AMENDMENT VII
WHOLE PERSON CARE PILOT
APPLICATION
November 22, 2016

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Whole Person Care Pilot Application

Section 1: WPC Lead Entity and Participating Entity Information

1.1 Whole Person Care Pilot Lead Entity and Contact

San Bernardino County Designated Public Hospital, Arrowhead Regional Medical Center (ARMC) is serving as the lead agency for this application. Ron Boatman, Associate Hospital Administrator – Business Development and Strategic Planning, will serve as the single point of contact for DHCS and is responsible for coordinating and monitoring the WPC Pilot.

Organization Name	Arrowhead Regional Medical Center
Type of Entity	San Bernardino County Designated Public Hospital
Contact Person	Ron Boatman
Contact Person Title	Associate Hospital Administrator
Telephone	(909) 580-2655
Email Address	Boatmanr@armc.sbcounty.gov
Mailing Address	400 North Pepper Avenue Colton, CA 92324

1.2 Participating Entities

The San Bernardino County Whole Person Care Pilot (WPC) focuses on integrating public and private health and social need providers to address the individual needs of County residents who are either high-utilizers, or at risk of becoming high utilizers of health services.

Arrowhead Regional Medical Center (ARMC), the County's designated public hospital, will serve as the lead entity for the Whole Person Care Pilot. ARMC is a 456-bed acute care, level II trauma center. The hospital system includes four primary care clinics, emergency services, a burn center, 90-bed inpatient behavioral health center, outpatient pharmacy, ancillary services, and over 41 subspecialty clinics. ARMC's role as the lead-entity is to establish and provide oversight for the Whole Person Care Pilot team. Components of this role include:

1. Serve as the facilitator for the Whole Person Care Steering Committee

2. Establish and maintain data systems to facilitate bi-directional data sharing
3. Develop Pilot infrastructure, and manage staffing
4. Establish affiliations with necessary participating entities

Required Organizations: **1.** Medi-Cal Managed Care Plan (1)

Organization Name: Inland Empire Health Plan

Contact Name and Title: Bev Ching, Strategic Project Manager

Entity Description and WPC Role: Inland Empire Health Plan (IEHP) is a Medi-Cal Managed Care Plan serving San Bernardino County. Many of their members will comprise the target population of the pilot. IEHP serves as a participants of the WPC steering committee, will assist with best demonstrated practices for outreach and coordination, and will provide participants utilization data to include:

a) Inpatient
b) Emergency
c) Specialty
d) Pharmacy
e) Diagnosis codes
f) Mild to moderate behavioral health

In addition, IEHP shall have access to the Population Health Management system allowing for bi-directional data sharing.

Required Organizations: 2**.** Medi-Cal Managed Care Plan (2)

Organization Name: Molina Healthcare

Contact Name and Title: Maria Lugo, AVP, Market Lead

Entity Description and WPC Role: Molina Healthcare is a Medi-Cal Managed Care Plan serving San Bernardino County. Molina members will comprise a part of the target population of the pilot. Molina serves as a participants of the WPC steering committee, will assist with best

demonstrated practices for outreach and coordination, and will provide participants utilization data to include:

g) Inpatient

h) Emergency

i) Specialty

j) Pharmacy

k) Diagnosis codes

l) Mild to moderate behavioral health

In addition, Molina shall have access to the Population Health Management system allowing for bi-directional data sharing.

Required Organizations: 3. Health Services Agency

Organization Name: Arrowhead Regional Medical Center

Contact Name and Title: Ron Boatman, Associate Hospital Administrator, Pilot Lead

Entity Description and WPC Role: Arrowhead Regional Medical Center (ARMC) is a designated public hospital. The ARMC system includes primary medicine, specialty care, emergency and inpatient medical services, emergency and inpatient mental health services, ancillary support services, and specialty health care. Primary clinics will serve as medical homes for a portion of the target population, and the hospital will provide specialty and inpatient services as appropriate.

As the lead entity, ARMC will serve on the executive steering committee, facilitate the WPC steering committee, Establish and maintain bi-directional data systems for bi-directional data sharing, develop the pilot infrastructure, manage staffing, manage affiliations with participating entities. ARMC will also share, and receive, all health related data for target population participants.

Required Organizations: 4. Specialty Mental Health Agency

Organization Name: San Bernardino County Department of Behavioral Health

Contact Name and Title: Veronica Kelly, Director

Entity Description and WPC Role: The Department of Behavioral Health (DBH) will serve as the specialty mental health agency for the pilot. Services include crisis intervention, assessment/referral, individual/group therapy, medication support, case management, drug/alcohol, and psycho-educational workshops. The DBH data analytics team manages data compilation and review to score the target population. DBH also serves on the executive steering committee, participate on the WPC steering committee, and share all bi-directional mental health related data for target population participants.

Required Organizations: 5. Public Agency/Department

Organization Name: San Bernardino County Human Services Department

Contact Name and Title: CaSonya Thomas, Assistant Executive Officer

Entity Description and WPC Role: The County Department of Human Services includes multiple participating departments; Public Health, Transitional Assistance, and Aging and Adult Services. The Public Health department operates four (4) Federally Qualified Health Centers, and four (4) community clinics who will serve as medical homes to participants of the target population. The Transitional Assistance department administers eligibility to public assistance programs. Participants will receive support through this department for qualified programs such as CalFresh and General Relief. Aging and Adult Services manages adult day care centers; elderly participants of the target population may receive services through this venue. The Director of Human Services and Public Health will serve on the executive steering committee, and staff from each Human Service department will serve on the WPC steering committee. All departments will share bi-directional health and eligibility data for target population participants.

Required Organizations: 6. Community Partner (1)

Organization Name: Community Clinic Association of San Bernardino County

Contact Name and Title: Deanna Stover, Ph.D., R.N., CEO

Entity Description and WPC Role: The Community Clinic Association of San Bernardino County (CCA of SBC) members include 17 community clinics and FQHC's serving underserved populations throughout San Bernardino County. Many of these clinics will serve as medical home to participants of the target population. They will provide primary care services, and share bi-directional health data for target population participants. They also have representation on the WPC steering committee.

Required Organizations: 7. Community Partner (2)

Organization Name: Inland Behavioral and Health Services Inc.

Contact Name and Title: Dr. Temetry A. Lindsey, CEO/President

Entity Description and WPC Role: Inland Behavioral and Health Services (IBHS) is a Federally Qualified Health Center located in the City of San Bernardino. IBHS will serve as a medical home to participants of the target population. They will serve on the WPC steering committee, and share bi-directional health data for target population participants.

Optional Organizations: 8. Community Partner (3)

Organization Name: Inland Temporary Homes

Contact Name and Title: Jeff Little, CEO

Entity Description and WPC Role: Inland Temporary Homes (ITS) will serve as a housing services resource available to assist housing needs of target population participants. WPC patient navigators will coordinate appointments for participants who qualify for ITS's support services. All services provided shall be funded through their existing funding streams.

Optional Organizations: 9. Community Partner (4)

Organization Name: S2

Contact Name and Title: Burt Clark, Executive Director

Entity Description and WPC Role: S2 will serve as a housing services resource available to assist housing needs of target population participants. WPC patient navigators will coordinate

appointments for participants who qualify for S2's support services. All services provided shall be funded through their exiting funding streams.

***Optional Organizations: 10*.** Community Partner (5)

Organization Name: San Bernardino County Sheriff's Office

Contact Name and Title: Terry Fillman, Health Services Manager

Entity Description and WPC Role: The County Sheriff's Office manages the health system in the San Bernardino County jail system. Target population participants may transition in and out of the correctional health system. In addition to health services provided to confined participants, the Sheriff's department shall have representation on the WPC steering committee, and share bi-directional health and incarceration information for target population participants.

***Optional Organizations: 11*.** Community Partner (6)

Organization Name: San Bernardino County Information Services Department

Contact Name and Title: Tyrone Smith, Department Technology Chief

Entity Description and WPC Role: The San Bernardino County Information Services Department (ISD) provides platform, infrastructure, and support through the countywide ISD system. They manage information systems, user licensure, and outlook accounts. They will serve as a member of the WPC steering committee, provide IS support during the acquisition and implementation of bi-directional data sharing systems, and continued support for user access and bi-directional data sharing.

1.3 Letters of Participation and Support

The WPC pilot is a county-wide effort, bringing together the major service providers that can affect health outcomes and service utilization by positively impacting the social determinants of health, health disparities, and access to needed services. Letters of Participation are provided by all required and optional entities listed in Section 1.2. Letters of Support are also provided for this needed pilot by influential community physician groups who currently are devoted to providing services to the underserved and are committed to achieving better outcomes for the

target population through the WPC pilot. These provider groups are listed below and are dispersed among the county's geographic areas:

1. Inland Empire Health Plan (IEHP), Bradley P. Gilbert, MD, Chief Executive Officer
2. Molina Health Plan (MHP), Maria Lugo, Assistant Vice President, Market Lead
3. Arrowhead Regional Medical Center (ARMC), William L. Gilbert, Hospital Director
4. San Bernardino Behavioral Health (DBH), CaSonya Thomas, Director
5. San Bernardino Human Services (HHS), Linda Haugan, Assistant Executive Officer
    a. Department of Aging and Adult Services (DAAS)
    b. Department of Behavioral Health (DBH)
    c. Department of Child Support Services (DCSS)
    d. Children and Family Services (CFS)
    e. Preschool Services Department (PSD)
    f. Department of Public Health (DPH)
    g. Transitional Assistance Department (TAD)
    h. Veterans Affairs (VA)
    i. Management Services
6. Community Clinic Association of San Bernardino County (CCAofSB), Deanna Stover, Ph.D.,RN, Chief Executive Officer
    a. Al-Shifa Clinic
    b. Arrowhead Regional Medical Center
    c. Central City Community Health Center
    d. Community Health Systems, Inc.
    e. San Bernardino County Department of Public Health
    f. Hi-Desert Family Health Clinics
    g. Lestonnac Free Clinic
    h. Mission City Community Network, Inc.

i. Montclair Medical Clinic

j. Mountains Community Hospital

k. Planned Parenthood of Orange and San Bernardino Counties

l. Pomona Community Health Center

m. Redlands Community Hospital

n. SAC Health System

o. Tri-State Community Health

p. Unicare Community Health Centers, Inc.

q. Well of Healing Mobile Medical Clinic

r. Kaiser Permanente

s. Lutheran Social Services of Southern California

t. Mental Health Systems, Inc.

u. Molina Healthcare of California

7. Inland Behavioral and Health Services, Inc.(IBHS), Dr. Temetry A. Lindsey, Chief Executive Officer/President
8. Inland Temporary Homes (ITH), Jeff Little, Chief Executive Officer
9. S2, Burt Clark, Executive Director
10. San Bernardino County Sheriff's Department (SBSD), CeCe Spurlock, RN, BSN, CCHP, Staff Development Coordinator, Health Services Division
11. San Bernardino County Information Services Department (ISD), Jennifer Hilber, Chief Information Officer
12. San Bernardino Public Health (DPH), Corwin Porter, Assistant Director

Ron Boatman, Associate Hospital Administrator Arrowhead Regional Medical Center (ARMC), (909) 580-2655, BoatmanR@armc.sbcounty.gov may be contacted for access to the letters.

