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

Whole Person Care

Lead Entity Annual Narrative Report

Reporting Checklist

Kings County Human Services Agency
Annual Report PY 3
June 12, 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.*

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

Coordination of health, behavioral health, and social services.
The Kings County Whole Person Care (WPC) Pilot is achieving success, increasing integration among county agencies, health plans, and other entities as exhibited by the continuing existence and increasing role of a the Kings County WPC Pilot steering committee known as Local Advisory Committee (LAC). LAC includes county agencies, a major health plan, service providers, and other entities, comprising of senior administration representation who possess the authority to enact expedient decision making and policy implementation. One example of success is LAC utilizing the Plan-Do-Study-Act (PDSA) process for accessing and sharing enrollees Major Depressive Disorder (MDD) diagnosis, and shifting the reporting responsibility from Champions Recovery to Kings View Counseling Services. Champions Recovery experienced difficulty accessing the necessary MDD diagnosis data yet another participating entity Kings View Counseling Services, has easy access to the information and can provide it to the Lead Entity more efficiently and effectively.

LAC is instrumental in the formulation of a comprehensive work group to address improper and overutilization of the county emergency department. The work group consists of Case Managers from the Kings County WPC Pilot and Adventist Health Network Emergency Department Case Managers to create linkage and warm hand off opportunities without duplicating services. Adventist Case Managers arrange for WPC Case Managers to screen potential enrollees before discharge. The Case Managers between the two agencies maintain communication regarding enrollee progress.

Improved beneficiary health and well-being through more efficient and effective use of resources.
The aforementioned comprehensive work group benefits enrollee health and well-being by presenting opportunities for expedient referrals being administered while simultaneously receiving separate and specific important case management and care coordination services.

Incorporate SSI Advocacy Policy into processing for WPC team
The SSI policy provides guidance for the WPC team regarding referrals to the SSI Advocate, as well as, guidance to the Advocate responsibilities. The policy creates structure for referrals and expectations for both the advocate and the team. SSI is an intervention for those that have substantial disabilities that prevent them from working and provides a stable income for shelter, food, and basic necessities. There are no modifications for this policy as it is the first finalized version.
Adherence to this policy will be measured at quarterly Quality Assurance reviews.

Increasing coordination and appropriate access to care:

Coordination of health, behavioral health, and social services.
Increasing coordination and appropriate access to care is currently being demonstrated by care coordination provided by the county Public Health Community Health Aide. During the initial screening process a county Public Health Community Aide assists enrollees with setting up needed medical, dental, and optometrist appointments with service providers. The appointments are then added to the enrollee's care plan to ensure the assigned Case Manager follows up with the enrollee. The progress of the care plan is also monitored through the attendance of these appointments and other measurable goals identified at the care plan creation. Coordination continues to increase with the county probation office which is the primary referral source to the Kings County WPC Pilot. Enrollee care plans are developed weekly and the referring entity is invited to attend to provide helpful insight. The Kings County WPC Pilot is utilizing the PDSA process to implement a dedicated phone line in the care plan meeting room for referral sources to utilize and participate in the care plan process in the event they are not able to attend in person. This will lead to an increase in participation.

A barrier for enrollees with children was identified by service providers. Screening tools ask personal and at times embarrassing information. Adults who lacked day care were unable to comfortably complete the screening while their children were present; however it was unsafe to leave unsupervised children in the office lobby. Using the PDSA cycle, one interview booth was re-designed to create an adjoining child's play area. A sound barrier was created by installing a white noise machine and a television. This new interview room allowed enrollees with small children to have complete access to staff members.

Improved beneficiary health and well-being through more efficient and effective use of resources.
The county Public Health Community Aide removes the barrier of navigating the basic medical, dental, and vison needs which is an efficient use of resources and increases the probability of the enrollee continuing to engage in Kings County WPC Pilot care coordination. Probation Officer participation in the enrollee care plan meetings fosters a partnership between the case manager and the Probation Officer to assist in reducing recidivism rates.

Improve outreach and staff availability through more efficient work hours

WPC originally offered extended hours from 5pm to 7pm to allow more time for clients to contact KARELink services. Staff members assigned to work the late shift report little utilization of the program after 5pm. There was a total of three enrollees assisted after 5pm for three months. This confirmed the extended hours were being underutilized by enrollees and partnering agencies. Customer services hours were reevaluated and a revision included change in office hours to a traditional to 8am to 5pm, Monday thru Friday schedule. Prior to the change in hours, a two week marketing assessment was conducted to inform partners and advertise change for walk in customers. Marketing items (brochures, business cards) were updated to reflect change in hours. By decreasing office hours and creating a single shift for all staff, WPC was able to expand outreach by offering on-the-spot screenings both in and out of the office. The decreased office hours and increased outreach effort increased overall enrollments.

Improved pilot job development services

Tattoo removal, also known as Community Integration, was identified as a beneficial service for those enrollees that are attempting to secure employment. The original vendor was unable to provide the services described in the application. The PDSA cycle was initiated to secure a new vendor by utilizing existing Request for Proposal (RFP) county policy. A contract was executed in November of PY3. The goal is to increase enrollee's ability to secure employment.

