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

County of San Diego, Health and Human Services Agency
Annual Narrative Report PY2
4/2/2018

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

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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.*

Live Well San Diego envisions a region that is healthy, safe and thriving. Consistent with that vision, the Whole Person Care pilot is known as Whole Person Wellness (WPW), which establishes an approach of working with people to promote their overall wellness through comprehensive, person-centered strategies.

Increasing Integration

During PY2, San Diego's WPW Pilot brought together multiple stakeholders, including Medi-Cal Managed Care Plans (MCPs), Regional Task Force on the Homeless, Public Safety Group, 211, San Diego Health Connect (the Regional Health Information Exchange), the Hospital Association and various divisions within the Health and Human Services Agency including Integrative Services, Behavioral Health Services, Medical Care Services, Housing and Community Development Services, and ConnectWellSD.

Increasing Coordination and Appropriate Access to Care

PY2 established the necessary infrastructure and executed contracts to implement the program. This was achieved through the execution of MOAs with 4 of the 5 MCPs in San Diego. An additional 2 MCPs entered the San Diego market during the year, and MOAs are being established with them. The procurement of two contractors for the three WPW Regions was completed with contracts executed on December 1, 2017.

Reducing Inappropriate Emergency and Inpatient Utilization

During the reporting period, data was reviewed to identify those individuals with high Emergency Department and Inpatient Utilization for potential participation in the project.

Improving Data Collection and Sharing

The County chose to add IBM's **Cúram** Outcome Management program management software to its IBM based ConnectWell San Diego electronic information sharing hub. Cúram is being built to allow users to record outreach and engagement encounters, create and manage comprehensive care plans (CCP), generate reports, and house assessments to guide the CCP, amongst other tasks. At the end of this reporting period, IBM successfully deployed the ability to add a new customer, record outreach and engagement encounters, and update Releases of Information.

Data was collected from the MCPs, and matched with the Homeless Management Information System and Behavioral Health Services to identify the baseline and target population.

Achieving Quality and Administrative Improvement Benchmarks

During PY2, the County of San Diego (COSD) established processes to share data across multiple entities, began implementation of an information sharing hub to improve coordination of care and provide ongoing reports, procured contracted organizations for service delivery, and hired project staff.

Increasing Access to Housing and Supportive Services

Through funding available by the California Department of Social Services' Housing and Disability Advocacy Program, the COSD received $3m to provide housing and disability advocacy for people enrolled in WPW.

Improving Health Outcomes

Efforts during PY2 to establish the administrative and delivery infrastructures necessary will ultimately result in improved health outcomes as services are implemented in January, 2018. Between October and December of PY2, COSD enlisted referrals from the County's front line service providers in the Family Resource Centers, Homeless Outreach Teams, Public Health Nurses, San Diego County Psychiatric Hospital and Behavioral Health Clinics for early enrollment into WPW. The COSD exceeded its expectations of enrolling 200 people and enrolled 302 individuals through this early enrollment process.

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	0	0	0	0	0	0	0

Item	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12	Annual Unduplicated Total
Unduplicated Enrollees	0	0	0	0	0	0	0

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							
Utilization 1	0	0	0	0	0	0	0
Service 2							
Utilization 2							

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							
Utilization 1	0	0	0	0	0	0	0
Service 2							
Utilization 2							

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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	$							
MM Counts 1		0	0	0	0	0	0	0
Bundle #2	$							
MM Counts 2		0	0	0	0	0	0	0

PMPM		**Amount Claimed**						
	Rate	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12	Total
Bundle #1	$							
MM Counts 1		0	0	0	0	0	0	0
Bundle #2	$							
MM Counts 2		0	0	0	0	0	0	0

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

During this period San Diego deployed an Early Enrollee process. Our front line service providers in the Family Resource Centers, Homeless Outreach Teams, San Diego County Psychiatric Hospital and Behavioral Health Clinics enrolled 302 individuals experiencing homelessness and appearing to meet the eligibility criteria. Of these 302 Early Enrollees, 66 individuals had over $2,000 of Medi-Cal costs in CY2016 and 14 of those had costs exceeding $20,000.The contracted organizations will conduct outreach and engagement to these individuals, as well as those identified through data matching efforts, to complete the secondary enrollment process so they can begin the Stabilization Phase of the program.

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.

During PY2, there were significant efforts to establish the administrative infrastructure necessary for successful delivery of services. The Whole Person Wellness Coordinator began in mid-July, and provides overall coordination of the project across the various stakeholders and the services to ensure the project meets it goals. In addition, an Administrative Analysts II and an Analyst III have ensured reports are submitted timely to the State, and have led the effort to procure contracts for services. A Senior Policy Senior Health Policy Advisor provides overall guidance for the project and specifically focuses efforts to ensure data is collected and analyzed to support project goals. An Operations Research Analyst from the Office of Business Intelligence conducts all data analysis and data matching to inform the project, including receiving and processing all of the data from the MCPs and the County's information systems, processing, and synthetizing usable reports. During the Early Enrollee process, the Research Analyst additionally verified basic Medi-Cal eligibility and communicated with referring entities. The majority of the Coordinator's efforts during PY2 have been dedicated to the ensuring the design of the **Cúram** Outcome Management social program management software meets the needs for WPW and is person-centered and trauma informed.

