State of California - Health and Human Services Agency

Department of Health Care Services

Whole Person Care

Kings County Annual Narrative Report

Kings County Human Services Agency
Annual Report PY 4
Submitted: 2020.05.13
Last Revised: 2020.07.14

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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May 13, 2020

I. REPORTING INSTRUCTIONS

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

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

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

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

II. PROGRAM STATUS OVERVIEW

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.

Increasing integration among county agencies, health plans, providers, and other entities:

Case Manger Provide Screenings in County Jail

Kings County Whole Person Care is expanding its services to conduct referrals and screenings in Kings County jail. In an effort to increase access to resources for former inmates, a Case Manager works alongside jail administrative staff and the Human Services Agency Eligibility Worker. Through this collaboration, inmates being released are able to receive a screening and be linked to appropriate resources upon release. Critical linkages for a former inmate is to Substance Use Treatment, Mental Health or Housing. Simultaneously, Kings WPC will review the screening during Multi-Disciplinary Team (MDT) meeting to determine eligibility for enrollment. Three primary goals for having a case manager in the jail are 1) direct warm handoffs to appropriate providers, or housing resources. 2) Reduce recidivism 3) Increase enrollment in substance use treatment. Placement of a case manager in the jail will be assessed quarterly and procedures and coordination will be amended, if needed.

Increasing coordination and appropriate access to care:

Case Manger Provide Screenings in Emergency Room and Complex Care Department

Emergency Room (ER) use among target population has steadily increased in the past year. In an effort to address this increase, Kings WPC coordinated to add a case manager to work between the emergency room and the complex care center. Kings WPC has previously established a sharing agreement in part to close gaps when it comes to medical information of shared enrollees. The goal of this coordination is to reduce inappropriate use of ER and increase Primary Care Physician appointments to address chronic condition. Having someone placed in the ER will also assist in increasing linkage to Mental Health Provider, particularly persons that lost contact with

mental health provider. The complex care unit patients have critical chronic conditions who are in need of care coordination to access additional resources needed.

Reducing inappropriate emergency and inpatient utilization:

Inclusion of Emergency Room Screener

Keeping at the forefront Kings WPC objective to reduce inappropriate Emergency Room (ER) and impatient visits, the Community Health Aide (CHA) developed an emergency room screener to identify high utilizers during initial intake screening. Reduction of inappropriate ER and inpatient utilization has been a challenge in Kings County. Assessment of high utilizers indicated a need for education on how to navigate through the various medical systems, including medical transportation. The overall intent of adding an ER specific screener to intakes is to divert high utilizers from using the ER for chronic conditions or prescription fillings. The ER screener will be included as a touchpoint in order to further assess ER usage for program reviews.
Kings WPC also found many of the high utilizers do not plan for routine checkups for chronic conditions, leading to conditions worsening which as a result, require emergency attention. Identifying which enrollee is a high utilizer of the ER contributes to the creating a more holistic care plan. Emergency Room use information also provides case managers with additional guidance on how to assist the enrollee develop a plan to address chronic medical or mental health conditions. The ER screener also provided insight on what to include in self-care education. Self-care education has led to the initial planning of creating a medical education class as a life skill.

Developed a Medical Education Brochure

Reducing inappropriate utilization of the ER and Inpatient care, has proven to be a challenge. In an effort to reduce high ER utilization, a medical brochure was created explaining how to determine whether a current medical or mental health need is an emergency or if there are other ways to receive same day care. Many of the reasons enrollees have frequent visits to the ER or inpatient care is due to not setting routine appointments with a PCP for chronic conditions or prescription medication. It’s anticipated that by providing and reviewing the educational brochure with the enrollee, the enrollee will be able address chronic needs on a routine basis with their PCP. In addition enrollee’s will be better equipped to determine if an Urgent Care can meet their needs as oppose to going to the ER.