Reducing inappropriate emergency and inpatient utilization:

Coordination of health, behavioral health, and social services.

Consistent communication was established with Emergency Room Case Managers and WPC. This communication allows for WPC and the ER to better coordinate the best intervention, especially with high utilizers. When WPC enrollees are seen in the ER, the ER Case Managers can communicate directly with the assigned WPC Case Manager. Both Case Managers find the most beneficial resources to ensure the enrollee continues to work towards their stated goals.

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

The toll free nurse access line creates an opportunity for Anthem Blue Cross member enrollees to navigate the Kings County health care system more efficiently and effectively by having (24) hour access to medical health experts that can answer medical related questions expediently day or night when the enrollee is experiencing a medical issue. Another resource for enrollees is Live Health Online (LHO), which offers 24 hour, 7 days a week access to medical health experts. Currently, Kings County WPC is expanding this access for enrollees by installing web cameras on computers in the intake booths. One of WPC goals for creating this access is to reduce ER visits by providing another avenue of approach for enrollees in need of non-emergency care or in the event a PCP appointment is not immediately available.

LHO also provides mental health professional assistance to address minor mental health needs, such as mild anxiety and depression symptoms.

Improving data collecting and sharing:

Coordination of health, behavioral health, and social services.
Kings County WPC Pilot Lead Entity and Kings County Human Services Agency (HSA), purchased and utilized a cloud based data base known as Efforts to Outcomes (ETO) to improve data collection and sharing. ETO is a data based system which attains and tracks data used for the formulation of Department of Health Care Services (DHCS) reports including Kings County WPC Pilot Universal and Variant Metrics outcomes. The ETO system is shared and accessible to participating entities who work collaboratively with Kings County WPC. Entities working in collaboration with Kings WPC include, a County Public Health Community Aide, a Human Services Agency (HSA), Eligibility Worker, the County Behavioral Health Acute Care Case Manager and Champions Recovery who provide care coordination, housing navigation services, job development services, and case management services. Collectively, these entities contribute through ETO, the tracking of referrals, screening of potential enrollees for eligibility, and care plan formulation.

The Kings County WPC Pilot, Implementation Team collaborates sharing of information by its development of a universal authorization for Release of Information (ROI) document. This ROI allows for sharing of information with all participating entities and primary referral sources, effectively improving communication amongst WPC providers directly working with the target population. The universal ROI was approved by participating entities as well as County Counsel.

Executed Agreement/Memorandum of Understanding (MOU) between Lead Entity, Public Health, Sheriff, and Kings View
Barriers to receiving confidential and Protected Health Information (PHI) was the driving force in establishing a bi-directional data sharing agreement. The intent of the data sharing policy is to provide comprehensive care coordination between WPC Pilot, Public Health, Sheriff Department, and Kings County primary mental health provider, Kings View. WPC negotiated and executed a final agreement between Kings County HSA (LE), Public Health, Sheriff Department and Kings View. The agreement and internal Release of Information (ROI) have generated a robust and open line of communication between WPC entities.

Improved beneficiary health and well-being through more efficient and effective use of resources.
Enrollees receive an efficient chronological continuum of care coordination through the ETO system which maintains enrollee data and coordination case notes. The central data base affords the participating entities access to real time data which assist in preventing duplication of services and increases service efficiency.

Data from the ETO system allows LE to create trends and utilization reports, which are then shared in the monthly Kings County WPC Lead Advisory Committee (LAC). Reports are used to assess the implementation of pilot practices or policy. Based on a LAC vote to adjust practices, a Plan-Do-Study Act (PDSA) process is utilized to address any need to revise pilot practices. Efficient use of resources was also demonstrated through the implementation of a Universal Authorization for Release of Information. The Universal Authorization for ROI expedited services and reduced time delays traditionally caused by the need for ROI's from each service provider.

Improved reporting of Major Depressive Disorder (MDD) and suicide screener.
The original vendor utilized for MDD reporting and suicide screening was unable to complete the necessary steps to complete a MDD diagnosis. In an effort to meet the needs of the enrollees a new vendor was attained. As a result the intake process time was greatly reduced and enrollees identified with possible MDD were linked to proper mental health services.

Improved access to resources and services needed upon discharge from Adventist Health
Adventist Health initiated a PDSA to address needs for patients who were being discharged from the hospital. Hospital staff, as well as their entire network, were informed of the various resources. As a result, an all-inclusive task force was created which included WPC. The task force meets every month to identify current resources, and investigate potential funding sources for new projects to fill in the identified gaps. This group communicates and trains other staff throughout the perspective entities on available resources.

