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 County
Annual PY 3
April 24, 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.

Whole Person Care

San Bernardino County
Annual PY3 Narrative Report
4/24/19

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 Whole Person Care (WPC) Pilot Program for San Bernardino County continues to implement the plan, do, study, and act principle. As we continue to examine, revise, and build upon the successes, challenges, and lessons learned during the reporting period of July 1, 2018 through December 31, 2018, we are able to reflect over the last few years and identify how we served our clients and create new goals for the future.

We continue to refine integration among our partners (County agencies, health plans, providers, and all other entities) through standard monthly and quarterly meetings such as the data governance, operations, steering committee, and fiscal workgroup. Data collecting and sharing are on monthly schedules and continue to work well. Now that we are in program year three of five and working efficiently, an ongoing challenge is lack of attendance. Some meetings were changed from weekly to monthly, monthly to quarterly, and quarterly to as needed. In addition to the food we continue to distribute to our clients, we established a clothing drive at the Colton TAD office and a toiletries drive in the five Arrowhead Regional Medical Center's Family Health Centers. The lessons we learned were our clients' needs differ from each other and other basic needs were not being met, such as simple toiletries (soap, shampoo, deodorant, etc.). This modest supplement gives additional dignity to our clients and increases their overall physical and mental health and is an influence in reducing inappropriate emergency and inpatient utilization.

We determined the structure of 10 mobile teams works very well to meet the challenge of successfully increasing coordination, appropriate access to care, and to identify and reduce inappropriate emergency and inpatient utilization for our clients. To recap, each team consists of a Patient Navigator, R.N. Care Manger, Social Worker, Alcohol and Drug Counselor, Utilization Technician, and an Office Assistant. Each team is now responsible for maintaining 53 enrolled clients. The monthly Whole Person Care Accountability Review (WAR) conferences have proven to be a valuable strength to the program. Every enrolled client is studied and reviewed at the WAR conference to ensure data sharing, case management, and monitoring is shared with everyone who is involved in the building of our client's self-management skills.

One success story is: A homeless client was enrolled in Whole Person Care in February 2018. New contact information was found on IEHP's provider portal, so the Patient Navigator and RN Care Manager, found the client was no longer homeless, no longer battling substance abuse, and was following up with assigned physical and mental health providers on a regular basis. Client knew all of her medications, what they were for and why she was taking them. Client continues to follow up with her primary care physician and her psychiatrist on a monthly basis. Client saw an optometrist and received her new glasses. Client saw a dentist and continued to follow up until all her dental work was done. Client has now been sober for 10 months. Client uses religious practices to stay sober. WPC Drug & Alcohol Counselor continues to follow up with the client to make sure the client stays connected so she can continue her plan for sobriety. Client is limited to exercise due to a wound on her foot, but continues to eat healthy and follow a strict diet. Client's sugar levels (A1C) at the time of our initial visit were 8.1. RN Care Manager stressed the importance of lowering her levels below 7. Client is connected to Charter Home Health and a care nurse goes out to check on her regularly 3x/week. Client hasn't had a hospitalization for 10 months and continues to follow up with her providers. Client has all medical supplies she needs from diabetes supplies, a shower chair, power wheelchair, cane, and walker. Client smokes cigarettes and was educated on the dangers of smoking. RN Care Manager also educated client on her high blood pressure levels and sugar levels in order to assist the client on reducing her A1C and blood pressure. Client is now receiving In Home Supportive Services (IHSS) and continues to follow up on her doctor's appointments on her own. Client has come a long way and continues to stay connected. Overall, client's health has improved dramatically and will be graduated successfully from the Whole Person Care Program.

