State of California - Health and Human Services Agency
**Department of Health Care Services**
**Whole Person Care**
Lead Entity Narrative Report

Riverside University Health System
Annual Narrative Report, Program Year 5
April 2, 2021

## REPORTING CHECKLIST

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

| Component | Attachments |
|---|---|
| **1. Narrative Report**<br>**Submit to:** Whole Person Care Mailbox | ☐ Completed Narrative report<br>☐ List of participant entity and/or stakeholder meetings *(if not written in section VIII of the narrative report template)* |
| **2. Invoice**<br>**Submit to:** Whole Person Care Mailbox | ☐ Customized invoice |
| **3. Variant and Universal Metrics Report**<br>**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.)**<br><br>**Note: If a Policy and Procedures document has been previously submitted and accepted, you do not need to resubmit unless it has been modified.**<br><br>**Submit to:** Whole Person Care Mailbox | ☐ Care coordination, case management, and referral policies and procedures, which may include *protocols and workflows.)*<br>☐ 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**<br>**Submit to:** Whole Person Care Mailbox | ☐ Completed WPC PDSA report<br>☐ Completed PDSA Summary Report |
| **6. Certification of Lead Entity Deliverables**<br>**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

*Instructions: 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.*

*Please limit responses to 500 words. If additional information is needed, please contact your assigned Analyst.*

**SUCCESSES:**

1. Increasing integration among county agencies, health plans, providers, and other entities: The WPC team has stayed connected and maintained our collaboration via the internet despite the pandemic. Our integration increased during this time. We worked closely and diligently with each entity to ensure access to care due to the unique circumstances of the pandemic.

2. Increasing coordination and appropriate access to care: We were able to successfully modify to adjusted business hours and electronic ways of communication to get the care our clients needed during a unique time in history. The WPC leadership began oversight of a complex care coordination program within our community health centers and this expanded our resources. We were able to obtain bus passes for clients that we receive on a monthly basis so our clients could continue to access care.

3. Improving data collecting and sharing: We were able to launch our electronic health record care plan tool making it easier to access and share, shared care plans.

4. Increasing access to housing and supportive services: We were instrumental in providing medical screening and referring WPC patients to Project RoomKey. This supportive service helped those at higher risk of contracting COVID (elderly, homeless, medically compromised, etc.) These efforts placed our at-risk clients into temporary housing with long term case management in hopes of keeping

them COVID-free and establish long-term housing. We also assisted with the emergent efforts to screen and test our patients for COVID throughout the entire county.

5. Improving health outcomes for the WPC population: Despite significant changes and barriers to in-person care, WPC continued to be available and engaged in the clients' care providing emotional support telephonically addressing fear, stress, and the unknown. This required extensive time on the phone. Clients expressed sincere appreciation for these social interactions.

**CHALLENGES:** The COVID pandemic caused office closures to valuable resources in the community. This was a significant barrier to getting supportive services.

**LESSONS LEARNED:** We were able to stay engaged despite the challenges of the pandemic. We used internet meetings to stay connected. We spent more time on the phone. We were increasingly aware of the need for smart devices for telehealth appointments, communication, and virtual meetings.

## III. ENROLLMENT AND UTILIZATION DATA

*Instructions: 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 | 318 | 215 | 133 | 76 | 61 | 98 | 901 |

| Item | Month 7 | Month 8 | Month 9 | Month 10 | Month 11 | Month 12 | Annual Unduplicated Total |
|---|---|---|---|---|---|---|---|
| Unduplicated Enrollees | 215 | 187 | 163 | 190 | 103 | 56 | 1815 |

# Whole Person Care

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***4/2/2021***

*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 | 951 | 856 | 770 | 674 | 625 | 674 | 4550 |
| Utilization 1 | $249,751.62 | $224,802.72 | $202,217.4 | $177,005.88 | $164,137.5 | $177,005.88 | $1,194,921 |
| Service 2 | 44 | 24 | 13 | 77 | 54 | 52 | 264 |
| Utilization 2 | 10,507.64 | $5,731.44 | $3,104.53 | $18,388.37 | $12,895.74 | $12,418.12 | $63,045.84 |
| | | | | | | | |
| | | | | | | | |

## 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 | 827 | 870 | 844 | 832 | 658 | 622 | 4,653 |
| Utilization 1 | $217,186.74 | $228,479.40 | $221,651.28 | $218,499.84 | $172,803.96 | $163,349.64 | $1,221,970.86 |
| Service 2 | 30 | 42 | * | 56 | 32 | * | 182 |
| Utilization 2 | $7,164.30 | $10,030.02 | * | $13,373.36 | $7,641.92 | * | $43,463.42 |
| | | | | | | | |
| | | | | | | | |

