THE INFORMATION IN THIS BOX IS NOT A PART OF THE CONTRACT AND IS FOR COUNTY USE ONLY

SAN BERNARDINO COUNTY

Contract Number
16-986 A-1

SAP Number

Arrowhead Regional Medical Center

Department Contract Representative	William L. Gilbert
Telephone Number	(909) 580-6150
Contractor	California Department of Health Care Services
Contractor Representative	Jillian Clayton
Telephone Number	Jillian.Clayton@dhcs.ca.gov
Contract Term	November 29, 2016 through June 30, 2022
Original Contract Amount	$12,268,500 matching grant amount
Amendment Amount	$2,453,700 matching grant amount
Total Contract Amount	$14,722,200 matching grant amount
Cost Center	8895

Briefly describe the general nature of the contract: Amendment No. 1 to the Whole Person Care Grant Agreement with the California Department of Health Care Services, to extend the expiration date of the Agreement by one year, from June 30, 2021 through June 30, 2022.

FOR COUNTY USE ONLY

Approved as to Legal Form	Reviewed for Contract Compliance	Reviewed/Approved by Department
►	►	►
Charles Phan, Deputy County Counsel		William L. Gilbert, Director
Date 6/11/2021	Date	Date 6/14/21

WHOLE PERSON CARE AGREEMENT- Amendment A-01 Program Year 6 Extension

The overarching goal of the Whole Person Care (WPC) Pilot program is the coordination of health, behavioral health, and social services, as applicable, in a patient-centered manner with the goals of improved beneficiary health and wellbeing through more efficient and effective use of resources.

The Department of Health Care Services (DHCS) published a Request for Application (RFA) relating to the WPC Pilot Program on May 16, 2016. Arrowhead Regional Medical Center, by and through the County of San Bernardino (hereinafter referred to as "Arrowhead Regional Medical Center"), submitted its WPC application (Attachment A), in response to DHCS' RFA on July 1, 2016. DHCS accepted Arrowhead Regional Medical Center's WPC application to the RFA on October 24, 2016 with an allocation of (see table below) in federal financial participation available for each calendar year for the WPC pilot beginning in program year one through program year five.

Total Funds PY 1 - PY 5			
PY	Federal Financial Participation	Local Non-federal Funds	Total Funds
PY 1	$2,453,700.00	$2,453,700.00	$4,907,400.00
PY 2	$2,453,700.00	$2,453,700.00	$4,907,400.00
PY 3	$2,453,700.00	$2,453,700.00	$4,907,400.00
PY 4	$2,453,700.00	$2,453,700.00	$4,907,400.00
PY 5	$2,453,700.00	$2,453,700.00	$4,907,400.00

In May 2020, DHCS officially announced the delay of California Advancing and Innovating Medi-Cal Initiative (CalAIM) due to the impact of the public health emergency caused by COVID-19. As a result of the delay of CalAIM, the Centers for Medicare and Medicaid Services approved a 12-month extension of WPC Pilot Program to expire on December 31, 2021.

On December 29, 2020 DHCS extended Arrowhead Regional Medical Center's WPC pilot with an allocation of (see table below) in federal financial participation available for the program six calendar year subject to the signing of this Agreement.

Total Funds PY 6			
PY	Federal Financial Participation	Local Non-federal Funds	Total Funds
PY 6	$2,453,700.00	$2,453,700.00	$4,907,400.00

Per STC 126, in the event that the number of approved WPC Pilots results in unallocated funding for a given Demonstration year, participating Lead Entities may submit applications to the state in a manner and timeline specified by DHCS proposing that the remaining funds be carried forward into the following program year, or to expand Pilot services or enrollment for which such unallocated funding will be made available. DHCS accepted Arrowhead Regional Medical Center's application to carry forward any unspent funding from program year five into program year six on March 3, 2021.

The Parties agree:

A. That Terms and Conditions Item 2 shall be amended and replaced by the following:

2. **Term and Termination**. This Agreement will be effective from the date both DHCS and Contractor have executed this Agreement and terminate on June 30, 2022 unless the application is renewed or the WPC Pilot program is extended, or the WPC pilot is terminated in accordance with procedures established pursuant to STC 120 and Attachment HH thereof.

B. That "Section 6: Attestations and Certification" of Attachment A shall be amended and replaced by the following:

Section 6: Attestations and Certification
6.1 Attestation
I certify that, as the representative of the WPC pilot lead entity, I agree to the following conditions:

1. The WPC pilot lead entity will help develop and participate in regular learning collaboratives to share best practices among pilot entities, per STC 119.
2. The intergovernmental transfer (IGT) funds will qualify for federal financial participation per 42 CFR 433, subpart B, and will not be derived from impermissible sources, such as recycled Medicaid payments, federal money excluded from use as a state match, impermissible taxes, and non-bona fide provider-related donations, per STC 126.a. Sources of non-federal funding shall not include provider taxes or donations impermissible under section 1903(w), impermissible intergovernmental transfers from providers, or federal funds received from federal programs other than Medicaid (unless expressly authorized by federal statute to be used for claiming purposes, and the federal Medicaid funding is credited to the other federal funding source). For this purpose, federal funds do not include PRIME payments, patient care revenue received as payment for services rendered under programs such as the Designated State Health Programs, Medicare, or Medicaid
3. Within 30 days of the determination of the interim payment due based on the mid-year and annual report, DHCS will issue requests to the WPC pilot for the necessary IGT amounts. The WPC pilot shall make IGT of funds to DHCS in the

amount specified within 7 days of receiving the state's request. If the IGTs are made within the requested timeframe, the payment will be paid within 14 days after the transfers are made.

4. The WPC pilot lead entity will enter into an agreement with DHCS that specifies the requirements of the WPC pilot, including a data sharing agreement per STC 118. [See Exhibit A "HIPAA Business Associate Addendum (BAA)" of this Agreement. Many of the provisions in the DHCS boilerplate BAA apply only to BAA-covered information that is shared by DHCS to the pilot specifically for the purpose of Whole Person Care pilot operation and evaluation. DHCS does not anticipate that BAA-covered information will be shared with pilots for the purpose of Whole Person Care pilot operation or evaluation. DHCS anticipates limited, or no, BAA-covered information sharing from the pilot to DHCS. However, DHCS will include a BAA in the case that data need to be shared. The BAA will apply to the transfer of BAA-covered information should the need arise.]
5. The WPC pilot will report and submit timely and complete data to DHCS in a format specified by the state. Incomplete and/or non-timely data submissions may lead to a financial penalty after multiple occurrences and technical assistance is provided by the state.
6. The WPC pilot shall submit mid-year and annual reports in a manner specified by DHCS and according to the dates outlined in Attachment GG. The WPC pilot payments shall be contingent on whether progress toward the WPC pilot requirements approved in this application has been made.
7. The WPC pilot will meet with evaluators to assess the WPC pilot.
8. Federal funding received shall be returned if the WPC pilot, or a component of it as determined by the state, is not subsequently implemented.
9. Payments for WPC pilots will be contingent on certain deliverables or achievements, and will not be distributed, or may be recouped, if pilots fail to demonstrate achievement or submission of deliverables (STC 126).
10. If the individual WPC pilot applicant expends its maximum approved pilot year budget funding before the end of the pilot year, the individual WPC pilot will continue to provide WPC pilot services to enrolled WPC participants through the end of the pilot year.
11. WPC pilot payments shall not be used for activities otherwise coverable or directly reimbursable by Medi-Cal.
12. The lead entity shall complete an analysis of their proposed WPC pilot and their county's Medi-Cal Targeted Case Management Program (TCM) to ensure that their WPC pilot activities and interactions of their care coordination teams do not duplicate their county's TCM benefit. If the lead entity identifies any overlapping activities or interactions, the lead entity shall 1) apply a TCM budget adjustment, where appropriate, to reduce the request for WPC funds; and 2) document the adjustment(s) in the application in accordance with the DHCS guidance provided to the lead entity during the DHCS application review process.

13. The lead entity will respond to general inquiries from the state pertaining to the WPC pilot within one business day after acknowledging receipt, and provide requested information within five business days, unless an alternate timeline is approved or determined necessary by DHCS. DHCS will consider reasonable timelines that will be dependent on the type and severity of the information when making such requests.
14. The lead entity understands that the state of California must abide by all requirements outlined in the STCs and Attachments GG, HH, and MM. The state may suspend or terminate a WPC pilot if corrective action has been imposed and persistent poor performance continues. Should a WPC pilot be terminated, the state shall provide notice to the pilot and request a close-out plan due to the state within 30 calendar days, unless significant harm to beneficiaries is occurring, in which case the state may request a close-out plan within 10 business days. All state requirements regarding pilot termination can be found in Attachment HH.

☐ **I hereby certify that all information provided in this application is true and accurate to the best of my knowledge, and that this application has been completed based on a good faith understanding of WPC pilot program participation requirements as specified in the Medi-Cal 2020 waiver STCs, Attachments GG, HH and MM, and the DHCS Frequently Asked Questions document.**

C. WPC Pilot Program Agreement

Notice

All inquiries and notices relating to this Agreement should be directed to the representatives listed below. Either party may make changes to the information above by giving written notice to the other party. Said changes shall not require an amendment to this Contract.

The Agreement representatives during the term of this Agreement will be:

Department of Health Care Services	**WPC Pilot Lead Entity**
Managed Care Quality & Monitoring Division	County of San Bernardino on behalf of Arrowhead Regional Medical Center
Attention: Michel Huizar	Attention: Ernest Barrio
Telephone: (916) 345-7836	Telephone: (909) 421-4088

As a condition for participation in the WPC Pilot program, the WPC pilot lead entity (referred to as "Contractor" below) agrees to comply with all of the following terms and conditions, and with all of the terms and conditions included on any attachment(s) hereto, which is/are incorporated herein by reference:

1. **Nondiscrimination.** Pursuant to Affordable Care Act section 1557 (42 U.S.C. section 18116), during the performance of this Contract, Contractor shall not, and shall also require and ensure its subcontractors, providers, agents, and employees to not, cause an individual, beneficiary, or applicant to be excluded on the grounds prohibited under Title VI of the Civil Rights Act of 1964 (42 U.S.C. 2000d et seq.), Title IX of the Education Amendments of 1972 (20 U.S.C. 1681 et seq.), the Age Discrimination Act of 1975 (42 U.S.C. 6101 et seq.), or section 504 of the Rehabilitation Act of 1973 (29 U.S.C. 794), or subject to any other applicable State and Federal laws, from participation in, be denied the benefits of, or be subjected to discrimination under, any health program or activity offered through DHCS.

2. **Term and Termination.** This Agreement will be effective from the date both DHCS and Contractor have executed this Agreement and terminate on ~~June 30, 2021~~ June 30, 2022, unless the application is renewed or the WPC Pilot program is extended.