Section 2: General Information and Target Population

2.1 Geographic Area, Community and Target Population Needs

San Bernardino County is the largest county in the contiguous United States covering over 20,000 square miles of land. It is located in southeastern California, with Inyo and Tulare Counties to the north, Kern and Los Angeles Counties to the west, and Orange and Riverside Counties to the south. It is bordered on the east by Nevada and Arizona. San Bernardino County is mostly undeveloped with more than three-quarters being vacant land. It is home to the fifth largest population in California, and is the twelfth most populous county in the nation. Within San Bernardino County, the Valley Region is the most densely populated area, and contains the majority of the entities included in this pilot. However, many of the participants serve members located in the lesser populated Mountain and Desert Regions.

The County will create a best-practice model with new teams to establish complex case coordination for the most vulnerable population at-risk for frequent, emergency medical and behavioral services. To identify this population, data was gathered from Public Health, Behavioral Health, and Arrowhead Regional Medical Center, for a one-year period. The data was combined to form one dataset. The dataset was analyzed and scored based on utilization of emergency visits, inpatient hospital days, and urgent care visits. The highest ranking Medi-Cal beneficiaries in this dataset were deemed the target population. This process will repeat each twelve months to refresh the waitlist. The pilot model will be field-based, driven by engagement, and create consultative linkages to existing resources. The team will work one-to-one with individuals who over-utilize emergent, or inappropriate services to establish relationships and create paths to improved outcomes. Through the use of relationship coaching, performance improvement tools and lessons, the WPC team will work with all stakeholders to improve existing workflows, enhance education, and advance the appropriate interactions between the target population and available resources. The WPC team will not replace any existing resources. The pilot will establish an outcome-based healthcare approach and increase

collaboration between providers and community-based organizations. It will enhance multiple agencies and educate the population to allow them to understand and better utilize existing resources appropriately.

San Bernardino County provides many services to its growing population. These services are diverse in nature and spread out across the county. The goal of the San Bernardino County WPC pilot is to develop effective processes and pathways for this population to successfully and effectively find the care and services they need to prosper and achieve well-being. The WPC pilot is designed to improve the outcomes of the identified high-risk individuals and educate them in becoming more engaged in the care needs. All County departments and community partners will work to build and strengthen existing systems of care and services. This pilot will provide learning for potential future efforts and improve collaboration by building infrastructure to improve communications across the delivery systems beyond the term of the pilot. A successful WPC pilot will demonstrate that a relationship-based case coordination system, with partners working together to develop interventions for better outcomes, is an ideal solution.

The WPC pilot will reduce avoidable utilization of related system components by addressing the systemic problem of patients being unable to effectively access and navigate through various health systems. The pilot outcomes will provide potential changes in standard practice across participating health systems to better facilitate the most appropriate, effective care for this population.

2.2 Communication Plan

San Bernardino County's Whole Person Care (WPC) pilot will convene required regularly scheduled monthly meetings of all participating entities to manage the operational integrity, problem-solving, communication/idea sharing, decision-making, participation in Plan-Do-Study-Act (PDSA) and evaluation activities, and progress towards milestone achievements. Communication among the participating entities and

WPC will occur through these monthly collaborative meetings, along with collaborative-wide informational and quality improvement emails; site visits; PDSA activities; monthly data reports about utilization, cost and metric progress; integrated care plan development; and the expansion of technologies and platforms.

As an entity of San Bernardino County, the WPC pilot will be governed by the San Bernardino County Board of Supervisors, which has established an Integrated Multi-Disciplinary Executive Steering Committee to oversee and provide guidance to the Case module. The WPC Steering Committee, with ARMC as the Lead Entity/Pilot Care Coordinator will convene regularly scheduled required monthly meetings for all participating entities. The committee will track and approve the work of all workgroups. All policies and procedures will be approved by the Executive Steering Committee, which will meet at least quarterly. All WPC administrative functions will be headed by the WPC Program Director.

San Bernardino County's WPC pilot has representative staff from all major entities embedded within the Care model, with all other partners providing contacts and personnel as needed. The WPC Program Director will conduct required monthly meetings and provide required quarterly trainings for all participating entities in order to build cross agency coordination, educate staff on bi-directional data and information sharing policies and procedures, and support bi-directional data collection, reporting, and PDSA activities. These training opportunities will also be important resources for gaining staff input and understanding how the pilot is working and address quality improvement activities that address key challenges or areas for improvement.

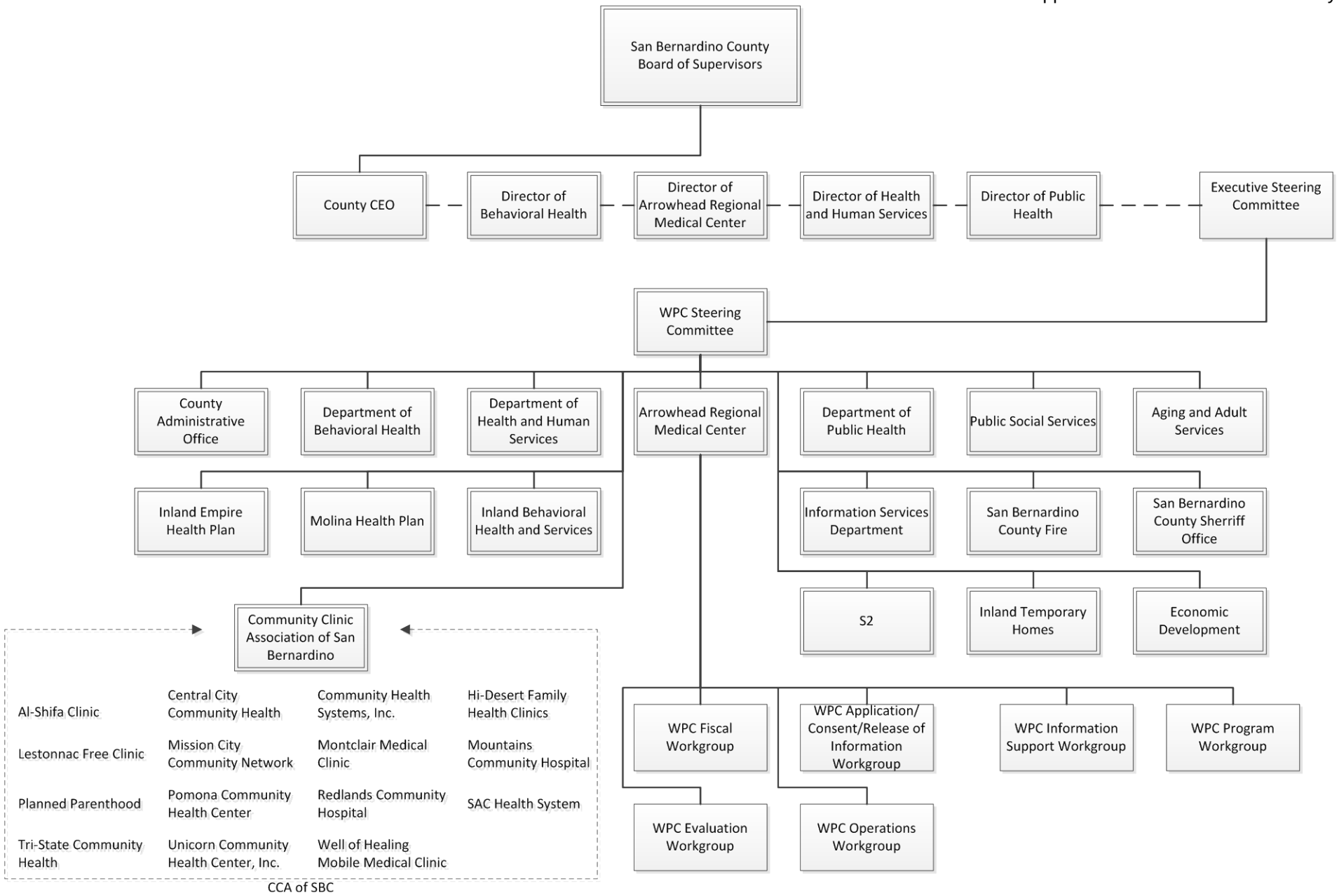
The WPC Steering Committee has established additional sub-committees to develop, support, and monitor specific policies and procedures addressing each workgroups specific expertise. These workgroups allow members of all entities to provide input and suggestions to develop and improve processes and procedures. Each committee is explained below:

Executive Steering Committee

The executive steering committee consists of executive county leadership. This group will meet to discuss high level decisions that require Board approval. Decisions include submission of the application; funding availability; authority to accept the award; and authority to make payments to downstream participating entities.

WPC Steering Committee

The WPC steering committee consists of representation from all participating entities. This is the level that will develop the structure of the program, hire the staff, operationalize the teams, and maintain general oversight of pilot performance. This committee will also assign members to workgroups to oversee specific components of the pilot.


San Bernardino County Board of Supervisors
County CEO
Director of Behavioral Health
Director of Arrowhead Regional Medical Center
Director of Health and Human Services
Director of Public Health
Executive Steering Committee
WPC Steering Committee
County Administrative Office
Department of Behavioral Health
Department of Health and Human Services
Arrowhead Regional Medical Center
Department of Public Health
Public Social Services
Aging and Adult Services
Inland Empire Health Plan
Molina Health Plan
Inland Behavioral Health and Services
Information Services Department
San Bernardino County Fire
San Bernardino County Sherriff Office
S2
Inland Temporary Homes
Economic Development
Community Clinic Association of San Bernardino
Al-Shifa Clinic
Central City Community Health
Community Health Systems, Inc.
Hi-Desert Family Health Clinics
Lestonnac Free Clinic
Mission City Community Network
Montclair Medical Clinic
Mountains Community Hospital
Planned Parenthood
Pomona Community Health Center
Redlands Community Hospital
SAC Health System
Tri-State Community Health
Unicorn Community Health Center, Inc.
Well of Healing Mobile Medical Clinic
CCA of SBC
WPC Fiscal Workgroup
WPC Application/ Consent/Release of Information Workgroup
WPC Information Support Workgroup
WPC Program Workgroup
WPC Evaluation Workgroup
WPC Operations Workgroup

WPC Fiscal Workgroup

The fiscal workgroup is chaired by a Deputy Executive Officer with the county administrative office. This group will manage all fiscal aspects of the program including: budget management; IGT preparation; fund distribution; and downstream performance payments.

