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

Kings County
Annual Narrative, PY 5
April 09, 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.

Whole Person Care

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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.

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

Coordination with Health Net (Cal Viva)

California Advancing and Innovating Medi-Cal (Cal AIM) is the Department of Health Care Services (DHCS) initiative to improve the quality of life and health outcomes of beneficiaries. One of the objectives of Cal AIM involves Managed Care Providers (MCP) strategic input to incorporate Whole Person Care approaches and address Social Determinant of Health. In order to accomplish this, Kings WPC and Health Net have increased joint discussions with members from the Lead Advisory Committee (LAC) to further improve full community integration. Collaborations with Kings MCPs, Anthem Blue Cross and Cal Viva (Health Net) will be vital to the development of a comprehensive plan and seamless transition to Cal AIM in 2022.

Increasing coordination and appropriate access to care:

Substance Use Disorder (SUD) Liaison

During PY5, quarterly enrollment reviews identified a growing trend of individuals in the SUD population increasingly refusing SUD treatment. Although SUD treatment is an elective service, a recommended solution to understand the growing trend, was to dedicate an experienced case manager to the SUD population.

As result, SUD treatment referrals increased from 11 referrals in *three* months to 15 referrals in *one* month. Making the month's equivalent, SUD referrals increase to 24 in *three* months. This can be attributed to designating a case manager with education and professional experience as a SUD Liaison. The SUD liaison was assigned a lower caseload to allow him to engage more frequently with enrollees with high SUD assessment scores. Through rapport and applying skills learned from previous experiences, the SUD liaison contributed to the increase in individuals accepting referral to SUD treatment.

Reducing inappropriate emergency and inpatient utilization:

Implementation of the Wellness Recovery Action Plan (WRAP)
A challenge Kings WPC has identified but has yet to be implemented is receiving an enrollee's outcome after providing care coordination and connecting them to appropriate services. A program review of this component, revealed there was minimal follow up after an enrollee's appointment or linkage to other services. Determining the cause revealed a need to clarify the current policies. In addition, training on how to create and implement WRAP was provided to care coordinators. The purpose of WRAP is to provide the enrollee and Case Manager a tool to open dialogue and provide the enrollee with a step by step guide on identifying triggers and creating an action plan to mitigate a crisis related to their condition(s). If implemented, the intent of WRAP would be for the enrollee to complete a WRAP within 30 days of enrollment and prior to disenrollment. In addition to educating the enrollee on how to utilize WRAP techniques, the case manager would continue to follow up with service providers to receive enrollee updates, based on the level of disclosure allowed. Using WRAP and provider input as a tool to identify triggers, can help determine if the enrollee is able to independently use WRAP techniques to avoid triggers that lead to a crisis. In turn, Kings WPC can use information collected to determine the positive and negative effects to connecting certain populations to specific services. This will help better understand how to engage with certain populations to improve care coordination approach, increase compliance with appointments to have successful outcomes.

Even though Kings WPC did not implement WRAP in 2020, implementing WRAP will be recommended in 2021, to examine if case management follow up engagements improves the enrollees long term outcome once linked to services. Including outcome responses in the PY6 program review would contribute to improving care plans and staff service delivery.

Improving data collecting and sharing:

Homeless Questionnaire added to Initial Screening
With the addition of the homeless population, screening documents required additional questions in order to capture homeless data for future analysis and determination of metric outcomes. Although over half of the WPC population are homeless, current screening tools were designed to primarily capture information regarding the original target populations. Homeless population data coupled with county homeless statistics can support Kings efforts identifying additional gaps in services or barriers to develop solutions and better address complex needs directly impacting the homeless population.

