Kings County Human Services Agency

Kings Area Resource and Enhanced Linkages (KARELink)

Whole Person Care Pilot Project 2017

Section 1: WPC Lead and Participating Entities Information

1a. Lead Entity Description

Kings County Human Services Agency (HSA) will provide leadership and support for this project. HSA will be the single point of contact for the Department of Health Care Services (DHCS) as well as provide the necessary leadership, coordination, and monitoring of this project. Kings County will lead the Local Advisory Committee (LAC).

1.1 WPC Lead Entity and Contact Person

Organization Name	Kings County Human Services Agency (HSA)
Type of Entity	County Human Services Agency
Contact Person	Sanja Bugay or Shannon Tolbert
Contact Person Title	Director and Program Specialist
Telephone	(559) 852-2200 or (559) 852-4636
Email Address	sanja.bugay@co.kings.ca.us or shannon.tolbert@co.kings.ca.us
Mailing Address	1400 W. Lacey Blvd. #8 Hanford, CA 93230

1.2 Participating Entities

Required Organizations	Organization Name	Contact Name & Title	Entity Description & Role in WPC
Medi-Cal Managed Care Health Plan	Anthem Blue Cross	Janet Paine, Program Director	• One of the two managed health care plans for Kings County. • Bi-directional data, ED utilization, data analysis • Provide services in health plan including transportation, telehealth, 24/7 nurse line, health classes, wellness tips • Member of Local Advisory Committee (LAC).
Health Services Agency/Department	Kings County HSA	Sanja Bugay, Director & Shannon Tolbert, Program Specialist	• Lead on LAC • staff Multi-Disciplinary Team and LAC • Admin & fiscal support • Manage WPC • Develop data sharing & bi-directional data sharing infrastructure • Ensure collaboration between public & private entities
Specialty Mental Health	Kings County Behavioral Health Department	MaryAnn Ford Sherman, Director	• Provide support and staff to the Multi-Disciplinary Team. • member of LAC • Provide services & bi-directional data
Public Agency/Department	Kings County Public Health Department	Debbie Grice, Deputy Director	• Provide support and staff to the Multi-Disciplinary Team. • member of LAC • Provide services & bi-directional data • Member WPC

Community Partner #1	Champions Recovery Alternative Programs, Inc.	Crystal Hernandez, Director	• Lead community partner. • provide care coordinators, life skills peers, and a job navigator • Short Term Recuperative Care • Care coordinators focus on co-occurring treatment, residential treatment, & many of the support services • Member of LAC • Bi-directional data
Community Partner #2	Adventist Health	Rebecca Russell, Community Wellness Director	• Emergency Department for Kings County • provide ED utilization data & analysis • Provide Comprehensive Care Coordination and a High Intensity Mental Health Respite • Member LAC • Provide integrated care coordination for complex cases, • Bi-directional data
Additional Organizations	**Organization Name**	**Contact Name & Title**	**Entity Description & Role in WPC**
Public Agency/Department	Kings County Sheriff's Office	Robert Thayer, Assistant Sheriff	• Jurisdiction over jail for Kings County. • Main source of referrals into WPC. • Provide data • Member LAC

Public Agency/Department	Kings County Probation Department	Kelly Zuniga, Chief Probation Officer	• member of LAC • staff to manage the Multi-Disciplinary Team & Care Coordination team • KARELink coordinator for WPC.

1.3 Kings County Human Services Agency at 1400 W. Lacey Blvd. #8 Hanford, CA 93230 may be contacted for access to the letters. Refer to section 1.1.

Section 2: General Information and Target Population

2.1 Geographic Area, Community and Target Population Needs

Community Description:

Kings County is comprised of urban and rural communities with a significant divide between ethnicities and socioeconomic statuses, and disproportionately high levels of poverty, violence, crime, gang participation, mental illness, and substance use. The county is 1,436 square miles of largely agricultural land within the San Joaquin Valley with a population of 150,373 that includes 56,875 Medi-Cal Beneficiaries. Approximately 33,270 people (22%) live in the rural communities of Corcoran, Avenal, Stratford, Armona, and Kettleman City. Hanford is the largest city in the county with a total of 55,840 which is 37% of the county population. Each city in our county is separated by vast amounts of agricultural land. Kings County is entirely within the 21st Congressional District. The 21st Congressional District ranks last in health, education, and standard of living.

According to the Unites States Census Bureau, the percentage of people living in poverty in Kings County is 22.4% compared to the state average of 15.3% in 2015. One reason for this is the low graduation rates within the county. Between 2011 and 2015, only 72.2% of the population graduated from high school in Kings County compared to a state-wide average of 81.2%.

Kings County has consistently experienced high unemployment rates for the last ten years. In December 2016, the rate was 9.9% compared to the state average of 5.0%. (California Employment Development Department).

Target Population Needs:

Our county experiences a high rate of incarceration of 333 arrests per 100,000 residents, which is 76% higher than the state average of 189 arrests per 100,000 residents (Board of State and Community Corrections, 2017). Kings County is home to

three state correctional facilities with another facility within 30 miles of the county line. The county receives an average of twenty pre-release applications per month from the California Department of Rehabilitation and Corrections. From 2011 through 2015, Kings County had a 72.5% recidivism rate according to Kings County District Attorney's Integrated Justice System. Of those incarcerations, 76% had a co-occurring symptom or diagnosis.

Kings County experiences a higher than average rate of opioid related overdoses, deaths, hospitalizations, and prescription rates. According to the California Opioid Overdose Surveillance Dashboard, in 2014 Kings County experienced: 8.4 overdose deaths/100,000 residents; 12.4 overdose Emergency Department visits/100,000 residents; and 19.8 overdose inpatient hospitalizations/100,000 residents. During 2015 there were 683.7 opioid prescriptions/1,000 residents which is higher than the state average of 619.19/1,000 residents.

A contributing factor to high substance use is the gaps in care for those experiencing mental health issues. Currently, Kings County uses the Emergency Department in Hanford as the sole resource for those experiencing severe mental health crises. In 2016, Adventist Health Emergency Department reported an average of five crisis patients screened daily per California Welfare and Institution Code-5150 (W&IC 5150). The only service provider for the WIC 5150 is Adventist Health Emergency Department. Long term facilities are located outside the county line and are often at capacity. Currently, Kings County uses the Emergency Department as the sole service for those experiencing acute psychiatric emergencies.

As data was collected for this project, a gap was identified for preventive health specifically those with diabetes and high blood pressure. In 2015, 74% of diabetics received the HbA1c test which is the best indicator as to whether the patient is monitoring their diabetes well. The weighted average of patients administered this test was 85.8% and the goal is to have more than 90% of patients with diabetes tested. The 57% tested showed that they did not have good control of their diabetes compared with the state weighted average of 36.6%. Good control is indicated by a score of 9 percent or less on this test and the goal is to have 30% or less with a percentage of less than nine percent. According to the Burden of Diabetes in California Report from September 2014, 9.4% of Kings County residents have Type 2 Diabetes and 36.6% of residents suffer from obesity as measured by a Body Mass Index (BMI) at or above 30. Kings County ranks 56th out of the 58 counties for the number of deaths as a result of diabetes. The state average is 20.4% compared to Kings County at 30.3%. 49% of

members do not have control of their hypertension as compared with the weighted state average of 61%. (2015 Healthcare Effectiveness Data and Information Set Aggregate Report).

How Other Participating Entities Took Part in Defining the WPC Vision and Structure:

In developing the KARELink Program, HSA engaged potential participating entities and held multiple meetings to identify current services offered throughout the county, duplication of services between multiple entities, as well as some gaps in services for those in our community in order to create the vision and develop the structure for KARELink. The planning process included a multi stakeholder data analysis effort to develop comprehensive understanding of the challenges and opportunities to address gaps in current county health care system efforts to serve the target population.

Once the discussion of the existing services to the target population began, the gaps in the existing system became clear, providing us with an opportunity for improvement. The planning process that occurred over the next year evaluated the existing services to understand how this target population could get access to comprehensive services. When a root cause was identified, key community stakeholders were brought together to develop a potential solution to and new process for accessing comprehensive services. The community stakeholders included: Kings County HSA, Public Health, Behavioral Health, Anthem Blue Cross, Kings County Sheriff, Kings County Probation, Champions, Adventist Health, and First 5. Gaps that were identified through this process are: the lack of acute psychiatric emergency services; a lack of a crisis residential resource; a lack of intensive case management for the severely and persistently mentally ill and those suffering chronic health conditions; a lack of a centralized evaluation of need; and a lack of comprehensive care coordination and care coordination. The gaps allowed the group to identify substance use, mental illness, and chronic health conditions as a root cause of high inappropriate emergency department visits as well as high recidivism in the jail. Interventions to address each of these gaps have been developed and are in various stages of implementation. As lead entity, HSA will employ a rigorous and efficient process for interagency communication.

General Description:

As lead entity, Kings County HSA will lead the implementation of the Whole Person Care Pilot Project. Locally, this project will be known as Kings Area Resource Enhanced Linkages (KARELink) Kings County is committed to this pilot, and KARELink aligns with the with the County Vision to cut the number of adults with mental illnesses and co-occurring substance use disorders in our jails by building off of evidence-based practices that have shown success throughout the country. Additionally, Adventist Health Central Valley Network (AHCVN), a group of local agencies and partners, has a

mission to build a collaborative bridge to wellness for people with behavioral health issues who are homeless or at risk of homelessness. Innovative Individual-Focused Design: Kings County is proposing a large paradigm shift with the design of the KARELink Program when compared to current services within the county. Currently, each agency or community partner operates in silos and relies on referrals to each separate entity. Wait lists are then created from the referrals which delay services for those in need. KARELink will create an enrollee-centered, individualized system of care that meets the unique needs of each enrollee and his/her immediate family by quickly linking each person in need to services. Many of the service providers will be located in the same building, which will help streamline this process. KARELink will increase capacity to cut wait lists for the most successful and used services. KARELink will serve a total of 600 unduplicated Medi-Cal beneficiaries with the linked services including existing, expanded, and those newly created with this project.

Although Kings County did not apply for the first round of WPC, it started having discussions about WPC and the project in April 2016 and began identifying some of the barriers to services for Kings County. The original pilot group developed into the LAC which includes all the participating entities as well as the District Attorney, Job Training Office, legal aid, and county finance. HSA, Public Health, Behavioral Health, and Champions are represented at both the LAC and the Wellness Bridge Project which provides a link to both groups. As the groups met, shared statistics, and discussed the implications of the statistics, the target population was identified. Some efforts were deemed most needed and funding was identified immediately. These efforts include: respite services for the mentally ill, acute psychotic episodes longer than 72 hours, sobering centers, re-entry services for those leaving the local jail, and the need for trained EMT staff to quickly identify and transport those needing emergency substance use and/or mental health issues. As the program continues, the participating entities will continue to find revenue sources to continue the successful components for KARELink. Anticipated revenue sources include: savings associated with reduced recidivism, savings at Adventist Health with reduced emergency room utilization, and other revenue sources available through the county general fund.

KARELink multi-disciplinary team (MDT) will serve as the comprehensive screening and assessment mechanism to determine eligibility for system participation. This is an entirely new approach to serving our impacted populations for substance abuse, mental health, and chronic health conditions. The disciplines included within the MDT are a Clinician (Psychologist), Registered Nurse, County Eligibility Worker, Housing Navigator, and Job Developer. The MDT will be led by the KARELink Coordinator, staffed by the Kings County Probation Department, who will work closely with the lead entity, Kings County Human Services. For each enrollee deemed eligible for KARELink, a complete screening and assessment will be completed.

Data obtained from the MDT process will be incorporated into a coordinated plan of care for the enrollee and provided to the KARELink CCT for implementation of services.

Each referral will receive a quick triage within 24 hours to determine the level of priority. Potential enrollees will be placed in the appropriate living situation which includes: High Intensity Mental Health Respite (highest level of need), crisis residential, medical respite, residential treatment, transitional housing, short term recuperative care unit, or in home placement (lowest level of care need). Situations that require emergency medical services will be routed directly to the Emergency Department with follow-through post discharge.

How KARELink Will Address the Needs of the Target Population:

KARELink will target those in our community who access care inappropriately (e.g., emergency rooms) and are considered high cost and high utilizers of various public systems. The target population must have one or more of the following: a substance use disorder, mental health issues, or a chronic health condition of diabetes or high blood pressure. KARELink will provide comprehensive assessment of all enrollees and then link enrollees to services and individualized levels of care ranging from intense to moderate through care coordinators. The placements will be based on the assessments made by the MDT.

Kings County lacks a gateway to services, therefore creating a new system is essential. The four main referral sources to KARELink will include: health services, law enforcement, the county jail, and community business organizations. KARELink will be promoting the new program and working with the community organization to make people aware of it via power point presentations and flyers. Anthem Blue Cross will also refer people as will our other Medi-Cal managed care plan serving Kings County (Cal Viva Health) and many referrals are expected to come from Kings sole emergency department, emergency medical technicians (EMTs), local clinics, and anyone receiving services at the High Intensity Mental Health Respite unit and the Short Term Recuperative Care Unit. Law enforcement referrals include all the city police departments (Hanford Police Department, Lemoore Police Department, Corcoran Police Department, and Avenal Police Department), Kings County Sherriff, District Attorney, and Kings County Probation. The Kings County Jail is expected to refer all inmates who are eligible through a newly created re-entry program. Other referral sources include but are not limited to: Kings Community Action Organization (KCAO), Family Resource Centers, the United Way, the Salvation Army, and various church organizations that assist those within the target populations. The referral process will be simplified for quick screening and turnaround from the various referral sources to not create a barrier of entry into the program. The screening form will be vetted and potentially refined by the community stakeholder group that will be comprised of the primary referral sources.

2.2 Communication Plan

The KARELink 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 KARELink 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.

KARELink will include MDT and Care Coordinator Team (CCT) which will meet together daily to discuss and share bi-directional data. The MDT will include seven staff from various governmental agencies and community- based organizations. Each member will bring distinctive specialties representing health, mental health, Medi-Cal Eligibility, and others. The team will be located in the same building to allow for regular, consistent meetings to discuss each enrollee regarding his/her needs, system of care, and all other outside resources that are available or made available in the future. The MDT will assess each enrollee on need and eligibility. Their recommendations will then be shared with the CCT. The MDT team is accountable to the LAC and HSA. The policies and procedures under which the MDT will work will be reviewed and approved by the LAC. In addition, the monitoring of the MDT's productivity, outcomes and resolutions of issues that impede the operations of the pilot will be elevated to the LAC by the KARELink Coordinator or the Program Analyst.

The MDT will work collaboratively with the CCT and will also be co-located with the MDT. Co-location allows for constant communication between the MDT and the CCT, especially when re-assessments are necessary. The CCT will consist of six care coordinators from our lead community based organization, Champions. The CCT will be utilizing a software system called Efforts to Outcomes (ETO) for case load management and tracking of recidivism rates, suicide assessments, ongoing preventive health measures, and the participation service usage rates of enrollees. The CCT workload will be driven by the MDT and the operational policies and procedures will be subject to both the MDT's and LAC's review and approval. The CCT outcomes, workload, and operational issues that may impact the operations of the pilot will be addressed during CCT meetings. The KARELink Coordinator and the Program Analyst will resolve normal day- to- day working issues and bring only structural and significant administrative issues to the LAC.

