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

San Bernardino
Annual Report PY2
5/2/2018

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

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

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

Whole Person Care

San Bernardino

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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 San Bernardino County Whole Person Care Pilot Program's (WPC) successes and challenges through December 31, 2017 continues to be the foundation which the Pilot Program embraces and continues to examine, revise, and build. Even though only seven enrolled clients were obtained as of June 30, 2017, we were able to successfully enroll 330 clients by December 31, 2017. The increased integration among San Bernardino County agencies include Arrowhead Regional Medical Center (ARMC), San Bernardino County Sheriff's Department Homeless Outreach Progressive Enforcement (H.O.P.E), Department of Behavioral Health (DBH), Transitional Assistance Department (TAD), 211 Coordinated Entry System (CES), proved to be indispensable resources.

The WPC team with our Health Plan partners, Inland Empire Health Plan (IEHP) and Molina Healthcare along with ARMC, provides us the gateway to better navigate our enrolled clients to increase care coordination and the appropriate access to care, which reduces inappropriate emergency and inpatient utilization. An example of this is illustrated by two Patient Navigators conducting a home visit at the request of Step Up, which is a mental wellness center. Upon arrival, the Patient Navigators found the client outside of his home, laying on the sidewalk, bloody. The navigators helped him up and into his home, obtained towels and wiped his wounds. The Patient Navigators called Step Up and were instructed to send the client to the ED. Upon assisting the client in cleaning his wounds, the client stated he did not need to go to the ED. The Patient Navigators contacted his Health Plan and coordinated an appointment for the client to be seen by his primary care physician the next day.

Our improved data collection and data sharing allows us to accurately identify those WPC Clients who need additional assistance and help with Medi-Cal annual recertification. WPC now receives recertification dates from TAD which allows WPC to proactively assist clients with renewing their coverage. This innovative and proactive hands-on approach has decreased our monthly disenrollment rate, due to non-renewal, to less than 1%.

The San Bernardino WPC program continues to work diligently to improve health outcomes for the WPC population through new and pioneering methods. We are inspired when a client thanks our RN Care Manager for taking the time to show him/her how to accurately take their own blood pressure using a home digital blood pressure

monitor, and when our Social Worker receives a hug from a parent because we were able to encourage their child to see a Behavior Health Counselor for attempted suicide.

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						*	*

Item	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12	Annual Unduplicated Total
Unduplicated Enrollees	32	45	*	57	69	90	323

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

FFS	Costs and Aggregate Utilization for Quarters 1 and 2						
	Month 1	Month 2	Month 3	Month 4	Month 5	Month 6	Total
Service 1						$16,709	$16,709
Utilization 1						77	77

FFS	Costs and Aggregate Utilization for Quarters 3 and 4						
	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12	Total
Service 1	$14,539	$12,586	$20,398	$44,702	$144,050	$122,106	$358,381
Utilization 1	67	58	94	206	663	562	1,650

For ***Per Member Per Month (PMPM),*** please report your rate, amount claimed and member months by PMPM type. These reports should tie to your budget, invoice and

utilization reports. For "Bundle #" below, use the category number as reported in your submitted Quarterly Enrollment and Utilization Report. Add rows as needed.

PMPM		Amount Claimed						
	Rate	Month 1	Month 2	Month 3	Month 4	Month 5	Month 6	Total
Bundle #1	$283						$*	$*
MM Counts 1							*	*

PMPM		Amount Claimed						
	Rate	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12	Total
Bundle #1	$283	$11,037	$24,055	$32,545	$48,676	$68,486	$93,956	$278,755
MM Counts 1		39	85	115	172	242	332	985

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

August 2017 FFS Utilization was low because we realigned and recalculated our query used to identify our target population, assuring we are targeting the appropriate clients.

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.

After the Mid-Year report was submitted, additional support staff hired, and WPC clients were being enrolled, we learned the frequency of the committees and subcommittee meetings required modification. Some meetings were changed from bi-weekly to monthly, monthly to quarterly, and some meet as needed. We realized meeting too soon, such as every other week, did not provide value as we were not able to test and implement new objectives before the next scheduled meeting. The meetings became unnecessary and developed into a review of the previous meeting.