Release of Information (ROI) Restricts Bi-directional Information Sharing

Although Kings has increased information sharing, data sharing continues to be a challenge. Physical health assessment, includes chronic health questionnaire, however, all clients are not forthcoming or may not be aware of certain conditions. Missing information from screenings have made it challenging for care coordinators to address all of the client's need. The absence of self-disclosure and limited access to databases with medical information, can create a barrier to gaining critical information necessary to best coordinate and improve the enrollee's outcome. Despite the few enrollees reluctant to share medical history, most medical data is documented during screenings, however, if critical medical needs are not disclosed, chronic health population data may exclude vital information to improve outcomes.

Despite sharing agreements or with enrollee authorization to release medical information, coordinators continue to have difficulty in obtaining status of an enrollee's compliance with appointments or overall outcomes. Lack of bi-directional information sharing limits assessment of service delivery. A recommendation for future programs would be to consider identifying all medical care facilities and define the level of information to be shared when a mutual client is being served.

Achieving quality and administrative improvement benchmarks:

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

Developing staff training to correspond with revised procedures on data collection showed a 2% improvement in updating and recording an enrollee's progress. Quality assurance review also indicated adherence to completion of case notes within two days from engagement, but has declined by 3% for the Comprehensive Care Coordination (Acute) component. Implementation of a data entry checklists has assisted in improving completion of touchpoint data entries 1%.

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

Overall activities during the fourth quarter of PY 5 were scaled down due to WPC transition activities. The remaining cases were transferred to the Human Services Agency case managers. Of the cases reviewed, there was a 4% overall improvement from third quarter to fourth quarter in care plan development.

PY5 2020 Program Component Review

An initial program review of Kings WPC components revealed a need to improve data collection and care coordination processes. Although overall pilot outcomes were included in the initial WPC application, specific benchmarks to meet those outcomes were not included into agreements with vendors. As a result, the only benchmarks initially available to determine the effectiveness of WPC services were those set in the initial

application. Lessons learned include, research how other programs with similar objectives or components measured or collected data, expand on overall strategic and operational objectives, determine why these objectives are important (develop hypothesis), if objectives are achieved what are the next steps, develop a data collection plan and include all possible data points and reports in vendor agreements.
In addition to this, follow up engagements with enrollee or service provider did not occur on a consistent basis, leaving a void in information to immediately address service gaps. Additional lessons learned in Care Coordination included, a lack of staff oversight, standardized systems and training on daily operations for new staff. Restructuring of Kings WPC operational staff is needed to increase staff oversight, and quality control reviews.

Increasing access to housing and supportive services:

Removing Barriers to Shelter during Project Roomkey
Kings County faced increased housing challenges during the Coronavirus (COVID-19) pandemic. With the shortage of affordable housing and homeless shelters, the homeless population posed an increase health risk in Kings County. In response to similar statewide challenges, Kings and Tulare Continuum of Care (CoC) were awarded a grant to develop a housing plan to provide shelter to the homeless population, thereby, reducing the spread of COVID-19.

Housing individuals in hotels not only helped reduce the spread of COVID-19, it allowed for co-location of physical health, mental health, substance use, housing services and other community organizations in support of the homeless population. Co-location of services help identify critical needs to quickly connect to services immediately. This reduces the time between identification of a need to when care is provided. Co-location of services also helped reduce barriers for homeless individuals with mobility restrictions, severe medical or mental health conditions. Additionally, individuals with severe conditions and living in remote or secluded areas without access to transportation, faced greater challenges. To remove this barrier the Peer Support Specialist provided transportation from homeless encampments to PRK, increasing access to care and expediting the referral process.

Increasing Affordable Housing through Project Homekey

Additional state funding was granted to develop permanent affordable housing and wraparound services. This funding contributed to the manufacturing of 24 affordable homes. In addition to developing permanent housing, tenants will be connected with services to assist in the process of leading an independent life. Project Homekey will continue to be developed through 2021.

