts 3		1848	1900	1946	1995	2049	2119	11857
90-Day Post Incarceration	$1,800	$63,000	$99,000	$50,400	$61,200	$46,800	$64,800	$385,200
MM Counts 4		35	55	28	34	26	36	214

Amount Claimed for Quarters 3 and 4

PMPM	Rate	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12	Annual Total
Moderate Housing Support	$171	$19,836	$17,271	$18,126	$20,691	$21,204	$21,546	$118,674
MM Counts 5		116	101	106	121	124	126	694
COVID-19 Care Management Expansion	$500	$6,500	$9,500	*	*	*	*	$25,000
MM Counts 6		13	19	*	*	*	*	50

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

Kern discovered slight discrepancies in PY5 mid-year FFS counts and PMPM counts as there were a few people who were incorrectly reported on at Mid-Year (MY). 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 PY5 MY changes:

FFS – Benefits Advocacy: +10
FFS – Screening Assessment and Referral: +4
FFS – Information and Referral: +19
FFS – Community Integration Treatment: +1
FFS – COVID-19 Warm Call Screening: +5
FFS – COVID-19 TIU Screening: +6
PMPM – Housing Navigation: -3
PMPM – Employment Services: -4
PMPM – WPC Care Coordination: -17
PMPM – 90-Day Post-Incarceration: +37
PMPM – WPC Care Coordination: -1

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.

Kern's adoption of Cerner in November of 2019 has been presented many new challenges that we as a pilot continued to navigate through the end of PY5. Many service deliveries have benefited from the new electronic health record; however, this has not come without cost. The complexities of extracting newly defined data as well as the multiple ways data can now be stored, Kern has been working diligently to ensure that documentation is standardized so that data extraction can be more efficient, accurate and less labor intensive.

The pilot continued to leverage multiple existing database analyst and information systems specialists throughout PY5 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 and telehealth visits, which has greatly enhanced 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, we continued to experience increased amounts of time spent working on the program comparable to what was reported at PY4 annual when we launched Cerner in Q4.

The Lead Entity also continues to implement 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.

HealtheCare has also been a huge build demand in Q2 and Q3 as we began that project design and build during the height of the pandemic. HealtheCare was successfully launched by the projected go-live target by the end of Q3.

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.

LE successfully secured an independent WPC clinic in December 2018. LE had another 6 months of WPC Independent Clinic Rent for PY5 Annual totaling $96,201.48.

Care Pods were also operational for the second reporting period. Kern had $240,893.24 in care pod set-up, supplies, contracts, and operating costs at PY5 Annual. The care-pods have been a huge success in terms of outreach and engagement as well as helping to boost morale among the homeless population. Their ability to partake in the simplest act of taking a shower has led to increase trust of our WPC staff and an increase in their willingness to follow through with basic asks from the WPC staff to achieve more stability-even if that only means regular showers. Operating the care pods has been just as rewarding for the WPC staff as it has been for the beneficiaries. The care pods were closed for a time during the pandemic; however, they have been fully operational since the summer, and we plan to keep them operating at full capacity.

Kern also claimed $76,263.52 in PPE and Disinfecting supplies costs for July-December 2020. This was part of our COVID-19 Alternate Budget submission. Telehealth costs were also included in the COVID-19 Alternate Budget proposal, as Kern had to purchase the remaining $27,113 of equipment to provide telehealth services to our WPC beneficiaries as part of our care delivery redesign post COVID-19 pandemic. Telehealth services provide their own challenges. There was definitely a learning curve not only for our patients, but also for our providers and staff, as we learned together how to most efficiently navigate through the challenges of dropped calls, registration mishaps, connectivity issues, etc. We saw an overall decrease in patient volumes early in the pandemic, and for many of our patients who do not have access to a smartphone (or any phone for that matter), delivering telehealth services was virtually impossible. We ultimately had to create a room where we could have the patients come in person to be seen and set up telehealth equipment in those exam rooms and have our provider see the patients from another room in the clinic.

Kern continued to provide services at the shelter throughout the entire pandemic. The services were greatly minimized at times and the expansion was postponed due to the

City limiting the number of occupants for obvious health concerns in the congregate living conditions. Kern shifted some of those dollars to PY6 where we plan to fully expand the services provided at the City Shelter and hope to see their client volume reach the maximum capacity of 350 by the end of PY6.

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.

