State of California - Health and Human Services Agency **Department of Health Care Services**

Whole Person Care

Lead Entity Mid-Year or Annual Narrative Report

Reporting Checklist

Kern Medical Center
Annual PY 3
04/02/2019

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

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

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

I. REPORTING INSTRUCTIONS

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

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

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

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

II. PROGRAM STATUS OVERVIEW

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

The Kern Medical WPC program increased enrollment through marketing the WPC program at community outreach events, meetings and gatherings throughout the community, including Binational Health Week and faith based homeless outreach activities.

The WPC education program provided program information and outreach to community members at school district events, private incarceration facilities and to adults who have aged out of the county foster care system. They also met with program case management teams from various community organizations that work with individuals with similar demographics. By doing so, the program informed staff about the benefits and services offered within the WPC program and educated advocates on how to refer their clients to it.

We held onsite enrollment events at halfway houses, sober living facilities, post incarcerated check in meetings at the probation department, homeless shelter, and the rescue mission. Some of these enrollment events also included screenings by our program social workers.

The Care Coordinators outreached by making hundreds of calls to post incarcerated individuals, inviting them to learn more about the WPC program and then mailing them additional information on the services that could be provided if they wished to participate. Our provider and program manager met with soon to be released inmates to inform them about WPC services that could be available to them once released from incarceration.

Once personal points of contact were established at the various community based organizations and agencies, the WPC team conducted subsequent visits and outreach at those locations to inform staff and potential participants about the program. Ongoing check in meetings continue to occur to answer questions, enroll participants and troubleshoot and issues with referrals or services.

III. ENROLLMENT AND UTILIZATION DATA

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

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

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

Item	Month 1	Month 2	Month 3	Month 4	Month 5	Month 6	Unduplicated Total
Unduplicated Enrollees	8	4	32	6	21	33	104

Item	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12	Annual Unduplicated Total
Unduplicated Enrollees	10	31	21	55	123	141	381

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

	Costs and Aggregate Utilization for Quarters 1 and 2						
FFS	Month 1	Month 2	Month 3	Month 4	Month 5	Month 6	Total
Child Care	0	0	0	0	0	0	0
Utilization 1	0	0	0	0	0	0	0
Training	0	0	0	0	0	0	0
Utilization 2	0	0	0	0	0	0	0
Benefits Advocacy	0	0	0	0	0	0	0
Utilization 3	83	69	86	67	95	92	492
Information and Referral	0	0	0	0	0	0	0
Utilization 4	369	361	389	379	378	376	2252

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	Costs and Aggregate Utilization for Quarters 3 and 4						
FFS	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12	Annual Total
Training	0	0	0	0	0	0	0
Utilization 1	0	0	0	0	0	2	2
Benefits Advocacy	0	0	0	0	0	0	0
Utilization 2	69	91	68	96	135	156	615
Screening, Assessment, Referral	0	0	0	0	0	0	0
Utilization 3	0	193	181	131	68	54	627
Information and Referral	0	0	0	0	0	0	0
Utilization 4	325	366	354	831	443	414	2733
Respite Care	0	0	0	0	0	0	0
Utilization 5	0	0	0	0	0	0	0

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

		Amount Claimed						
PMPM	Rate	Month 1	Month 2	Month 3	Month 4	Month 5	Month 6	Total
Housing Navigation	$480	0	0	0	0	0	0	0
MM Counts 1		2	2	7	10	17	47	85
Employment Services	$200	0	0	0	0	0	0	0
MM Counts 2		0	0	0	**1**	0	0	**1**
WPC Care Coordination	$450	0	0	0	0	0	0	0
MM Counts 3		90	92	123	128	147	179	759
90-Day Post Incarceration	$1800	0	0	0	0	0	0	0
MM Counts 4		2	**3**	**6**	**6**	**5**	**10**	**32**
Moderate Housing Support	$171	0	0	0	0	0	0	0
MM Counts 5	0	0	0	0	0	0	0	0

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		Amount Counts						
PMPM	Rate	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12	Total
Housing Navigation	$480	0	0	0	0	0	0	0
MM Counts 1		52	62	73	91	105	112	495
Employment Services	$200	0	0	0	0	0	0	0
MM Counts 2		1	5	0	13	43	94	156
WPC Care Coordination	$450	0	0	0	0	0	0	0
MM Counts 3		188	215	231	286	408	549	1877
90-Day Post Incarceration	$1800	0	0	0	0	0	0	0
MM Counts 4		11	18	21	47	124	192	413
Moderate Housing Support	$171	0	0	0	0	0	0	0
MM Counts 5	0	0	0	0	0	21	29	50

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

Kern drastically increased enrollment in Q4 which provided many successes, but also many challenges. The rapid growth we experienced made it difficult to manage overall pilot maintenance as we were trying to balance the enrollment overload we were facing.