Improving health outcomes for the WPC population:

California Advancing and innovating Medi-Cal (Cal AIM) Service Mapping
Initial Cal AIM planning included review of WPC and Cal AIM services. Review of services revealed gaps in services. Early identification of service requirements and gaps allowed Kings to initiate workgroups focused on identifying all community resources aligned with Enhanced Care Management (ECM) and In Lieu of Services (ILOS) requirements. Mapping of services will be a living document as Cal AIM In addition to identifying requirements for Cal Aim, Kings WPC identified internal processes needing improvement.

Brief overview of program successes, challenges, and lessons.

The Kings County WPC Pilot is experiencing the following successes:
1. Increasing or presence within the community and collaborating with other organizations allowed for a greater understanding of the target population needs. Other community collaborations including the Peer Support Specialist, vital role in increasing engagement with the homeless population. The Peer Support Specialist contributed vital input, which assisted in better engaging the homeless population and gain a greater understanding of the homeless population needs.

2. Strengthen partnerships with County Government Departments and Community Based Organizations (CBO). This allowed for increase in collaboration with organizations servicing mutual clients. Through these partnerships we were able to extend services to underserved homeless population. Through collaboration, focused discussions were initiated to identify solutions to increase information sharing across multiple County departments, CBO's and Manage Care Providers.

3. Automated 100% of required enrollment documents for screening and care plan development. Automating all screening tools allowed for a more efficient screening process by eliminating unreadable written notes, avoiding having to write down information to duplicate it into the data base. Automation also minimized missed information, in the event a screener is not able to write at the speed of the client's speech. Quantifying all available responses, provided a more detailed depiction of the impact a process or program component had on services or enrollee outcome. Additional

quantifiable data also contributed to better defining of service gaps and identifying target population complex needs.

Kings County WPC Pilot is experiencing the following challenges:

1. Enrollee engagement has been a challenge throughout the project years. Loss of contact primarily occurred following screenings, while pending case evaluation process. This process can at times take a week to two weeks. During this time, Case Management was not assigned, leaving the client with little to no engagement during the two weeks timeframe.

2. A major constraint during the enrollment process is requirement to hold a Multi Disciplinary Team Meeting to determine enrollment eligibility, target population, care plan recommendations, followed by a separate meeting the following days. A solution to this would be to create the care plan during the MDT meeting, avoiding the need for a separate care plan meeting. To increase client engagement, the care plan meeting was intended to increase enrollee participation in setting their goals. However, the majority of enrollees were discourage to attend or missed the scheduled time. Staff's work day became less productive due to being required to attend multiple care plan meetings without the need of their input.

3. The data system currently used has not allowed for efficiency within WPC. Although the current data system, allows us to customize data collection and reports, the system was acquired after the program commenced, delaying the development of a collection plan compatible with the systems capability and program objectives. One of the primary objectives for WPC is improving information sharing, however the current data system has limitations on how data can be shared. ETO was able to allow select partners access to view enrollee data, however, it does not allow for real time data sharing of a clients encounter in a medical facility, ER or jail. This creates a lag in communication, care coordination and increases the probability of duplicating services.

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. Despite statewide and national studies, demonstrating the social, health and cost benefits to communities when these programs are creating and sustained, Kings County entities advocating for these programs find reluctance in the process to attaining support.

Kings County WPC Pilot lessons learned include:

1. Building a data collection plan. When the pilot commenced data collection needs were specified and only minimal data points to complete state requirements were included in procedures and data base infrastructure. As a result assessing the effectiveness of the pilot could not be fully validated due to the lack of data and documentation. Recording all data using a measureable process, could provide a more in depth trend analysis of all areas within the pilot. It is difficult to predict what data will be useful for future analysis in the beginning of a new project. For this reason collecting all information using quantifiable answers will allow for more flexibility on ways to assess the pilot's processes.

2. Having only one care coordination meeting. Combining the MDT and Care Plan procedures will improve efficiency in day to day operations and staff productivity.

3. Incorporating voluntary group discussions and activities to increase enrollee engagement and improve long term outcomes. Offer incentives and prizes for participation. In essence, the goal is to integrate the target population, particularly homeless and previously incarcerated, into a community atmosphere.