Kern's eligible incentive payments earned at PY5 Annual report include:

- Managed Care Plan Referrals – Kern received * 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 one month of referrals from Health Net.
- Mental Health Reporting: Kern BHRS submitted a report in August 2020 and earned $20,000 for PY5 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 2020 through December 2020.
- 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.
- 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.
- 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 5 meeting attendances could be billed by the County Departments/CBOs and LE for the PY5 annual report as we had to cancel the meeting scheduled in November. Achievement is measured by attendance. Kern and County Departments/CBO's who were eligible to bill for this incentive are listed below:
The overall attendance was 92.31% with 60 of 65 total CBO attendees.

Kern Medical Center – 5 meetings x $10,000 = $50,000
Housing Authority – 5 meetings x $10,000 = $50,000
Probation – 5 meetings x $10,000 = $50,000
Aging and Adult Services – 5 meetings x $10,000 = $50,000
Health Net – 5 meetings x $10,000 = $50,000
KCSO – 5 meetings x $10,000 = $50,000
Kern Health Systems – 5 meetings x $10,000 = $50,000

Golden Empire Gleaners – 5 meetings x $10,000 = $50,000
Public Health – 0 meetings x $10,000 = $0.00
America's Job Center (Formerly E.T.R.) – 5 meetings x $10,000 = $50,000
Kern B.H.R.S. (Formerly Kern County Mental Health) – 5 meetings x $10,000 = $50,000
DHS – 5 meetings x $10,000 = $50,000
Flood Ministries – 5 meetings x $10,000 = $50,000

- Each WPC enrollee w/primary care clinic appointment scheduled within 7 days discharge from inpatient stay or release from jail Kern had 26 for a total of $7,800.
- 90% in Outreach and Engagement Phase, Enrolled in a Pilot within 3 months of first encounter. Kern has been successfully able to enroll over 97.6% of patients into WPC within 2 months of the first encounter. Total earned by the LE was $500,300.
- Proportion of patients with Medication Reconciliation within 14 days of hospital discharge 65%, Kern earned $250,054.50 at a rate of 97.1%

- Community Partnerships to Relocate Homeless Individuals into Temporary Housing and WPC Services 100% TIU residents will be offered enrollment into WPC: Kern Medical's WPC Pilot has worked extremely hard to partner with the County and Public Health to be the go to medical providers for our homeless population here in Kern County. These efforts gave us a unique advantage to again offer our services to assist in the County's COVID-19 Temporary Isolation Trailer Units project. Kern Medical's WPC Pilot does not receive any funding form the county for the services we render at the TIUs. We partnered in an effort to provide necessary services to a population that we feel (as the County's WPC Pilot), we are best equipped to render the most appropriate and meaningful services to in our community. Kern earned 0.5 units totaling $200,000 at PY5 Annual, funding benefit flows down to Community Partnerships as well as county partners who work with homeless individuals.

- HealtheCare Go-Live Implementation by end of Q3: Kern successfully was able to launch our new HealtheCare care management platform in our production environment of our EMR, Cerner on September 17, 2020. This incentive achievement allowed Kern to claim $500,000 on our PY5 Annual report. Funding benefit will flow down to the infrastructure development for the care management team as well as county partners that provide services to WPC enrollees.
- Capacity building with Local Health Department: Kern created an incentive in our COVID-19 Alternate budget which allowed us to draw down the remaining $500,000 at PY5 Annual for the work that we are doing partnering with our local

public health department on our County's COVID-19 Temporary Isolation Units (TIUs). Funding benefit will flow down to local public health department that provide services in response to the impact of COVID-19 and the individuals who have contracted or at risk of contracting the virus.

- Placement for Homeless Individuals upon Discharge: Kern created an additional incentive in our COVID-19 Alternate budget which allowed us to draw down $5,000 for each individual that was able to be placed into a shelter or some form of housing with family, or a sober living facility, group home, etc. upon discharge from the TIUs. From July to December Kern was able to claim 46 for a total of $230,000. Funding benefit will flow down to support local public health departments that provide services in response to the impact of COVID-19 and the individuals who have contracted or at risk of contracting the virus.

- 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.

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.

Kern elects to use the COVID-19 Alternative Payment method for Pay for Outcome payments in Program Year 5. Kern achieved 73% of our Pay for Outcomes in Program Year 4. Kern will receive 73% payment in Program year 5, in the total amount of $5,173,736.56; amount claimed at annual is $3,825,291.81. The narrative below and the invoice show actual performance for PY5.

