Whole Person Care Pilot Application

Application due July 1, 2016

Section 1: WPC Lead Entity and Participating Entity Information

1.1 Whole Person Care Pilot Lead Entity and Contact Person (STC 117.b.i)

Organization Name	Kern Medical Center
Type of Entity (from lead entity description above)	Hospital Authority
Contact Person	Tyler Whitezell
Contact Person Title	Interim Vice President Administrative Services
Telephone	661-326-2760
Email Address	tyler.whitezell@kernmedical.com
Mailing Address	1700 Mt. Vernon Avenue Bakersfield, CA 93306

1.2 Participating Entities

Required Organizations	Organization Name	Contact Name and Title	Entity Description and Role in WPC
1. Medi-Cal managed care health plan	Kern Health Systems (KHS)	Emily Duran Director of Provider Relations	• Managed care provider • Referring agency • Steering Committee • Data sharing • Collaborative Committee
2. Health Services Agency/Department	Kern Medical Center	Tyler Whitezell Interim Vice President Administrative Services	• Lead Entity • Hospital Authority • Steering Committee • Direct service provider • Data sharing • WPC financial management • Collaborative Committee • Care Coordination PMPM • Post-Incarceration PMPM • Employment Services PMPM
3. Specialty Mental Health Agency/Department	Kern County Mental Health (KCMH)	Brad Cloud Deputy Director	• County Mental Health Provider • Steering Committee • Direct service provider • Data sharing • Collaborative Committee • Care Coordination PMPM Bundle
4. Public Agency/ Department (if housing services are provided, must include the public housing authority)	Housing Authority of Kern County (HA)	Cristina Provencio Housing Specialist II	• Provider of affordable housing • Collaborative Committee • Direct service provider • Data sharing • Housing Navigation PMPM Bundle

Required Organizations	Organization Name	Contact Name and Title	Entity Description and Role in WPC
5. Community Partner 1	Community Connection for Child Care (CCCC)	Cheryl Nelson Director	• Provider of child care and development • Collaborative Committee • Direct service provider • Data sharing • FFS Provider
6. Community Partner 2	Golden Empire Gleaners	Jim Wheeler Executive Director	• Local food bank • Collaborative Committee • Direct service provider • PMPM Bundle
Additional Organizations (Optional)	**Organization Name**	**Contact Name and Title**	**Entity Description and Role in WPC**
7. Community Partner 3	Kern County Homeless Collaborative	Christine Lollar Director of Homeless Resources	• Community based organization • Collaborative Committee • Data Sharing
8. Public Agency	Kern County Public Health (KCPH)	Claudia Jonah, M.D. Health Officer	• County health organization • Collaborative Committee • Direct service provider • Data sharing • Nurse Assessment FFS provider
9. Public Agency	Kern County Sherriff's Office (KCSO)	Anthony Gordon Detentions Lieutenant	• County detention facility provider • Steering Committee • Direct service provider • Data sharing • Referring agency • Collaborative Committee • Post-Incarceration PMPM Bundle
10. Public Agency	Kern County Probation	Rebecca Jamison Division Director, Fiscal, Research & Planning	• County probation • Collaborative Committee • Direct service provider • Data sharing • Care Coordination PMPM Bundle
11. Public Agency	KC Aging & Adult Services (AAS)	Jeremy Oliver Program Director	• County advocate for older adults and disabled individuals • Collaborative Committee • Direct service provider • Data sharing
12. Public Agency	Kern County Employers' Training Resource (ETR)	Aaron Ellis Deputy Director	• County workforce training provider • Collaborative Committee • Direct service provider • Data sharing • Employment Services PMPM Bundle

Required Organizations	Organization Name	Contact Name and Title	Entity Description and Role in WPC
13. Medi-Cal managed care health plan 2	Health Net Community Solutions, Inc.	Abbie Totten Director, Government Programs Policy and Strategic Initiatives	• Managed care provider • Referring agency • Collaborative Committee • Data sharing
14. Public Agency	KERN County Department of Human Services (DHS)	Cindy Uetz Chief Deputy	• County Safety Net Program Provider • Collaborative Committee • Direct service provider • Data Sharing

Although only 3 community partners are included in this pilot, it includes the support of 6 additional county departments as well as an additional Managed Care Plan. Noting the current lack of infrastructure for such a global program, it is critical to success that the pilot is built upon a firm foundation. As this foundation is established, additional community partners will be added in the future.

1.3 Letters of Participation and Support

Letters of participation and support are available upon request. Please contact the Whole Person Care Pilot Lead Entity contact person: Tyler Whitezell, Vice President Administrative Services, 1700 Mount Vernon Avenue, Bakersfield, CA 93306, 661-326-2760, tyler.whitezell@kernmedical.com

Section 2: General Information and Target Population

2.1 General Information

Kern County is located in Central California. According to the most recent information from the U.S. Census Bureau, the county has a total area of 8,163 square miles and a population of 839,631. The population is dispersed widely in urban, suburban, rural, and remote areas. Bakersfield, California, home to Kern Medical Center, represents the largest city in Kern County with a population of 529,169, or 63% of the total county population. The main staples of the local economy include large-scale warehousing, chemical refineries, oilfield operations, and agriculture. Due to the extensive agriculture the area is subject to significant population shifts in migrant farm workers.

According to United States Census Bureau, 24.5% of the population lives in poverty, compared to 16.4% statewide. Historically, a large percentage of the population was uninsured; however, with the passage of the Affordable Care Act, the number of uninsured has dropped considerably, to 14.5% of the population, comparable to the statewide rate of 14.0%. The population has low levels of education relative to the rest of California with only 73.0% of individuals with a high school or higher level of education and 15.2% with a bachelor's degree or higher, compared to 81.5% and 31.0%, respectively. Low education levels combined with a high rate of non-native speakers of English greatly impacts the health literacy of the population, precipitating the need for personalized care plans.

Populations with low levels of health literacy are more likely to overlook preventive services which can lead to an increase in preventable hospital visits and use of emergency rooms, where costs are far greater. This leads to overcrowding of both the inpatient setting, as well as emergency rooms, which yields excessive waiting times for other non-avoidable visits. This low level of health literacy also contributes to the County's health care disparities which can be summarily describe as follows:

- 50.4% of adults are obese compared to 27% statewide
- 13.5% diabetes rate compared to 10.5% statewide
- 9.4% adults are diagnosed with heart disease compared to 6.1% statewide
- 43.7% have lower respiratory disease compared to 35.3% statewide
- 17.1% of adults experienced psychological distress compared to 7.7% statewide
- 41% of adults reported having engaged in binge drinking during the previous year, compared to 32.6% statewide

The county is home to five state prisons and four county detention centers which include a juvenile hall. Kern Medical Center currently provides medical care for all county detention centers. In 2015, inmates from these institutions accounted just over $22 million in healthcare costs and over one third of this population suffers from chronic illness. While incarcerated these individuals receive regular medical care, however upon release, many fail to continue this care. Additionally, many of these individuals are released to homelessness.

The 2015 Homeless Collaborative point-in-time census identified 953 individuals. In this same report 79 individuals reported being discharged to homeless after being released from incarceration.[1] A study in the

[1] United States. Kern County Homeless Collaborative. *2015 Homeless Census Report*. N.p.: n.p., n.d. Print.

New England Journal of Medicine found that homeless individuals spend approximately four days longer per hospital visit than a comparable non-homeless visit which leads to a substantial increase in costs.[2] Of the more than 25,000 lives assigned to Kern Medical Center from KHS, those homeless or at risk of homelessness accounted for 16% of Emergency Room costs and 15% of inpatient costs in 2015. The point-in-time census further found that the majority of the homeless population suffers from mental, physical or social ailments, respectively:

- 109 Have been hospitalized for mental issues
- 401 Admitted to substance use disorder
- 65 Are infected with Hepatitis
- 28 Are infected with Valley Fever
- 19 Are infected with Tuberculosis
- 2 Persons have HIV/AIDS
- 77 Reported being victims of domestic violence

Partners within the community have attempted to address these health care disparities, most recently with the Kern Get Connected (KGC) initiative launched by the Kern County Public Health Department in 2014. This program aimed to decrease avoidable-utilization of emergency services through case management and coordination of care across various services throughout the community. Using data from various sources, EMS and local hospitals identified eighteen beneficiaries who accounted for 241 emergency room visits in the prior six months or approximately 2 visits per individual, per month. Common conditions that were not being addressed were identified among these individuals, including behavioral health, substance use disorder, poor disease management, homeless or at risk of homelessness, negligible support from family, no reliable transportation and a general lack of health education.

Based upon their needs, each beneficiary was linked to one or more of the following services:

- Primary care provider linkage
- Health insurance services
- Life skills programs
- Behavioral health services
- Housing advocacy
- Disease management

KGC realized significant improvements for program beneficiaries, including a reduction in ER visits by 68%, a decrease in average cost per patient visit by 89%, and administrative success over the first year. The KGC program displayed the value of case management and the importance of inter-agency communication. Notwithstanding the benefits that this program precipitated, turnover, lack of resources and waning support caused the program to stall.

[2] Salit S.A., Kuhn E.M., Hartz A.J., Vu J.M., Mosso A.L. Hospitalization costs associated with homelessness in New York City. New England Journal of Medicine 1998; 338: 1734-1740.

With the announcement of the WPC program, Kern Medical Center created the WPC Committee consisting of community partners desiring to enhance care coordination throughout the community and reduce redundancy in services provided with the overarching goal of improving the health of the entire patient. This committee met on a regular basis to discuss shortfalls within the community, brainstorm solutions to those shortfalls and create a strategy that would be implemented through the WPC Pilot program.

The target population for the WPC pilot program will consist of high utilizers of emergency and inpatient services, with an emphasis on those who are homeless or at risk of becoming homeless, and those recently released from incarceration. The pilot will initially receive referrals from the two managed care partners and from Kern Medical Center, who contracts with the County for correctional medicine services. These beneficiaries will opt-in to the WPC program, and will be assigned to one of Kern Medical Center's Patient Center Medical Homes (PCMH) or Patient Centered Specialty Practices (PCSP) based on their specific needs and where they fall in our four-quadrant model.

These PCMHs and PCSPs will function as hosts and central hubs for WPC care coordination teams. In addition to hosting, the PCMHs and PCSPs will also provide logistical and other supportive services for the WPC care coordination teams. Within these homes, beneficiaries will be assigned a WPC care coordination team who will develop a unique health action plan (HAP). The partnering organizations will use shared case management software, allowing for the sharing of social determinants across the organizations. For recently incarcerated individuals, a clinic will be established right outside the gates of the jail facility where individuals will be receive a medication reconciliation and have a follow-up appointment scheduled with a primary care provider. Those homeless or at risk of homelessness will be assigned a Housing Navigator who will assist them through the housing process.

The WPC Committee will meet on a regular basis throughout the pilot to review the performance of the pilot and use the Plan, Do, Study, Act (PDSA) approach to performance improvement. The committee will adapt to lessons learned from the established strategies and take necessary steps to quality and process improvement. As over-utilization is reduced, the partners will come together to identify opportunities for alternative payment methodologies (APM) based upon the financial savings of the program. It is anticipated that the APMs will sustain the program beyond the pilot.

2.2 Communication Plan

Through the strategic building process, Kern Medical Center created two governing WPC Committees consisting of all participating entities listed in Section 1.1.2. These committees will meet regularly to evaluate the WPC program and share information. These committees are:

- Steering Committee – Responsible for overall direction and strategy. This committee has the ultimate decision making authority.
    - Kern Family Health Systems
    - Kern County Sherriff's Office
    - Kern County Mental Health
    - Health Net
    - Kern Medical Center
- Collaborative Committee – Implements and facilitates services, care coordination support and identifies ways to improve data sharing

- Health Net
- Kern County Department of Human Services
- Kern Family Health Systems
- Kern County Sherriff's Office
- Kern County Mental Health
- Kern County Public Health
- Kern County Probation
- Kern Medical Center
- Kern County Employer's Training Resources
- Kern County Aging & Adult Services
- Community Connection for Child Care
- Housing Authority of Kern County
- Golden Empire Gleaners

A barrier identified early in the planning process was that throughout Kern County there is a lack of foundational infrastructure necessary for successful sharing of data across organizations. Noting this weakness, the partnering organizations felt that it would be more manageable and practical to begin with a manageable group of partnering organizations. As the program grows and future needs are identified, it is anticipated that additional community partners will be incorporated.

Kern Medical Center's, Director of Whole Person Care is the main point of contact for the partnering organizations and will be responsible for coordinating continued planning and support for WPC program committees. This point of contact will administer the day-to-day operations of the program, have the authority to make decisions, and create an atmosphere of regular communication amongst participants.

Through the program, each partnering organization will have an individual assigned to work at their organization. This individual will be the point of contact for day-to-day operational items and for accepting and administering referrals. Committees will meet regularly to monitor progress, discuss issues and concerns and share lessons learned.

Communication is critical to the success of the pilot, and participation in committees will be incentivized to ensure greater participation. Each meeting will have standing agenda items which will include, but not limited to:

1. Review of previous month's data on all performance metrics.
2. Evaluation of existing processes using the Plan, Do, Study, Act process to identify inefficiencies and improve existing processes. This will occur on a revolving basis allowing for processes to be revisited regularly.
3. Introduction of new processes necessary for program success.
4. Lessons learned and program successes.
5. Challenges and barriers identified.

Care coordination teams will huddle on a daily basis discuss beneficiaries with appointments that day, and to ensure that the health action plan has been updated with their most recent labs, review prior visits and discuss barriers to care, enhance team communication, and improve beneficiary flow and planning efforts. These huddles help to reduce surprises and frustration amongst team members, which in turn contribute to improved beneficiary communication and outcomes.

2.3 Target Population(s)

During initial WPC Committee meetings, the partnering organizations met together frequently to discuss shortfalls and disparities within the community and to identify the target population that would be best served by addressing these shortfalls. The committee's methodology for identifying our target population consisted of research and review of the following information and data:

- Review of the past program outcomes – The KGC pilot program was initiated by Kern County Public Health and shared similar objectives as whole person care and provided invaluable insight into the challenges and possible outcomes of such programs. The pilot focused on case management of high utilizers of emergency and inpatient services, but yielded drastic reductions in avoidable utilization.

  As mentioned above, KGC identified common attributes that might have been addressed, but there was no centralized hub coordinating the services. This led to inefficiencies in the provision of care, and lack of follow-through. Through case management, KGC realized significant improvements in the quality of life for beneficiaries through the elimination of barriers to health care and linkages to social support services.

  The specific needs of the population which the KGC program was unable to meet included:
  - Integration of behavioral health services
  - Integrated data systems allowing true case management across agencies
  - Methods for identifying and engaging the homeless population
  - Staffing resources needed to meet additional referrals from EMS and hospitals
  - Integration of CBOs into the care coordination process

- Existing managed care plan (MCP) provider data – Kern Family Health Systems, the largest MCP in Kern County, provided data indicating 5% of their membership contributed to 64% of their costs. Of the 25,000 lives assigned to Kern Medical Center, 6% accounted for 87% of the costs associated with medical care accounting for more than $26 million in 2015.

- 2016 Bakersfield Memorial Hospital Community Health Needs Assessment – Review of this needs assessment found several areas of focus which also contributed to the committee's methodology in identifying our target population:
  - Significant Health Needs – The following significant health needs were determined:
    - Access to care
    - Asthma
    - Cancer

        - Cardiovascular disease
        - Dental Health
        - Diabetes
        - Environmental health
        - Lung disease
        - Maternal and infant health
        - Mental health
        - Overweight and obesity
        - Sexually Transmitted Infections
        - Substance Abuse

    - Mental Health Needs – this community assessment identified that 17.1% of adults in Kern County experienced some form of behavioral health distress and 21.4% of adults needed help for emotional, mental health, alcohol or drug issues and 85.5% of those who sought help did not receive it.

    - Food Insecurity – Among the entire population in Kern County, 15.1% experience food insecurity.

    - Homeless – Of the reported homeless population, 41.8% are unsheltered.

- Incarceration Data – As the county provider of health care services for County Facilities, Kern Medical Center has access to utilization data of this population while they are incarcerated. Through discussions with medical staff at these facilities, often times, individuals are released with little prior notification, and there is no smooth transition of care. While incarcerated healthcare was brought to these individuals. Meds were passed on a regular schedule, Physicians and nurses went to the facility to see the patients, and if a situation was escalated, the individual would be transported to a hospital. This structure becomes a way of life, but post-release this rigid structure vanishes with little education or preparation. Discussions with Kern County Sheriff's Office and Probation both reinforced this lack of transition. Individuals are released from incarceration with insufficient, if any, medications, and are expected to provide for themselves, when they don't know how. In turn, these individuals consistently forego medications and filling prescriptions, they do not make appointments to see a primary care provider, and they end up in the emergency room when their ailments become too great. This leads to higher costs, crowded emergency rooms, and although the ailments might be addressed, the root cause is not. These individuals receive little if any follow-up, and they leave with the same level of health education as they had prior, creating a vicious cycle of overutilization.

