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

San Bernardino County
Annual Narrative Report, Program Year 4
Revised July 8, 2020

REPORTING CHECKLIST

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 Narrative Report, Program Year #4
March 30, 2020

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.

San Bernardino County's Whole Person Care (WPC) Pilot Program continues to implement the plan, do, study, and act principle. We continue to examine, revise, and build upon the successes, challenges, and lessons learned during the reporting period of July 30, 2019 through December 31, 2019. We added homeless and street medicine services in the fourth quarter of program year four and will build the services through program year five.

To increase/refine integration among County agencies, health plans, and other entities, we continue to reinforce regular communication with our partners (County agencies, health plans, providers, and all other entities) through standard meetings, e-mails, text, and telephone conversations to confirm our clients receive the care coordination and appropriate access to care they need.

We meet on a regular basis for our data governance, operations, steering committee meetings, and meet as needed for our fiscal workgroup. It is in these meetings where we identify and address those clients with inappropriate emergency or inpatient utilization. Once identified, the information is given to the client's WPC team for research, outreach, and resolution. We also communicate with Forward Health (population management platform) on weekly conference calls to discuss data collecting, metric updates, and information sharing.

To achieve our quality and administrative improvement bench marks, San Bernardino's WPC's outreach is structured with 10 mobile teams consisting of a Patient Navigator, RN Care Manager, Social Worker, Alcohol and Drug Counselor, Utilization Technician and an Office Assistant, who meet throughout the month in team meetings, where each team reviews every enrolled client in that team. The Program Manager meets with each team once a month is what we call Whole Person Care Accountability Review (WAR) conferences to once again, review every enrolled client's needs. WAR conferences were established to train and guide teams to identify every client's needs and to

promote constant communication within each team so we as a whole, we can better support our clients in building self-management skills so they can become a part of their health care team and graduate from the program.

The mobile outreach team structure continues to work very well and will continue in program year five. One success story is: client(s) who have chronic health conditions, and admitted substance abuse issues since an early age, enrolled in WPC because they were in and out of ED/hospitalizations and chronic homelessness. They were not compliant with prescribed medication because the client chose alcohol instead of treatment. They expressed desire to “straighten” their life out but had poor to no social support. They also had expressed interest in seeking out mental health services for the relationship issues they had throughout their life. WPC team was able to connect them to MH services, re-establish care w/PCP and support them through the steps in entering detox. To date, they are in the process of reclaiming sobriety through continuing alcohol treatment programs.

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	26	28	19	28	60	16	177

Item	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12	Annual Unduplicated Total
Unduplicated Enrollees	20	33	36	53	[redacted]	[redacted]	163

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*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	$ 29,114.18	$ 20,640.65	$ 21,509.73	$ 45,626.70	$ 53,448.42	$ 9,559.88	$ 179,899.56
Utilization 1	134	95	99	210	246	44	828
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	$ 18,033.41	$ 29,983.26	$ 13,688.01	$ 23,465.16	[redacted]	[redacted]	$ 90,601.59
Utilization 1	83	138	63	108	[redacted]	[redacted]	417
Service 2 $217.97				$19,399.33	$20,053.24	$18,091.51	$57,359.28
Utilization 2				89	92	83	264

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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*

Amount Claimed								
PMPM	Rate	Month 1	Month 2	Month 3	Month 4	Month 5	Month 6	Total
Bundle #1	283.00	$ 149,141.00	$ 142,632.00	$ 144,613.00	$ 146,311.00	$ 150,839.00	$ 146,877.00	$ 880,413.00
MM Counts 1		527	504	511	517	533	519	3,111
Bundle #2	$							
MM Counts 2								

Amount Claimed								
PMPM	Rate	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12	Total
Bundle #1	$283.00	$ 141,500.00	$ 143,481.00	$ 141,217.00	$ 149,424.00	$ 146,877.00	$ 148,292.00	$ 870,791.00
MM Counts 1		500	507	499	528	519	524	3,077
Bundle #2								
MM Counts 2								

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

We started our FFS 2 (Homeless Outreach/Street Medicine) in October 2019

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.

Staci McClane, Associate Hospital Administrator for Ambulatory Services and Population Health Management continues to be the WPC program lead at Arrowhead Regional Medical Center.

We continue to have turnover and new hires. Having a 100% outreach offers employees great freedom to prioritize their day; however, with that great freedom comes great accountability and integrity. We added two homeless navigator positions to complement the WPC outreach teams. The homeless navigators work closely with our partners, and work specifically close with the San Bernardino County Homeless Outreach Progressive Enforcement (H.O.P.E) team to assist in identifying our target population of homeless individuals who are 55 years and older and have a medical condition.

V. 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.

San Bernardino County Whole Person Care practices the PDSA cycle. The identified limitations in the population coordinator section of the platform acknowledged at the mid-year report are resolved. The identified limitations and resolutions were defined in the program year four mid-year report and the program year three annual report.