5% Improvement over previous PY of ER Utilization Kern's pilot had a baseline of 41% and a PY4 annual rate of 38.82% with a rate of 56.94% at PY5 annual – **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% with a rate of 63.06% at PY5 annual – ***Attained achievement at PY4 Annual**

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. At PY4 annual, the reported rate was 62.50% within 7 days of discharge and 87.50% within 30 days of discharge. At PY5 annual, the reported rate was 35.00% within 7 days of discharge and 45.00% within 30 days of discharge – **Not Attained**

5% Improvement over previous PY Initiation and engagement of ETOH and other dependence Kern's pilot had a baseline of 0. PY4 Annual rate of 80% within 30 days. At PY5 annual, the reported rate was 56.67% 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%, PY4 annual rate of 1.39%, and a PY5 annual rate of 0.0% **- Not Attained.**

2% Improvement over previous PY of Hba1C Control <8% Kern's pilot had a baseline of 66.0%, PY4 annual rate of 62.32%, and a PY5 annual rate of 51.61% - ***Attained achievement at PY4 Annual**

5% Improvement over previous PY for preventative care measures of WPC beneficiaries – Kern's pilot was able to achieve this metric for the first at PY4 annual with a rate of 60.74% (229/377). For PY5 annual, Kern reported a rate of 51.05% (339/664). This measured colorectal cancer screening, breast cancer screening, cervical cancer screening. – ***Attained achievement at PY4 Annual**

40% Post-incarceration primary care visit within 60 days of release – Kern's pilot had 52.87% (129/244) post-incarcerated beneficiaries who had a primary care visit within 60 days of release for a total of $453,600 – **Attained**

5% Improvement over previous PY 30 day all cause readmission - Kern's pilot had a baseline of 20%, a PY4 rate of 20.31% and a PY5 annual rate of 10.45%. DHCS runs this metric on an Annual basis. – **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%, PY4 annual rate of 76.46%, and a PY5 annual rate of 90.14% - **Attained**

5% Improvement over previous PY: Overall Beneficiary Health – Kern's pilot was not capturing this survey before PY4 Mid-Year. At the end of PY4 annual we had data reporting 21.21% (204 of 962 eligible clients met this measure) for the overall health question and 19.23% (185 of 962 eligible clients met this measure) for the mental and emotional health question. At the end of PY5 annual we had data reporting 19.59% (67 of 342 eligible clients met this measure) for the overall health question and 17.84% (61 of 342 eligible clients met this measure) for the mental and emotional health question – ***Attained achievement at PY4 Annual**

5% Improvement over previous PY: Controlling High Blood Pressure Kern's pilot had a baseline of 65.63%, PY4 rate of 73.64% and a PY5 annual rate of 55.06% - ***Attained partial achievement at PY4 Annual**

Med Reconciliation completed within 30 days of enrollment – 70% Kern's pilot had 97.15% of med reconciliations completed within 30 days of enrollment – **Attained**

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**

Screening for clinical depression and follow-up plan – 10% improvement over prior year Kern's pilot had a baseline of 0%, PY4 annual rate of 83.70% and a PY5

annual rate of 82.35% (420 of 510 eligible clients met this measure) **–** ***Attained partial achievement at PY4 Annual**

Percent of homeless receiving housing services in PY that were referred for housing services – 85% Kern's pilot had an annual rate of 100% - **Attained**

Completion of Universal Assessment Tool with Homeless individuals – 80%
Kern's pilot achieved 100% compliance– **Attained**
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

- 60/65 = 92.31%

PHQ 9 Depression Remission at 12 months

- PY5 annual rate of 0.0%

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

- Kern's pilot had an annual rate of 100%

Mental Health Reporting: SBIRT

- PY5 mid-year rate of 90.14%

Ambulatory Care – Emergency Department visits

- PY5 annual rate of 5.69%

Ambulatory Care – General Hospital/Acute Care

- PY5 annual rate of 6.31%

Follow-up after hospitalization for mental illness

- At PY5 annual, [REDACTED*] patients had a follow-up within 30 days, [REDACTED*] that had a follow-up within * days and [REDACTED*] patients had no follow-up.

Initiation and engagement of Alcohol and other drug dependence treatment

- 56.67% (34/60) at PY5 annual

Adult BMI assessment

- PY5 annual rate of 97.44%

Controlling High Blood Pressure

- PY5 annual rate of 55.06%

Hba1C <8%

- PY5 annual rate of 51.61%

Wellness/Lifestyle Class Attendance

Of the various wellness/lifestyle classes, there were 478 patient contacts made through education classes attended by WPC beneficiaries for July-December 2020.

Number of WPC Enrollees Inducted in MAT Re-Entry Program – During July-June 2020 Kern was able to successfully induct a total of 12 WPC beneficiaries into our MAT Re-Entry Program. Many of these inductees came from our county jails.

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.