WPC/Application/Consent/Release of Information Workgroup

This workgroup is responsible for development of enrollment forms to include informed consent allowing bi-directional data sharing among all participating entities. This group is chaired by the lead entity and consists privacy officers from each participating department. Counsel shall review and approve consents developed from this group prior to implementation.

WPC Information Support Workgroup

This workgroup is responsible for managing all information technology decisions related to the pilot. The group consists of IT leaders from various participating entities. Operation of systems and servers used for the pilot may reside in various departments, or with third party vendors, but managerial oversight of their use and access shall reside in this workgroup.

WPC Program Workgroup

The program workgroup is responsible for developing the operations of the program. This group is chaired by the lead entity, with membership from a variety of steering committee members. The group will oversee the operational development, and continued guidance of the pilot. The group is responsible for the recruitment of the program manager who will oversee day-to-day operations.

WPC Evaluation Workgroup

The evaluation workgroup is responsible for oversight of data compilation, preparation of required reports, entity performance tracking, pilot reporting, and identifying areas requiring corrective action. This group is chaired by the Program Manager, and includes various steering members and the Business System Analyst.

2.3 Target Population(s)

The eligible WPC population consists of over 19,000 high-utilizing patients who accessed care from the County during fiscal year 2016. As outlined below, the list was scored based on utilization and a list comprised ranging from highest utilizers, to lowest. WPC activities will focus on a group of no more than 500 Medi-Cal beneficiaries at a time who are the highest users of multiple urgent, emergent, and hospital service systems. Once the enrollment cap of 500 enrollees is reached, enrollment shall remain at 500 at all times during the year. As participants leave the pilot, the next highest scoring individual on the list is contacted to enroll in their place. There will be no less than 500 participants at any given time after Pilot Year 2, with a minimum 2,000 participants being serviced throughout the pilot. This enrollment cap has been identified by the San Bernardino County Integrated Multi-Disciplinary Executive Steering Committee in order to ensure appropriate staff to patient ratios for effective intensive case coordination and testing of these strategies, which are expected to be intricate and time-consuming. All participants of the target population will be Medi-Cal eligible. It is expected that although some beneficiaries will require long-term assistance, the majority of beneficiaries will only remain in the pilot for approximately 12 months. Their ability to manage their own care will be monitored by the Patient Activation Measure, and it is expected that participants will be discharged as they maintain a Level 3 on their PAM scoring.

As beneficiaries discharge from the WPC pilot, the next qualified beneficiary from the waitlist will be contacted for outreach services. Therefore, it is believed the cap of 500 enrollees will roll over at least once each year, and at a minimum there will be a total of 2,000 unique participants enrolled by the end of the fifth year. Once reached, enrollment shall remain at 500 at all times during the year. As participants leave the pilot, the next highest scoring individual on the list is contacted to enroll in their place. Exact beneficiaries will be identified via a quantitative stratification based on a scoring methodology focusing on complex chronic health conditions,

and housing status. Stratification of the population requires a scoring methodology that appropriately weights interactions according to severity, frequency, and duration. Once the WPC profile of highest utilizers is established, other indicators, like cost and social determinants, will be overlaid on the data set to further stratify the high-utilizer population. WPC will use scoring and stratification methodology to develop a predictive analytics model unique to our County to better identify individuals before they become high-utilizers, particularly in settings like correctional facilities and public health. Preliminary scoring methodology, based on a system developed by the Santa Clara Valley Health and Hospital System, has been applied to data sets representing beneficiaries served by all entities.

Procedure	Point Value Given
Hospital medical inpatient	1 point per day
ED encounter	3 points per encounter/admission/event
Psychiatric/SUD inpatient admission	3 points per admission
Psychiatric/SUD acute care	1 point per day
Urgent/express/crisis care	1 point per event
Public health utilization	0.5 point per encounter
Flagged as Chronically Homeless (overrides either below)	300 points
Most recent prior residence homeless	200 points
Most recent prior residence temporary (receiving services, so at risk of homelessness)	150 points
Most recent prior residence permanent (receiving services, so at risk of homelessness)	100 points

Data will continue to be analyzed and refined. This scoring methodology may be adjusted to ensure the correct stratification of the target population.

This population has difficulty traveling to and dealing with wait times for appointments; may not be able to complete multi-step processes and multiple assessments without support; has difficulty remembering instructions for managing their own health, organizing their care or

needs, and identifying their needs. Additionally, this population may not have adequate support from their families or support systems. Negative past histories with health care, a sense of hopelessness, isolation, and a feeling of disenfranchisement coupled with the difficulty in coordinating services is experienced by patients and family members. This population's acuity of both physical and mental illness requires an adaptive, field-based, responsive outreach and case coordination model that is relationship-centric in which care emphasizes engagement in non-traditional settings through established in-person relationships with the patient, family members or support systems. The WPC team is an active supporter and coordinator of care for this population as opposed to a traditional clinical interaction as a "clinical expert."

Preliminary testing of this methodology has provided effective stratification of beneficiaries served across County Departments. The County will continue to refine the methodology in order to appropriately weight various utilization and conditions. The remaining population will be placed on a waitlist in order of their scoring and contacted for enrollment as openings become available. The waitlist will be reviewed and refreshed at least annually. The goal of WPC is to work with all entities to find the best processes and procedures to achieve the best outcomes for the participants. The WPC team will consistently use the Plan-Do-Study-Act (PDSA) cycle to identify and refine the best processes and determine procedures for obtaining desired outcomes.

Section 3: Services, Interventions, Care Coordination, and Data Sharing

3.1 Services, Interventions, and Care Coordination

San Bernardino County will design and structure services in keeping with the overarching goal of the WPC initiative to: "coordinate health, behavioral health and social services, as applicable, in a patient-centered manner with the goals of improved beneficiary health and well-being through more efficient and effective use of resources." This pilot is designed to "integrate care

for a particularly vulnerable group of Medi-Cal beneficiaries who have been identified as high users of multiple systems and continue to have poor health outcomes." To this aim, San Bernardino County will structure and design services that will provide a full-service case coordination team who will actively make physical contact at their place of choice to provide activities to reflect a model of intervention that allows for field-based outreach based on the following principles and strategies outlined in the legislation:

1. Increase integration among county agencies, health plans, and providers, and other entities within the participating county through bi-directional data sharing with outreach and care coordination of high-risk, high-utilizing beneficiaries;
2. Develop an infrastructure that will ensure local collaboration through bi-directional data sharing and coordinated services among the entities participating in the WPC pilots over the long term;
3. Increase coordination and appropriate access to care for the most vulnerable Medi-Cal beneficiaries through a field-based care coordination team who will remove systemic barriers and go where the participants actually are to encourage and educate;
4. Reduce inappropriate emergency and inpatient utilization through case coordination and education of participants and family/support teams;
5. Improve bi-directional data collection and sharing amongst local entities to support ongoing case management, monitoring, and strategic program improvements in a sustainable fashion;
6. Achieve targeted quality and administrative improvement benchmarks through quarterly required trainings with participating entities;
7. Increase access to housing and supportive services through field-based outreach and case coordination; and
8. Improve health outcomes through field-based case coordination for the WPC population.

The WPC pilot will be a concierge style, clinical navigation program that will provide coordination and navigation services to the target population and create intentional system change management through coordinated care transitions between the WPC team, County, and community based organizations. The pilot will be run by field-based WPC outreach teams and involve a combination of services: telephone case coordination with participating providers, in-person field-based case coordination and relationship building with participants, and educational visits with participants and their support teams at the location of their choice. The WPC team will use team vehicles to approach participants at any location they can be found and are comfortable with meeting and discussing their needs. The activities in the field will be based on the degree of intervention required to assist patients. The WPC Team, staffed by 3 Registered Nurses (1 to 167 participants), 1 Clinical Therapist (1 to 500 participants), 4 Social Workers (1 to 125 participants), 3 Utilization Review Technicians (1 to 167 participants), 2 Alcohol and Drug Counselors (1 to 250 participants) and 12 Patient Navigators (1 to 42 participants) will manage the case load (provide assessment, case coordination, and care management) and be available and actively deployed to assist and educate the participants and participating entities as case needs arise. The pilot will be designed to address systemic barriers to access that have previously failed chronically-ill patients to ensure that with WPC coordination efforts, WPC teams will provide assistance and education to enable the participants and participating entities to work through gaps and overcome case coordination challenges, such as difficulty traveling to and dealing with wait times for appointments; inability to complete multi-step processes and multiple assessments without support; difficulty remembering instructions for managing their own health, organizing their care or needs, and identifying their needs. This population may not have adequate support from their families or support systems. Negative past histories with health care, a sense of hopelessness, isolation, and a feeling of disenfranchisement coupled with the difficulty in coordinating services is experienced by patients and family members. This population's acuity of both physical and mental illness requires an adaptive, field-based,

responsive outreach and case coordination model that is relationship-centric in which care emphasizes engagement in non-traditional settings through established in-person relationships with the patient, family members or support systems at the location of their choosing.