<u>Governance Structure and Decision-Making:</u>

The LAC includes representatives from all the participating and supporting entities and will meet monthly. The participating and supporting entities include: Kings County Human Services Agency, Anthem Blue Cross, Public Health, Behavioral Health, Kings County Sherriff, Kings County Probation, Champions, and Adventist Health. The LAC and KARELink administrative staff will hold regular monthly meetings to make sure that the program and following items are monitored: 1) review of monthly data from the program on all performance metrics, 2) evaluation of processes, inefficiencies, and efficiencies for quality and process improvement, 3) challenges and barriers, and 4) continued planning. The LAC will have decision-making responsibility and will work collaboratively with the KARELink staff and others to make sure barriers such as access, support for staff, and the coordination of services are resolved. The LAC will confront areas of concern and address each issue in a collaborative way with KARELink staff and others, as needed.

As lead agency, Kings County HSA will lead the monthly LAC meetings. Prior to each meeting, members of the LAC will receive an agenda with the items to be discussed that month which will include the following each month: Program Analyst/KARELink Coordinator report, Anthem Blue Cross Trend reports, and review of additional available resources/services added within the county network from all participating entities including the status of barrier process improvement. During the WPC 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. Each meeting agenda will include a PDSA line item for barrier process improvement. The LAC 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. The Program Analyst and the KARELink Coordinator will present an overview of the progress from the month prior report on monthly trends. This report will include high- level data related to the outcomes from the bi-directional data monthly data that was collected from the various, participating entities such as Anthem Blue Cross, Public Health, Champions, Kings County Sheriff's Department and Adventist Health.

2.3 Target Population

The target population was selected after careful local data evaluation, which identified the most vulnerable populations with the most emergent needs. The creation of strategies and services to discuss the needs of each target population will create wellness for the populations and increase overall health of the community.

The primary target population is the high cost, high utilizers of services who access care primarily on a crisis basis via an emergency room or do not access care on an ongoing

basis and are often incarcerated. These individuals must have at least one or more of the following: a substance use disorder, a mental health issue, poor control of diabetes, or poor control of hypertension (high blood pressure).

- **Substance Use Disorders–** As indicated above, Kings County has high rates of use of various substances including opioids, heroin, and methamphetamine. Addiction to these substances has shown increased emergency room utilization and incarceration.

- **Mental Health** – Gaps have been identified for individuals with mental health issues as shown by the lack of services mentioned above. The only services available for people with persistent mental health issues within the county are the emergency department and incarceration.

- **Chronic Health Conditions (Diabetes and High Blood Pressure)** – Kings County is consistently rated low on both preventive care and indicators of good control for both diabetes and high blood pressure as seen by the statistics related to the health in Kings County.

The barriers that exist in our county including high incarceration rates, high unemployment rates, a lack of transportation, and educational barriers all compound the issues for the target populations within Kings County.

KARELink will fill the gaps and decrease the silos that are inherent in the various entities within the county. A single care coordinator will act as the guide to the enrollee to lead him/her through the varied new and existing services within the county. The care coordinator will be the key to creating a coordinated care plan that is individualized for each eligible enrollee and based on comprehensive assessments for which services are then provided. KARELink will serve a total of 600 unduplicated Medi-Cal Beneficiaries throughout the entire project.

Data from Champions showed 2,000 unduplicated individuals were served last year. This number was adjusted for the maximum capacity of the KARELink program being designed which was not as high as Champions capacity to enable increased case management and coordinated care amongst various entities. The maximum capacity was first determined by caseload size (20 enrollee per Coordinated Care case manager with six case managers' equals 120 enrollees per month). In addition 1440 is the maximum number of member months per year with 50 percent attrition rate KARELink is projecting approximately 790 unduplicated clients. (20 x 6 x 12= 1440. 1440 x .5 = 720). We anticipated each enrollee to be within the program for an average of 6 months to a year. To ensure success in KARELink, the unduplicated numbers was limited to a manageable amount.

The approximate attrition rate currently experienced in Behavioral Health, Public Health, and Champions was used to estimate the number of enrollees remaining from the prior year.

Natural attrition will occur and some enrollees may have resistance towards intervention services and difficulty with attendance or adhering to program policies. When resistance occurs, partnering agencies will use rapport building, peer mentorship, and consistent follow-up with enrollees in order to reduce the potential attrition compounding issues.

The MDT and CCT will be housed in the same building within the Kings County Government Complex near the center of the city. Being co-located will be a fundamental part of the success of KARELink and a critical component of our communication plan. A majority of the key entities will not only be located in the same building, many will be in the same office within that building, which will create prompt and constant access to each discipline and eliminate silos. Co-location will allow members to quickly share bi-directional data to update one another on enrollee specific information impacting current plans, share information regarding new resources available through other efforts within county/community members, and provide immediate access to information needed from other agencies and most importantly, share information pertaining to enrollees. Co-location will reduce attrition, in large part due to the communication component created by KARELink.

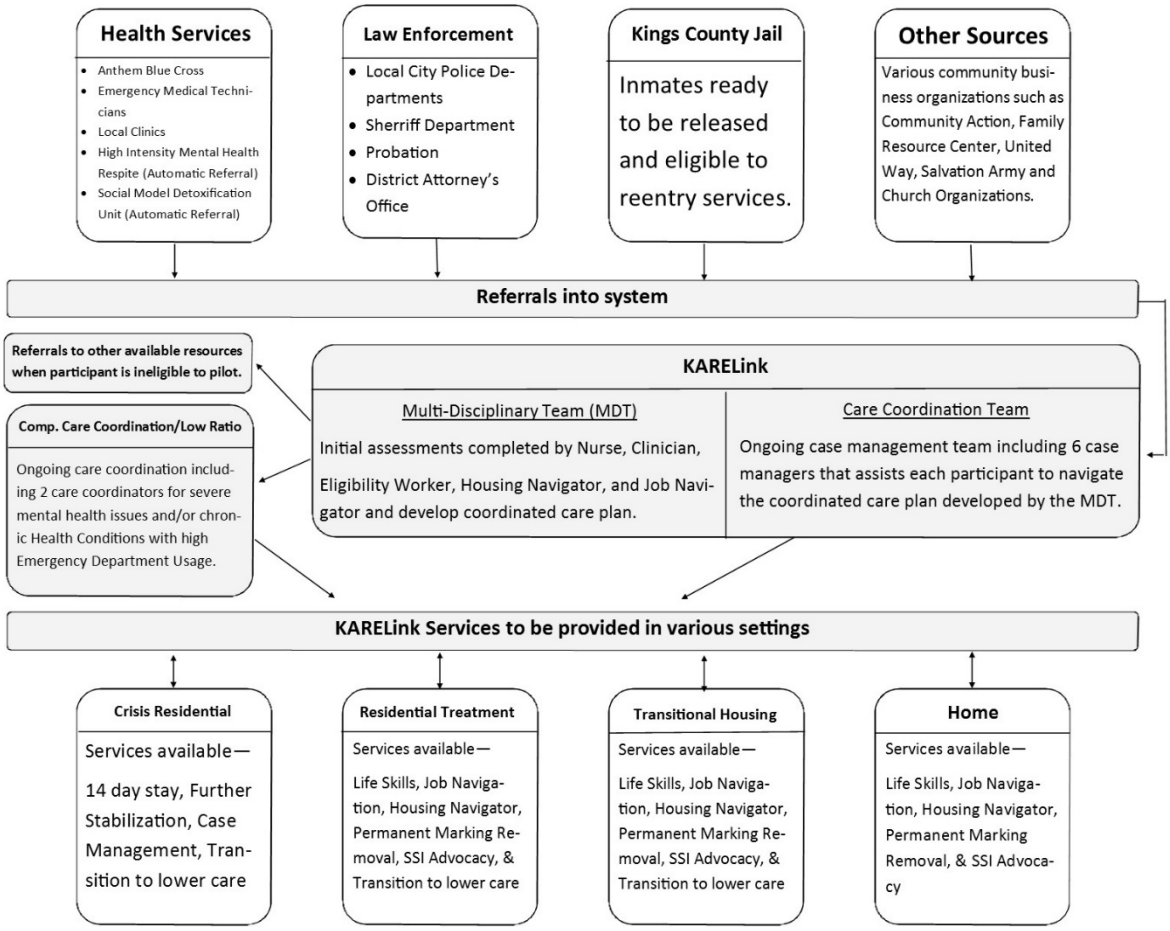
The anticipated overlap of enrollees from year to year will be approximately 50%, taking into account enrollees who have successfully completed the program and others who have chosen to leave the program. The natural attrition mentioned above was also taken into account for year to year overlap. Care coordinators will determine the success for an enrollee by evaluating the level of care he/she has reached, evaluating the predetermined benchmarks set at initial assessment, and reviewing the ongoing successes achieved, which will include, but not be limited to: stable housing, stable mental/physical health, and/or employment or other consistent income source. Enrollees who have transitioned to in home services, successfully graduated from their individualized plan, and have maintained consistency with their individualized goal will be deemed as no longer having a need for KARELink.

The LAC recognizes that we will serve less people in project year two given that by design this year will be 6 months shorter than the other years. An increase in participation is expected in later years of the project due to full implementation of expanded services, the expectation that staff will have gained increased knowledge and experience, and KARELink's successful marketing efforts within the community of the services available. The following table shows the anticipated number of enrollees and overlap for each project year.

Target Population	PY2	PY3	PY4	PY5	Total
Number of new enrollees (Unduplicated)	**105**	**155**	**165**	**175**	**600**
Number of enrollees remaining from prior year		50	70	70	
Total Served Per Year	**105**	**205**	**235**	**245**	**790**

As lead entity, HSA will lead the implementation of KARELink. The participating entities have met to find current services offered throughout the county, identify any duplication of services through multiple entities, as well as some of the gaps in services for those in our community in need. KARELink will target individuals in our community who suffer from at least one or more of the following: substance use disorders, mental health issues, diabetes, or high blood pressure. KARELink will link eligible enrollees to a level of care that fits their needs ranging from intense to moderate with care coordination to align with that need. The placements will be based upon the assessments made by the MDT.

Section 3: Services, Interventions, Care Coordination, and Data Sharing
3.1 Services, interventions and care coordination



KARELink, as pictured above, is an entirely new system of care and a paradigm shift in how this community impacts individuals who are experiencing ongoing complex health and behavioral health conditions. At planning meetings, it was determined that one of the largest and most pressing issues facing Kings County is the reality that there is no singular agency or organization in Kings County that can address the continuum of care and complete needs of the target population.

KARELink will pool resources and funding together to address the multi-systemic gaps and silos inherent in agencies and organizations within Kings County and create a paradigm change that will result in links between multiple partners to provide holistic and coordinated care to individuals and their families. After a careful examination of local cross-sectional data of current services offered within the county and listening to stakeholders, the concept for KARELink was developed and as an entity, will make informed decisions to address programmatic expansions to new and modification to existing services within the community with an overarching goal of adding services/interventions into Kings County as they do not currently exist. They include:

- Local Advisory Committee (LAC)– This committee is comprised of all of the participating entities as well as other community business organizations that have a vested interest in assisting our targeted populations for those whom suffer from substance use disorders, mental health conditions, and chronic health conditions but specifically diabetes and high blood pressure. This committee meets monthly to discuss ongoing efforts within the community and further expand upon those efforts. The LAC will be the governing force of our Whole Person Care Project and will be implementing the PDSA model throughout the project ensuring that the residents of Kings County receive the best care possible.

- Assessment – in-depth assessment of each enrollee including physical health, mental health, substance use disorders, Medi-Cal eligibility, education, housing stability and employability to be completed in one location and shared with a care coordinator.

- Care Coordination – professionals trained in working with those with substance use, mental health issues, and/or chronic health conditions to navigate the currently available and newly created services to assist with recovery, management, and self-sufficiency. Services will be offered at various levels of care and dependent on the individualized needs of each enrollee. The care coordinators will provide care coordination to make sure the proper wraparound services are offered and completed by the enrollee. Each enrollee's needs will be addressed and the care coordination service will provide active coordination and follow up to achieve those needs. At each step, each enrollee's assigned coordinator will be responsible for directly providing those services or actively coordinating those services. No enrollee will fall through the cracks and be left with a phone number to call for assistance, as in referrals, for example. Instead, enrollees will be provided the services directly or coordinate with a partner service provider to directly link the enrollee to services including a personal introduction to other service providers and following up with the enrollee and service provider to ensure that the linkage is successful and the enrollee is accessing services. The care coordinator will follow -up with all enrollees who do not successfully access needed services with the goal of addressing any challenges and completing a successful linkage. All enrollees will be tracked in the EOS which will support documentation of actual KARELink services provided and assessment and linkage to all KARELink services that will support the enrollee with improved health and behavioral health outcomes and decreased utilization of acute care services. The care coordinator will work to remove any barriers to needed services as they are identified.

- Services – Care coordinators will link enrollees to new WPC services and existing services by remaining current on available resources and by establishing networks to the resources, continually monitoring the enrolled enrollees, and staying current with best practices with treatment for co-occurring needs. New WPC services will include high intensity mental health respite, short term recuperative care, assistance with applying for SSI/SSDI, housing navigator, engagement, community integration, care coordination and comprehensive care coordination/low-ratio services. Care coordination will create the solid foundation for the success of these new services. Our target population experiences difficulty in accessing available resources due to the nature of current life situations. By providing care coordinators to link enrollees to the needed, individualized care we will stabilize the target population, reduce improper emergency room visits, reduce recidivism in our jail, and link those with chronic health conditions to the proper preventive steps needed to control health conditions. A single care coordinator will assist enrollees with obtaining services from various agencies, community organizations, and health care providers to increase the proper utilization of services.

- Administrative Infrastructure – multiple entities will combine resources and share information to fully integrate coordinated care and wraparound services. HSA will provide the administrative oversight to ensure continued integration of services and development of reports. Appropriate data is shared among all entities with consistent, regular meetings with stakeholders, participating entities, and those agencies directly involved with providing services. HSA will develop contracts or memorandums of understanding with all participating entities. The entities that provide the majority of services (HSA, Champions, and Public Health) will be located together on the County Campus. This is part of the overall design of the program to increase bi-directional data sharing and decrease silos between the departments. Other participating agencies (Probation and Behavioral Health) will include staff within the KARELink office as an effort to broaden the resource network and increase bi-directional data with other impacted agencies.

<u>How Care Coordination Will be Implemented Administratively:</u>

The mission of KARELink is to provide timely, individualized care coordination and services to a vulnerable population who lack the necessary skills to access appropriate and meaningful services. The large and rural geography of Kings County is not going to change, yet KARELink will provide a solution to the critical need for a much needed centralized referral point. The goal is for each person to reach his/her optimal level of health and wellness and be self-sufficient, productive members of the community. There are two overall aims for KARELink. The first is to reduce the improper utilization of the

emergency department for the following: high intensity mental health episode, substance use detoxification, and acute health issues that are connected with poor control of diabetes, and/or poor control of high blood pressure. By increasing preventive health care and linking enrollees to the correct treatment options. The second is to reduce improper utilization of the County Jail for minor infractions associated with substance use and/or mental health issues. KARELink will decrease the current recidivism rate by linking the enrollee to the correct treatment options and newly created services.