The mid-year report read: We are now using a new and improved population coordinator platform through MD Revolution, who are based out of San Diego

The program year three annual report read: 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

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.

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, 2019 – December 31, 2019) and the detail of payments are:

Participating Entity	Data Shared	Percentage	Amount Earned
Arrowhead Regional Medical Center (ARMC)	17.2G	70%	$122,500
Inland Empire Health Plan (IEHP)	7.5G	30%	$52,500
Molina	.0G	0%	$0
Department of Behavioral Health (DBH)	.0G	0%	$0

The second incentive of $11,735.40 is intended for the program to maintain WPC client enrollment above 90% of the 500 enrollment cap. The San Bernardino WPC program maintained client enrollment at or above 500 throughout program year four. The total earned was $11,735.40 paid to county partners.

The third incentive of $73,500 is intended for the program maintain the street medicine/homeless outreach services above 90% of the 50 homeless/street medicine client cap for quarter four in program year four. The San Bernardino WPC program maintained a monthly average of 88 clients above the cap in the fourth quarter of program year four, exceeding 100%. Total earned was $73,500 paid to county partners.

VII. 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.

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. Our data shows PY 4 year-end with [redacted] a 124.4% increase from PY3 year-end.

The second pay for outcome is diabetes care. Our data shows PY 4 Year-End with a denominator of 133 and a numerator of 93, giving us [redacted] an improvement of 8.47%.

VIII. 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.

- 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.

  8-8-2019 Minutes Attached

- WPC Fiscal Workgroup

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

- WPC Information Support Workgroup (Data Governance)

  7-2-19 Minutes Attached
  9-5-19 Minutes Attached

- WPC Program Workgroup (Operations). This meeting occurs every other month

  7-25-19 Minutes Attached
  9-25-19 Minutes Attached

IX. PROGRAM ACTIVITIES

Briefly describe 1-2 successes you have had with care coordination.
Homeless Outreach Team came into contact with client(s). They stated they are Veteran and were homeless since 2019. They stated they had a housing voucher but due to memory problems were unsure of the voucher's status. Homeless outreach contacted Housing Authority who verified voucher was still active. Homeless Outreach located them and contacted 211 so that they can complete necessary screening and we contacted the VA for Veterans Services who came to a local park to assist them with services. VA will be assisting them with locating housing and other services that the VASH program offers.

Briefly describe 1-2 challenges you have faced with care coordination, and lessons learned from those challenges.
We continue to do our best to prevent duplication of services within the County, which has proven to be challenging in navigating this issue in care coordination. The lessons learned from the challenges reinforce the importance of communication and follow-up. Communication is the foundation; however, without follow-up and action, communication becomes nothing more than a cliché.

Briefly describe 1-2 successes you have had with data and information sharing.
The data and information sharing process and platform created continues to perform very well. We have been maintaining a consistent monthly data exchange with our partners, which includes ARMC, IEHP, Molina, Public Health, and DBH. This has allowed us to reach out to the San Bernardino County Medi-Cal beneficiaries in a strategic approach. We have been improving a system that scores the combined data from all the sources and identifies at-risk high utilizers. The potential clients list have yielded better results after each adjustment is applied. The feedback from team members has been crucial to these refinements and has made our process more efficient.

Briefly describe 1-2 challenges you have faced with data sharing, and lessons learned from those challenges.
It has been a challenge to maintain monthly participation with some partners due to staff turnover and changes in policy in their different departments. We have learned from these challenges that it is crucial to communicate regularly with our partners in addition

to the Operations Meetings. Having key contacts that we keep informed of our data exchange status has also been helpful.

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

The collection we have accomplished so far has allowed for us to begin building historical and comprehensive statistical data. We are now able to examine client demographics that will contribute to important decision making. The data collected in our platform includes encounter details that assist the specialties in determining which clients need their assistance. These workflow enhancements are contributing to more efficient use of time and opens the doors for enrollment capacity.

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

Our staff is constantly in the field and requires a mobile method of data collection. Hard copies are still required for enrollment agreements, but we are progressively moving towards making data collection electronic. We have provided staff with iPads making their access to our platform mobile. We have been converting forms to electronic formats and the data entry follows a practical style appropriate for mobile devices.

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

Looking ahead, we foresee the possible delay of CalAIM as the biggest barrier for the WPC Program overall. In the event CalAIM is postponed, the San Bernardino County Whole Person Care will need to obtain alternative funding to continue the program until such time CalAIM is implemented. If CalAIM is postponed and alternative funding is not obtained, the program may be suspended, which would have a severely negative impact on the physical, mental, and spiritual wellbeing of our enrolled clients.

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. Administrative care coordination case management PY4-4
2. Administrative comprehensive care plan PY4-4
3. Health outcome ED visits PY4-4
4. Health outcomes impatient utilization PY4-4