Improving data collecting and sharing:

Addition of Community Health Aide and Acute Case Manager Programs in Efforts to Outcomes (ETO) Data Base

In addition to adding an ER screener to intakes, Kings WPC discovered the need to capture medical and acute mental health data and case notes as separate programs in the Efforts to Outcome (ETO) database. Originally, care coordination was the primary ETO program capturing all case notes related to one enrollee. This did not allow room for deeper analysis of medical and acute mental health related data, limiting quantifiable information of the root cause of someone's medical or Severe Mental Illness (SMI) needs. By separating the Acute Case Management (CM) caseloads and Community Health Aide (CHA) or Chronic health population caseloads from the Case Management program in ETO, Kings WPC will be able to improve data analysis by more efficiently distinguishing between chronic medical and acute mental health notes from less acute cases.

Achieving quality and administrative improvement benchmarks:

3rd Quarter Quality Assurance (Monitoring & Oversight for Policy Adherence)

Although staff training was conducting in the first two quarters of PY4, an increase in staff turnover required training for the incoming staff. However, formal training for incoming staff was not fully established. In the third quarter QA, results indicated a need to retrain the current WPC staff on how to properly and thoroughly document case notes, complete touchpoints and enter service linkage data. In addition to retraining current staff, training for incoming staff was created to ensure all new staff are properly trained in all areas of their position. Checklists were created to ensure each staff area follows all steps to completing a task. In the event a staff member is not able to transition to new staff, a continuity book for each area will be created to ensure the new staff member not only receives formal training but has a reference to throughout their employment with Kings WPC.

4th Quarter Quality Assurance (Monitoring & Oversight for Policy Adherence)

The fourth quarter of PY 4 carried some of the third quarter's errors while other areas showed improvement. Areas of improvement included care plans. However, there is still a significant need for improvement in documentation, case note writing and recording aggregate data touchpoints areas of the Effort to Outcome (ETO) database. Overall, there was a 2% improvement from third quarter to fourth quarter.

Increasing access to housing and supportive services:

Collaboration with Kings County Human Services Homeless Outreach Team

Kings County single adult homeless population limited resources has been one of the driving forces to increase collaboration to address this populations needs. Human Services Agency (HSA) conducted an assessment of on the street homeless needs and barriers to addressing these needs. Consequently, HSA social services, housing support and Kings WPC, Peer Support Specialist and Housing Navigator collaborated with various Community Based Organizations (CBO), to include Animal Control, and Police Department Homeless Assistance Team. Through this collaboration, funding gaps have improved by increasing awareness of resources available through various organizations. Discussion and coordination with supportive services assist Kings County's ability to increase a community of wrap around services to address the service gap to single adult homeless population. In addition to these efforts, discussions with Kings County Homelessness Committee has created an open public forum to discuss combined efforts and various funding sources. Kings WPC's will continuously support these ongoing efforts to bridge resource gaps for single homeless adults.

Improving health outcomes for the WPC population:

Focus on Increasing Medical and Mental Health appointment Follow Ups

Although Kings WPC care coordinators assist enrollees in navigating medical systems to locate and schedule appointments with a Primary Care Provider, many enrollees missed their appointments. Some of the reasons for missed appointments have been, issues accessing medical transportation services, lack of coordination for WPC staff transport or hygiene reasons for some homeless individuals. In an effort to better assess issues with missed appointments or not complying with follow up appointments, Kings WPC has developed a touchpoint in ETO, to better assess the reasons enrollees have missed appointments with Primary Care Providers (PCP). This assessment will allow for understanding how to create solutions to reduce any barriers. Results from this touchpoint will yield further discussions with county providers on ways to ensure enrollee's arrive at their scheduled appointments