3. **Compliance with Laws and Regulations.** Contractor agrees to, and shall also require and ensure its subcontractors to, comply with all applicable provisions of Chapters 7 and 8 of the Welfare and Institutions Code, and any applicable rules or regulations promulgated by DHCS pursuant to these chapters. Contractor agrees to, and shall also requires its subcontractors to, comply with all federal laws and regulations governing and regulating the Medicaid program.

4. **Fraud and Abuse.** Contractor agrees, and shall also require its subcontractors to agree, that it shall not engage in or commit fraud or abuse. "Fraud" means intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or herself or some other person. "Abuse" means provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the Medicaid program or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care.

5. **Governing Law.** This Agreement shall be governed by and interpreted in accordance with the laws of the State of California.

6. **Complete Integration**. This Agreement, including any attachments or documents incorporated herein by express reference is intended to be a complete integration and there are no prior or contemporaneous different or additional agreements pertaining to the subject matters of this Agreement.

7. **Amendment.** No alteration or variation of the terms or provisions of this Agreement shall be valid unless made in writing and signed by the parties to this Agreement, and no oral understanding or agreement not set forth in this Agreement, shall be binding on the parties to this Agreement.

8. **Discrepancy or Inconsistency.** If there is a discrepancy or inconsistency in the terms of this Agreement and Attachment A, then this Agreement controls.

Signature of WPC Lead Entity Representative

SIGNED AND CERTIFIED THAT A COPY OF THIS DOCUMENT HAS BEEN DELIVERED TO THE CHAIRMAN OF THE BOARD
LYNNA MONELL
Clerk of the Board of Supervisors
of the County of San Bernardino
By _____ Deputy

Date JUN 22 2021

Name: Curt Hagman

Title: Chairman, Board of Supervisors

Signature of DHCS Representative

Date

Name: Nathan Nau

Title: Chief, Managed Care Quality & Monitoring Division

Whole Person Care Agreement

Exhibit A – Health Insurance Portability and Accountability Act (HIPAA Business Associate Addendum (BAA)

I. Recitals

A. This Contract (Agreement) has been determined to constitute a business associate relationship under the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191 ("HIPAA"), the Health Information Technology for Economic and Clinical Health Act, Public Law 111-005 ('the HITECH Act"), 42 U.S.C. section 17921 et seq., and their implementing privacy and security regulations at 45 CFR Parts 160 and 164 ("the HIPAA regulations").

B. The Department of Health Care Services ("DHCS") wishes to disclose to Business Associate certain information pursuant to the terms of this Agreement, some of which may constitute Protected Health Information ("PHI"), including protected health information in electronic media ("ePHI"), under federal law, and personal information ("PI") under state law.

C. As set forth in this Agreement, Contractor, here and after, is the Business Associate of DHCS acting on DHCS' behalf and provides services, arranges, performs or assists in the performance of functions or activities on behalf of DHCS and creates, receives, maintains, transmits, uses or discloses PHI and PI. DHCS and Business Associate are each a party to this Agreement and are collectively referred to as the "parties."

D. The purpose of this Addendum is to protect the privacy and security of the PHI and PI that may be created, received, maintained, transmitted, used or disclosed pursuant to this Agreement, and to comply with certain standards and requirements of HIPAA, the HITECH Act and the HIPAA regulations, including, but not limited to, the requirement that DHCS must enter into a contract containing specific requirements with Contractor prior to the disclosure of PHI to Contractor, as set forth in 45 CFR Parts 160 and 164 and the HITECH Act, and the Final Omnibus Rule as well as the Alcohol and Drug Abuse patient records confidentiality law 42 CFR Part 2, and any other applicable state or federal law or regulation. 42 CFR section 2.1(b)(2)(B) allows for the disclosure of such records to qualified personnel for the purpose of conducting management or financial audits, or program evaluation. 42 CFR Section 2.53(d) provides that patient identifying information disclosed under this section may be disclosed only back to the program from which it was obtained and used only to carry out an audit or evaluation purpose or to investigate or prosecute criminal or other activities, as authorized by an appropriate court order.

E. The terms used in this Addendum, but not otherwise defined, shall have the same meanings as those terms have in the HIPAA regulations. Any reference to statutory or regulatory language shall be to such language as in effect or as amended.

II. Definitions

A. Breach shall have the meaning given to such term under HIPAA, the HITECH Act, the HIPAA regulations, and the Final Omnibus Rule.

B. Business Associate shall have the meaning given to such term under HIPAA, the HITECH Act, the HIPAA regulations, and the final Omnibus Rule.

C. Covered Entity shall have the meaning given to such term under HIPAA, the HITECH Act, the HIPAA regulations, and Final Omnibus Rule.

D. Electronic Health Record shall have the meaning given to such term in the HITECH Act, including, but not limited to, 42 U.S.C Section 17921 and implementing regulations.

E. Electronic Protected Health Information (ePHI) means individually identifiable health information transmitted by electronic media or maintained in electronic media, including but not limited to electronic media as set forth under 45 CFR section 160.103.

F. Individually Identifiable Health Information means health information, including demographic information collected from an individual, that is created or received by a health care provider, health plan, employer or health care clearinghouse, and relates to the past, present or future physical or mental health or condition of an individual, the provision of health care to an individual, or the past, present, or future payment for the provision of health care to an individual, that identifies the individual or where there is a reasonable basis to believe the information can be used to identify the individual, as set forth under 45 CFR section 160.103.

G. Privacy Rule shall mean the HIPAA Regulation that is found at 45 CFR Parts 160 and 164.

H. Personal Information shall have the meaning given to such term in California Civil Code section 1798.29.

I. Protected Health Information means individually identifiable health information that is transmitted by electronic media, maintained in electronic media, or is transmitted or maintained in any other form or medium, as set forth under 45 CFR section 160.103.

J. Required by law, as set forth under 45 CFR section 164.103, means a mandate contained in law that compels an entity to make a use or disclosure of PHI that is enforceable in a court of law. This includes, but is not limited to, court orders and court-ordered warrants, subpoenas or summons issued by a court, grand jury, a governmental or tribal inspector general, or an administrative body authorized to require the production of information, and a civil or an authorized investigative demand. It also includes Medicare conditions of participation with respect to health care providers participating in the program, and statutes or regulations that require the production of information, including statutes or regulations that require such information if payment is sought under a government program providing public benefits.

K. Secretary means the Secretary of the U.S. Department of Health and Human Services ("HHS") or the Secretary's designee.

L. Security Incident means the attempted or successful unauthorized access, use, disclosure, modification, or destruction of PHI or PI, or confidential data that is essential to the ongoing operation of the Business Associate's organization and intended for internal use; or interference with system operations in an information system.

M. Security Rule shall mean the HIPAA regulation that is found at 45 CFR Parts 160 and 164.

N. Unsecured PHI shall have the meaning given to such term under the HITECH Act, 42 U.S.C. section 17932(h), any guidance issued pursuant to such Act, and the HIPAA regulations.

III. Terms ofAgreement

A. Permitted Uses and Disclosures of PHI by Business Associate

Permitted Uses and Disclosures. Except as otherwise indicated in this Addendum, Business Associate may use or disclose PHI only to perform functions, activities or services specified in this Agreement, for, or on behalf of DHCS, provided that such use or disclosure would not violate the HIPAA regulations, if done by DHCS. Any such use or disclosure must, to the extent practicable, be limited to the limited data set, as defined in 45 CFR section 164.514(e)(2), or, if needed, to the minimum necessary to accomplish the intended purpose of such use or disclosure, in compliance with the HITECH Act and any guidance issued pursuant to such Act, the HIPAA regulations, the Final Omnibus Rule and 42 CFR Part 2.

1. Specific Use and Disclosure Provisions. Except as otherwise indicated in this Addendum, Business Associate may:

a. Use and disclose for management and administration. Use and disclose PHI for the proper management and administration of the Business Associate provided that such disclosures are required by law, or the Business Associate obtains reasonable assurances from the person to whom the information is disclosed that it will remain confidential and will be used or further disclosed only as required by law or for the purpose for which it was disclosed to the person, and the person notifies the Business Associate of any instances of which it is aware that the confidentiality of the information has been breached.

b. Provision of Data Aggregation Services. Use PHI to provide data aggregation services to DHCS. Data aggregation means the combining of PHI created or received by the Business Associate on behalf of DHCS with PHI received by the Business Associate in its capacity as the Business Associate of another covered entity, to permit data analyses that relate to the health care operations of DHCS.

B. Prohibited Uses and Disclosures

1. Business Associate shall not disclose PHI about an individual to a health plan for payment or health care operations purposes if the PHI pertains solely to a health care item or service for which the health care provider involved has been paid out of pocket in full and the individual requests such restriction, in accordance with 42 U.S.C. section 17935(a) and 45 CFR section 164.522(a).

2. Business Associate shall not directly or indirectly receive remuneration in exchange for PHI, except with the prior written consent of DHCS and as permitted by 42 U.S.C. section 17935(d)(2).

C. Responsibilities of Business Associate

Business Associate agrees:

1. Nondisclosure. Not to use or disclose Protected Health Information (PHI) other than as permitted or required by this Agreement or as required by law.

2. Safeguards. To implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the PHI, including electronic PHI, that it creates, receives, maintains, uses or transmits on behalf of DHCS, in compliance with 45 CFR sections 164.308, 164.310 and 164.312, and to prevent use or disclosure of PHI other than as provided for by this Agreement. Business Associate shall implement reasonable and appropriate policies and procedures to comply with the standards, implementation specifications and other requirements of 45 CFR section 164, subpart C, in compliance with 45 CFR section 164.316. Business Associate shall develop and maintain a written information privacy and security program that includes administrative, technical and physical safeguards

appropriate to the size and complexity of the Business Associate's operations and the nature and scope of its activities, and which incorporates the requirements of section 3, Security, below. Business Associate will provide DHCS with its current and updated policies.

3. Security. To take any and all steps necessary to ensure the continuous security of all computerized data systems containing PHI and/or PI, and to protect paper documents containing PHI and/or PI. These steps shall include, at a minimum:

a. Complying with all of the data system security precautions listed in Attachment A, the Business Associate Data Security Requirements;

b. Achieving and maintaining compliance with the HIPAA Security Rule (45 CFR Parts 160 and 164), as necessary in conducting operations on behalf of DHCS under this Agreement;

c. Providing a level and scope of security that is at least comparable to the level and scope of security established by the Office of Management and Budget in OMB Circular No. A-130, Appendix III - Security of Federal Automated Information Systems, which sets forth guidelines for automated information systems in Federal agencies; and

d. In case of a conflict between any of the security standards contained in any of these enumerated sources of security standards, the most stringent shall apply. The most stringent means that safeguard which provides the highest level of protection to PHI from unauthorized disclosure. Further, Business Associate must comply with changes to these standards that occur after the effective date of this Agreement.