*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 for Quarters 1 and 2

| PMPM | Rate | Month 1 | Month 2 | Month 3 | Month 4 | Month 5 | Month 6 | Total |
|---|---|---|---|---|---|---|---|---|
| Bundle #1 | $349.61 | 241 | 237 | 246 | 252 | 212 | 280 | 1468 |
| MM Counts 1 | | $84,256.01 | $82,857.57 | $86,004.06 | $88,101.72 | $74,117.32 | $97,890.8 | $513,225.52 |
| Bundle #2 | $468.66 | 107 | 123 | 97 | 171 | 164 | 168 | 830 |
| MM Counts 2 | | $50,146.62 | $57,645.18 | $45,460.02 | $80,140.86 | $76,860.24 | $78,734.88 | $388,987.45 |

### Amount Claimed for Quarters 3 and 4

| PMPM | Rate | Month 7 | Month 8 | Month 9 | Month 10 | Month 11 | Month 12 | Annual Total |
|---|---|---|---|---|---|---|---|---|
| Bundle #1 | $349.61 | 228 | 191 | 197 | 200 | 201 | 191 | 1208 |
| MM Counts 1 | | $79,711.08 | $66,775.51 | $68,873.17 | $69,922 | $70,271.61 | $66,775.51 | $422,327.26 |
| Bundle #2 | $468.66 | 142 | 115 | 29 | 111 | 65 | 32 | 494 |
| MM Counts 2 | | $66,549.72 | $53,895.9 | $13,591.14 | $52,021.26 | $30,462.9 | $14,997.12 | $231,517.83 |

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

COVID 19 impacted WPC's ability to provide services in person due to Probation Office closure to prevent the spread of the virus. In addition, WPC nurses were redirected to help test community members for COVID. The latter affected Riverside's ability to screen new Probationers which affected the enrollment unduplicated count.

## IV. NARRATIVE – Administrative Infrastructure

*Instructions: 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. Please limit your responses to 500 words.*

RUHS WPC Program was designed to be a solution for clients to receive care in "the right place, at the right time" and to engage clients for transition out of incarceration via screening and referral. WPC works closely with the Probation department and has developed a process to identify individuals that can be referred to the WPC Registered Nurse, for screening and referral, in all 9 Riverside County Probation and 2 Parole offices.

RUHS WPC personnel continue to work closely with Riverside County Department of Public Services personnel to streamline the Medi-Cal enrollment process so that individuals can access medical, substance and behavioral health services and have their care coordinated by a WPC RN CM.

Once the client has transitioned into Care Coordination, the Complex Care (CC) RN coordinates the care and needs of each Probationer. The CC RN conducts ongoing coordinated case conferences for individuals with multiple needs to ensure the care is coordinated.

The WPC program is comprised of the following:

- Housing Navigators in the Coordinated Entry System are working to capacity and several clients have been successful in securing housing.
- Director of Population Health who oversees the program and provides administrative direction.
- Program Coordinator implements and monitors the county wide program.
- Two Nurse Coordinators (one in the East Region and one in the West Region) oversee staff nurses to implement the program in the Probation/Parole sites and the Federally Qualified Medical Clinics.
- Five Care Coordinator Nurses are actively employed.
- Five Screening Nurses are actively employed.

- Three nurses doing both the screening and care coordination are actively employed.
- 12 Housing Navigators in Coordinated Entry System.
- Due to the uncertainty of continued funding for WPC, there have been changes in employment status. Most FTEs are still in place, but some have chosen to accept permanent positions rather than temporary per diem employment.

## IV. NARRATIVE – Delivery Infrastructure

*Instructions: 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. Please limit your responses to 500 words.*

SAS:

Riverside WPC continues to rely on the SAS software for reporting and day to day operations to view trends in program participant data. Riverside WPC continues to use Manifest Medex (MX-the health information exchange platform), to identify clients who have accessed services in any Emergency Department or as an inpatient in any hospital in both Riverside and San Bernardino counties. MX sends an admission/discharge/transfer (ADT) notification directly to the RN Care Manager who has the client enrolled in her/his list when these events occur. The RN then contacts the client immediately and provides any needed services to prevent further need of ED or inpatient services. The Care Management platform within EPIC electronic health record was built for use by WPC Care Managers; in addition, Partner agency's staff are given read-only access to the Care Management platform.

Riverside WPC is using the EPIC CareLink Care Management Platform to provide all key partners real time documentation. The platform went live in December. The total expense is $300,000.00 payable to county partners.

Care Management Platform Oversight & Administration is ongoing to ensure that the data is reporting correctly. The total expense is $100,000.00 payable to county partners.