Each individual in the pilot population will be assigned to a Patient Navigator, who will actively contact them at their location to discuss their participation in the WPC pilot. The Navigator will work with the beneficiary to establish a relationship that will encourage and teach them and their support team to better navigate through the established systems. The Patient Navigator, Clinical Therapist, and Social Worker will work with the participant and their family/support unit to encourage participation in the WPC pilot. This is accomplished by actually going to wherever the participants are located to educate and build relationships that will allow for participants to engage with the WPC team, these activities are covered by the Field-based Outreach Activity. Through consistent contact, and in-person visits, a Patient Navigator and others will work with the beneficiary and their family/support team to build relationships and help them identify their weaknesses and opportunities for establishing clear processes for participating in their care. Members of the Outreach Team will spend the majority of their time out in the field interacting with participants and educating them on opportunities to improve their well-being. A staff of Office Assistants will be available at all times as the vital communication link between the participant and Patient Navigator and will aid participant's ability to contact their assigned Patient Navigator promptly. Each Office Assistant will be assigned to a minimum of three Patient Navigators, and will also provide clerical duties for all members of the WPC team, including processing paperwork and documenting activities and lessons learned in the population health management system, to allow for field-based staff to spend more quality time with each individual and less time engaging in operational duties. Once the beneficiary has determined they are willing to participate in the WPC pilot, they will sign an enrollment form authorizing their participation and permitting the sharing of all necessary information. All participating entities will have access to all available data regarding WPC participants in the

Population Health System. This information will include bi-directional data regarding emergency visits, clinical visits, behavioral visits, diagnosis, eligibility to public assistance programs, and other available information. Arrowhead Regional Medical Center (ARMC) shall manage the bi-directional data system, ensuring user level accesses are granted and audited to ensure compliance with HIPAA, PHI, and PII requirements. It is this enrollment into the WPC pilot that will qualify the participant for inclusion in the Per-Month Per Member (PMPM) bundle.

Patient Navigators and their assigned Office Assistants will oversee the day-to-day activity of ensuring the participants are appropriately identified, enrolled, and linked to resources. This staff will have access to a multi-level, interdisciplinary support team of subject matter experts who will advise WPC staff about appropriate resources, services, and interventions, including primary care providers (PCPs), specialists, pharmacists, nurses, behavioral health specialists, housing services representatives, social service representatives, etc. The entire WPC team will provide field-based coordination and integrations support as required by providers. Patient Navigators will be assigned at least 42 participants, with each Office Assistant being assigned at least 3 Patient Navigators to support.

Once the participant has agreed to participate, the WPC team will utilize an automated Population Health System that will correlate the bi-directional data from participating resources to address the needs and next steps for engaging and concentrating on the most important needs of the individual. Once the participant's action plan is developed in coordination with the entire multi-level interdisciplinary WPC team, the Patient Navigators will engage the participants in person to establish a relationship and encourage participation and adherence to the individualized action plan. This trusting relationship will enable them to serve as a liaison, link, and intermediary between health, behavioral health, social services, and the community resources to facilitate access to services and improve the quality of services. All participating entities will have access to all applicable information available in the Population Health System to allow for better coordination of care and encourage participation in the case coordination of

each participant. The Patient Navigator will work with the beneficiary and their family/support team to educate and assist in navigating the complexities of establishing clear and concise paths to necessary services. The WPC team will work with the beneficiary's PCP, Managed Care Provider, and other entities to ensure that all necessary information, paperwork and authorizations are provided to allow for integrated care in a timely and efficient manner. As the information is received, the WPC team will establish a plan of action to accomplish required outcomes for the beneficiary. The WPC team will act as an intermediary between each beneficiary and their PCP, specialists, and other care providers to ensure that all necessary information is made available. WPC will assist in building individual and community capacity by increasing health knowledge and self-sufficiency through a range of activities such as engagement, community education, informal counseling, social support, and advocacy. These activities will link participants with community resources such as housing and public assistance, reduce access barriers, provide in-person ongoing case management and support with system-wide entities to provide necessary resources. All activities will be documented and PDSA cycles will be used to improve and actualize effective processes and procedures. These activities will be covered by the "Case Coordination" bundle and the participant will stay enrolled within this bundle until they have reached a level three (3) on the Patient Activation Measure (PAM) scale, or choose disenrollment.

WPC team members will engage in the following activities:

- Comprehensive Case Management; to include collaborating with participants and their family/support team in person-centered care planning. An Action Plan will be developed with the participant.
- Case Coordination; to include a comprehensive, individualized care plan and may include in-person and electronic coordination between providers.
- Health Promotion; to include services to encourage and support participants to make lifestyle choices based on health ideas and behavior, with the goal of motivating participants and building self-efficacy through coaching, linking participants to supportive services, and working with family/support members.
- Comprehensive Transitional Care; to include services to facilitate participants' transitions among admission and discharges at treatment facilities in order to avoid admissions and/or readmissions.
- Individual and Family Supportive Services; to include supportive service activities that ensure the participants and family/support team are knowledgeable about participant's

conditions, goals for health improvement, and adherence to treatment and medication management.

- Referral to Community and Social Supports; to include referrals to community and social support services and following up with participants on accessing social supports.

Additional activities include:

- Daily review of referrals to assess potential and existing participants of the program.
  - Tracking referrals and responses; to include time to communicate with the provider making the referral and review enrollee's medical, behavioral and social history.
  - Calls or in-person contacts to establish relationship, build trust.
- Daily team huddles to develop the strategy for the day for responding to referrals, leads, new requests, and additional needs for participants and how best to meet the participants in the field (in their home, in their place of medical care, or potentially in temporary housing or places where they are homeless).
- Departure of some WPC team members into the field for engagement to make contact with participants, understand their immediate needs, and establish relationship building. This could take multiple contacts over many days, depending on the participant.
  - To include time educating the family/support team on the participants needs.
  - Time educating and teaching the participant and their family/support team on accessing and coordinating their needs.
  - Time working to build those skills necessary to allow each participant to actively participate and understand their own needs and how best to access available resources.
  - Time to work with consumer and family or supportive individuals on services and resources available to the enrollee and treatment plan.

- Some WPC team members will work from the office or out in the field to perform daily complex care coordination activities:
  - Making phone calls to primary care to establish appointments or work with primary care on established enrollees.
  - Medication check-ins to make sure enrollees are taking important medications.
  - Check-ins with diabetic patients on management of their sugars.
  - Check-in calls or contacts with patients taking medications for psychiatric needs.
  - Coordination with patients when symptoms escalate and they require primary or specialty care appointments.
  - Management and monitoring of tests or labs that are ordered in the outpatient care setting to ensure compliance.
  - Time to work-through and coordinate transportation assistance needs in order for enrollee to meet appointments.
  - Assessments on progress for established enrollees, to include required program assessments
  - Medication reconciliation monitoring (RN's)
  - Managed care plan coordination calls and navigation on behalf of consumers in-need of services under their benefit structure
    - ✓ Transportation benefits
    - ✓ Approvals for key resources or services needed by the consumer
    - ✓ Expedited primary or specialty care requests
    - ✓ Approvals for tests, labs or prescriptions, when necessary.
    - ✓ Diagnostic test and follow-up on new or emerging conditions.
  - Psychiatric coordination for participants:
    - ✓ Work with county DBH for Psychiatry appointment and medication appointments as needed.

- ✓ Coordination with mental health case managers and shared treatment planning.
- ✓ Crisis intervention work with county teams when participants decompensate or require crisis psychiatric care

- Work with Public Health in population management
  - ✓ Flu shots, vaccines and other routine annual appointments.
  - ✓ Primary care visits and support for basic medical needs.
- For participants who are in the ED or hospitalized:
  - ✓ Team visits to hospital to participate in discharge plan.
  - ✓ Team visits or consultation to emergency room and hospitals for participants for improved discharge planning and follow-up in the outpatient setting.

Each Patient Navigator will have immediate access to medical, behavioral, and social experts to better address and communicate with WPC pilot individuals, their family/support team and participating entities. As each participating entity engages in the bi-directional exchange of data regarding each participant, they will be able to engage with the participants in an informed cohesive manner to further encourage and educate each participant to actively participate in the care. The WPC team will have a working relationship with employees at each participating entity to facilitate care and options. Participating entities, such as Inland Temporary Homes and S2, will improve the coordination and communication between health care and homeless service providers to bridge the gap between homeless and health related services. They will partner with appropriate agencies to create transitional care and stabilization options for chronically homeless persons and individuals exiting hospitals/in-patient settings, integrating into associated health processes the awareness of "Housing First," an evidence-based practice as it relates to the housing, and subsequent supportive health care interventions to ready individuals for housing stabilization. These housing support services are supported through existing funding streams.

The goal of WPC is to work with all entities to find the best processes and procedures to achieve the best outcomes for this population. The WPC team will consistently use the PDSA cycle to identify and refine the best processes and determine the best procedures for obtaining the desired outcomes.

3.2 Data Sharing

Whole Person Care (WPC) team members will have access to all appropriate information available within all of the entity systems for this population, Arrowhead Regional Medical Center (ARMC) will secure and preserve the integrity of participants' information. ARMC shall manage the data system, ensuring user level accesses are granted and audited to ensure compliance with HIPAA requirements to secure and protect the participants PHI, and PI data at all times. Based on each individual's role and responsibilities, access to information will be granted to allow each entity to perform all duties necessary to provide coordination and navigation through health care systems. Each entity has automated systems that will track access and provide appropriate information to insure the security and protection of all participants' data. Employees from all participating entities and WPC will work together to verify shared information is accurate and secured, and coordinate all items needed to provide the best outcome for the participants. The WPC pilot team and all entities will comply with all applicable state and federal law. All required information will be gathered, analyzed and reported from the individual systems available until an overarching system can be established. In addition to the existing systems, the San Bernardino County Information Services Department (ISD) will work with the WPC team and all participating entities to develop an overarching system to maintain, track, and provide appropriate access, security and protection as allowed by state and federal regulations. This new platform, to be developed in the first year and implemented during the second pilot year, will allow personnel to track and review progress, as well as allow for analysis of information gathered in a secure and regulatory compliant environment. The development of this new

platform will enable the pilot to qualify for an incentive payment which will be distributed to all WPC partners who participate in sharing bi-directional data. To qualify, participating entities must sign a data sharing agreement, and provide individual or organizational/department participant data. Each entity is expected to provide full demographic and encounter data for all enrolled WPC beneficiaries for whom they have data. Examples of this bi-directional data consist of health information for physical and mental health providers, incarceration and health information for the Sheriff's department, eligibility information from the human services departments (CalFresh, CalWORKs), and housing activities for homeless organizations. The total incentive funds received for achieving this metric shall be distributed to participating entities who share bi-directional data. The distribution model shall establish a per data record value by dividing the total incentive ($350,000.00) by the total participant records submitted; each submitting entity shall receive an amount equal to the data record value multiplied by the number of total unique records they submit during the incentive period.

The WPC pilot will obtain and install, during the first and second year, an automated Population Health System that will aggregate data from all participating sources to allow staff to find and address those best practice items missing from each participant's goals in a secure and regulatory compliant system. This system will extract information from all available data systems, including appropriate systems within the participating entities, and provide data analytics to the WPC team to allow for review and discussion of PDSA cycles to achieve best practices. All participating entities will have access to view the aggregated datasets for the population served. Through the usage of the PDSA cycle all participating entities will participate in processes and procedures that will enhance all services and improve the lives of the population.