Business Associate shall designate a Security Officer to oversee its data security program who shall be responsible for carrying out the requirements of this section and for communicating on security matters with DHCS.

D. Mitigation of Harmful Effects. To mitigate, to the extent practicable, any harmful effect that is known to Business Associate of a use or disclosure of PHI by Business Associate or its subcontractors in violation of the requirements of this Addendum.

E. Business Associate's Agents and Subcontractors.

1. To enter into written agreements with any agents, including subcontractors and vendors, to whom Business Associate provides PHI or PI received from or created or received by Business Associate on behalf of DHCS, that impose the same restrictions and conditions on such agents, subcontractors and vendors that apply to Business Associate with respect to such PHI and PI under this

Addendum, and that comply with all applicable provisions of HIPAA, the HITECH Act the HIPAA regulations, and the Final Omnibus Rule, including the requirement that any agents, subcontractors or vendors implement reasonable and appropriate administrative, physical, and technical safeguards to protect such PHI and PI. Business associates are directly liable under the HIPAA Rules and subject to civil and, in some cases, criminal penalties for making uses and disclosures of protected health information that are not authorized by its contract or required by law. A business associate also is directly liable and subject to civil penalties for failing to safeguard electronic protected health information in accordance with the HIPAA Security Rule. A "business associate" also is a subcontractor that creates, receives, maintains, or transmits protected health information on behalf of another business associate. Business Associate shall incorporate, when applicable, the relevant provisions of this Addendum into each subcontract or subaward to such agents, subcontractors and vendors, including the requirement that any security incidents or breaches of unsecured PHI or PI be reported to Business Associate.

2. In accordance with 45 CFR section 164.504(e)(1)(ii), upon Business Associate's knowledge of a material breach or violation by its subcontractor of the agreement between Business Associate and the subcontractor, Business Associate shall:

a. Provide an opportunity for the subcontractor to cure the breach or end the violation and terminate the agreement if the subcontractor does not cure the breach or end the violation within the time specified by DHCS; or
b. Immediately terminate the agreement if the subcontractor has breached a material term of the agreement and cure is not possible.

F. Availability of Information to DHCS and Individuals. To provide access and information:

1. To provide access as DHCS may require, and in the time and manner designated by DHCS (upon reasonable notice and during Business Associate's normal business hours) to PHI in a Designated Record Set, to DHCS (or, as directed by DHCS), to an Individual, in accordance with 45 CFR section 164.524. Designated Record Set means the group of records maintained for DHCS that includes medical, dental and billing records about individuals; enrollment, payment, claims adjudication, and case or medical management systems maintained for DHCS health plans; or those records used to make decisions about individuals on behalf of DHCS. Business Associate shall use the forms and processes developed by DHCS for this purpose and shall respond to requests for access to records transmitted by DHCS within fifteen (15) calendar days of receipt of the request by producing the records or verifying that there are none.

2. If Business Associate maintains an Electronic Health Record with PHI, and an individual requests a copy of such information in an electronic format, Business Associate shall provide such information in an electronic format to enable DHCS to fulfill its obligations under the HITECH Act, including but not limited to, 42 U.S.C. section 17935(e).

3. If Business Associate receives data from DHCS that was provided to DHCS by the Social Security Administration, upon request by DHCS, Business Associate shall provide DHCS with a list of all employees, contractors and agents who have access to the Social Security data, including employees, contractors and agents of its subcontractors and agents.

G. Amendment of PHI. To make any amendment(s) to PHI that DHCS directs or agrees to pursuant to 45 CFR section 164.526, in the time and manner designated by DHCS.

H. Internal Practices. To make Business Associate's internal practices, books and records relating to the use and disclosure of PHI received from DHCS, or created or received by Business Associate on behalf of DHCS, available to DHCS or to the Secretary of the U.S. Department of Health and Human Services in a time and manner designated by DHCS or by the Secretary, for purposes of determining DHCS' compliance with the HIPAA regulations. If any information needed for this purpose is in the exclusive possession of any other entity or person and the other entity or person fails or refuses to furnish the information to Business Associate, Business Associate shall so certify to DHCS and shall set forth the efforts it made to obtain the information.

I. Documentation of Disclosures. To document and make available to DHCS or (at the direction of DHCS) to an Individual such disclosures of PHI, and information related to such disclosures, necessary to respond to a proper request by the subject Individual for an accounting of disclosures of PHI, in accordance with the HITECH Act and its implementing regulations, including but not limited to 45 CFR section 164.528 and 42 U.S.C. section 17935(c). If Business Associate maintains electronic health records for DHCS as of January 1, 2009, Business Associate must provide an accounting of disclosures, including those disclosures for treatment, payment or health care operations, effective with disclosures on or after January 1, 2014. If Business Associate acquires electronic health records for DHCS after January 1, 2009, Business Associate must provide an accounting of disclosures, including those disclosures for treatment, payment or health care operations, effective with disclosures on or after the date the electronic health record is acquired, or on or after January 1, 2011, whichever date is later. The electronic accounting of disclosures shall be for disclosures during the three years prior to the request for an accounting.

J. Breaches and Security Incidents. During the term of this Agreement, Business Associate agrees to implement reasonable systems for the discovery

and prompt reporting of any breach or security incident, and to take the following steps:

1. Notice to DHCS. (1) To notify DHCS immediately upon the discovery of a suspected security incident that involves data provided to DHCS by the Social Security Administration. This notification will be by telephone call plus email or fax upon the discovery of the breach. (2) To notify DHCS within 24 hours by email or fax of the discovery of unsecured PHI or PI in electronic media or in any other media if the PHI or PI was, or is reasonably believed to have been, accessed or acquired by an unauthorized person, any suspected security incident, intrusion or unauthorized access, use or disclosure of PHI or PI in violation of this Agreement and this Addendum, or potential loss of confidential data affecting this Agreement. A breach shall be treated as discovered by Business Associate as of the first day on which the breach is known, or by exercising reasonable diligence would have been known, to any person (other than the person committing the breach) who is an employee, officer or other agent of Business Associate.

Notice shall be provided to the DHCS Program Contract Manager, the DHCS Privacy Officer and the DHCS Information Security Officer. If the incident occurs after business hours or on a weekend or holiday and involves data provided to DHCS by the Social Security Administration, notice shall be provided by calling the DHCS EITS Service Desk. Notice shall be made using the "DHCS Privacy Incident Report" form, including all information known at the time. Business Associate shall use the most current version of this form, which is posted on the DHCS Privacy Office website (www.dhcs.ca.gov, then select "Privacy" in the left column and then "Business Use" near the middle of the page) or use this link: http://www.dhcs.ca.gov/formsandpubs/laws/priv/Pages/DHCSBusinessAssociatesOnly.aspx

Upon discovery of a breach or suspected security incident, intrusion or unauthorized access, use or disclosure of PHI or PI, Business Associate shall take:

a. Prompt corrective action to mitigate any risks or damages involved with the breach and to protect the operating environment; and
b. Any action pertaining to such unauthorized disclosure required by applicable Federal and State laws and regulations.

2. Investigation and Investigation Report. To immediately investigate such security incident, breach, or unauthorized access, use or disclosure of PHI or PI. If the initial report did not include all of the requested information marked with an asterisk, then within 72 hours of the discovery, Business Associate shall submit an updated "DHCS Privacy Incident Report" containing the information marked with an asterisk and all other applicable information listed on the form, to the

extent known at that time, to the DHCS Program Contract Manager, the DHCS Privacy Officer, and the DHCS Information Security Officer:

3. Complete Report. To provide a complete report of the investigation to the DHCS Program Contract Manager, the DHCS Privacy Officer, and the DHCS Information Security Officer within ten (10) working days of the discovery of the breach or unauthorized use or disclosure. If all of the required information was not included in either the initial report, or the Investigation Report, then a separate Complete Report must be submitted. The report shall be submitted on the "DHCS Privacy Incident Report" form and shall include an assessment of all known factors relevant to a determination of whether a breach occurred under applicable provisions of HIPAA, the HITECH Act, the HIPAA regulations and/or state law. The report shall also include a full, detailed corrective action plan, including information on measures that were taken to halt and/or contain the improper use or disclosure. If DHCS requests information in addition to that listed on the "DHCS Privacy Incident Report" form, Business Associate shall make reasonable efforts to provide DHCS with such information. If necessary, a Supplemental Report may be used to submit revised or additional information after the completed report is submitted, by submitting the revised or additional information on an updated "DHCS Privacy Incident Report" form. DHCS will review and approve or disapprove the determination of whether a breach occurred, is reportable to the appropriate entities, if individual notifications are required, and the corrective action plan.

4. Notification of Individuals. If the cause of a breach of PHI or PI is attributable to Business Associate or its subcontractors, agents or vendors, Business Associate shall notify individuals of the breach or unauthorized use or disclosure when notification is required under state or federal law and shall pay any costs of such notifications, as well as any costs associated with the breach. The notifications shall comply with the requirements set forth in 42 U.S.C. section 17932 and its implementing regulations, including, but not limited to, the requirement that the notifications be made without unreasonable delay and in no event later than 60 calendar days. The DHCS Program Contract Manager, the DHCS Privacy Officer, and the DHCS Information Security Officer shall approve the time, manner and content of any such notifications and their review and approval must be obtained before the notifications are made.

5. Responsibility for Reporting of Breaches. If the cause of a breach of PHI or PI is attributable to Business Associate or its agents, subcontractors or vendors, Business Associate is responsible for all required reporting of the breach as specified in 42 U.S.C. section 17932 and its implementing regulations, including notification to media outlets and to the Secretary. If a breach of unsecured PHI involves more than 500 residents of the State of California or its jurisdiction, Business Associate shall notify the Secretary of the breach immediately upon discovery of the breach. If Business Associate has reason to believe that duplicate reporting of the same breach or incident may occur

because its subcontractors, agents or vendors may report the breach or incident to DHCS in addition to Business Associate, Business Associate shall notify DHCS, and DHCS and Business Associate may take appropriate action to prevent duplicate reporting. The breach reporting requirements of this paragraph are in addition to the reporting requirements set forth in subsection 1, above.

1. DHCS Contact Information. To direct communications to the above referenced DHCS staff, the Contractor shall initiate contact as indicated herein. DHCS reserves the right to make changes to the contact information below by giving written notice to the Contractor. Said changes shall not require an amendment to this Addendum or the Agreement to which it is incorporated.