Achieving quality and administrative improvement benchmarks:

Coordination of health, behavioral health, and social services.
Quality improvement benchmarks are currently being demonstrated through the implementation of a Quality Assurance (QA) checklist and policy. The QA ensures the processes in place are addressing enrollees necessary screenings, are receiving a detailed copy of their rights while participating in the Kings County WPC Pilot, and formulation of a patient centered care plan are occurring within 30 days.
Administrative improvement benchmarks are evident by the establishment of the Implementation Team comprised of participating entities that review, revise, and submit all proposed program policy to the LAC for final review and approval. This creates a multi leveled system of policy and procedure implementation oversight. An example of this oversight is the infrastructure policy developed by the implementation team, which considered all participating entities' customer needs. The infrastructure policy includes procedures on how to access Kings County WPC Pilot services via the referral process with a "No Wrong Door" philosophy. This policy enables potential enrollees the availability to self-refer via telephone, electronically, or via a walk in basis and be served immediately.

The referral process for an enrollee advocate is made as simple and user friendly as possible and contains only the very basic information necessary to initiate a referral which raises the likelihood of referrals being made.

Kings County WPC goal to reduce employment barriers proved successful in securing a new vendor to provide tattoo removal services. This service is known as Community Integration in the pilot application. The vendor is authorized to provide up to 200 sessions for approximately 30 enrollees with the intention of removing the stigmatizing images that can be a barrier to many types of employment. Images which trigger traumatic experiences are allowable as well when requested by the enrollee. Polices were created to provide a referral infrastructure, eligibility requirements, and establish a point of contact for the source.

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

Enrollees experience an ease of access to timely and quality care coordination leading to increasing numbers of peer and self-referrals. This is attributed to current enrollees sharing positive information about Kings County WPC services with other community members. Tattoo removal services provided by Kings County WPC are of particular interest to those seeking employment opportunities and stable housing, but have visible or possibly offensive tattoos. In some cases tattoos have created barriers to employment and consequently stable housing. By receiving tattoo removal services, enrollees are more likely to remain engaged in their care plan which subsequently increases pilot participation retention rates.

Clearly written job duties and responsibilities for each Kings County WPC staff member ensures enrollees' health and well-being are being addressed in its entirety. Staff members are then able to quickly have a clear direction on the type of services they are responsible for in addressing each enrollees needs, increasing efficiency of the Kings County WPC Pilot as a whole.

Quarter Quality Assurance (Monitoring & Oversight for Policy Adherence)

The Human Services Agency Program Manager conducts a quarterly quality assurance review to assess adherence to policy. Each quarter, the Program Manager reviews 5% of the total enrollee monthly count using a quality assurance form approved by LAC. The QA process consist of reviewing documents, data and case notes entered in ETO and determine if program policy and procedures are being adhered to. Reports on findings are submitted to LAC for guidance on areas needing improvement and areas of refresher training.

Reclassifying Public Health Nurse to Public Health Community Health Aide

In an effort to create a cost effective and expedient health screening for referrals into the WPC Pilot, an analysis of job duties of various Community Health Workers duties from other WPC Pilots was conducted. The reason for this reclassification of position is due to budget constraints that have occurred since the conception of the program in the department that hires the Nurse.

In comparing the duties the assigned Public Health Nurse was completing for the WPC pilot, it was discovered the duties WPC required were more aligned with the scope of work of a Community Health Aide. This job description could allow for the same level of service for the enrollees at a lower salary range. The implications of this change is that the same level of service will be available to both staff and enrollees but at a level that is sustainable to the hiring agency and for long term sustainability of the pilot. The Community Health Aide received training and a warm hand off from the Nurse.

Improving Mental Health Screener Workflow

In an effort to increase efficiency in screening enrollees and creating care plans, the screening tool was revised. The tool was redesigned to be user friendly with a logical flow from one topic to the next. The new tool decreased the length of time needed as well. Training was conducted with staff who administer the screenings.

Increasing access to housing and supportive services:

Coordination of health, behavioral health, and social services.

Increasing access to housing and supportive services is currently conducted by a Housing Navigator who utilizes a universal software program known as the Homeless Management Information System (HMIS) to assess risk of homelessness for enrollees. This process facilitates appropriate linkage and referrals, in addition to providing advocacy services on behalf of the enrollees.

The Housing Navigator works closely with various housing resources such as: the local Continuum of Care (CoC), emergency shelters, Housing Authority and other government funded resources such as Human Services Agency. The Housing Navigator works with other community based organizations through grass roots collaborations. These collaborations include “on-the-streets” staff members who link homeless individuals to the local resources. They have helped develop local initiatives such as a “Landlord Support Committee” or more recently a Homeless Resource Pop Up event to be held weekly. The “Landlord Support Committee” holds quarterly events in which Service Providers can meet with landlords to provide information on the various levels of support and funds available for housing.

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

When enrollees attain stable housing they demonstrate an ability to address other issues identified in their care plan with a higher rate of success and follow through. In an effort to address varies factors impacting homelessness, the Lead Entity (LE) participates in multiple collaborative meetings where homelessness in Kings County is addressed.