A recommendation would be to organize presentations and small group discussions led by a peer support or someone with lived experience. Topics discussed can incorporate enrollee individual goals and range from self-care to education on basic life skills.

4. Closing the educational gap by teaching enrollees how to navigate complex medical systems gives enrollees greater confidence to become self-sufficient. Initially 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. Care coordination process now includes case managers coaching enrollee's on how to set up appointments, coordinate transportation and assist in creating a plan for routine appointments.

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	31	25	28	*	*	33	**130**

Item	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12	Annual Unduplicated Total
Unduplicated Enrollees	15	17	12	13	*	*	**70**

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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 Recuperative Care Unit	**36**	**37**	**20**	**24**	**19**	**131**	**267**
Utilization 1	$5,400	$5,550	$3,000	$3,600	$2,850	$19,650	$40,050
Service 2 Community Integration	*****	*****	*****	*****	*****	*****	**15**
Utilization 2	*	*	*	*	*	*	$3075
Service 3 Engagement	**118**	**113**	**109**	**49**	**78**	**114**	**581**
Utilization 3	$19,588	$18,758	$18,094	19	$12,948	$18,924	$88,331
Service 4 SSI Advocacy	**14**	*****	*****	**19**	**15**	*****	**72**
Utilization 4	$31,150	*	*	$42,275	$33,375	*	$164,650

Costs and Aggregate Utilization for Quarters 3 and 4

FFS	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12	Total

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 Recuperative Care Unit	**49**	**21**	**13**	**84**	**13**	**64**	**244**
Utilization 1	$7,350	$3,150	$1,950	$12,600	$1,950	$9,600	$36,600
Service 2 Community Integration	*****	*****	*****	*****	*****	*****	**0**
Utilization 2	*	*	*	*	*	*	$0
Service 3 Engagement	**89**	**39**	**61**	**45**	**22**	**24**	**280**
Utilization 3	$14,774	$6,474	$10,126	$7,470	$3,818	$3,818	$46,480
Service 4 SSI Advocacy	*****	*****	*****	*****	*****	*****	**0**
Utilization 4	*	*	*	*	*	*	$0

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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 for Quarters 1 and 2

PMPM	Rate	Month 1	Month 2	Month 3	Month 4	Month 5	Month 6	Total
PMPM	**Rate**	**Month 1**	**Month 2**	**Month 3**	**Month 4**	**Month 5**	**Month 6**	**Total**
Bundle #1 Care Coordination	$526	180	164	167	169	176	208	**1064**
MM Counts 1		$94,680.00	$86,264.00	$87,842.00	$88,894.00	$92,576.00	$109,408.0	$559,664
Bundle #2 Housing Navigation	$157	62	57	60	76	85	110	**450**
MM Counts 2		$9,891	$8,949	$10,362	$11,932	$13,345	$17,270	$71,749
Bundle #3 Comp. Care Coordination/Low Ratio	$1152	*	*	*	*	*	*	**49**
MM Counts 3		*	*	*	*	*	*	$56,448

Amount Claimed for Quarters 3 and 4

PMPM	Rate	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12	Total
Bundle #1 Care Coordination	$526	**216**	**214**	**211**	**205**	**180**	**127**	**1153**
MM Counts 1		$113,616.00	$112,564.00	$110,986.00	$107,830.00	$94,680.00	$66,802.00	$606,478
Bundle #2 Housing Navigation	$157	**117**	**126**	**119**	**109**	**61**	**51**	**583**
MM Counts 2		$18,369	$19,782	$18,683	$17,113	$9,577	$8,007	$91,531
Bundle #3 Comp. Care Coordination/Low Ratio	$115	*	*	*	*	*	*	**40**
MM Counts 3		*	*	*	*	*	*	$46,080

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.