KARELink will create an overarching coordinated care plan in which various entities work together to create an integrated approach of offering varying services. The system of care is designed so that a potential enrollee will be referred into KARELink by one of four main sources: Health, Law Enforcement, Jail, and Community Business Organizations. Once the enrollee is deemed eligible for the Whole Person Care Pilot Project, the enrollee will be assigned to a care coordinator. The care coordinator will utilize a menu of services from the PMPM bundled and/or fee for service items that meet the individual needs of the enrollee based on the completed comprehensive assessments. The care coordinator, along with a final assessment from the multi-disciplinary team, will determine if the enrollee has achieved stability and self-sufficiency. If an enrollee is stable and self -sufficient, he/she will be dis enrolled from the pilot project. KARELink expects the average enrollee to achieve this standard within six to nine months.

It is anticipated that emergency room staff and jail staff as well as first responders (police, child welfare, emergency medical technicians, etc.) will be the largest source of referrals to the MDT. Proper screening will be applied to target enrollees for the pilot, initially, and we will continue utilizing our current referral mechanisms for any person who is not eligible for WPC. The screening form is simple, to make sure that it does not become a barrier to entry into the program.

The MDT and the CCT will be located within the same office as well as other non-funded staff including eligibility and behavioral health to establish an all-inclusive office devoid of silos. The MDT serves as the entry and exit assessment for eligibility, mental health, substance use, and physical health. The CCT, trained in co-occurring mental health/substance use disorders, will provide the necessary case management to assist the enrollee in navigating the proper services to best assist the enrollee in better health. As a referral is sent to the KARELink office, the MDT will screen the enrollee. The MDT and CCT will meet to establish the coordinated care plan for that enrollee. When it is established that the enrollee is better suited for comprehensive coordination, the enrollee will then be transferred to that level of care. The CCT will initially meet with the comprehensive care coordinator to ensure that the enrollee is in

full understanding of the services and process to reduce attrition and/or confusion as well as ensure quick implementation of the comprehensive care plan.

All services will be under the KARELink umbrella. Access to services will be through the case managers to each of the services. Since a variety of other services not linked with WPC will also be available, the KARELink Coordinator as well as the case managers will ensure access to services as well as the proper billing for those services are completed.

First responders will be educated on the added services that the pilot will offer the community and will know that individuals who would have previously been taken to the jail or the emergency room will now automatically be diverted to the new resources (Short term recuperative care and High Intensity Mental Health Respite) which will in turn trigger an automatic referral to the MDT.

All referrals will be tracked by the MDT by source. Data and feedback will be compiled and provided to referring entities on the sufficiency of information and the appropriateness of referrals. The information will be provided to the LAC to further refine referral processes and forms.

The MDT will check all referrals and for people that are deemed to meet the target population, a more comprehensive assessment and care coordination plan will be developed in conjunction with the CCT individual assigned. The intent would be to make sure that the person has a proper living arrangement, is accessing the appropriate care timely and that all services are coordinated so that a duplication or gap in services is avoided (both of which currently contribute to high cost and high utilization of various public systems).

All referral sources will be offered presentations to review all the services, interventions, and the intended outcomes for KARELink. The information presented will include power point presentations and the distribution of flyers, business cards, sample referrals, and other outreach materials. Multiple presentations will be offered when KARELink is first implemented and throughout the pilot to make sure providers are reminded about services and know how to refer people to services, which will help ensure its ongoing success.

EMTs' and Law Enforcement will be educated on the additional services that the pilot will provide (short term recuperative care and the High Intensity Mental Health Respite) to increase the proper utilization of these services and decrease improper Jail or Emergency Room utilization. Any person diverted to the services will automatically be referred into KARELink.

What Each Participating Entity is Responsible for and How Link to Other Participating Entities?

Kings County will contract with Champions as its lead community entity. Champions have providing services in Kings County for approximately 17 years. All services and programs holistically address the family system, the individual, and the needs within each differing community. Champions will provide short term recuperative care and housing navigator services. All services provided adhere to Federal Culturally and Linguistically Appropriate Standards (CLAS) and all programs utilize evidence-based models and trauma-informed practices.

Adventist Health will offer high intensity mental health respite and comprehensive care coordination services using a low ratio of enrollees to staff (10:1) eligible enrollees. In particular, Adventist Health will link a care coordinator to an enrollee requiring a higher level of need. The care coordinator will specialize in serving individuals with severe mental disorders and/or severe health conditions. As the MDT completes the assessments and determines a higher need, the enrollee will be referred to the Comprehensive Care Coordinators within the Adventist Health Network. A care coordinator from the CCT will be assigned temporarily to make sure the transition to the Comprehensive Care Coordinator occurs seamlessly. As the Comprehensive Care Coordinator will not be located with the rest of the KARELink Team, the KARELink Coordinator will stay in contact with the Comprehensive Care Coordinators to continue the flow of communication regarding enrollees assigned to Adventist Health on a minimum of a monthly basis or more and to also make sure that the enrollee specific data needed for tracking is maintained.

KARELink Services

1. **High Intensity Mental Health Respite** (Fee for Service (FFS)) – home like environment for people who need stabilizing services and supports while recovering from a crisis mental health episode, as determined by either a community paramedic, law enforcement, and/or doctor. The unit will only provide those services that cannot otherwise be covered by Medi-Cal. The purpose of the beds is to provide a place for those who have had interaction with law enforcement, found not to be a threat to themselves or others, but still in need of stabilization, while diverting them from incarceration. An enrollee will be cleared by medical staff, not covered under this fee, as no longer being a threat to themselves or others. This service will prompt an immediate referral into the KARELink System.

   This new service will be added in 2018 by Adventist Health for people with mental health issues who may require respite services for 20 to 70 hours. The average length of time will be 20 hours. Enrollees eligible for this service will be in need of stabilization and respite.

The equivalent of 5 beds will be available for WPC enrollees. Expected number of admissions 1,875 annually representing approximately 200 enrollees. The expectation is the enrollees in need of this service will utilize this item more than once during their enrollment period.

2. **Short Term Care Recuperative Care** (FFS) – Champions will provides this service for enrollees in need of a safe place to withdraw and commence treatment as an alternative to utilizing the Emergency Room and/or being incarcerated for substance abuse disorders. Enrollees will be eligible for this service if they are Medi-Cal eligible, are currently intoxicated, have been medically cleared, are not a threat to themselves or others, and are seeking treatment. Referrals for this service will be from health service models and may be in cooperation from law enforcement or emergency room. An enrollee can self- refer. An enrollee who seeks treatment at the short term recuperative care unit will receive an automatic referral into KARELink if they are not a current enrollee in KARELink.

   Expected length of stay is up to three days and the expectation is that the enrollees whom need this service will use it more than once while enrolled. They are discharged from the Short Term Recuperative Care Unit when the enrollee test negative from any substances and no longer have displays of active withdrawal symptoms or they become a threat to themselves or others.

   The equivalent of 8 beds will be available for WPC enrollees. Expected number of admissions 1,500 in PY 2 and 2,775 in PY 3-5 representing approximately 500 enrollees.

3. **Engagement** (FFS) –Initial screening will be conducted by the clinician and registered nurse to establish a priority level for the referral. This will be part of a bundled service for each potential enrollee. People who require emergency services will be screened within a business day and immediately assisted. The remainder of the assessments, such as job readiness, will be completed later when the enrollee is deemed stable. Assessments will be part of the overall plan for the coordinated care plan that is developed for each individual and will be completed for every referral. Referrals that appear to meet initial eligibility requirements will receive a more comprehensive assessment. Referrals that do not meet the minimum requirements will be referred to other existing resources throughout the county such as Behavioral Health or Kings View Mental Health Services. The intent would be to make sure the enrollee has an appropriate living arrangement, is accessing the appropriate care timely, and that all services are coordinated to ensure that duplication or gap in services are avoided as this currently contributes to high cost and high utilization of various public systems.

Engagement is a mandatory step for all enrollees as the staff will screen for eligibility and create the coordinated care plan. Up to seven assessments may be completed in order to conduct a thorough plan, including Mental health (varies dependent on individual but will include a Suicide Risk assessment for all enrollees); substance use (Addiction Severity Index) histories and presenting problems; medical and/or health needs, benefits eligibility and enrollment; housing and/or placement needs; education and/or employability; and criminogenic and legal needs (Static Risk and Needs Assessment). Each assessment will include an interview with the enrollee and a meeting with the entire MDT and assigned care coordinator to develop the coordinated care plan. The interview will take up to an hour with the enrollee to be done face to face with telephone interviews done on an emergency case by case basis. The meeting with the MDT and care coordinator will take 30 minutes. The two meetings (enrollee interview and MDT review) may not be held on the same day with the standard being set between two calendar weeks to 30 days. An exit assessment will be required as part of the disenrollment process for the enrollee as he/she shows stability with the Care Coordination bundle.

720 assessments in PY 2 and 1,440 in PY 3-5 from 600 enrollees. Each enrollee is expected to need at least two assessments (entrance and exit of the program) and possible midterm assessments.

4. **Housing Navigator** (PMPM bundle) – This service will provide enrollees with assistance in remaining in their current living situation by mediating any issues that may cause an enrollee to becoming homeless or prevent an enrollee from obtaining a living arrangement, such as credit repair at yearly renewals with apartment complexes, repairs to housing, replacing broken appliances disagreements with landlords due to behavioral issues, past history, etc.

   Champions will provide this bundled service which may be used at any time during enrollment in the program and concurrently with one of the care coordination bundles. It is expected that this service will be provided for two months given the nature of types of services offered and the coordination of multiple persons. This service will be available to enrollees who have been assessed and determined to be in need of housing assistance. Those needing housing will be referred to programs outside KARELink

   The housing navigator will develop a network throughout the county of landlords that offer affordable housing. The housing navigator will screen for eligibility to payments to increase housing stability by offering services such as: repairs to current housing, mitigating issues with current landlord, and/or replacement of appliances/furniture.

Eligibility Criteria – In addition to the initial eligibility requirements, stability within their treatments, full cooperation with their care coordinator, and determination made by MDT and/or care coordinator is needed before enrollees are eligible for this service. Receipt of similar services through HSA will disqualify an enrollee from this service.

Disenrollment Criteria – Enrollment in this bundled service will terminate when housing is stable, if the enrollee refuses services through KARELink, or becomes incarcerated.

Estimated number of enrollees per year – 20 for PY 3-5 totaling approximately 60 enrollees.

Estimated member months – The annual total of member months per year is 240 for PY 2 and 480 for PY 3-5. Anticipate 40 members per month/monthly case load amount

Care coordinator ratio – It is anticipated that the housing navigator will carry a caseload of 40 enrollees each month including new and carry over enrollees with 20 new enrollees per month.

PMPM case rate – $3,768 per enrollee per year.

5. **Care Coordination** (PMPM bundle) – Provide care coordination to develop the individual coordinated care plan and fully implement, with enrollees complying with their own individual care plan. Each care coordinator will monitor and screen each enrollee as the enrollee navigates the individualized coordinated care plan developed for him/her and impacted family members.

   This bundle will include job navigator, Life Skills and offering educational opportunities to enrollees with co-occurring issues as part of the individualized system of care through Champions. Peers will facilitate the training sessions in group settings to assist with health education, alcoholism and drug addiction, anger management, support for batters' and/or victims of violence and other types of non-medical billable educational opportunities.

   Life Skills are provided by peers who have had personal experiences with mental health and/or substance use disorders that will provide peer mentoring and support through targeted educational opportunities such as: recovery, anger management, stress management, financial training, health education, and parenting/family services. Peers will facilitate these training sessions in group settings to assist with health education, alcoholism and drug addiction, anger

management, support for batters' and/or victims of violence and other types of educational opportunities.

The job navigator will complete assessments associated with job readiness such as education and previous experience and will provide any necessary trainings needed for those seeking employment including interviewing skills and resume writing/building.

Eligibility Criteria – Must be Medi-Cal eligible and experiencing at least one of the following: substance use disorder, mental health issues, poor control of diabetes, or high blood pressure to be established during the Engagement bundle. All enrollees will be assigned a care coordinator from Champions from the engagement bundle initially; however, enrollees who meet eligibility requirements for a comprehensive care coordinator will be transferred to the comprehensive care coordinator within a month. Enrollees may not receive both the comprehensive care coordination and care coordination bundles simultaneously.

Enrollee may be placed in the following levels of care to receive these services: Crisis Residential, Residential Treatment, Transitional Housing, and in their home.

The enrollee may also utilize the other short term treatment options such as: hospitalization, High Intensity Mental Health Respite, and/or Short Term Recuperative Care.

Expected length of this bundled service is from six to twelve months.

An enrollee is only eligible for one care coordination bundle at a time.

20 - 25 enrollees per care coordinator per month totaling approximately 500 enrollees over the life of the pilot.

Disenrollment Criteria – enrollee refuses services; enrollee becomes incarcerated for more than a calendar month; or enrollee has completed all life skills classes, clears a second screening done through an engagement bundled service, and is in a stable shelter situation. Incarcerated enrollees have the option to re-enroll upon release.

Estimated total number of enrollees during PY 3-5 – 500.

Estimated member months – The annual total of member months per year is 720 for PY 2 and 1,440 for PY 3-5. This amount was derived by taking the total number of enrollees for each month to be served by the combined six care

coordinators (120) including new and carry over amounts. This number was multiplied by the number of months in the project year.

6. **Comprehensive Care Coordination/Low-Ratio** – This bundle will be for enrollees who require more frequent and ongoing care coordination, especially those that are high utilizers of the emergency room due to severe mental issues and/or chronic health conditions. Enrollees who require more comprehensive care coordination than can be provided by the Care Coordination Team will be referred to the Comprehensive Care Coordination Team/Low-Ratio. With comprehensive care coordination, a coordinated care plan is developed, fully implemented and completed by each enrollee. Enrollees are closely monitored and screened as the enrollee navigates the individualized system of care developed for enrollees who require more intense care coordination with a lower staff ratio of 10-15:1 due to the needs of the enrollees. Each enrollee is provided a single point of contact and daily contact, as needed, to assist the enrollee in navigating the multiple services available through the pilot.

   The comprehensive care/low ratio services are unique services that are independent from the care coordination services due to the population it will serve. Enrollees in this bundle will require the additional care and oversight from a dedicated care coordinator. The care coordinators will have a smaller caseload with the ability to provide intense support. The enrollees will require increased contact with each enrollee including but not limited to: daily telephone interactions and regular, consistent home visits. Eligibility for the bundle is determined by the following: having a substance use disorder, mental health issue or chronic health issue and high utilization of the emergency room which results in the need for a high level of support.. Care coordinators will also provide transportation to non Medi-Cal billable appointments, when needed. The comprehensive care coordinators will provide medication management and accountability for each enrollee in their case load.

   Enrollee may be placed in the following levels of care to receive these services: Crisis Residential, Residential Treatment, Transitional Housing, and in their home.

   The enrollee may also utilize the other short term treatment options such as: hospitalization, High Intensity Mental Health Respite, and/or Short Term Recuperative Care.

   10-15 enrollees per comprehensive care coordinator per month.

Disenrollment Criteria – The enrollee will be dis enrolled from the bundled service if or when any of the following occur: enrollee refuses services; enrollee becomes incarcerated for more than a calendar month; enrollee is placed into a long term facility; or enrollee has completed all life skills classes as part of the coordinated care plan, clears a second health screening, and is in a stable shelter situation. Incarcerated or hospitalized enrollees have the option to re-enroll upon release or discharge.