Manage Care Provider Attendance at Multi-Disciplinary Team Meetings

Kings County Multi-Disciplinary Team (MDT) meetings were intended to have service providers assist in providing insight to potential enrollee's case. As a quality improvement goal, Kings WPC coordinated with Anthem Blue Cross to review Anthem manage care beneficiaries medical history and provide insight to care approaches during the MDT meetings. Although Cal Viva is the primary managed care provider in

the county, Kings WPC only has a sharing agreement with Anthem Blue Cross, leaving an informational gap when creating care plans. This sharing process also assist manage care provider in building a bigger picture when assessing a shared client medical visit. Additionally, including manage case in MDT discussions provides useful information regarding emergency room visits in other counties. ER visits in other counties are not always accessible to the local hospital. This allows case managers to increase their focus on their enrollee's emergency room utilization. It also, helps the pilot analyze how to improve coordination and internal processes to address high emergency room utilization. This sharing process also assist manage care provider in building a bigger picture when assessing a shared client medical visit.

Brief overview of program successes, challenges, and lessons.

The Kings County WPC Pilot is experiencing the following successes:
1. Kings County WPC Pilot enrollment is steadily increasing each month.

2 County agencies are proactively communicating and collaborating to combat the various challenges faced by Kings WPC target population and homeless population. This is leading to a continual increase in understanding of how to collectively create solutions to overcome gaps in addressing the homeless populations need. Such needs include building shelters with supportive services or a system of care specifically for homeless population with Severe Mental Issues (SMI), chronic medical conditions or disabilities or Substance Use Disorder (SUD).

3. Increase collaboration with Kings County homeless efforts.

4. The hiring of a Peer Support Specialist has proven beneficial to outreach efforts and reconnecting enrollees with WPC staff or Mental Health providers. The peer support specialist will also expand their efforts to assist with county wide homeless outreach efforts by providing outreach and coordination to rural areas of King County.

5. A dedicated Life Skills manager has been assigned to track, coordinate and provide some life skills training. Having a dedicated life skills manager will assist in coordinating group classes and provided focused feedback on participation.

The Kings County WPC Pilot is experiencing the following challenges:

1. Kings County WPC Pilot enrollees are not consistently attending life skills classes provided by the contractor Champions Recovery as part of the PMPM1 Care Coordination bundle.

2. The Kings County WPC Pilot is experiencing a high degree of attrition staff loss across multiple levels.

3. Kings County WPC Pilot Case Managers are not fully aware of best practices regarding case managing enrollees with health related issues.

4. Kings County has very limited amount of entry level jobs, affordable housing resources, respite facilities and transitional housing available for single adults exiting hospitals and jails.

5. Kings County WPC Pilot enrollees are demonstrating a reluctance to reengage with service providers due to past negative experiences. The dilemma is compounded by the fact that multiple service providers are the sole service provider in the county.

6. Kings County has limited sobering bed facilities. Currently there is only one male and one female sobering center with limited availability.

7. Criteria for use of sober beds is limited to enrollees with a medical clearance, creating a barrier for treatment for those with alcohol abuse treatment needs. This criteria also limits the ability for law enforcement to redirect newly arrested persons for minor infractions to a sobering center as opposed to jail.

<u>Kings County WPC Pilot lessons learned include:</u>

1. Increasing the presence of Kings WPC case managers in medical and jail locations provide a broader avenue for potential enrollees to learn about Kings WPC services.

2. Closing the educational gap by teaching enrollees how to navigate complex medical systems gives enrollees greater confidence to become self-sufficient. Originally case managers did not have a hands on approach to educating enrollees on how to navigate complex medical and mental health systems. As a result many of those disenrolled were unsure how to set up personal appointments or plan for routine appointments. Currently, case managers teach enrollee's how to set up appointments, coordinate transportation and assist in creating a plan to for routine appointments. As a result, enrollees began to independently schedule and track appointments prior to disenrollment. With additional knowledge on how to navigate resources and develop practical life skills, enrollees essentially are reducing barriers and increasing their potential to self-sufficiency.

3. At the beginning of the pilot, all data was not collected. As a result, program reviews conducted have questions unanswered due to the lack of data initially collected. Recording all data using a measureable process, will allow for a more in depth trend analysis of all the areas within the pilot. It is difficult to predict what data will be useful for future analysis at the beginning of a new project. For this reason collecting all

information using quantifiable answers will allow for better assessment of the pilots successes.