DHCS Contract Contact	**DHCS Privacy Officer**	**DHCS Information Security Officer**
Chief, Coordinated Care Program Section	Privacy Officer c/o: Office of HIPAA Compliance Department of Health Care Services P.O. Box 997413, MS 4722 Sacramento, CA 95899-7413 Email: privacyofficer@dhcs.ca.gov Telephone: (916) 445-4646 Fax: (916) 440-7680	Information Security Officer DHCS Information Security Office P.O. Box 997413, MS 6400 Sacramento, CA 95899-7413 Email: iso@dhcs.ca.gov Fax: (916) 440-5537 Telephone: EITS Service Desk (916) 440-7000 or (800) 579-0874

K. Termination of Agreement. In accordance with Section 13404(b) of the HITECH Act and to the extent required by the HIPAA regulations, if Business Associate knows of a material breach or violation by DHCS of this Addendum, it shall take the following steps:

1. Provide an opportunity for DHCS to cure the breach or end the violation and terminate the Agreement if DHCS does not cure the breach or end the violation within the time specified by Business Associate; or
2. Immediately terminate the Agreement if DHCS has breached a material term of the Addendum and cure is not possible.

L. Due Diligence. Business Associate shall exercise due diligence and shall take reasonable steps to ensure that it remains in compliance with this Addendum and is in compliance with applicable provisions of HIPAA, the HITECH Act and the HIPAA regulations, and that its agents, subcontractors and vendors are in compliance with their obligations as required by this Addendum.

M. Sanctions and/or Penalties. Business Associate understands that a failure to comply with the provisions of HIPAA, the HITECH Act and the HIPAA

regulations that are applicable to Business Associate may result in the imposition of sanctions and/or penalties on Business Associate under HIPAA, the HITECH Act and the HIPAA regulations.

IV. Obligations of DHCS

DHCS agrees to:

A. Notice of Privacy Practices. Provide Business Associate with the Notice of Privacy Practices that DHCS produces in accordance with 45 CFR section 164.520, as well as any changes to such notice. Visit the DHCS Privacy Office to view the most current Notice of Privacy Practices at: http://www.dhcs.ca.gov/formsandpubs/laws/priv/Pages/default.aspx or the DHCS website at www.dhcs.ca.gov (select "Privacy in the left column and "Notice of Privacy Practices" on the right side of the page).

B. Permission by Individuals for Use and Disclosure of PHI. Provide the Business Associate with any changes in, or revocation of, permission by an Individual to use or disclose PHI, if such changes affect the Business Associate's permitted or required uses and disclosures.

C. Notification of Restrictions. Notify the Business Associate of any restriction to the use or disclosure of PHI that DHCS has agreed to in accordance with 45 CFR section 164.522, to the extent that such restriction may affect the Business Associate's use or disclosure of PHI.

D. Requests Conflicting with HIPAA Rules. Not request the Business Associate to use or disclose PHI in any manner that would not be permissible under the HIPAA regulations if done by DHCS.

V. Audits, Inspection and Enforcement

A. From time to time, DHCS may inspect the facilities, systems, books and records of Business Associate to monitor compliance with this Agreement and this Addendum. Business Associate shall promptly remedy any violation of any provision of this Addendum and shall certify the same to the DHCS Privacy Officer in writing. The fact that DHCS inspects, or fails to inspect, or has the right to inspect, Business Associate's facilities, systems and procedures does not relieve Business Associate of its responsibility to comply with this Addendum, nor does DHCS':

1. Failure to detect or

2. Detection, but failure to notify Business Associate or require Business Associate's remediation of any unsatisfactory practices constitute acceptance of

such practice or a waiver of DHCS' enforcement rights under this Agreement and this Addendum.

B. If Business Associate is the subject of an audit, compliance review, or complaint investigation by the Secretary or the Office of Civil Rights, U.S. Department of Health and Human Services, that is related to the performance of its obligations pursuant to this HIPAA Business Associate Addendum, Business Associate shall notify DHCS and provide DHCS with a copy of any PHI or PI that Business Associate provides to the Secretary or the Office of Civil Rights concurrently with providing such PHI or PI to the Secretary. Business Associate is responsible for any civil penalties assessed due to an audit or investigation of Business Associate, in accordance with 42 U.S.C. section 17934(c).

VI. Termination

A. Term. The Term of this Addendum shall commence as of the effective date of this Addendum and shall extend beyond the termination of the contract and shall terminate when all the PHI provided by DHCS to Business Associate, or created or received by Business Associate on behalf of DHCS, is destroyed or returned to DHCS, in accordance with 45 CFR 164.504(e)(2)(ii)(I).

B. Termination for Cause. In accordance with 45 CFR section 164.504(e)(1)(ii), upon DHCS' knowledge of a material breach or violation of this Addendum by Business Associate, DHCS shall:

1. Provide an opportunity for Business Associate to cure the breach or end the violation and terminate this Agreement if Business Associate does not cure the breach or end the violation within the time specified by DHCS; or
2. Immediately terminate this Agreement if Business Associate has breached a material term of this Addendum and cure is not possible.

C. Judicial or Administrative Proceedings. Business Associate will notify DHCS if it is named as a defendant in a criminal proceeding for a violation of HIPAA. DHCS may terminate this Agreement if Business Associate is found guilty of a criminal violation of HIPAA. DHCS may terminate this Agreement if a finding or stipulation that the Business Associate has violated any standard or requirement of HIPAA, or other security or privacy laws is made in any administrative or civil proceeding in which the Business Associate is a party or has been joined.

D. Effect of Termination. Upon termination or expiration of this Agreement for any reason, Business Associate shall return or destroy all PHI received from DHCS (or created or received by Business Associate on behalf of DHCS) that Business Associate still maintains in any form, and shall retain no copies of such PHI. If return or destruction is not feasible, Business Associate shall notify DHCS of the conditions that make the return or destruction infeasible, and DHCS and Business Associate shall determine the terms and conditions under which

Business Associate may retain the PHI. Business Associate shall continue to extend the protections of this Addendum to such PHI, and shall limit further use of such PHI to those purposes that make the return or destruction of such PHI infeasible. This provision shall apply to PHI that is in the possession of subcontractors or agents of Business Associate.

VII. Miscellaneous Provisions

A. Disclaimer. DHCS makes no warranty or representation that compliance by Business Associate with this Addendum, HIPAA or the HIPAA regulations will be adequate or satisfactory for Business Associate's own purposes or that any information in Business Associate's possession or control, or transmitted or received by Business Associate, is or will be secure from unauthorized use or disclosure. Business Associate is solely responsible for all decisions made by Business Associate regarding the safeguarding of PHI.

B. Amendment. The parties acknowledge that federal and state laws relating to electronic data security and privacy are rapidly evolving and that amendment of this Addendum may be required to provide for procedures to ensure compliance with such developments. The parties specifically agree to take such action as is necessary to implement the standards and requirements of HIPAA, the HITECH Act, the HIPAA regulations and other applicable laws relating to the security or privacy of PHI. Upon DHCS' request, Business Associate agrees to promptly enter into negotiations with DHCS concerning an amendment to this Addendum embodying written assurances consistent with the standards and requirements of HIPAA, the HITECH Act, the HIPAA regulations or other applicable laws. DHCS may terminate this Agreement upon thirty (30) days written notice in the event:

1. Business Associate does not promptly enter into negotiations to amend this Addendum when requested by DHCS pursuant to this Section; or

2. Business Associate does not enter into an amendment providing assurances regarding the safeguarding of PHI that DHCS in its sole discretion, deems sufficient to satisfy the standards and requirements of HIPAA and the HIPAA regulations.

C. Assistance in Litigation or Administrative Proceedings. Business Associate shall make itself and any subcontractors, employees or agents assisting Business Associate in the performance of its obligations under this Agreement, available to DHCS at no cost to DHCS to testify as witnesses, or otherwise, in the event of litigation or administrative proceedings being commenced against DHCS, its directors, officers or employees based upon claimed violation of HIPAA, the HIPAA regulations or other laws relating to security and privacy, which involves inactions or actions by the Business

Associate, except where Business Associate or its subcontractor, employee or agent is a named adverse party.

D. No Third-Party Beneficiaries. Nothing express or implied in the terms and conditions of this Addendum is intended to confer, nor shall anything herein confer, upon any person other than DHCS or Business Associate and their respective successors or assignees, any rights, remedies, obligations or liabilities whatsoever.

E. Interpretation. The terms and conditions in this Addendum shall be interpreted as broadly as necessary to implement and comply with HIPAA, the HITECH Act, the HIPAA regulations and applicable state laws. The parties agree that any ambiguity in the terms and conditions of this Addendum shall be resolved in favor of a meaning that complies and is consistent with HIPAA, the HITECH Act and the HIPAA regulations.

F. Regulatory References. A reference in the terms and conditions of this Addendum to a section in the HIPAA regulations means the section as in effect or as amended.

G. Survival. The respective rights and obligations of Business Associate under Section VI.D of this Addendum shall survive the termination or expiration of this Agreement.

H. No Waiver of Obligations. No change, waiver or discharge of any liability or obligation hereunder on any one or more occasions shall be deemed a waiver of performance of any continuing or other obligation, or shall prohibit enforcement of any obligation, on any other occasion.

HIPAA BAA
Attachment A
Business Associate Data Security Requirements

I. Personnel Controls

A. Employee Training. All workforce members who assist in the performance of functions or activities on behalf of DHCS, or access or disclose DHCS PHI or PI must complete information privacy and security training, at least annually, at Business Associate's expense. Each workforce member who receives information privacy and security training must sign a certification, indicating the member's name and the date on which the training was completed. These certifications must be retained for a period of six (6) years following contract termination.

B. Employee Discipline. Appropriate sanctions must be applied against workforce members who fail to comply with privacy policies and procedures or any provisions of these requirements, including termination of employment where appropriate.

C. Confidentiality Statement. All persons that will be working with DHCS PHI or PI must sign a confidentiality statement that includes, at a minimum, General Use, Security and Privacy Safeguards, Unacceptable Use, and Enforcement Policies. The statement must be signed by the workforce member prior to access to DHCS PHI or PI. The statement must be renewed annually. The Contractor shall retain each person's written confidentiality statement for DHCS inspection for a period of six (6) years following contract termination.

D. Background Check. Before a member of the workforce may access DHCS PHI or PI, a thorough background check of that worker must be conducted, with evaluation of the results to assure that there is no indication that the worker may present a risk to the security or integrity of confidential data or a risk for theft or misuse of confidential data. The Contractor shall retain each workforce member's background check documentation for a period of three (3) years following contract termination.

II. Technical Security Controls

A. Workstation/Laptop encryption. All workstations and laptops that process and/or store DHCS PHI or PI must be encrypted using a FIPS 140-2 certified algorithm which is 128bit or higher, such as Advanced Encryption Standard (AES). The encryption solution must be full disk unless approved by the DHCS Information Security Office.