Improving health outcomes for the WPC population:

Coordination of health, behavioral health, and social services.
To improve health outcomes, Kings County WPC partnered with the sole county hospital known as Adventist Health Network. This partnership links enrollees recently discharged from Adventist Health Emergency Room (ER) with Kings County WPC Case Managers who provide 30 to 60 day health related case management intervention. The Case Managers assist enrollees with accessing follow up medical care and linkages to various resources associated with social determinants of health. The Kings County WPC Pilot participated in a Kings County Mental Health Continuum of Care (CoC) collaborative, Co-chaired by Kings County Behavioral Health and Adventist Health Network. This collaborative has evolved into a monthly Adult System of Care (ASOC) collaboration meeting, which includes Mental Health service providers, community law enforcement agencies, WPC, and Human Services Department that specifically serve adults in the community.

Mapping Medical Services for Medi-Cal Recipients
One of the initial pilot goals was to reduce Emergency Department (ED) visits which could be properly addressed through a Primary Care Provider (PCP). In an effort to educate enrollees on better ways to access health care, a visual step-by-step process was created to assist enrollees in choosing a PCP, make appointments, and information on other medical resources. This is shared with enrollees without a PCP or who have high Emergency Department utilization.

Improved beneficiary health and well-being through more efficient and effective use of resources.
The Kings County WPC pilot has demonstrated an increase in enrollees managing their diabetes, exceeding our HbA1c goal. Enrollees with diabetes receive education and encouragement from their Case Manager and the Community Health Aide. Barriers, such as transportation or lack of a medical home, were removed. Enrollees are informed of the importance of the HbA1c test. These interventions help decrease medical costs by having the enrollee access preventative, less costly services and to rely less on emergency room services for complications related to unmanaged diabetes.

Improved communication with Emergency Room/IUP Utilization Workgroup
WPC developed a weekly communication link between WPC and Care Coordinators in Adventist Medical Network, primarily within the ER and inpatient discharge department. This weekly communication link between partners was not originally anticipated during the implementation of the pilot. Communication via email with consistent reports showing the status of referrals and current enrollees into the programs will allow for Care Coordinators to alert WPC Case Managers in real time of enrollees still relying on ED for primary health care needs.

Brief overview of program successes, challenges, and lessons.

The Kings County WPC Pilot is experiencing the following successes:

1. Kings County WPC Pilot enrollment is steadily increasing each month.
2. County Deputy Probation officers are allowing enrollees to continue receiving services as opposed to incarcerating enrollees for minor infractions and violations.
3. County agencies are communicating and interacting on a proactive and consistent basis which is leading to a continual break down of individual.
4. Duplication of services is decreasing across county agencies and participating entities.
5. Multiple enrollees are accessing residential substance abuse treatment and other behavioral health disorder interventions, who may not otherwise have accessed these services without the assistance of Kings County WPC Pilot Care Coordination.
6. The LAC meeting restructure is leading to a more efficient and effective Kings County WPC Pilot steering committee.
7. The Kings County WPC Pilot is significantly decreasing the time frame from the point of referral to enrollment.
8. There is a positive increase in the overall number of enrollees receiving housing placement and employment offers.
9. Addition of an Acute Case Manager has allowed Kings County WPC to better address clients with needs which require frequent contact.
10. Finalization of data sharing policy allows partnering entities to better communicate information regarding WPC clients, resulting in having a holistic understanding of the clients needs.

The Kings County WPC Pilot is experiencing the following challenges:

1. Kings County WPC Pilot enrollees are not consistently attending life skills classes provided by the contractor Champions Recovery as part of the PMPM1 Care Coordination bundle.
2. Kings County WPC Pilot enrollees are disengaging from care coordination at an increasing rate.
3. The Kings County WPC Pilot is experiencing a high degree of attrition staff loss across multiple levels.
4. Kings County WPC Pilot Case Managers are not fully aware of best practices regarding case managing enrollees with health related issues.
5. Kings County has very limited amount of entry level jobs and affordable housing resources available to Kings County WPC Pilot enrollees.
6. Kings County WPC Pilot enrollees are demonstrating a reluctance to reengage with service providers due to past negative experiences. The dilemma is compounded by the fact that multiple service providers are the sole service provider in the county.
7. Kings County has limited sobering bed facilities. Currently there is only one male and one female sobering center with limited availability.

The Kings County WPC Pilot is experiencing the following challenges (cont.):

8. Criteria for use of sober beds is limited to enrollees with a medical clearance, creating a barrier for treatment for those with alcohol abuse treatment needs. This criteria also limits the ability for law enforcement to redirect newly arrested persons for minor infractions to a sobering center as opposed to jail.
9. Hiring of a Peer Support Specialist who possesses the preferred required job qualifications and is able to successfully pass background checks has been challenging. This position is vital to reengaging with clients who are "on the streets homeless" and have lost contact with their Case Managers. The Peer Support Specialist would also aide in outreach services by connecting and developing rapport with target population and conduct intakes while in the field.