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	**20**	**25**	**20**	**21**	**39**	**36**	**161**

Item	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12	Annual Unduplicated Total
Unduplicated Enrollees	**34**	**23**	**14**	**32**	**21**	**29**	**153**

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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
Service 1 Short Term Recupertive Care Unit	26	20	58	43	35	17	199
Utilization 1	$3,900	$3,000	$8,700	$6,450	$5,250	$2,550	$29,850
Service 2 Community Integration	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
Utilization 2	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
Service 3 Engagement	114	116	113	117	122	129	711
Utilization 3	$18,924	$19,256	$18,758	$19,422	$20,252	$21,414	$118,026
Service 4 SSI Advocacy	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	22
Utilization 4	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	$68,975

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 Short Term Recupertive Care Unit	14	58	36	51	16	64	446
Utilization 1	$2,100	$8,700	$5,400	$7,650	$2,850	$10,350	$66,900
Service 2 Community Integration	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	24
Utilization 2	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	$4,920
Service 3	135	126	109	153	105	129	1468
Utilization 3 Engagement	$22,410	$20,916	$18,094	$25,232	$17,430	$21,414	$243,522
Service 4 SSI Advocacy	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	44
Utilization 4	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	$97,900

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*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								
PMPM	Rate	Month 1	Month 2	Month 3	Month 4	Month 5	Month 6	Total
Bundle #1 Care Coordination	$526	129	123	138	132	150	173	845
MM Counts 1		$64,854	$64,698	$72,588	$69,432	$78,900	$90,998	$444,470
Bundle #2 Housing Navigation	$157	35	44	45	53	59	74	310
MM Counts 2		$5,495	$6,908	$7,065	$8,321	$9,263	$11,618	$48,670
Bundle #3 Comprehensive Care Coordination/Low Ratio	$1152	8	12	14	17	14	18	83
MM Counts 3		$9,216.00	$13,824.00	$16,128.00	$19,584.00	$16,128.00	$20,736.00	$95,616

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Amount Claimed								
PMPM	Rate	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12	Total
Bundle #1 Care Coordination	$526	196	181	166	185	190	182	1945
MM Counts 1		$103,096	$95,206	$87,316	$97,310	$99,940	$95,732	$578,600
Bundle #2 Housing Navigation	$157	92	83	76	69	65	58	753
MM Counts 2		$14,444	$13,031	$11,932	$10,833	$10,205	$9,106	$69,551
Bundle #3 Comrehensive. Care Coordination/Low Ratio	$1152	16	12	12	[redacted]	[redacted]	[redacted]	[redacted]
MM Counts 3		$18,432	$13,824	$13,824	[redacted]	[redacted]	[redacted]	[redacted]

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

IV. NARRATIVE – Administrative Infrastructure

Kings County WPC Pilot is utilizing an Administrative Infrastructure designed developed specifically for achieving goals identified in the original application. Goals identified include, but is not limited to, the coordination of health, behavioral health, and social services, in a patient centered manner. Additional objective includes improvement of enrollee health and wellbeing through a more efficient use of resources.

Multiple entities are combining resources and sharing information to fully integrate coordinated care and wraparound services. Kings County HSA provides Administrative oversight to ensure continued integration of services and development of reports. Data is being shared amongst all entities, providers, and stakeholders with consistent, regular meetings.

In order to achieve the identified objectives, the administrative infrastructure incorporated two staff members, a Program Manager and Program Specialist. The Program Manager and Program Specialist are the primary points of contact for various participating entities. Their duties include ensuring effective communication and coordination amongst all entities. The Program Manager administers the daily operations of the program and ensures effective flow of communication among all partnering entities. The Program Specialist is the central point of contact for sharing and analyzing data throughout the pilot. HSA provides oversight, leadership, communicates Kings County WPC Pilot requirements to all participating entities and makes final determination of the pilot's objectives and processes. HSA also ensures data is collected and shared with stakeholders and participating entities. The Program Manager and Program Specialist work to attain Universal and Variant metrics data from participating entities and formulate detailed reports which are submitted to DHCS to ensure program goals are being met. The Kings County WPC Pilot also includes two staff members to support fiscal responsibilities. The Fiscal Account Specialist and Account Clerk provide participating entity with payments for services, incentives and reporting outcomes.