Using both qualitative and quantitative analyses, the partnering organizations determined that the target population will consist of, high utilizers of emergency and inpatient services, with an emphasis on those who are homeless or at risk of becoming homeless, and those recently released from incarceration. All

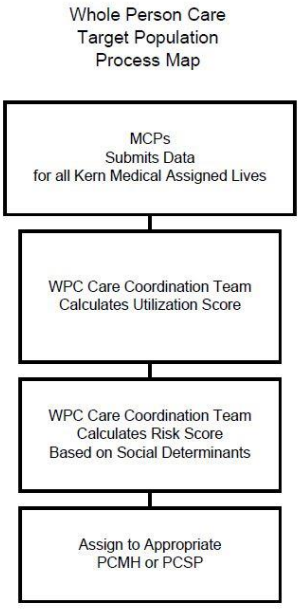
individuals taking part in the program will be Medi-Cal beneficiaries, and initial referrals will come directly from the Managed Care Organizations.

The care coordination teams will be stationed within Patient Centered Medical Homes to provide for care coordination. This pilot will have an enrollment cap of 1,500 beneficiaries. The largest restraint in capacity is our ability to establish and administer Patient Centered Medical Homes (PCMH). Currently, Kern Medical Center has one established, NCQA certified PCMH with plans to open an additional PCMH in the coming months. The medical center also has established specialty clinics, which we will continue to develop into Patient Centered Specialty Practices (PCSP).

The capacity on each of the PCMHs is 1,000 and the capacity of each of the PCSPs will be 50 for the HIV clinic, 250 in the Hypertension clinic and 350 in the Diabetes clinic. By the end of the program, we expect total enrollment in these clinics to reach just under 2,000 lives. We have based a conservative estimate that 75% of the individuals within these clinics will opt-in to Whole Person Care, thus the enrollment cap of 1,500. In order to account for the additional 25% enrollment in the clinics that will not be paid for with WPC funds, positions have been excluded from our PMPM bundles and the positions within the bundles that will crossover have been reduced accordingly. Initial analysis has shown that approximately 20%, or 400 of these individuals will be homeless, or at risk of homelessness. Although we anticipate 400 to be homeless or at risk of homelessness, capacity for the enhanced housing navigation will be capped at 40 beneficiaries at any given time. All beneficiaries in need of housing will be referred to agencies able to provide that assistance, but the housing navigation services are for those who are in the greatest need. Traditional services help individuals up to the point of habitation, but housing navigation services go far beyond. Housing navigators will follow these individuals through the entire continuum of care, ensuring that once individuals are placed in a home, that they have the resources and support necessary to remain in the home. Understanding the level of resources, time and commitment necessary to provide these services, this cap will allow for focused coordination, leading to successful results. After individuals have remained in a home for one year, the level of resources necessary will drop substantially, and a new beneficiary will begin receiving these services. There is no additional cap on enrollment of individuals recently incarcerated, apart from the overarching constraint on medical homes. Understanding that there are shared services with Targeted Case Management, the budgets for care coordination have been adjusted accordingly.

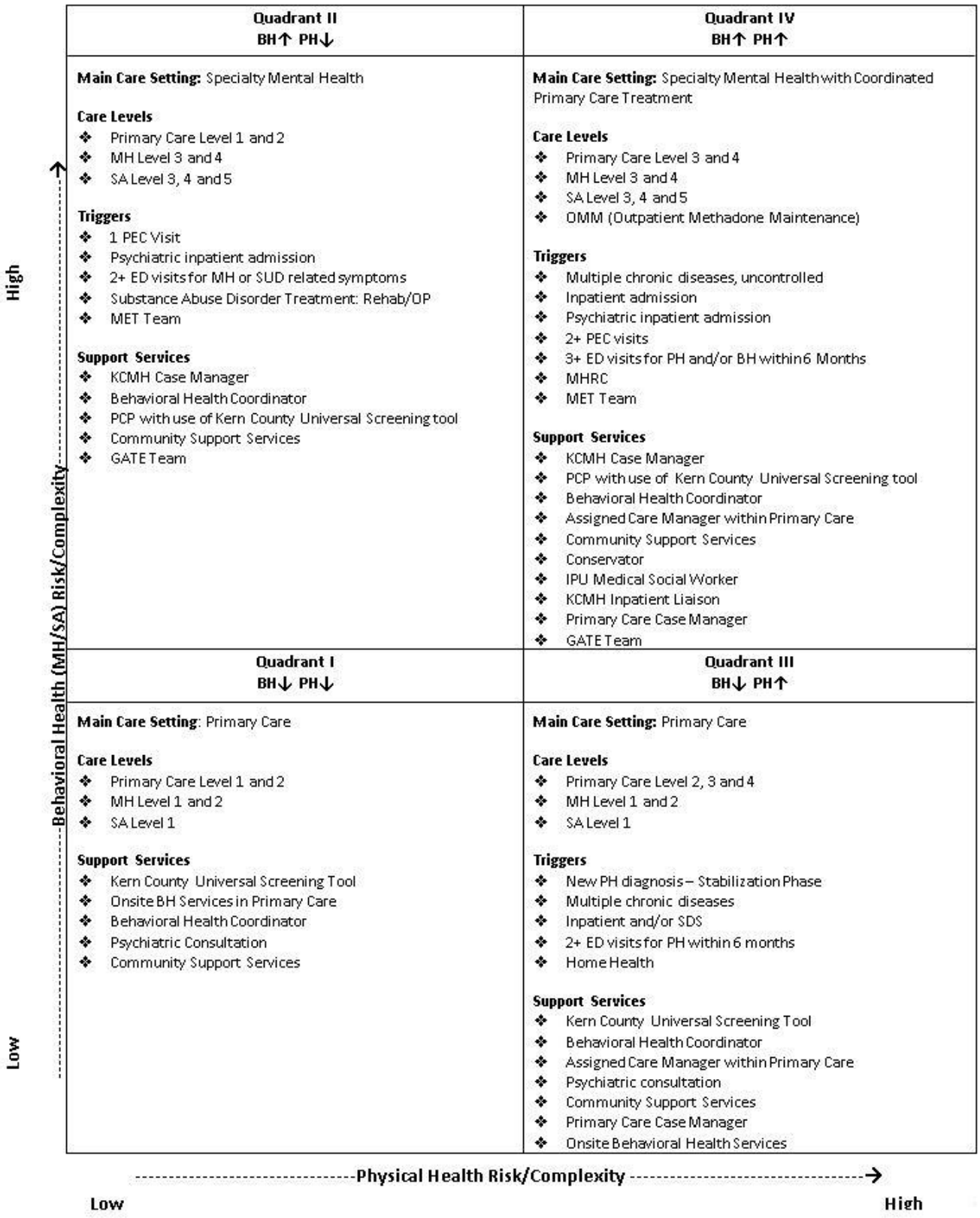
The MCP partners will provide a beneficiary list of all beneficiaries assigned to Kern Medical Center. The WPC care coordination team will evaluate the referred beneficiaries and apply an algorithm which will produce a utilization score for each of the individuals based on their utilization practices and medical conditions. Once the utilization score has been established, the care coordination team will apply a risk algorithm which will provide an overall score incorporating not only utilization, but also social determinants of homeless, transportation support, employment status, incarceration within past six months, etc. which will help to identify the individuals who will benefit most from the WPC program. In order to ensure that these algorithms will produce the desired target population without overlooking other high utilizers, the homeless and recent incarceration social determinants will be over weighted. Over time the algorithms will be re-evaluated using the PDSA methodology, to ensure the program is providing the maximum benefit.

Target Population Process Map



Once beneficiaries are identified, they will be assigned to a PCMH or PCSP based on their specific needs using a modified four quadrant model. Developed in 2006 by the National Council for Behavioral Health, the four quadrant model "describes the levels of integration in terms of primary care complexity and risk and MH/SU complexity and risk."[3] Kern Medical Center has tailored this model to fit the needs of the WPC program. Modifications to the model include standardization of established screening tools, services to be rendered, support services, and established trigger points (see below). The beneficiary's enrollment period will include the full month in which they opt-in to the program and the full month in which they opt-out, or graduate, from the program.

[3] [3] "Four Quadrant Model" *SAMHSA-HRSA Center for Integrated Health Solutions*. N.p., n.d. Web. 28 June 2016.


Quadrant II
BH↑ PH↓
Main Care Setting: Specialty Mental Health
Care Levels
Primary Care Level 1 and 2
MH Level 3 and 4
SA Level 3, 4 and 5
Triggers
1 PEC Visit
Psychiatric inpatient admission
2+ ED visits for MH or SUD related symptoms
Substance Abuse Disorder Treatment: Rehab/OP
MET Team
Support Services
KCMH Case Manager
Behavioral Health Coordinator
PCP with use of Kern County Universal Screening tool
Community Support Services
GATE Team
Quadrant IV
BH↑ PH↑
Main Care Setting: Specialty Mental Health with Coordinated Primary Care Treatment
Care Levels
Primary Care Level 3 and 4
MH Level 3 and 4
SA Level 3, 4 and 5
OMM (Outpatient Methadone Maintenance)
Triggers
Multiple chronic diseases, uncontrolled
Inpatient admission
Psychiatric inpatient admission
2+ PEC visits
3+ ED visits for PH and/or BH within 6 Months
MHRC
MET Team
Support Services
KCMH Case Manager
PCP with use of Kern County Universal Screening tool
Behavioral Health Coordinator
Assigned Care Manager within Primary Care
Community Support Services
Conservator
IPU Medical Social Worker
KCMH Inpatient Liaison
Primary Care Case Manager
GATE Team
Quadrant I
BH↓ PH↓
Main Care Setting: Primary Care
Care Levels
Primary Care Level 1 and 2
MH Level 1 and 2
SA Level 1
Support Services
Kern County Universal Screening Tool
Onsite BH Services in Primary Care
Behavioral Health Coordinator
Psychiatric Consultation
Community Support Services
Quadrant III
BH↓ PH↑
Main Care Setting: Primary Care
Care Levels
Primary Care Level 2, 3 and 4
MH Level 1 and 2
SA Level 1
Triggers
New PH diagnosis – Stabilization Phase
Multiple chronic diseases
Inpatient and/or SDS
2+ ED visits for PH within 6 months
Home Health
Support Services
Kern County Universal Screening Tool
Behavioral Health Coordinator
Assigned Care Manager within Primary Care
Psychiatric consultation
Community Support Services
Primary Care Case Manager
Onsite Behavioral Health Services
High
Low
Behavioral Health (MH/SA) Risk/Complexity
Physical Health Risk/Complexity
Low
High

It is estimated that enrollment will be approximately 700-800 beneficiaries by the end of program year 2 and the program will continue to increase enrollment to the established cap. The member cap is necessary due to restraints on infrastructure and the desire to maintain sustainable growth. Historically, there has been little data collaboration amongst departments within the county, and the initiatives and processes developed within this pilot will be new for many. Given this, much of the WPC pilot program will be spent building, monitoring, and proving the benefit of this initiative. Given the program objectives to accurately evaluate the impacts of providing true wrap around services to increase health outcomes, this pilot is cautious to overextend beyond its reasonable capabilities. As the pilot reaches capacity, a wait list will be established so that individuals in need will have a future chance at these benefits.

Once at capacity, the WPC Committee will first work with the Managed Care Organizations to identify alternative services within the community through which eligible individuals will still be able to receive an enhanced level of care coordination, including Targeted Case Management. Individuals referred to, eligible for, and desirable to participate in Whole Person Care will be placed on a wait list. As members disenroll or graduate out of the program, individuals from the wait list will be contacted for participation in the program. On semi-annual basis beneficiaries will be reviewed and those who are meeting goals, are medically stable and no longer meet the criteria of the program will be graduated from the program. The wait list will be prioritized based on level of need, as identified by the calculated risk scores. For individuals on the wait list, the risk score will be regularly reviewed in order to reprioritize, and to identify continued eligibility for the program.

Section 3: Services, Interventions, Care Coordination, and Data Sharing

3.1 Services, Interventions, and Care Coordination

This pilot will focus on high utilizers of emergency and inpatient services, with an emphasis on those homeless or at risk of homelessness and on those recently incarcerated. While all beneficiaries will be eligible to receive services for high utilizers, enhanced services will be provided to those recently incarcerated and to those homeless or at risk of homelessness.

High Utilizers

Through the analysis and determination of the target population, the WPC committee was quick to ascertain a lack of coordination of services within the community to meet this population's needs. Although many services are being provided, they are not coordinated across organizations. This lack of coordination has led to redundancy in services provided and a lack of follow-through on referrals outside of the referring agency. To address these shortfalls, this pilot will provide the following services, available to all WPC beneficiaries:

- Information sharing across partnering organizations
- Wellness Education including hygiene, healthy eating, women's health, fitness, risk factor reduction interventions, preventive medicine counseling and behavior change interventions
- Lifestyle Education including personal finance, home care, parenting, resume building, employment training
- Care Coordination
- Personalized care plans
- Frequent in home care and assessments
- Regular Mental Health screenings

- Telephone visits
- PharmD Medication therapy management services
- Health Coach
- Panel Management
- Home Nursing visits for acute or chronic disease management, including history taking, physical exam, phlebotomy, assessment of ADL and adjustment of diet, activity level or medications
- Podiatry Services

As many of the positions providing the services above will also be providing services reimbursable by Medi-Cal, budgeted positions within this proposal have been adjusted accordingly so that services are not being reimbursed multiple times. These services are meant to improve upon the health of the whole individual by addressing the physical, behavioral and social elements contributing to the health of each beneficiary.

Care coordination plays a critical role in the success of this pilot and is used to refer to non-clinical functions including establishing and maintaining a care coordination plan, transition management, logistical assistance, timely and accurate transfer of patient information, referral tracking and follow-up, identifying and adjusting for barriers to care, being a source of support and point of contact for all beneficiaries. Care coordinators will be involved with population health management, needs assessments, resource brokerage and panel management. The qualifications required for a care coordinator does not exceed beyond a bachelor's degree, and this position will not be a registered nurse. The care coordinator will be the main point of contact for beneficiaries; they will build relationships of trust with beneficiaries, which will lead to more successful outcomes. The frequency of care coordination will be much higher than is currently reimbursed by Medi-Cal, which the partnering organizations feel is critical to the success of this pilot.

The REACH clinic was established in 2014 through collaboration between Kern Medical Center and a local Managed Care Organization, and is an NCQA certified patient centered medical home. The results precipitated throughout the two years of operation have far exceeded expectations, including a reduction of ED visits by 42.6% and the associated costs of those visits by 46% as well as a reduction in acute inpatient hospitalizations by 28.1% and the associated costs by 13.9%. Building upon that foundation, prior to the announcement of the Whole Person Care pilot program, Kern Medical Center had begun discussions to establish a behavioral health medical home (GROW), which provides for all of the same services found within REACH, but includes specialized behavioral health service through a partnership with Kern County Mental Health. To address very specific conditions prevalent within the community, Kern Medical Center has a number of patient centered specialty practices which follow the model of a PCMH, but for specialty practices and provide enhanced services focused on specific ailments, namely Diabetes, Hypertension and HIV/AIDS.

Whole Person Care will expand upon this proven model by integrating a greater level of care coordination across various organizations addressing more than physical and behavioral health, but also social determinants of health. The services provided within the patient centered medical homes positions them perfectly as hosts to whole person care coordination teams. By locating the entire care coordination team in these medical homes and creating a beneficiary focused mission of whole person care, services provided will be exponentially enhanced and truly patient centric. A hallmark of this patient centered approach is the presence of a single, multidisciplinary, integrated Health Action Plan (HAP), which is tailored to serve each patient's unique needs.

Through the analysis of this population, it was identified that there are often barriers that prevent individuals from attending their appointments. These barriers can range from lack of transportation to lack of desire. In order to address these concerns, this pilot will develop a mobile team capable of providing on site services, which are otherwise not reimbursable through Medi-Cal. This team will provide home nursing visits by RNs to patients at home for acute or chronic disease management. These visits may include taking a history, physical exams, phlebotomy for lab testing, assessment of ADL, and adjustment of diet, activity level or medications. Nursing visits will also include skilled services by an RN for management and evaluation of the plan of care (HCPCS G0162). These mobile teams will be dynamic in staffing, dependent on the needs of the patients scheduled on a given day. At times these visits will simply provide social support, life coaching, supportive interventions and hygiene coaching, which will not require a licensed professional. Staffing for the mobile teams will be comprised of:

- Nurse Practitioner
- Registered Nurse
- Medical Assistant
- Behavioral Health Specialist
- Substance Abuse Specialist
- Probation Officer – Probation Officers will be necessary for mobile team visits of beneficiaries on parole or recently released from incarceration

It is anticipated that mobile visits will occur frequently upon initial enrollment into the program. As beneficiaries become stabilized and reliable, these visits decline, replaced by in office visits. Notwithstanding an increase in reliability, the target population is often unable to attend appointments or services due to a lack of child care. The Community Connection for Child Care (CCCC) is a local child care advocacy group. Through this pilot, CCCC will provide beneficiaries with child care services for physical and behavioral health appointments, lifestyle education, job training courses and employment interviews.

