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 5
April 1, 2021

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.

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 continued to implement and practice the plan, do, study, and act (PDSA) principle in 2020; however, as we are ending program year five (PY 5), we find less PDSAs needed. We made great advancements through the program years, and have a well running operation. As with every California County dealing with COVID-19, we were limited in our outreach and face-to-face interactions with our clients, but we made modifications and serviced our clients and continued to graduate and enroll clients. We examine, revise, and build upon the successes, challenges, and lessons learned during the reporting period of July 1, 2020 through December 31, 2020. Our newly added services of homeless outreach and street medicine were stopped due to COVID-19. We are hopeful we can resume the homeless outreach and street medicine in the near future, possibly with CalAIM.

Due to COVID-19, we found it challenging as we increase/refine integration among County agencies, health plans, and other entities. All past regular communication done in person with our partners (County agencies, health plans, providers, and all other entities) are now conducted solely through telephone conferences, e-mails, and text to verify clients receive the care coordination and appropriate access to care they need. In addition, the building where WPC is physically located, implemented a mandatory telecommuting decree in mid-December due to positive CODIV-19 test rates.

We meet on an as needed basis for our data governance, operations, steering committee meetings, and 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 two to three times a month in team meetings. Each team reviews those clients who require additional attention. Team meetings are designed to guide team members to identify those clients who require constant communication and support to attain their goals in building self-management skills so they can become a part of their health care team and graduate from the program.

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	24	37	*	*	17	104	190

Item	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12	Annual Unduplicated Total
Unduplicated Enrollees	39	34	19	15	*	*	125

Whole Person Care

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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	26,941	23,465	11,515	1,955	16,947	57,577	138,400
Utilization 1	124	108	53	9	78	265	637
Service 2 $217.97	5,214	9,777	7,604				22,669
Utilization 2	24	45	35	0	0	0	104

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	43,671	40,412	40,195	19,337	17,816	27,159	188,590
Utilization 1	201	186	185	89	82	125	868
Service 2							
Utilization 2	0	0	0	0	0	0	0

*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	$282.78	146,480	147,611	145,066	142,521	139,693	137,714	859,794
MM Counts 1		518	522	513	504	494	487	3,038
Bundle #2	$							
MM Counts 2								

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	$282.78	147,894	153,550	151,005	145,914	143,935	138,562	881,545
MM Counts 1		523	543	534	516	509	490	3,115
Bundle #2	$							
MM Counts 2								

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

[Remove brackets and input response here, size 12 Arial font only]

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 is the WPC program lead at Arrowhead Regional Medical Center and Ernest Barrio is the WPC Program Manager.

As we continue to serve our clients through the COVID-19 restrictions, we find ourselves relying on virtual meetings, telephone, text, and e-mail communications with our clients. We added two homeless navigator positions to complement the WPC outreach teams; however, due to COVID-19 restrictions, the homeless outreach was put on hold. We hope to resume the services in PY6.

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.

San Bernardino County Whole Person Care continues to practice the PDSA cycle with our partners and meet when needed with our managed care partners Inland Empire Health Plan (IEHP) and Molina Healthcare via Zoom meetings, telephone calls, and communicate regularly through e-mails. The partnerships and collaboration with our managed care associates have positive results with WPC clients because everyone is working in harmony with WPC clients and there is no duplication of services; in addition, WPC clients have one source of information/interaction which reduces confusion and ultimately provides better services for our clients.

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

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.

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 total earned was $175,000 paid to county partners:

The following data was shared (July 1, 2020 – December 31, 2020) and the detail of payments are:

Participating Entity	Data Shared	Percentage	Amount Earned
Arrowhead Regional Medical Center (ARMC)	19.6 GB	65%	$113,750
Inland Empire Health Plan (IEHP)	10.1 GB	34%	$59,500
Molina	00.0 GB	0%	$0.00
Department of Behavioral Health (DBH)	.19 GB	1%	$1,750

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 an average client enrollment at or above 500 throughout program year five.

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. Due to COVID-19, the San Bernardino WPC program stopped the street medicine/homeless outreach services. Total earned was $0.00.

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.

The San Bernardino County Whole Person Care Pilot program elects to use the COVID-19 Alternative Payment method for Pay for Outcome payments in Program Year 5. San Bernardino achieved 100% of our Pay for Outcomes in Program Year 4. San Bernardino will receive 100% payment in Program year 5, in the total amount of $700,000 ($350,000 at mid-year and $350,000 at annual).