Multi-Disciplinary Team (MDT) consists of WPC subject matter experts and various local governmental agencies and community based organizations. A portion of MDT is located in the Kings WPC building to allow for consistent and regular dialogue and coordination. The MDT is accountable to LAC and Lead Entity Kings County HSA. The MDT assesses identified needs of each potential enrollee and determine eligibility based on target population objectives. The MDT also processes and reviews bi-directional data and make recommendations to the Care Coordination Team, LAC, and Implementation Team. Recommendations include, linkages to service providers such as behavioral health services, substance use disorder treatment, medical specialty practitioners, HSA public assistance, veterans' services, and other services that support an increased quality of life for the enrollee.

The LAC consists of stakeholders and participating entities. Through collaboration, LAC reviews monthly data from all program performance metrics, evaluates existing processes, identifies systematic inefficiencies, and generates ideas regarding pilot quality improvement, efficiency and coordination of care objectives. The LAC possesses decision making ability and works directly with Kings County WPC Pilot staff to remove barriers to accessing care and prioritize approaches to pilot revisions. The LAC meets at least once a month. The LAC is currently facilitated by the Lead Entity HAS, Program Specialist.

IV. NARRATIVE – Delivery Infrastructure

The delivery infrastructure provides timely, individualized care coordination services to enrollees who meet the criteria of the target population. The identified target population includes individuals suffering from Substance Use Disorders, Mental Health illness, poor control of diabetes or hypertension.

This target population historically experiences difficulty accessing, becoming and remaining engaged in services aimed to assist persons within the target population. Such services include a Medical Primary Care Provider (PCP), substance abuse treatment, mental health services, shelter, and income stability services. Being able to properly and consistently access these services may decrease their need to utilize local emergency department rooms and/or reduce their recidivism rate.

Kings County WPC Pilot has a centralized referral point which can be accessed via telephone, e-mail, website, or in person by a referring entity or self-referred. Upon receiving a referral, coordinated care professionals from the Kings County WPC Pilot team – which includesn Eligibility Worker, County Public Health Community Health Aide, and Case Manager–perform an initial screenings for eligibility. Screenings can be completed in the field or in the pilot's office intake rooms. If the enrollee expresses a need for housing and or job placement assistance during the initial screening, then the enrollee is scheduled to meet with the Kings County WPC Pilot Housing Navigator or Job Developer to assess specific needs and available resources.

Upon the enrollee going through the screening process, the individual's circumstances and case details are reviewed by the MDT to determine program eligibility and enrollee's initial stated goals. This is the first instance in which possible duplicated services are discussed and a lead service provider is established to ensure there is no duplication of services.

A care plan meeting is conducted which includes, the Kings County WPC Pilot Program Manager or Program Specialist, assigned Case Manager, Housing Navigator, Job Developer, SSI Advocate and any Care Service Providers (CSP) previously identified. CSP's may include County Probation, Mental Health professionals, Substance Use Disorder (SUD) treatment providers, housing programs, outside Case Managers, and medical professionals. These CSP's may have been or will be working directly with the enrollee to meet their l needs.

During the Care Plan the client has the option to attend. If the client attends they are briefed on the process of the meeting and invited to set their own goals. The Care Plan facilitator reviews initial screening information and asks the enrollee to create goals they intend to reach in each identified medical, mental health, SUD or other services. Goals

are set using the SMART (Specific, Measureable, Attainable, Realistic, Timely) methodology. Enrollees are also encouraged to prioritize their goals. In including the enrollee, into the care plan meeting they are taking ownership in achieving goals they set for themselves. In taking ownership of their goals they increase the probability of becoming more independent and maintaining goals they set. Case managers and all other supporting entities will continuously support the enrollee in achieving their goals and assist in revising or creating new goals throughout their enrollment period.

