



Kern Health Systems: CalAIM Incentive Payment Program (IPP) Application - Part A

Section 1: Basic Organization Information

Organization Name:			
Organization Type:			
Organization Mailing Address:			
Tax Identification Number (TIN):			
National Provider Identifier (NPI) (i.e., Type 2 NPI)			
Completed By:		Date:	
Title:			
Phone Number:		Email Address:	

*Please indicate if your organization does not have an NPI with "N/A"

Please indicate whether you are a <u>CURRENT</u> or <u>PROSPECTIVE</u> provider for the following services:	
Enhanced Care Management	<input type="checkbox"/> Current <input type="checkbox"/> Prospective
CS: Asthma Remediation	<input type="checkbox"/> Current <input type="checkbox"/> Prospective
CS: Day Habilitation	<input type="checkbox"/> Current <input type="checkbox"/> Prospective
CS: Environmental Accessibility Adaptations	<input type="checkbox"/> Current <input type="checkbox"/> Prospective
CS: Housing Deposits	<input type="checkbox"/> Current <input type="checkbox"/> Prospective
CS: Housing Tenancy and Sustaining Services	<input type="checkbox"/> Current <input type="checkbox"/> Prospective
CS: Housing Transition Navigation Services	<input type="checkbox"/> Current <input type="checkbox"/> Prospective
CS: Meals/Medically Tailored Meals	<input type="checkbox"/> Current <input type="checkbox"/> Prospective
CS: Nursing Facility Transition / Diversion to Assisted Living Facilities	<input type="checkbox"/> Current <input type="checkbox"/> Prospective
CS: Nursing Facility Transition Services / Diversion to Home	<input type="checkbox"/> Current <input type="checkbox"/> Prospective
CS: Personal Care and Homemaker Services	<input type="checkbox"/> Current <input type="checkbox"/> Prospective
CS: Recuperative Care (Medical Respite)	<input type="checkbox"/> Current <input type="checkbox"/> Prospective
CS: Respite (for Caregivers)	<input type="checkbox"/> Current <input type="checkbox"/> Prospective
CS: Short-term Post-Hospitalization Housing	<input type="checkbox"/> Current <input type="checkbox"/> Prospective
CS: Sobering Centers	<input type="checkbox"/> Current <input type="checkbox"/> Prospective

If you are a current or prospective Enhanced Care Management (ECM) provider, please indicate your current or proposed population(s) of focus:

High utilizers are members with multiple hospital admissions, OR multiple short-term skilled nursing facility stays, OR multiple emergency room visits that could be avoided with appropriate outpatient care or improved treatment adherence. **Go-Live Date: January 1, 2022**

Individuals experiencing homelessness, including chronic homelessness and have one complex physical, behavioral, or developmental health need for whom coordination of services would likely result in improved health outcomes or decreased utilization of high-cost services. **Go-Live Date: January 1, 2022**

Adults & Children/Youth transitioning from incarceration within the last 12 months who have significant complex physical or behavioral health needs requiring immediate transition of services to the community. **Go-Live Date: January 1, 2022**

Adults with Serious Mental Illness or Substance Use Disorder who have a co-occurring chronic health conditions and: Serious Mental Illness (SMI) or Substance Use Disorder (SUD), are actively experiencing one complex social factor influencing their health and meet different high risk criteria or high acuity. **Go-Live Date: January 1, 2022**

Adults at risk for institutionalization, eligible for long-term care. Medi-Cal beneficiaries who, in the absence of services and supports would otherwise require care for 90 consecutive days or more in an inpatient nursing facility. Individuals be able to continue to live safely in the community with wrap around supports. **Go-Live Date: January 1, 2023**

Nursing facility residents who desire to return to living in the community, who are strong candidates for successful transition back to the community. Transition from the Nursing Facility to community is strictly voluntary and must be able to transition safely to the community. **Go-Live Date: January 1, 2023**

Children or youth with Serious Emotional Disturbance (SED or enrolled in in California Children Services (CCS)/CCS Whole Child Model with additional needs beyond CCS or involved in Child Welfare (including those with a history of involvement, and foster care up to 26). **Go-Live Date: July 1, 2023**

Please provide an overview of the demographics of the populations you serve including race, ethnicity and languages:

Please attest if your organization has or will be requesting funding from other Managed Care Organizations (MCOs), foundations, or other sources to support this project: YES NO

If yes, please provide the following information regarding other funding sources. Add additional lines or attachments as necessary.