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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	91	94	11	3	6	10	215

Item	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12	Annual Unduplicated Total
Unduplicated Enrollees	49	26	20	30	13	19	157

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 $217.27	34,980.47	5,214.48	0	434.54	0	19,771.57	60,401.06
Utilization 1	161	24	0	2	0	91	278
Service 2							
Utilization 2							

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 $217.27	31,069.61	57,142.01	10,211.69	35,197.74	22,161.54	18,467.95	174,250.5
Utilization 1	143	263	47	162	102	85	802
Service 2							
Utilization 2							

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 $283	Month 1	Month 2	Month 3	Month 4	Month 5	Month 6	Total
Bundle #1	$	117,728	143,481	143,481	144,896	144,613	143,198	837,397
MM Counts 1		416	507	507	512	511	506	2,959
Bundle #2	$							
MM Counts 2								

Amount Counts								
PMPM	Rate	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12	Total
Bundle #1	$283.00	$157,348	$146,594	$149,141	$149,141	$144,047	$145,462	$891,733
MM Counts 1		556	518	527	527	509	514	3,151
Bundle #2								
MM Counts 2								

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

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.

Staci McClane, Associate Hospital Administrator for Ambulatory Services and Population Health Management is the WPC program lead at Arrowhead Regional Medical Center. The alignment with Ambulatory Services has enhanced the WPC program with direct contact and shared client/patient care plans and outcomes with ARMC's Family Health Centers. Beginning in January 2019, Health Homes will also be affiliated with Ambulatory Services. Although separate from WPC, we will be able to serve all clients/patients with a shared administrative infrastructure.

In the third and fourth quarters of 2018, we encountered turnover, promotions, and new hires. We had a Social Worker II opening and were able to refill the vacancy by promoting a Patient Navigator, who is in a MSW program. An Office Assistant II was promoted to the open Patient Navigator position, and a new Office Assistant was hired.

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 continues to practice the PDSA cycle with our population management platform supported by the Forward Health Group (FHG). We identified a limitation in the population coordinator section of the platform. The population coordinator section of the platform is where staff utilize client data (demographics, notes, etc.) and record notes. We found it challenging to edit information in a timely manner because requests had to be sent to FHG. We sought to streamline this process. Working with FHG we identified the source of the restriction and will be operating in a new and improved population coordinator platform in early 2019.

Computer software, mobile data charges, and ISD support along with other tools and established mechanisms continue in accordance with established procedures.

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 program incentive payment is intended to incentivize participating entities to share bi-directional data necessary to achieve desired outcomes. All participating entities will work together with the WPC team to verify shared information and coordinate those items needed to provide the best outcomes for our targeted population and enrolled clients. Each entity is expected to provide full data for all enrolled WPC beneficiaries for whom they have data.

The following data was shared (July 1, 2018 – December 31, 2018):
Total incentive payment: $350,000

Total 201.93 G

Molina	0.378	G	-	0%	= $0
IEHP	3.56	G	-	2.0%	= $7,000
ARMC	198	G	-	98.0%	= $343,000

The San Bernardino County Whole Person Care Pilot Program is incentivized when it reaches and maintains 450 enrolled clients (90%) of the target enrolled cap of 500 enrolled clients. 83% of the goal was attained.
Total incentive payment: $117,354 made to San Bernardino County WPC

Month	Enrolled clients
July 2018	556
August 2018	518
September 2018	527
October 2018	527
November 2018	509
December 2018	514

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 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. A PAM survey is performed on every client. We were able to increase the scores from 2017 by 10.26%. A challenge we continue to have is as we enroll new clients, the new PAM scores will most likely be a one or two, which has the potential to negatively affect our overall gains.

The second pay for outcome relates to managing diabetes. Our data shows in 2017, a denominator of 96 and a numerator of 42, giving us a rate of 43.75%. Our denominator for PY 3 annual report is 58 and our numerator is 37, giving us a rate of 63.79% (64% listed on Variant Metric Report), an improvement of 20.04%.

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. This committee meets quarterly

8-7-18 Minutes Attached
11-6-18 Minutes Attached

- WPC Fiscal Workgroup

No official meeting during this reporting period. Conference calls as necessary.

- WPC Information Support Workgroup (Data Governance)

7-3-18 Minutes Attached
9-4-18 Minutes Attached
11-6-18 Minutes Attached

- WPC Program Workgroup (Operations).