Each Patient Navigator will have immediate access to medical, behavioral, and social experts who will have access to all necessary data and information to better address and communicate with WPC pilot individuals. The WPC team will have immediate access to employees of each

participating entity for unfettered access to necessary care and options for the beneficiaries. Incentive and pay-for-outcomes payments will be used to establish downstream funding opportunities to incentivize WPC partners to share data, and achieve target pay for outcome metrics. To qualify, participating entities must provide individual or organizational/department data related to universal and variant metrics. Each entity is expected to provide full bi-directional data for all enrolled WPC beneficiaries for whom they have data. Examples of this bi-directional data consist of health information for physical and mental health providers, incarceration and health information for the Sheriff's department, eligibility information from the human services departments (CalFresh, CalWORKs), and housing activities for homeless organizations. The total incentive funds received for achieving this metric shall be distributed proportionally based on the number of data records each partner submits.

Section 4: Performance Measures, Data Collection, Quality Improvement, and Ongoing Monitoring

4.1 Performance Measures

The metrics chosen for the WPC pilot present an opportunity to track improvements in various levels of participating entities. The measures are a mixture of improvements in inpatient and emergency services, chronic disease management, patients with behavioral issues, and data tracking to improve our ability to assess the target population.

WPC will establish a baseline in each metric for the target population and will improve all universal and chosen variant metrics each year. It is expected that WPC will decrease Emergency Department Visits, decrease General Hospital/Acute Care Utilization, realize Gains in Patient Activation, improve Diabetic Care, and increase Depression Disorder and Suicide Risk Assessment by 5% over baseline each year of the pilot. Due to the complexity and severe nature of the selected population it is expected that WPC will improve Follow-Up after Hospitalization for Mental Illness, Initiation and Engagement of Alcohol and Other Drug

Dependence Treatment, and data compilation of Depression Remission at 12 months by 5% over baseline during each pilot year.

WPC will establish action plans through PDSA cycles that will be tracked and used to quantify the level of improvement of each participant. Through usage of an automated Population Health Care system and additional systems created to aid in tracking, data will be gathered and mined for significant changes and possible areas to use PDSA cycles to improve outcomes. Patient Navigators and WPC team members will document intervention activities in the appropriate systems. The automated Population Health Care system will mine each of the individual systems and identify areas of concern and need. The team will address the missing data, use and document PDSA cycles to determine the best course of action to achieve desired health outcomes.

All performance areas will be reviewed and action taken to achieve targeted benchmarks. The WPC team will also use the collected data to determine other areas of concern and establish processes and procedures to improve outcomes in all areas. This approach will allow each of the WPC team members to become experts in PDSA cycle implementation and outcomes, and will enable them to share their knowledge and experience with others throughout the community.

4.1.a Universal Metrics

Please check the boxes below to acknowledge that all WPC pilots must track and report the following universal metrics.

- [X] **Health Outcomes Measures**
- [X] **Administrative Measures**

SAN BERNARDINO WHOLE PATIENT CARE METRICS

Universal Metrics	Pilot Year 1	Pilot Year 2	Pilot Year 3	Pilot Year 4	Pilot Year 5
Health Outcomes: Ambulatory Care - Emergency Department Visits (HEDIS) including utilization of PDSA with measurement and necessary changes a minimum of quarterly	Establish baseline.	Maintain baseline.	Obtain a 5% improvement over baseline.	Obtain a 10% improvement over baseline.	Obtain a 15% improvement over baseline.
Health Outcomes: Inpatient Utilization – General Hospital/Acute Care (IPU) (HEDIS) including utilization of PDSA with measurement and necessary changes a minimum of quarterly	Establish baseline.	Maintain baseline.	Obtain a 5% improvement over baseline.	Obtain a 10% improvement over baseline.	Obtain a 15% improvement over baseline.
Health Outcomes: Follow-up After Hospitalization for Mental Illness (FUH (HEDIS)	Establish baseline.	Maintain baseline.	Obtain a 2.5% improvement over baseline.	Obtain a 5% improvement over baseline.	Obtain a 7.5% improvement over baseline.
Health Outcomes: Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET) (HEDIS)	Establish baseline.	Maintain baseline.	Obtain a 2.5% improvement over baseline.	Obtain a 5% improvement over baseline.	Obtain a 7.5% improvement over baseline.
Administrative: Care coordination, case management and referral infrastructure	Establish policies and procedures for care coordination, case management and referral infrastructure.	Monitor, review and revise policies and procedures for care coordination, case management and referral infrastructure. Document PDSA utilization.	Monitor, review and revise policies and procedures for care coordination, case management and referral infrastructure. Document PDSA utilization.	Monitor, review and revise policies and procedures for care coordination, case management and referral infrastructure. Document PDSA utilization.	Monitor, review and revise policies and procedures for care coordination, case management and referral infrastructure. Document PDSA utilization.

4.1.b Variant Metrics

Variant Metrics	Pilot Year 1	Pilot Year 2	Pilot Year 3	Pilot Year 4	Pilot Year 5
Administrative: Data and information sharing infrastructure	Establish policies and procedures for data information and sharing infrastructure. Document PDSA utilization.	Monitor, review and revise policies and procedures for data information and sharing infrastructure. Document PDSA utilization.	Monitor, review and revise policies and procedures for data information and sharing infrastructure. Document PDSA utilization.	Monitor, review and revise policies and procedures for data information and sharing infrastructure. Document PDSA utilization.	Monitor, review and revise policies and procedures for data information and sharing infrastructure. Document PDSA utilization.
Administrative Metric – Gains in Patient Activation (PAM) Scores at 12 Months (NQF 2483) Numerator: Summary score change for the aggregate of eligible patients. Denominator: Sum of all patients with two or more PAM scores.	Establish baseline.	Maintain baseline.	Obtain a 5% improvement over baseline.	Obtain a 5% improvement over previous year.	Obtain a 5% improvement over previous year.
Health Outcome Metric - Comprehensive diabetes care: HbA1c Poor Control <8% Numerator: Within the denominator, who had HbA1c control (<8.0%). Denominator: Members 18 – 75 years of age with diabetes (type 1 and type 2).	Establish baseline.	Maintain baseline.	Obtain a 5% improvement over baseline.	Obtain a 5% improvement over previous year.	Obtain a 5% improvement over previous year.
NQF 0710: Depression Remission at 12 Months Numerator: Adults who achieved remission at twelve months as demonstrated by a twelve month (+/- 30 days) PHQ-9 score of less than five. Denominator: Adults age 18 and older with a diagnosis of major depression or dysthymia and an initial PHQ-9 score greater than nine during an outpatient encounter.	Establish baseline.	Maintain baseline.	Obtain a 5% improvement over baseline.	Obtain a 5% improvement over previous year.	Obtain a 5% improvement over previous year.

Variant Metrics	Pilot Year 1	Pilot Year 2	Pilot Year 3	Pilot Year 4	Pilot Year 5
NQF 0104: Suicide Risk Assessment Numerator: Patients who had suicide risk assessment completed at each visit. Denominator: All patients aged 18 years and older with a new diagnosis or recurrent episode of Major Depressive Disorder	Establish baseline.	Maintain baseline.	Obtain a 5% improvement over baseline.	Obtain a 5% improvement over previous year.	Obtain a 5% improvement over previous year.

4.2 Data Analysis, Reporting and Quality Improvement

The foundation of data analysis, reporting, and quality improvement will be the application of universal and variant metrics. Utilization data will be accessible from participating entities' existing systems that allow them to track and document information on the targeted population, and will provide for data collection, analysis and reporting until overarching bi-directional data sharing information systems can be developed and/or purchased and installed. This utilization data can be matched across systems to assess County-wide impact. This approach was used in preliminary stratification scoring, which also demonstrates San Bernardino County's ability to perform this type of analysis. The aforementioned scoring will be repeated both to identify new potential participants in the WPC pilot, as well as assess score changes in participants as part of the outcome analysis.

Additional systems will be necessary to collect and combine other non-utilization data in the metrics. WPC will acquire and implement an automated Population Health System. This system will collect data from all existing systems and correlate it into quantitative and actionable items. The team will use this information to establish action plans for this population.

Project year one (1) will be a discovery year, allowing us to more accurately learn how data analysis will impact enrollment and PDSA cycles beyond theory. Utilization data collected from service sites will be aggregated, matched and scored by analytic staff to identify potential enrollees. This same data will also be used to evaluate the utilization scores of enrollees as an

element of the performance outcome evaluation. This information will be shared among the WPC team and partners as part of the PDSA cycles. We intend to have this process increasingly automated into the population health system we will procure, and we now expect this to be live by pilot year two (2). This will make the data more readily available to users and potentially allow for faster analysis cycles.

Using the PDSA cycle, team members will be able to try different processes to determine the best practice and develop repeatable processes for all involved. The PDSA cycle begins with *Plan*, defining the objective, questions and predictions. In this step WPC will review the data collected and determine the best information available and what may still need to be collected. The next step is *Do*, in which plans are executed, data collected, and begin to analyze the information available. The next step, *Study,* is where WPC completes the analysis of the data and compare it to predictions, and summarize what has been learned. Finally, *Act* by deciding whether the change is effective and can be implemented in other areas. All PDSA cycles will address small-targeted group before applying to the entire population. All PDSA cycles will complete multiple iterations to determine the best practices before implementing over all entities. PDSA cycles require frequent data "check-ins" to ensure best practices are identified. Therefore, data will be analyzed and reported regularly to the WPC team and tied to particular PDSA cycles and the nature of the metric data. The aforementioned Population Health System will also help facilitate rapid feedback to the team. Early on, individual-level results may be the most helpful, utilizing small PDSA samples, thereby allowing for prompt adjustments within the actual engagement process to improve quality. More systemic reviews of the data will inform larger scale adjustments.

This PDSA approach will help to continue to inform the existing metrics and determine whether adjustments to the variant metrics are recommended. It is likely that new questions and associated analyses will arise through implementation that will help San Bernardino County better evaluate and improve its WPC pilot. Further, PDSA cycles have been used in preliminary

analyses, such as the stratification scoring, and will continue to help the County refine the analysis process and methodology. Therefore, flexibility and nimbleness are keys to the data analysis, reporting, and quality improvement process.