Estimated number of enrollees per year – 20 for PY 3-5. None expected in PY 2 as this bundled service will be implemented in PY 3.

Estimated member months – The annual total of member months per year is 240. This was calculated by taking the total monthly caseload for each of the care coordinators (20) and multiplying this by the total number of months for the project year.

Average enrollment period – The time of enrollment is expected to be up to six months. An enrollee is only eligible for one care coordination bundle at a time.

PMPM case rate – $13,824 per year per enrollee. This amount was calculated by dividing the total yearly amount ($276,480) by the number of expected enrollees per year (20) for a total of approximately 60 over the three years.

7. **Community Integration** (Fee for Service) –This service will remove stigmatizing body ink for those who would like such visible markings removed. Visible, ink markings are stigmatizing and often a hindrance for those attempting to obtain employment. This service will remove markings and by doing so, help increase employability by eliminating the potential barrier of being judged. Gang affiliated markings are particularly stigmatizing. The job navigator or care coordinator will determine if the enrollee will benefit from this service. The expectation is that an enrollee will need an average of six treatments to completely remove one marking.

   Max of 200 visits per year representing a total of approximately 140 enrollees over the life of the pilot.

   An enrollee is eligible for this service when they are actively seeking employment and have a stigmatizing, visible ink marking on the face, neck, arms, and/or hands. This service will continue until either of the two has been met: when all visible body ink markings have been removed; or when enrollee has been dis enrolled from pilot.

8. **SSI/SSDI Advocacy** (Fee for Service) – Assists those that may qualify through the difficult process of applying and obtaining SSI and/or Social Security Disability. These services assist with obtaining necessary eligibility documents like birth certificates, identification cards, certified mail, and potential copy costs for health records or resources. An enrollee may be eligible to this service if they have a documented long term disability. This is a onetime cost for the entire length of the service. The enrollee will need to have a documented, long-term disability as discovered by the MDT and CCT as they develop the coordinated plan. Provide assistance to obtain SSI/SSDI services. SSI/SSDI benefits provide enrollees who may not be employable due to a long- term disability with much needed financial assistance. The application process for SSI/SSDI is known to be confusing and this is particularly true for the enrollees who will be enrolled in this program, who lack skills in navigating the arduous application/appeal process and are likely to be denied eligibility unless someone provides help. Advocating for this essential service is in alignment with the larger goals of WPC and the Substance Abuse and Mental Health Services. The eligibility specialist will be skilled in helping gather detailed medical reports to include in the application. This task will require time- consuming research and data collection so that each application is submitted with accurate information. This service also includes the work associated with appealing denials for the same 40 enrollees per year, if needed.

   Max of 40 cases per year, totaling approximately 130 enrollees over the life of the pilot.

Plan Do Study Act (PDSA)

The KARELink Pilot will create an administrative infrastructure, coordinated care services, and supporting services to reduce high utilization within the Emergency Department and the County Jail. The target population was identified as having the highest rates of using services. Services and coordinated care were designed to increase preventive measures that will be completed by enrollees to decrease their needs for Adventist's Emergency Department and/or decrease negative interactions with law enforcement. Regular, consistent data collection, monitoring, and evaluation will be done throughout the entire pilot project to effectively evaluate those services and interventions that appear to be successful and identify if any areas need to be re-evaluated.

All quality improvement efforts will apply a PDSA methodology and will incorporate community partners input and collaboration. All participating entities will be actively involved in the identification of barriers and resolutions critical to the PDSA process.

3.2 Data Sharing

Communication Plan

By having KARELink co-located, bi-directional data regarding an enrollee will be easily shared as an electronic infrastructure is researched, implemented, and established. For participating entities that will not be sharing the same location, the KARELink Coordinator will be the main point of contact for information specific to each enrolled individual. The Program Analyst will work closely with the KARELink Coordinator as the main points of contact for data shared amongst all participating entities for both individual specific information as well as the overall statistics needed for measuring the success or identifying any areas that may need improvement.

Each of the participating entities has agreed to share the following information:

Adventist Health – Total number of enrollees seen in the Emergency Room (ER) each calendar month, total number of patients seen in ER specifically for: substance use issues, mental health issues including crisis episodes, emergency directly associated with poor control of diabetes, and emergency directly associated with high blood pressure.

Anthem Blue Cross – Total number of enrollees seen in Emergency Room each calendar month and number of enrollees seen for a pre-determined set of billing codes associated with the treatments for our targeted populations broken down by each billing code. Quarterly, Anthem will share the number of enrollees that have received the HbA1c test as well as the percentage of those that showed they had a score of 8% or more on that test.

Kings County Sheriff's Department – Monthly recidivism rates.

All high-level information reported to the Program Analyst will be shared with the LAC at monthly meetings. The reports created by the Program Analyst will allow the LAC to quickly see trends and identify areas of success as well as areas of improvement by following the PDSA model outlined throughout this application.

The KARELink Program will use ETO software from Social Solutions, contingent upon the approval of this pilot. ETO software offers a configuration which enables re-entry service providers to track the work that they do with their enrollees. The product encourages evidence-based practices based on the risk-need-responsivity principle, tracking risk assessment, treatment planning, and coordination of services. Reports are available to help ensure that expected progress is being made at the individual, group, and program-wide levels so that recidivism is reduced and public safety is improved. This software will offer program improvement and outcome reports, cross-provider

aggregate reporting, uniform data collection, care coordination decision support, employer engagement dashboard, automated referrals, and a follow up module. As the software is implemented and capabilities are explored, the intention is to expand the available modules to include more agencies within the ETO software network for an electronic means of bi-directional data sharing as well as adding components to include electronic health records. Savings from decreased emergency room visits and reduced recidivism will be used to sustain KARELink beyond the pilot program.

How Data Sharing Will Occur Between Participating Entities:

Data-sharing tools will be developed as KARELink is implemented. Each entity has a different data system and different organizational policies on data sharing. By December 31, 2017, KARELink will develop the infrastructure to share data; create a shared Release of Information form that meets the legal requirements of all entities; and develop Memorandum of Understandings, where appropriate, to ensure that each participating entity has a clear understanding of the proper way to handle the confidential nature of information as well as the various levels of confidentiality prevalent in each area. Initial and ongoing training will be completed at regular intervals to ensure the data is being properly stored and shared.

Sharing meaningful and useful data and patient specific information electronically will be developed over the life of the pilot with the initial purchase of software (ETO, further explained below). Modifications to ETO will be made throughout the pilot project, as needed.

Governance:

Kings HSA will be the lead agency for collecting and analyzing the shared data and ensure that all state and federal regulations concerning confidentiality are followed. The Program Analyst will be the main point of contact for all reports, data, and ongoing statistics. The KARELink Coordinator will also play a vital role in this process and approve the data sharing agreements, protocols, procedures and policies prior to the implementation of the IT infrastructure.

Building Sustainable Infrastructure:

The design, development, and implementation of the complete KARELink data sharing structure/system will be completed during the WPC pilot period. Once data is available for analysis, KARELink will estimate continuation costs and evaluate cost savings realized through the pilot to develop a realistic sustainability plan. The use of a full time dedicated program analyst will help ensure the ongoing sustainability.

Time Lines for Communication Plan:

KARELink LAC has created the base outline for a manual, bi-directional data sharing to be used beginning in PY 2 of the pilot. The necessary contracts, memorandums of understanding, and enrollee release of information forms will be created during 2017. ETO will be purchased immediately upon notification that KARELink has been authorized funds for this pilot project. The time frame for implementing ETO Social Solutions is three months from the date the signed contract. As the pilot progresses, further modifications to newly purchased and existing software may be identified and implemented such as the components mentioned above to integrate electronic health records between Adventist, Public Health, and Champions.

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

4.1 Performance Measures

Pay for outcomes metrics	
Universal Metric – Proportion of enrollees with comprehensive care plan, accessible by the entire care team, within 30 days	85% of eligible new enrollees into KARELink will have a coordinated care plan developed and assigned to a care coordinator each year.
Variant Metric – Decreasing HbA1c Poor Control <8%	Decrease the number of those with poor control of their diabetes by 5% each year as indicated by a score of less than 8% on the HbA1c test.
Variant Metric – Decreasing Jail Recidivism	Decrease the jail recidivism rate by 10% each year.

Performance measures will be collected from each entity, as well as the data collected internally from the KARELink program. Each entity will be responsible for reporting data to the Program Analyst. The analyst will review the data received monthly to quickly see trends as well as report these trends to the LAC every month.

Kings County Public Health will be the responsible entity for implementing the universal metric for ensuring that a comprehensive care plan is developed and assigned to a care coordinator within thirty days. The clinician and public nurse will be doing the initial assessment for every referral within one business day to establish the priority level. This assessment will include a full physical assessment utilizing the SOAP method (Subjective – what the patient tells you, Objective – what the nurse can see or measure, Assessment and Plan). The clinician will conduct a mental health assessment by screening for Suicide Risk and Addiction Severity Index score. People with emergency situations will be screened immediately and may be referred to the emergency room or other emergency service, as needed. The rest of the MDT team will conduct assessments for Medi-Cal eligibility, job readiness, and housing stability. The entire team will meet and develop a comprehensive care plan to be shared with the assigned care coordinator within thirty days of the referral.

Adventist Health will be responsible for the variant metric on the control of diabetes through the HbA1c test. This metric will be measured by the utilization data that is received from Anthem Blue Cross on both the number of recipients that receive the test as well as the number of recipients that show they have poor control over their diabetes as determined by the HbA1c test. The utilization data will show the measurement of success for this outcome.

Champions will be responsible for the variant metric relating to jail recidivism as the care coordinator will be specifically trained in assisting enrollees and managing the linkages to the recovery and/or life skills necessary to decrease recidivism among our largest target population. This outcome will be measured with ETO software as it tracks the recidivism rates for our enrollees, the overall recidivism numbers from our local jail, and the data obtained from the local jail on overall recidivism rates in the county.

Payments for the three outcomes are contingent upon each entity meeting the expected outcome as determined at the mid- year and annual reports. As an incentive for reporting the necessary data that cannot be obtained via shared software, other participating entities will receive payment for their reports. The data will be shared with the Program Analyst by the fifth of each month via email and through share point sites, as deemed necessary. These entities include: Adventist Health, Champions, Kings County Jail and Anthem Blue Cross.

The MDT and CCT will use ETO software to input each assessment completed for every enrollee. Each member of the team will use the right assessment tools to meet the needs of each enrollee, being sure to include a suicide risk assessment and full Head to Toe assessment from the Public Nurse. The Head to Toe assessment will be done in the SOAP format, described above. The Suicide Risk Assessment and health assessment will be done within one business day of the received referral to set up priority. An individual having any type of emergencies will have the emergency situation resolved before the rest of the intake process is completed. Job readiness and/or housing stability may be revisited, as needed.

Each of the assessments will be made available to the assigned care coordinator and entered into the purchased software specifically obtained for this purpose (ETO Software). Other information obtained during the referral assessment phase will include: individual demographics; demographic information for other family members in the household; current housing situation; incarceration history; and health history. Within two weeks this entire process will be completed and shared with the assigned care coordinator.

The PDSA Model will be used by the Program Analyst as well as the LAC as a whole throughout the entire project. The reports generated by the Program Analyst will allow

for trends to be readily identified. These will be shared with the LAC for continued evaluation.

4.1. a Universal Metrics

Universal Metric	PY1	PY2	PY3	PY4	PY5
Health Metric: Decrease Emergency Department Utilization for Mental Health	NA	Maintain baseline of Emergency Department Utilization	Reduce the amount of Emergency Department Utilization by 10% from baseline.	Reduce the amount of Emergency Department Utilization by 20% from baseline.	Reduce the amount of Emergency Department Utilization by 30% from baseline.
Health Metric: Inpatient Utilization	NA	Maintain baseline of inpatient utilization	Reduce the amount of inpatient utilization by 5% from baseline.	Reduce the amount of inpatient utilization by 10% from baseline.	Reduce the amount of inpatient utilization by 15% from baseline.
Health Metric: Follow-up After Hospitalization for Mental Illness	NA	Maintain baseline for follow up appointments hospitalization for mental illness.	75% of enrollees hospitalized for mental illness will have a follow-up appointment each year.	80% of enrollees hospitalized for mental illness will have a follow-up appointment each year.	85% of enrollees hospitalized for mental illness will have a follow-up appointment each year.

Health Metric: Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	NA	Maintain baseline for number of enrollees for initiation and engagement of alcohol and other drug dependence treatment	75% of new enrollees with a substance abuse disorder will engage in alcohol and other drug dependence treatment each year.	80% of new enrollees with a substance abuse disorder will engage in alcohol and other drug dependence treatment each year.	85% of new enrollees with a substance abuse disorder will engage in alcohol and other drug dependence treatment each year.
Administration Metric: Proportion of enrollees with comprehensive care plan, accessible by the entire care team, within 30 days	NA	Maintain baseline comprehensive care plan accessible by the entire care team within 30 days each year.	75% of new enrollees will have a comprehensive care plan accessible by the entire care team within 30 days each year.	80% of new enrollees will have a comprehensive care plan accessible by the entire care team within 30 days each year.	85% of new enrollees will have a comprehensive care plan accessible by the entire care team within 30 days each year.

Administration Metric: Care Coordination, management, and referral infrastructure	NA	Draft documentation establishing policies and procedures.	Finalize policies and procedures.	Implement policies and procedures.	Revise policies and procedures according to ongoing review and evaluation of pilot using PDSA model to continue to evaluate and determine if any modifications are needed in care coordination, management, or the referral process.

Administration Metric: Data and Information Sharing Infrastructure	NA	Draft documentation establishing policies and procedures.	Finalize policies and procedures.	Implement policies and procedures.	Revise policies and procedures according to ongoing review and evaluation of pilot using PDSA model to continue to evaluate and determine if any modifications are needed in care coordination, management, or the referral process.

4.1.b Variant Metrics

Variant Metric	Numerator	Denominator	PY 1	PY2	PY3	PY4	PY5
Administrative Metric	NA	NA	NA	Establish LAC to lead the KARELink Project from participating entities. Begin monthly meetings.	LAC fully implemented.	Meet monthly to use the PDSA model to evaluate and determine if any modifications are needed for participating entities and/or addition of other entities.	Continue to meet monthly. Make final revisions per PDSA.
Decrease jail recidivism	Total number of incarcerations of WPC enrollees during the reporting period.	Total number WPC enrollees during the reporting period.	NA	Maintain baseline for recidivism	Reduce the amount of recidivism by 10% from baseline.	Reduce the amount of recidivism by 20% from baseline.	Reduce the amount of recidivism by 30% from baseline.

Decrease the HbA1c Poor Control <8%	Within the denominator, who had HbA1c control <8%.	Members 18-75 year old with diabetes (Type 1 or 2)	NA	Maintain the baseline of HbA1c Poor Control <8%	Reduce the number of those with HbA1c Poor Control <8% by 5% from baseline.	Reduce the number of those with HbA1c Poor Control <8% by 10% from baseline.	Reduce the number of those with HbA1c Poor Control <8% by 15% from baseline.
Suicide Risk Assessment	Enrollees who had a suicide risk assessment completed at each visit.	All enrollees aged 18 years or older with a new diagnosis or recurrent episode of Major Depressive Disorder	NA	Maintain baseline of the assessed risk	Reduce the assessed risk by 5% from suicide risk assessments done at initial intake of referrals from baseline.	Reduce the assessed risk by 10% from suicide risk assessments done at initial intake of referrals from baseline.	Reduce the assessed risk by 15% from suicide risk assessments done at initial intake of referrals from baseline.