8-22-18 Minutes Attached
10-25-18 Minutes Attached
11-28-18 Minutes Attached

IX. PROGRAM ACTIVITIES

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

(1) 51 y/old male with Guillen-Barre syndrome who also had multiple falls, was struggling with obtaining physical therapy, seated walker, and braces for his lower legs. He stated he did not believe his current PCP was listening. He stated he felt frustrated by long wait times from Medicare on the phone. After helping him organize his top health concerns and providing education, he was able to verbalize his needs to his PCP. Since enrollment with WPC, client re-established care with his PCP f and is receiving the care he feels he was not receiving. Client attends physical therapy and received the DME he needed. Client was prescribed new medication to assist with his tremors and feels it has increased his quality of life significantly. Client stated he was feeling somewhat "isolated" due to family being away at work. Client expressed desire in socializing but did not have transportation every day to do so. In collaboration with IEHP, a referral was placed for CBAS which client is looking forward to attending. Client was also connected to mental health services by WPC Social Worker. He stated he is grateful for the assistance and direction WPC has provided and feels he is now where he needs to be.
(2) 61 y/old female with diabetes, HTN, Hyperlipidemia, was having difficulty with managing her chronic conditions and was noncompliant with medications. Client demonstrated poor insight in reference to what her medications were and what they were intended for; therefore, she did not understand the importance and would miss doses. Client thought she was managing her diabetes despite her HBA1c being consistently above 10. After some health education, encouragement, and discussions with her PCP, client made significant changes. Her A1c had dropped from 13.7 as of 05/18/18 to 7.8 as of 01/18/19 and LDL is 78 as of 01/18/19. Blood pressure is now controlled and client is cognizant of the dietary and lifestyle choices needed to maintain a healthy life style.

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

(1) Long wait times for telephone customer service among clients providers can become discouraging and clients tend to want to hang up

(2) Clients are not always in a position mentally or emotionally to accept education in the hospital or clinical setting where it is given. At that point, they may need numerous encounters at home that employ teach back methods to identify knowledge deficits.

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

(1) We have been able to maintain a consistent data exchange with the majority of our partners, which includes ARMC, IEHP, Molina, Public Health, Health Homes, and DBH. This has allowed us to reach out to the public in a strategic approach versus cold calls. A system was developed early on to score the patients and match them to our qualifications. Another success we have had is due to our established practice of data sharing. When HHP (Health Homes Program) was launched on January 1st 2018, we were able to collaborate with them to identify enrollment overlapping. This has led to more efficient use of our time and resources.

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

(1) It has been a challenge to maintain 100% participation with all partners due to staff turnover and changes in policy in the different departments. Another challenge is due to both programs reaching out to potential clients on a daily basis, the data exchange is difficult to maintain as real-time as possible. We have learned from these challenges that it has been helpful to maintain a record of the data sharing process. We developed a data exchange schedule that we share with our partners so all participants know their roles and expectations. Also, communication within the both programs is key. Collaboration also involves discussing some patients on a case-by-case basis to determine who will keep the enrollee.

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

Success Story 1
We continue to document all encounter details in our platform. This allows for all roles in the team to have access to the client history and provide services that are relevant. Another success we have had has to do with a parallel system that was implemented in the development stage of the platform. We established a contingency plan to track our Enrollment & Utilization which includes PMPM and FFS in the event information is not available in the population management platform. This secondary/backup plan is a safeguard and serves as a checks and balances ensuring reporting data is accurate.

f.) Briefly describe 1-2 challenges you have faced with data collection and/or reporting.
Due to our staff being constantly in the field, they get backed up with notes that need to be entered into the platform. This creates a need to set aside time for data entry. We are addressing the issue with our new platform that enables data entry via mobile devices using encrypted and secure connections. We found the combination of a learning curve for staff and the ongoing fine-tuning of the platform challenging. This is being addressed in our new platform design and with new documentation and training provided to the staff.

g.) Looking ahead, what do you foresee as the biggest barriers to success for the WPC Program overall?
Looking ahead, because of the uncertainty of the WPC program after 2020, we foresee employee turnover as a barrier to success.

X. PLAN-DO-STUDY-ACT

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

List PDSA attachments:

Administrative Comprehensive Care Plan PY3-3
Administrative Comprehensive Care Plan PY3-4
ED Visits PY3-3
ED Visits PY3-4
Inpatient Utilization PY3-3
Inpatient Utilization PY3-4