4.3 Participant Entity Monitoring

San Bernardino County's WPC pilot is establishing a concierge Case Coordination Team that will work with members of the community to establish the best pathways to service and wellness. The main purpose of the unit is to work with each of the participating entities to determine the best way to provide and confirm access for the pilot participants. The pilot will utilize the Plan-Do-Study-Act (PDSA) process to review each procedure and institute the demonstrated best practice. As each best practice is established the WPC team will work with each entity to establish processes and procedures to allow for implementation of the system.

WPC understands the value of performance monitoring as the basis for programmatic fine-tuning, reorientation, future planning and accountability. We believe all participating entities must be engaged as partners to reach desired outcomes under a common commitment to improving lives. The WPC team will provide expertise and training to each entity on the PDSA methodology and review changes on a small scale in order to determine the best practice for each process. Each entity is required to be represented at the monthly meetings; discussion of issues and corrective actions can be addressed as they arise and changes can be made through PDSA to establish best practices for all involved. It is believed that as this team works together, they will find numerous ways to improve communication and provide better service to participants.

The WPC Evaluation Workgroup will conduct and oversee ongoing monitoring, analysis and corrective activities related to the universal and variant metrics. The evaluation workgroup is responsible for oversight of data compilation, preparation of required reports, entity performance tracking, pilot reporting, and identifying areas requiring corrective action. This group is chaired

by the Program Manager, and includes various steering members and the Business System Analyst. The workgroup will submit updates as a standing item on the WPC Steering Committee's monthly agenda.

The WPC Evaluation Workgroup under the direction of the WPC Steering Committee will issue corrective action requests to participating entities when root causes to barriers and process inefficiencies have been identified. WPC teams will work with participating entities to improve processes and address barriers to improve outcomes. Training and educational opportunities will be available to assist with addressing corrective actions.

Section 5: Financing

5.1 Financing Structure

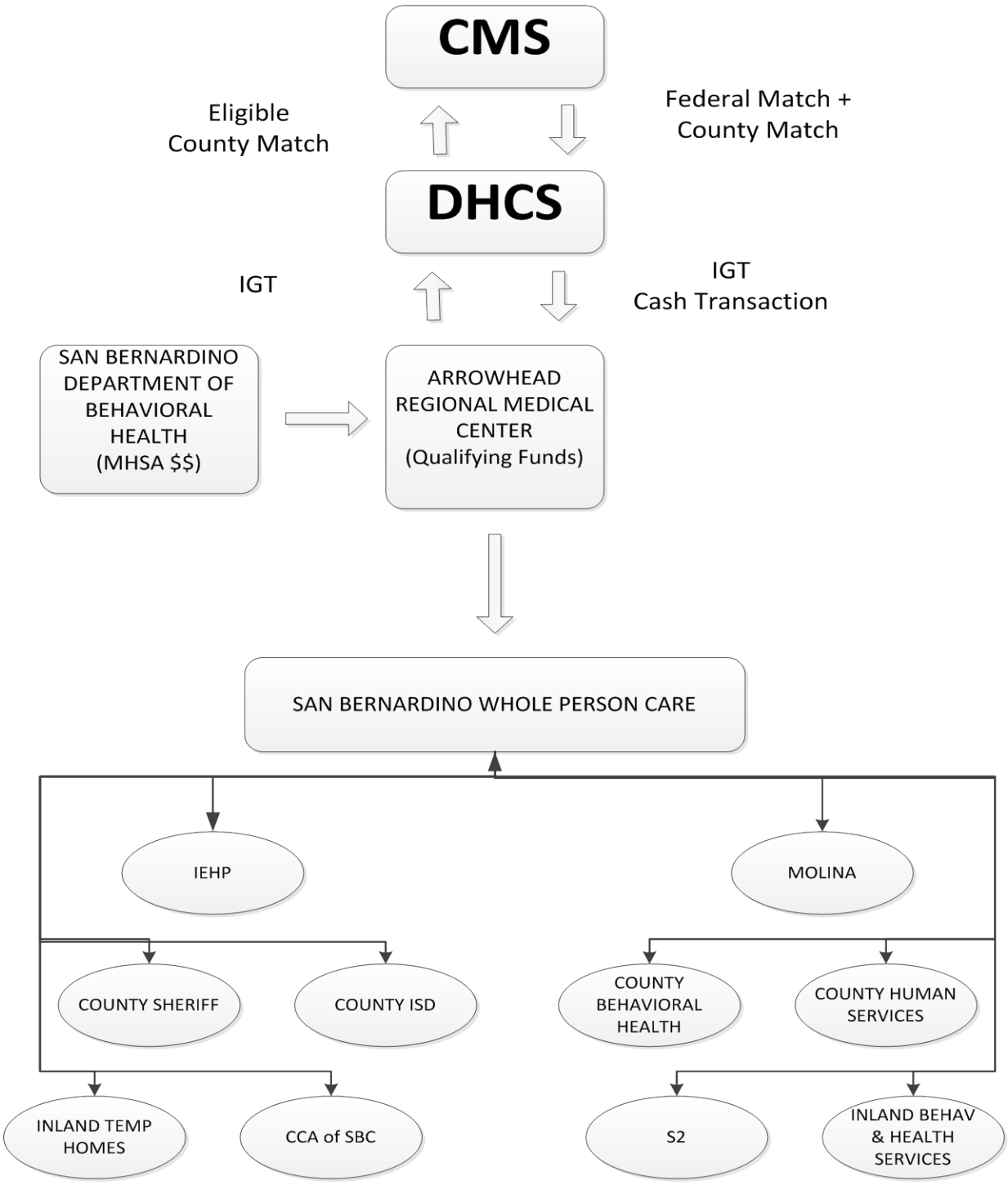
San Bernardino County's WPC pilot is a patient-centered case coordination and care coordination system. Infrastructure, pay-for-reporting, and bundled payment funds will be used to establish a completely new WPC team focused on helping and teaching participants to navigate through the multiple County and community systems. Incentive and pay for outcomes funds will be used to incentivize WPC partners to participate in bi-directional data sharing, and achieve desired outcome metrics. WPC will assist those individuals who are the highest utilizers of emergency care and will aid them in the proper use of appropriate levels of care based on their need to achieve better utilization of resources and improved health outcomes. All participants of the WPC pilot will be Medi-Cal beneficiaries, and therefore, all service providers will receive reimbursement from Medi-Cal for direct clinical services. The WPC pilot will not pay for any existing Medi-Cal healthcare services. All funds requested for the pilot will be used for establishing and maintaining the WPC relationship-based team, and incentivizing partners to share data and achieve desired outcomes. This team will assist each entity to become more efficient and aware of participant outcomes. This approach will prepare all participating entities

to establish processes and procedures necessary to receive value-based payments in the future.

The WPC pilot will have direct oversight through the lead-entity, ARMC. San Bernardino County recognizes the importance of an inclusive model which aligns efforts of all supporting resources. As such, the activities of the WPC team will be governed through the executive steering committee, comprised of leadership from all participating entities.

5.2 Funding Diagram

5.2
WHOLE PERSON CARE PILOT FUNDING DIAGRAM



5.3 Non-Federal Share

ARMC and San Bernardino County Behavioral Health will share funding of the non-federal share of the pilot through retained revenues and Mental Health Substance Abuse funds.

5.4 Non-Duplication of Payments and Allowable Use of Federal Financial Participation

San Bernardino County's WPC pilot is directly focused on developing the care coordination and patient engagement necessary to elicit positive engagement from high utilizing Medi-Cal recipients. The funding requested through this pilot application does not include funding for alternative care models as referenced in STC's 132 and 133. Alternative care models currently available through existing resources shall be available to all participants of the target population under currently budgeted programs. This approach will mitigate concerns with duplicate payment of qualified WPC services.

5.5 Funding Request

San Bernardino County WPC is a field and relationship-based, patient-centered coordination team that provides patient engagement, assistance in obtaining services, and education opportunities to the highest users of existing resources. The team consists of both clinical and non-clinical members to provide community and home-based services to meet each participant's needs.

Each participant is assigned a Patient Navigator who becomes their personal advocate and will assist him/her in navigating through the existing complex system. WPC will work with all entities to improve processes and establish best practices. Establishing a Population Health System and using existing systems to obtain and analyze data will allow the team to improve outcomes and prepare all involved for the coming value-based systems.

The budget is based on creating a field-based team of specialists who will work together to establish and adjust for the best way to aid each individual participant. This team will work

separate from existing organizations but will have access to each system and will work with each entity to ensure that each participant's needs are met. The pilot will be reimbursed on a PMPM basis for enrolling individuals into an engagement system that will work with the individuals and their support team to engage them with their healthcare providers to improve outcomes.

The WPC Budget consists of Administrative Infrastructure, Delivery Infrastructure, Incentive Payments, FFS Services, PMPM Bundle, Pay for Reporting and Pay for Outcomes.

6.1 Attestation

This attestation is superseded by the revised attestation included in the agreement.

WPC Budget Narrative

San Bernardino County's Whole Person Care (WPC) Pilot budget consists of an administrative and delivery infrastructure, incentive payments, Per Member per Month (PMPM) bundle, Fee-For-Service, and pay for reporting and pay for outcomes. Funds shall be used to establish and operate the program, and incentivize participation and performance for WPC partners.

The structure of the program is to have WPC staff equipped to engage high-risk/high-utilizing Medi-Cal beneficiaries/family support unit, coordinate their needs with multiple health and social providers, and maintain ongoing collaboration with the participant to ensure improved outcomes. The goal of the program is to engage, educate, monitor success, and graduate participants from the program to lead healthier, more productive lives. The WPC pilot expects participants to achieve a satisfactory level of self-reliance for health and social needs, allowing for a successful program discharge in 12 months.

The newly established multidisciplinary WPC team is aimed at constructing skill sets for both the enrolled participant and the WPC team member. The aim is for the team member to attain the skills to educate the participant to manage his or her own health; to accomplish this, the participant must demonstrate the ability to successfully self-manage a multitude of needs. Engaging the high-risk members will build trust and relationships necessary to alter care habits, promoting a willingness to engage and participate with providers.

The WPC Executive Steering committee shall form a fiscal subcommittee, chaired by a representative from the County Administrative Office to govern over distribution of WPC funds.