The information gained through mobile visits will be invaluable to each beneficiary's plan of care. This pilot has partnered with a local food bank, Golden Empire Gleaners, to provide food for those individuals who have shown evidence of inability to properly nourish themselves. As the need is provided for, education will also be given both within and without of the home on food preparation and proper food handling.

As chronic conditions can make consistent employment difficult, the pilot has partnered with Kern County Employers' Training Resource (ETR) to provide workforce training on personal finance, resume building and interview skills. Through discussions with ETR a concern was voiced that often more extensive services are provided with little to no benefit, as the individuals are still building basic life skills. For that purpose, the general education services will be provided to all beneficiaries, but for those who consistently meet their goals and who are medically stable, and have a desire, will receive more enhanced individualized services to build interviewing skills, assistance in developing a resume, help with finding and applying for jobs, and all other items needed in order to be prepared for interviews. Once employed, these individuals will have a resource for questions and advice for a duration of at least six months. Dependent on the specific needs of the beneficiary, this resource can be extended in order to ensure long term employment.

Many individuals included in the identified target population are eligible for existing services but do not understand or cannot locate sources for gaining access to these services. Care coordinators will make referrals to the

Department of Human Services (DHS), who will provide education on and assistance in enrolling in eligible programs and services, such as, Safety Net Programs, CalFresh, and/or CalWORKs to WPC beneficiaries.

Of patients currently enrolled in the REACH clinic 18% exceed 60 years in age. This pilot will work with Kern County Aging and Adult Services (AAS) to provide referrals for WPC beneficiaries who would benefit from AAS's services which include social support through group events, meals on wheels, and non-medical in-home support services. These services will not be funded with WPC funding.

Kern County Public Health (KCPH) was the originator of the KGC program which provided many lessons learned that are incorporated in this WPC strategy. Given this, KCPH will be used to train the Mobile Care Team in whole health assessment skills which will provide the Mobile Care Team the ability to assess not only the patient but the entire environment and its impacts on the beneficiary's health.

Homeless or at Risk of Homelessness

The Kern County Housing Authority is a public corporation focused on providing safe housing for homeless persons. They are a contributing member of the Kern County Homeless Collaborative (KCHC) and the local Continuum of Care (COC). The KCHC is a network of nonprofit service providers, businesses, charitable and faith-based organizations, volunteers, homeless or formally homeless individuals, and working together to end homelessness. During the Housing & Health Care Coordination Initiative in Southern California, members of the Kern County COC along with the Director of WPC participated in a strategic planning session attempting to address the homeless problem within Kern County. Through this planning session, the group determined that implementing a Housing Navigator position within the community would drastically improve the opportunity for individuals to not only find, but remain in housing.

Housing navigators will work closely with care coordinators to identify barriers to provide communication on housing efforts and to share any foreseen obstacles that would have an impact on future care. Housing Navigators will assist beneficiaries with the entire housing process, and continue to assist beneficiaries after housing has been secured. This ongoing support will help beneficiaries build relationships with property owners and create a stable atmosphere. Specific services can be categorized into two groups, transition services – finding and securing housing, and sustaining services – creating long-term housing solutions.

Individual Housing Transitions Services:

- Conducting tenant screening and housing assessments
- Developing individualized housing support plans
- Assisting with the housing application and/or search process
- Identifying and securing resources to cover expenses allowable the abovementioned CMCS bulletin
- Ensuring that the living environment is safe and ready for move-in
- Assisting in the move by identifying moving resources
- Developing a crisis plan that includes prevention and early intervention services when housing is jeopardized

Individual Housing and Tenancy Sustaining Services:

- Providing early identification and intervention for behaviors that may jeopardize housing

- Educating and training on the role, rights, and responsibilities of the tenant and landlord
- Coaching on developing and maintaining key relationships with landlords/property managers
- Assisting in resolving disputes with landlords and/or neighbors
- Advocating and linking individuals to community resources when housing may become jeopardized
- Continuing training on being a good tenant

As the workload and resources required for this initiative are so intensive, housing navigation services will be capped at 20 individuals at a given time. Once an individual has remained in housing for 6 months, they will no longer be assigned to a housing navigator, and regular checkups will be performed by the care coordinator. These positions will be funded through the Housing Authority of Kern County; no WPC funds will be used to staff these positions. In accordance with STC 114(b), housing pool investments in housing units or housing subsidies including payment for room and board will not be eligible for WPC Pilot payments unless otherwise identified in CMS Informational Bulletin, 'Coverage of Housing-Related Activities and Services for Individuals with Disabilities.

Recently Incarcerated

Incarcerated individuals often suffer from medical, behavioral, or substance abuse conditions. While incarcerated, their medical and behavioral health needs are routinely provided for, with little effort required by the individual. Doctors are brought to the individual, medications are circulated on a regular schedule without cost to the individual, and there is consistent follow-up. Unfortunately, when these individuals are released from incarceration they are subsequently cut off from the care provided during that time. With freedom comes an extra responsibility of taking care of one's self, but this is often overlooked due to time and financial constraints, or lack of adequate skills. Also, as mentioned above, some of these individuals are released to homelessness. Given these challenges this pilot will provide for an enhanced level of care coordination for 90 days.

In order to address the needs of this population, this pilot will establish a clinic directly outside of the facility so that upon release, prisoners who have obtained presumptive Medi-Cal eligibility can obtain an immediate wellness check. Two PharmDs will reside in the clinic to provide medication reconciliations, medication education regarding chronic diagnosis management, and ensure that these individuals have two weeks of prescriptions and means to retrieve these prescriptions. Two registered nurses will work in the clinic to provide for comprehensive discharge planning. The nurses will complete a full health risk assessment, provide any specialized medical training, and evaluate needs for durable medical equipment. Working closely with office staff, the nurses will provide for a smooth transition of care to the primary care environment through scheduling a two-week checkup. Office staff in the clinic will assist the beneficiaries in identifying and applying for programs for which they are eligible, enroll the individuals in Whole Person Care and facilitating the scheduling of a follow-up appointment.

In coordination with our Health Education Department we will offer during this 90 day period a variety of Life Skills Transition Classes, geared to lower recidivism amongst this very fragile population. In conjunction with their initial post incarceration visit, a post incarceration liaison will be added to the care coordination team to help assess the member's specific transitional course needs. The post incarceration liaison will also be tasked with tracking the status of class enrollment and attendance, transportation needs, reincarceration status, as well as members that disenroll, or graduate. Some examples of our Life Skills Transition Classes may include, Crime Theory - Breaking the Cycle, Anger Management, Coping Skills, Co-Dependency, Parenting, and Relapse Prevention. These courses will assist the beneficiaries in building structure with the challenges of post-incarceration.

At the conclusion of 90 days this post incarceration team will assess the members' success and provide a report for our Quality review team to assess monthly for system improvement.

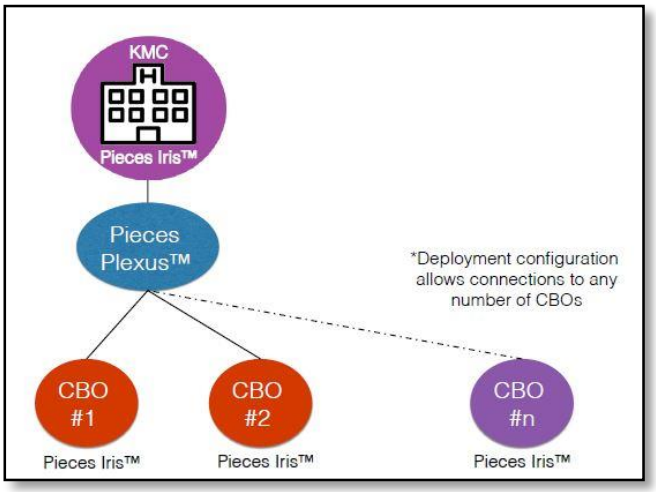
These beneficiaries will receive an enhanced care coordination PMPM for 3 months post release in addition to the standard complex care coordination PMPM bundle. These beneficiaries will count as one member month for the entire calendar month in which they enroll in Whole Person Care, and will be counted for a maximum of 3 member months.

3.2 Data Sharing

Coordinating data sharing across organization was identified early in the process as a challenge. Implementing a new software system within any organization can be a major feat, and attempting to implement a software system across multiple organizations can be near impossible. This requires changes in workflows, processes and behaviors. As a result of these challenges, we have developed a thorough approach to data sharing, maintaining a level of control at the lead entity, and offering incentives. The success of this pilot will help to perpetuate the support of this initiative across organizations.

Currently the WPC program plans on deploying the Pieces Plexus and Pieces Iris software systems Developed by PCCI. PCCI is a non-profit research and development company in Dallas, TX focused on real-time predictive and surveillance analytics for healthcare. PCCI's software interprets EMR data in real time and translates it into useful intervention warning tools that assist physicians and hospitals on complex clinical decisions in every field of medicine to better treat patients. The Pieces platform uses electronic medical record (EMR) for data collection, early disease detection and monitoring and care coordination for patients with chronic medical conditions (CMC). Pieces helps patients get care sooner to reduce hospitalizations, unplanned readmissions, and cardiovascular events and deaths.

Iris is case/care management software and Plexus is the central hub, which also includes data analytics and predictive modeling services. The Iris software will be used (web based) by each participating organization and the information they collect will be shared across all WPC participating organizations. See Figure 3 below. This platform will provide for bi-directional data sharing across the partnering organizations.



The participating agencies can be classified in two category types: medical and support providers. Supportive providers (i.e. DHS, Housing Authority, ETR, etc.), those that to do not clinically care for beneficiaries, will capture social determinant data on WPC beneficiaries. Social determinant data includes:

- Education level
- Employment status
- Dietary status
- Housing situation
- Disabilities
- Legal status
- Family life
- Social services support needs
- Transportation needs

Medical support providers will capture their customary patient care data within their respective EHR and a data migration will occur into the Plexus platform where future risk and predictive modeling can occur.

WPC Data Exchange Implementation Timeline		
Mo.#	**Month**	**Product/Service**
1	November'16	Pieces DS
2	December'16	Model configuration
3	January'17	
4	Februar'17	Pieces DS launch
5	March'17	Iris Implementation
6	April'17	Iris Launch

The largest data challenge the WPC program will face is strict local, state, and federal laws associated with the sharing of PHI. This includes FBI and DOJ information from participating organizations such as KCSO and Probation or in the case of behavioral health systems certain mental health and substance use disorders. Given this, each respective organization will only be able to view data pertinent to their area of participation. For example, the food bank agency does not need to know, nor can they see what any particular individual is being treated for; they only need to see that the individual is eligible, and has been referred, for food bank services. Regardless, and to comply with local, state, and federal law, each participating organization will enter into a business associate agreement (BAA) to cover the confidentiality of PHI.

In addition to the execution of BAAs, and since the WPC program is an opt-in program, the WPC program will develop standardized consent forms for all participating agencies in order to obtain the beneficiary's permission for care coordination and for the sharing of data. In addition to the consent from, the WPC program will develop

standardized templates and questionnaires to be used by all WPC participating agencies. This will be necessary to build data integrity which will be critical to the success of the program.

An additional data challenge the WPC program will encounter is the need to alter/customize the established data system to meet the changing needs of the program as it continues to develop. Because of unforeseen data system modification needs, the WPC program will build data system change contingency costs in the budget. The vendor has provided us with an hourly rate for additional changes to the system. This will allow us to build a true data integration process which will contribute to the success and sustainability of the program.

A challenge that was identified early on is the ability of the partnering organizations to use this software concurrently with their already established systems. For those organizations whose system is capable, funds have been budgeted in order to establish an interface between their data system and Iris. In addition, for the initial partners, funds are being budgeted to provide for a position to be stationed at each partnering agency to assist in implementing processes throughout the partnering organization and providing support to ensure maintenance and integrity of the data. These positions will report directly to the lead entity, and will allow for accountability with regards to data sharing. Without proper safeguards on data sent to the database, a program of this magnitude is bound to fail. For this reason the WPC program will enlist the expertise of a database analyst and a health systems analyst to monitor and extract usable data pertinent to the objectives of the program. These two positions will also be critical in monitoring and assuring true data integrity and assuring a garbage-in/garbage-out (GI/GO) condition is not created.

Evolution of the data system is another challenge and will occur as changes are needed and deficiencies are identified. One early evolution of the data system will be realized in the referral process. Initially, only the MCPs will be able to refer WPC beneficiaries. However, as the program progress agencies will need to be able to refer WPC beneficiaries. Given this, this function will be built into the software package allowing for an easy transition.

Data governance for the system will be maintained through the steering committee. Before additional data is incorporated into the system, the steering committee must approve the addition, and identify sources of data. Staff located at each partnering organization will work to ensure the proper flow of data into the Pieces system and along with the database team, they will work to validate data and work with each organization to incorporate this additional data into their workflows. Although each partner will independently govern their own respective data systems, it is critical that any changes to how data is collected, or where data is stored, are communicated quickly so that changes to the external mapping can be adjusted.

Section 4: Performance Measures, Data Collection, Quality Improvement and Ongoing Monitoring

4.1 Performance Measures

Performance measures have been established within the pilot to measure progress and to allow for accountability across the organizations.

The following performance measures have been created for all WPC participating agencies.

- It is expected that each participating agency will be actively involved in the identification of barriers and resolution of those barriers. This will be measured based on attendance to respective committee meetings, as noted in the minutes of the meeting. Those unable to attend committee meetings who receive prior

approval from the Director of Whole Person Care and who submit notes and suggestions prior to meeting will be counted as successfully fulfilling this metric.

- It is expected that information regarding program beneficiaries will be updated timely and accurately within the data sharing system. Details should be entered within the system within 30 days of service. This will be measured by comparing the record creation date within the system to the date of service provided. Performance targets will be 60% during PY2, 65% for PY 3, 70% PY4 and 75% PY5

The following performance measures will be monitored by the steering committee to determine the effectiveness of pilot efforts:

- Housing Authority: WPC beneficiaries referred to housing navigation services are contacted by navigator within 30 days: 60% during PY2, 65% for PY 3, 70% PY4 and 75% PY5.The purpose of this performance measure is to measure ability and capacity of Housing Navigation staff, as well as responsiveness.
- KCPO: Parole Officers provide security to Mobile Care team while in the field assessing WPC beneficiaries currently on parole or recently released from incarcerations no less than 50% of the time. The purpose of this performance measure it to assure security for the Mobile Team while in the field only for individuals on probation or recently released from incarceration.
- GEG: WPC beneficiaries referred for food bank services receive identified food box provisions within 2 weeks: 50% PY2, 55% PY3 60% PY4 and 65% PY5. This metric will measure the efficiency and ability of care teams to work with community partners to achieve timely results.
- ETR: Enhanced employment training outreach within 2 weeks of referral: 50% PY2, 55% PY3 60% PY4 and 65% PY5. This metric measures the efficiency and ability of care teams to work with community partners to achieve timely results.
- CCCC: Child care outreach within 2 weeks of referral: 50% PY2, 55% PY3 60% PY4 and 65% PY5. This metric measures the efficiency and ability of care teams to work with community partners to achieve timely results.
- KCMH: PHQ-9 form used on all WPC beneficiaries referred for behavioral health interventions for the following annual benchmarks: Maintain baseline PY2 PY3-5 5% improvement over prior year, if the 90 percent is achieved, performance will be achieved through maintenance of 90%. The purpose of this performance measure is to measure and promote the use of the PHQ-9 evaluation.
- AAS: Contact made within 2 weeks of referral: 50% PY2, 55% PY3 60% PY4 and 65% PY5. This metric measures the efficiency and ability of care teams to work with community partners to achieve timely results.
- KCPH: Referral response within 2 weeks of receiving referral. 50% PY2, 55% PY3 60% PY4 and 65% PY5. This metric measures the efficiency and ability of care teams to work with community partners to achieve timely results.

The following performance measures have been created for the WPC program:

- Reduction in ER usage. This performance measure will have the following annual targets: PY2 maintain baseline, in each subsequent year, reduce ER utilization by 5%. Reductions in ER utilization are critical to the overall success of this project. Overutilization of the ER leads to higher healthcare costs, crowded waiting rooms and low patient satisfaction. A reduction in ER visits will save costs and provide for better healthcare.

- Reduction in inpatient utilization. This performance measure will have the following annual targets: PY2 maintain baseline, in each subsequent year, reduce inpatient utilization by 5%. This metric will gauge overall success of the pilot. Healthcare delivery is most expensive within the inpatient setting, and a reduction in utilization will yield significant cost savings and provide for better care to beneficiaries.

- Follow-up after hospitalization for mental illness (NCQA). Targets for this metric are to maintain the baseline in PY 2, and then in each subsequent year improve performance by 5% over the prior year, if the 90th percentile is achieved, then performance will be achieved through maintenance of the 90th percentile. Follow-up visits after hospitalization allows for a more seamless transition to the home and work environment, and encourages retention of gains made during hospitalization.

- Initiation and engagement of alcohol and other dependence treatments (NCQA). Performance targets have been set to maintain the baseline in PY 2, and in each subsequent year improve performance by 5%, if the 90th percentile is achieved, then performance will be achieved through maintenance of the 90th percentile. These dependencies are one of the most preventable health conditions, and evidence has shown that improving upon alcohol and other drug dependencies can drastically improve health and social outcomes, as well as creating a large source of financial savings.