- County Administrative Office (CAO)
- Kern Behavioral Health & Recovery Services (BHRS)
- Kern County DHS
- Flood Ministries
- Community Action Partnership of Kern (CAPK)

We have met with the CAO, BHRS and DHS, Flood Ministries and CAPK to collaborate on how to most efficiently serve our extremely vulnerable homeless populations that require isolation due to COVID symptoms and/or testing COVID positive. The CAO partnered with Kern Medical to be the operator of the COVID-19 Temporary Isolation Units (TIUs), and we took that opportunity to strategically link our WPC teams with these individuals in an effort to produce the best possible outcomes for them post discharge from the TIUs.

WPC staff coordinate with DHS in an effort to secure Medi-Cal and other such benefits for these individuals if not already linked. We also coordinate with BHRS to ensure that crucial behavioral health care is not interrupted and encourage telehealth services on supplied iPad devices during their TIU stay. WPC also works diligently with Flood Ministries who is the leading homeless outreach provider in our area to assist in placement (shelter or otherwise), upon discharge from the TIU. Lastly, the county has also partnered with CAPK in our area to be the Operators for the Low Barrier Navigation Center (LBNC), which is our newly developed county shelter. We have successfully created a referral system to where many times beds will be reserved for TIU patients in an effort to safely discharge. These stakeholders have been a huge part of the successes we have experienced with our County's COVID TIUs.

VIII. PROGRAM ACTIVITIES

Care Coordination

A. Briefly describe 1-2 successes you have had with care coordination.
    1. On September 17, 2020, Kern officially went live with HealtheCare. HealtheCare is a robust referral/case management component of our EHR system that has been designed to improve WPC's workflow and better the management of patient care. We have seen the benefits of the time and resources invested into this system. As we continue to build the system, HealtheCare will evolve into a tool that will help us build more comprehensive care plans for our patients, improve our case management capabilities, and eventually evolve into a true population health management system.
B. Briefly describe 1-2 challenges you have faced with care coordination, and lessons learned from those challenges.
    1. During 2020, Kern has gone beyond our traditional clinic setting and has been providing on-site clinics at two of our community's homeless shelters. Providing care at shelters have presented new challenges. From the first day of providing care at these shelters, it was immediately evident that the shelter patients were much more complicated than our typical clinic patients. Generally, the shelter patients' level of general health was poorer, their behavioral conditions were less managed, and the shelter population is very transient, making case management exceedingly difficult.
    By working with the shelter population, we have adapted our methods and formed effective communication channels with shelter administrators to mitigate these new challenges. We have also formed a great shelter clinic team that has the passion and experience to find creative methods to care for this get this population. The main lesson that we have learned from expanding to the local shelters is the homeless population is in desperate need and we are doing everything we can to help.

Data Sharing

A. Briefly describe 1-2 successes you have had with data and information sharing.
    1. Communication is a requirement to have any success in service to our WPC population. Expanding our services to our community shelters, we continually maintain two-way communication with shelter administrators. The shelter teams help us stay in touch and manage the care of their residents. Conversely, we communicate the information that is needed to

keep their residents healthy. Overall, we are immensely proud of the partnerships that we have developed with these teams.

B. Briefly describe 1-2 challenges you have faced with data sharing, and lessons learned from those challenges.
    1. Working with the homeless population is particularly challenging. The population is transient in nature, coupled with a tendency of non-compliance (as it relates to their own medical care) does present a significant challenge to the coordination of care. We continue to work to find different methods to communicate with our patients and really focus on coordinating efforts with shelter personnel.

Data Collection

A. Briefly describe 1-2 successes you have had with data collection and/or reporting.
    1. The recent implementation of HealtheCare has expanded our capabilities to track care coordination and patient care management. With the adoption of this system, we have been able to streamline our workflow, while enhancing our reporting capabilities.
B. Briefly describe 1-2 challenges you have faced with data collection and/or reporting.
    1. The impacts of HealtheCare have been immediate; however, we are still in the learning and growing phase of adoption. As we refine the system and build the population data, we will face the growing pains associated with any new system.

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

If the managed care plans do not work with providers to continue the extensive services afforded to these extremely vulnerable and transient populations, then WPC will not be able to continue. The costs associated with the hands-on care required to make significant impacts on these populations are extensive, however, the rewards are truly life changing for the affected beneficiaries.
Additionally, the ongoing pandemic has been an enormous barrier in the way of our program's continued success. We have been in a reactive state since this pandemic unfolded. For the foreseeable future, we expect more challenges, before the world returns to some semblance of normalcy. As we have planned for PY6, our primary focus is to do everything we can to help with the vaccination of our population and find creative methods to better serve them during these trying times.

IX. PLAN-DO-STUDY-ACT

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

PDSA Attachments:

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