Respite Care Beds were approved by DHCS at a cost of $257 per day. From July to December 2020, a total of 3,078 days in respite beds for a total of $791,070.72 payable to county partners.

## V. NARRATIVE – Incentive Payments

*Instructions: 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. Please limit your responses to 500 words.*

Warm handoff between the RUHS Detention Health Nurse and the RUHS WPC Nurse (for individuals that have chronic health conditions in the jail that need to continue access to care once released) is approved at $200 per individual. WPC has screened 1764 individuals that have been released from jail with chronic health conditions. The maximum amount approved for reimbursement is 1000 units which were reached in the first half of 2020 (January-June.)

DBH/FQHC follow up appointment made within 30 days of being referred by WPC to the FQHC and/or Department of Behavioral Health. A payment of $200 per individual will be earned for achieving this incentive. During the second half of PY 5, WPC made 808 follow up appointments within 30 days for WPC participants. The total amount earned for this incentive is $161,600. Payment made to County Partners.

DPSS jail eligibility determinations: Department of DPSS is actively conducting Medi-Cal application assistance in the Jails in Riverside County, prior to release. However, applications have decreased due to the inability to conduct face to face interviews with customers due to the current events related to COVID-19. DPSS is currently exploring various methods to provide a safe place for applicants and DPSS staff to collect applications in person while developing a non-face to face process for applicants to apply for benefits electronically and/or by telephone. The incentive payment of 100K is to assist in covering the additional cost of Medi-Cal eligibility determination/barrier identification and resolution, prior to release from jail that the Department of Public Social Services (DPSS) conducts. This incentive payment goes to DPSS to offset some of their expenses in these activities.

## VI. NARRATIVE – Pay for Outcome

*Instructions: 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. Please limit your responses to 500 words.*

Medication Reconciliation to a minimum of 70% of those that show up to their physical health appointment done within 30 days: 1348 individuals have been referred to an Out Patient clinic. 880 individuals showed up to their appointment at the medical centers and of those 100% have had a medication reconciliation. The total earned for this pay for outcome is $250,000 which is half of the total max amount for this item.

## VII. STAKEHOLDER ENGAGEMENT

*Instructions: 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. An attachment to this report is also acceptable, please note below if this option is being used. 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.*

**CDCR Teleconferences**
**Attendees:** Prison Staff, RUHS BH/SAPT, WPC
**Purpose:** Discuss clients releasing with multiple needs.
**Frequency:** As needed, at least monthly

**Criminal Justice Committee**
**Attendees:** RUHS BH/SAPT WPC, attorneys, Probation
**Purpose:** Discuss Prop 47 and other court related collaborations
**Frequency:** Quarterly

**Jail High Utilizer/J-SCI**
**Attendees:** Sherriff, Police, WPC, BH, SAPT, Probation, Community Based Organizations, Faith-Based Organizations
**Purpose:** Discuss or debrief on outreach efforts done to offer services to jail high utilizers
**Frequency:** Monthly

**WPC Collaborations (East & West)**
**Attendees:** WPC, BH, SAPT, Probation, Parole, Community Based Organizations, Faith-Based Organizations, Police, IEHP, Molina, WPC Outreach Team, DPSS
**Purpose:** Share resources, collaborate, network, meet mutual goals of the clients
**Frequency:** Monthly

**WPC Staff Meetings**
**Attendees:** WPC staff, guest speakers
**Purpose:** Program updates, expectations, feedback, problem solving, group discussion
**Frequency:** Monthly

**WPC Leadership Meetings**
**Attendees:** Director, Nurse Coordinators, Program Coordinator
**Purpose:** High level discussions about data, upcoming changes, stats, barriers, successes, problem solving
**Frequency:** Every week

**De Novo/WPC Meeting**
**Attendees:** De Novo Administrators, WPC Nurse Coordinators, De Novo RN Care Manager
**Purpose:** Discuss successes, barriers, improvements, data
**Frequency:** Monthly

**Probation Staff Meetings**
**Attendees:** Probation, WPC
**Purpose:** Discuss collaboration/successes/barriers/specific cases
**Frequency:** At least monthly, sometimes more

**PACT Meetings (Parole led)**
**Attendees:** Parole, Probation, WPC, BH, SAPT, Community Based Organizations, Faith-Based Organizations, Clients
**Purpose:** Offer services and resources to newly released clients
**Frequency:** Monthly

**CES HomeConnect Navigation Meeting**
**Attendees:** Parole, Probation, WPC, BH, SAPT, Community Based Organizations, Faith-Based Organizations, Community Members, Police
**Purpose:** Discuss resources and clients on list for housing
**Frequency:** Every Tuesday