Kings County WPC Pilot lessons learned include:

1. Utilizing a comprehensive electronic information gathering software system is necessary to accurately track and report Kings County WPC Pilot evolving measurable outcomes and sharing requested outcomes with stakeholders who desire to provide a more efficient and effective service.
2. Overall Community awareness and engagement is a key contributing factor to current and potential enrollees being aware of the Kings County WPC Pilot services. The Kings County WPC Pilot is learning that branding or marketing the Kings County WPC Pilot is important to gaining trust of potential enrollees in the communities served.
3. Incorporating the patient centered evidence based practice of Motivational Interviewing is effective as it pertains to enrollee engagement and retention. Meeting the enrollee where they are in regards to their readiness to make sustainable changes is an important component of providing case management services.
4. The majority of enrollees have many factors and variables contributing to their current circumstances that require long term care coordination.
5. Mental health and substance use disorder case management and care coordination varies greatly from health related issues case management and care coordination. .

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	9	19	8	13	21	18	88

Item	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12	Annual Unduplicated Total
Unduplicated Enrollees	22	21	15	31	26	22	225

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
Service 1	0	0	14	0	4	17	35
Utilization 1	$0	$0	$2,100	$0	$600	$2,550	$5,250
Service 2	0	0	0	0	0	0	0
Utilization 2	$0	$0	$0	$0	$0	$0	$0
Service 3	59	105	119	112	83	91	569
Utilization 3	$9,794	$17,430	$19,754	$18,592	$13,778	$15,106	$94,454
Service 4	0	2	3	2	4	2	13
Utilization 4	$0	$4,450	$6,675	$4,450	$8,900	$4,450	$28,925

Costs and Aggregate Utilization for Quarters 3 and 4							
FFS	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12	Annual Total
Service 1	4	0	6	24	23	25	82
Utilization 1	$600	$0	$900	$3,600	$2,400	$3,450	$123,000
Service 2	0	0	0	0	0	2	2
Utilization 2	$0	$0	$0	$0	$0	$410.00	$410.00
Service 3	121	95	135	136	110	84	681
Utilization 3	$20,086	$15,770	$22,410	$22,576	$18,260	$13,944	$113,046
Service 4	8	4	3	3	2	8	28
Utilization 4	$17,800	$8,900	$6,675	$6,675	$4,450	$17,800	$62,300

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
Bundle #1	$526	$17,358	$25,248	$26,300	$27,352	$34,716	$38,398	$169,372
MM Counts 1		33	48	50	52	66	73	322
Bundle #2	$157	$1,413	$1,413	$1,413	$2,512	$1,570	$2,355	$10,676
MM Counts 2		9	9	9	16	10	15	68
Bundle #3	$1152	$0	$0	$2,304	$9,216	$10,368	$10,368	$32,256
MM Counts 3		0	0	2	8	9	9	28

Amount Counts								
PMPM	Rate	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12	Total
Bundle #1	$526	$40,502	$43,658	$43,658	$52,600	$57,860	$62,594	$300,872
MM Counts 1		81	83	83	100	110	119	576
Bundle #2	$157	$4,396	$3,925	$4,710	$3,925	$4,082	$4,710	$25,748
MM Counts 2		28	25	30	25	26	30	164
Bundle #3	$1152	$9,216	$10,368	$10,368	$11520	$9,216	$6,912	$57,600
MM Count 3		8	9	9	10	8	6	50

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

5 enrollees re-engaged during PY 3 with almost all of those enrollees maintaining contact with the pilot into PY 4. The large spike in enrollments in month 10 coincides with the implementation of offering drop in, seen on the same day screenings.

IV. NARRATIVE – Administrative Infrastructure

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

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

The Kings County WPC Pilot is utilizing an Administrative Infrastructure designed and developed specifically for achieving the goals identified in the original application. This includes, but is not limited to, the coordination of health, behavioral health, and social services, with a patient centered manner. Additionally, the objectives of improved enrollee health and wellbeing through a more efficient use of resources. In order to achieve these identified goals and objectives, the following Administrative Infrastructure are being practiced.

Multiple entities are combining resources and sharing information to fully integrate coordinated care and wraparound services. Kings County HSA provides Administrative oversight to ensure continued integration of services and development of reports. Data is being shared amongst all entities, providers, and stakeholders with consistent, regular meetings. The administrative infrastructure consists of two staff members including a Program Manager and Program Specialist, fulfilling these duties in addition to the responsibility of achieving program goals. The Program Manager and Program Specialist are the main points of contact to support and coordinate with for the various participating entities and make sure all entities are communicating. The Program Manager administers the daily operations of the program, has authority to make decisions, and ensures effective flow of communication among all partnering entities. The Program Specialist is the central point of contact for sharing and analyzing data throughout the pilot. HSA provides oversight, leadership, communicates Kings County WPC Pilot requirements to all participating entities. Also HSA makes decisions and ensures that data is gathered and being shared with stakeholders and participating entities. The Program Manager and Program Specialist work to attain Universal and Variant metrics data from participating entities and formulate detailed reports which are submitted to DHCS to ensure program goals are being met. The Kings County WPC Pilot also includes two staff members to support fiscal responsibilities. The Fiscal Account Specialist and Account Clerk provide participating entity oversight of payments for incentives and reporting outcomes.