4.2 Data Analysis, Reporting and Quality Improvement

KARELink is in an excellent position to collect, report, and analyze data to continually evaluate access, quality, cost-effectiveness, and outcomes. The MDT will be led by the KARELink Coordinator, staffed by the Kings County Probation Department. Areas within the screening and assessment include: 1) mental health (varies dependent on population but every referral will include a Suicide Risk assessment) and substance use (Addiction Severity Index) histories and presenting problems, 2) medical and/ or health needs (history and physical), 3) benefits eligibility and enrollment, 4) housing and/ or placement needs, 5) education and/ or employability, and 6) criminogenic and legal needs (Substance Risk and Needs Assessment). Data obtained from the MDT process

will be incorporated into a plan of care for the enrollee and provided to the KARELink Care coordination Team (CCT) based within Champions for implementation of services.

The KARELink Coordinator will make sure that the data obtained in the process of screening each enrollee is maintained and delivered to the Program Analyst each month. This will include the Suicide Risk Assessments, the number of days from receiving each referral to finalizing the screening process, the total number of referrals received, the number of referrals that screened out, and the number of enrollees referred to the Adventist Health Comprehensive Care Coordinator. The KARELink Coordinator will report the ongoing case count of the CCT, the number of enrollees readmitted into either the hospital or jail, the number referred to Court Diversion, the number who have completed the process for Court Diversion, and account for the number in each of the various placements to the Program Analyst each month.

Kings County recognizes that as the data sharing infrastructure is being developed, trained, and implemented; manual reports will be needed in the interim. After the purchase of ETO Software, many of the reports will be available electronically for those within the multi-disciplinary and care coordination teams. KARELink will continue to research other practical solutions to sharing and accessing data across the entire project throughout the pilot, especially in those areas that will not interface with ETO Software.

Anthem Blue Cross will send their files through a secured file share point indicating the following: the number of persons who utilized the emergency room specifically for mental health, substance use, diabetes, or high blood pressure issues; the utilization for inpatient services; the number of persons who received the HbA1c test for diabetes; and the number of persons who show poor control of their diabetes as determined by a score of 8% or higher on the HbA1c test. This information will be shared with the Program Analyst where both the analyst and the Anthem Blue Cross representative will look at trends to present to the LAC at the monthly meetings.

As the program continues and further reporting needs are identified, the KARELink Coordinator and Program Analyst will work together to create the necessary reports. The data will be analyzed collectively by the LAC as part of the PDSA process for comparison to the change in the data for the period being evaluated as well as quantitative measurements identified for the matrices. Other balance measurements may also be reviewed. The LAC recognizes the PDSA approach for quality improvement as a continual process. In the “Study-Act” part of the process, the results of analyzing the data, summarizing what was learned, and reviewing what did not to work may lead to changes in KARELink that put the intervention back in the “Plan-Do” phase. Data will be aggregated and reviewed on a monthly basis. The coordinator and program analyst will be held responsible for data integrity and will regularly inform the

LAC of the success of pilot strategies and change management efforts. Even if the results were as desired, a review of the unintended consequences and variables not known during the initial “Plan-Do” phase may also prompt enhancements that start the cycle again to see if there can be added improvements. KARELink will include the LAC in all discussions about the outcomes and proposed changes to get comments and agreement on the review of the data and any changes that need to happen for implementation to meet the desired results in improvement in health outcomes.

Kings County Human Services and the other participating entities will continue the efforts being made in implementing the project. It is anticipated the staff needed for the Administrative Infrastructure, Multi-Disciplinary Team and Care coordination Team will be hired prior to project year two. The necessary policy, procedures, contracts, and memorandums of understanding will be finalized before July 1, 2017.

Kings County is committed to seeing KARELink become a long-standing service available in our county. Multiple revenue sources are being researched to sustain KARELink beyond the five-year pilot project. These revenue sources include various grant efforts and the potential cost savings from within Adventist Health and Kings County Jail as a result of the reduced utilization.

4.3 Enrollee Entity Monitoring

HSA will be working closely with Kings County Probation Department, Public Health Department, Behavioral Health Department, and Champions to monitor the entire program. Each department head will make sure they are present at each LAC meeting to monitor and analyze the program for desired outcomes, continued efforts made and gained in data sharing, and any potential areas of improvements.

The formal memorandum of understanding for county departments and Board Approved Agreements for non -county entities will be utilized as formal documentation that outline roles and responsibilities for each entity, agreed upon program outcomes, reporting format for data, outcome and expenditures. LAC meetings will be utilized to check outcome and issues. One on one performance monitoring meetings may also be employed if a particular agency is encountering issues or struggling with performance and need added technical help and support.

Kings County recognizes that with this new system of care developed for KARELink, there will be issues that often arise when multiple partners with various specialties work together with a single mission. Co-locating is a way to decrease many of these specific issues to reduce working in silos and increasing availability for bi-directional data between the agencies and community partners.

The LAC will create any plans for improvement if the desired outcomes are not being met. Each advisory member on the LAC is committed to working collaboratively within the group for successful implementation of the KARELink Program. This same group will carry out any changes to the overall program, when it has been deemed necessary. If a need for a change is deemed necessary, the entity will present the proposed change to the LAC at a monthly meeting. The LAC will finalize the change after consulting with DHCS, when necessary via the terms and conditions of this pilot. The changes will then be communicated, via LAC representatives, to the various departments within KARELink.

HSA will employ a Program Analyst who will maintain all reports on a monthly basis. The Program Analyst will be actively involved with the LAC to report their assessment and recommendations. The LAC will work to determine the need the need to impose sanctions such as disallowances, recoupments, or requests for plans of action.

If an entity is not meeting agreed upon performance standards or required activities, the lead entity will offer technical assistance to remedy the situation. If the performance issues persist over more than two periods, in addition to technical assistance, a written agreed upon corrective action plan will be implemented. Each period is measured by the evaluation periods set forth by the Department of Health Care Services. This will be done in conjunction with the oversight by the LAC. If the corrective action plan goals and expectations are not met, the program analyst will check all the available data and circumstances and make a recommendation to the LAC for program changes to be requested or to terminate the services due to lack of performance. The LAC in conjunction with the lead entity will evaluate and act on the recommendations.

HSA will offer overall monitoring of the fiscal actions of this pilot. HSA will monitor that: funding is used for allowable and budgeted items; proper documentation is provided to substantiate the expenditure; each contractor does not exceed the contract maximum without proper amendments being made; applicable fiscal records are maintained to provide an audit trail; and that all contracts have adhered to all applicable federal, state, and county contract regulations.

Section 5: Financing

5.1 Financing Structure

Financing Structure of WPC**:** Kings County will provide all the local non-federal funds from County General Fund including, but not limited to, 1991 Realignment, and Mental Health Services Act. Headed by the Lead Entity, Kings County HSA, will request approval for the establishment of a separate budget fund solely for KARELink. The Kings County Auditor-Controller's Office has established a fund to be used to support and separate all financial transaction for purposes of accounting for KARELink.

There will be an interim deposit made by HSA into the KARELink Fund. This deposit will be the non-federal share of the pilot and shall remain in the fund until the official request is received, from DHCS, to process the first Intergovernmental Transfer (IGT). Deposits made into this fund will be the sole source of funding for all activities.

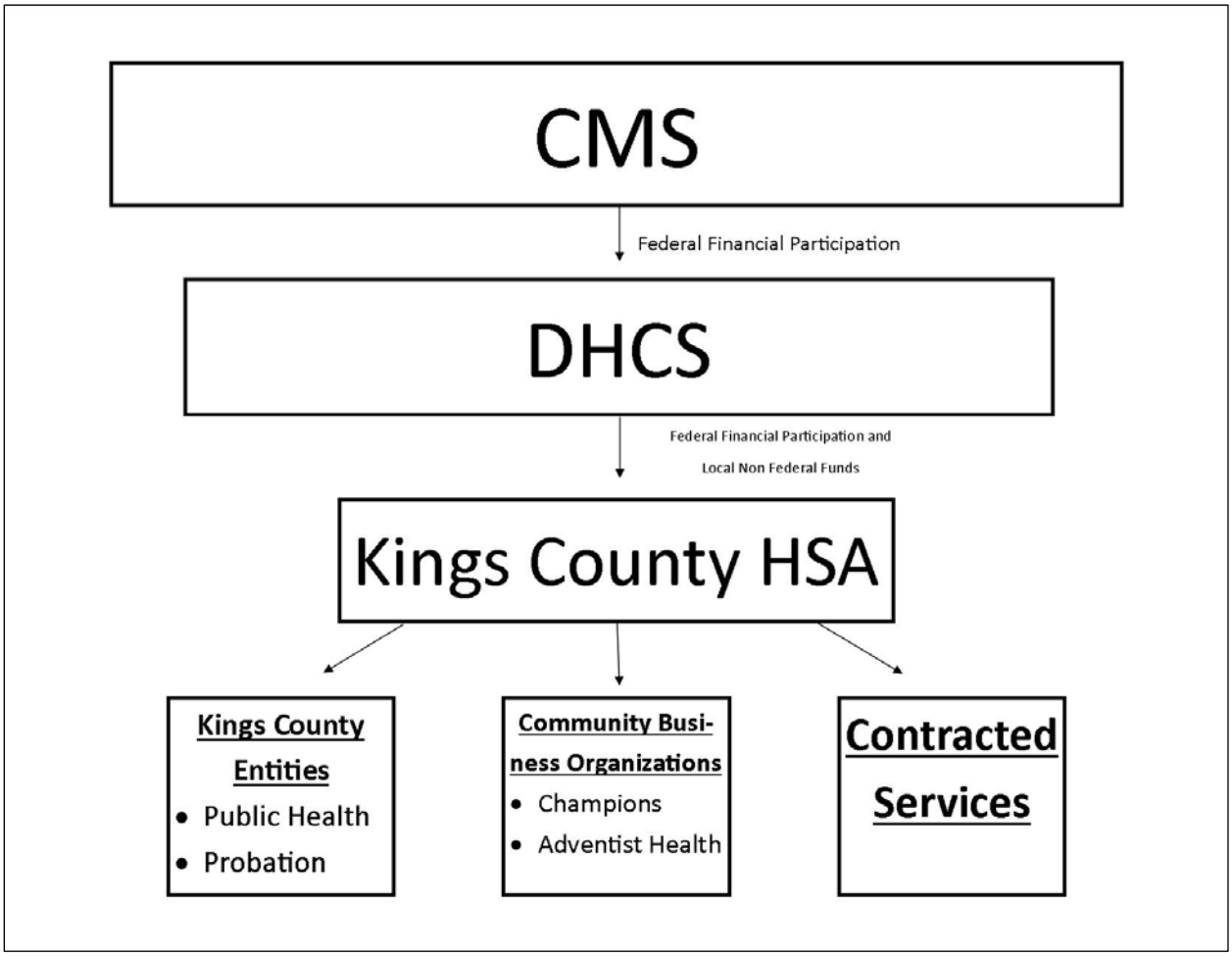
Payment Process**:** Each participating entity will be reimbursed based upon incentive payments, pay for reporting, fee for service, and bundled payment structure which will be outlined through individual contracts and memorandum of understanding (MOU) established for KARELink. Subject to their agreed upon contract or MOU, participating entities will be required to submit claims either monthly or quarterly. Claims will be required to be submitted to the Lead Entity within 30 days after the close of each calendar month or quarter, as required, to allow for sufficient time to process the claim. Upon review and approval of each submitted claim, payment will be distributed from the fund to the participating or contracted entity. As part of the governance structure for the pilot, entities receiving funds must document eligibility status for service recipients.

Payment Tracking**:** All transactions impacting the fund will be accounted for in Kings County financial management system E-Finance. Financial records will be generated to support all KARELink fiscal transactions. HSA will be responsible for a monthly reconciliation of the trust fund to track and analyze.

Financial Oversight**:** HSA will be responsible for the financial activities and will adhere to established policy and procedures. Per county policy, HSA will review all submitted claims and will only release payment once it's verified that all requested services/goods were met for the requested reimbursement period. Reporting of these amounts and identifying specific payments to entities by reporting period will be part of the annual audits and be made available to the DHCS. No direct patient care costs will be charged to KARELink.

5.2 Funding Diagram

The Funding Diagram illustrates the flow of requested funds from DHCS to the lead entity as well as the distribution of funds to the other participating entities.



5.3 Non-Federal Share

Kings County will provide all the local non-federal funds from County General Fund including, but not limited to, 1991 Realignment, and Mental Health Services Act. The non-federal share will be appropriated and provided using the same process as other programs requiring IGTs.

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

KARELink is limited to Medi-Cal beneficiaries. As such, KARELink funds will be not be used for non Medi-Cal beneficiaries. The infrastructure budgeted for this pilot will be used exclusively for KARELink enrollees. 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.

All KARELink service funding will only reimburse services that are not otherwise billable to Medi-Cal. All services and bundles that were created for the KARELink pilot were reviewed by the LAC to make sure the services were not an allowable billable service to Medi-Cal. When additional Medi-Cal covered services are needed for an enrolled enrollee, the existing referral system will be utilized to obtain those services for that enrollee. These services would not be billed through KARELink.

Payments will be made to individual entities as they claim for the expenses as described above. The expenses will be itemized to ensure that bundles or fee for service items are not inclusive of any item eligible for Medi-Cal claiming as the bundles were created with services not currently billable to Medi-Cal. Fiscal staff will be trained of any/all changes in Medi-Cal billable services if any item available through our services offered becomes eligible for Medi-Cal billing. At this point, the claim would be denied.

Kings County does not provide Medi-Cal Targeted Case Management services and is not approved in the CA State Plan Amendment.

5.5 Funding Request – Detail

Budget Summary

Kings County is creating an entirely new approach to provide an integrated, holistic system of care with the KARELink Program. The program will allow those with substance use disorders, mental health issues, and selected chronic health conditions a central access point for the various new services, expanding existing successful services, and a care coordinator. Kings County's KARELink Pilot Program is requesting a total of $12,848,360 for the duration of the five year demonstration program.

Program Year 1 Budget Allocation:

A total of $1,606,045 is requested for PY 1. This amount is required for the application and baseline data submission.

Funding Request Program Year 1	PY 1
Submission of Application 75%	$1,204,534
Submission of Baseline Data 25%	$401,511
Program Year 1 Total	**$1,606,045**

There will be no KARELink members served during PY 1.

Program Year 2 Budget Allocation:

A total of $1,606,045 is requested for PY 2. The requested budget is for the initial year of implementation of the KARELink Pilot Program. All costs were prorated by 50% to represent PY 2 six month time period. Startup costs such as office equipment, KARELink vehicles, and community engagement for the KARELink program was captured in both Administrative Infrastructure and Delivery Infrastructure. Moving into PY 3-5, these costs will move to ongoing costs to help Kings County administer and promote our KARELink program.