**Detention Warm Handoff**
**Attendees:** WPC, TRU Probation, Detention Care Managers, Sherriff
**Purpose:** Discuss workflow for better handoffs
**Frequency:** Quarterly and as needed

**Whole Person Care Health Score Workgroup**
**Attendees:** Dr. Leung, WPC, clinic staff (clinical therapists, health coaches)
**Purpose:** Discuss tool
**Frequency:** Varies (weekly to monthly)

**County of Riverside Continuum of Care**
**Attendees:** City of Riverside, Behavioral Health, WPC, DPSS, Path of Life, Board of Supervisors Office, Riverside County Sheriff's Department, Valley Restart Shelter
**Purpose:** Promotes community-wide planning and the strategic use of resources addressing homelessness
**Frequency:** Monthly

**CCPEC (Community Corrections Partnership Executive Committee)**
**Attendees:** Probation, District Attorney, Public Defender, Sheriff's Department, Riverside University Health System, Police
**Purpose:** High level discussion of stakeholders' activities in providing services to individuals in the justice system.

**IEHP Meetings**
**Attendees:** Director, Nurse Coordinators, Program Coordinator
**Purpose:** Collaboration, member needs, data, barriers, successes, problem solving
**Frequency**: At least weekly

## PROGRAM ACTIVITIES

### Care Coordination

A. Briefly describe 1-2 successes you have had with care coordination.
    1. Implemented and went LIVE with electronic shared care plans within our electronic health record 12/2020.
    2. Direct designated DPSS contact for client applications/needs to expedite Medi-Cal access.
B. Briefly describe 1-2 challenges you have faced with care coordination, and lessons learned from those challenges.
    1. Sudden interruption of services due to the pandemic. We learned to get creative in how we communicate to continue providing essential care coordination.
    2. Clients not having smart devices to attend appointments. We learned to adapt with what was available to the clients.

### Data Sharing

A. Briefly describe 1-2 successes you have had with data and information sharing.
    1. SAS has helped increase productivity. We have shared this resource with others with plans to expand to other departments.
    **2.** WPC partners across our systems are very responsive in providing data via flat files, system integration or reports. The latter makes the reporting to DHCS efficient since the data is provided on a monthly basis.
B. Briefly describe 1-2 challenges you have faced with data sharing, and lessons learned from those challenges.
    1. Multiple electronic systems among partners. We have found other ways to obtain the information (security chats, specialized access, InBasket feature in electronic health record).
    2. WPC data needs to have individuals uploading the files into secure folders which means that our data is a month behind from some of our partners. WPC Behavioral Health has designated one individual to be the point of contact in their IT division so we are able to communicate any glitches or needs that the Program has in between reports.

### Data Collection

A. Briefly describe 1-2 successes you have had with data collection and/or reporting.
    1. Data collection via SAS report bench is easy. SAS can patient match across three record systems that do not talk to each other and Medi-Cal to make sure the same individual is on all platforms.
B. Briefly describe 1-2 challenges you have faced with data collection and/or reporting.

1. The platforms need to be updated constantly and as such builds need to updated to match the data coming in. There are glitches in the system that need to be resolved by IT which makes the reports delayed. We have a dedicated staff member from the IT department that WPC can reach out to fix any discrepancies in the data.
2. Our partners are very responsive to share data; however, sometimes they forget to let us know that their systems have been updated and as a result our reports are incomplete. Keeping close communication via phone and email with partner is key to having the reports updated in a timely manner in order for the WPC reports to be accurate.

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

Barriers discussed in Riverside County's response to the CalAIM initiative specific to the obstacles to doing pre-eligibility work in the jails. Hoping for a change in policy that will allow for an eligibility determination at admission into jail that can be on suspend for THE DURATION of the incarceration and then can be switched to active status at the end of sentence date.

If the DPSS and Social Security Administration offices continue to have limited in-person availability this will continue delaying valuable services to our clients. These are our two biggest resources that help our clients get access to the care they need. This affects almost all our clients.

Our community partners rely on Whole Person Care to provide valuable care coordination. This has been brought up recently regarding the continuation of the program and future plans.

## VIII. PLAN-DO-STUDY-ACT

*Instructions: 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.*

PDSA Attachments:

1. WPC PDSA Care Coordination via Epic PY5 Q3
2. WPC PDSA Care Coordination via Epic PY5 Q4
3. Ambulatory Care Emergency Department Visits PY5 Q3
4. Ambulatory Care Emergency Department Visits PY5 Q4
5. Avoiding Preventable Hospitalization PY5 Q3
6. Avoiding Preventable Hospitalization PY5 Q4
7. Sharing of Care Plan among WPC Partners PY5 Q3
8. Sharing of Care Plan among WPC Partners PY5 Q4