V. NARRATIVE – Delivery Infrastructure

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

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

The County chose to add IBM's **Cúram** Outcome Management social program management software to its IBM based ConnectWell San Diego electronic information sharing hub. The Outcome Case Management (OCM) module of ConnectWellSD will give San Diego's Whole Person Wellness staff access to risk rating tools (a.k.a. Psycho-Social risk assessment) and other assessment tools such as the PHQ-9, VI-SPDAT, and Suicide Risk to identify program participant strengths and needs that may hinder their ability to be self-sufficient. The module will also give users the ability to create Comprehensive Care Plans for their participants to identify, schedule, and manage activities; schedule and monitor services being provided; establish goals; and monitor outcomes.

Cúram is being built to serve as a source system, allowing users to add a new customer, record outreach and engagement encounters, update releases of information (ROIs), or authorizations, create and manage comprehensive care plans (CCP), generate reports, and house assessments to guide the CCP. At the end of this reporting period, IBM successfully deployed the ability to add a new customer, record outreach and engagement encounters, and update ROIs.

The Out-Of-The-Box software design is very linear which has created the need for more in-depth development to allow for a person-centered, trauma informed approach in care planning, including assessments. The County's ConnectWellSD and IBM teams are committed to developing these capabilities to be used across our service providers, internal and partnered.

At the end of this reporting period, WPW ConnectWellSD users could create/edit WPW participant information, capture outreach and engagement activity information, and allow for no address in the Authorization wizard (a previously required field), to meet the needs of this Special Population.

Total cost of $812,573 is tied to the cost of the licenses purchased for the case management module to give County and County provider staff access to Care Plan and Assessment functionality. In addition, $49,932 is included in the invoice which covers a 20% fee paid to the County's IT vendor, DXC, to provide contract oversight to IBM, review project documentation, assist with testing and defect resolution both pre and post go-live, among other activities. COSD is also claiming $200,000 for the payment deliverable tied to completion of the procurement process.

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 County of San Diego has not claimed any Incentive Payments during this reporting period.

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 County of San Diego has not claimed any Pay for Outcome Payments during this reporting period.

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.

The WPW Management Committee was established to coordinate the overall Pilot across regions and all the partnering entities. The Clinical Review Team (CRT) was implemented to identify potential participants and provide quality assurance and clinical problem solving as necessary. Efforts of the Data Work Group have been focused on receiving data from the MCPs and data analysis to determine what population would benefit most from WPW services. The Data Work Group has been looking at available data, demographics, and diagnoses.

The CRT reviews and verifies the data from the Data Work Group then adds best practices. The CRT and Data Work group report their data analysis to the Management Committee to help make decisions about the pilot design and processes.

The Management Committee was particularly instrumental in developing the Early Enrollee mitigation plan and obtaining buy-in from WPW partners. Now that the program is up and running, the Management Committee has absorbed the Integrated Health, Housing, and Human Services Advisory Council's duties such as identifying and resolving system challenges to achieving progress and intended outcomes, and ensuring project learnings are captured in PDSA's.

Attached is a list of meeting dates for each of these groups. (1B)

IX. PROGRAM ACTIVITIES

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

(1) Working with the Health Plans to develop a Care Coordination Matrix which defined how each Plan provides Care Management, how each Plan identifies people for inclusion in their Care Management, and key contact people for their individual Care Management Services. This will assist in ensuring coordinated care across WPW and the individual health plans.….

(2) Engaging County partners in the Early Enrollment process which has strengthened relationships, improved understanding and enhanced communication about program services to support shared clients.

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

(1) San Diego's WPW Service providers were contracted near the end of this reporting period and were starting-up, therefore there were no challenges or lessons learned at this point.

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

(1) Obtaining claims data from four of the five Managed Care Plans.

(2) Ability to synthesize useable reports from large, unstandardized claims dumps.

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

(1) Obtaining data from Managed Care Plans in standardized formats. When requesting data from Managed Care Plans, we now emphasized the importance of it being submitted following the standardized format.

(2) Vigilance regarding HIPPA compliance and avoiding any potential violations have made it challenging to locate potential WPW participants. We have learned to speak simply, letting partners know that we are looking for an individual and asking the partner

to pass along the message or help facilitate contact with the service providers, avoiding sharing any PHI.

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

N/A – contracts were not in place, so no data collection and/or reporting during this period.

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

N/A – contracts were not in place, so no data collection and/or reporting during this period.

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

Currently the biggest concern is finding participants who have been identified as potential project participants through matched data sets. This is being addressed through a multi-pronged strategy that engages various other points of potential service and referral to assist in finding people. Partners assisting in this effort include the region's Health Information Exchange, Hospital Discharge Planners, Managed Care Plans, the Sheriff, Behavioral Health Services, the Region's Homeless Continuum of Care, and 211.

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.

5A COSD WPC Pilot PDA Summary
5B WPW Eligibility Criteria
5C WPW Transfer of Care
5D WPW ED Communication
5E WPW ID Card
5F WPW CCP Integration
5G WPW CCP Monitoring
5H WPW CCP Screening Tool
5I WPW Care Coordination
5J WPW ConnectWell SD Data
5K WPW Early Enrollee Cohort