The LAC consists of stakeholders and participating entities that review monthly data from all program performance metrics, evaluates existing processes, identifies systematic inefficiencies, and generates ideas regarding improving the quality and efficiency and coordinated care. The LAC possesses decision making ability and works directly with Kings County WPC Pilot staff to remove barriers to accessing care and prioritizing programmatic revisions. The LAC meets at least once a month. The LAC is currently facilitated by the Lead Entity HSA Program Manager and Program Specialist.

A Multi-Disciplinary Team (MDT) processes and reviews bi-directional data and makes recommendations to the Care Coordination Team, LAC, and Implementation Team. The subject matter expertise recommendations include linkage to service providers that would potentially benefit Kings County WPC Pilot enrollees such as linking enrollees to behavioral health services, substance use disorder treatment, medical specialty practitioners, HSA public assistance, veterans' services, and other ancillary services that foster and support an increased quality of life for the enrollee. The MDT's recommendations are included on the initial enrollee care plan which is reviewed with the enrollee, who prioritizes his or her care plan goals with their Case Manager. The MDT consists of staff from various local governmental agencies and community based organizations. The team is currently located in the same building to allow for consistent and regular dialogue and meetings. The MDT assesses each potential enrollee regarding identified needs and eligibility. The MDT is accountable to LAC and Lead Entity Kings County HSA.

VI. NARRATIVE – Delivery Infrastructure

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

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

The delivery infrastructure provides timely, individualized care coordination services to a vulnerable population that meets the eligibility criteria of the Kings County WPC Pilot. The identified target population includes individuals suffering from Substance Use Disorders, Mental Health illness, and poor control of diabetes or hypertension.

This target population historically experiences difficulty accessing, engaging in, and remaining engaged in services that will assist them in decreasing their need to utilize local emergency department rooms and/or returning to law enforcement custody.

The Kings County WPC Pilot possesses a centralized referral point which can be accessed via telephone, e-mail, website, or in person by a referring entity or self-referred. Upon receiving a referral, coordinated care professionals from the Kings County WPC Pilot team (including; an Eligibility Worker, county Public Health Community Health Aide, and Case Manager) perform initial screenings for eligibility in person, either in the field or in the pilot office with a patient centered approach. During the initial screening process, if the enrollee expresses a need for housing and or job placement assistance, the enrollee is scheduled to meet with the Kings County WPC Pilot Housing Navigator or Job Developer to assess specific needs and available resources.

Upon the enrollee going through the screening process the individual's circumstances and case details are reviewed by the MDT to determine program eligibility. When the enrollee is eligible for the pilot, the MDT discusses initial goals for the enrollee. This is the first instance in which possible duplicated services are discussed and a lead is established to ensure there is no duplication of services.

A care plan meeting is conducted which includes the Kings County WPC Pilot assigned Case Manager and other individuals and entities (including, County Probation, Mental Health professionals, Substance Use Disorder (SUD) treatment providers, housing programs, outside Case Managers, and medical professionals) who will be working directly with the enrollee to meet their l needs. The enrollee's care plan issues will be vetted through a prioritization process, revised if needed, and a care plan will then be finalized by the Case Manager obtaining the enrollees signature.

The enrollee has the option to revise his or her individualized care plan upon initial implementation, and at any point during care coordination. 100% of enrollees receive a care plan within 30 days of enrollment which is an identified pilot goal.

A PDSA cycle was initiated in PY3 to revise the Care plan policy. This PDSA cycle will be initiated in PY4. The change focuses on more actively involving the enrollee with the Care plan creation.

The Kings County WPC Pilot Case Manager maintains consistent contact with the enrollee assisting the enrollee with building self-efficacy, advocating with service providers, removing transportation barriers, assisting with accessing and attaining prescribed medications, assisting with Social Security Insurance (SSI) advocacy, assisting the enrollee with securing a government telephone, performing follow up correspondence with service providers, and working with the enrollee to fill in any other identified service gaps.

The Case Manager's role is to assist the enrollee in meeting their individualized care plan needs which ultimately contributes to a decreased need for the enrollee to rely on local emergency rooms and significantly decreases the probability of the enrollee returning to custody and improve the enrollee's health outcomes.

The Kings County WPC Pilot is adding another staff member to the contractor Champions Recovery care coordination team. The new position is called a "Peer Support Specialist" (PSS). The PSS provides support to the community individually and as a team member to build strong relationships specifically with marginal population hesitant to receive services. The Kings County WPC Pilot PSS goes in the field on a consistent basis to engage with the target population and develop rapport with potential and existing Kings County WPC Pilot enrollees. The PSS attempts to re-engage enrollees that have lost contact with their Kings County WPC Pilot Case Managers. The Peer Support Specialist also attempts to re-connect the enrollee with services and meet the enrollee at their residence or other locations in the community where the target population frequents or congregates.