Funding Request Program Year 2	PY 2
Administrative Infrastructure	$364,875
Delivery Infrastructure	$367,500
Incentive Payments	$0
Fee For Services	$387,270
PMPM Bundles	$416,400
Pay for Reporting	$40,000
Pay for Outcomes	$30,000
Program Year 2 Total	**$1,606,045**

Program Year 3-5 Budget Allocation:

Funding Request Program Year 3-5	PY 3	PY 4	PY 5
Administrative Infrastructure	$477,750	$477,750	$477,750
Delivery Infrastructure	$106,020	$106,020	$106,020
Incentive Payments	$50,000	$50,000	$50,000
Fee For Services	$940,000	$940,000	$940,000
PMPM Bundles	$1,348,320	$1,348,320	$1,348,320
Pay for Reporting	$182,000	$182,000	$182,000
Pay for Outcomes	$108,000	$108,000	$108,000
Program Year 3-5 Total	**$3,212,090**	**$3,212,090**	**$3,212,090**

A total of $9,636,270 was requested for PY 3-5. By PY3, KARELink will be fully operational. Administrative staff will continue to provide accurate and timely reports to the LAC. Analysis and adjustments will be made to the KARELink accordingly to ensure proper implementation and achievement of stated metrics.

Administrative Infrastructure

The administrative infrastructure will be combined within this program as well as additional support given to the lead entity for the overall oversight and distribution of funds. The additional staffing includes: KARELink Coordinator, Fiscal Specialist, IT Support, Program Analyst, and Account Clerk. All staffing will include salaries and benefits based on estimated costs. Benefits include medical/dental and retirement under the retirement program for the entity of hire. This amount is calculated at approximately 40% of the annual base wage. Salaries are reduced for program year 2 to account for the shorter time period for program year 2.

Personnel Costs	Wages	*Benefits	Annual Costs PY 2		Annual Costs PY 3-5	
			FTEs	Annual Costs	FTEs	Annual Costs
KARELink Coordinator	$73,840	$26,160	0.5	$50,000	1.0	$100,000
Fiscal Specialist	$56,860	$23,140	0.5	$40,000	1.0	$80,000
Account Clerk	$26,406	$13,594	-	-	1.0	$40,000
Program Analyst	$73,840	$26,160	0.5	$50,000	1.0	$100,000
IT - System Analyst	$105,000	@2080 hr/yr	0.5	$52,500	1.0	$105,000
Total Personnel Costs				**$192,500**		**$425,000**

*Benefits include the staff costs per contract and include but are not limited to medical/dental as well as retirement totaling approximately 40% of the annual base salary

KARELink Coordinator - will provide overall management of the KARELink MDT & CCT as well as be a vital component of the flow of bi-directional data. The coordinator will ensure the services and metrics are being met, provide guidance, attend the LAC Meetings, and collaborate with the Program Evaluator and Program Analyst. The KARELink Coordinator will meet regularly with the various departments represented in the MDT.

Fiscal Specialist and **Account Clerk -** will provide a centralized point of contact for coordinating and communicating items related to the budgeting of KARELink. They will gather the various fiscal tracking mechanisms needed to properly claim and assemble an audit trail for expenditures claimed to the Whole Person Care. The Fiscal Specialist will dedicate 50% of their time to this project. The Account Clerk will be full-time.

Program Analyst - will be a new position to be the main point of entry of all data from outside areas including the District Attorney, Kings County Jail, Adventist Health, and

Anthem Blue Cross. The Program Analyst will work closely with the KARELink Coordinator to ensure the objectives of this program are being met as well as provide guidance for any changes to the program that may be needed to ensure the metrics are being met. In PY 2, all staffing amounts were reduced by 50% to account for the reduced amount of time for the project year.

IT Support - will provide experience and skills required for setting up a new software system including setting up the work stations, troubleshooting issues, elevating issues to the vendor, as well as onboarding/off boarding users. The staff needed for IT will expand on current staff within the county and agency and will be equivalent to one full time employee. IT costs are reduced in PY 2 to reflect the reduced time for that project year.

In addition to staffing, other administrative costs have been identified for training and operating overhead.

Administrative Infrastructure Annual Budget - Training				
	Units	Cost -	Annual Budget for PY 2	Annual Budget for PY 3-5
Staff Training	1	$30,000	$15,000	$30,000
Travel / Conference Registration		$15,000	$7,500	$15,000
Training Materials / Supplies		$14,000	$7,000	$14,000
Indirect Costs		$1,000	$500	$1,000
Total Provider Training Costs		$30,000	**$15,000**	**$30,000**

Annual Budget – Training

Training – Training costs have been estimated at a total of $15,000 for PY 2 and $30,000 for PY 3-5. Training costs will also include refresher training as changes are made due to findings from the PDSA model being utilized by the LAC. Conferences and various training opportunities are anticipated to occur that would allow care coordinator or other members of the MDT to stay current on successful methodologies used for our target populations for an annual total of $15,000. The cost of materials and training supplies has been set at $14,000 annually. These training supplies and materials include software manuals, policies and procedures, and other associated training costs. $1000 per year is the estimated amount for indirect costs which include but are not limited to: office machine maintenance, pens, paper, and etcetera.

Administrative Infrastructure Annual Budget - Office Equipment				
	Units	Cost per Unit	-	Annual Budget for PY 2
Start Up Costs - KARELink Office	**1.0**			$140,000

Equipment			
KARELink Co-Located Workstations	14 0	$2,000	$28,000
Cubicles	14.0	$3,200	$44,800
Filing Cabinets	14.0	$500	$7,000
Phones	14.0	$300	$4,200
Computers	14.0	$3,500	$49,000
Chairs	14.0	$500	$7,000
Total KARELink Office Equipment			**$140,000**

KARELink Office Equipment – Startup cost for the majority of KARELink members for PY 2. Estimated costs will cover the required expenses to house the notated KARELink team members together which will allow for further effective and efficient program operations. Funding will allow for the purchase of 14 workstations, 14 cubicles, 14 secured filing cabinets, 14 phones to allow for communication between participants and staff, 14 network connected desktop computers equipment and 14 chairs.

Administrative Infrastructure Annual Budget - Operating Overhead				
	Units	Cost per Unit -	Annual Budget for PY 2	Annual Budget for PY 3-5
5% of Administrative Budget	1.0		$17,375	$22,750
Total Operating Overhead			**$17,375**	**$22,750**

Operating Overhead – This amount Includes office expenses, postage & freight, printing, and supplies.

Delivery Infrastructure

In developing KARELink, the county recognizes the need to set up a strong delivery infrastructure as the foundation of the project. As stated above, co-locating a majority of the services is the key component to the success of our model. Data infrastructure is another needed component to the success. Kings County has included these two items as well as addressing one of the largest yet easiest to overcome barriers to services within our community, transportation. The items identified for delivery of services include: ETO Software, Vehicles/transportation costs, KARELink Office Space, Community Engagement.

Delivery Infrastructure Annual Budget - ETO Software				
	Units	Cost per Unit	- Annual Budget for PY 2	Annual Budget for PY 3-5
Start Up Costs -ETO Software	**1.0**		$215,000	$30,971
Software Development		$165,000	$180,000	$0
Software Installation		$25,000	$25,000	-
Software Licensing		$10,000	-	$25,971
Software Training		$10,000	$10,000	$5,000
Total ETO Software			**$215,000**	**$30,971**

ETO software - is the current contract being considered. In PY 2, the costs are anticipated at a higher rate due to start up prices. In each additional year, ongoing licensing and upkeep fees were anticipated.

Delivery Infrastructure Annual Budget - KARELink Vehicles				
	Units	Cost per Unit	-	Annual Budget for PY 2
KARELink Vehicles	**2.0**			$100,000
KARELink Car	1.0	$50,000		$50,000
KARELink Van	1.0	$50,000		$50,000
Total KARELink Vehicles				**$100,000**

Delivery Infrastructure Annual Budget - KARELink Vehicle Maintenance				
	Units	Cost per Unit	-	Annual Budget for PY 2
KARELink Vehicle Maintenance Costs	**2.0**	$4,000		$8,000
Vehicle Insurance Costs		$2,000		$4,000
Vehicle Maintenance & Fuel		$2,000		$4,000
Total KARELink Vehicle Maintenance				**$8,000**

Delivery Infrastructure Annual Budget - KARELink Vehicle Maintenance				
	Units	Cost per Unit	-	Annual Budget for PY 3-5
KARELink Vehicle Maintenance Costs	**2.0**	$4,000		$8,000
Vehicle Insurance Costs		$2,000		$4,000
Vehicle Maintenance & Fuel		$2,000		$4,000
Total KARELink Vehicle Maintenance				**$8,000**

KARELink Transportation Costs - The purchase of a car and a passenger van to be utilized for home visits, accompanying enrollees to Life Skills Support opportunities, and other important appointments deemed necessary by the care coordinator. These will be purchased in PY 2 and a standard ongoing amount added for the remainder of the pilot for insurance, maintenance, and fuel. Additional monies have been allocated for access to the general motor pool in the county for any additional, unforeseen needs for transportation.

Delivery Infrastructure Annual Budget - KARELink Office Spaces				
	Units	Cost per Unit	-	Annual Budget for PY 2
KARELink Office Space Costs	**1.0**			$12,000
Allocable Lease Costs		$5,500		$5,500
Utility Costs / Janitorial Costs		$4,000		$4,000
IT Network Costs		$2,000		$2,000
Allocable Public Works Services		$500		$500
Total KARELink Office Space				**$12,000**

Delivery Infrastructure Annual Budget - KARELink Office Spaces				
	Units	Cost per Unit	-	Annual Budget for PY 3-5
KARELink Office Space Costs	**1.0**			$24,000
Allocable Lease Costs		$11,000		$11,000
Utility Costs / Janitorial Costs		$8,000		$8,000
IT Network Costs		$4,000		$4,000
Allocable Public Works Services		$1,000		$1,000
Total KARELink Office Space				**$24,000**

KARELink Office Space – The total amount requested for Office Space is $24,000 for PY 3-5. The amount is reduced by 50% for PY 2 for a total of $12,000 due to the decreased time period for PY 2. The amount was derived by calculating a yearly lease cost of $11,000; yearly utilities and janitorial costs at $8,000; IT Network Costs at $4,000 annually; and an annual charge from Public Works at $1,000. The space will be located within the Government Complex. This space is currently unused and available for this project.

Delivery Infrastructure Annual Budget - Provider Training				
	Units	Cost per Unit -	Annual Budget for PY 2	Annual Budget for PY 3-5
Community Engagement Costs	**1.0**	$30,000	$30,000	$30,000
Training Curriculum / Supplies		$13,500	$10,000	$13,500
Outreach Material / Brochures		$13,500	$10,000	$13,500
Training Equipment		$7,000	$7,000	-
Indirect (Meeting Supplies)		$3,000	$3,000	$3,000
Total KARELink Provider Training			**$30,000**	**$30,000**

Provider Training – The total costs for provider training is $30,000 for PY 2-5. As the overall costs will not fluctuate, the various supplies and materials will change from PY 2 to PY 3-5. In PY 2, curriculum and supplies will include the necessary tools to train the various referral sources including but not limited to: PowerPoint Presentations, paper referrals, demonstrations on electronic referrals, and cheat sheets on referrals. For PY 2, the amount is calculated at $10,000 and will increase to $13,500 for PY 3-5. It is anticipated that the per diem amount is higher in PY 2 as there will be multiple presentations to ensure all referral sources receive effective training on the overall program and referral process. As the program grows and adjusts using the PDSA model, refresher trainings will be given throughout the entirety of the pilot. Outreach material and brochures will include posters, brochures, and business cards to be made available at each presentation. This cost is estimated at $10,000 for PY 2 and $13,500 for PY 3-5. PY 2 is estimated to be higher given the shorter time period for the increased number of presentations. Training Equipment such as a laptop and/or projector with necessary software loaded is anticipated in PY 2 only to be used throughout the project. This cost is estimated at $7,000. Indirect costs are estimated at $3,000 per year to include but not be limited to: training venue costs, advertising, pens, paper, and etcetera.

Delivery Infrastructure Annual Budget - Operating Overhead				
	Units	Cost per Unit -	Annual Budget for PY 2	Annual Budget for PY 3-5
5% of Delivery Infrastructure Budget	1.0		$17,500	$5,049
Total Operating Overhead			**$17,500**	**$5,049**

Delivery Infrastructure Operating Overhead - was calculated at less than 5% of the total grant amount to provide for needed office expenses, postage & freight, printing, and supplies. Decrease for PY 3-5 due to removal of startup costs from budget.

Incentive Payments for Downstream Providers

There are no incentives budgeted for PY 2.

All participating entities will be actively involved in the identification of barriers and resolutions to those barriers. An important component of the WPC program will be KARELink's LAC and its ability to quickly identify and resolve all identified barriers to services. When roadblocks and problems are not identified, it can negatively impact the delivery of timely and high quality services to people who need them the most. Barriers can also limit the programs ability to be truly effective and proactive. Identification of these barriers is also critical to the PDSA process.

To support this endeavor, Kings County WPC program is requesting funding incentive payments for its five participating organizations for the active involvement in barrier identification, reporting, and resolution of program barriers at $10,000 annually per entity in PY 3-5. The five-year estimation for this budget line item is $150,000. The entities include Adventist Health, Champions, Kings County Jail, Anthem Blue Cross, and Kings County Behavioral Health.

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 to the lead entity. Additionally, the LAC will ensure that the identified barriers and their associated solutions are discussed during the LAC monthly meeting minutes based on the information it receives.

KARELink will analyze or discuss each barrier report with the five entities. Specifically, the PDSA related to barrier process improvement will be reviewed, along with the plan strategies for addressing identified barriers; the corrective actions to address each barrier; the monitoring of the applied corrective actions for efficacy; and adjustments for each corrective action according to the observed results.

Performance for this incentive will be measured based on the reports it receives on barriers using the PDSA process. Should a participating organization fail to provide a report on barriers on time, no payment shall be requested/issued for that month. Each report must indicate a potential barrier that has been identified as well as possible solutions to that barrier. If the barrier from the previous month has not been resolved, the same barrier may be used along with additional solutions. The report will be included on the agenda for the upcoming LAC meeting. Failure to provide the agenda item for the report prior to the LAC meeting will result in a decrease in the incentive. The five participating organizations will be the recipients of these incentive funds set at $10,000 per year per entity.

Incentives will be paid out as follows dependent upon the participation each entity establishes at the monthly LAC meetings for that project year as demonstrated by the prepared reports provided that identifies barriers as well as resolutions to that barrier. Reports provided at 25% of the meetings will result in 25% of the possible max payment. 50% is the threshold for the next payment step increase. 75% is the next step increase. 100% is the last step increase.

Incentives	
	Annual Budget for PY 3-5
Sheriff's Department	$10,000
Adventist Health	$10,000
Anthem Blue Cross	$10,000
Champions	$10,000
Behavioral Health	$10,000
Total Incentives	**$50,000**

Bundled PMPM Services

Three types of bundled services will allow for the new services and additional staffing needs for administering the newly created KARELink Program and some of the additional services to be made available. The lead community partner, Champions, will be providing most of the newly created and expansion services. The bundled services are: Care coordination Team (Champions), Housing Navigator (Champions), Comprehensive Care Coordination (Adventist Health).