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 is 75% of WPC clients will have a PCP visit within 60 days of enrollment. This is a new measure for 2021 and due to COVID-19, it was extremely challenging because the majority of PCP clinics did not see patients in person or would not schedule appointments. Many PCP appointments were done via telemedicine, which again, was difficult because many of our enrolled clients do not have the tools necessary to complete a telemedicine appointment. With these challenges and limitations, we were able to attain 81.22%.

The second pay for outcome is diabetes care. Our data shows PY 5 Year-End with a rate of 54.43%.

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.

When San Bernardino County Whole Person Care Pilot program started, it was designed so that before program year five, the program would be running efficiently, thus, the need to have committees and workgroups meet regularly would not be necessary. It was framed to continue open communication when needed.

- 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.
  Due to COVID-19 no official meeting during this reporting period, only conference calls as needed.

- WPC Fiscal Workgroup
  Due to COVID-19, no official meeting during this reporting period.
  Conference calls as necessary.

- WPC Information Support Workgroup (Data Governance)
  Due to COVID-19, no official meeting during this reporting period.
  Conference calls as necessary.

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

  Due to COVID-19, no official meeting during this reporting period.
  Conference calls as necessary.

VIII. PROGRAM ACTIVITIES

Care Coordination

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

1. A client who was very difficult in accepting help, knowing that she needed the help in order to be mentally and physically stable, was struggling. Client was aware of what she was going through at that time; however, client was not ready to accept help. Social Worker and Patient Navigator from Whole Person Care, worked together in order to help client with services she needed. Both specialties went to visit client multiple of times in order to get her connected with services. However, every time both specialties went out to help client, client would always say something is going on that is interfering with her being able to receive the help. Client was in an abusive relationship which caused a lot of trauma. It took a while for client to admit she needed help. Patient Navigator explained the services social worker offers and the benefits of those services. Client had a negative stigma of being connected to behavioral health services because she believed these services were only for the “crazy people” as stated by client. After working with the Social Worker, the client agreed to be connected to a psychiatrist and a therapist in order to get the help she needed with her anxiety, PTSD and depression. After a few months, the Patient Navigator and Social Worker noticed a difference in client’s behavioral health. Client does not shake while she is talking and her speech has improved, which was caused by her anxiety. Team noticed that client was healthier and happier after receiving services from Whole Person Care. Client also had high blood pressure, now client’s blood pressure is now under control.

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

1. It was very difficult scheduling appointments for our clients due to all the restrictions caused by CODID-19. We learned patients did not always have the ability to have a telemedicine “visit” and preferred in-person appointments.

Data Sharing

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

We have implemented a feature in our patient platform that notifies our specialties of clients that are outside our metrics, such as High Blood Pressure and Diabetes. This provides our staff with a list of clients they can focus on resulting in improved quality of life for them. We have also benefited from the local Health Information Exchange. Our staff is able to monitor our clients' health services activities that include visits to the Emergency Room. Many of our clients move around a lot so it is helpful to have a system that allows us to locate them and assist them at critical moments.

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

The biggest challenge we have faced to date is COVD-19. The interruptions it has caused in the lines of communication has been a difficult challenge to overcome. Some of our key contacts with our data sharing partners are unavailable and changes in staffing have caused delays in our data exchange. However, we have continued to press forward with our tasks at-hand. We have learned that even well-outlined agreements with our partners can benefit from clauses addressing interruptions of service like the one we are experiencing. At the moment, we are maintaining active communication and keeping detailed records so we can resume at full pace when operations normalize.

Data Collection

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

With the assistance of our vendor we have streamlined the process of maintaining a real-time count of our enrollments and disenrollments. This has been an essential aspect for our enrollment performance during the pandemic. Our Patient Navigators get instant feedback on their efforts and have access to reports for their team meetings. All other staff likewise have access to performance reports that we pull from Tableau.

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

Our vendor developed a dashboard that we requested and this has been a trial and error effort. The various scopes required in our reporting require plenty of reviewing, troubleshooting, and data flow adjustments. The issues we have had are not with receiving the data but reporting it correctly. Fortunately, our vendor is good about focusing on issues we detect and taking corrective measures immediately. The review process between the Program Manager and Business Systems Analyst has proven effective with our reports submissions in regards to accuracy and meeting the deadlines.

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

Looking forward, we foresee the following as the biggest barriers to the success of the San Bernardino County WPC program:

- Employee attrition due to the uncertainty of CalAIM
- Continued COVID-19 restrictions in 2021
- Telecommuting - our program's foundation is 100% face-to-face outreach, which has quantifiable and confirmed outcomes; which cannot be attained through virtual methods.

IX. 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.