- Proportion of participating beneficiaries with a comprehensive care plan, accessible by the care team within 30 days. This metric will have a target of 60% in PY2, 65% in PY3, 70% PY4 75% PY5. The purpose of the measure it to assure timely access to the care plan to the entire care coordination team so that team members are apprised of beneficiary needs and goals and updates can be made.

- Percentage of adult patients age 18 and older with major depression or dysthymia and an initial PHQ-9 score > 9 who demonstrate remission at twelve months defined as PHQ-9 score less than 5 (NQF 0710). In PY 2 the target will be to maintain the baseline, in each subsequent year improve upon prior year by 5%. Those with a diagnosis of depression are significantly more likely to have cardiovascular disease, diabetes, asthma and obesity, be a smoker and be physically inactive and to drink heavily. Standardized and regular use of the Patient Health Questionnaire (PHQ-9) will help to identify symptoms and begin early treatment and interventions preventing more severe diagnoses later.

  During the 2016 Community Needs Assessment, research identified 17.1% of adults in Kern County experienced some form of behavioral health distress and 21.4% of adults needed help for emotional, mental health, alcohol or drug issues and 85.5% of those who sought help did not receive it. Also, through medical cart audits of Kern Medical Center records, it was learned that many incarcerated individuals also suffer from behavioral health conditions. Additionally, during the 2015 Homeless Census Report, it was learned that 109 individuals were hospitalized for behavioral health conditions. Finally, lessons learned from the KGC program also indicated many high utilizers of emergency services suffer from behavioral health conditions.

  Given the identified disparity in behavioral health needs compared to actual services provided, it is important to accurately identify and address local behavioral health conditions. Moreover, our WPC care

coordination integration with behavioral health providers has great potential in addressing these deficiencies.

- Comprehensive diabetes care, percentage of individuals with a diagnosis of diabetes who had an Hba1C <8.0% during the year. PY2 target will be to maintain the baseline, each subsequent year will improve by 2% over the prior year, if the 90th percentile is achieved, future year targets will be to maintain the 90th percentile. Diabetes is recognized as a leading cause of death within the US, and further complications include poor circulation, damaged nerves in the feet as well as damage to the kidneys.

  Per Healthy Kern County, during the 2010 Kern County Community Needs Assessment, "Kern County placed in the bottom quartile of California counties for *all* diabetes-related indicators. The age-adjusted diabetes death rate averaged over 3 years (2006-2008) is nearly 34 per 100,000 compared to the State value of 21 per 100,000.

  Kern County ranks in the bottom ten percent for all hospital utilization rates due to diabetes-related admissions and emergency room visits. During the 2006-2008 measurement period, the hospitalization rate due to diabetes was 28.4 hospitalizations per 10,000 population and ranked 55 out of 58 California counties. The hospitalization rate due to long-term and short-term complications of diabetes was 17.2 and 8.9 hospitalizations per 10,000 population, respectively – ranking 52nd and 54th out of 58 California counties."

  Given the above measurements, this metric will help the WPC program understand the performance of this pilot in addressing this need within the county. Additionally, early diagnosis and education on diabetes management will prevent downstream complications, improving the overall health of the WPC population.

- Hypertension is a comorbidity for diabetes and heart disease. In the 2016 Community Health Needs Assessment, research identified 40.3% of adults in Kern County have been diagnosed with hypertension. These rates were higher than the state average of 28.5%. Given the high number of diabetes and heart disease diagnoses in Kern County this is not a surprise.

  Given the focus of the WPC program, the county health needs, and the connection with other diseases, such as diabetes, it is important to accurately identify and address this health condition within our WPC population. Moreover, our WPC care coordination integration with specialty centers provides great potential in addressing this medical condition and improves health outcomes for our population.

  PY2 target will be to maintain the baseline, each subsequent year will improve by 5% over the prior year, if the 90th percentile is achieved, future year targets will be to maintain the 90th percentile. Preventive medicine has been proven to be more effective and efficient than diagnostic treatment. By encouraging and completing regular screenings for those at risk, this pilot aims to address possible complications as soon as possible.

4.1.a Universal Metrics

X Health Outcomes Measures

X Administrative Measures

4.1.b Variant Metrics

Variant Metric	PY 1	PY 2	PY 3	PY 4	PY 5
Administrative Metric	WPC Committee meeting effectiveness	WPC Committee meeting effectiveness	WPC Committee meeting effectiveness	WPC Committee meeting effectiveness	WPC Committee meeting effectiveness
	This measure is tied to budgeted meeting incentives. The rationale behind this metric is that through past experiences, we have seen support for multi-departmental projects such as this wane after the initial launch. This metric allows for incentivizing partnering agencies to continue to participate not just in the operation of the pilot, but also in the overarching strategic discussions and process improvements throughout the entire process. We understand that regular communication across entities is critical to the success of this pilot. This metric will be measured by percentage of partnering agencies in attendance at the meetings, with exceptions for those excused with prior notice, and will be reported with minutes from the meetings covering items discussed, lessons learned and action items.				
Adult Major Depression Disorder (MDD): Suicide Risk Assessment (NQF 0104) or Alternative Metric	Comprehensive Diabetes Care: HbA1C Poor Control <8%	Comprehensive Diabetes Care: HbA1C Poor Control <8% **Benchmark:** Maintain Baseline **Numerator:** Within the denominator, who had HbA1c control (<8.0%) **Denominator:** Members 18–75 years of age with diabetes (type 1 and type 2)	Comprehensive Diabetes Care: HbA1C Poor Control <8% **Benchmark:** 2% improvement over prior year **Numerator:** Within the denominator, who had HbA1c control (<8.0%) **Denominator:** Members 18–75 years of age with diabetes (type 1 and type 2)	Comprehensive Diabetes Care: HbA1C Poor Control <8% **Benchmark:** 2% improvement over prior year **Numerator:** Within the denominator, who had HbA1c control (<8.0%) **Denominator:** Members 18–75 years of age with diabetes (type 1 and type 2)	Comprehensive Diabetes Care: HbA1C Poor Control <8% **Benchmark:** 2% improvement over prior year **Numerator:** Within the denominator, who had HbA1c control (<8.0%) **Denominator:** Members 18–75 years of age with diabetes (type 1 and type 2)

Depression Remission at Twelve Months or Alternative Metric (NQF 0710)	PHQ-9 Depression Remission at 12 Months NQF 0710	PHQ-9 Depression Remission at 12 Months NQF 0710 **Benchmark:** Maintain baseline **Numerator:** Adults who achieved remission at twelve months as demonstrated by a twelve month (+/- 30 days) PHQ-9 score of less than five **Denominator:** Adults age 18 and older with a diagnosis of major depression or dysthymia and an initial PHQ-9 score greater than nine during an outpatient encounter	PHQ-9 Depression Remission at 12 Months NQF 0710 **Benchmark:** 5% improvement over prior year **Numerator:** Adults who achieved remission at twelve months as demonstrated by a twelve month (+/- 30 days) PHQ-9 score of less than five **Denominator:** Adults age 18 and older with a diagnosis of major depression or dysthymia and an initial PHQ-9 score greater than nine during an outpatient encounter	PHQ-9 Depression Remission at 12 Months NQF 0710 **Benchmark:** 5% improvement over prior year **Numerator:** Adults who achieved remission at twelve months as demonstrated by a twelve month (+/- 30 days) PHQ-9 score of less than five **Denominator:** Adults age 18 and older with a diagnosis of major depression or dysthymia and an initial PHQ-9 score greater than nine during an outpatient encounter	PHQ-9 Depression Remission at 12 Months NQF 0710 **Benchmark:** 5% improvement over prior year **Numerator:** Adults who achieved remission at twelve months as demonstrated by a twelve month (+/- 30 days) PHQ-9 score of less than five **Denominator:** Adults age 18 and older with a diagnosis of major depression or dysthymia and an initial PHQ-9 score greater than nine during an outpatient encounter
Controlling High Blood Pressure	Controlling High Blood Pressure	Controlling High Blood Pressure **Benchmark:** Maintain Baseline **Numerator:** Within the	Controlling High Blood Pressure **Benchmark:** 5% improvement over prior year **Numerator:** Within the	Controlling High Blood Pressure **Benchmark:** 5% improvement over prior year **Numerator:** Within the	Controlling High Blood Pressure **Benchmark:** 5% improvement over prior year **Numerator:** Within the

		denominator, whose BP was adequately controlled during the measurement year based on the following criteria: • Members 18–59 years of age whose BP was <140/90 mm Hg. • Members 60–85 years of age with a diagnosis of diabetes whose BP was <140/90 mm Hg. • Members 60–85 years of age without a diagnosis of diabetes whose BP was <150/90 mm Hg **Denominator:** Members 18–85 years of age who had a diagnosis of hypertension (HTN)	denominator, whose BP was adequately controlled during the measurement year based on the following criteria: • Members 18–59 years of age whose BP was <140/90 mm Hg. • Members 60–85 years of age with a diagnosis of diabetes whose BP was <140/90 mm Hg. • Members 60–85 years of age without a diagnosis of diabetes whose BP was <150/90 mm Hg **Denominator:** Members 18–85 years of age who had a diagnosis of hypertension (HTN)	denominator, whose BP was adequately controlled during the measurement year based on the following criteria: • Members 18–59 years of age whose BP was <140/90 mm Hg. • Members 60–85 years of age with a diagnosis of diabetes whose BP was <140/90 mm Hg. • Members 60–85 years of age without a diagnosis of diabetes whose BP was <150/90 mm Hg **Denominator:** Members 18–85 years of age who had a diagnosis of hypertension (HTN)	denominator, whose BP was adequately controlled during the measurement year based on the following criteria: • Members 18–59 years of age whose BP was <140/90 mm Hg. • Members 60–85 years of age with a diagnosis of diabetes whose BP was <140/90 mm Hg. • Members 60–85 years of age without a diagnosis of diabetes whose BP was <150/90 mm Hg **Denominator:** Members 18–85 years of age who had a diagnosis of hypertension (HTN)
Housing-Specific Metric (if applicable)	Percent of homeless receiving housing services	Percent of homeless receiving housing services	Percent of homeless receiving housing services in PY	Percent of homeless receiving housing services	Percent of homeless receiving housing services in PY

	in PY that were referred for housing services	in PY that were referred for housing services **Benchmark:** Maintain baseline **Numerator:** Number of participants referred for housing services that receive services **Denominator:** Number of participants referred for housing services	that were referred for housing services **Benchmark:** 5% improvement over prior year **Numerator:** Number of participants referred for housing services that receive services **Denominator:** Number of participants referred for housing services	in PY that were referred for housing services **Benchmark:** 5% improvement over prior year **Numerator:** Number of participants referred for housing services that receive services **Denominator:** Number of participants referred for housing services	that were referred for housing services **Benchmark:** 5% improvement over prior year **Numerator:** Number of participants referred for housing services that receive services **Denominator:** Number of participants referred for housing services

4.2 Data Analysis, Reporting and Quality Improvement

Currently existing sources of data are diverse and decentralized; each respective participating organization has their own data system. This diversity in data systems creates a great deal of variability and challenges. These data systems vary in sophistication just as much as they vary in the amount and type of data collected. Due to this diversity initial data aggregation, reporting, and analysis will rely heavily on manual methods of sharing data as an automated approach is established.

Initially, and absent an established data exchange or health information exchange, data collection processes for the Kern County WPC project will use simple forms of data sharing. The referring MCPs will simply provide referral sheets in an Excel spreadsheet via SFTP. PCMH and PCSP care coordination staff will access these referral sheets and, upon initial beneficiary assessment, will enter WPC beneficiary's pertinent information into Kern Medical Center's EHR. The PCMH and PCSP care coordination staff will then refer beneficiaries to any services provided by our participating organizations.

Referrals for WPC services provided by participating agencies will initially be accomplished by a simple form which will be sent with the beneficiary to the participating agency to program coordinators stationed at each participating entity. The care coordination team will capture these referrals in the notes of the EHR. Participating agencies will capture referral and pertinent information from the form in simple Excel spreadsheets for tracking purposes. On a monthly basis, participating agencies will provide copies of their spreadsheets to the lead entity for aggregation and analysis. This process will continue until a true data exchange can be established.

As noted earlier, Kern Medical Center has evaluated several integrated data exchange systems (see Section 3.2 for anticipated project timeline). Currently the WPC program plans on deploying the Pieces Plexus and Pieces Iris software systems. Iris is case management software and Plexus is the central hub which also includes data analytics and predictive modeling. Plexus will be able to provide predictive modeling on beneficiaries who are at risk of greater illness as well as which beneficiaries will likely generate the most health care costs in the future. The Iris software will be used (web based) by each participating organization and the information they collect will be shared across all WPC participating organizations.

Finally, having the entire WPC beneficiary data housed in one location will facilitate the ability of the program to generate custom reports using common reporting tools. The success of the reporting capabilities will also be greatly increased with the inclusion of a Data Analyst, Healthcare Analyst, and Research Director positions and other committees.

Initially, in PY 2, reports will be run and analyzed on a weekly basis. For PY 3-5 reports will be run and analyzed on a monthly basis. Initial analysis of the reports will focus on the validity of data integrity, reports, and current processes. During this process all aspects of the WPC program will be evaluated using the PDSA. The PDSA principles can be applied to any process or functions within an organization and is essential to eliminating process variance. The PDSA approach is cyclical in the sense that the monitoring and necessary adjustments are conducted on revolving process; each process is reevaluated on a regular basis.

In conjunction with the abovementioned data practices, Kern Medical Center has established collaborative advisory/oversight committees, departments, and work groups tasked with assisting in more completely and cohesively aligning the combined goals, objectives, and metrics of PRIME with other quality-based initiatives and improvements. These committees (includes WPC committees), departments, and work groups, listed below, will be leveraged for the WPC program:

- An OP Quality Department tasked with implementing rapid-cycle improvement plans and comprehensive, continuous quality assurance/improvement methodologies ;

- A Care Coordination Department tasked with establishing the methodologies/protocols necessary to achieve respective core components/metrics;

- An Outpatient Integration Team tasked with further aligning our resources and competencies with the corresponding objectives of WPC realization;

- A LEAN Six Sigma-centered Performance Improvement Team tasked with using said principles and practices towards identifying respective gaps in process, flow, and outcomes.

As process variations are identified using the processes above, the same committees, departments, and work groups will develop strategies for implementing the necessary changes and the PDSA process will be repeated. Once an

established process has been determined to be functioning properly, that process will be reevaluated on a quarterly basis and identified variation will be addressed.

4.3 Participant Entity Monitoring

This application provides a robust plan of coordination across multiple organizations. The level of work and attention required to make this pilot a success is substantial, and as such, processes will be in place to monitor entities to ensure the program is producing the anticipated outcomes. Each participating agency, and WPC program as a whole, will be required to submit regularly scheduled data reports providing the details necessary to evaluate performance. Should any of the following conditions occur, an in-depth evaluation of the participating agency will be conducted.

- Any performance measures not being met in four consecutive months
- Any outcomes not being met by a margin greater than 20% in four consecutive months
- Failure to provide information for 4 consecutive months
- Any combination of two or more of the abovementioned not being met in two consecutive months
- Intentional violation of established policies and/or procedures

The evaluation of the participating agency will be conducted by an ad hoc Evaluation Committee consisting of:

- WPC Director from the lead entity
- One member of the WPC Collaborative Committee
- One of the Care Coordinators from one of the PCMH or PCSP
- LEAN Six Sigma team member

The Evaluation Committee will review all applicable processes and data in an attempt to identify the source of unanticipated results. Upon completion of the review, the evaluation committee will provide the WPC Committee with a summary report consisting of:

- Review/conclusion of established processes
- Review/conclusion of established data practices and reports
- Review/conclusion of established performance measures
- Review/conclusion of established outcomes
- Summary of review findings (i.e. data structure inadequate, performance measure unrealistic, etc.)
- Evaluation Committee recommendation/s

The Evaluation Committee will be vested with the authority to recommend any one, or a combination of, the following actions:

1. Revision Requested – Evaluation of area in question requires the revision to an existing policy, process, data processes, performance measure, outcome, or incentive due to poor design or evolutions in the WPC program landscape.
2. Review Meeting – Meeting with participating agency, or WPC Lead Entity, to review identified issues and formulate strategies to resolve the issue and prevent reoccurrences.

3. Recommendation for Remediation – Should deficiencies by a participating agency be identified, the agency will have sixty days to provide a written plan of action for correcting the deficiencies. The plan of action will be reviewed and approved by the Evaluation Committee. Should consensus not be met, the plan may be revised and delivered within thirty days.
4. Recommendation for Removal – Based on evaluated processes and evidence, Evaluation Committee can recommend the participating agency be removed from the WPC program. Should this occur, the participating agency, or program, will have an opportunity to appeal the decision of the Evaluation Committee to the WPC Committee after providing a corrective action plan to address the identified deficiencies.