Kern was granted permission by DHCS to go back to Q1 and add outreach FFS items such as Screening, Assessment and Referral and Information and referral. In addition to those outreach FFS categories, Kern was also given permission to count state and federal releases in the Post-Incarcerated PMPM bundle back to Q1 as well. One overlooked Employment Services PMPM was found for March of 2018. It was discovered that not all Benefits Advocacy encounters were pulling over and January-June 2018 amounts were corrected. All Mid-Year FFS and PMPM changes are reflected in bold. Due to these changes, additional units were requested in the annual reporting section of the PY3 Invoice template to account for the aforementioned unbilled PY3 Mid-Year services.

IV. NARRATIVE – Administrative Infrastructure

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

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

LE has successfully hired two additional Medical Assistants to perform the functions of Care Coordination for the expected exponential rise in enrollees throughout the remainder of the pilot.

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

The Lead Entity is in the process of implementing an Electronic Data Warehouse, which will house data from various sources and allow for more real time data analysis. This infrastructure will also assist in providing timely and relevant data sharing to CBOs regarding WPC Beneficiaries.

Indirect Costs are used to cover any variable/unknown items, which cannot be predicted in conceptual programs. The lessons learned, research, and possible outcomes for the WPC program are far too important to allow program failure for lack of funding for unknown circumstances.

V. NARRATIVE – Delivery Infrastructure

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

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

The Kern County WPC Pilot had an approved budget for WPC Clinic Tenant Improvements in addition to the Pre-Manage – EDIE Software. Only the WPC Clinic Tenant Improvements were available to draw down for the PY3 Annual Report. Kern successfully opened an Independent WPC Clinic in mid-December 2018.

Kern has already requested that the Pre-Manage – EDIE Software funds be approved in the PY3 rollover to be utilized in PY4. Kern executed the contract for the Pre-Manage – EDIE Software in PY3 quarter 4, however, the funds are not due until implementation which did not happen until the first quarter of PY4.

VI. NARRATIVE – Incentive Payments

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

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

Kern's eligible incentive payments earned at Annual PY3 report include:

1. Bi-weekly Learning Collaborative Calls attendance (Kern Medical Center only) – Met by attending on DHCS Learning Collaborative Calls. Kern Medical achieved 12 incentives at $200 each for a total of $2,400
2. DHCS Learning Collaborative Meeting attendance (Kern Medical Center, Kern Health Systems and Health Net only) Met by attending in person Learning Collaborative meeting reimbursed at $1,000 per attendee. Kern Medical Center had 4 in attendance and Kern Health Systems and Health Net each had 1.
3. Active involvement in barrier identification and resolution by way of monthly "Collaborative Committee Meeting" attendance (County Departments/CBOs and LE)
4. Managed Care Plan Referrals – Kern received 7 referrals from Kern Health System and Health Net for $20,000 each. Kern received 6 months of referrals from Kern Health Systems as their referral process is automated and one month of referrals from Health Net.
5. 80% in Outreach and Engagement Phase, Enrolled in a Pilot within 3 months of first encounter. Kern has been successfully able to enroll over 80% of patients into WPC within 3 months of the first encounter.
6. 200 New Recently Incarcerated Enrollments incentive for $400,000, KMC successfully enrolled 535 enrollees with 233 within the Post-Incarcerated population by December 2018.
7. Patient Focus Group - Kern held 6 focus group meetings from July through December 2018. At least 9 people attended the focus group meetings each quarter. Kern earned 5,000 each quarter, earning a total of $10,000 for PY3 annual.
8. Proportion of patients with Primary Care follow-up visit within 14 days of hospital discharge 40% earned $410,600
9. Proportion of patients with Medication Reconciliation within 14 days of hospital discharge 40% earned $250,054.28