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

VIII. 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.

The Kings County WPC Pilot incentives are paid at the submission of the annual reports for each project year. All incentive payments are for participation in LAC as well as the PDSA requirement of the Kings County WPC Pilot.

Each month, LAC meets with the directors or assigned designees of each of the participating entities. A total of (9) entities are represented in the LAC meetings. HSA is the only entity not eligible for an incentive payment.

All eight participating entities contributed to the PDSA requirement. Entities were required to be lead on at least one PDSA cycle throughout the project year. All PDSA's are received at LAC meetings and participating entities contribute to the dialogue necessary to complete the PDSA.

Three of the eight participating entities attended 100% of the LAC meetings. They are Kings County Behavior Health, Champions and Anthem Blue Cross. Two of the eight entities attended 81% of the LAC meetings. They are Public Health and Sherriff. The last two entities, Probation and Adventist attended 72% of the LAC meetings.

X. NARRATIVE – Pay for Outcome

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

The Kings County WPC Pilot pay for outcomes are paid at the submission of the annual reports for each project year. Below indicates the progress we have made to date for this current project year.

Comprehensive Care plan, Accessible by the Entire Care Team, Within (30) Days
The Kings County WPC Pilot is using Efforts to Outcomes (ETO) Social Solutions as a central communication data base for all participating entities who provide direct services to enrollees. One benefit of ETO is, it allows participating entities to identify vocabulary with different definitions. For example, similar acronyms or words are used by various organizations, but have different definitions which could potentially pose miscommunication. ETO allows for customizable templates, known as touchpoints that are currently uploaded into the software. A coordinated care plan exists in ETO and adapts to meet the ongoing needs of the Kings County WPC Pilot. Some of the adjustments made from the original template are: adding areas of recommendation for recidivism, relationship building, and tracking dates for re-evaluation of care plan. The key components that remain are focusing on the goals and strengths of the enrollee, mental health recommendations, and physical health recommendations. There are a total of (9) recommendations made by the Multi-Disciplinary Team. The information regarding the enrollee is available to the entire team from the day of referral through disenrollment from the program.

At the time of this report, the entire Kings County WPC Pilot care team has access to the coordinated care plan for 100% of Kings County WPC Pilot enrollees. Kings County was able to meet the 30 day care plan requirement 100% of the time in PY3. The PY 3 goal was 75%.

Decreasing HbA1c Poor Control <8%
The current screening process for enrollment into the Kings County WPC Pilot includes self-disclosure of all health information. Enrollees that self-disclose either an official diagnosis of diabetes or that they are prescribed medication commonly used to treat diabetes, are included in the health recommendations to link with a Primary Care Physician (PCP). In most instances, the health screener works with the enrollee to secure an initial visit with a PCP prior to enrollment. Case Managers educate the enrollee on the HbA1c test and the ramifications of the test score.

Most enrollees that have diabetes disclose that they are not aware of the test nor the implications the results of the test have on their health. The health screener and Case Manager work cooperatively to continue motivating and educating the enrollee on methods to best manage their diabetes and to ask for the HbA1c test to secure the results for their own monitoring.

The Kings County WPC Pilot is working with their health partners to continue expanding educational opportunities for both enrollees and for the Case Managers on topics related to ways in which to control diabetes as this has been identified as a challenge in our pilot. By educating both the enrollee and the Case Manager, they are able to work as a team to find solutions that work best for the enrollee. Homeless enrollees exhibit the highest needs and barriers when locating resources that will assist with their health concerns and individual needs.

A PDSA is partnering with Anthem Blue Cross training for Case Managers in best practices related to health case management. Kings County was able to exceed our stated goal of 5% of enrollees with diabetes to have a score of 8% or less on their HbA1c with a final 46% of enrollees meeting or exceeding the target.

Decreasing Jail Recidivism

The Kings County WPC Pilot works closely with Kings County Probation and Kings County Sheriff in identifying potential enrollees whom appear to meet the target population. Deputy Probation Officers work closely with Case Managers to encourage enrollees to continue working towards their goals identified in the comprehensive care plan. In addition, efforts have been made to educate Sheriff Deputies on services provided by Kings County WPC Pilot as well as the referral process. The Kings County Jail Watch Commander has taken it upon himself to model this best practice by tracking the success of referred individuals to model for his staff.

Kings County was able to meet our target decrease of jail recidivism of 63 incarcerations for every 1,000 member months. At mid-year this target did not appear attainable; however, through continued interactions with enrollees we were able to hit our target. We will continue to monitor enrollees, especially those with past justice involvement, to ensure our rates continue to decrease.

The Kings County WPC Pilot continues to encounter two specific challenges. The first challenge is difficulty engaging referred individuals post release from incarceration. The second challenge is not possessing the opportunity to start services with potential clients and referred individuals while they are incarcerated. If WPC services and screenings, were started prior to release of an inmate, engagement and retention in Kings County WPC Pilot services would also increase due to; a reduction of disenrollment's related to loss of contact by enrollees incarcerated more than 30 days, time to develop professional rapport and initiation of advocacy being established prior to release from incarceration.