Administrative Infrastructure PILOT YEAR 2:

Item	*Max Amount Per Unit*	*Max Units*	*Max WPC Fund Amount*
Administrative Governance *Percentage of overall costs to cover the executive and administrative salaries, infrastructure, and resources of County departments not assigned directly to WPC.*	226,720	1	226,720
Office Assistant *Provide clerical assistance to Program Director and WPC team members*	47,958	4	191,832
Business System Analyst II *Will support Information Systems and retrieve and compile data for the program.*	77,124	1	77,124
Program Manager	146,567	1	146,567
Landline Phones *Yearly fee for County equipment and connections.*	230	6	1,377
Office Supplies	2,500	1	2,500
ISD Support *Yearly fee for technical support and maintenance*	97	6	582
Office Furniture	60,000	1	60,000
Office Space	40,000	1	40,000
Computers and Software	1,484	6	8,901
Printer	1,370	2	2,740
Copier	2,800	2	5,600
Collaborative Travel	450	6	2,700
		TOTAL	**766,643**

Administrative Infrastructure PILOT YEARS 3-5:

Item	*Max Amount Per Unit*	*Max Units*	*Max WPC Fund Amount*
Administrative Governance *Percentage of overall costs to cover the executive and administrative salaries, infrastructure, and resources of County departments not assigned directly to WPC.*	226,720	1	226,720
Office Assistant	47,958	4	191,832

Item	*Max Amount Per Unit*	*Max Units*	*Max WPC Fund Amount*
Provide clerical assistance to Program Director and WPC team members			
Business System Analyst II *Will support Information Systems and retrieve and compile data for the program.*	77,124	1	77,124
Program Manager	146,567	1	146,567
Landline Phones *Yearly fee for County equipment and connections.*	230	6	1,377
Office Supplies	2,500	1	2,500
ISD Support *Yearly fee for technical support and maintenance*	97	6	582
Office Space	50,000	1	50,000
Collaborative Travel	600	6	3,600
		TOTAL	**700,302**

The items covered in this portion of the budget consist of administrative governance, positions required to run everyday activities of the office, along with rent, office furniture, office supplies and equipment. The WPC pilot, while field-based, will have a home-base office (or offices) to house other team members, and include training and meeting locations. The Program Manager will be responsible for all aspects of WPC, and will report directly to the Steering Committee. There are also four (4) Office Assistants and a Business System Analyst II included in the budget to support all WPC staff and interact with all entities involved with the project. We have included all travel necessary for the bi-annual State-required Collaborative training.

Administrative oversight includes all County department heads responsible for the executive steering committee, and department leadership positions from the WPC steering committee, and subsequent subcommittees. The costs and positions for inclusion are listed below:

	Salary	**Benefits**	**Total**	**Percentage**	
Associate Admin Profession Svcs	$141,440	$45,261	$186,701	52%	$97,084

	Salary	Benefits	Total	Percentage	
Assistant Executive Officer - HS	$220,754	$70,641	$291,395	6%	$17,532
Director - ARMC	$265,557	$84,978	$350,535	6%	$21,090
Deputy Director - Program Devel	$113,235	$36,235	$149,470	6%	$8,993
Deputy Director - Aging & Adult	$113,235	$36,235	$149,470	6%	$8,993
Deputy Director - BH Program Svc	$113,235	$36,235	$149,470	6%	$8,993
Deputy Technology Chief	$141,440	$45,261	$186,701	6%	$11,233
Deputy Executive Director	$168,084	$53,787	$221,871	6%	$13,349
Director Public Health	$168,587	$53,948	$222,535	6%	$13,389
Division Chief - Public Health	$134,638	$43,084	$177,722	6%	$10,693
Director Behavioral Health	$193,528	$61,929	$255,457	6%	$15,370
					$226,720

The Program Manager duties include:

- Plans, organizes, directs and evaluates assigned program area.
- Evaluates and monitors services and programs, and
- Formulates policies, procedures, protocols and standards of care ensuring compliance with federal, state, contractual, and departmental requirements.
- Formulates administrative controls and quality assurance policies and procedures to improve and monitor the efficiency and effectiveness of service.
- Develops community resources and establishes health service infrastructure.

The Business Systems Analyst II identifies, analyzes, tests and documents business requirements in providing business analysis service to the department.

The Office Assistant performs clerical work in support of a department and requires knowledge of specific departmental procedures and practices of varying complexity and interpretation.

Delivery Infrastructure PILOT YEAR 2:

Item	*Max Amount Per Unit*	*Max Units*	*Max WPC Fund Amount*
Information Systems	510,532	1	510,532
Mid-Size Vehicles	26,000	8	208,000
Fuel & Maintenance	11,736	8	93,888
Landline Phones *Yearly fee for County equipment and connections.*	230	25	5,750
ISD Support *Yearly fee for technical support and maintenance*	97	25	2,425
Computers and Software *Maintenance and possible replacement costs*	1,484	25	37,100
Cell Phones *Maintenance and possible replacement costs*	150	26	3,900
Cell Phone Data Plans	600	26	15,600
Mobile Data Charges *Fees for allowing additional devices to mobile sync with information systems.*	3,270	1	3,270
45% of Patient Navigators (salary and benefits	25,830	12	309,960
45% of Clinical Therapist I (salary and benefits)	36,743	1	36,743
45% of Social Worker II (salary and benefits)	35,701	4	142,804
50% of Registered Nurse Care Manager (salary and benefits)	61,317	3	183,951
50% of Utilization Review Tech (salary and benefits)	28,638	3	85,914
50% of Alcohol & Drug Counselor (salary and benefits)	34,814	2	69,628
Enhanced Care Coordination	80	250	20,000
		TOTAL	**1,729,465**

Delivery Infrastructure PILOT YEAR 3-5:

Item	*Max Amount Per Unit*	*Max Units*	*Max WPC Fund Amount*
Information Systems	876,112	1	876,112
Fuel & Maintenance	11,736	8	93,888

Item	*Max Amount Per Unit*	*Max Units*	*Max WPC Fund Amount*
Landline Phones *Yearly fee for County equipment and connections.*	230	25	5,750
ISD Support *Yearly fee for technical support and maintenance*	97	25	2,425
Computers and Software *Maintenance and possible replacement costs*	1,484	2	2,968
Cell Phones *Maintenance and possible replacement costs*	150	3	450
Cell Phone Data Plans	600	26	15,600
Mobile Data Charges *Fees for allowing additional devices to mobile sync with information systems.*	3,270	1	3,270
		TOTAL	**1,000,463**

Items included in this portion of the budget consist of those infrastructure items necessary to deliver the actual outcomes expected in this pilot. The information systems infrastructure includes developing and/or purchasing a project management system during program year two, along with a data aggregation system for sharing of actionable data to establish engagement plans, bi-directional sharing of information, and planning tools. The system built or purchased for year two will consist of a project management tool for WPC team members to input participants, baseline data, and track interactions/interventions. By pilot year three, WPC will lease a web-based system to aggregate data for bi-directional sharing across the pilot. WPC is a field-based engagement process needing vehicles to allow Patient Navigators and others to meet with participants and their families in familiar surroundings and allow for the building of trust. Through consistent contact, and in-person visits, a Patient Navigator will work with the beneficiary and their family/support team to build relationships and help them identify their

weaknesses and opportunities for establishing clear processes for participating in their care. Computers and cell phones are included to aid in the delivery of timely information with all staff. Enhanced care coordination is included for year two as patient navigators will issue incentives for participants who complete an individual needs assessment once engaged as a participant in the pilot. In years three through five, enhanced care coordination shall be used to incentivize participants to meet specific pilot goals.

The budget for pilot year two (2) includes a portion of positions that were not covered in the ramp up period of the PMPM bundle. These percentages were removed for pilot years three through five (3 – 5) as they are covered by the fully-enrolled PMPM bundle.

Incentive Payments:

Item	*Max Amount Per Unit*	*Max Units*	*Max WPC Fund Amount*
Establish and Maintain data and information sharing infrastructure	350,000	1	350,000
		TOTAL	**350,000**

This incentive payment is intended to incentivize participating entities to share bi-directional data necessary to achieve desired outcomes. Employees from all participating entities will work together with the WPC team to verify shared information and coordinate those items needed to provide the best outcome for the participants. Funds received for achieving this goal shall be shared with all WPC partners who actively participate in establishing and maintaining bi-directional information sharing. To qualify, participating entities must provide individual or organizational/department data related to universal and variant metrics. Each entity is expected to provide full data for all enrolled WPC beneficiaries for whom they have data. Examples of this data consist of health information for physical and mental health providers, incarceration and health information for the Sheriff's department, eligibility information from the human services departments (CalFresh, CalWORKs), and housing activities for homeless organizations. The

total incentive funds received for achieving this metric shall be distributed proportionally to partners who participate in submitting member data records. The distribution model shall establish a per-data record value by dividing the total incentive ($350,000.00) by the total unique member data records submitted for the incentive period. Entities qualifying for payment shall receive an amount equal to the data record value multiplied by the number of unique data records submitted during the incentive period. The WPC pilot will also work directly with all participating entities to ensure the information sharing is used for PDSA activities.

The trigger for this incentive is full aggregation and sharing of all submitted health data from the participating plans and providers for all beneficiaries enrolled in the pilot.

FFS Services PILOT YEAR 1:

Item	*Max Amount Per Unit*	*Max Units*	*Max WPC Fund Amount*
Field-based Outreach Activity *(10% of 12 Patient Navigators (Salary $44,616;Benefits $12,660) Ratio: 1:42* *10% of Clinical Therapist I (Salary $62,774; Benefits $18,876) Ratio 1:500* *10% of 4 Social Worker II (Salary $59,800; Benefits $19,536) Ratio: 1:125)*	217	750	162,953
		TOTAL	**162,953**

FFS Services PILOT YEAR 3-5:

Item	*Max Amount Per Unit*	*Max Units*	*Max WPC Fund Amount*
Field-based Outreach Activity *(10% of 12 Patient Navigators (Salary $44,616;Benefits $12,660) Ratio: 1:42* *10% of Clinical Therapist I (Salary $62,774; Benefits $18,876) Ratio 1:500* *10% of 4 Social Worker II (Salary $59,800; Benefits*	217	500	108,635

Item	*Max Amount Per Unit*	*Max Units*	*Max WPC Fund Amount*
$19,536) Ratio: 1:125)			
		TOTAL	**108,635**

This FFS Service will be charged when a patient engages in dialogue in a pre-enrollment period, as evidenced by a Patient Navigator connecting with the potential candidate by phone or in-person. The reality of many people living with complex medical conditions is that navigating the complex, layered, and often demanding healthcare system is a serious impediment to care. While they experience functional impairment, they may not always meet medical necessity for the full scope of disability and supportive services that are needed to prevent further decline. It is also not uncommon for beneficiaries living with complex medical conditions to have multiple treatment providers and specialists, further complicating the demand on the beneficiary to navigate multiple systems with little-to-no success. The technicalities of benefit structures can create an unintentional disparity and barrier, and requires additional provider effort to overcome so that beneficiaries can easily access necessary care. These challenges are the reason that once a participant is enrolled it is important that the existing relationships remain in order to maintain on-going engagement with both the WPC team and the participant's full health care team. Through consistent contact, and in-person visits, utilizing vehicles purchased for overcoming these barriers, Patient Navigators and other members of the WPC team will work with the beneficiary and their family/support team to build relationships and help them identify their weaknesses and opportunities for establishing clear processes for participating in their care.