Following the care plan meeting, the Case Manager meets one on one with the enrollee to review the plan and acquire the enrollee's signature on the care plan. The enrollee has the option to revise their individualized care plan upon initial implementation, and at any point during care coordination. 100% of enrollees receive a care plan within 30 days of enrollment which is an identified pilot goal.

In the event the client declines the invitation to attend their care plan, selected MDT member's and care service providers will conduct a care plan meeting to discuss options for the enrollee. The case manager will then meet with the enrollee at a later date to review the care plan and make adjustments as needed.

To ensure continuous enrollee support, Kings County WPC Pilot Case Manager's maintain consistent contact with the enrollee to assist the enrollee meet their care plan needs. Successful linkages to appropriate services and mentorship in various aspects of their life, contributes to positive health outcomes, a decrease in emergency room utilization and reduction of recidivism rate.

In addition to Case Management, Kings County WPC Pilot has hired a Peer Support Specialist (PSS) to provide support to community outreach efforts and assist WPC staff, locate enrollees who have lost contact with WPC staff. The primary responsibility of the PSS is to build strong relationships, specifically with marginal population hesitant to receive services. The Kings County WPC Pilot PSS will primarily work in the field to engage with the target population and develop rapport with potential and existing Kings County WPC Pilot enrollees. The PSS role is to to re-engage enrollees that have lost contact with their Kings County WPC Pilot Case Managers. The Peer Support Specialist also connects the enrollee with services and meet the enrollee at their residence or other locations in the community where the target population frequents or congregates.

The Delivery Infrastructure incorporates entities that provide the majority of services such as HSA Medi-Cal Eligibility, Champions Care Coordination, Behavioral Health Care Coordination, and Public Health Medical screening, all of which are located together on a the county campus. This is part of the overall design of the program to increase bi-directional data sharing and decrease department practices that limit

collaboration.

V. NARRATIVE – Incentive Payments

The Kings County WPC Pilot incentives are paid at the submission of the annual reports for each project year. All incentive payments are for participation in LAC as well as the PDSA requirement of the Kings County WPC Pilot.

Each month, LAC meets with the directors or assigned designees of each of the participating entities. A total of (9) entities are represented in the LAC meetings. HSA is the only entity not eligible for an incentive payment.

Incentive payments will be based on the following;

- 100% LAC attendance and participation in LAC meetings - $10,000
- 99-75% LAC attendance and participation in LAC meetings - $7,500
- 74-50% LAC attendance and participation in LAC meetings - $5,000
- 49-25% LAC attendance and participation in LAC meetings - $2,500
- 24-0%0 LAC attendance and participation in LAC meetings - $0

Nine, of the nine participating entities contributed 100% to the PDSA requirement. They are Human Services Agency, Kings County Behavior Health, Kings County Public Health, Champions, Kings View, Adventist Health, Anthem, Blue Cross Sheriff and Probation. Entities were required to be lead on at least one PDSA cycle throughout the project year. All PDSA's are received at the LAC meetings and participating entities contribute to the dialogue necessary to complete the PDSA.

Five of the nine entities attended 100% of the LAC meetings. They are Kings County Public Health, Champions, Kings View, Probation and Anthem Blue Cross. Three of the nine attended 75% of meetings. They are Adventist Health, Kings County Behavior Health, and Kings County Jail Sheriff Department.

Incentives to be paid to participating entities are;

- Champions – 100% ($10,000)
- Kings View – 100% ($10,000
- Public Health – 100% ($10,000)
- Probation – 100% ($10,000)
- Anthem - 100% ($10,000)
- Behavioral Health – 75% ($7,500)
- Kings County Jail - Sheriff Department – 75% ($7,500)
- Adventist Health - 75% ($7,500)

NARRATIVE – Pay for Outcome

The Kings County WPC Pilot pay for outcomes are paid at the submission of the annual reports for each project year. The narrative below indicates the progress we have made to date for this current project year.

