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

Reporting Checklist

Kern County Hospital Authority
Annual PY2
4/2/2018

The following items are the required components of the Mid-Year and Annual Reports:

Component	Attachments
1. Narrative Report **Submit to:** Whole Person Care Mailbox	☐ Completed Narrative report ☐ List of participant entity and/or stakeholder meetings *(if not written in section VIII of the narrative report template)*
2. Invoice **Submit to:** Whole Person Care Mailbox	☐ Customized invoice
3. Variant and Universal Metrics Report **Submit to:** SFTP Portal	☐ Completed Variant and Universal metrics report
4. Administrative Metrics Reporting **(This section is for those administrative metrics not reported in #3 above - the Variant and Universal Metrics Report.)** **Note: If a Policy and Procedures document has been previously submitted and accepted, you do not need to resubmit unless it has been modified.** **Submit to:** Whole Person Care Mailbox	☐ Care coordination, case management, and referral policies and procedures, which may include *protocols and workflows.)* ☐ Data and information sharing policies and procedures, which may include *MOUs, data sharing agreements, data workflows, and patient consent forms.* One administrative metric in addition to the Universal care coordination and data sharing metrics. Describe the metric including the purpose, methodology and results.
5. PDSA Report **Submit to:** Whole Person Care Mailbox	☐ Completed WPC PDSA report ☐ Completed PDSA Summary Report
6. Certification of Lead Entity Deliverables **Submit with associated documents to:** Whole Person Care Mailbox and SFTP Portal	☐ Certification form

NOTE: The WPC Quarterly Enrollment and Utilization Report is submitted on a quarterly basis to the DHCS SFTP site.

Whole Person Care

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I. REPORTING INSTRUCTIONS

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

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

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

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

II. PROGRAM STATUS OVERVIEW

Please provide a brief overview of your program's successes and challenges and any lessons learned during the reporting period. Structure your responses in alignment with the WPC program's goals using the following as headers (from STC 112): *increasing integration among county agencies, health plans, providers, and other entities; increasing coordination and appropriate access to care; reducing inappropriate emergency and inpatient utilization; improving data collecting and sharing; achieving quality and administrative improvement benchmarks; increasing access to housing and supportive services; and improving health outcomes for the WPC population.*

Our pilot was able to begin enrolling patients into our WPC Program in August of 2017. We ended PY2 with 88 unduplicated enrollees and learned many crucial things about how to assist our patients access their care.

Our biggest success has been the creation and implementation of our six core WPC Care Coordination classes that all WPC enrollees must take once they enrolled in the program. Core classes include:

- Health Literacy
- Hospital Relapse Prevention
- Job & Volunteer Readiness
- Basic Nutrition
- Household Budgeting
- Life Skills

Patients have been heavily educated on both health literacy and hospital relapse prevention, which has proven to be extremely beneficial in reducing the ER occurrences for our enrollees in PY2. This education coupled with intense care coordination has resulted in patients reaching out to their care coordinators before making a decision to go to the ER. These relationships and their newly acquired knowledge of basic health literacy as well as hospital relapse prevention concepts have been the two main factors in our reduction in ER visits with our WPC pilot population.

The pilot has worked extensively to build data collection infrastructure to better enhance the overall view of the patient and garner relevant information regarding potential future enrollees. The Lead Entity has gone under contract to acquire Electronic Data Warehouse (EDW) software and population health analytics tools through Cerner. The implementation of the EDW will provide for a single repository for housing not only healthcare related information, but also social and other data points. This information will be leveraged and analyzed to provide better and more efficient care to WPC Beneficiaries, while enhancing the ability to collaborate and share data with community partners.

The pilot has worked closely with community partners and continues to improve on data sharing across organizations, working through challenges of privacy issues and

technological capabilities to provide relevant information to appropriate agencies. The implementation of the EDW will allow an enhanced ability to provide regular data updates, and give a clearer picture of beneficiaries to community partners.

Our biggest challenge has been the change in our proposed infrastructure. Throughout the development of the application, the pilot intended to use pre-existing clinic infrastructure through which to facilitate care coordination. These clinics were established through careful collaboration with a managed care plan to provide a high level of care coordination to medically fragile patients, however, it was decided that these clinics would not be used for Whole Person Care Beneficiaries instead being used for the Health Homes Program. This change has caused a complete re-design of our WPC PCMH delivery infrastructure and forced us to hire a whole new care team, which has proven challenging within this medically, underserved area. However, creating this new clinic for WPC will allow the flexibility to provide a high level of care, specific to each individual. The pilot continues to refine data feeds from the managed care plans in order to identify those who would most benefit from the program.