In addition, some of the participants in the committees and subcommittees changed from an administrative outlook to a functional or hands-on perspective. This fresh evaluation is evident in the WPC Workgroup (Operations) where participants now include a WPC Patient Navigator, WPC Social Worker, WPC Alcohol and Drug Counselor, WPC Utilization Technician, ARMC RN Care Manager, ARMC Social Worker, San Bernardino County Sheriff's Nurse Supervisor and Sheriff's Deputy, IEHP Care Managers, Molina Care Manager, and Forward Health (population management platform). Guest speakers are invited as needed such as Gary Madden, Director of 211, San Bernardino County's Community Resource Hub.

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.

San Bernardino County Whole Person Care Pilot continues to work with the Forward Health Group (FHG) in maintaining the information system that meets the program's goals. We continue to work in partnership with FHG to assist our potential and enrolled clients. One innovative enhancement to the FHG platform provides the ability for WPC to see the client's Medi-Cal recertification date. WPC proactively assists with recertification for WPC clients with a hands-on method, which produced a less than 1% monthly disenrollment rate due to non-compliance. Other enrichments to the FHG platform include maintaining a completed PHQ-9 form, release of information (ROI), and Patient Survey (needs assessment).

We ended 2017 renting eight mid-size San Bernardino County vehicles. We submitted and are approved for a rollover to purchase the eight mid-size County vehicles. The WPC staff utilizes these vehicles to perform potential and enrolled client outreach to physically meet with each potential and enrolled client.

Computers, notebooks, and cell phones were purchased to assist in the delivery of real-time communication and information with all team members, potential clients, enrolled clients, support services, and participating entities. Computer software, mobile data charges, and ISD support along with other tools and mechanisms were purchased and established.

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.

The San Bernardino County Whole Person Care Pilot began making significant progress toward full aggregation and sharing of health data to meet the program's needs and goals. Arrowhead Regional Medical Center (ARMC), the Department of Behavioral Health (DBH), the Department of Public Health, and Inland Empire Health Plan (IEHP) have all submitted robust data sets on potential and enrolled clients. This data has been matched, combined, and shared with the Whole Person Care navigators, and participating entities, to better identify the needs and opportunities for enrollees. Initial data for universal and variant metrics has successfully been obtained from ARMC, DBH, and IEHP. The population health data system is developed and implemented, allowing additional future data sources, aggregation, and sharing.

VII. NARRATIVE – Pay for Outcome

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

The San Bernardino County Whole Person Care Pilot program pay for outcomes includes payments for reaching anticipated outcomes within the designated population. The outcomes are tied directly to the variant metrics found in Section 4.1 Performance Measures of the WPC application, and are coordinated to achieve the expected outcome for each year.

The first pay for outcome measure relates to the Patient Activation Measure (PAM). This indicates the patients' engagement in managing their own health needs and direction. This measure is compiled by the patient navigator through ongoing needs assessment. The goal is to maintain the baseline during pilot year two, and increase by 5% in years three through five.

The second pay for outcome relates to managing diabetes. The goal focuses on maintaining the baseline for HbA1c for pilot year two, and achieving a 5% improvement over prior year for years three through five. To qualify, the client must maintain their panel's baseline for year two, and achieve a 5% improvement in years three through five.

San Bernardino County Whole Person Care Pilot program continues to compile baseline data for enrolled members.

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.

- Executive Steering Committee
  No official meeting during this reporting period. Conference Calls as necessary.

- WPC Steering Committee
  Health Care Reform Coalition Meeting/Whole Person Care
  7/1/17 – Minutes attached
  8/1/17 - Minutes attached
  9/5/17 – Minutes attached
  11/7/17 – Minutes attached
  12/5/17 - Minutes attached

- WPC Fiscal Workgroup
  11/3/17 - Agenda Attached - Conference calls as necessary.

- WPC Application/Consent/Release of Information Workgroup - No official meeting during this reporting period. Conference Calls as necessary. Work completed for this workgroup. Will reconvene if need arises.