10. PY3 Independent WPC Clinic Opening earned $600,000 ($60,000 for each milestone)
    - Identify Realtor $60,000
    - Identify Location
    - Identify contractor for tenant improvements
    - Place Offer
    - Pass and complete inspection
    - Fully execute lease (we ended up purchasing the building)
    - Finalize tenant improvement plan
    - Tenant improvements completed
    - Equipment and furnishings completed
    - First client intake by 12/31/2018 (first intake on 12/17/2018)

11. Active involvement in barrier identification and resolution:

This incentive is reimbursed at $10,000 per meeting to our eight Inner-governmental Transfer CBOs/County Departments (as well as us as the LE) and $5,000 for the additional five CBO's. Role was taken at each meeting to accurately record attendance. A maximum of 6 meeting attendances could be billed by the County Departments/CBOs and LE for the PY3 annual report. Achievement is measured by attendance. In addition to the LE, the County Departments/CBO's who were eligible to bill for this incentive are listed below:

The overall attendance was 91% with 71 of 78 total CBO attendees.

- Kern Medical Center – 6 meetings x $10,000 = $60,000
- Housing Authority – 6 meetings x $10,000 = $60,000
- Probation – 6 meetings x $5,000 = $30,000
- Aging and Adult Services – 6 meetings x $10,000 = $60,000
- Health Net – 3 meetings x $10,000 = $60,000
- KCSO – 6 meetings x $10,000 = $60,000
- Kern Health Systems – 5 meetings x $10,000 = $50,000
- Golden Empire Gleaners – 6 meetings x $5,000 = $30,000
- Public Health – 3 meetings x $10,000 = $50,000
- America's Job Center (Formerly E.T.R.) – 6 meetings x $5,000 = $30,000
- Kern B.H.R.S. (Formerly Kern County Mental Health) – 6 meetings x $5,000 = $30,000
- DHS – 6 meetings x $10,000 = $60,000
- Flood Ministries – 6 meetings x $10,000 = $60,000

VII. NARRATIVE – Pay for Outcome

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

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

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

Housing Authority has proven to be instrumental in locating our homeless population, keeping them current with physician appointments, and assisting with housing navigation services. Aggregated data from the PY3 Annual report indicate that Housing Authority has assisted with 580 months of services on a PMPM basis.

Maintain Baseline of ER Utilization Kern's pilot had a baseline of 4.07%, PY2 rate of 3.64% and a PY3 annual rate of 3.63% - **Attained**

Maintain baseline of Inpatient Utilization Kern's pilot had a baseline of 3.41%, PY2 rate of 1.45% and a PY3 mid-year rate of .79% - **Attained**

Maintain Baseline for Follow-up after hospitalization for Mental Illness Kern's pilot had no hospitalizations for mental illness in the baseline year and no in PY2. At PY 3 Annual, there were 7, 4 of which had a follow up in 30 days and 3 had no follow up - **Attained**

Maintain Baseline for Initiation and engagement of ETOH and other dependence Kern's pilot had a baseline of 0, 0 in PY2 and 96% (44/46) at PY 3 Annual - **Attained**

Maintain Baseline for PHQ-9 depression remission at 12 months - Kern's pilot had a baseline of 0%, PY2 rate of 0% and a PY3 annual rate of 0% **- Not Attained.**

This metric looks back one year for the PHQ score, so this population was screened prior to enrollment in the program. Now when enrolled, individuals are being screened for depression and work immediately with social workers in the event the score greater than 9.

Maintain baseline of Hba1C Control <8% Kern's pilot had a baseline of47.83%, PY2 rate of 65.38% and a PY3 annual rate of 60.56% - **Attained.**

As populations increase, variation and volatility in this metric should decrease.