Bundled Per-Member-Per-Month (PMPM) Services PILOT YEAR 2:

Item	*PMPM*	*Max Member Months*	*Max WPC Fund Amount*
Case Coordination	283	3,000	848,340

Item	*PMPM*	*Max Member Months*	*Max WPC Fund Amount*
(90% of 12 Patient Navigators (Salary $44,616;Benefits $12,660) Ratio: 1:42 *90% of Clinical Therapist I (Salary $62,774; Benefits $18,876) Ratio 1:500* *90% of 4 Social Worker II (Salary $59,800; Benefits $19,536) Ratio: 1:125* *3 Registered Nurse Care Manager (Salary $101,483; Benefits $21,151) Ratio 1:167* *3 Utilization Review Tech (Salary $44,616;Benefits $12,660) Ratio: 1:167* *2 Alcohol & Drug Counselor (Salary $54,330; Benefits $15,299) Ratio: 1:250* *Enhanced Care Coordination)*			
		TOTAL	**848,340**

Bundled Per-Member-Per-Month (PMPM) Services PILOT YEAR 3-5:

Item	*PMPM*	*Max Member Months*	*Max WPC Fund Amount*
Case Coordination *(90% of12 Patient Navigators (Salary $44,616; Benefits $12,660) Ratio: 1:42* *90% of Clinical Therapist I (Salary $62,774; Benefits $18,876) Ratio 1:500* *90% of 4 Social Worker II (Salary $59,800; Benefits $19,536) Ratio: 1:125* *3 Registered Nurse Care Manager (Salary $101,483; Benefits $21,151) Ratio 1:167* *3 Utilization Review Tech (Salary $44,616;Benefits $12,660) Ratio: 1:167* *2 Alcohol & Drug Counselor (Salary $54,330; Benefits $15,299) Ratio: 1:250* *Enhanced Care Coordination)*	283	6,000	1,698,000
		TOTAL	**1,698,000**

This budget includes a PMPM bundle to cover the major services being provided to those participants enrolled into the WPC pilot. The PMPM bundle maximum member months increases in pilot year three (3), as we expect to be at full enrollment by the beginning of pilot

year three (3). The percentages of positions found in the Delivery Infrastructure for year two (2) shift from pilot year two to pilot year three to account for a ramp up of enrollment in year two. Each potential participant will be an active Medi-Cal enrollee and have scored within the highest range of a cross-system matching of individuals who: have repeated incidents of avoidable emergency use, hospital admissions, or nursing facility placement; have two or more chronic conditions; have mental health and/or substance use disorders; are currently experiencing homelessness; and/or are at risk of homelessness, including individuals who will experience homelessness upon release from institutions (hospital, sub-acute care facility, skilled nursing facility, rehabilitation facility, county jail, state prisons, or other).

The Patient Navigator assists patients by facilitating timely medical care to avoid delays in treatment, and provides patient, family education and awareness, and consults with other members of the care delivery team. The ratio for Patient Navigator to participant is 1 to 42. The WPC Clinical Therapist will be responsible for family engagement and family skill-building by providing health education and psychoeducation. These services are non-covered Medi-Cal benefits. The WPC Clinical Therapist will provide these important services as part of the strategy to build resiliency and strengthen social supports as related to Medi-Cal complexity. The aim is to increase the family unit's ability to respond to and advocate on behalf of their family member's health needs. The Clinical Therapist ratio to participant is 1 to 500. The Social Worker II provides complex social work to assist individuals and/or families in enhancing their capacity for social functioning. The Social Worker II ratio to participant is 1 to 125.

Case Coordination is where the multi-disciplinary team will collaborate to determine the appropriate strategy to assist each participant. It is during this stage that team members will document and provide feedback on developing and executing a plan to achieve designated goals for the participant.

A participant is placed in this category once they are formally enrolled in the WPC pilot. At this point, the whole WPC team becomes fully engaged with the participant. Participants will remain in this PMPM bundle until they no longer participate, request to be removed or have achieved an expected level three (3) scoring on the Patient Activation Measure (PAM) scale. It is expected that although some beneficiaries will require long-term assistance the majority of beneficiaries will only remain in the program for approximately 12 months. As a beneficiary is detached from the WPC team, the next qualified beneficiary from the waitlist will be contacted for enrollment. Therefore, it is believed the cap of 500 enrollees will roll over at least once each year, and at a minimum there will be a total of 2,000 participants enrolled by the end of the fifth year.

The Patient Navigator will work with the beneficiary and their family/support team to educate and assist in navigating the complexities of establishing clear and concise paths to necessary services. The WPC team will work with the beneficiary's PCP, Managed Care Provider, and other entities to ensure that all necessary information, paperwork and authorization are provided to allow for integrated care in a timely and efficient manner. As the information is received and analyzed, the WPC team will work to establish the best possible plan of action to accomplish required health and social outcomes for the beneficiary. The WPC team will act as a concierge between each beneficiary and their PCP, specialists, and other care providers to ensure that all necessary information is shared and made available as requested and/or required.

The Registered Nurse Care Manager assesses and identifies the needs of participants, incorporating age specific criteria and coordinating the delivery of care services throughout the continuum of care. The care manager-to-participant ratio staffing assumption is one Registered Nurse Care Manager to 167 participants. The Utilization Review Technician reviews and monitors medical records and recommends and takes actions to assure patient care is

appropriate, medically necessary, and is delivered in the most cost effective manner. The Utilization Review Technician ratio to participant is 1 to 167. An Alcohol and Drug Counselor shall assist with those encountering substance abuse disorders in an attempt to promote engagement in substance abuse treatment programs. The Alcohol and Drug Counselor ratio is 1 to 250 participants. Enhanced care coordination will allow members of the engagement team to assist each participant with their nutritional and non-medical needs and bring non-traditional coordination opportunities to those in need.

Pay for Reporting:

Item	*Incentive Payment for Achievement*	-	*Max WPC Fund Amount*
Completing and submitting all Mid-year reporting goals	100,000		100,000
Completing and submitting all Year-end reporting goals	250,000		250,000
		TOTAL	**350,000**

The WPC budget includes payments for reporting all universal and variant metrics and any additional information requested by the state and/or federal government. These reporting requirements include submission of data to support the following metrics:

- Emergency Department Visits
- General Hospital/Acute Care Inpatient Utilization
- Follow-up After Hospitalization for Mental Illness
- Gains in Patient Activation Scores (PAM)
- HbA1c Poor Control <8.0
- Depression Remission PHQ-9 scores

Payment of Pay for Reporting funds will be triggered by successful transmission of data to the State. Funds received for pay-for-reporting shall be distributed to County departments who are funding reporting resources under the direction of the fiscal subcommittee.

Pay for Outcomes:

Item	*Incentive Payment for Achievement*	-	*Max WPC Fund Amount*
Obtain a 5% over previous year in PAM Scores at 12 months	350,000		350,000
Obtain a 5% over previous year in Diabetes Care, Monitoring and Screening for People with Mental Illness	350,000		350,000
		TOTAL	**700,000**

In addition, the WPC budget includes payments for reaching anticipated outcomes within the designated population. These 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. Funds received for pay for outcomes shall be distributed to WPC partners whose performance supports achievement of the desired improvement.

The first pay for outcome measure relates to the PAM. This indicates the patients' engagement in managing their own health. This measure will be compiled by the patient navigators through ongoing needs assessments. The goal is to maintain the baseline during pilot year two, and increase by 5% in years three through five. Funds for achieving this score shall distribute to the WPC pilot given the engagement activities are driven by the patient navigators.

The second pay for outcome relates to managing diabetes. The goal shall focus on maintaining the baseline for HbA1c for pilot year two, and achieving a 5% improvement over prior year for years three through five. To qualify, the clinic must maintain their panel's baseline for year two, and achieve a 5% improvement in years three through five. The funds will be divided equally

among all clinics which meet their goals, based on the number of qualifying participants assigned. Pay for outcome funds are not distributed to participants of the WPC pilot.

WPC Budget Template: Summary and Top Sheet

WPC Applicant Name:	SAN BERNARDINO COUNTY

	Federal Funds *(Not to exceed 90M)*	**IGT**	**Total Funds**
Annual Budget Amount Requested	2,453,700	2,453,700	4,907,400

PY 1 Budget Allocation (Note PY 1 Allocation is predetermined)	
PY 1 Total Budget	4,907,400
Approved Application (75%)	3,680,550
Submission of Baseline Data (25%)	1,226,850
PY 1 Total Check	OK

PY 2 Budget Allocation	
PY 2 Total Budget	4,907,400
Administrative Infrastructure	766,643
Delivery Infrastructure	1,729,465
Incentive Payments	350,000
FFS Services	162,953
PMPM Bundle	848,340
Pay For Reporting	350,000
Pay for Outomes	700,000
PY 2 Total Check	OK

PY 3 Budget Allocation	
PY 3 Total Budget	4,907,400
Administrative Infrastructure	700,302
Delivery Infrastructure	1,000,463
Incentive Payments	350,000
FFS Services	108,635
PMPM Bundle	1,698,000
Pay For Reporting	350,000
Pay for Outomes	700,000
PY 3 Total Check	OK

PY 4 Budget Allocation	
PY 4 Total Budget	4,907,400
Administrative Infrastructure	700,302
Delivery Infrastructure	1,000,463
Incentive Payments	350,000
FFS Services	108,635
PMPM Bundle	1,698,000
Pay For Reporting	350,000
Pay for Outomes	700,000
PY 4 Total Check	OK

PY 5 Budget Allocation	
PY 5 Total Budget	4,907,400
Administrative Infrastructure	700,302
Delivery Infrastructure	1,000,463
Incentive Payments	350,000
FFS Services	108,635
PMPM Bundle	1,698,000
Pay For Reporting	350,000
Pay for Outomes	700,000
PY 5 Total Check	OK