A counter measure to this challenge that is occurring organically between Probation and the Kings County WPC Pilot. Probation Officers will walk an enrollee to the Kings County WPC office for a seamless and expedited referral process. This helps with the enrollment process and continued participation as the enrollee sees that the Kings County WPC Pilot and Probation are working cooperatively to assist the enrollee in achieving their goals. This trend is especially prevalent with Probation Officers who are actively involved in the care plan meetings to formalize the overall comprehensive care plan and goals for the individual enrollee.

XI. STAKEHOLDER ENGAGEMENT

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

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

XII. PROGRAM ACTIVITIES

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

(1) One area of success with care coordination is the ability to assist enrollees with SSI advocacy and screening in an efficient manner, and in securing needed documentation from medical treatment providers to strengthen initial and appealed SSI cases.

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

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

(1) One challenge the Kings County WPC Pilot has experienced with care coordination is enrollees are told by referring entities that attaining housing and employment are guaranteed. Enrollees are discouraged when informed that there is a sequential process to follow, and there are no guarantees of attaining housing or employment. The lesson learned is the need to clearly communicate to referring entities what realistic expectations are for care coordination. And communicating this accurate information to potential enrollees is important to enrollee engagement and retention.

(2) Another challenge the Kings County WPC Pilot is facing is Case Manager's level of experience and available training. Currently, WPC has one CM with experience in assisting high needs clients. In this CM's absence there is no CM outside of management that is able to assist high needs enrollee. Entry level CM's are limited on methods of approach when interacting with enrollee's requiring high mental health services and domestic violence assistance.

A lesson learn is to ensure management is well versed in various training opportunities for CM's prior to beginning and while employed with WPC. This will assist CM's and enrollees during the intake and routine engagement process.

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

1. One success the Kings County WPC Pilot with information sharing is the weekly care plan meeting which creates and implements an enrollee's centered individualized care plan within 30 days which is S.M.A.R.T (specific, measurable, attainable, relevant, and time oriented) based upon the enrollee's stated needs and strengths stated during the screening process. The care plan consists of the enrollee's objectives and goals in combination with recommendations from the Multi-Disciplinary Team which includes initial screening recommendations concerning demographic information, Mental Health/Suicide Risks, identified Medical issues, Substance Use Disorder needs, housing needs, legal issues, and employment/educational needs.

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

2. A recent success is finalizing a data sharing policy for entities involved with WPC. This policy will allow Kings County WPC to better communicate amongst each other as well as coordinate and establish the flow of information for each enrollee. This data will assist the WPC pilot in assessing the overall accomplishment of its goals.

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

1. One challenge the Kings County WPC Pilot is facing with data sharing is accessing enrollee specific metric data from participating entities for which the authorization of for release of information does not cover. ROI's are only valid for one year from the signature date and some metrics require enrollee data from the baseline year of 2016. The Kings County WPC Pilot does not have valid ROI's for enrollees from that calendar year. Participating entities are reluctant to share enrollee information that is not covered by a valid ROI.

The lesson learned is that the universal ROI for starting a Kings County WPC Pilot should include language which is retroactive to the baseline year and time frame.

2. Receiving information on a client's mental health and substance abuse is a major hurdle, especially in understanding the overall effectiveness of the linkages provided, and identifying any gaps in services for specific clients.

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

1. One success Kings County WPC Pilot is experiencing regarding data collection and reporting is the establishment of an executed Memorandum of Understanding (MOU) with almost all partnering entities which allows for the data collection needed to routinely monitor the universal and variant metrics.

2. Another success with data collection is a newly approved data sharing policy which allows Kings County Emergency Department to share information on a client's visits to the Emergency Room. This will allow for better understanding of a client's needs and therefore CM's are able to better link them to the proper services.

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

1. One challenge the Kings County WPC Pilot is experiencing with data reporting is participating entities having competing priorities for time and resources thus reporting metrics to the Lead Entity can be placed low on the priority scale and trickle in sporadically.

The lesson learned includes requesting information with longer turnaround times to allow more time for staff to pull the necessary data.

2. Internal data collection within ETO is not consistently used by all staff members. Oversight measures have been enacted to ensure staff are capturing information needed to monitor enrollees.

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

Looking ahead the Kings County WPC Pilot foresees the biggest barriers to success are: Current lack of stable housing options for enrollees, lack of entry and mid-level employment opportunities, and continual staff turnover or onboarding.

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

Please see attached PDSA's for PY3 Quarter #1, Quarter #2, Quarter #3, Quarter #4

The PDSA attachments includes a list of PDSA's in the WPC Summary Report for reporting period 01.01.18 – 12.31.18 PY3. The PDSA attachments will attempt to demonstrate Kings County WPC Pilot's progress in relation to the infrastructure, services, and other strategies as described in the approved Kings County WPC LE application and WPC STC's.