III. ENROLLMENT AND UTILIZATION DATA

For the Mid-Year report, provide data for January-June 30 of the Program Year and for the Annual Report, provide data for January-December 31 of the Program Year.

The tables below should reflect enrollment and utilization numbers, consistent with your invoice and quarterly enrollment and utilization reports.

For revisions of enrollment and utilization data submitted during the Mid-Year Report (Months 1-6), changes should be made in bold. Additionally, note explicitly in the additional box at the end of this section if no changes were made to the Mid-Year reported data.

Item	Month 1	Month 2	Month 3	Month 4	Month 5	Month 6	Unduplicated Total
Unduplicated Enrollees	0	0	0	0	0	0	*

Item	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12	Annual Unduplicated Total
Unduplicated Enrollees	0	*	13	22	27	*	88

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

FFS	Costs and Aggregate Utilization for Quarters 1 and 2						
	Month 1	Month 2	Month 3	Month 4	Month 5	Month 6	Total
Childcare							
Utilization 1	0	0	0	0	0	0	0
Training							
Utilization 2	0	0	0	0	0	0	0

FFS	Costs and Aggregate Utilization for Quarters 3 and 4						
	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12	Total
Childcare							
Utilization 1	0	0	0	0	0	0	0
Training							
Utilization 2	0	0	0	0	0	0	0

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For ***Per Member Per Month (PMPM),*** please report your rate, amount claimed and member months by PMPM type. These reports should tie to your budget, invoice and utilization reports. For "Bundle #" below, use the category number as reported in your submitted Quarterly Enrollment and Utilization Report. Add rows as needed

PMPM		**Amount Claimed**						
	Rate	Month 1	Month 2	Month 3	Month 4	Month 5	Month 6	Total
Housing Navigation	$480							
MM Counts 1		0	0	0	0	0	0	0
Employment Services	$200							
MM Counts 2		0	0	0	0	0	0	0
WPC Care Coordination	$450							
MM Counts 3		0	0	0	0	0	0	0
90 Day Post Incarceration	$1800							
MM Counts 4	$480	0	0	0	0	0	0	0

PMPM		**Amount Claimed**						
	Rate	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12	Total
Housing Navigation	$480						$*	$*
MM Counts 1		0	0	0	0	0	*	*
Employment Services	$200							
MM Counts 2		0	0	0	0	0	0	0
WPC Care Coordination	$450		$8,550	$14,400	$24,300	$35,100	$36,900	$119,250
MM Counts 3		0	19	32	54	78	82	265
90 Day Post Incarceration	$1800			$*	$*	$*	$*	$*
MM Counts 4	$480	0	0	*	*	*	*	*

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

The pilot is continuing to refine referral practices with the managed care plans in order to identify individuals who would most benefit from the program, and also exploring additional ways to identify Homeless and at risk of Homelessness, as well as those recently incarcerated. A challenge in enrolling recently incarcerated individuals was the unpredictable timing of releases from the jail. Although individuals are given an anticipated release date, due to California Legislation providing for early release, actual dates of release are not predictable. While current processes for healthcare in the jail system are primarily paper-based, staff have begun screening and identifying potential beneficiaries upon intake so that upon release, these individuals can be enrolled into the program. This should create a more robust inflow into the program, although timing may still not be easily predicted.

IV. NARRATIVE – Administrative Infrastructure

Please describe the administrative infrastructure that has been developed specifically for the WPC program and how it relates to achievement of program goals. Reimbursement will be based on actual costs expended and employees hired/employed for the WPC pilot, and only up to the limit of the funding request in the approved budget.

Please note the narrative submitted during the Mid-Year report will be considered part of the Annual report and will not need to be resubmitted. Include updates, notable trends, and highlights of achievements/progress as well as any changes since the report.

Through the administrative infrastructure, we have begun hiring administrative positions to facilitate the pilot program.

The Director of Whole Person Care administers to the daily operations of the project, acting as the primary contact for all of the Community Based Organizations, as well as DHCS and other trade organizations. This individual leads and facilitates meetings with both internal and external stakeholders, facilitates collaboration and seeks out input from community partners and potential beneficiaries, and helps to develop policy and helps drive the mission of the pilot.

The Director of Community Health and Wellness spends much of their time developing curriculum for WPC education courses. The Health and Wellness curriculum focuses on teaching beneficiaries social skills, how to take care of themselves, ultimately helping them to become independent, and reduce the services upon which they rely.

We hired and additional onsite program coordinator for the Housing Authority who has been assisting with developing referral and data sharing workflows with the Housing Authority.

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

Indirect Costs are used to cover any variable/unknown items, which cannot be predicted in conceptual programs. The lessons learned, research, and possible

outcomes for the WPC program are far too important to allow program failure for lack of funding for unknown circumstances.

Our Finance team has worked closely to help develop workflows for data capture, member identification, and for receiving invoices and providing funding to CBO's.

V. NARRATIVE – Delivery Infrastructure

Please describe the delivery infrastructure that has been developed as a result of these funds and how it relates to achievement of pilot goals. Reimbursement will be based on actual pilot expenditure for the final deliverable or outcomes, up to the limit projected or estimated costs in the approved budget.

Please note the narrative submitted during the Mid-Year Report will be considered part of the Annual Report and will not need to be resubmitted. Include updates, notable trends, and highlights of achievements/progress as well as any changes since the prior report.

The Kern County WPC Pilot does not have budgeted funds for Delivery Infrastructure.

VI. NARRATIVE – Incentive Payments

Please provide a detailed explanation of incentive payments earned during the Reporting Period. Elaborate on what milestones were achieved to allow the payment, the amount of each payment, and to whom the payment was made. The lead entity will only be permitted to invoice for actual incentive payments made.

Please note the narrative submitted during the Mid-Year Report will be considered part of the Annual Report and will not need to be resubmitted. Include updates, notable trends, and highlights of achievements/progress as well as any changes since the prior report.

Kern's eligible incentive payments earned at Annual PY2 report include:

- Bi-weekly Learning Collaborative Calls attendance (Kern Medical Center only) – Met by attending on DHCS Learning Collaborative Calls. Kern Medical achieved 12 incentives at $200 each for a total of $2,400
- DHCS Learning Collaborative Meeting attendance (Kern Medical Center, Kern Health Systems, and Health Net only) – Met by attending in person Learning Collaborative meeting reimbursed at $1,000 per attendee. Kern Medical Center had 4 in attendance Kern Health Systems and Health Net each had 1.
- Active involvement in barrier identification and resolution by way of monthly "Collaborative Committee Meeting" attendance (County Departments/CBOs and LE)

Active involvement in barrier identification and resolution:
This incentive is reimbursed at $10,000 per meeting to our twelve CBOs/County Departments as well as us as the LE. Role was taken at each meeting to accurately record attendance. A maximum of 6 meeting attendances could be billed by the County Departments/CBOs and LE for the PY2 annual report. Achievement is measured by attendance. A list of all meetings held is included as attachment KernCounty.WPCAdminMetric.MeetingEffectiveness, and minutes will be attached separately. In addition to the LE, the County Departments/CBO's who were eligible to bill for this incentive are listed below:

The overall attendance was 73/78 of 93%

Kern Medical Center – 6 meetings x $10,000 = $60,000
Housing Authority – 6 meetings x $10,000 = $60,000
Probation – 6 meetings x $10,000 = $60,000
Aging and Adult Services – 6 meetings x $10,000 = $60,000
Health Net – 6 meetings x $10,000 = $60,000
KCSO – 6 meetings x $10,000 = $60,000
Kern Health Systems – 6 meetings x $10,000 = $60,000
Golden Empire Gleaners – 6 meetings x $10,000 = $60,000
Public Health – 4 meetings x $10,000 = $40,000
E.T.R. – 6 meetings x $10,000 = $60,000
C.C.C.C. – 3 meetings x $10,000 = $30,000

Kern B.H.R.S. (Formerly Kern County Mental Health) – 6 meetings x $10,000 = $60,000

DHS – 6 meetings x $10,000 = $60,000

VII. NARRATIVE – Pay for Outcome

Referencing the Whole Person Care Universal and Variant Metrics Technical Specifications, please provide a detailed explanation of the status of your program's performance on the pay-for-outcome metric(s). For the Mid-year report, only report those measures that are reported semi-annually; for the Annual report, please report all. Provide details that demonstrate what was achieved for each outcome, any challenges, and any lessons learned. Reimbursement will occur for achieved outcomes based on proposed annual target and methodology.

Our DHCS analyst instructed us to report our Pay for Outcome metrics as "NA" under the column and to claim the full amount, as we do not yet have our baseline data for this reporting period.

As indicated by California Department of Healthcare Services, the Kern County Whole Person Care Pilot will submit the Variant and Universal Metric report once metrics have been confirmed.

At this time, Kern anticipates to achieve all Pay for Outcomes requested.

As the LE we learned that building a strong relationship with our patients through extensive care coordination was crucial in minimizing avoidable emergency room visits and inpatient stays. Once patients developed a relationship with their care coordinator, they were frequently calling them to inquire how to address whatever medical issue they were facing. That relationship allowed our pilot to leverage the ability to collaborate with our patients and to encourage them to access proper, efficient levels of care for whatever medical situation they were facing.

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

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

VIII. STAKEHOLDER ENGAGEMENT

Stakeholder Engagement - In the text below or as an attachment to this report, please provide a complete list of all program policy meetings you have held with participating entity/ies and/or stakeholders during the reporting period, and a brief summary, with topics and decisions, of the proceedings. The list of meetings will not count against your word limit. Please Note: Do not include meetings held as part of providing WPC services (e.g. care planning, MDT meetings). Meeting information provided in the Mid-Year Report does not need to be resubmitted.

A Steering Committee was formed which consisted of the following County Departments/CBOs:

- Kern Health Systems
- Health Net
- Kern County Sheriff's Department
- Kern Behavioral Health and Recovery Services
- Kern Medical Center

This steering committee met in July and October and the overall goals of the Steering Committee are to provide overall direction and strategy, data governance, monitor performance measures, evaluate reentry into WPC service bundles, review evaluation committee summary report, hear appeals, provide notice of earned incentives, etc.

At our July meeting, in preparation for our first list of potential enrollees, we discussed the enrollment process in order to get ideas on how this workflow could take place. We also discussed the referral process for WPC patients to CBOs, including using our data sharing software. The data sharing software was not ready at the time, but we took time to explore possible methods for sharing information and referrals using software.

In October, we announced our new staff members who would help in all aspects of the patient care process, including the full time clinic physician, MA, and enrollment specialists/care coordinators, after having successfully enrolled a number of patients in the previous months. We discussed the successes and challenges we had faced with our newly enrolled list. We further discussed referral workflows to individual CBOs, and how they would be tailored individually. We also gave additional updates on our data sharing software and the progress we felt we had made in implementing it.

IX. PROGRAM ACTIVITIES

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

(1) Built and implemented a "Quick Reg" process, which allowed us to streamline non-billable encounters and be able to record them as care coordination touches. This increased our ability to document care coordination encounters in the chart so that the information was more readily available to the care team.

(2) Relationships that the care coordinators have built with the individual WPC enrollees have resulted in enrollees reaching out directly to their assigned care coordinator when they need guidance or are in crisis. This has afforded our care team to divert care from the ER and coordinate more appropriate levels of care our enrollees, ultimately resulting in reduced ER and inpatient utilization while enrolled in the program.

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

(1) Meeting enrollees needs when it comes to resources such as transportation can be challenging. Non-emergency medical transportation typically requires a 4-hour window to alert staff to pick up our enrollees. This makes same day appointments difficult. We have developed relationships with the non-emergency medical transportation providers and explained that our WPC population is medically fragile and that we need to be able to leverage these services for same day appointments where ER diversion is the most critical. In many cases, we have been able to coordinate services; however, we do see the need to have our own transportation up and running to negate these more acute needs in the future.

(2) Referrals for the program come through the partnered managed care plans; however, it was observed early on that contact information is regularly inaccurate or lacking. This has made the initial outreach challenging and a strain on outreach resources. In order to mitigate this challenge, the pilot has worked with Managed Care Plans to identify early on individuals with inaccurate contact information by identifying duplicate phone numbers, and cross-referencing contact information from the managed care plans with information currently held at the lead entity.

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

(1) The Lead Entity executed out agreement with Cerner for our HealtheIntent platform which will provide us with vital population health tools necessary to better track and aggregate data on our WPC Pilot population.

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

(1) We continue to work on leveraging i2i Tracks for our data sharing needs prior to the implementation of our Cerner HealtheCare platform. Because i2i Tracks was not intended to function as a care coordination platform, we continue to collaborate with technical support on ways to manipulate the software to better fit our immediate needs. Throughout this process, we have become acutely aware of what elements are crucial for tracking to facilitate the needs of our population.

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

(1) With the use of tracking types in i2i, we have been able to tailor those components of a Whole Person Care tracking types to fit the needs and specific data points we want for Whole Person Care individuals in a single, easily accessible location. This has allowed for quicker data entry, granting us more time to take care of patient needs.

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

(1) Not having access to the complete baseline data has made it very difficult for us to gauge our progress on metrics. This has additionally caused confusion around reporting for this annual report.

(2) We have no centralized repository for data collection and reporting. This has led to many manual processes, and a lack of real time data availability. The Lead Entity has acquired a new Population Health and analytics tool, including an EDW that will allow for streamlined processes, and more effective and timely sharing of data.

g.) Looking ahead, what do you foresee as the biggest barriers to success for the WPC Program overall?
For a pilot working with various partners across various organizations, the biggest challenge we foresee is the ability to keep all parties engaged throughout the process, especially those with varying levels of participation. Effecting change throughout an organization can be difficult, and when trying to replicate that change across multiple organizations, it becomes exponentially more challenging.

X. PLAN-DO-STUDY-ACT

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

List PDSA attachments

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