Care Coordination Bundle	**Units**	**Annual Cost Per Unit**	**Annual Base Salary Per Unit**	**Annual Benefit Salary Per Unit**	**Annual Costs PY 3-5**	**Annual Cost PY 2**
Personnel Costs						
CMT Care Coordinator	6.0	$43,960	$26,376	$17,584	$262,962	$131,880
Life Skills Facilitators	8.0	$38,455	$23,073	$15,382	$307,640	$153,820
Job Navigator	1.0	$75,048	$45,028	$30,019	$75,048	$37,524
Receptionist/Clerk	1.33	$33,102	$19,861	$13,240	$44,026	$22,013
Total Personnel Costs	16.3				**$689,676**	**$344,838**
Operating Costs						
Engagement / Training Materials	1	$4,000			$4,000	$2,000
Curriculum Supplies	1	$2,000			$2,000	$1,000
Potential Costs- Customer Supportive Services	1	$1,625			$1,625	$1,625
Monthly Transportation	250	$2,500			$2,500	$1,240

Vouchers (@ $10 each)					
Cell Phones (Maintenance/Protection Costs)	15	$3,570		$3,570	$1,783
Cell Phone Usage Cost ($50 month * # Cells)	15	$9,000		$9,000	$4,200
Staff Mileage -FTEs * 100 miles/mo. (@ $.54/mile)	15	$9,000		$9,000	$4,000
Total Operating Costs				**$31,695**	**$15,848**
Indirect Costs					
Indirect Costs	5%	$36,069		**$36,069**	**$18,034**
Total Annual Expense					
Total Annual				**$757,440**	**$378,720**
Annual Max Member Months				**1440**	**720**
				$526	**$526**

*Benefits include the staff costs per contract and include but are not limited to medical/dental as well as retirement totaling approximately 40% of the annual base salary

Care Coordination – This bundled service will provide the majority of the coordinated care within KARELink. The amount per bundle is $526 from PY2 and $526 for PY 3-5. This amount was determined by the following:

- Personnel costs – Staffing needs for this bundle include: six care coordinators, eight life skills facilitators, one job navigator, and a two office assistants. One office assistant will only dedicate .33 of their time to this service. The total amount of personnel costs for PY 2 is $345,237. The amount for PY 3-5 is $690,474. The reduced amount for PY 2 is due to the shorter time frame for that project year. Each salary was determined by incorporating the annual base salary and benefits costs. Benefits include medical/dental as well as retirement totaling approximately 40% of the annual base salary.

- Operating Costs – Operating costs for this bundled service include a set amount for engagement/training materials needed for enrollees, curriculum costs for life skills, potential customer support payments, monthly transportation vouchers for job searches, 15 cell phones for each full time position, and staff mileage for each full time employee. The total operational costs for PY2 are $15,449 and are $33,728 for the PY 3-5.

- Indirect Costs – This amount includes but is not limited to: office expenses, postage & freight, printing, office machine maintenance, and supplies. This amount is estimated to be $17,375 for PY 2 and $22,750 for PY 3-5.

- Care Coordination: – With a 20:1 ratio, each of the six care coordinators will be providing a single point of contact to assist the enrollee in navigating the multiple services available through the pilot. The care coordinators will monitor each enrollee's physical and mental health for a decrease in symptoms and increased stability. Interactions will be scheduled and/or unscheduled which may be done telephonically, at their residence, or within the office. The goal of the interactions is to monitor the enrollee and provide an accountability measurement.

  Life Skills: Eight peer facilitators are included in the bundle, provided by people who have had personal experiences with mental health and/or substance use disorders that will provide peer mentoring and support through targeted educational opportunities such as: recovery, anger management, stress management, financial training, health education, and parenting/family services. As part of the individualized system of care through Champions, peers will facilitate these training sessions in group settings to assist with health education, alcoholism and drug addiction, anger management, support for batters' and/or victims of violence and other types of educational opportunities. This service will be offered at various venues throughout the county. Champions Facilitators offer a variety of group settings to encourage recovery and obtain self- sufficiency and optimum health. This will be part of a bundled service to include access to a variety of educational opportunities as well as proven peer counseling/mentoring situations.

  Job Navigation: The job navigator will complete assessments associated with job readiness such as education and previous experience and will provide any necessary trainings needed for those seeking employment including interviewing skills and resume writing/building. The job navigator will be using best practices from the Employment & Training program within HSA as well as best practices from the Jobs Training Office (JTO) program. The targeted populations have shown a great need for these types of services, as navigating through the various entities for similar services is difficult.

- Eligibility Criteria – Must be Medi-Cal eligible and experiencing at least one of the following: substance use disorder, mental health issues, poor control of diabetes, or high blood pressure to be established during the Engagement bundle. All enrollees will be assigned a care coordinator from Champions from the

engagement bundle initially; however, enrollees who meet eligibility requirements for a comprehensive care coordinator, explained below, will be transferred to the comprehensive care coordinator within a month. Enrollees may not receive both the comprehensive care coordination and care coordination bundles simultaneously.

- Disenrollment Criteria – enrollee refuses services; enrollee becomes incarcerated for more than a calendar month; or enrollee has completed all life skills classes, clears a second screening done through an engagement bundled service, and is in a stable shelter situation. Incarcerated enrollees have the option to re-enroll upon release.

- Estimated number of enrollees PY 3-5 – 500.

- Estimated member months – The annual total of member months per year is 720 for PY 2 and 1,440 for PY 3-5. This amount was derived by taking the total number of enrollees for each month to be served by the combined six care coordinators (120) including new and carry over amounts. This number was multiplied by the number of months in the project year.

- Average enrollment period – The expected average enrollment period for each enrollee is six months.

- Care coordinator ratio – It is anticipated that each care coordinator will carry a caseload of 20-25 enrollees each month with approximately 10 new enrollees in each month as 10 enrollees are dis enrolled due to attrition or attaining disenrollment conditions. These amounts include new and carry over enrollees.

- Non-duplication/sup plantation – Champions offers similar services on a smaller scale to community members. Those that are in receipt of services through the KARELink Project will be tracked separately as part of the contract developed between the lead entity, HSA, and Champions. The care coordination services will only be offered by the care coordinators hired specifically for KARELink. The six care coordinators will be in addition to the existing staff to ensure supplantation does not occur.

Housing Navigator	Units	Annual Cost Per Unit	Annual Base Salary Per Unit	Annual Benefit Salary Per Unit	Annual Costs PY 3-5	Annual Cost PY 2
Personnel Costs						
Housing Navigator*	1.0	$55,188	$33,124	$22,063	$55,188	$27,594
Office Assistant*	0.33	$34,350	$20,610	$13,740	$11,336	$5,668
Total Personnel Costs	1.3				**$66,524**	**$33,262**
Operating Costs						
Potential Costs-Customer Supportive Services	1	$2,000			$2,000	$1,000
Engagement / Training Materials	**1**	$2,000			$2,000	$760
Cell Phones (maintenance/Protection Costs)	**1**	$240			-	$240
Cell Phone Usage Cost ($50 month * # Cells)	1	$600			$600	$300
Staff Mileage -FTEs * 100 miles/mo. (@ $.54/mile)	1	$648			$648	$324
Total Operating Costs					**$5,248**	**$2,624**
Indirect Costs						
Indirect Costs	5%	$3,589			**$3,589**	**$1,794**
Total Annual Expense						
Total Annual					**$75,360**	**$37,680**
Annual Max Member Months					**480**	**240**
PMPM					**$157**	**$157**

*Benefits include the staff costs per contract and include but are not limited to medical/dental as well as retirement totaling approximately 40% of the annual base salary

Housing Navigator – This bundle is part of the overall Multi-Disciplinary Team (MDT) and will be used as deemed necessary given the following parameters and may be used at any time during enrollment in the program and concurrently with one of the care coordination bundles. This bundled service is $157 per month.

- Personnel costs – The housing navigator bundle will include a housing navigator to be hired through Champions as well as an office assistant calculated to be .33 of an FTE. The total cost for personnel for PY 2 is $33,262 and for PY 3-5, it is

$66,524. PY 2 is reduced due to the shorter time period for PY 2. Each salary was determined by incorporating the annual base salary and benefits costs. Benefits include the staff costs per contract and include but are not limited to medical/dental as well as retirement totaling approximately 40% of the annual base salary.

- Operating Costs – Operating costs include a determined amount needed for customer supportive services which include but are not limited to: repairs to current housing, mitigating issues with current landlord, and/or replacement of appliances or furniture. Engagement and training materials have been included tor educate the network of landlords who offer affordable housing about the services we can provide for those eligible to the pilot project. One cell phone has been included as well as staff mileage for the housing navigator to do home visits to determine eligibility for the supportive services. Total operating costs for PY 2 is $2,624. Total operating cost for PY 3-5 is $5,248.

- Indirect Costs – This amount includes but is not limited to: office expenses, postage & freight, printing, office machine maintenance, and supplies. This amount is estimated to be $17,094 for PY 2 and $3,589 for PY 3-5.

- Services Offered & Need – The housing navigator will develop a network throughout the county of landlords that offer affordable housing. This will be accomplished by educating landlords of the potential services that will be offered through this bundle. Similar efforts have been made in our county through the Housing Support Program (HSP) offered through HSA and will have access to the worker within HSA as well as the network of landlords that has been established. The housing navigator will screen for eligibility to payments to increase housing stability by offering services such as: repairs to current housing, mitigating issues with current landlord, and/or replacement of appliances/furniture. This service is needed in this community to assist with building bonds between those that have historically been difficult to rent/lease and the landlord to decrease hesitation of renting to those in need.

- Eligibility Criteria – In addition to the initial eligibility requirements, stability within their treatments, full cooperation with their care coordinator, and determination made by MDT and/or care coordinator is needed before enrollees are eligible for this service. Receipt of similar services through HSA will disqualify an enrollee from this service.

- Disenrollment Criteria – Enrollment in this bundled service will terminate when housing is stable, if the enrollee refuses services through KARELink, or becomes incarcerated.

- Estimated number of enrollees per year – 20 for PY 3-5.
- Estimated member months – The annual total of member months per year is 240 for PY 2 and 480 for PY 3-5. This amount was derived by taking the total number of enrollees for each month to be served by monthly case load amount (40) including new and carry over amounts. This number was multiplied by the number of months in the project year.
- Average enrollment period – The average enrollment period is two months given the amount of time needed to resolve the issues involved within this service.
- Care coordinator ratio – It is anticipated that the housing navigator will carry a caseload of 40 enrollees each month including new and carry over enrollees with 20 new enrollees per month.
- PMPM case rate – $3,768 per enrollee per year. This amount was calculated by dividing the annual PY 3 cost ($75,360) by the annual number of enrollees (20).
- Non-duplication/supplantation – These services do exist at various entities within the county; however, they are not currently offered at Champions. By placing this service within the Champions network of services, KARELink will avoid duplicating or supplantation of services as well as broaden the availability of these services.

Comprehensive Care Coordination /Low Ratio	**Units**	**Annual Cost Per Unit**	**Annual Base Salary Per Unit**	**Annual Benefit Salary Per Unit**	**Annual Costs PY 3-5**
Personnel Costs					
Adventist Care Coordinator *	2.0	$100,000	$60,000	$40,000	$200,000
Clerk *	1.0	$44,907	$26,945	$17,961	$44,907
Total Personnel Costs	3.0				**$244,907**
Operating Costs					
Adventist Health Office Costs (559 sqft@$5.37 sqft)/FTE	3	$1,000			$3,000
Engagement / Training Materials	1	$2,500			$2,500
Cell Phones (maintenance/Protection Costs)	2	$400			$800
Cell Phone Usage Cost ($50 month * # Cells)	2	$1,800			$3,600
Network Connected Notebook	2	$1,750			$3,500
Network Connected Printer/Copier	1	$2,415			$2,415

Staff Mileage (FTEs *200/mo at $.54/mile)	2	$1,296	$2,592
Total Operating Costs			**$18,407**
Indirect Costs			
Indirect Costs	5%	$13,166	**$13,166**
Total Annual Expense			
Total Annual			**$276,480**
Annual Max Member Months			**240**
PMPM			**$1,152**

*Benefits include the staff costs per contract and include but are not limited to medical/dental as well as retirement totaling approximately 40% of the annual base salary

Comprehensive Care Coordinators/Low Ratio – This bundle will be for enrollees who require more frequent and ongoing care coordination, especially those that are high utilizers of the emergency room due to severe mental issues and/or chronic health conditions.

- Personnel costs – Adventist health will hire two comprehensive care coordinators who will have a higher level of education/more clinical experience in providing services to enrollees with substance use disorders or chronic mental health conditions. A clerk will also be hired by Adventist health to assist the care coordinators. Total personnel costs for PY 3-5 is $244,907. The comprehensive care managers will be hired to begin in PY 3. Each salary was determined by incorporating the annual base salary and benefits costs. Benefits include medical/dental as well as retirement totaling approximately 40% of the annual base salary.

- Operating Costs – Operating costs include office space, engagement materials for enrollees, two cell phones, connection costs for notebooks, and staff mileage. The total costs for PY 3-5 is $18,407.

- Indirect Costs – This amount includes but is not limited to: office expenses, postage & freight, printing, office machine maintenance, and supplies. This amount is estimated to be $13,166 for PY 3-5.

- Services Offered & Need – Comprehensive Care Coordinators will offer similar services as the CCT bundle but with increased contact with each enrollee including but not limited to: daily telephone interactions and regular, consistent home visits. Each of the care coordinators will be providing a single point of contact to assist the enrollee in navigating the multiple services available through the pilot. The care coordinators will have focused training in assisting those in our

target populations and trained in the various assessment models as described in Section 3. They will monitor each enrollee's physical and mental health for a decrease in symptoms and increased stability. Care coordinators will also provide transportation to non Medi-Cal billable appointments, when needed. The targeted populations have shown a great need for this type of service as navigating through the various entities for similar services is difficult. The comprehensive care coordinators will provide medication management and accountability for each enrollee in their case load.

- Eligibility Criteria – Eligibility requirements are similar in that an enrollee must be a Medi-Cal beneficiary. Enrollees eligible for comprehensive care coordination must also have a documented, severe mental health issue with high Emergency Department usage or one of the chronic health conditions with high Emergency Department Usage. Enrollees who receive services in the care coordination bundle may not receive services in this bundle at the same time.

- Disenrollment Criteria – The enrollee will be dis enrolled from the bundled service if or when any of the following occur: enrollee refuses services; enrollee becomes incarcerated for more than a calendar month; enrollee is placed into a long term facility; or enrollee has completed all life skills classes as part of the coordinated care plan, clears a second health screening, and is in a stable shelter situation. Incarcerated or hospitalized enrollees have the option to re-enroll upon release or discharge.

- Estimated number of enrollees per year – 20 for PY 3-5. None expected in PY 2 as this bundled service will be implemented in PY 3.

- Estimated member months – The annual total of member months per year is 240. This was calculated by taking the total monthly caseload for each of the care coordinators (20) and multiplying this by the total number of months for the project year.

- Average enrollment period – The time of enrollment is expected to be up to six months.

- Care coordinator ratio – It is anticipated that the comprehensive care coordinator will carry a caseload of 10 enrollees each with approximately 2 new enrollees in each month as two enrollees are dis enrolled each month. These amounts include new and carry over enrollees

- PMPM case rate – $13,824 per year per enrollee. This amount was calculated by dividing the total yearly amount ($276,480) by the number of expected enrollees per year (20).