Kings WPC is comprised of county and community stakeholders with shared organizational objectives. Common objectives include to, increase efficiency in coordination of health, behavioral health, and social services and improve the health and wellbeing of the target population. To achieve this, county and community partners identify their *highest-risk* clients, who are homeless, have diabetes, high blood pressure, substance use, or mental health conditions. Some individuals identified as *highest risk* are also frequently involved in the criminal justice system. Consequently, WPC aims to combat recidivism among the target population.

To address the target population's needs and meet overall WPC objectives, Kings WPC governing body includes Kings County Human Services Agency as the Lead Entity (LE), who provides administrative oversight, leadership, communicates state requirements to participating entities and makes final determination of the pilot's objectives and processes. LE and its partnering entities, formed a Lead Advisory Committee (LAC). Primary role of LAC is to develop and improve policy, information sharing infrastructure, to contribute to developing synchronized operations with the intent to fully integrate coordinated care and reduce inappropriate use of resources.

LAC meets monthly and is currently facilitated by the Lead Entity. LAC possesses decision-making ability and works directly with Kings WPC staff to remove barriers to access care and prioritize approaches to pilot revisions. LAC review's program performance data, successes, challenges during regular monthly meetings, to evaluate existing processes, identify systematic inefficiencies, and generate ideas for process improvement.

Operational oversight is led by a Program Manager and Program Specialist. The Program Manager and Program Specialist who are the primary points of contact for stakeholders. Their duties include coordination amongst all entities and ensuring effective communication. The Program Manager has authority to make decisions in coordination with the Lead Entity Executive Management. The Program Specialist is the central point of contact for sharing and analyzing data throughout the pilot and ensures effective flow of communication among all partnering entities. The Program Specialist works to attain Universal and Variant metrics data from participating entities to formulate detailed reports, which are submitted to DHCS to ensure program goals are being met. Kings WPC also

includes fiscal support staff, Fiscal Account Specialist and Account Clerk to provide oversight of payments for services, incentives and reporting outcomes.

Multi-Disciplinary Team (MDT) consists of WPC operational staff, subject matter experts in mental health, substance use disorders, social services and Community Service Provider's. A portion of MDT is located in the Kings WPC building to allow for consistent coordination. The MDT is accountable to LAC and the Lead Entity, assesses identified needs of each potential enrollee and determines eligibility based on target population objectives. MDT also processes and reviews bi-directional data and makes 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.

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.

Kings WPC delivery infrastructure is intended to provide timely, individualized care coordination of services to enrollees who meet the criteria of the target population. The identified target population includes homeless single adults, individuals with Substance Use Disorders (SUD), Mental Health illness, poor control of diabetes or hypertension.

This target population has historically experienced difficulty accessing, engaging medical or Behavioral Health services. Kings focuses its care coordination on supporting the target population in obtaining and scheduling routine Medical Primary Care Provider (PCP) appointments, motivating to remain engaged in substance use treatment, ensuring compliance with regular mental health appointments, coordinating and advocating for shelter, and income stability services. Kings works towards increasing community collaboration to further discuss solutions based discussions. Successful delivery of coordination and services will contribute to improving Kings County resident's appropriate and consistent access to these services, thereby decreasing the need to utilize local emergency department rooms and/or reduce their recidivism rate.

To support accessibility to services, Kings WPC referrals can be submitted via telephone, e-mail, website, or in person by referring entities or self-referred. Upon receiving a referral, Kings WPC coordinated care professionals, perform an initial eligibility screening. The care coordination team includes, Human Services Eligibility Worker, County Public Health Community Health Aide, Case Managers, and Acute Case Manager(s). Screenings are conducted in the field or in the Kings WPC office. During the initial screening process, if the enrollee expresses a need for housing and or job placement assistance, the enrollee is scheduled for a meeting with Kings WPC Housing Navigator or Job Developer to assess immediate needs and coordinate for available resources. Following the screening process, the individual's stated needs, goals and assessment details are reviewed by a Multi-Disciplinary Team (MDT).