Section 5: Financing

5.1 Financing Structure

The lead entity will work to develop MOU's with the participating entities to establish a formal agreement regarding the flow of funds between the organizations. Upon the completion of these MOU's, the entities will have the ability to invoice the lead entity for services provided on a monthly basis. The finance department of the lead entity will provide oversight of the funds, and, with the approval of the Director of Whole Person Care and their direct superior, be authorized to make payments on behalf of the pilot. Partnering agencies will have the ability to invoice for incentive payments twice annually, after they have received written notification from the WPC committee indicating whether or not the incentives have been earned.

The lead entity will request funds twice annually through the submission of the Mid-year and Annual reports. The lead entity will then respond to DHCS' request for the necessary intergovernmental transfer amounts from DHCS pursuant to Attachment GG within 30 days of the determination of payment due based on the mid-year or annual reports.

As indicated in the attached budget, this WPC pilot budget has a diverse payment structure.

Incentive payments, Pay -for-Reporting and Pay-for Performance metrics will be drawn down twice annually based on attainment, or partial of attainment, of the metrics at the time of the mid-year and annual reports. With each of these categories, partial attainment is allowed based on percentage of completion of the total goal.

Administrative Infrastructure provides for items that are truly administrative. The majority of these costs are related to database governance and program administration.

In addition, we have incorporated a mix of both Fee-For-Service (FFS) and Per Member Per Month (PMPM) service bundles. Through the development of this budget, we identified a number of items that were truly dependent on the volume of services provided, and there is an associated cost for each service. These funds will be requested on a claims based system and the tracking of these services will be initiated by the referral of the care coordinator. These referrals will require an element of follow-up, and in order for the participating entity to receive the associated funds, they will be required to invoice for these services, no more than once per month. Based upon these invoices and after reconciliation with care coordination referrals, the lead entity will draw these funds semi-annually.

Our PMPM bundled services will be invoiced based on enrollment. For any given member, a full member month will be counted for the entire month in which they enroll in the program. Upon disenrollment or graduation out of the pilot, a full member month will be counted for the month in which the disenrollment is effective. We have

identified 5 tiers of PMPM. Care Coordination services which all members will receive; Mobile outreach and engagement which all members will receive, upon graduation from the care coordination program, beneficiaries will still have follow-up from the mobile outreach team; Housing Navigator services which those who are homeless or at risk of homelessness will receive; specialized employment services, for those with a desire to, are physically able, and have been meeting care goals to obtain employment; and 90-Day post incarceration coordination which will meet the needs of individuals who have recently been released from incarceration for 90 days and then they will transition into the abovementioned standardized services. Within Iris, these individuals will be tracked based on the service bundles that they are receiving, and these payments for these individuals will be scheduled each half-year based upon reported enrollment. Funds will be drawn down semi-annually based on member months for the 6 months of the year.

As we monitor the beneficiaries, we will continually monitor utilization of inpatient services as well as utilization across various organizations. Results from our REACH clinic have already proved the benefit of medical homes, and it is anticipated that over time this model will provide for a drastic reduction in inpatient services, which in turn will provide for a drastic reduction in costs. We will continually compare the amounts saved to the amount of funding provided on their behalf. As we identify net savings, we will work with the managed care organizations to develop alternative payment methodologies which would have the potential to sustain this model post pilot.

5.2 Funding Diagram

Attached

5.3 Non-Federal Share

All participating public agencies will be providing the non-federal share for their respective incentive payments. For those unable to contribute non-federal share, the Lead Entity will provide the non-federal share. The Lead Entity will compile these funds, and submit 1 IGT to DHCS for the entire requested amount:

- Kern Health Systems
- Housing Authority of the County of Kern
- County of Kern

5.4 Non-Duplication of Payments and Allowable Use of Federal Financial Participation

Kern County's Whole Person Care application is currently limited to Medi-Cal beneficiaries. As such, it is not anticipated that any of these funds will be used for non Medi-Cal beneficiaries. The infrastructure budgeted for this pilot will be used exclusively for Whole Person Care beneficiaries. Generally, funding will be received after services have been provided. Payments will be clearly identified, and there should be little question as to whether monies have been earned.

The vast majority of the activities and interactions of the care coordination teams will not duplicate Medi-Cal's targeted case management ("TCM") benefit. Specifically, Activities of daily living, obtaining and maintaining safe housing, assisting with employment readiness (A comprehensive service in regards to how to search for a job, providing resume building assistance, coaching around proper interview attire and process, etc); social skills and family life services and supports; managing finances; benefits management (ie assisting in the application process for SSI, food stamps, housing assistance, or other eligible benefits); conducting needs assessments and providing referrals to community resources based upon identified needs extending beyond the scope provided for within TCM; and providing counseling and coaching to the patients identified support system in as much as the patient consents and/ or allows their involvement. These services depart significantly from the encounter-based structure of TCM, and in the vast majority of cases the encounters between this specialized WPC team and

patients/clients/members as they are not outlined in the services covered under the TCM program. Additionally, services included in the WPC project that do mirror services provided under the TCM program would not be eligible for reimbursement, as the workers either would not meet the educational/experience requirements for TCM case workers or the team members would be in a supervisory role and would have few, if any, direct contact with clients. In addition, there will not be a180 day time limit in which services, including those provided under the TCM benefit, are provided.

Moreover, the scope of care support and coordination activities available through WPC is intended to be more robust than available through Medi-Cal TCM. WPC teams will engage in activities such as peer support, trust-building, motivational supports, disease specific education, and general reinforcement of health concepts, which are distinct from and outside the TCM benefit. WPC will also provide direct social and other services that would not be recognized as TCM, such as those mentioned above. Specifically, the program is to provide intensive social support services that are not covered under either the TCM benefit, or billable under Medi-Cal. This population of patients are at high risk for homelessness therefore a great amount of focused support surrounding that problem are included in this program. For instance, support to obtain and maintain safe housing, followed by working one on one with patients in their effort to remain safely housed is included. This would include tasks such as promoting health and hygiene with proper coaching and assisting around house cleaning to ensure the home environment is safe and free of bugs etc, laundering clothing, budgeting, grocery shopping and food preparation, providing coaching around safe food hygiene such as putting away grocery items needing refrigeration timely, cooking items safely to avoid illness, etc. For these reasons, we have concluded that the vast majority of WPC Pilot activities will not duplicate services available through Medi-Cal TCM. However, in response to concerns of duplication of payment, we have applied a TCM budget adjustment of 5% to the care coordination PMPM from 495 to 470 PMPM. Each TCM budget adjustment can be found in the corresponding service description.

5.5 Funding Request

Project Year 1 Budget Narrative

PY 1 Budget Allocation (Note PY 1 Allocation is	
PY 1 Total Budget	32,987,300
Approved Application (75%)	24,740,475
Submission of Baseline Data (25%)	8,246,825

For Budget Year 1, the requested funding is for the submission of the application and the required baseline data.

Project Year 2-5 Administration Budget Narrative

For project years two through five the Kern County WPC Lead Entity requests funding for the following administration budget items:

- Director of Whole Person Care (1 FTE): This position is responsible for the day-to-day operations, oversight and fulfillment of the WPC program responsibilities to the lead agency, County of Kern, and DHCS. His/hers role is to provide program oversight; maintain partnering agency engagement; identify and promote the inclusion of new partnering agencies; ensure performance measures are being met; conduct regularly

scheduled meetings; program evaluation and improvement using PDSA; identify program barriers and implement solutions; supervise applicable staff; conduct data analysis; submit required reports and metrics; budget administration; and keep the WPC program running smoothly. The requested funding for this position is $200,000 annually ($1,000,000 for five-year program) which includes salary and benefits.

- PCMH and PCSP Director (REACH, GROW, Diabetes, Hypertension, and HIV/AIDS clinics) (0.5 FTE): This position is responsible for day-to-day oversight and operations of all the WPC PCMH and PCSP clinics. As care coordination teams will be housed within the PCMH, this position will spend a considerable amount of time providing oversight to care coordinators and their teams. This position will assist in policy creation and implementation. In addition, this individual will have operational responsibility of meeting targets outlined within this application. As this individual plans and executes that plan, a considerable amount of time will be spent directly serving the WPC pilot. This position works closely with the Director of WPC to develop care coordination HAPs for WPC program beneficiaries. The requested funding for position is $100,000 annually ($500,000 for five-year program) which includes salary and benefits.
- Director of Community Health Education (0.75 FTE): Responsible for developing plans for community-based health programs aimed at the prevention of disease and promotion of health. This individual develops and implements curriculum for various courses within WPC and monitors attendance and satisfaction. Based on feedback and results, the director will make changes to the curriculum to meet specific needs. Recommends community health initiatives, policy implications and best practices after reviewing health literature and statistics. Identifies community health programs related to identified WPC grant deliverables. Manages specific community health programs from planning and design through implementation and evaluation. This position works closely with the Director of WPC and the PCMH/PCSP Director to develop content relative to the WPC program beneficiaries. The requested funding for position is $150,000 annually ($750,000 for five-year program) which includes salary and benefits.
- Database Analyst II (0.75 FTE): This position develops and maintains database modeling, access and file structure requirements through discussion with users and other technical staff. Prepares related documentation addressing design, data relationships, operational procedures, and programming procedures for databases. Assures logical and physical data models meet County standards for naming, metadata and other common data structures. Participates in systems analysis, design and implementation and advises and consults with application programmers during systems analysis. Implements and maintains major mainframe, internet or beneficiary server database environments; and maintains the security and integrity of the database. Reviews database utilization and performs tuning to ensure optimal performance; and responds to system problems that may affect the database. Implements and insures adherence to database backup, restart, recovery, and reorganization standards. Analyzes database management systems software and develops recommendations for acquisition as appropriate. Evaluates new applications to determine compatibility with existing applications, hardware and software. Trains staff in the use of database tools and techniques. Develops and maintains data warehouse design and mining. Implements disaster recovery procedures. Stays abreast of new trends and innovations in the field of data network operations. The requested funding for position is $112,500 annually ($562,500 for five-year program) which includes salary and benefits.
- Information System Specialist II (0.75 FTE): This position is responsible for identifying and coordinating departmental data processing activities to ensure that quality and quantity of input and output are met. Assists in the design and the development of systems on a department's mini, microcomputer or mainframe. Assists with network system requirements and assists in determining solutions to network computer problems. Assists in the maintenance of network servers including installing and configuring user accounts and peripheral devices. Researches, designs and develops small, less complex application

programs on departmental computers; installs and configures unmodified package software and utility programs for departmental mini or micro-computers. Oversees the implementation and maintenance of the data processing systems within the department and configures, maintains and installs PC hardware and software including network cards. Provides technical advice to staff, trains staff in the use of computer hardware and software. Maintains inventory of computer equipment, software and licenses. The requested funding for position is $112,500 annually ($562,500 for five-year program) which includes salary and benefits.

- Research Director (0.5 FTE): This position is responsible for directing and managing all activities of research, including overseeing the development, implementation, and evaluation of research to meet the goals of the WPC pilot program. Developing and preparing the WPC pilot program long-term goals for research including creation of a research plan. Data mining and evaluation of existing data analysis and improvement programs implemented by the collaborative advisory/oversight committees, departments, and work groups. Planning, organizing, coordinating, directing, and managing research, both internally and externally, and including monitoring new and existing projects' content, staffing, and timeliness; for external research, responsibilities extend to oversight of contract obligations and payments. In proving the benefit of this WPC model, active research into the results will prove invaluable and identify areas into which the services can be expanded. Disseminating the results of completed research, as appropriate, to the public and various internal and external stakeholders. The requested funding for position is $100,000 annually ($500,000 for five-year program) which includes salary and benefits.
- Research Assistant (0.5 FTE): This position is responsible for assisting with academic research; assisting with the editing and preparation of manuscripts. Assists with duties related to the production of academic journals. Performs research work in archives, through interviews, online, or whatever may be appropriate to assist the assistant's supervisor. Prepares literature reviews. Gathers and analyzes data. The requested funding for position is $75,000 annually ($375,000 for five-year program) which includes salary and benefits.
- Onsite Program Coordinator (12 FTE): For this WPC pilot program Kern County is requesting funding for twelve (12) onsite program coordinators. These positions will be located at all participating agencies and are responsible for entering and maintaining care coordination data within the integrated data exchange system. These positions will also serve as referral intake for WPC beneficiaries at each respective participating agency. They will be responsible for cross system verification between the host agency and the WPC data exchange. In addition to these tasks this role is also responsible for responding to requests for information from the general public, other internal departments, and employees; researches and resolves discrepancies with information. Performs various clerical duties. Prepares routine documents and information; compiles data for routine reports. Prepares meeting agendas; assembles agenda packets; attends meetings and takes minutes; distributes meeting minutes to appropriate individuals. The requested annual funding for these positions is $1,080,000 (12 FTEs with individual annual salaries of $90,000) annually ($4,950,000 for five-year program) which includes salary and benefits.
- Printing and Office: Printing and office supplies are estimated at $24,000 per year ($120,000 for five-year program). This budget line item is based on estimated costs distributed across existing programs and departments as well as strategic planning activities conducted thus far during PY 1.
- Meeting Budgets: As part of the WPC program monitoring and deliverables, regularly scheduled meetings with participating agencies are required and essential when evaluating the program through the PDSA methodology. Meeting budgets for the WPC program are estimated at $300 per meeting, $7,200 annually ($36,000 for five-year program). Like printing and office supplies, this budget line item is based on

estimated costs distributed across existing programs and department as well as strategic planning meetings conducted thus far during PY 1.

- Travel: One requirement of the WPC program is attendance by all participating agencies at DHCS's Learning Collaborative Meetings to be held twice a year. Travel is based on average mileage/airfare, lodging, and meal per diem for fifteen travelers (one representative from each participating agency and WPC administrative staff) for one night and one day. No meeting location has been provided so estimated costs are for participating agency representatives to travel to Sacramento. The requested annual funding for this budget line item is $24,000 ($120,000 for five-year program).
- HIE Costs: One of the objectives of the WPC pilot program is the development and processes of sharing data. For this, the Kern County WPC will be implementing an integrated data exchange using the Pieces Iris and Pieces Plexus systems by PCCI (see description above). The following pricing for these services was obtained from PCCI: Implementation and first year (PY 2) software license agreement and participating agency HIE integration at $460,000. The following project year license agreements were quoted at $350,000 annually. The total HIE costs requested for the five-year program is $1,510,000. It must also be noted that data exchange costs are not stable and as data integration processes are be implemented the likelihood of encountering additional unknown and unbudgeted costs are high. Because of this, the WPC will use funds from the indirect costs budget line item to cover these unknown events during the implementation of the data exchange system.
- Indirect Costs: Indirect costs for the WPC program is estimated at $1,600,000 annually ($8,000,000 for the five-year program). This budget line item is used to cover any variable/unknown items which cannot be predicted in conceptual programs. The lessons learned, research, and possible outcomes for the WPC program are far too important to allow program failure for lack of funding for unknown circumstances.
- Finance Support (0.3 FTE): The lead entity will be receiving and tracking invoices, making payments, and managing the other financial aspects of this pilot. Finance support accounts for the financial accounting team within the lead entity, including director of finance (0.1 FTE $180,000), treasury (0.1 FTE $150,000), as well as accounts payable (0.1 FTE $70,000) positions.

Project Year 2-5 Delivery Infrastructure Budget Narrative

There are no anticipated Delivery Infrastructure budget items for this WPC pilot program. However, should circumstances change funds from indirect costs can be used to cover these items.

Project Year 2-5 Incentive Payments Budget Narrative

Included in the WPC pilot program budget are allowable incentive payments estimated at $3,682,600 annually and a total five-year estimation of $21,382,000. These incentive payments will be paid for the following categories and amounts:

- Managed Care Plan Referrals: As the Managed Care Plans have information on the total cost of healthcare, this pilot intends to make these organizations the main source of referrals. This budget item has been created in order to incentivize referrals from the plans
    - In order to be eligible for this incentive a managed care plan must make 10 referrals to the pilot each month.
    - The managed care plans will be the recipient of this incentive, $20,000/month. Managed Care Plans can request this money twice annually, once performance has been measured.
- Mental Health Reporting Incentive: Regular and timely reporting of WPC and HEDIS data is critical to the successful monitoring and improvement of established processes. However, the staff costs and time spent

generating reports can place burdens on the reporting agency. Because of this, the Kern County WPC program is requesting funding incentive payments to our mental health provider estimated at $240,000 annually. This includes monthly (12) reporting annually, for each program year of critical referral, utilization, and other quality improvement data. The five-year estimation for this budget line item is $1,200,000.

- The Mental Health Department is expected to submit monthly reports timely and accurately to the Lead Entity
- In order to be eligible for this incentive, the managed care provider must submit their monthly reports to the Lead Entity within 30 days after the previous month. If the required report is not submitted within the allotted timeframe, no payment shall be requested/issued for that month.
- The Mental Health Department will be the recipient of this incentive, $20,000/report each month.