- Non-duplication/supplantation – These services do exists at various entities within the county; however, they are not currently offered at Adventist Health or for our target population. By placing this service within the Adventist Health network of services, KARELink will avoid duplicating or supplantation of services as well as broaden the availability of these services to a wider population.

Fee for Service (FFS)

Many of the individualized needs of the enrollees eligible to KARELink require individualized services. The items included for fee for service addresses many of the individualized needs that have been recognized by Kings County. Services such as Community Integration and beds at the High Intensity Mental Health Respite unit are entirely new services to be offered in our county. Short Term Recuperative Care Unit is a very new service that has quickly demonstrated a need for expansion. These services are: Engagement, Short Term Recuperative Care Unit, Community Integration Treatments, SSI Advocacy, and High Intensity Mental Health Respite.

Engagement	**FTE**	**Cost Per Unit**	**Total**
Nurse *	1.00	$73	$73.00
Clinician*	1.00	$73	$73.00
Office Assistant*	0.33	$15	$15
Assessments		$5	$5
Max Amount per Unit			$166
Total Annual Expense		PY 2	PY 3-5
Annual Max Units		720	1440
Total Annual Expense		$119,520	$239,040

*Benefits include the staff costs per contract and include but are not limited to medical/dental as well as retirement totaling approximately 40% of the annual base salary

Engagement – Engagement will be completed for every referral. This service will include the staff needed for the immediate assessment of each referral to include a full physical health assessment for chronic health conditions and a mental health assessment from the clinician, a licensed psychologist, including screening for suicide risk and substance use risk as well as the exit assessment needed to determine stability and self-sufficiency of each enrollee. An office assistant will be utilized at .33 of FTE. Each assessment will include an interview with the enrollee and a meeting with the entire MDT and assigned care coordinator to develop the coordinated care plan. The interview will take up to an hour with the enrollee to be done face to face with telephone interviews done on an emergency case by case basis. The meeting with the MDT and care coordinator will take 30 minutes. The two meetings (enrollee interview and MDT

review) may not be held on the same day with the standard being set between two calendar weeks to 30 days. All potential enrollees that do not meet eligibility requirements will be referred to other available resources throughout the county including but not limited to: Kings View Mental Health Services, Behavioral Health, other public health services/programs, etc.

Short Term Recuperative Care Unit (Per Bed Day)	**Cost Per Unit**	**Total**
Community Based Organization Bed Cost	$100	$100
Community Based Organization Staffing Costs*	$40	$40
Supplies and Materials	$10	$10
Max Amount per Unit		**$150**
Total Annual Expense	**PY 2**	**PY 3-5**
Annual Max Unit	**1,500**	**2,775**
Total Annual Expense	**$225,000**	**$416,250**

Benefits include the staff costs pe contract and include but are not limited to medical/ dental as well as retiremenet totalingapproximattely 40% of the annual base salary

Short Term Recuperative Care Unit - This service is a recently added service to our county through Champions and uses the short term recuperative care which is not an allowable Medi-Cal billable service. The need for this service exceeds the number of beds currently available. This fee for service looks to expand this service to a total of 8 beds. The fee includes the staffing needs as well as the overhead costs associated with this service such as higher costs linens. It is expected that each enrollee will require an average of 3 days for complete detox and may need more than one round of services while enrolled in the pilot due to relapse. Enrollees will be eligible for this service if they are Medi-Cal eligible, are currently intoxicated, have been medically cleared, are not a threat to themselves or others, and are seeking treatment. Referrals for this service will be from health service models and may be in cooperation from law enforcement. An enrollee who seeks treatment at the Short Term Recuperative Care Unit will receive an automatic referral into KARELink if they are not a current enrollee in KARELink. They are discharged from the Short Term Recuperative Care Unit when the enrollee test negative from any substances and no longer have displays of active withdrawal symptoms or they become a threat to themselves or others.

Community Integration	**Cost Per Unit**	**Total**

Public Health Utilization Fee		$145	$145
KC Public Health Physician Asst. Hourly Rate *		$40	$40
Community Integration Maintenance Cost per Treatment		$20	$20
	Max Amount per Unit		**$205**
Total Annual Expense		**PY 2**	**PY 3-5**
	Annual Max Unit	**100**	**200**
	Total Annual Expense	**$20,500**	**$41,000**

Community Integration

*Benefits include the staff costs per contract and include but are not limited to medical/dental as well as retirement totaling approximately 40% of the annual base salary

Community Integration Treatment - Kings County Public Health Department has been awarded a machine that is capable of removing ink markings. The removal of stigmatizing ink markings is not a service covered or billable to Medi-Cal. Public Health will be making Community Integration available in Kings County and to KARELink enrollees. The cost for this service was calculated by accounting for the staffing needs, charge for the office visit, and machine maintenance. The fee is per treatment with the understanding that most ink markings require multiple treatments for complete removal. It is anticipated that we would serve approximately 40 enrollees a year with an average of five treatments needed to fully remove the ink marking. This is a total number of 200 visits/treatments for each year. An enrollee is eligible to this service when they are actively seeking employment and have a stigmatizing, visible ink marking on the face, neck, arms, and/or hands. This service will continue until either of the two has been met: when all visible ink marking have been removed; or when enrollee has been disenrolled from pilot.

SSI/SSDI Advocacy (per case)	**FTE**	**Cost Per Unit**	**Total**
Eligibility Worker Case Management *	0.5	$3,050	$1,525
Potential Supportive Services		$500	$500
Transportation Costs		$200	$200
	Max Amount per Unit		**$2,225**
Total Annual Expense		**PY 2**	**PY 3-5**
	Annual Max Units	**10**	**40**
	Total Annual Expense	**$22,250**	**$89,000**

SSI SSDI Advocacy (per case)

*Benefits include the staff costs per contract and include but are not limited to medical/dental as well as retirement totaling approximately 40% of the annual base salary

SSI/SSDI Advocacy – The cost for this service was determined by accounting for half of a full time Eligibility Worker (EW) assigned solely with assist those that may qualify through the difficult process of applying and obtaining SSI and/or Social Security Disability. The cost includes the salary and benefits of an EW and support services. Potential supportive services are fees associated with obtaining necessary eligibility documents like birth certificates, identification cards, certified mail, and potential copy costs for health records or resources. Transportation costs are for staff transportation. This position is not currently eligible for funds through Medi-Cal claiming. It is anticipated that the EW will assist up to 40 beneficiaries each year. An enrolled enrollee may be eligible to this service if they have a documented long term disability. This is a onetime fee for the entire length of the service.

High Intensity Mental Health Respite (Per Bed Day)	**Cost Per unit**	**Total**
Adventist Health Bed Cost	$100	$100
Staffing Cost *	$75	$75
Space Costs	$25	$25
Indirect	$10	$10
Max Amount per Unit		$210
Total Annual Expense	**PY 3-5**	
Annual Max Unit	**1875**	
Total Annual Expense	**$393,750**	

*Benefits include the staff costs per contract and include but are not limited to medical/dental as well as retirement totaling approximately 40% of the annual base salary

High Intensity Mental Health Respite – This service currently does not exist in the county. The price used for these are based on estimates by using the current daily price residential treatment and accounting for increased staffing needs. The High Intensity Mental Health Respite is anticipated to be implemented in 2018. Adventist Health, in cooperation with the Wellness Bridge Project, is in the planning stages for establishing a facility for the High Intensity Mental Health Unit. The fee for service will expand the number of beds as well as cover any services not covered by Medi-Cal. It is anticipated that there will be 5 beds available per day for KARELink enrollees for an annual total of 1,875 daily bed usages. The expectation is the enrollees in need of this service will utilize this item more than once during their enrollment period. The average length of time for a stay is set at 20 hours. The purpose of the beds is to provide a place for those who have had interaction with law enforcement, found not to be a threat to themselves

or others, but still in need of stabilization, while diverting them from incarceration. An enrollee will be cleared by medical staff, not covered under this fee, as no longer being a threat to themselves or others. Patients that have used this service will receive an automatic referral into the KARELink program.

Pay for Metric Reporting

Data from each of the participating entities is necessary to ensure both bi-directional sharing as well as ensuring the outcomes laid out in section four are being met. Data will be used to analyze the successes of the coordinated care, provide enrollee specific information, and identify additional gaps or areas of improvement. The following entities are eligible for funding for reporting in that area. These are: Jail for recidivism amount, Adventist for ER utilization for Mental Health data, Champions for Suicide Risk Assessment data and Anthem Blue Cross for HbA1c Control data.

Pay for Reporting		
	Annual Budget for PY 2	Annual Budget for PY 3-5
Recidivism Rate – Kings County Sheriff's Dept.	10,000	48,500
ER Utilization for Mental Health - Adventist	10,000	48,500
Suicide Risk Assessment - Champions	10,000	48,500
HbA1c Control – Anthem Blue Cross	10,000	36,500
Pay for Reporting	**40,000**	**$182,000**

Pay for Reporting

Each entity responsible for the items listed above will be eligible for a payment for timely reporting. The entity will be required to report their necessary information every month to the Program Analyst. They will receive 50% of the payment if they provide the monthly data needed for the six-month report. The entity will eligible for the other 50% of the payment if all required monthly data has been provided for the annual report.

Pay for Metric Outcomes Achievement

KARELink recognizes that a large amount of time and effort will be needed to meet the specific outcomes included in the plan. Payments for outcomes have been established for three of our measurable outcomes. The payable outcomes are: 85% of enrollees will have a comprehensive care plan created and accessible by entire care team within 30 days; decreasing the number of diabetic enrollees with poor control of their diabetes; and decreasing jail recidivism in our local jail. Metric outcome achievements will be paid annually to the listed entities if that outcome is achieved in that project year. Each entity

is eligible to $36,000 a year. Failure to meet the benchmark forfeits the pay for outcome payment.

Pay for Metric Outcomes		
	Annual Budget for PY 2	Annual Budget for PY 3-5
Comprehensive Care Plan – Public Health	$18,000	$36,000
Decrease poor control Diabetes – Adventist Health	$18,000	$36,000
Decrease Jail Recidivism by 10% each year - Champions	$18,000	$36,000
Pay for Metric Outcomes	**$54,000**	**$108,000**

Pay for Metric Outcomes

Champions will be eligible for the payment for decreasing jail recidivism in our local jail. Jail recidivism rates will be measured in two different ways. The first will be through ETO software to measure each individual's risk of recidivism. The official benchmark for this outcome will be the recidivism rate as determined at the County Sheriff's Department. This percentage will be measured by taking using the total number of individuals that were incarcerated this month and had been incarcerated in the

previous 12 months by the total number of incarcerated individuals that month. KARELink expects 500 enrollees to have been justice impacted (incarcerated, booked, and/or charged) at some point prior to enrolling into KARELink. Success will be measured by the yearly average. Failure to meet the benchmark forfeits the pay for outcome payment.

Metric for Champions	
	All
	Variant Metric – Decreasing Jail Recidivism by 10% each year.
	PY3: 10% PY4: 20% PY5: 30%
	From denominator, number of incarcerated individuals at County Jail that have been previously incarcerated in the previous 12 months.

Denominator:	Total number of incarcerated individuals at County Jail.	
Metric Outcome	$18,000 in PY 2	$36,000 in PYs 3-5

Metric for Champions

Adventist Health will be eligible for the payment for the decreased number of diabetics with poor control of their diabetes. KARELink expects to have 75 total enrollees with poor control of their diabetes throughout the entire pilot program. The Program Analyst will receive the data from our managed care partner on a monthly basis. Success will be measured on the yearly average. Failure to meet the benchmark forfeits the pay for outcome payment

Metric for Adventist Health		
Target Population:	KARELink Diabetic enrollees	
Measure Type:	Variant Metric – Decreasing HbA1c <8% by 5% each year.	
Benchmark:	PY3: 5% PY4: 10% PY5: 15%	
Numerator:	Within the denominator, who had HbA1c control <8%	
Denominator:	Members 18-75 years of age with diabetes (Type 1 or 2)	
Annual Pay for Metric Outcome	$18,000 in PY 2	$36,000 in PYs 3-5

Metric for Adventist Health

Public Health will be eligible for the payment for coordinated care when KARELink has shown success each month with establishing coordinated care for each enrollee within 30 days. The KARELink Coordinator and Program Analyst will be tracking each enrollee from referral through the progression of the entirety of the program. Each MDT and CCT will have access to the coordinated care plan as the teams will be located within the same office. Bi-directional sharing of information between the Comprehensive Care Managers and KARELink will be completed through a central point of contact, the KARELink Coordinator, as well as through regularly scheduled meetings. Success will

be measured by the yearly average of initial assessment to assignment to a care coordinator. Failure to meet the benchmark forfeits the pay for outcome payment.

Metric for Public Health		
Target Population:	All	
Measure Type:	Universal Metric – Proportion of enrollees with comprehensive care plan, accessible by the entire care team, within 30 days	
Benchmark:	PY3: 75% PY4: 80% PY5: 85%	
Numerator:	Number of new referrals that have been assessed and linked with a care coordinator manager within 30 days.	
Denominator:	Total number of referrals.	
Annual Pay for Metric Outcome	$18,000 in PY 2	$36,000 in PYs 3-5

Metric for Public Health

Second Round WPC Budget Template, New Applicant: Summary and Top Sheet

New WPC Applicant Name:	*Kings County KARELink*

	Federal Funds *(Not to exceed 90M)*	**IGT**	**Total Funds**
PY 1 Annual Budget Amount Requested	803,023	803,023	1,606,045
PY 2 Annual Budget Amount Requested	803,023	803,023	1,606,045
PYs 3-5 Annual Budget Amount Requested	1,606,045	1,606,045	3,212,090

Second Round PY 1 Budget Allocation (Note PY 1 Allocation is predetermined)	
PY 1 Total Budget	1,606,045
Approved Application (75%)	1,204,534
Submission of Baseline Data (25%)	401,511
PY 1 Total Check	OK
Does PY 1 Total = 50% of PY 3 Total?	Yes

Second Round PY 2 Budget Allocation	
PY 2 Total Budget	1,606,045
Administrative Infrastructure	364,875
Delivery Infrastructure	367,500
Incentive Payments	0
FFS Services	387,270
PMPM Bundle	416,400
Pay For Reporting	40,000
Pay for Outcomes	30,000
PY 2 Total Check	OK
Does PY 2 Total = 50% of PY 3 Total?	Yes

Second Round PY 3 Budget Allocation	
PY 3 Total Budget	3,212,090
Administrative Infrastructure	477,750
Delivery Infrastructure	106,020
Incentive Payments	50,000
FFS Services	1,179,040
PMPM Bundle	1,109,280
Pay For Reporting	182,000
Pay for Outcomes	108,000
PY 3 Total Check	OK

Second Round PY 4 Budget Allocation	
PY 4 Total Budget	3,212,090
Administrative Infrastructure	477,750
Delivery Infrastructure	106,020
Incentive Payments	50,000
FFS Services	1,179,040
PMPM Bundle	1,109,280
Pay For Reporting	182,000
Pay for Outcomes	108,000
PY 4 Total Check	OK

Second Round PY 5 Budget Allocation	
PY 5 Total Budget	3,212,090
Administrative Infrastructure	477,750
Delivery Infrastructure	106,020
Incentive Payments	50,000
FFS Services	1,179,040
PMPM Bundle	1,109,280
Pay For Reporting	182,000
Pay for Outcomes	108,000
PY 5 Total Check	OK