Prior to Coronavirus Disease (COVID-19) emergency stay at home orders, Kings WPC adhered to approved policies for meetings and face-to-face engagements. In accordance with County restrictions, the Multi-Disciplinary Team (MDT) and care plan weekly meetings are conducted using video and/or telephone conferencing.

MDT meetings serve as the primary comprehensive evaluation to resolve target population criteria, determine needs, deconflict duplication of services, determine program eligibility and provide recommendations for the enrollee's comprehensive care plan. MDT meeting participants include Kings WPC contracted service vendor, Program Manager or LE Program Specialist, assigned Case Manager, Housing Navigator, Job Developer, SSI Advocate, Subject Matter Experts (SME) in Mental Health and Substance use, Coordinating Service Providers (CSP). CSP's may include County Probation, Mental Health Case Manager or Counselor, Substance Use Disorder (SUD) treatment providers, housing programs representative(s), medical professionals or other community service coordinators.

The objective of the care plan meeting is develop an active care plan, assist the enrollee create individualized goals and eliminate duplication of services. With a focus on increased client engagement, the client has the option to participate in the care plan meeting. Increased enrollee engagement during the initial planning strengthens care coordinators ability to continue encouraging enrollee's development towards self-sufficiency and maintain goals. During the care plan meeting, the facilitator reviews the initial screening and refers to the enrollee to create and prioritize their goals, as it relates to identified social determinants of health needs. Goals are set using the SMART (Specific, Measureable, Attainable, Realistic, Timely) methodology.

Following the care plan meeting, the Case Manager reviews the plan with the enrollee and acquires the enrollee's signature, approving his/her care plan. 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 WPC Case Manager's maintain consistent contact with the enrollee to assist the enrollee meeting 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 WPC 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 WPC PSS will primarily work in the field to engage with the target population and develop rapport with potential and existing Kings WPC enrollees. Additional task includes re-engaging enrollees that have lost contact with Kings WPC Case Managers. In order to re-connect the enrollee with services, the Peer Support Specialist attempts to locate enrollees at their residence or other locations an enrollee may frequent.

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. The delivery infrastructure is design to increase bi-directional data sharing and decrease department practices that limit collaboration.

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.

The Kings WPC 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 WPC. 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.

To date, all nine of the 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.

Four of the nine participating entities attended 100% of the LAC meetings. They are Behavioral Health, Probation and Anthem Blue Cross and Public Health. The other four of the nine attended 75% of meetings and they are Champions, Kings View, Sheriff and Adventist Health. As the Lead Entity, Human Services Agency facilitates LAC meetings and does not receive incentive payment for LAC attendance.

Incentives to be paid to participating entities are;

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

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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.

Kings WPC elects to use the COVID-19 Alternative Payment method for Pay for Outcome payments in Program Year 5. Kings achieved 100% of our Pay for Outcomes in Program Year 4 so Kings will receive 100% payment in Program year 5, in the total amount of $ 90,000.00 during PY5 annual.

Kings WPC 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 entire Kings WPC team has access to the comprehensive care plan within 30days. Kings County has met the 30-day comprehensive care plan requirement 100% of the time for PY5. The PY 5 goal is 83%. Accessibility to the care plan can be attributed to the care coordination database, Efforts to Outcomes (ETO) Social Solutions. In addition to care coordination ETO serves as an internal centralized system to Kings WPC team communication database. In combination with co-locating Kings WPCs team, ETO's database provides continuity of service and care coordination. Continuity of services and care coordination increases Kings WPC components awareness of the enrollee's activities and care plan updates, potentially impacting other components of the team.

Decreasing HbA1c Poor Control <8%.

Kings County PY5 stated goal to reduce the number of enrollees with HbA1c score of 8% or more by 15% was not met. Of the enrollees with diabetes, 49% reported a score of HbA1c score higher than 8%.