- Bi-Weekly Learning Collaborative Call Attendance: Attendance at the bi-weekly learning collaborative calls is a requirement of the WPC program for all participating organizations. However, attendance on these calls require staff time which decrease production in other areas of their respective agencies. Secondary to this, the Kern County WPC program is requesting funding incentive payments to our participating agencies for call attendance at $62,400 annually (twenty-four (24) calls annually with twelve (13) participating organizations). The five-year estimation for this budget line item is $312,000.
  - Each participating organization is expected to attend bi-weekly learning collaborative conference calls with DHCS.
  - The Lead Entity will participate in a roll call for all participating organizations for these calls. In order to be eligible for this incentive, each participating organization must attend each learning collaborative call. Calls missed by a participating organization will result in no payment being requested/issued for that call.
  - Each participating organization will be the recipient of these incentive funds, $200/call for each participating organization.
- DHCS Learning Collaborative Meeting Attendance: Attendance at DHCS learning collaborative in-person meetings, held twice a year, is a requirement of the WPC program for all participating agencies. However, attendance at these meetings places a great burden on participating organizations. Staff members will have to travel out of county for attendance which includes an overnight stay. This will result in two days of lost productivity for the respective participating agencies. Secondary to this, the Kern County WPC program is requesting funding incentive payments to our participating agencies for meeting attendance at $26,000 annually. The five-year estimation for this budget line item is $130,000.
  - Each participating organization is expected to attend learning collaborative meetings with DHCS twice a year.
  - The Lead Entity will conduct a roll call at each learning collaborative meetings. In order to be eligible for this incentive, each participating organization must attend each learning collaborative meeting. Meetings missed by a participating organization will result in no payment being requested/issued for that meeting.
  - Each participating organization will be the recipient of these incentive funds, $1,000/meeting for each participating organization.
- Timely Submission and Data Integrity for Social Determinants/Care Coordination: Accurate and timely care coordination data submission is extremely critical to WPC program success. Without accurate and timely data WPC programs will not be able to provide accurate reporting establishing the benefit of the WPC

approach. Tracking of data elements and their associated integrity will be extremely labor intensive. In order to promote timely and accurate submission of data, the Kern County WPC program is requesting funding incentive payments for the timely and accurate submission of data in the care coordination data system at $1,560,000 annually (monthly (12) data submission by twelve (13) participating agencies). The five-year estimation for this budget line item is $7,800,000.

- Each participating organization is expected to maintain data integrity for WPC beneficiary encounters.
- For each beneficiary encounter, each participating organization should enter beneficiary encounter data in the Pieces Iris care coordination software within 30 days of encounter. The deliverable for each month will be the percentage of compliance with updates to beneficiaries as compared to the date of service. This will be tracked by the Data Analyst and Care Coordinators as they track the progress of the beneficiary through the referral system. Payment requests/issuance for participating organizations who do not enter encounter data for each WPC beneficiary will not processed.
- Performance targets will be 60% during PY2, 65% for PY 3, 70% PY4 and 75% PY5
- Each participating organization will be the recipient of these incentive funds, $10,000/month for each participating organization

- Active involvement in barrier identification and resolution: It is expected that each participating agency will be actively involved in the identification of barriers and resolution of those barriers. This will be measured based on attendance to respective committee meetings, as noted in the minutes of the meeting. Those unable to attend committee meetings who receive prior approval from the Director of Whole Person Care and who submit notes and suggestions prior to meeting will be counted as successfully fulfilling this metric. Critical to the success of the WPC program is the early identification and resolution to all identified barriers to services. Failure to address barriers to services will critically hamper the programs ability to fill WPC beneficiary needs, as well as create negative experiences associated with the program. Identification of these barriers is also critical to the PDSA process. To encourage this process, and ensure reporting, the Kern County WPC program is requesting funding incentive payments to our participating organizations for the active involvement in barrier identification, reporting, and resolution of program barriers at $1,560,000 annually. The five-year estimation for this budget line item is $7,800,000.
  - During the WPC Pilot Program it is expected that each participating organization identify, capture, and propose solutions to encountered barriers. This will allow for process improvement of the WPC program through the PDSA process.
  - This will be accomplished by the capturing and reporting of identified barriers, and associated solutions, at WPC Committee meetings. Additionally, the WPC Committee will capture participating organization attendance, identified barriers and their associated solutions, in the meeting minutes. These meeting minutes will be reviewed and discussed at each WPC Committee meeting.
  - Each meeting agenda will include a PDSA line item for barrier process improvement. The Committee will review each barrier report; plan strategies for addressing identified barriers; implement corrective actions to address each barrier; monitor the applied corrective actions for efficacy; and adjust each corrective action according to the observed results.
  - All of these items will be captured in the meeting minutes. Performance for this incentive will be measured based on attendance to WPC meetings as documented in meeting minutes.

- Should a participating organization fail to provide the above information or fail to attend that month's WPC Committee meeting, no payment shall be requested/issued for that month.
- Each participating organization will be the recipient of these incentive funds, $10,000/month for each participating organization.

- Partners with Data Sharing Software Implemented: Data sharing is integral to the success of this pilot. It is anticipated that bringing multiple organizations online will be a considerable effort taken on by the lead entity to work with the software vendor and each partnering agency's IT. Due to the scope of this, coordination will require additional other staff, including IT Project Managers working concurrently with these parties. This measure will be self-reported by the lead entity with signed verification by the software vendor as well as the representative at the partnering organization for whom the software was implemented. This total request is $871,100 or $67,008 for each installation and this request is only for the second year of the pilot, as such, the total pilot request is $871,100. Upon successful installation, the partnering agencies will work to further collaborate and integrate across the shared system.

Project Year 2-5 FFS Budget Narrative

Included in the WPC pilot program budget are allowable FFS estimated at $681,000 for PY 2, $900,000 for PY 3 – 5. The total FFS requested budget for the five-year program is $3,381,000. The following services are proposed for the five-year pilot program:

- Child Care Support Services - Care Center: This FFS will be used to provide Community Connection for Child Care for child care support of WPC beneficiaries while they attend wellness classes, employment training classes, locating employment opportunities, attending interviews, and other social appointments. According to the California Department of Education the current rate for part-time hourly child care market ceiling is 11.93/hr. However, this same department indicated that a 10% increase of this rate is expected within this year brining the hourly rate to 13.12. Given that the hourly rate is variable and dependent on, full-time vs. part-time, child age, and care provider, this value has been rounded up to $15/hr. The FFS is estimated at $15/hr., for 1.5 hours per visit, 3 visits a month, for 12 months, 2 children per family, and 400 members (43,200 rounded down to 43,000) for an annual estimated total of $645,000 for PY 2. For PY 3 – 5 the max units allowed has been increased to 60,000 to account for increased in beneficiary enrollment for an annual estimated total of $900,000 annually and a five-year estimation of $3,990,000.

- Public Health – In Home Assessment Training: This FFS was established to provide mobile team members with the necessary training and skills to expand their beneficiary assessment skills. Using staffing and training costs data from Public Health these classes were estimated at $3,000 per class with max units of 12 classes for an annual estimated total of $36,000. These classes will consist of an entire day of training on the environment of care assessment skills and will be taught by public health nurses.

Project Year 2-5 PMPM Budget Narrative

Included in this WPC program budget is allowable estimated PMPM bundled services estimated at $5,441,000 for PY 2, $7,346,000 for PY 3, $9,523,500 for PY 4, and $11,448,500 for PY 5. The total PMPM bundled requested budget for the five-year program is $37,580,000. The following PMPM Bundles are proposed for the five-year pilot program:

- Housing Navigation: Housing Navigation services go above and far beyond traditional housing placement services. Housing Navigators assist in barrier identification and assist beneficiaries in overcoming those

barriers to housing.

During WPC Committee strategy meetings, discussion with local Continuum of Care (COC) members, and discussions at the Housing and Health Care Coordination in Southern California meeting, it was discovered that many individuals face many barriers to actually obtaining housing. These barriers are numerous and often too insurmountable to overcome. It is not uncommon for individuals, who have a housing voucher, to unsuccessfully obtain housing because of a lack of available homes, requirements for up-front payment of first and last month's rent and other costs necessary to acquire housing.

In addition to the abovementioned barriers, some individuals who are fortunate enough to obtain housing often encounter living conditions which are not conducive to their health and safety given their respective medical conditions. The simple addition of a wheelchair ramp, improving ventilation/cooling so common respiratory exacerbations don't occur, and other living condition changes are solutions to barriers this population faces. This bundled PMPM seeks to identify and remove these barriers through the WPC program and the creation of Housing Navigator positions.

In this WPC program the Housing Authority of Kern County will hire two Housing Navigators funded through this pilot program. This bundle will also support these Housing Navigators by providing funds for supportive resources for this segment of the population. In accordance with STC 114(b), housing pool investments in housing units or housing subsidies including payment for room and board will not be eligible for WPC Pilot payments unless otherwise identified in CMS Informational Bulletin, "Coverage of Housing-Related Activities and Services for Individuals with Disabilities."

This PMPM Bundle has an annual estimated value of $230,400 for PY 2 – 5. The total PMPM bundle requested budget for the five-year program is $1,152,000. This bundled PMPM is estimated at $430/member with a max member months of 480. The estimated PMPM is based on average costs for items allowed under the abovementioned CMS bulletin necessary to create a housing environment conducive to the beneficiary's health and safety. The annual salary of a Housing Navigator inclusive of benefits is $90,000. These Housing Navigators will be solely dedicated to Whole Person Care, and the Housing Authority will invoice the lead entity monthly to receive these funds. Additional costs eligible for funding through Whole Person Care based on the CMS Informational Bulletin "Coverage of Housing-Related Activities and services for Individuals with Disabilities" are $50,000, or $1,250 per beneficiary per year. These costs range from $450 to $1,800 for security deposits, in addition to other costs. These funds will help beneficiaries secure and maintain long-term housing.

Item	QTY	Cost	Total	%	WPC
Housing Navigator	2	$90,000	$180,000	100%	$180,000
Expenses to obtain/retain housing	1	$50,000	$50,000	100%	$50,000
Max Member Months		480		Total	$230,000
PMPM					$480

Care Coordinators will refer homeless, or those at threat of becoming homeless to the Housing Authority of Kern

County, Housing Navigators. Housing Navigation services provided by the Housing Authority of Kern County, for the homeless, or at treat of becoming homeless, include, but are not limited to:

Individual Housing Transitions Services by:

- Conducting tenant screening and housing assessments
- Developing an individualized housing support plan
- Assisting with the housing application and/or search process
- Identifying and securing resources to cover expenses allowable the abovementioned CMCS bulletin
- Ensuring that the living environment is safe and ready for move-in
- Assisting in the move by identifying moving resources
- Developing a crisis plan that includes prevention and early intervention services when housing is jeopardized

Individual Housing and Tenancy Sustaining Services by:

- Providing early identification and intervention for behaviors that may jeopardize housing
- Educating and training on the role, rights, and responsibilities of the tenant and landlord
- Coaching on developing and maintaining key relationships with landlords/property managers
- Assisting in resolving disputes with landlords and/or neighbors
- Advocating and linking individuals to community resources when housing may become jeopardized
- Continuing training in being a good tenant

Unlike other listed bundles, the max units in this bundle will remain constant at 480/members per month for PY 2-5. The constant units are necessary due to position capability limitations of 20 members per month for two Housing Navigators. Our member months are based on current data indicating approximately 20% of WPC referrals have been identified as homeless, or at risk of becoming homeless. Member months will begin to be counted for a full month for the month in which a member is assigned a housing navigator and will extend until beneficiary has obtained continuous housing for 6 months, at this time, the housing navigator will be assigned a new beneficiary, and that care coordinator will coordinate regular assessments of housing. An individual placed in housing who is at risk of losing housing can return to the housing navigation pool, as determined by the care coordinator, housing navigator and director of WPC.

- Employment Services: One objective of the WPC program is to assist individuals in becoming self-sufficient. Because of this, the WPC Committee established a process that would assist WPC beneficiaries who are capable, or become capable through the WPC program, with employment opportunities through Kern County ETR.

  Through WPC Committee strategy sessions, ETR's expertise and involvement was requested in order to assist in meeting the abovementioned objective. ETR provides workforce training for the needs of the local economy and provides assistance in the business hiring process. Through ETR's experience and recommendations, the WPC Committee created the Employment Services PMPM bundle to assist WPC beneficiaries in obtain workforce training and employment. These services will go beyond the personal finance and employment classes offered through the care coordination bundle, but will extend to support in locating and applying for opportunities, assistance to and from interviews, and ongoing mentoring and

support. Individuals chronically unemployed often encounter difficulties remaining employed due to the increased pressures and constraints they encounter. Having individuals available to offer that support will be invaluable throughout their process to employment.

ETR will provide WPC beneficiaries job/skills training, resume building classes, assistance locating employment opportunities, assistance applying, assistance attending interviews, and other supportive services providing for all things necessary to be prepared for interviews. Costs incurred are expected to be heavier upon initial enrollment as this will require the greatest efforts educating, training and building a profile of each candidate.

Item	Cost	Unit Per Month	Extended Price Per Month
Assistance with job search and applications	$25/Hour	3	$75
Skills Training (ETR)	$50/class	1	$50
Interview Preparation	$200	.3	$60
Mentoring and Support	$25/Hour	2	$50

This line item is estimated at $600,000 for PY 2 – 4 and $620,000 for PY 5. The total PMPM bundle requested budget for the five-year program is $3,020,000. This bundled PMPM is estimated at $200/member with max member months of 3,000 for PY 2-4 and 3,100 for PY 5. Member months will begin to be counted the month in which the beneficiary is approved for the extended services and will extend until six months of successful, continuous employment. Based upon the specific needs of the beneficiary and the level of support required, these 6 months can be extended, as approved by the Director of WPC and WPC Steering Committee. This PMPM will be in addition to the care coordination PMPM.

- WPC Care Coordination: While traditional case management focuses mainly on physical health issues, care coordination as provided within this pilot is much more comprehensive, covering not only physical health, but mental health and social issues, and coordinating care across multiple organization to reduce redundancy and overutilization. Care coordination is more in depth and focuses on other aspects or factors that contribute to poor health outcomes. It is because of these other factors that we are striving to implement programs such WPC. However, due to the close overlap between the two approaches it is prudent to discuss them here. The Care Coordination services provided within this WPC pilot extend far beyond the Medi-Cal billable codes for Case Management and Targeted Case Management Services.

  These Care Coordination teams will be housed within one of the PCMHs at the lead entity, where the following Within the WPC program it is more appropriate to think of care coordination under the PCMH framework and their key concepts:
  - Link patients with community resources to facilitate referrals and respond to social service needs
  - Integrate behavioral health and specialty care into care delivery through co-location or referral protocols
  - Track and support patients when they obtain services outside the practice

- Follow-up with patients within a few days of an emergency room visit or hospital discharge
- Communicate test results and care plans with patients/families

It is these distinct characteristics that separate case management from care coordination. Through care coordination WPC beneficiaries will be assigned a care coordination team which will provide the following:

- Evaluation and assessment of current medical and social health. These services will be performed by clinical and non-clinical staff which are not covered by Medi-Cal. Only assessment of medical condition is covered by Medi-Cal and only for physicians, physician assistant, or nurse practitioners.
- Evaluation and assessment of current living environment by mobile team members – these services are not covered by Medi-Cal.
- Provision of security by probation officers for mobile team members for WPC beneficiaries who were recently released from incarceration and who are on probation. These services are not covered by Medi-Cal.
- Medication reconciliation – these services are not covered by Medi-Cal.
- Referral and connection to established social services offered through participating organizations within the WPC program. These services are not covered by Medi-Cal.
- Linking beneficiaries with other community resources and the associated follow-up and coordination with these resource providers. These services are not covered by Medi-Cal
- Assistance attending wellness classes, ETR classes, identifying housing, and other WPC services other than medical care. These services are not covered by Medi-Cal.
- Providing information and logistical support to WPC beneficiaries. These services are not covered by Medi-Cal.
- Frequent visits by mobile teams for follow up assessments and environmental conditions assessments. These services will be performed by clinical and non-clinical staff which are not covered by Medi-Cal.
- Access to behavioral health and substance abuse professionals
- Identification and resolutions to barriers encountered for all WPC services. These services are not covered by Medi-Cal.
- Information sharing across partnering organizations
- Wellness education
- Lifestyle Education
- PharmD Medication Therapy Management Services
- Telephone Visits
- Health Coaches
- Panel Management
- Home Nursing visits for acute or chronic disease management, including history taking, physical exam, phlebotomy, assessment of ADL and adjustment of diet, activity level or medications
- Podiatry Services.

Acknowledging that some of the services provided within the clinics are covered by Medi-Cal, the allocation of positions and expenses has been adjusted to ensure that funding is not being duplicated. The care coordination team will be involved in every aspect of the WPC beneficiaries care inside and outside of the clinical setting. Given the objectives of this program it is expected that the bulk of the care coordination will occur outside of the clinical setting which is not covered under Medi-Cal.

Given the main objective of the WPC program is to provide complete wrap around coordinated services using novel solutions, only an extremely small percentage of care coordination will be conducted by physicians. Instead, care coordination will be conducted by Care Coordinators, supervised by Registered Nurses, Medical Assistants, Pharmacists, and other clerical positions whose services are not reimbursable by Medi-Cal, or are extremely limited. The majority of these positions and their functions within the WPC framework are not eligible for reimbursement through Medi-Cal and the services provided will far exceed the allowable reimbursement limitations.