B. Server Security. Servers containing unencrypted DHCS PHI or PI must have sufficient administrative, physical, and technical controls in place to protect that data, based upon a risk assessment/system security review.

C. Minimum Necessary. Only the minimum necessary amount of DHCS PHI or PI required to perform necessary business functions may be copied, downloaded, or exported.

D. Removable media devices. All electronic files that contain DHCS PHI or PI data must be encrypted when stored on any removable media or portable device (i.e. USB thumb drives, floppies, CD/DVD, smartphones, backup tapes etc.). Encryption must be a FIPS 140-2 certified algorithm which is 128bit or higher, such as AES.

E. Antivirus software. All workstations, laptops and other systems that process and/or store DHCS PHI or PI must install and actively use comprehensive anti-virus software solution with automatic updates scheduled at least daily.

F. Patch Management. All workstations, laptops and other systems that process and/or store DHCS PHI or PI must have critical security patches applied, with system reboot if necessary. There must be a documented patch management process which determines installation timeframe based on risk assessment and vendor recommendations. At a maximum, all applicable patches must be installed within 30 days of vendor release.

G. User IDs and Password Controls. All users must be issued a unique user name for accessing DHCS PHI or PI. Username must be promptly disabled, deleted, or the password changed upon the transfer or termination of an employee with knowledge of the password, at maximum within 24 hours. Passwords are not to be shared. Passwords must be at least eight characters and must be a non-dictionary word. Passwords must not be stored in readable format on the computer. Passwords must be changed every 90 days, preferably every 60 days. Passwords must be changed if revealed or compromised. Passwords must be composed of characters from at least three of the following four groups from the standard keyboard:

- Upper case letters (A-Z)
- Lower case letters (a-z)
- Arabic numerals (0-9)
- Non-alphanumeric characters (punctuation symbols)

H. Data Destruction. When no longer needed, all DHCS PHI or PI must be cleared, purged, or destroyed consistent with NIST Special Publication 800-88, Guidelines for Media Sanitization such that the PHI or PI cannot be retrieved.

I. System Timeout. The system providing access to DHCS PHI or PI must provide an automatic timeout, requiring re-authentication of the user session after no more than 20 minutes of inactivity.

J. Warning Banners. All systems providing access to DHCS PHI or PI must display a warning banner stating that data is confidential, systems are logged, and system use is for business purposes only by authorized users. User must be directed to log off the system if they do not agree with these requirements.

K. System Logging. The system must maintain an automated audit trail which can identify the user or system process which initiates a request for DHCS PHI or PI, or which alters DHCS PHI or PI. The audit trail must be date and time stamped, must log both successful and failed accesses, must be read only, and must be restricted to authorized users. If DHCS PHI or PI is stored in a database, database logging functionality must be enabled. Audit trail data must be archived for at least 3 years after occurrence.

L. Access Controls. The system providing access to DHCS PHI or PI must use role based access controls for all user authentications, enforcing the principle of least privilege.

M. Transmission encryption. All data transmissions of DHCS PHI or PI outside the secure internal network must be encrypted using a FIPS 140-2 certified algorithm which is 128bit or higher, such as AES. Encryption can be end to end at the network level, or the data files containing PHI can be encrypted. This requirement pertains to any type of PHI or PI in motion such as website access, file transfer, and E-Mail.

N. Intrusion Detection. All systems involved in accessing, holding, transporting, and protecting DHCS PHI or PI that are accessible via the Internet must be protected by a comprehensive intrusion detection and prevention solution.

III. Audit Controls

A. System Security Review. All systems processing and/or storing DHCS PHI or PI must have at least an annual system risk assessment/security review which provides assurance that administrative, physical, and technical controls are functioning effectively and providing adequate levels of protection. Reviews should include vulnerability scanning tools.

B. Log Reviews. All systems processing and/or storing DHCS PHI or PI must have a routine procedure in place to review system logs for unauthorized access.

C. Change Control. All systems processing and/or storing DHCS PHI or PI must have a documented change control procedure that ensures separation of duties and protects the confidentiality, integrity and availability of data.

IV. Business Continuity / Disaster Recovery Controls

A. Emergency Mode Operation Plan. Contractor must establish a documented plan to enable continuation of critical business processes and protection of the security of electronic DHCS PHI or PI in the event of an emergency. Emergency means any circumstance or situation that causes normal computer operations to become unavailable for use in performing the work required under this Agreement for more than 24 hours.

B. Data Backup Plan. Contractor must have established documented procedures to backup DHCS PHI to maintain retrievable exact copies of DHCS PHI or PI. The plan must include a regular schedule for making backups, storing backups offsite, an inventory of backup media, and an estimate of the amount of time needed to restore DHCS PHI or PI should it be lost. At a minimum, the schedule must be a weekly full backup and monthly offsite storage of DHCS data.

V. Paper Document Controls

A. Supervision of Data. DHCS PHI or PI in paper form shall not be left unattended at any time, unless it is locked in a file cabinet, file room, desk or office. Unattended means that information is not being observed by an employee authorized to access the information. DHCS PHI or PI in paper form shall not be left unattended at any time in vehicles or planes and shall not be checked in baggage on commercial airplanes.

B. Escorting Visitors. Visitors to areas where DHCS PHI or PI is contained shall be escorted and DHCS PHI or PI shall be kept out of sight while visitors are in the area.

C. Confidential Destruction. DHCS PHI or PI must be disposed of through confidential means, such as cross cut shredding and pulverizing.

D. Removal of Data. DHCS PHI or PI must not be removed from the premises of the Contractor except with express written permission of DHCS.

E. Faxing. Faxes containing DHCS PHI or PI shall not be left unattended and fax machines shall be in secure areas. Faxes shall contain a confidentiality statement notifying persons receiving faxes in error to destroy them. Fax numbers shall be verified with the intended recipient before sending the fax.

F. Mailing. Mailings of DHCS PHI or PI shall be sealed and secured from damage or inappropriate viewing of PHI or PI to the extent possible. Mailings which include 500 or more individually identifiable records of DHCS PHI or PI in a single package shall be sent using a tracked mailing method which includes verification of delivery and receipt, unless the prior written permission of DHCS to use another method is obtained.

AMENDMENT VII

WHOLE PERSON CARE PILOT

APPLICATION

November 22, 2016

Table of Contents

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

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 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 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.

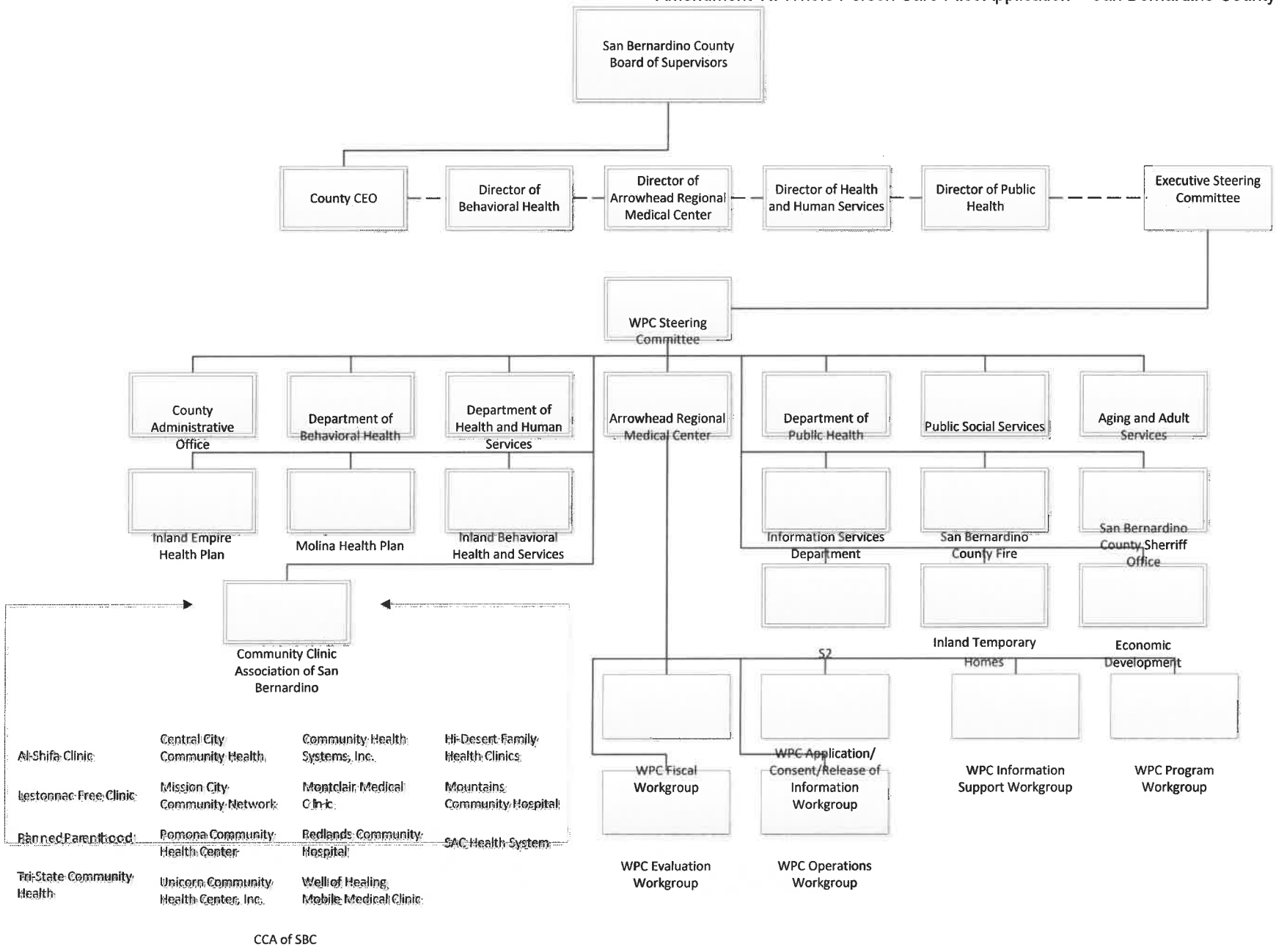
The WPC Steering Committee has established additional sub-committees to develop, support, and monitor specific policies and procedures addressing each workgroups specific expertise. These workgroups allow members of all entities to provide input and suggestions to develop and improve processes and procedures. 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
Community Clinic Association of San Bernardino
Inland Temporary Homes
Economic Development
52
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 twelve (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 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 & 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 (3) 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. 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 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

WPC team members will have access to all appropriate information available within all of the entity systems for this population, 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.