Most enrollees that have diabetes disclose that they are not aware of the test nor the implications results of the test may have on their health. The physical health assessment assists the 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. Strategies implemented to help the target population with reducing HbA1c scores are through continues education on how to manage their condition. Case Managers will also provide nutrition and information on controlling

diabetes and connect enrollee(s) with a Primary Care Provider or teach the enrollee how to coordinate for a medical appointments and transportation, if needed. Kings implemented the following steps to improve the monitoring of an enrollees HbA1c scores: review or update an enrollee's initial physical health assessment monthly or bi-monthly, record any changes to the enrollee's score and track most recent test. The goal for additional tracking and monitoring is to improve care coordination, obtain the most recent information and address uncontrolled conditions appropriately. In addition to the HBA1c scores, increased monitoring of High Blood Pressure scores is included in this procedure. Although there has been some improvement in collecting the most recent HbA1c information, many individuals with diabetes do not maintain routine medical appointments to help monitor diabetes scores. Kings WPC continues to work with health partners to expand education related to maintaining healthy levels of all chronic conditions.

Decreasing Jail Recidivism

The total the number of incarcerations for 2020 is 54 (49%) of the 1142 member months, this is a 4% decrease in incarcerations, not attaining the metric outcome goal of 15% reduction in PY5. Of those incarcerated in 2020, 44 were incarcerated once, * were arrested twice and * enrollees had three incarcerations in the year. In comparison to previous WPC outcomes, incarceration rates have not had a considerable decrease or increase. In terms of county wide incarcerations, there were 4,766 incarcerations in Kings County, WPC enrollees account for * of all incarcerations in Kings County. Kings WPC will continue to work closely with Kings County Probation and Kings County Sheriff Department to find solutions to connect with inmates prior to being discharged in order to reduce potential of former inmates becoming homeless or reoffending.

The Kings WPC continues to encounter the following challenge. Kings WPC cannot start services with potential enrollees and refer individuals while they are incarcerated. Previously, Kings County placed a case manager to work more closely and coordinate with jail staff to receive names of inmates interested in being 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 released. 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 being able to fully engage with an inmate to coordinate with other providers or Community Based Organizations (CBO).

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.*

Lead Advisory Committee agendas are attached.

VI. PROGRAM ACTIVITIES

Care Coordination

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

1. Kings County faced increased housing challenges during the Coronavirus (COVID-19) pandemic. With the shortage of affordable housing and homeless shelters, the homeless population posed an increase health risk in Kings County. In response to similar statewide challenges, Kings and Tulare Continuum of Care (CoC) was awarded a grant to develop a housing plan to provide shelter to the homeless population, thereby, reducing the spread of COVID-19.

2. Housing individuals in hotels not only helped reduce the spread of COVID-19, it allowed for co-location of physical health, mental health, substance use, housing services and other community organizations in support of the homeless population. Co-location of services helped identify critical needs quickly and connect to services immediately. This reduces the time between identification of a need to when care is provided. Co-location of services also helped reduce barriers for homeless individuals with mobility restrictions, severe medical or mental health conditions. Additionally, individuals with severe conditions and living in remote or secluded areas without access to transportation, faced greater challenges. To remove this barrier the Peer Support Specialist provided transportation from homeless encampments to PRK, increasing access to care and expediting the referral process.

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

1. A review of service delivery revealed a lack of information on the person's status or outcomes after being connected to appropriate services. Follow up engagements with enrollee or service provider did not occur on a consistent basis, leaving a void in information to immediately address service gaps. This portion of care coordination was not included in the initial policies for Kings.

A lesson learned from this is to identify what success truly means beyond the states broader definition. Identify the impact the target population currently has and the impact or change needed to reach the intended goal. Detailing each care coordination phase to determine what data is needed to capture the effectiveness of care coordination and program impact to the broader community.