Comprehensive Care plan, Accessible by the Entire Care Team within (30) Days
The Kings County WPC Pilot continues to use Efforts to Outcomes (ETO) Social Solutions as a central communication data base for all participating entities who provide direct services to enrollees. One benefit of ETO is, it allows participating entities to identify vocabulary with different definitions. For example, similar acronyms or words are used by various organizations, but have different definitions which could potentially pose miscommunication. ETO allows for customizable templates, known as touchpoints that are currently uploaded into the software. A coordinated care plan exists in ETO and adapts to meet the ongoing needs of the Kings County WPC Pilot. Some of the adjustments made from the original template are: creating new screening tools to clarify screening questions. The key components that remains focused on goals and strengths of the enrollee, mental health recommendations, and physical health recommendations. An addition to the physical health component was added to emphasize food insecurity needs and highlight any nutrition concerns for those with chronic medical conditions. Life skills questions were added to directly address the desire or need associated with self-improvement in budgeting, anger management, smoking cessation, and parenting.

There are a total of [redacted] recommendations made by the Multi-Disciplinary Team. The information regarding the enrollee is available to the entire team from the day of referral through disenrollment from the program.

At the time of this report, the entire Kings County WPC Pilot team has access to the coordinated care plan for 100% of Kings County WPC Pilot enrollees. Kings County has met the 30 day care plan requirement 100% of the time for third and fourth quarters of PY4. The PY 4 goal is 80%. The total amount earned was $36,000.

Decreasing HbA1c Poor Control <8%
The current screening process for enrollment into the Kings County WPC Pilot includes self-disclosure of all health information. Enrollees that self-disclose either an official diagnosis of diabetes or that they are prescribed medication commonly used to treat diabetes, are included in the health recommendations to link with a Primary Care Physician (PCP). In most instances, the health screener works with the enrollee to secure an initial visit with a PCP prior to enrollment. Case Managers educate the enrollee on the HbA1c test and the ramifications of the test score. Most enrollees that have diabetes disclose that they are not aware of the test nor the implications the results of the test have on their health. The health screener and Case Manager work

cooperatively to continue motivating and educating the enrollee on methods to best manage their diabetes and to ask for the HbA1c test to secure the results for their own monitoring.

The Kings County WPC Pilot is working with their health partners to continue expanding educational opportunities for both enrollees and for the Case Managers on topics related to ways in which to control diabetes as this has been identified as a challenge in our pilot. By educating both the enrollee and the Case Manager, they are able to work as a team to find solutions that work best for the enrollee. Homeless enrollees exhibit the highest needs and barriers when locating resources that will assist with their health concerns and individual needs.

Kings County met the stated goal of [redacted] of enrollees with diabetes to have a score of 8% or less on their HbA1c with a final 48% of enrollees meeting or exceeding the target. The total amount earned was $36,000.

Decreasing Jail Recidivism

The Kings County WPC Pilot works closely with Kings County Probation and Kings County Sheriff in identifying potential enrollees whom appear to meet the target population. Deputy Probation Officers work closely with Case Managers to encourage enrollees to continue working towards their goals identified in the comprehensive care plan.

Kings County was able to meet our target decrease of jail recidivism of 22 incarcerations for every 1,000 member months. We will continue to monitor enrollees, especially those with past justice involvement, to ensure our rates continue to decrease. The total amount earned was $36,000.

The Kings County WPC Pilot continues to encounter the following challenge. Kings WPC cannot start services with potential enrollees and refer individuals while they are incarcerated. Currently, Kings County has placed a case manager to work in the jail to more closely coordinate with jail staff and receive names of inmates wanting to be screened by Kings WPC or receive warm hand off to mental health or housing resources. Introducing inmates to Kings WPC services and screenings immediately after discharge allows for increase coordination and less loss of contact after being incarcerated. Ideally, having WPC receive referrals and screenings, prior to release of an inmate would allow time for engagement, building professional rapport, initiation of advocacy, and linkage to services. Although some improvement has been made with regard to immediate contact on discharge day for inmates, Kings WPC still faces challenges with be able to fully engage with an inmate to coordinate with other providers or Community Based Organizations (CBO).