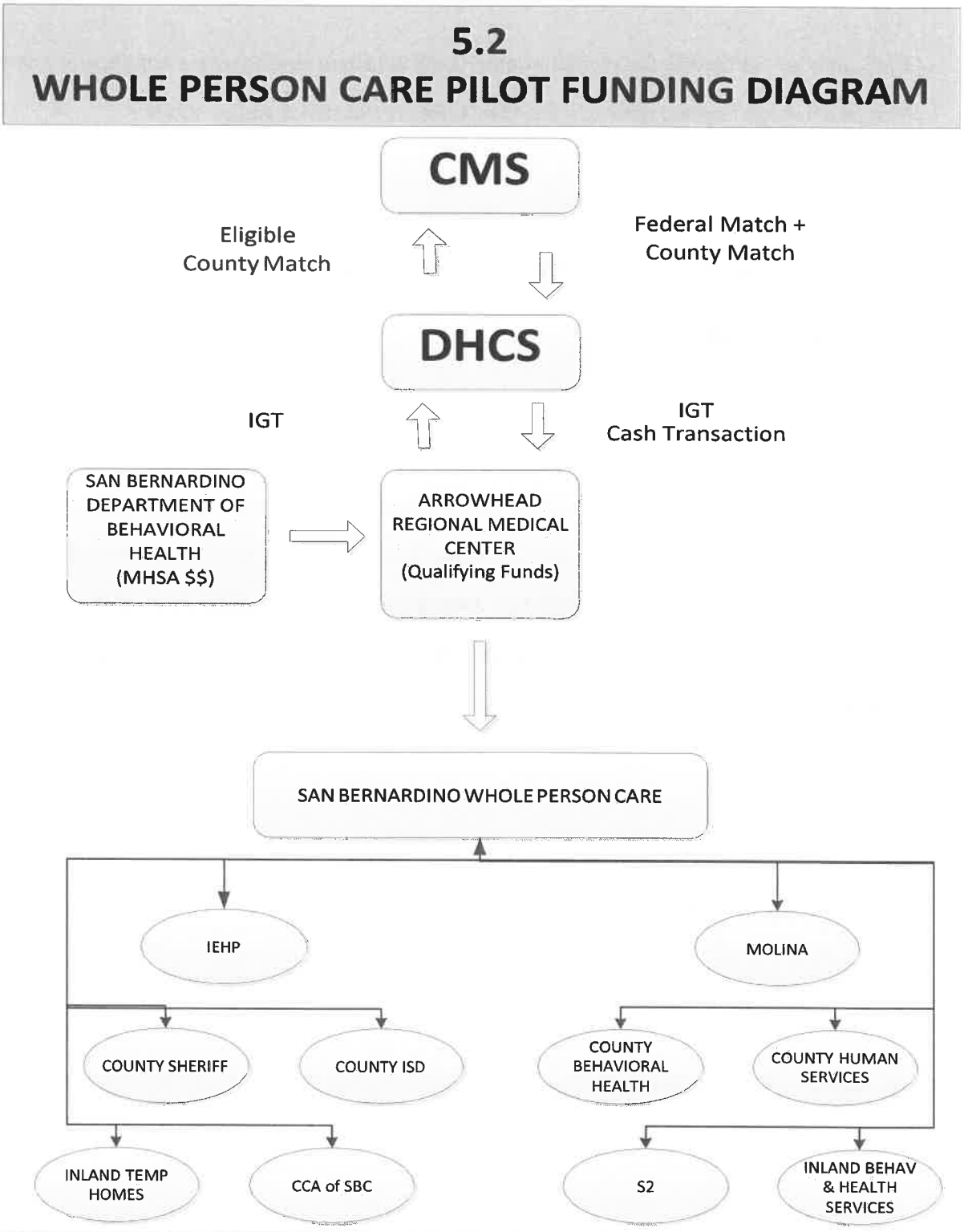
Section 5: Financing

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



5.3 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.

Page intentionally left blank. See Whole Person Care Agreement Section A for Attestations and Certification.

June 3, 2016

Ron Boatman
Associate Hospital Administrator
400 N. Pepper Avenue
Colton, CA. 92324

Re: Whole Person Care Program

Mr. Boatman,

Inland Empire Health Plan (IEHP) is enthusiastic about the opportunity to participate in a program that seeks to enhance the community's well being. This letter of intent indicates the partnership between IEHP and San Bernardino County to support their application for the Whole Person Care (WPC) program.

The WPC goal is to flawlessly integrate health, behavioral health and social services in a patient-centered manner to improve the community health with targeted wellness resource usage. This program will benefit the most susceptible Medi-Cal recipients and provide them complete, harmonized care to improve health outcomes. Using a systematic approach, the WPC program will target specific populations, share data and coordinate real-time care and population progress.

IEHP is a Knox-Keene licensed Health Plan located in Rancho Cucamonga, California. IEHP is a not-for-profit public agency serving low income and vulnerable populations in San Bernardino and Riverside Counties and has over 1,150,956 Members in the following programs: Medi-Cal (including seniors and people with disabilities), Healthy Kids, and a Medicare Advantage Special Needs Program and our Cal MediConnect Plan serving dual eligibles. Through a dynamic partnership with providers, award-winning service and innovative products, IEHP is fully committed to providing our Members with quality, accessible and wellness based healthcare services. By partnering with providers, we deliver high quality health care coverage to low-income working families with children, adults, seniors, and people with disabilities.

The WPC program goals align with IEHP's. We look forward to our continued partnership with San Bernardino County to carry out and implement this program.

Sincerely,

Bradley P. Gilbert, MD
Chief Executive Officer

P.O. Box 1800, Rancho Cucamonga, CA 91729-1800
Tel (909) 890-2000 Fax (909) 890-2019 For TTY Users (909) 890-0731
Visit our website at: www.iehp.org

MOLINA HEALTHCARE

Your Extended Family.

June 28, 2016

California Department of Health Care Services
Attn: Sarah Brooks, Deputy Director, Health Care Delivery Systems

RE: Letter of Participation for the Whole Person Care Pilot

Dear Ms. Brooks,

Molina Healthcare is committed to partnering with Arrowhead Regional Medical Center toward the successful completion and fulfillment of the Whole Person Care Pilot program initiatives.

Since 1980 the mission of Molina Healthcare has been to provide high-quality health services to financially vulnerable families and individuals care. Molina Healthcare has been selected for several dual demonstration projects as part of enhancing our member-centered health care approaches. Our community partnerships and programs put the patient's needs first and ensure they have access to trustworthy services in a safe environment.

Arrowhead Regional Medical Center has been the foundation of healthcare, community wellness and medical education in San Bernardino County. San Bernardino County is the largest county in the contiguous United States covering over 20,000 square miles of land. The County will create a new 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.

Through the use of collaboration and relationship coaching, performance improvement tools and lessons, the WPC management team will work with all stakeholders to improve existing workflows, find better ways to educate and advance the appropriate interactions between the County population and available County resources by way of establishing relationships and creating paths to better outcomes.

Molina HealthCare is fully committed to and supportive of the goals of the WPC project as demonstrated by our participation in the design of the pilot for San Bernardino County. Molina HealthCare's ongoing participation in the Whole Person Care Pilot Project will be determined by our mutual agreement with the WPC provisions and all requirements of Molina as they develop, including future expectations of health plans. We anticipate that these provisions and requirements will be acceptable and workable for Molina.

Molina Healthcare will support Arrowhead Regional Medical Center in the application of the Whole Person Care Pilot program that will assist this population in the following ways:

- Increasing integration among the county agencies, Molina Healthcare, providers and other entities.
- Molina Healthcare will aid in facilitating enrollment and access to services.
- Increase coordination and appropriate access to care for the target Medi-Cal beneficiaries.
- Reducing inappropriate emergency and inpatient utilization.
- Improving data collection and sharing among local entities to support ongoing case management;
- Improving health outcomes for the WPC population.

Molina Healthcare is committed to the Whole Person Care Pilot program thus has committed many hours to the development of the program design. We are looking forward to working with the many partners to improve the health outcomes of the WPC population.

Sincerely,

Maria Lugo
AVP, Market Lead

Cc:
Mohit Ghose, Vice President, Government Contracts & Policy

ARROWHEAD
REGIONAL MEDICAL CENTER

400 N. Pepper Avenue, Colton, California 92324-1819 | Phone: 909.580.1000
www.arrowheadregional.org

The Heart of a Healthy Community

June 22, 2016

Re: San Bernardino County Whole Person Care Program

To whom it concerns,

ARMC is committed to the pursuit of health and wellness for San Bernardino County. As such, ARMC commits to serve as the lead entity for the San Bernardino County Whole Person Care (WPC) pilot program. ARMC will coordinate the WPC Pilot and will be the single point of contact for DHCS.

ARMC recognizes WPC as a unifying framework to improve patients' health and well-being through increased coordination across county and community sectors. Such new levels of collaboration is essential to address the complex array of health, behavioral health and socioeconomic issues that ultimately impact patient experiences, utilization patterns, and health outcomes.

Further, WPC can facilitate a galvanizing platform for diverse county and community partners to deliver medical, behavioral health, and social services for vulnerable populations. ARMC, along with other county and community partners, is excited to realize the improved clinical outcomes, innovation and collaboration that WPC will deliver.

Sincerely,

William L. Gilbert
ARMC Hospital Director

303 East Vanderbilt Way, San Bernardino, CA 92415-0026 | Phone: 909.388.0801 Fax: 909.890.0435
www.SBCounty.gov

SAN BERNARDINO COUNTY

Behavioral Health
Administration

CaSonya Thomas, MPA,CHC
Director

Veronica Kelley, LCSW
Assistant Director

June 21, 2016

William L. Gilbert, Director
Arrowhead Regional Medical Center
400 North Pepper Avenue
Colton, CA 92324-1819

Re: Letter of Support - Whole Person Care

Dear Mr. Gilbert,

The San Bernardino County Department of Behavioral Health (DBH), and County Mental Health Plan (MHP), is pleased to support joint county efforts on Whole Person Care (WPC). Please accept this letter on behalf of our department, which works very closely with Arrowhead Regional Medical Center (ARMC), as well as numerous other county departments, as a colleague department on a number of health and program related efforts.

DBH supports and will be an active partner in a Whole Person Care engagement strategy which will establish effective relationships with those individuals who have difficulty effectively engaging in non-emergency, routine, preventative, primary and specialty health care services available to them and frequently access health care through emergency services or high cost county systems of care. The goal of this engagement strategy is, by relationship building, to increase coordination, access, and integration of health and social services needs of county residents between multiple county departments and community partners, ultimately resulting in improved outcomes for residents.

DBH understands the need and fully supports the creation of a new best-practice model to establish complex care coordination for the most vulnerable population who, due to the complexity of multiple chronic health conditions are: disengaged from available non-emergency health care services; ineffectively accessing available care; at-risk for frequent, emergency medical and behavioral services; and are homeless or at-risk for homelessness, including individuals released from institutions such as county jail.