2. Large case loads. Ideally, enrollee's with complex conditions require additional engagement and guidance to process through systems navigate and understand systems of care or other community services. Assigning smaller caseloads

would allow for more dedicated engagement for those with the highest, most critical needs.

Data Sharing

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

1. Automation of all required screening and confidentiality consent forms has allowed Kings to share more thorough analysis of the target population. Also, adding forms used for screenings to the ETO software system has reduced the amount of time case managers spent transmitting information from screening documents to the software database. In addition, information gathered through screenings was previously not completely captured in the database. Policy dictated specific information to be entered into the database, leaving out other useful details gathered through screenings.

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

1. Current data system has limitations on how data can be shared. It does not allow for real time data sharing of a clients encounters in a medical facility, ER or jail. This creates a lag in communication, care coordination and increases the probability of duplicating services. In addition to reducing duplication of services, creating an information infrastructure, which includes all medical facilities and specialty care, mental health services, law enforcement and other relevant organizations, could decrease staff's time verifying or conducting a screening for information recorded in another health database. Also, having the capability to access housing databases will contribute to better coordination and de-conflicting duplicated services.
2. Not incorporating bi-directional information sharing in agreements and Universal ROI. This limited the ability to analyze true outcomes of individuals linked to services. Also, not having bi-directional information access through an automated system with near real-time information, creates an extensive delay in information sharing, resulting in duplicating services or gaps in information regarding the enrollee.
3. Policy approval process delayed the ability to deliver improved or more efficient services. The current Care Coordination Policy was intended to include enrollee's in the care plan meetings. Enrollee's participation in care plan meetings was intended to increase enrollee's engagement in the development of a care plan. In order to increase enrollee engagement, enrollee's were invited to create their goals to begin the process of self-sufficiency. However, enrollee's participation was minimal or were unable to attend the meeting in the scheduled care plan days. One of the reasons enrollee's gave for not participating was being discouraged to share personal information in a room with multiple people. The current policy also reduced work productivity of MDT staff members and case managers due to policy requiring to dedicate two weekdays for scheduled care plan meetings. Care plan meeting normally lasted the majority of the workday.

Data Collection

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

1. Automated 100% of required enrollment documents for screening and care plan development. Automating all screening tools allowed for a more efficient screening process by eliminating unreadable written notes, avoiding having to write down information to duplicate it into the data base. Automation also minimized missed information, in the event a screener is not able to write at the speed of the client's speech. Quantifying all available responses, provided a more detailed depiction of the impact a process or program component had on services or enrollee outcome. Additional quantifiable data also contributed to better defining service gaps and identifying target population complex needs.

2. Additional data request from partners, identified the need to create data collection plan to ensure information acquired can depict barriers and gaps in services and provide estimate on program outcome.

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

1. Pre-established data collection plan included in agreements and incorporated in the primary care coordination database. Although overall pilot outcomes were included in the initial WPC application, specific benchmarks to meet those outcomes were not included into agreements with vendors. Lessons learned include, research other programs data plan. Expand on overall strategic and operational objectives, determine why these objectives are important (develop hypothesis), if objectives are achieved what are the next steps, develop a data collection plan and include all possible data points and reports in vendor agreements.

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

Collaborating for a county wide integrated sharing infrastructure will allow for ideal to fully address target populations social determinants of health.

Developing a proposal for a respite facility. Currently, there is only one shelter that provides minimal respite services, but has very limited space to offer individuals needing additional care after ER inpatient discharge. The need for a respite facility was identified after reviewing 2020s Emergency Room data. ER usage for chronic conditions has not decreased as intended. Having a respite facility would provide a clean and safe environment for individuals, who are homeless or cannot care for themselves following a medical procedure. Increasing capacity of a respite facility may potentially reduce the need to return to the ER if the medical condition worsened due to the lack of care.

VII. PLAN-DO-STUDY-ACT

Whole Person Care

Kings County
Annual Narrative Report, PY 5
April 09, 2020

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 Attachment: