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

Kings County Human Services Agency
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

Kings County Human Services Agency

Annual PY2

4/2/2018

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.*

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

Coordination of health, behavioral health, and social services.

The Kings County WPC Pilot has achieved success Increasing integration among county agencies, health plans, and other entities as exhibited by the formulation of a the Kings County WPC Pilot steering committee know as the Local Advisory Committee LAC including county agencies, a major health plan, service providers, and other entities, comprising of senior administration representation who possess the authority for expedient decision making and policy implementation. The LAC has successfully prioritized and implemented WPC Pilot issues such as increasing target population community engagement as evident by the formulation and implementation of a Plan-Do-Study-Act PDSA.

Improved beneficiary health and well being through more efficient and effective use of resources.

One PDSA example has improved beneficiary health and well being by developing an infrastructure and plan of action to reach out and engage beneficiaries who otherwise would not access services of their own accord. The steering committee possesses a clear understanding of what the needs are of the target population and utilizes the PDSA process as a viable change agent.

Increasing coordination and appropriate access to care:

Coordination of health, behavioral health, and social services.

Increased coordination and appropriate access to care is demonstrated by the care coordination provided by the county Public Health Nurse. During the initial screening process a county Public Health Nurse assists enrollees with setting up needed medical, dental, and optometrist appointments with service providers. The appointments are then added to the enrollees care plan so the assigned case manager can follow up with the enrollee and encourage follow through and monitor care plan progress referencing measurable goals identified by the enrollee and care coordination team.

Improved beneficiary health and well being through more efficient and effective use of resources.

The county Public Health Nurse removes the barrier of navigating the healthcare system and advocates on behalf of the enrollee based upon the enrollees specific and individualized basic medical, dental, and vison needs which is an effective and efficient use of resources and increases the probability of the enrollee continuing to engage in WPC Pilot care coordination.

Reducing inappropriate emergency and inpatient utilization:
Coordination of health, behavioral health, and social services.
Reducing inappropriate emergency and inpatient utilization is evident by health care provider Anthem Blue Cross sharing with all WPC Pilot participating entities the resource of enrollees utilizing the (24) hour cost free nurse line (1-800-224-0336) which can be accessed by all Anthem Blue Cross members and exists as valuable alternative to inappropriately utilizing emergency departments or inpatient utilization due to lack of subject matter expertise. Triage can be performed over the telephone thus subsequently reducing emergency room visits unnecessarily.

Improved beneficiary health and well being through more efficient and effective use of resources.
The toll free nurse access line creates an opportunity for Anthem Blue Cross member enrollees to navigate the Kings County health care system more efficiently and effectively by having (24) hour access to medical health experts that can answer medical related questions expediently day or night when the enrollee is experiencing a medical issue.

Improving data collecting and sharing:
Coordination of health, behavioral health, and social services.
Improved data and collection sharing is exhibited by the WPC Lead Entity Kings County Human Services Agency (HSA) creating a shared electronic network data collection drive for the purpose of data tracking and capturing measurable outcomes. This shared drive is accessible to participating entities who work collaboratively in the WPC Pilot office including the county Public Health Nurse that screens enrollees for medical issues, the HSA Eligibility Worker who screens enrollees for potential benefits and Medi-Cal status, the county Behavioral Health Acute Care Case Manager who enters data regarding acute case management progress and services, and the contractor Champions Recovery Alternative who provides tracking of the referral process, screening potential enrollees for WPC eligibility, care plan formulation, housing navigation services, job development services, and case management services.

Improved beneficiary health and well being through more efficient and effective use of resources.
The enrollees receive an efficient chronological documented continuum of care coordination via the utilization of the shared electronic data collection drive. The centralized data base affords the participating entities access to real time data which assist in preventing duplication of services and increasing service efficiency.

Achieving quality and administrative improvement benchmarks:
Coordination of health, behavioral health, and social services.
The Whole Person Care Pilot achieves quality and administrative improvement benchmarks in multiple ways. Quality improvement benchmarks are demonstrated by the implementation of a quality assurance document and policy that ensures the enrollee has received all necessary screenings, formulation of a patient centered care plan, and receives a detailed copy of their rights while participating in the WPC Pilot. Administrative improvement benchmarks are evident by the formulation of the Implementation Team comprised of participating entities that review, revise, and submit all approved program policy to the WPC Pilot steering committee for final review and approval which creates a multi leveled system of policy and procedure implementation oversight which is necessary when developing a working infrastructure of a pilot program that takes into consideration the specific challenges and available resources of the county being served. Infrastructure development policy created by the Implementation Team includes procedures pertaining how to access WPC Pilot services via the referral process and creating a ,"No Wrong Door" policy . This policy enables potential enrollees the availability to self refer via telephone, electronically, or via a walk in basis and be served immediately. The referral process for an enrollee advocate has also been made as simple and user friendly as possible and contains only the very basic information necessary to initiate a referral which raises the likelihood of referrals being made.

Improved beneficiary health and well being through more efficient and effective use of resources.
Enrollees experienced ease of access to timely and quality care coordination which has lead to a continual increasing number or peer and self referrals as word of mouth in communities within Kings County spreads positive information about the cost free service.

Increasing access to housing and supportive services:
Coordination of health, behavioral health, and social services.
Increasing access to housing and supportive services is demonstrated by the WPC Pilot employing a Housing Navigator that utilizes a universal software program known as the Homeless Management Information System HMIS to assess risk of homelessness for enrollees and then subsequently facilitate appropriate linkage and referrals, in addition to providing advocacy services on behalf of the enrollees. The Housing Navigator collaborates with other housing resources in the community such as the United Way and the Kings-Tulare Alliance for the purpose of consolidating and sharing resources that benefit a shared target population while simultaneously utilizing the HMIS software to track measureable progress and decrease duplication of services.

Improved beneficiary health and well being through more efficient and effective use of resources.
When enrollees attain stable housing they demonstrate a propensity to address other issues identified on their individualized care plan with a higher rate of success and follow through due to one of their most basic needs being met.

Improving health outcomes for the WPC population:
Coordination of health, behavioral health, and social services.
Improving health outcomes for the WPC population is evident by the WPC Pilot partnering with one county medical entity known as Adventist Health Network and links enrollees with Adventist Health Network short term case managers who provide 30-60 day health related case management intervention to enrollees that have been recently discharged from the local emergency room. The case managers assist enrollees with accessing follow up necessary medical care.

Improved beneficiary health and well being through more efficient and effective use of resources.
Enrollees that receive follow up short term case management services from subject matter experts exhibit a pattern of engagement and follow through in aftercare related medical services thus decreasing the need and frequency of return to the emergency room.

Brief overview of program successes, challenges, and lessons.

The Kings County WPC Pilot has experienced the following successes**:**
1. WPC Pilot enrollment has steadily increased each month.
2. County Deputy Probation officers are more inclined to allow enrollees to continue receiving services as opposed to re-incarcerating for minor infractions and offenses.
3. County agencies are communicating and interacting on a proactive and consistent basis which leads to gradually breaking down silos.
4. Duplication of services has decreased across county agencies and participating entities.
5. Multiple enrollees are accessing residential substance abuse treatment and other behavioral health disorder interventions, who may not otherwise have accessed these services without the assistance of WPC Pilot Care Coordination.

The Kings County WPC Pilot has experienced the following challenges:
1. Case managers have experienced difficulty safely and respectfully securing belongings of enrollees who are suffering from homelessness and in need of transportation. Enrollees are reluctant to engage in services if their belongings are not safely secured.

2. Participating entities have been reluctant to share sensitive Protected Health Information PHI due to a Universal Authorization for Release of Information incorporating updated CFR Part 2 regulations not being available.

Kings County WPC Pilot lessons learned include:

1. Utilizing a comprehensive electronic information gathering software system is necessary to accurately track and report WPC Pilot evolving measurable outcomes and sharing requested outcomes with stakeholders who desire to provide a more efficient and effective service.
2. Overall Community awareness and engagement is a key contributing factor to current and potential enrollees being aware of the Kings County WPC Pilot provided services. The WPC Pilot has learned that branding or marketing the WPC Pilot is important to gaining trust of potential enrollees in the communities served.
3. Incorporating the patient centered evidence based practice of Motivational Interviewing is effective pertaining enrollee engagement and retention. Meeting the enrollee where there are at in regards to their readiness to make sustainable changes is an important component of providing case management services.

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	0	*	*	*	*	29

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
Service 1	0	0	0	0	0	0	0
Utilization 1	0	0	0	0	0	0	0
Service 2	0	0	0	0	0	0	0
Utilization 2	0	0	0	0	0	0	0
Service 3	0	0	0	0	0	0	0
Utilization 3	0	0	0	0	0	0	0
Service 4	0	0	0	0	0	0	0
Utilization 4	0	0	0	0	0	0	0

Whole Person Care

Kings County Human Services Agency

Annual PY2

4/2/2018

FFS	Costs and Aggregate Utilization for Quarters 3 and 4						
	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12	Total
Service 1	0	0	0	0	0	0	0
Utilization 1	0	0	0	0	0	0	0
Service 2	0	0	0	0	0	0	0
Utilization 2	0	0	0	0	0	0	0
Service 3	0	0	11	54	56	36	157
Utilization 3	0	0	$1,826	$8,964	$9,296	$5,976	$26,062
Service 4	0	0	0	*	0	0	*
Utilization 4	0	0	0	$*	0	0	$*

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
Bundle #1	$526	0	0	0	0	0	0	0
MM Counts 1		0	0	0	0	0	0	0
Bundle #2	$157	0	0	0	0	0	0	0
MM Counts 2		0	0	0	0	0	0	0

PMPM		Amount Claimed						
	Rate	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12	Total
Bundle #1	$526	0	0	$*	$*	$10,520	$14,202	$31,034
MM Counts 1		0	0	*	*	20	27	59
Bundle #2	$157	0	0	$*	$*	$*	$1,884	$4,239
MM Counts 2		0	0	*	*	*	12	27

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

Enrollment and Utilization, FFS 3 (Engagement) and PMPM 1 (Care Coordination) /PMPM 2 (Housing Navigation) all gradually and incrementally increased in PY2 as evident by the reported Enrollment and Utilization Quarterly reports.

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.

The Kings County WPC Pilot has developed an Administrative Infrastructure designed and developed specifically for achieving the goals identified in the WPC Pilot which include but are not limited to the coordination of health, behavioral health, and social services as applicable, in a patient centered manner with the objectives of improved enrollee health and wellbeing through a more efficient and effective use of resources. In order to achieve these identified goals and objectives, the following Administrative Infrastructure was established.

Multiple entities have combined resources and share information to fully integrate coordinated care and wraparound services. Kings County Human Services Agency HSA provides the Administrative oversight to ensure continued integration of services and development of reports. Appropriate data is shared amongst all entities with consistent, regular meetings, including stakeholders, participating entities, and service providers. The administrative infrastructure consists of two staff members including a Program Coordinator and Program Analyst, hired to fulfill these duties in addition to the responsibility of achieving program goals. The Program Coordinator and Program Analyst will be the main points of contact to support and coordinate with for the various participating entities and make sure all entities are communicating and not operating in silos. The Program Coordinator will administer the daily operations of the program, have authority to make decisions, and ensure effective flow of communication among all partnering entities. The Program Analyst will be the central point of contact for sharing and analyzing data throughout the pilot. HSA will provide oversight, leadership, communicate WPC requirements to all participating entities, make decisions and ensure that data is gathered and shared with stakeholders and participating entities. The Program Coordinator and Program Analyst work to attain Universal and Variant metrics data from participating entities and formulate detailed reports which are submitted to DHCS to ensure program goals are being met. The WPC Pilot also includes a two staff to support fiscal responsibilities. The Fiscal Account Specialist and Account Clerk t provide participating entity oversight of payments for incentives and reporting outcomes.

A Local Advisory Committee LAC was formulated consisting of stakeholders and participating entities that review monthly data from all program performance metrics, evaluates existing processes, identifies systematic inefficiencies, and generates

proactive and reactive ideas regarding improving the quality and efficiency and coordinated care, which is an overarching WPC goal. The LAC possesses decision making ability and works directly with WPC Pilot staff to remove barriers to accessing care and prioritizing programmatic revisions. The LAC meets once a month at a minimum. The LAC is facilitated by the Lead Entity HSA Program Manager and Program Specialist, as indicated above.

A Multi Disciplinary Team MDT was created for the purpose of processing and reviewing bi-directional data and the making recommendations to the Care Coordination Team, LAC, and Implementation Committee. The subject matter expertise recommendations include linkage to service providers that would potentially benefit WPC enrollees such as linking enrollees to behavioral health services, substance use disorder treatment, medical specialty practitioners, Human Services Agency benefits, veterans' services, and other ancillary services that would foster and support an increased quality of life for the enrollee. The MDT's formal recommendations are included on the initial enrollee care plan which is then reviewed with the enrollee who will prioritize his or her care plan goals with their case manager based upon their intrinsic motivation to address the identified issues. The MDT consists of staff from various local governmental agencies and community based organizations. The team is be located in the same building to allow for consistent and regular dialogue and meetings. The MDT assesses each WPC Pilot potential client regarding need and eligibility. The MDT is accountable to the LAC and Lead Entity Kings County HSA.

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 delivery infrastructure that has been designed and developed to provide timely, individualized care coordination services to a vulnerable population that meets the eligibility criteria of the WPC Pilot project. This identified target population includes individuals suffering from Substance Use Disorders, Mental Health illness, and poor control of chronic medical conditions.

This target population has historically experienced difficulty accessing, engaging in, and remaining engaged in services that will assist them in decreasing their need to utilize local emergency rooms and re-experiencing a return to law enforcement custody.

The WPC Pilot has created a centralized referral point which can be accessed via telephone, e-mail, website, or in person by a referring entity or a potential enrollee them self.

Upon receiving a referral, Coordinated Care Professionals from the WPC Pilot team including; an Eligibility Worker, county Public Health Nurse, and case Manager, perform initial screenings and evaluations for WPC program eligibility in person either in the field or in the WPC office with a patient centered strength based approach. During the initial screening process, if the potential enrollee expresses a need for housing and or job placement assistance, the potential enrollee is then scheduled to meet with the WPC Housing Navigator and Job Developer to assess specific needs and available resources.

Upon the potential enrollee going through the screening and assessment processes the individual's circumstances and case details are presented to the Multi Disciplinary Team (MTD) to determine WPC Pilot program eligibility. If the potential enrollee is determined to be a candidate for Whole Person Care and meets eligibility requirements, a Client Centered Care Plan is developed by the initial WPC screening practitioner and formally presented and discussed at the weekly WPC Care Plan Meeting where enrollment is established and individual needs are assessed and prioritized.

The Care Plan meeting includes the WPC assigned Case Manager and other individuals and entities which will be working directly with the enrollee to meet their individual needs and can include, county probation, mental health professionals, substance use disorder treatment providers, housing programs, outside case managers, medical professionals, and other in network professionals that have the resources to assist the enrollee in need.

The enrollee's Care Plan issues are prioritized, revised if needed, and a Care Plan is developed and ready to present to the WPC enrollee by the assigned Case Manager. The enrollee has the option to revise his or her Individualized Care Plan upon initial implementation and also at any point during the Care Coordination episode. 100% of enrollees received a Care Plan within 30 days of enrollment which is an identified WPC goal.

The assigned WPC Case Manager maintains consistent contact with the enrollee and assists the enrollee in building self-efficacy, acts as an enrollee advocate with service providers, removes transportation barriers to Care Plan related appointments, assists the enrollee with accessing and attaining prescribed medications, assists with SSI advocacy if needed, assist the enrollee with allocating a telephone so communication and correspondence can occur, performs follows up correspondence with service providers, and works with the enrollee to fill in any identified service gaps.

The Case Manager's role is specifically designed to assist the enrollee in meeting their individualized Care Plan needs which will ultimately contribute to the decreased need for the enrollee to rely on local emergency rooms and significantly decreases the probability of the enrollee returning to custody and improve the enrollee's health outcomes.

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

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.

During the PY2 reporting period, the budget did not contain funding for incentives. Incentives are incorporated into the pilot beginning PY3.

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.

The WPC Pilot is in the process of establishing baseline data. DHCS extended the period of gathering baseline data to June 30, 2018 in order to capture a more realistic and larger sample size for the baseline for comparison throughout the pilot period. This was especially helpful for our pilot as we are a second round applicant with a condensed period to enroll individuals into our pilot. Below is the progress we have made so far for establishing our baseline due to be finalized in August 2018.

Comprehensive Care Plan, Accessible by the Entire Care Team, Within 30 Days
The WPC Pilot has created a workflow and process in which to ensure the entire Care Team has access to the Care Plan within 30 days. The first step was to establish a real time communication system between all entities that provide WPC services. The LE, HSA, worked with County IT Department to develop a central communication system utilizing shared network drives in which all KARELink staff have access. This allows each team member to have real time access to information for every client and enrollee from the moment a referral is received until the enrollee is dis-enrolled from the pilot.

An initial challenge was creating templates to be used by all to ensure communication was consistent and understandable to everyone on the team on the shared drive. This was quickly remedied by creating and agreeing upon templates and training any new staff on the expectations for each template. Training on appropriate ways in which to use Case Notes and creating templates was also done for similar reasons. At the time of this report, the entire WPC Care Team has access to the Coordinated Care Plan for 100% of WPC enrollees. The PY 2 baseline has been attained. This positive outcome possesses the capability to be replicated in PY 3-5. PY 3 has a target goal that 75% of enrollee Care Plans will be accessible to the Care Team within (30) days. PY 4 Has a target goal that 80% of enrollee Care Plans will be accessible to the Care Team within (30) days. PY 5 has a target goal that 85% of enrollee Care Plans will be accessible to the Care Team within (30) days.

Decreasing HbA1c Poor Control <8%
The WPC Pilot is in the process of finalizing MOU's and Contracts with Health Care Providers to obtain the information needed to track this information. The WPC Pilot has initiated gathering HbA1C data for the purpose of establishing a baseline. We feel

confident that we have achieved the goal in PY 2 to maintain baseline. The WPC Pilot has attained HbA1C for (3) enrollees. Of the (3) enrollees, (2) enrollees possessed HbA1c control levels <8.0% subsequently demonstrating a 67% desired outcome metric. The WPC Pilot is optimistic and confident that a larger sample size will produce similar positive outcomes in PY 3 and will incorporate and utilize the PDSA process as a catalyst for this process.

One challenge is lack of Primary Care Physician care and follow-up. Many of our other diabetic enrollees were first needing linkages to a Primary Care Physician PCP and continued motivation from their Case Manager to initiate communication with a PCP for recommendations of controlling diabetes.

Another challenge has been diabetic education. From statements made by enrollees, only one enrollee that has been diagnosed with diabetes was made aware of their HbA1c score. The WPC nurse also reports that the PCP does not tell many enrollees about the HbA1c test, the implications of the test, or their scores. Most enrollees are only educated on glucose levels and how to test glucose levels.

A PDSA will be done in PY 3 regarding this topic. The PDSA will address overcoming identified barriers to accessing enrollee health information and establishing a working system to access enrollee HbA1C data to compare and contrast to an existing data baseline.

Decreasing Jail Recidivism

The WPC Pilot works closely with Kings County Probation identifying potential enrollees whom appear to meet the target population. The findings from PY 2 are preliminary making current efforts uncertain to the overall success of this partnership but we feel confident that the PY 2 goal to maintain baseline has been attained. One item discovered is that of the current enrollees that are in our pilot, those with the highest compliancy rate are connected through the probation department. Care Coordination between the Probation Department and Case Managers have led to some success stories of enrollees being diverted from potential incarceration due to their continued work and contact with their Case Manager. The WPC Pilot has attained data to report which will be utilized to establish a baseline. As of June 30th 2017 for the age group (14) years or older, there were (*) incarcerations, within (59) member months, incorporating incarcerations per 1000 member months at an identified number of (68). For the same age group as of December 31st 2017 there were (*) incarcerations, within (59) total member months, incorporating incarcerations per 1000 member months at an identified number of (68). The WPC Pilot is optimistic that in PY 3, there will be a 10% recidivism reduction from the established baseline. The WPC Pilot is confident that PY 2 baseline will be maintained in PY 2.

The WPC Pilot did encounter two specific challenges. The first challenge is experiencing difficulty engaging referred individuals post release from incarceration. The second challenge is related to the first challenge in respects to the WPC Pilot not being afforded the opportunity to start services with potential clients and referred individuals while they incarcerated in the county jail. If services including screenings were started pre-release it is plausible that engagement and retention in WPC Pilot services would also increase due to professional rapport and initiation of advocacy being established.

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.

Please see the attachment formally referenced as VIII. Stakeholder Engagement.

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

The meetings initially focused on establishing roles and specific responsibilities of the LAC and Implementation Teams and the purposes of these working groups including short term objectives such as developing and voting on a proposed budget and delegating specific research tasks, long term goals including policy and procedure development and implementation and establishing workflows with desired measurable outcomes.

The LAC group then proceeded to work on researching and choosing an identified software program and service provider that the team would utilize to gather and share data. Initially one provider was chosen yet due to encountered obstacles the LAC then chose to move forward with an alternate provider named Efforts To Outcomes (ETO) Social Solutions.

The Implementation Team began to start the MOU and contract development process with Participating Entities within the County service delivery system. Priority was placed on establishing the Champions Contract due to this agency being the Lead Community Partner and core of the Care Coordination system of care.

Participating County agencies such as HSA Human Services Agency and Behavioral Health then began to identify who the assigned HSA Eligibility Worker and Low Ratio Case Manager was going to be and where they would be strategically stationed to increase communication and data sharing.

The Implementation Team then updated the IGT Inter Governmental Transfer Policy which emphasized transparency and fiscal accountability. The WPC logo was created and ADA Compliance issues were addressed in regards to office work stations.

The LAC shifted their focus to understanding the PDSA model and how to utilize the model care coordination, data sharing, case management, and care planning. The members were introduced to DHCS Enrollment and Utilization report expectations and discussed best practices to ensure accurate and valid data due to a formal software system not being up and running at that time. A WPC website was created, presented, and approved. The budget continued to be a static and ongoing information assessment and sharing process.

The Implementation team placed bids on WPC vehicles to be utilized, contracts and MOU's were still under development, and the referral infrastructure was discussed and implementation proposed.

A temporary referral, pending enrollee, and enrollee centralized data base drive was created out of necessity for the purpose of data tracking and storage and accessing data in real time for reporting and information/data sharing with all team members.

Ideas were presented on how to promote community outreach and engagement and strategies were identified on how to inform the professional community and general public about WPC services. GAP analysis reports were generated based upon the needs of enrollees and how to fill those gaps with available resources. One example includes identifying transportation as a service GAP and inviting Anthem Blue Cross to explain to the WPC team how enrollees can receive cost free transportation to care plan related appointments.

Additional brief summaries and policy meeting decisions by participating entities and stakeholders are included in the attachment formally referenced as VIII. Stakeholder Engagement.

IX. PROGRAM ACTIVITIES

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

(1) One of the successes the WPC Pilot has had with Care Coordination is the utilization of an evidence based Case Management practice know as Motivational Interviewing which emphasizes collaboration between the enrollee and the case manager creating a teamwork approach based upon the enrollee's stated needs during the time of initial screening. Time and energy is invested into establishing and fostering rapport and a professional relationship with the referred potential enrollee which has proven to enhance the care coordination episode as evident by enrollee peer and self-referrals steadily increasing.

(2) Another success experienced regarding Care Coordination is the utilization of cost free transportation services offered by Anthem Blue Cross and CalViva providing transportation to and from medical, mental health, and substance use disorder treatment appointments. Case Managers are linking enrollees to free transportation services that enrollees were not previously aware of which removes an identified barrier to accessing needed service provider appointments which are frequently not attended due to this barrier . The costs free transportation services can also continue after successful completion of the care coordination episode. This allows for the Case Manager to focus on other transportation needs as they arise.