VI. STAKEHOLDER ENGAGEMENT

Please see the attachment which is a detailed list of all LAC meetings for the designated time period.

The attachment describes in detail the agency, titles, and names of each individual that attended the LAC meetings in chronological order and includes the dates, times, and key points synopsis of each meeting covering discussed topics and decisions made.

VII. PROGRAM ACTIVITIES

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

1. One area of success with care coordination is the increase in collaboration between medical providers and Kings WPC. Care coordination is continuously improving as Kings County providers view the increased need to collectively discuss the challenges faced by Kings WPC, who also make up a large portion of the homeless population.

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

1. One challenge the Kings County WPC Pilot has experienced with care coordination is maintaining the enrollee engaged. One of the primary reasons for loss of contact is the location of homeless and homeless individuals losing or changing phone numbers.

   A lesson learned is for WPC staff to utilize the Peer Support Specialist to assist locating hard to reach individuals. Increasing the foot print in which Kings WPC provides homeless encampment outreach would assist in locating individuals moving away from near by encampments. Increasing Kings WPC foot print will also allow for closer coordination with providers and medical facilities closer to rural areas.

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

1. Data received has provided insight as to how to improve internal processes and program delivery to enrollee's.

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

1. One challenge Kings County WPC Pilot is facing with data sharing is accessing enrollee real time medical data, specifically ER visits and mental health appointments.

Briefly describe 1-2 challenges you have faced with data sharing, and lessons learned from those challenges.
The lesson learned is to develop a system to receive real time data from the ER. This may include county wide coordination. Although the placement of a case manager in the Emergency Department (ED) has increased awareness of challenges faced by the Emergency Department as well as, increased knowledge for ED staff regarding Kings WPC services, receiving immediate information to track enrollee's ED visits, immediately address a need or assist the enrollee with routine appointments, continues to be a gap in information sharing.

Briefly describe 1-2 successes you have had with data collection and/or reporting.
1. Increase data sharing among some partners has assisted in creating a more informed care plan thereby reducing the time between care plan signing and scheduling initial medical appointments. 2. Another success has been creating touchpoints within Kings WPC database to capture the all screening tools. This will increase Kings WPC ability to quantify data for further analysis of population needs.

Briefly describe 1-2 challenges you have faced with data collection and/or reporting.
1. Kings WPC still faces challenges with reporting having to come from various partners as oppose to having a centralize data base to securely link into provider data bases. The intent of this data sharing would solely be for partnering agencies to view enrollee activity when enrollees are visiting other providers. This sharing of data would increase collective understanding of a persons needs for a more holistic view when creating care plans.

Looking ahead, what do you foresee as the biggest barriers to success for the WPC Program overall?
1. Having a comprehensive shared database to assist medical providers in obtaining a holistic view of a patient. In many facilities such as the ER, Behavioral Health or Medical Jail staff, can spend extensive time evaluating someone's background to properly address their needs or process a case. With a cohesive shared data base of someone's medical, mental health, or prescription history, medical and mental health providers will be able to evaluate a person and minimize the potential for incorrectly treating an unresponsive or uncooperative patient.

PLAN-DO-STUDY-ACT

PDSA Attachments:

1. Please see attached PDSA's for PY4 Quarter #3, Quarter #4

The PDSA attachments include a list of PDSA's in the WPC Summary Report for reporting period 07.01.19 – 12.30.19 PY4. The PDSA attachments will attempt to demonstrate Kings County WPC Pilot's progress in relation to the infrastructure, services, and other strategies as described in the approved Kings County WPC LE application and WPC STC's.