We support a mobile strategy, that will be driven by engagement, linkages and consultation to existing health and social service programs; maximizes relationships; health coaching; performance improvement tools; system and provider learning; and incorporates community and stakeholder feedback. We are looking forward to the innovation that will occur in Whole Person Care and the opportunity to enhance multiple agency processes and effective utilization of existing health and social services related resources.

Sincerely,

CaSonya Thomas, Director
San Bernardino County Department of Behavioral Health

CT:SER:mt:dp

c: Executive Management Team, Department of Behavioral Health

385 North Arrowhead Avenue, San Bernardino, CA 92415-0128 | Phone: 909.387-4717 Fax: 909.387-5430
www.SBCounty.gov

SAN BERNARDINO COUNTY

Human Services Administration

Linda Haugan
Assistant Executive Officer

June 22, 2016

William Gilbert
Hospital Director
Arrowhead Regional Medical Center
400 North Pepper Avenue
Colton, CA 92324-1819

Dear Mr. Gilbert:

San Bernardino County Human Services is pleased to support joint county efforts on Whole Person Care (WPC) and is comprised of the following nine departments working to ensure that our county's citizens who are most in-need become healthy and productive members of society.

- **Department of Aging and Adult Services (DAAS)**
- **Department of Behavioral Health (DBH)**
- **Department of Child Support Services (DCSS)**
- **Children and Family Services (CFS)**
- **Preschool Services Department (PSD)**
- **Department of Public Health (DPH)**
- **Transitional Assistance Department (TAD)**
- **Veterans Affairs (VA)**
- **Management Services**

Human Services will be an active partner in a Whole Person Care engagement strategy which will establish effective relationships with those individuals who have difficulty effectively engaging in non-emergency, routine, preventative, primary and specialty health care services. The goal of this engagement strategy is, by relationship building, to increase coordination, access, and integration of health and social services needs of county residents between multiple county departments and community partners, ultimately resulting in improved outcomes for residents.

We are looking forward to the innovation that will occur in Whole Person Care and the opportunity to enhance multiple agency processes and effective utilization of existing health and social services related resources.

Sincerely,

Linda Haugan
Assistant Executive Officer

LH:nh

June 24, 2016

William L. Gilbert, CEO
Arrowhead Regional Medical Center
400 North Pepper Avenue
Colton, CA 92324

Re: Letter of Participation as a Community Partner for San Bernardino County in the Whole Person Care Pilot

Dear Mr. Gilbert,

On behalf of the Community Clinic Association of San Bernardino County (CCASBC), I am pleased to become a community partner with the County of San Bernardino and all other participants in the planning of the Whole Person Care (WPC) Pilot project. Additionally, I look forward to the continued collaboration post-award.

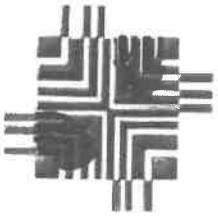
CCASBC is a non-profit organization that supports safety net clinics throughout the Inland Empire. Our organization provides advocacy, public policy promotion, education services, as well as resources to strengthen the provision of high-quality primary and specialty care services throughout the region. The association was founded in 2009, incorporated in 2010 and designated as a 501 (c)(3) nonprofit organization in 2011. CCASBC's mission is to build an effective, county-wide association of community clinics that efficiently deliver culturally appropriate quality healthcare to the medically indigent, underserved, uninsured and/or underinsured.

CCASBC supports the integration of Whole Person Care in San Bernardino County and looks forward to the continued collaboration with the Arrowhead Regional Medical Center, along with local clinics, non-profit organizations, faith-based organizations, county organizations, and other community partners in enhancing the utilization of existing health and social services and therefore improving the lives of not only our member safety net clinic patients but also the community as a whole.

Thank you for your leadership in this important endeavor and for inviting CCASBC to be a part of this positive, local change in improving and expanding upon coordinated care within San Bernardino County.

Sincerely,

Deanna Stover, Ph.D., RN
Chief Executive Officer
Community Clinic Association of San Bernardino County



INLAND BEHAVIORAL AND HEALTH SERVICES, INC.

June 17, 2016

Department of Health Care Services
Health Care Delivery Systems
ATTN: Sarah Brooks, Deputy Director
1500 Capitol Avenue
Sacramento, California 95814

RE: Letter of Participation as a Community Partner for San Bernardino County in the Whole Person Care Pilot

This letter serves as notice that it is the intention of Inland Behavioral and Health Services, Inc. (IBHS) to partner with the County of San Bernardino in their Whole Person Care Pilot (WPC Pilot). WPC Pilots will provide support through integrated 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. Through collaborative leadership and systematic coordination among public and private entities, WPC Pilot entities will identify target populations, share data between systems, coordinate care real time, and evaluate individual and population progress, with the goal of providing comprehensive coordinated care.

Inland Behavioral and Health Services, Inc. is a Federally Qualified Health Center in good standing that has served medically underserved and uninsured patients in the City of San Bernardino and surrounding areas since 1978 and in the City of Banning since 2012. IBHS is dedicated to *helping the community achieve and maintain general good health, education, and welfare through commitment in providing excellent service in the areas of physical health care, substance abuse treatment, mental health improvement, homeless services, and prevention education.* Additionally, IBHS achieved Ambulatory and Behavioral Health accreditation through The Joint Commission and was certified as a Primary Care Medical Home as of June 30, 2014.

IBHS proposes to continue delivering its comprehensive "one stop shopping" suite of services, with certain services referred to its other sites located just a few short miles away or through existing relationships with other local health care specialists. The services IBHS provides that will assist in the coordination of care for the identified populations include:

- ***Comprehensive Health Services*** consisting of those related to family medicine, internal medicine, and pediatrics. Services are provided by licensed physicians, advanced practice providers and where appropriate, nurses and/or medical assistants. ***Preventive Health services,*** annual physical assessments including prenatal and perinatal services, cancer screening, immunizations, and screenings for communicable and chronic diseases are all also available on-site.

- ***Case Management/Care Management for Chronic Conditions*** is provided by IBHS Case Managers who work to ensure care coordination and continuity of care between IBHS and other providers (e.g., specialty providers, referrals for enabling services). Case Managers ascertain and assess patient needs, identify relevant and necessary services, link the patient with services, and review and monitor the patient's progress in receiving those services. This is particularly necessary for patients with chronic illnesses. At the same time, IBHS works to involve people with conditions such as asthma or diabetes in their own care through comprehensive education. ***Referrals to Specialty Care*** are made for certain specialty services including cardiology, ENT, allergy, and podiatry. Many of these are provided through referral to the many excellent specialists available through the Inland Empire Health Plan (IEHP), San Bernardino and Riverside County's managed care health plan. Obstetrics and gynecology services are referred internally to our D Street location.

- ***Pharmaceutical Services*** are provided at the primary medical site on D Street and in Banning, or are referred out to local pharmacies.

- ***Full-Scope Dental Services*** are available at all three medical sites. Our oral health program includes comprehensive preventive care and education, basic restorative services, periodontal services, and an outreach component. We provide any

1963 North "E" Street, San Bernardino, California 92405 (909) 881-6146 Fax (909) 881-3479

service that a dentist in private practice would to any patient in need, including exams, X-rays, cleanings, fillings, crowns, root canals, extractions, and partial dentures.

- ***Behavioral Health Services***: IBHS continues to increase its expertise in the area of primary care/behavioral health integration with behavioral health screening questions integrated into primary care visits. Referrals are made as necessary to mental health specialists and/or substance abuse counselors at IBHS's WE Center, located on E Street. IBHS also has an award-winning outpatient perinatal substance abuse treatment program to which we can refer women with a substance abuse problem who are pregnant, have recently given birth, or have pre-school age children.

- ***WIC:*** Nutrition Services were implemented in 2011 at IBHS's two state funded WIC service sites, one of which is located on-site. At IBHS, WIC services work hand-in-hand with our overall primary care program. At both the main clinic and Whitney Young sites, health care providers are co-located, providing easy integration of the programs. OB/GYN, Pediatric Care, and many other comprehensive primary health care services for the entire family are readily available to all WIC-program participants. Medical patients are also introduced as needed to WIC.

- ***Radiology***: With assistance from HRSA, IBHS recently opened a state-of-the-art Diagnostic Imaging Center at our D Street clinic with mammography and X-ray services. Referrals from the other sites are made to this center as needed.

- ***Health Outreach and Education:*** IBHS and has an active health education department. Activities include education of patients and the general population served by the health center regarding the availability and proper use of health services.

- ***Insurance Eligibility and Enrollment***: IBHS has insurance eligibility determination practices in place. If a patient arrives and does not have insurance (or proof of insurance such as a Medi-Cal card), he or she can go to an in-house eligibility worker to determine whether they qualify for any insurance product, who can then help participants obtain health insurance, Healthy Families, etc.

- ***Transportation***: All agency sites in San Bernardino are conveniently located along major bus lines, and when patients lack their own transportation or are not ambulatory, we have program vans to transport patients between San Bernardino sites. We also provide bus passes to patients who cannot use our vans.

- ***Interpretation/Translation***: All IBHS services are designed to be responsive to the cultural and linguistic needs of community members. IBHS continues to employ a staff of diverse cultures, backgrounds, and languages, which enables the organization to be culturally and linguistically sensitive to the population we serve. Currently, staff speak many languages including Spanish, Vietnamese, Farsi and Tagalog. In addition, IBHS has additional translation services through a contract with Rolling Start, Inc. for the hearing impaired. Language translators are available during service hours on an as-needed basis.

IBHS is enthusiastically looking forward to the WPC Pilot and the coordinated efforts between Arrowhead Regional Medical Center, local clinics, county organizations, non-profit corporations, faith-based organizations and other community partners that will ultimately enhance the lives of our patients and our community as a whole.

Thank you for your attention this matter. If you have any questions or require further clarification, do not hesitate to contact my office directly at 909-708-8158.

Sincerely,

Dr. Temetry A. Lindsey
CEO/President

Date: May 20, 2016

To: Sarah Brooks, Deputy Director, Health Care Delivery Systems, Department of Health Care Services

Re: Letter of Participation as a Community Partner for San Bernardino County

The unique possibility of Whole Person Care, offers a quality of life to individuals who are suffering and have unfortunately become financial burdens to themselves and their community. Our goal is to offer Housing Search and Stabilization Services to those who are homeless or at risk of becoming homeless.

Inland Temporary Homes (ITH) has a 25 year track record of serving the diverse homeless population in San Bernardino County. The leadership has shown ingenuity and forward thinking in transitioning individuals from crisis to Permanent Supportive Housing. The goal is to create meaningful, long lasting change in the County, by housing and providing supportive services to those most in need.