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

(1) One challenge the WPC Pilot has faced is case managers experiencing difficulty contacting potential enrollees telephonically due to many of them not possessing a stable and reliable contact telephone number.

The lesson the WPC Pilot learned was to assist the enrollee with accessing a reliable telephone funded via the 2010 Affordable Health Care Act funding, as soon as possible.

(2) Another challenge the WPC Pilot has encountered providing care coordination is storing enrollees' belongings (e.g. shopping carts, pets, important personal items) when attempting to transport an enrollee to a community service provider scheduled appointment.

The lesson the WPC Pilot learned is to communicate transportation policies and procedures to the enrollee prior to transporting the enrollee while attempting to be as

accommodating as possible which has included utilizing an agency van to transport an enrollee's bicycle and or other important large personal belongings.

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

(1) One success the WPC Pilot has experienced with data and information sharing is the utilization of a centralized comprehensive data storage drive accessible to the Lead Entity Program Manager, Lead Community Partner Case Managers, Job Developer, Housing Navigator, Office Assistants, Mental Health Practitioner, Behavioral Health Case Manager, Public Health Nurse, and the Program Eligibility Worker. The aforementioned individuals are strategically stationed in one office complex which increases expedient verbal communication, decreases service silos, and affords each individual instant access to real time enrollee data.

(2) Another success the WPC Pilot has experienced in regards to information sharing is the weekly Care Plan Meeting that creates and implements a client centered individualized Care Plan which is S.M.A.R.T (specific, measurable, attainable, relevant, and time oriented) based upon the enrollee's stated needs and strengths as verbalized by the potential enrollee during the screening process. The Care Plan consists of the enrollee's objectives and goals in combination with recommendations from the Multi-Disciplinary Team which includes initial screening recommendations concerning demographic information, Mental Health/Suicide Risks, identified Medical issues, Substance Use Disorder needs, housing needs, legal issues, and employment/educational needs.

Referring entities in addition to services providers currently working with the enrollee are invited to attend the care plan meeting and provide detailed information which helps eliminate duplication of services and increase prioritization of the enrollee's identified needs while placing emphasis on the enrollee's intrinsic motivation for utilizing the WPC pilot, subsequently strengthening the probability of continual engagement in the WPC Pilot.

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

(1) The identified challenge the WPC Pilot has encountered regarding data sharing includes the utilization of provider specific enrollee Releases of Information that meets HIPAA guidelines. The WPC utilizes a general release of information for contacting

service providers/participating entities regarding enrollees yet specific data/information sharing elements can only be attained by utilizing the Service Provider's agency approved ROI which can delay the Care Coordination process.
The lesson learned is that a designated and reliable point of contact on the service provider end is beneficial when attempting to expedite Care Coordination services. An identified individual that possess the time and resources to allocate to WPC enrollees.

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

(1) One success the WPC Pilot has experienced regarding data collection and reporting is successful tracking and completion of the DHCS Enrollment and Utilization of WPC referrals, pending enrollees, and enrollees. The WPC Pilot tracks and reports detailed information about individuals and groups and can identify primary referral sources and where outreach efforts need to be focused.

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

(1) One challenge the WPC Pilot has experienced with data sharing is a lack of automation and fragmented reports due to an unestablished formal data collection software system.

The lesson learned includes creating a data infrastructure supported by field specific software prior to enrolling program participants and developing data outcome measurements to run parallel with programmatic expansion.

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

Looking ahead the County of Kings foresees the biggest barriers to success for the WPC Program overall are: Current lack of stable housing options for enrollees, competing demands on match source funds that may supersede the WPC Pilot, and the actual costs of provided services are higher than the amounts stipulated in bundle packages forcing vendors and/or service providers to possibly cancel their contracts.

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.

Please see attached PDSA's for PY2 Quarter #1 & Quarter #2

The PDSA attachments will attempt to demonstrating the WPC Pilot's progress in relation to the infrastructure, services, and other strategies as described in the approved WPC LE application and WPC STC's.