- WPC Information Support Workgroup (Data Governance)
  7/11/17 – Minutes attached
  8/8/17 - Minutes attached
  8/22/17 – Minutes attached
  10/31/17 – Minutes attached
  4/18/2017 – Minutes attached
  6/14/2017 – Minutes attached
  6/27/2017 – Minutes attached

- WPC Program Workgroup (Operations)
  7/13/17 – Agenda attached
  8/10/17 – Agenda attached
  8/24/17 – Agenda attached
  10/5/17 – Agenda attached
  10/19/17 - Agenda attached
  11/2/17 - Agenda attached
  12/27/17 - Agenda attached

IX. PROGRAM ACTIVITIES

a.) Briefly describe 1-2 successes you have had with care coordination.
(1) A client working with WPC for seven months who was reported to have been homeless, living under a bridge, addicted to methamphetamine, and suffered from mental illness was able to move into transitional housing, obtain a full-time job, and now attends a 12 step support group. (2) A WPC client who lives in a room and board had no teeth and was asking to go to a dentist and to a PCP for a physical. WPC coordinated, through IEHP, a local PCP for her physical. WPC also scheduled a DDS appointment for her to obtain dentures. The client called WPC Navigator and was proud to show-off her new dentures.

b.) Briefly describe 1-2 challenges you have faced with care coordination, and lessons learned from those challenges.
(1) Some agencies were reluctant to work with WPC because they felt WPC would take their patients away. After meeting with the agency and providing a presentation and an opportunity for Q&A, coordination has improved. (2) Coordinating care for WPC clients requires more than one or two attempts. Some WPC clients are stubborn and are very slow and reluctant to build self-management skills. This allows the WPC team to fashion new encounter techniques.

c.) Briefly describe 1-2 successes you have had with data and information sharing.
(1) WPC has successfully reduced monthly Medi-Cal Churn to less than 1% with assistance from TAD, preventing gaps in coverage. (2) Worked with Molina Health to establish ability to obtain patient demographics to compare with enrollment information.

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

(1) Data sharing between the Department of Behavioral Health (DBH) and Whole Person Care (WPC) initially was problematic, beginning with the scoring of clients. Although identifying information is used for developing the potential client's scores, the resulting file that is shared with the WPC team contains nothing that identifies any specific health provider the score is derived from, masking whether or not a potential enrollee has received behavioral health services. Difficulties exist in the use of Substance Use Disorder (SUD) data, this information is further restricted under CFR 42 and care must be taken that an individual's scoring is not primarily derived from those services.

(2) DBH data for enrollees: DBH compliance officer and county counsel initially required a separate ROI identifying the clinical source of the data and the use of the data. An attempt was made to create a blanket ROI that would cover all the partner entities in WPC, however DBH continued to require separate documentation. The initial attempt by WPC patient navigators to have the DBH ROI filled out and signed was found to be lacking the required specifics and were deemed unusable by the DBH compliance officer. A second attempt was then made wherein the specifics for mental health services were identified and the WPC team provided technical assistance in the proper method of obtaining consent. The amendment to W&I 5328 permitting the exchange of mental health data for health care operations, relieved the need for a specific DBH ROI and Data exchange was commenced.

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

One success we have had is sharing data with the County of San Bernardino Sherriff's Homeless Outreach Progressive Enforcement (H.O.P.E) team. The HOPE team has a database of homeless people in San Bernardino County. When the WPC team cannot locate a client, we run the client through the H.O.P.E database and once located, we update our population management platform and perform the encounter.

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

A challenge we still face with data collection is maintaining consistency among all departments as data is collected and transferred to the WPC population management platform. Data transfer from County departments are still difficult. Ideally, we would like to have every County department follow the same format or data type.

g.) Looking ahead, what do you foresee as the biggest barriers to success for the WPC Program overall?
One obstruction we are facing is limited resources in the Community from non-profit organizations. If these resources do not have funding, our ability to supply WPC clients with items such as food, clothing, and hygiene items becomes extremely 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.

- Initiation and Engagement of A&D Drug Dependence Treatment – PY2-3
- Inpatient Utilization Information – PY2-3
- Memo of Understanding – PY2-3
- Patient Survey – PY2-3
- Patient Activation Metrics-PY2-3
- Client Recovery Plan – PY2-4
- Identify Patients Hospitalized for Mental Illness – PY2-4
- Initiation and Engagement of A&D Drug Dependence Treatment – PY2-4
- Memo of Understanding- PY2-4
- Patient Survey-PY2-4
- Patient Activation-P2-4
- Client Recovery Plan-PY2-4