In addition, along with the efforts currently underway with the Global Payment Program, a number of non-traditional services will be provided through this bundle, including nursing visit for management and evaluation of the plan of care (HCPCS G0162) facilitated by one of two mobile teams. These mobile teams will be dynamic in staffing, dependent on the needs of the patients scheduled on a given day. At times these visits will simply provide social support, life coaching, supportive interventions and hygiene coaching, which will not require a licensed professional, which is why mobile teams are dynamic in nature. It is expected that these mobile services will be provided more frequently upon initial enrollment and wane as beneficiaries become stabilized and reliable.

This bundled PMPM is estimated at $473 per member per month; however we have applied a TCM budget adjustment to this PMPM of 5%, resulting in a PMPM of $450 with a max member months of 7,000 for PY 2, 10,000 for PY 13,500 for PY 4, and 16,500 for PY 5. The estimated annual values are $3,150,000 for PY 2, $4,500,000 for PY 3, $6,075,000 for PY 4, and $7,425,000 for PY 5. The total PMPM bundle requested budget for the five-year program is $29,268,000 (inclusive of year 1). This bundle is the focal point of the pilot, as this is the true hub for care coordination, service referrals, follow-up care, data coordination and these staff will build lasting relationships with the beneficiaries. All beneficiaries of the WPC program will be included in this bundle. Months will begin being counted as a full month for the month in which the beneficiary enrolls, and will end with a full month for the month during which the beneficiary disenrolls or graduates out of the program. The following costs are estimated for year 1:

Item	QTY	1 year Cost	Total	% Ask	Net Budget
Pharm D	3	$250,000	$750,000	80%	$600,000
Chiropractor	1	$250,000	$250,000	80%	$120,000
Nurse Practitioners	3	$200,000	$600,000	20%	$120,000
Registered Nurses	5	$175,000	$875,000	20%	$175,000
Registered Nurses (Mobile Team)	2	$175,000	$350,000	75%	$262,500
Care Coordinators	5	$75,000	$375,000	85%	$318,750
Medical Assistants	5	$80,000	$400,000	80%	$320,000
Licensed Certified Social Workers	5	$150,000	$750,000	75%	$562,500
Mental Health Therapists	3	$150,000	$450,000	50%	$225,000
Substance Abuse Counselors	3	$100,000	$300,000	50%	$150,000
Certified Diabetic Educators	3	$100,000	$300,000	20%	$60,000
Dietetic Technician	3	$80,000	$240,000	75%	$180,000
Director of Health Education	1	$180,000	$180,000	75%	$247,500
Health Educators	3	$110,000	$330,000	75%	$150,000
Community Liaison	2	$100,000	$200,000	75%	$220,000
Probation Officers	2	$110,000	$220,000	100%	$300,000
Office Service Technicians	4	$75,000	$300,000	100%	$60,000
WPC Graduates	3	$20,000	$60,000	100%	$414,000
Contracted Amounts	1	$414,000	$414,000	100%	$62,500
Van (w-wheelchair ramp)	2	$31,250	$62,500	100%	$75,000
Van	4	$18,750	$75,000	100%	$450,000
Light Vehicle Drivers	6	$75,000	$450,000	100%	$250,000
Wellness/Lifestyle Education	1	$250,000	$250,000	100%	$550
DELL Desktop PC	4	$172	$688	80%	$598
IBM Laptop PC	2	$374	$748	80%	$448
HP Network Printer	2	$280	$560	80%	$17,600
Access Points (POE)	80	$275	$22,000	80%	$7,598
Wireless Controller (MT Van)	2	$3,799	$7,598	100%	$1,150
Vehicle laptop mount (MT Van)	2	$575	$1,150	100%	$15,000
Van Maintenance ($2500/yr)	6	$2,500	$15,000	100%	$16,800
vehicle Insurance @4% per annum	6	$2,800	$16,800	100%	$12,000
Engagement Materials	4000	$3	$12,000	100%	$6,713
Single Ride Bus Passes	4475	$2	$6,713	100%	$60,429
Taxi Fare (Miles)	20143	$3	$60,429	100%	$52,500
Fuel (6 Vans)	15000	$4	$52,500	100%	

The positions within this bundle are reflective of the education emphasis of the pilot. 2.4 (3 at 80%) PharmDs have been budgeted to provide med reconciliations and education on chronic disease management and medication therapy management.

.8 (1 at 80%) Chiropractors have been budgeted to assist with mandibular, extremity and head treatments, which are not covered by Medi-Cal.

.6 (3 at 20%) Nurse Practitioners, will increase the diversity of the care team and add an additional level of primary care support through wellness education and reinforcement, management of chronic disease and conditions, and integration of care. Additionally, there is growing support and data indicating primary care provided by nurse practitioners is more cost effective. Given one of the objectives of the WPC pilot program is to explore novel and cost effective sources of care delivery, this position will assist in evaluating this role as an option.

The budget calls for a quantity of 5 Registered nurses to assist with care coordination, however due the level at which these nurses will be assisting, only 20%, or 1 total FTE was included in the budget. This nurse will provide supervisorial support for care coordinators and assist with discharge planning and transitions of care.

1.5 (2 at 75%) additional Registered nurses have been budgeted to assist with mobile teams to perform the services identified above.

4.25 (5 at 85%) Care Coordinators have been budgeted. As previously discussed, care coordinators are central to this pilot in coordinating services across various organizations and building relationships with the beneficiaries.

4 (5 at 80%) Medical Assistants will function in an administrative and clinical capacity and will increase the overall pilot capacity by assisting care coordinators and taking part in mobile teams.

3.75 (5 at 75%) Licensed Certified Social Workers will provide a level of oversight and coordination of services to assist with integration of behavioral and physical health.

1.5 (3 at 50%) Mental Health Therapists will provide focused behavioral health assistance including, recovery sessions, goal setting, stress reduction, eating disorder management, post-traumatic stress disorder, depression management, and behavior modifications necessary for improved health outcomes.

1.5 (3 at 50%) Substance Abuse Counselors will provide therapies to include establishing treatment goals, providing coping methods, advocating self-help programs, crisis interventions, and family counseling.

.6 (3 at 20%) Certified Diabetic Educators are essential to effective self-management for individuals with diabetes. These educators will provide individualized education, self-management goals, focused interventions for self-management, monitor self-management goal progression, and continued support.

2.25 (3 at 75%) Dietetic Technicians will develop individualized nutritional plans, counseling sessions for beneficiaries and family members, educate care coordination team members, nutrition therapy and other dietary functions necessary for improved health outcomes.

.75 (1 at 75%) Director of Health Education has been budgeted. This individual will have responsibility over developing curriculum and managing all aspects of health and wellness courses, monitoring attendance, and tailoring topics to the needs of beneficiaries.

2.25 (3 at 75%) Health Educators promote wellness and behavior changes necessary for better lifestyle outcomes and will assist with life skills courses offered to beneficiaries. This will be accomplished by developing and implementing health improvement and lifestyle strategies, goals, and counseling for WPC beneficiaries and their families.

1.5 (2 at 75%) Community Liaisons have been budgeted to promote the pilot program, and work with new organizations desirous to join the program.

2 (2 at 100%) Probation officers have been budgeted to assist with the mobile team. The officers will attend site visits with the mobile teams to continue to build enhanced relationships while performing their regular duties.

4 (4 at 100%) Office Service Technicians have been budgeted for, who will assist with coordination of the mobile team, specifically with scheduling and logistics for appointments. These individuals will also be critical in scheduling appointments and assisting with various other office tasks. A hallmark of this pilot is the inclusion of

3 (3 at 100%) positions for Whole Person Care Graduates. These individuals will join the community outreach team in promoting the program, and they will act as a support for those currently enrolled in the program.

Additionally, the above table includes single items purchases for: 2 vans with wheelchair ramps; 4 vans, 4 DELL Desktop PCs, 2 IBM Laptop PCs, 2 HP Network Printers, 80 Access Points, 2 wireless controllers, and 2 vehicle laptop mounts. The total cost of these items has been spread across the duration of the pilot program. The positions noted above have been adjusted based on estimates that there will be a 75% opt-in rate to WPC, noting that care coordinators were adjusted to 85% as it is anticipated that the WPC population will require a disproportional share of their time compared to standard clinic beneficiaries as the level of care coordination with outside agencies will require substantially greater time.

Also included in the Care Coordination PMPM are Health Wellness and Lifestyle Education Classes. These are group classes available to all WPC beneficiaries. Classes will be scheduled regularly and reviewed regularly by the director of Health Education. Attendants will be given opportunities for participation and feedback in order to continue to develop these classes to the needs of beneficiaries. Attendance at these classes will be measured, as well as satisfaction, which will allow the pilot to adapt to provide classes and curriculum that yield results. Classes to be included can be found below:

- Healthy Living
- Personal Finance
- Food Preparation
- Parenting
- Diabetes Management
- Hypertension Management
- Smoking Cessation
- Safe Sleep
- Breast Health
- Men’s Health
- Women’s Health
- Domestic Violence

- Care Giver
- Fitness
- Risk Factor Reduction Interventions
- Home Care
- Resume Building

The mobile outreach and engagement team will represent and promote the WPC program, its benefits, accomplishments, and proven methods to the community and WPC eligible persons. This mobile outreach and engagement is designed to engage the community and enlist/refer additional WPC beneficiaries to the program. An additional function of this group will be to identify and engage community business organizations for inclusion in the WPC program as participating organizations. Finally, this group will work with local organizations promoting the benefits of the WPC program and enlisting their assistance in establishing WPC sustainment support and strategies.

- 90 Day Post Incarceration Coordination: Incarcerated individuals often suffer from medical, behavioral, or substance abuse conditions. While incarcerated, their medical and behavioral health needs are routinely provided for, with little effort required by the individual. Doctors are brought to the individual, medications are circulated on a regular schedule without cost to the individual, and there is consistent follow-up. Unfortunately, when these individuals are released from incarceration they are subsequently cut off from the care provided during that time. With freedom comes an extra responsibility of taking care of one's self, but this is often overlooked due to time and financial constraints, or lack of adequate skills. Also, as mentioned above, some of these individuals are released to homelessness. Given these challenges this pilot will provide for an enhanced level of care coordination for 90 days.

  In order to address the needs of this population, this pilot will establish a clinic directly outside of the facility so that upon release, prisoners who have obtained presumptive Medi-Cal eligibility can obtain an immediate wellness check. Two PharmDs will reside in the clinic to provide medication reconciliations, medication education, and ensure that these individuals have adequate prescriptions and a plan to retrieve these prescriptions. Two registered nurses will work in the clinic to provide for comprehensive discharge planning. The nurses will complete a full health risk assessment, provide any specialized medical training, and evaluate needs for durable medical equipment. Working closely with office staff, the care team will provide for a smooth transition of care to the primary care environment through scheduling a two-week checkup. Office staff in the clinic will assist the beneficiaries in identifying and applying for programs, for which they are eligible, enroll the individuals in Whole Person Care and facilitating the scheduling of a follow-up appointment. For security, a detention deputy will reside at the clinic. In addition, this team will work to identify group homes, support groups and provide referrals for MAT groups.

  In coordination with our Health Education Department we will offer during this 90 day period a variety of Life Skills Transition Classes, geared to lower recidivism amongst this very fragile population. In conjunction with their initial post incarceration visit, a post incarceration liaison will be added to the care coordination team to help assess the member's specific transitional course needs. The post incarceration liaison will also be tasked with tracking the status of class enrollment and attendance,

transportation needs, reincarceration status, as well as members that disenroll, or graduate. Some examples of our Life Skills Transition Classes may include, Crime Theory - Breaking the Cycle, Anger Management, Coping Skills, Co-Dependency, Parenting, and Relapse Prevention. These courses will assist the beneficiaries in building structure with the challenges of post-incarceration.

At the conclusion of 90 days this post incarceration team will assess the members' success and provide a report for our Quality review team to assess monthly for system improvement.

These beneficiaries will receive enhanced care coordination PMPM for 3 months post release in addition to the standard complex care coordination PMPM bundle. These beneficiaries will count as one member month for the entire calendar month in which they enroll in Whole Person Care, and will be counted for a maximum of 3 member months. Beneficiaries will be enrolled in the care coordination bundle concurrently for the three months of enhanced post-incarceration, after which time, these individuals will be reviewed for eligibility to the program for continued consideration.

This bundled PMPM is estimated at $1,800/member based off a total 2,700 member months for PY 2-5. This bundled PMPM has an estimated annual value for $1,216,000 for PY 2-5. The total PMPM bundled requested for the five-year program is $6,080,000.

QTY	Item	Cost	Total	%	Annual Cost
1	Detention Deputy	$125,000	$125,000	80%	$100,000
2	Registered Nurse	$175,000	$350,000	80%	$280,000
2	Pharm D	$250,000	$500,000	80%	$400,000
1	Office Staff Bundle	$160,000	$160,000	80%	$128,000
1	Liaison	$90,000	$90,000	100%	$90,000
2	Medical Assistants	$80,000	$160,000	80%	$128,000
1	Office Space	$60,000	$60,000	80%	$48,000
1	Office Supplies/Equipment	$52,500	$52,500	80%	$42,000
				Total Value	**$ 1,216,000**

Project Year 2-5 Pay for Reporting Budget Narrative

Included in this WPC program budget is allowable estimated Pay for Reporting estimated at $6,735,600 for PY 2, $6,735,600 for PY 3, $7,006,100 for PY 4, and $7,015,100 for PY 5. The total PMPM bundled requested budget for the five-year program is $34,228,000 (counting PY2 twice to incorporate year 1). Pay for reporting is based on required universal and variant reporting metrics. The following reporting metrics are proposed and required metrics:

Reporting Metric	PY 2	PY 3	PY 4	PY 5
Administrative: Proportion of participating beneficiaries with a comprehensive care	350,000	350,000	350,000	350,000

Reporting Metric	PY 2	PY 3	PY 4	PY 5
plan, accessible by the entire care team, within 30 days of enrollment				
Administrative: Care Coordination, case management, and referral infrastructure	350,000	350,000	350,000	350,000
Administrative: Data and information sharing infrastructure	350,000	350,000	350,000	350,000
Administrative: WPC Committee Meeting Effectiveness measured by attendance 70% with the exception of pre-approved absences.	350,000	350,000	350,000	350,000
PHQ-9 Depression Remission at 12 months (GROW) NQF 0710	500,000	500,000	500,000	500,000
Housing – Percent of homeless receiving housing services in PY that were referred for housing services	500,000	500,000	500,000	500,000
Mental Health Reporting: Screening, Brief Intervention and Referral to Treatment (SBIRT)	500,000	500,000	500,000	500,000
Health Outcome: Ambulatory Care – Emergency Department Visits (HEDIS)	500,000	500,000	500,000	500,000
Health Outcome: Inpatient Utilization – General Hospital/Acute Care (HEDIS)	500,000	500,000	500,000	500,000

Reporting Metric	PY 2	PY 3	PY 4	PY 5
Health Outcome: Follow-up After Hospitalization for Mental Illness (HEDIS)	500,000	500,000	500,000	500,000
Health Outcome: Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (HEDIS)	500,000	500,000	500,000	500,000
Health Outcome: Adult Body Mass Index (BMI) Assessment (HEDIS)	500,000	500,000	500,000	500,000
Health Outcome: Controlling High Blood Pressure (HEDIS)	500,000	500,000	500,000	500,000
Health Outcome: HbA1c Poor Control <8%	500,000	500,000	500,000	500,000
Administrative: Wellness/Lifestyle Class Attendance	335,600	335,600	500,000	500,000

The above metrics were selected and established based on interviews and input from participating agencies. Additionally, the rationale behind the metric choices clearly aligns with the WPC project strategies and objectives of the program. Furthermore, the metrics are also closely related to the mission and objectives of not only the WPC program but the PCMH and PCSP mission and objective as well.

Payment for the reporting will be made to Kern Medical Center and are based on the level of staff expertise; estimated staff time necessary to generate the reports; estimated staff time and resources to monitor the progress and assure the reports are accurate and on time; and the required systems and mechanisms required to extract the data necessary for the metrics.

Initially, in PY 2, reports will be run and analyzed on a weekly basis. For PY 3-5 reports will be run and analyzed on a monthly basis. Initial analysis of the reports will focus on the validity of data integrity, reports, and current processes. During this process all aspects of the WPC program will be evaluated using PDSA principles. These reports and their respective data elements will be critical to the PDSA methodology. Information within these reports will be used to evaluate the program and take necessary corrective actions should the desired results not be achieved.

Half of the annual budgeted amounts may be drawn down upon submission of the mid-year report, and the remaining funds may be drawn down upon successful submission of year-end report.