Source	Amount	Description	Is request approved?
			<input type="checkbox"/> YES <input type="checkbox"/> NO
			<input type="checkbox"/> YES <input type="checkbox"/> NO
			<input type="checkbox"/> YES <input type="checkbox"/> NO
			<input type="checkbox"/> YES <input type="checkbox"/> NO

Section 2: Individual Funding Area – Request Information

To continue with the application, please summarize your proposal for the funding areas for which you are requesting funding. You may replicate and expand as needed.

Funding Area 1 - Delivery System Infrastructure

Please indicate which areas under Funding Area 1 – Delivery System Infrastructure you are requesting funding for.

1. Delivery System Infrastructure

- Electronic Health Record
- Care Management Documentation System
- Billing Systems/Services
- Health Information Exchange
- Closed Loop Referrals

Funding Dollar Amount Requested for Funding Area 1:

Please provide a project description including how it will advance infrastructure, capacity or quality in the ECM and/or CS programs. *Please include the justification under this funding category below. The review committee will closely review and may request additional documentation before making their final decision.*

Evaluation: Please describe your project goals and how you will evaluate success:

Milestone/Goal	Metric/Measure	Evaluation Process	Frequency	Target Completion Date

Funding Area 2 - ECM Provider Capacity Building

Please indicate which areas under Funding Area 2 – ECM Provider Capacity Building you are requesting funding for.

2. ECM Provider Capacity Building

- Building compliance and oversight capabilities to ensure populations of focus are effectively served
- Hiring of core ECM staff to ensure core competencies to support ECM requirements
- Training of core ECM staff to ensure core competencies to support ECM requirements
- Technical Assistance
- Reporting Capabilities
- Other (to be considered must indicate below which IPP measure will be achieved through this investment).

Funding Dollar Amount Requested for Funding Area 2:

Please provide a project description including how it will advance infrastructure, capacity or quality in the ECM and/or CS programs. *Please include the justification under this funding category below. The review committee will closely review and may request additional documentation before making their final decision.*

Empty box for project description.

Evaluation: Please describe your project goals and how you will evaluate success:

Milestone/Goal	Metric/Measure	Evaluation Process	Frequency	Target Completion Date

Funding Area 3 - CS Provider Capacity Building

Please indicate which areas under Funding Area 3 – CS Provider Capacity Building you are requesting funding for.

3. CS Provider Capacity Building

- Building compliance and oversight capabilities to ensure populations within the county are effectively served
- Hiring of core CS staff
- Training of core CS staff
- Workflow Redesign
- Technical Assistance
- Reporting Capabilities
- Other (to be considered must indicate below which IPP measure will be achieved through this investment).

Funding Dollar Amount Requested for Funding Area 3:

Please provide a project description including how it will advance infrastructure, capacity or quality in the ECM and/or CS programs.

Please include the justification under this funding category below. The review committee will closely review and may request additional documentation before making their final decision.

Empty text box for project description.

Evaluation: Please describe your project goals and how you will evaluate success:

Milestone/Goal	Metric/Measure	Evaluation Process	Frequency	Target Completion Date

Funding Area 4 - Quality Reporting

Please indicate which areas under Funding Area 4 – Quality Reporting you are requesting funding for.

4. Quality Reporting

- | | |
|---|--|
| <input type="checkbox"/> Inpatient Hospital Stays and Readmissions | <input type="checkbox"/> Hypertension Control |
| <input type="checkbox"/> ED Visits | <input type="checkbox"/> Homeless Population Focus |
| <input type="checkbox"/> Depression Screening and Follow Up Care | <input type="checkbox"/> Metabolic monitoring for Children/Adolescents on Antipsychotics |
| <input type="checkbox"/> Mental Illness and/or Alcohol or other Drug Abuse Dependence Follow Up | <input type="checkbox"/> Permanent Housing |
| | <input type="checkbox"/> Homeless Comprehensive Diabetes Care |

Funding Dollar Amount Requested for Funding Area 4:

Please provide a project description including how it will advance infrastructure, capacity or quality in the ECM and/or CS programs.

Please include the justification under this funding category below. The review committee will closely review and may request additional documentation before making their final decision.

Empty text box for project description.

Evaluation: Please describe your project goals and how you will evaluate success:

Milestone/Goal	Metric/Measure	Evaluation Process	Frequency	Target Completion Date

Section 3: Project Budget

Please complete and include with your submission: **Kern Health Systems: CalAIM IPP Application - Part B (Project Budget).**

Additional Documentation

In addition to **Part A** and **Part B** of the **CalAIM IPP Application**, please include the requested additional documentation with your submission:

- Recent Annual Fiscal Report (if available)
- 501(c)(3) or tax status designation

The funding recipient may be required to indemnify KHS against potential liability, depending on the type of project funded.