Maintain Baseline for preventative care measures of WPC beneficiaries – Kern's pilot did not attain this metric. Although annual wellness visits and colorectal cancer screenings were up, cervical and breast cancer screenings were down for this reporting period - **Not Attained.**

35% Post-incarceration primary care visit within 60 days of release – Kern's pilot had 42% post-incarcerated beneficiaries who had a primary care visit within 60 days of release – **Attained.**

Maintain Baseline 30 day all cause readmission - Kern's pilot had a baseline of 20%, PY2 rate of 0% and a PY3 annual rate of 8.16% - **Attained.**

Mental Health Reporting: Screening, Brief intervention and referral to treatment (SBIRT) Kern's pilot had a baseline of 68.4%, PY2 rate of 95.4% and a PY3 annual rate of 97.78% - **Attained.**

Maintain Baseline: Overall Beneficiary Health – Kern's pilot was not capturing this survey in the first part of PY3 – **Not Attained.**

Maintain Baseline: Controlling High Blood Pressure Kern's pilot had a baseline of 65.63%, PY2 rate of 39.13% and a PY3 annual rate of 69.64% - **Attained.**

Med Reconciliation completed within 30 days of enrollment – 60% Kern's pilot had 89.97% of med reconciliations completed within 30 days of enrollment – **Attained.**

60% of participating beneficiaries with a comprehensive care plan, accessible by the entire care team within 30 days Kern's pilot achieved 100% compliance - **Attained**

Screening for clinical depression and follow-up plan – 5% improvement over prior year Kern's pilot had a baseline of 0%, PY2 rate of 0% and a PY3 annual rate of 80.39% **- Attained**.

Percent of homeless receiving housing services in PY that were referred for housing services – 50% Kern's pilot had an annual rate of 82% - **Attained**

Completion of Universal Assessment Tool with Homeless individuals – 60%
Kern's pilot achieved 100% compliance. - **Attained**

Percentage of participants who have obtained TB clearance – 63% - Kern's pilot could not properly report on this metric and are not claiming attained at this time - **Attained.**

Pay for Reporting
Below is a summary of all pay for reporting items:

Proportion of participating beneficiaries with a comprehensive care plan, accessible by the entire care team, within 30 days of enrollment

- Kern's pilot achieved 100% compliance

Care Coordination, Case management and referral infrastructure

- Reported and accepted in prior year

Data and information sharing infrastructure

- Reported and accepted in prior year

WPC Meeting Effectiveness measured by attendance

- 71/78 = 91%

PHQ 9 Depression Remission at 12 months

- PY3 mid-year rate of 0%

  This metric looks back one year for the PHQ score, so this population was screened prior to enrollment in the program. Now when enrolled, individuals are being screened for depression and work immediately with social workers in the event the score greater than 9.

Percent of Homeless receiving housing services in PY that were referred to housing services

- Kern's pilot had a mid-year rate of 95%

Mental Health Reporting: SBIRT

- PY3 annual rate of 59.26%

Ambulatory Care – Emergency Department visits

- PY3 annual rate of 3.63%

Ambulatory Care – General Hospital/Acute Care

- PY3 annual rate of .79%

Follow-up after hospitalization for mental illness

- In PY 3 annual, there were 7, 4 of which had a follow up in 30 days and 3 had no follow up.

Initiation and engagement of Alcohol and other drug dependence treatment

- 96% (44/46) in PY 3

Adult BMI assessment

- 95.51% (489/512) in PY3

Controlling High Blood Pressure

- PY3 annual rate of 69.64%

Hba1C <8%

- PY3 annual rate of 60.56%

Wellness/Lifestyle Class Attendance

Of the various wellness/lifestyle classes, there were 496 classes attended by WPC beneficiaries.

VIII. STAKEHOLDER ENGAGEMENT

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

1. Kern Behavioral Health & Recovery Services
2. Kern County Sheriff's Office
3. Kern County DHS

Aside from the monthly CBO meetings, LE has met with Kern BHRS personnel on a 1:1 to go over, and provide clarification of, the criteria requirements for enrolling new clients into the WPC program. Additionally, LE has provided structured guidance on identifying these individuals and determining which of them will not be qualified for the program prior to submission of their referrals. We have been working closely with Kern BHRS and their street outreach teams for homeless to provide same day appointments for referrals. This process has been going smoothly and Kern BHRS has been grateful for the decrease in wait times and plethora of services not offered in a traditional PCP office. LE has also built a more collaborative relationship with Kern BHRS in the county jail setting as well. We have worked closely to have BHRS identify potential enrollees to WPC prior to release and we have worked out a referral process with the case managers to link patients to WPC and obtain a follow-up appointment prior to release.

We have met with the Sheriff's delegate to design and implement a linear data-sharing process that allows the LE to see a daily, updated, list of recently released incarcerated individuals. The purpose of the data-sharing is designed to mitigate the chances of losing potential clients do to their physical locations; particularly those who do not have stable living situations. The data is specifically designed as unidirectional to eliminate any possible violations or breaches of The Health Insurance Portability and Accountability Act (HIPAA). This long awaited data feed became live in September 2018.