Project Year 2-5 Pay for Outcomes Budget Narrative

Kern Medical Center
County of Kern
Whole Person Care Application – September 24, 2016

Included in this WPC program budget is allowable estimated Pay for Outcomes estimated at $10,376,000 for PY 2, $9,518,100 for PY 3, $7,402,600 for PY 4, and $5,753,600 for PY 5. The total Pay for Outcomes requested budget for the five-year program is $43,426,300 (counting PY2 twice to incorporate year 1). All performance metrics have the ability to pay out partial payments, based upon percentage of attainment (i.e., if 95%of goal attained, 95% of incentive will be earned). The recipient of these pay for outcomes will be the Lead Entity: Kern Medical Center. Pay for outcomes are based on required universal and variant reporting metrics. The following reporting metrics are proposed and required metrics:

Pay for Outcomes (PY 2 description)	PY 2	PY 3	PY 4	PY 5
5% Improvement Over PY in ER Utilization	900,000	1,000,000	600,000	450,000
5% Improvement Over PY in Inpatient Utilization	876,000	862,000	600,000	450,000
5% Improvement Over PY for Follow-up After Hospitalization for Mental Illness	800,000	700,000	600,000	400,000
5% Improvement Over PY for Initiation and Engagement of ETOH and Other Dependence Tx	750,000	700,000	500,000	400,000
5% Improvement Over PY for PHQ-9 Depression Remission at 12 Months NQF 0710	750,000	700,000	500,000	400,000
2% Improvement in PY of HbA1C Poor Control <8%	750,000	700,000	500,000	500,000
5% Improvement Over PY for Preventative Care Measures of WPC beneficiaries	750,000	700,000	500,000	400,000
40% Post-Incarceration Primary Care Visit Within 60 Days of Release	750,000	700,000	500,000	453,600
30 Day All Cause Readmissions 5% decrease in PY	800,000	900,000	624,000	400,000
Screening, Brief Intervention and Referral to Treatment (SBIRT) 5% improvement over PY	750,000	700,000	500,000	300,000

Pay for Outcomes (PY 2 description)	PY 2	PY 3	PY 4	PY 5
Overall Beneficiary Health 5% improvement over PY	750,000	700,000	500,000	400,000
Controlling Blood Pressure 5% improvement over PY	750,000	356,100	500,000	400,000
Med Reconciliation Completed within 30 days enrollment: 70%	500,000	300,000	478,600	400,000
70% of participating beneficiaries with a comprehensive care plan, accessible by the entire care team within 30 days	500,000	500,000	500,000	400,000

At its very core, the WPC program was designed, and its focus is to truly determine if preventative care measures outside of the clinical setting truly contribute to healthier outcomes. Kern County answered this question with a resounding "Yes" based on information gathered and learned from the KGC program. As stated above, in the *Geographic Area* and *Target Population* sections, the KGC pilot showed substantial reduction in emergency service use, 68% decrease in ER visits by enrolled members with a decrease in average cost per member by 89%, by simply linking high utilizers to existing services. However, due to increasing staffing shortages; county budgeting crisis; limited resources; partnering agency service limitations; lacking infrastructure; and no real sustainable methods to continue to drive the pilot, the program stalled. This evidence shows the importance of successful implementation of the WPC program.

Given the abovementioned identified challenges in the KGC pilot program, the Kern County WPC program proposes these pay for outcomes incentives for our program. We believe these outcomes provide the most incentives to mitigate the barriers identified in the KGC pilot program.

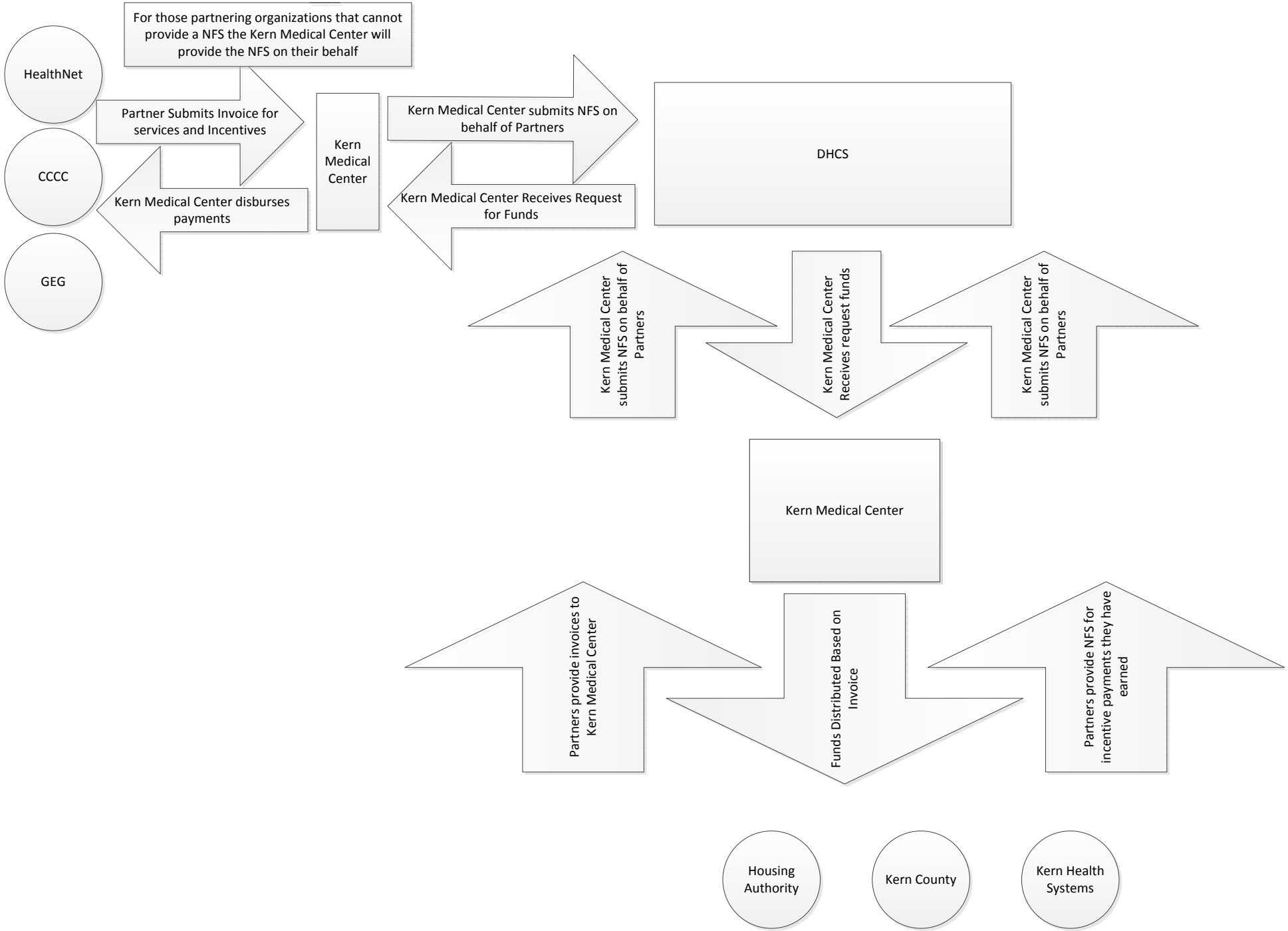
Our rationale for choosing these performance outcomes is their direct relationship and focus on identified key causes of ER overcrowding; increased medical costs; and increased insurance costs. Additionally, these outcomes align with the mission of many of our partnering agencies and overall county wide issues.

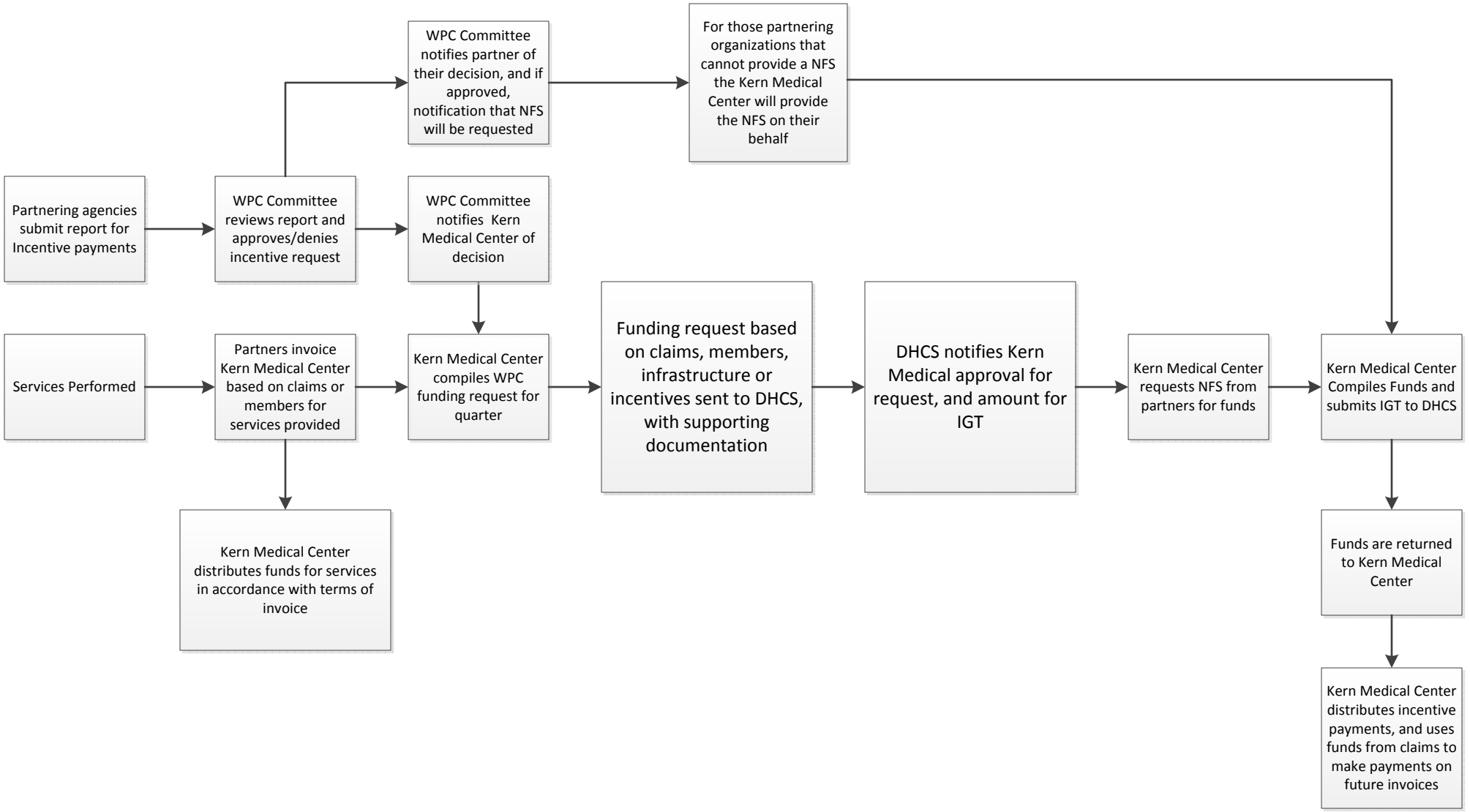
Up to one half of the designated funds may be drawn down upon the submission of the mid-year report, based on 50% attainment of the metric target. At the year-end report, all remaining funds may be drawn down based on metric

Section 6: Attestations and Certification

6.1 Attestation

This attestation is superseded by the revised attestation included in the executed agreement.


For those partnering organizations that cannot provide a NFS the Kern Medical Center will provide the NFS on their behalf
HealthNet
CCCC
GEG
Partner Submits Invoice for services and Incentives
Kern Medical Center disburses payments
Kern Medical Center
Kern Medical Center submits NFS on behalf of Partners
Kern Medical Center Receives Request for Funds
DHCS
Kern Medical Center submits NFS on behalf of Partners
Kern Medical Center Receives request funds
Kern Medical Center submits NFS on behalf of Partners
Kern Medical Center
Partners provide invoices to Kern Medical Center
Funds Distributed Based on Invoice
Partners provide NFS for incentive payments they have earned
Housing Authority
Kern County
Kern Health Systems


WPC Committee notifies partner of their decision, and if approved, notification that NFS will be requested
For those partnering organizations that cannot provide a NFS the Kern Medical Center will provide the NFS on their behalf
Partnering agencies submit report for Incentive payments
WPC Committee reviews report and approves/denies incentive request
WPC Committee notifies Kern Medical Center of decision
Services Performed
Partners invoice Kern Medical Center based on claims or members for services provided
Kern Medical Center compiles WPC funding request for quarter
Funding request based on claims, members, infrastructure or incentives sent to DHCS, with supporting documentation
DHCS notifies Kern Medical approval for request, and amount for IGT
Kern Medical Center requests NFS from partners for funds
Kern Medical Center Compiles Funds and submits IGT to DHCS
Kern Medical Center distributes funds for services in accordance with terms of invoice
Funds are returned to Kern Medical Center
Kern Medical Center distributes incentive payments, and uses funds from claims to make payments on future invoices

Attachment A

Page one of this document graphically depicts the flow of the non-federal share funds for the Whole Person Care project.

All participating public organizations will be providing the non-federal share for their respective incentive payments. For those unable to contribute the non-federal share, Kern Medical Center will provide the non-federal share. Kern Medical Center will compile these funds. The following entities will provide their portion of the non-federal share:

- Housing Authority of the County of Kern
- Kern Health Systems
- All participating County of Kern organizations

The following organizations cannot participate in the non-federal share process. For these entities, Kern Medical Center will provide the non-federal share.

- Health Net
- Community Connection for Child Care
- Golden Empire Gleaners

The funding process will proceed as follows:

1. Participating organizations will submit invoices for services provided and incentives earned to Kern Medical Center.
2. Kern Medical Center will review and validate submitted invoices for accuracy. Any discrepancies will be communicated to the respective participating organization.
3. Kern Medical Center will collect all non-federal share funds from participating organizations as described above.
4. Once all funds have been collected, Kern Medical Center will compile and submit one intergovernmental transfer to the California Department of Health Care Services for the entire requested amount.
5. The California Department of Health Care Services will evaluate the request and provide the federal share for the amount requested through an intergovernmental transfer.
6. Kern Medical Center will distribute the appropriate funds to each participating organization

Page two of this document graphically depicts the reporting and funding process in greater detail. The reporting and funding process will be conducted as follows:

1. Partnering organizations submit report for incentive payments to the Whole Person Care Committee for review. Concurrently, participating organizations submit invoices for services provided to Kern Medical Center based on claims or members for services provided.
2. The Whole Person Care Committee reviews reports and approves or denies incentive payment requests. Concurrently, Kern Medical Center reviews provided service invoices and approves, denies, or requested supporting documentation from the respective participating organization.

3. The Whole Person Care Committee notifies both Kern Medical Center and the partnering organizations of their decision. Concurrently, Kern Medical Center notifies the partnering organizations of the funding decision for services provided.
4. Kern Medical Center compiles the Whole Person Care funding request for the quarter.
5. Funding request based on claims, members, infrastructure, or incentive is sent to the California Department of Health Care Services with supporting documentation.
6. The California Department of Health Care Services notifies Kern Medical Center of approval for request and the amount of the intergovernmental transfer.
7. Kern Medical Center requests the non-federal share from partnering organizations. For those partnering organizations that cannot provide a non-federal share, Kern Medical Center will provide the non-federal share on their behalf.
8. Kern Medical Center compiles funds and submits a single intergovernmental transfer to the California Department of Health Care Services.
9. The California Department of Health Care Services provides the federal share of funds through an intergovernmental transfer.
10. Kern Medical Center distributes incentive payments, and uses funds from claims to pay pending invoices.

WPC Budget Template: Summary and Top Sheet

WPC Applicant Name:	Kern Medical Center (Kern County)

	Federal Funds *(Not to exceed 90M)*	**IGT**	**Total Funds**
Annual Budget Amount Requested	15,734,650	15,734,650	31,469,300

PY 1 Budget Allocation (Note PY 1	
PY 1 Total Budget	31,469,300
Approved Application (75%)	23,601,975
Submission of Baseline Data (25%)	7,867,325
PY 1 Total Check	OK

PY 2 Budget Allocation	
PY 2 Total Budget	31,469,300
Administrative Infrastructure	4,086,800
Delivery Infrastructure	0
Incentive Payments	4,799,500
FFS Services	681,000
PMPM Bundle	4,790,400
Pay For Reporting	6,735,600
Pay for Outomes	10,376,000
PY 2 Total Check	OK

PY 3 Budget Allocation	
PY 3 Total Budget	31,469,300
Administrative Infrastructure	3,976,800
Delivery Infrastructure	0
Incentive Payments	3,928,400
FFS Services	900,000
PMPM Bundle	6,410,400
Pay For Reporting	6,735,600
Pay for Outomes	9,518,100
PY 3 Total Check	OK

PY 4 Budget Allocation	
PY 4 Total Budget	31,469,300
Administrative Infrastructure	3,976,800
Delivery Infrastructure	0
Incentive Payments	3,928,400
FFS Services	900,000
PMPM Bundle	8,255,400
Pay For Reporting	7,006,100
Pay for Outomes	7,402,600
PY 4 Total Check	OK

PY 5 Budget Allocation	
PY 5 Total Budget	31,469,300
Administrative Infrastructure	3,976,800
Delivery Infrastructure	0
Incentive Payments	3,928,400
FFS Services	900,000
PMPM Bundle	9,895,400
Pay For Reporting	7,015,100
Pay for Outomes	5,753,600
PY 5 Total Check	OK