Target Population of Individuals:

- Who are currently experiencing homelessness; and/or
- Who are at risk of homelessness, including individuals who will experience homelessness upon release from institutions (hospital, skilled nursing facility, rehabilitation facility, jail, etc...)
- With mental health and/or substance use disorders
- With two or more chronic conditions

The WPC pilot takes into consideration the reduction in use of Emergency Department (ED) and transitional care of frequent users. Currently, no other agency is providing permanent supportive housing services with the added focus of reducing ED visits by utilizing the Triple Aim for Medicaid approach: 1. Improve the health of the defined population. 2. Enhance the patient care experience (including quality, access and reliability) 3. Reduce, or at least control, the per capita cost of care.

ITH utilizes a scattered site approach and works with individuals who are experiencing homeless and/or are at risk of homelessness. Based on Whole Person Care pilot objectives, services will include:

Individual Housing Transition Services: Housing transition services are meant to assist beneficiaries with obtaining housing and include:

- Conducting a tenant screening and housing assessment that identifies the participant's preferences and barriers related to successful tenancy.
- Developing an individualized housing support plan based upon the housing assessment that addresses identified barriers.
- Assisting with the housing application and/or search process, including identifying and securing available resources to assist with subsidizing rent.
- Identifying and securing resources to cover expenses, such as security deposit, moving costs, furnishings, adaptive aids, environmental modifications, moving costs, and other one-time expenses. Including a landlord risk mitigation fund for property damage.

- Ensuring that the living environment is safe and ready for move-in.
- Assisting in arranging for and supporting the details of the move.
- Developing a housing support crisis plan that includes prevention and early intervention services when housing is jeopardized.

Individual Housing and Tenancy Sustaining Services: This service is made available to support individuals in maintaining tenancy once housing is secured. The availability of ongoing housing-related services, in addition to other long-term services and supports, promotes housing success, fosters community integration and inclusion, and develops natural support networks. These tenancy support services are:

- Providing early identification and intervention for behaviors that may jeopardize housing, such as late rental payment and other lease violations.
- Educating and training on the role, rights, and responsibilities of the tenant and landlord.
- Coaching on developing and maintaining key relationships with landlords/property managers, with a goal of fostering successful tenancy.
- Assisting in resolving disputes with landlords and/or neighbors to reduce risk of eviction or other adverse action.
- Advocating and linking individuals to community resources to prevent eviction when housing is or may potentially become jeopardized.
- Assisting with the housing recertification process.
- Coordinating with the tenant to review, update, and modify their housing support and crisis plan on a regular basis to reflect current needs and address existing or recurring housing retention barriers.
- Continuing training in being a good tenant and lease compliance, including ongoing support with activities related to household management.

This project will be routed through a coordinated effort with ARMC, clinics, county, non-profit, faith based, and other community partner organizations that can reduce healthcare system costs per individual. Our goal is to lower the long-term financial burden shared by the medical and the non-medical community in SBC by providing safe, stable, and affordable housing to the targeted population.

In conclusion, this innovative housing approach will add benefit to the Whole Person Care pilot. The intention is to partner with existing agencies while concurrently designing a flexible system to bridge the housing resource gap within the SBC continuum of care. We look forward to your partnership and continued discussion moving forward.

Sincerely,

Jeff Little

Jeff Little, CEO
Inland Temporary Homes (ITH)

Date: May 20, 2016

To: Sarah Brooks, Deputy Director, Health Care Delivery Systems, Department of Health Care Services

Re: Letter of Participation as a Community Partner for San Bernardino County

S2 is an innovative organization with a wealth of experience and knowledge in development, coordination, indigent healthcare access, and education. Its leadership has a track record of running successful integrated community solutions. S2 is creating meaningful, long lasting change in the County by affecting the lives of those who are most vulnerable.

Individuals experiencing homelessness consume a disproportionate amount of mainstream resources. As stated by the Interagency Council on Homelessness, 10% of the homeless population consumes 50% of the resources. S2 seeks to serve individuals at the bottom of the care spectrum, thereby lightening the financial burden to all County organizations. According to the SBC 10 Year Strategy to End Homelessness, "Less than 30% of homeless and/or at risk of becoming homeless persons receive mainstream resources which consists of federal and state benefits programs, including medi-cal." In light of this dynamic, S2 will identify and enroll individuals who are eligible for medi-cal, and/or other mainstream resources, so that the total target population can be engaged within the WPC pilot.

Additionally, S2 will provide supportive care, including outreach and engagement services for those individuals currently experiencing homeless or at risk of being homeless. Ultimately to provide field based care and form trusting relationships with service providers. Once housed, S2 will provide the following services to permanent supportive housing recipients:

- Connect individuals to local clinic site and promote the benefits of clinic visits
- Connect individuals to prior community, including: Social, family, faith, work, etc...
- Care coordination and Health promotion;
- Comprehensive transitional care/follow-up;
- Referral to community and social support services

The availability of ongoing housing-related services, in addition to other long-term services and supports, promotes housing success, fosters community integration and inclusion, and develops natural support networks.

Sincerely,

Burt Clark
Executive Director, S2

JOHN McMAHON, SHERIFF-CORONER

SAN BERNARDINO COUNTY

June 28, 2016

Ron Boatman
Associate Hospital Administrator
Arrowhead Regional Medical Center
400 N. Pepper Avenue
Colton, CA 92324

Re: Letter of Participation for the Whole Person Care Pilot Program

Dear Mr. Boatman,

The Sheriff's Department Health Services Division is looking forward to the planning and development of the Whole Person Care (WPC) Pilot program for our County. Please anticipate our participation as we are very supportive of WPC's vision that would be highly beneficial to our community as a whole.

We understand the WPC Pilot program will allow public and private entities to work collaboratively in identifying the needs to improve and increase coordination of access to health, behavioral health and social services in a patient-centered manner. As we proceed as a part of the WPC team of community partners, we know the WPC Pilot program will enable us to identify the target populations, share data between systems, coordinate each individual's care in real time, which will allow us to effectively evaluate the individual's overall progress.

The Sheriff's Department has a population of approximately 6,000 inmates incarcerated in our jail facilities at any given time. Our department books approximately 76,000 inmates on an annual basis. We have the following four large jail facilities located throughout our county: West Valley Detention Center in Rancho Cucamonga, High Desert Detention Center in Adelanto, Glen Helen Rehabilitation Center in Devore and the Central Detention Center in San Bernardino. During their incarceration, the inmates have a multitude of health, behavioral health and social needs for services and resources, which they have access to. Unfortunately, after the inmates are released, their access to these services and resources are dramatically limited or inaccessible. With the integration of the Whole Person Care (WPC) Pilot program and collaboration with our community partners, it will allow effective coordination and preparation prior to the inmate's release. Overall, this will ensure the continuity of their healthcare and enhance the utilization of existing health, behavioral health and social services after their release.

Thank you for providing this opportunity and considering us as an integral part of the Whole Person Care (WPC) Pilot program.

Sincerely,

CeCe Spurlock, RN, BSN, CCHP
Staff Development Coordinator
San Bernardino County Sheriff's Department
Health Services Division

www.sbcounty.gov | Phone: 909.388.0556 Fax: 909.388.5919
www.SBCounty.gov

SAN BERNARDINO COUNTY

Information Services Department

Jennifer Hilber
Chief Information Officer

June 23, 2016

William L. Gilbert, Director
Arrowhead Regional Medical Center
400 North Pepper Avenue
Colton, CA 92324-1819

Re: Letter of Support – Whole Person Care

Dear Mr. Gilbert:

The San Bernardino County Information Services Department (ISD) looks forward to supporting joint County efforts on the Whole Person Care (WPC) project. We look forwarding to collaborating with you and the other Health Services County Departments on this effort.

ISD considers this an exciting and worthwhile effort. Participating in a project that will result in a computing platform to allow for sharing of data among the Health Services Departments will give us an opportunity to build on our expertise and extend the benefits to other County departments, as well.

We welcome the opportunity to take a leadership role in the coordination of data sharing across the health services departments. As you know, we have inaugurated a countywide data governance model and look at the Whole Person Care project as an opportunity to continue to extend, test and build that countywide model.

We look forwarding to working with the entire WPC team to provide assistance in developing an overarching system to maintain, track, and provide appropriate access to the data necessary to make this a successful project.

Sincerely,

Jennifer Hilber
Chief Information Officer

JH:ae

351 N. Mountain View Ave., San Bernardino, CA 92415 | Phone: 909.387.9146 Fax: 909.387.6228
www.SBCounty.gov

SAN BERNARDINO COUNTY

Public Health
Administration

Trudy Raymundo
Director

Corwin Porter
Assistant Director

Maxwell Ohikhuare, M.D.
Health Officer

June 22, 2016

William L. Gilbert, Director
Arrowhead Regional Medical Center
400 N. Pepper Avenue
Colton, CA 92324-1819

Re: Letter of Support – Whole Person Care

Dear Mr. Gilbert,

The San Bernardino County Department of Public Health (DPH) is pleased to support joint county efforts on Whole Person Care (WPC). Please accept this letter on behalf of our department which works closely with Arrowhead Regional Medical Center (ARMC), as well as numerous other county departments, as a colleague department on a number of health and program related efforts.

DPH supports a WPC engagement strategy which will establish effective relationships with those individuals who have difficulty effectively engaging in non-emergency, routine, preventative, primary and specialty health care services available to them and frequently access health care through emergency services or high cost county systems of care. The goal of this engagement strategy is, by relationship building, to increase coordination, access and integration of health and social services needs of county residents between multiple county departments and community partners, ultimately resulting in improved outcomes for residents.

DPH understands the need and fully supports the creation of a new best-practice model to establish complex care coordination for the most vulnerable population who, due to the complexity of multiple chronic health conditions are: disengaged from available non-emergency health care services; ineffectively accessing available care; at-risk for frequent, emergency medical and behavioral services; and are homeless or at-risk for homelessness, including individuals release from institutions such as county jail.

We support a mobile strategy, that will be driven by engagement, linkages and consultation to existing health and social service programs; maximizes relationships; health coaching; performance improvement tools; system and provider learning; and incorporates community and stakeholder feedback. We are looking forward to the innovation that will occur in WPC and the opportunity to enhance multiple agency processes and effective utilization of existing health and social services related resources.

Sincerely,

Corwin Porter
Assistant Director

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:

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 *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 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
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:

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
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 Payment:

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; in years three through five, this becomes part of the PMPM bundle. 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:

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 YEARS 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 $19,536) Ratio: 1:125)*	217	500	108,635
		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:

PMPM Bundle PILOT YEAR 2			
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	3,000	848,340
		TOTAL	**848,340**

PMPM Bundle PILOT YEARS 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:

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:

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