LE has also spent a considerable amount of time meeting with Kern County DHS to make process improvements in the way that the Medi-Cal eligibility and aid codes are reported to LE for both the general population as well as the incarcerated and recently post-incarcerated populations. We have been working with a DHS MCIEP assigned worker to more efficiently track and assist the transition from incarceration to release. Additionally, we have been working closely to reduce Medi-Cal churn amongst this pilot population. LE has also partnered with DHS to be a potential referral source for Kern's WPC Pilot.

We have developed a screening tool that General Assistance workers can use to send potential referrals for individuals applying for General Assistance. DHS has also set WPC up as a “CBO Assistor” which allows WPC affiliates to assist beneficiaries and check the status of applications, etc. This has greatly helped LE to better manage the application process for our WPC beneficiaries.

IX. PROGRAM ACTIVITIES

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

(1) The Care Coordinators were able to assist a patient who was homeless, had substance abuse issues, medical conditions that caused seizures, that was in an abusive relationship. The provider noticed the signs of abuse and the team coordinated help for her. She broke free from the abuser, stopped the substance abuse and is now living back with family in a safe environment.

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

(1) Some of the challenges the with care coordination include linking the patients to affordable housing. There is a greater need for housing than there are locations that match the limited incomes of our patients. This is a difficult task for our care coordination team.
(2) Assisting our patients with finding employment opportunities has been a challenge. We are finding that the able bodied patients who could work either cannot pass an employment drug screen, have felony convictions, or their skill level is too low for local employment agencies to assist them with job placement.

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

(1) The lead entity has experienced continued success in data sharing with DHS. LE has partnered with DHS to allow WPC to be a “CBO Assistor” to all WPC clients who sign the “assistor” form allow WPC affiliates to assist beneficiaries by allowing them to upload documents on their behalf and check the status of applications, etc. This has greatly helped LE to better manage the application process for our WPC beneficiaries.
(2) Data sharing with the Kern County Sheriff’s Office has proven to be necessary and essential in both identifying potential WPC enrollees, and locating them upon or immediately after release from incarceration. The Kern County Sheriff’s Office successfully began providing us the daily release list in September 2018.

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

(1) Kern is still not live with our HealtheIntent data-sharing platform which is set to go live in July 2019. We are still utilizing i2i Tracks for WPC tracking and much of our reporting, however, it does not have the ability to restrict certain sensitive identifiers, so at this time we are unable to do an automatic feed to CBOs.

Data sharing is still a much more manual process where a CBO requests something and then we tailor a report to meet their needs and send it over. We have worked with several CBOs to refine these monthly manual reports; however, the current process is both time and labor intensive.

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

(1) The daily release list that we get from the Kern County Sherriff's office has been a huge data collection win for Kern's WPC Pilot. As stated above, Post-incarcerated data has been the most difficult to collect-so having this daily release report to work off of on a daily basis has been instrumental in helping us identify releases-real time, so that we can provide timely outreach and hopefully increase our ability to maximize post-incarcerated PMPMs for those individuals.

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

(1) Post-incarcerated data has been the most difficult to collect. In October, we were granted permission by DHCS to also be able to include state and federal releases in our post-incarcerated PMPM bundle and although we were happy to be able to capture additional PMPMs for the PI bundle, we soon realized how difficult this information was to obtain with our current MOUs. We do not currently have a contract with CDCR for WPC and so we have no one to call to request data from. We resorted to utilizing probation data; however, they will only have information on those individuals released on probation. We have since began asking for more specifics regarding release when individuals are identified as post-incarcerated. We ask where they were released from (facility/institution), when they were released (day/month) and we also ask for proof of release if they have it.

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

Identification and engagement of this typically transient and non-compliant patient population is one of the largest barriers we face in WPC. Once you engage and even enroll a patient, it is so difficult to maintain contact, engagement, and compliance with the program. Additionally, substance abuse continues to be a tremendous barrier and until we can be more successful at reducing substance abuse among this population, proper linkage, participation and compliance will remain difficult.

X. PLAN-DO-STUDY-ACT

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

List PDSA attachments:

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