ALAMEDA COUNTY HEALTH CARE SERVICES AGENCY

ALAMEDA COUNTY CARE CONNECT (AC^3)

PROJECT NARRATIVE

SECTION 1: WPC LEAD ENTITY AND PARTICIPATING ENTITY INFORMATION

1.1. Whole Person Care Pilot Lead Entity and Contact Person Form – See Attached

1.2. Participating Entities Table – See Attached

1.3. Letters of Participation and Support – Not Attached

1.1 Whole Person Care Pilot Lead Entity and Contact Person (STC 117.b.1)

Organization Name	**Alameda County - Health Care Services Agency**
Type of Entity (from lead entity description in guidance)	County
Contact Person	Kathleen A. Clanon, MD
Contact Person Title	Medical Director
Telephone	510-618-3455 office; 510-612-5548, mobile
E-Mail Address	Kathleen.Clanon@acgov.org
Mailing Address	Alameda County - Health Care Services Agency 1000 San Leandro Boulevard, Suite 300 San Leandro, CA 94577

1.2 Participating Entities

Identify the participating entities in the WPC pilot, describe the entities, and explain their role in the WPC pilot. In the below chart, under "Required Organizations," please provide information for the entities that are required to participate. If you have additional participating entities, please list them under "Optional Organizations." If you are applying for an exception to the participating entities requirements, please explain which requirement you are unable to meet, your reason for seeking an exception, and supporting documentation of communications with the required entities for which an exception is being requested. (STC 117.b.ii)

Required Organizations	Organization Name	Contact Name and Title	Entity Description and Role in WPC
Medi-Cal Managed Care Health Plan	Alameda Alliance for Health	Scott Coffin, Chief Executive Director	**Entity:** Managed care plan for 80% of Medi-Cal patients in Alameda County **Role:** Administer Care Management bundles; Partner to design Care Coordination system; Sit on Steering Committee
Health Services Agency / Department	Alameda County - Health Care Services Agency	Rebecca Gebhart, Acting Director	**Entity:** County Agency overseeing Healthcare, including Behavioral Health and Public Health **Role:** Lead Entity; Has overall responsibility for AC^3program
Specialty Mental Health Agency / Department	Alameda County - Behavioral Health Care Services *(Alcohol, Drug & Mental Health Services)*	Aaron Chapman, MD Office of the Medical Director	**Entity:** Alameda County behavioral health safety net provider. **Role:** Provide substance abuse and behavioral health system enhancements; Partner to design Care Coordination system; Sit on Steering Committee
Public Agency / Department	Alameda County Community Development Agency – Housing & Community Development Dept.	Linda Gardner, Housing Director	**Entity:** County Agency overseeing development of housing and programs for low income, homeless, and disabled populations. **Role:** partner in designing data system that includes HMIS, development of housing and services
Public Housing Authority	Housing Authority of the County of Alameda	Christine Gouig, Executive Director	**Entity:** County Housing Authority **Role:** Partner in developing and coordinating homeless services
Community Partner 1	East Oakland Community Project	Wendy U. Jackson, Executive Director	**Entity:** CBO providing emergency and transitional housing **Role:** Partner in delivering homeless services
Community Partner 2	Community Health Center Network	Ralph Silber, Chief Executive Director	**Entity:** Network of 8 FQHC's caring for over 130,000 Medi-Cal patients. **Role:** Participate in care coordination design; Implement care coordination systems; Sit on Steering Committee

Additional Organizations (Optional)	Organization Name	Contact Name and Title	Entity Description and Role in WPC
Public Agency / Department	Alameda Health System	Delvecchio Finley, Chief Executive Officer	**Entity:** Alameda County public health and hospital system, with 3 acute care hospitals,4 four ambulatory care centers, 2 skilled nursing facilities, and a psychiatric hospital **Role:** Participate in care coordination design; Implement care coordination systems; Sit on Steering Committee
Medi-Cal Managed Care Health Plan	Anthem Blue Cross	Joel Gray, Executive Director CA Medicaid North Anthem Blue Cross Partnership Plan, Inc.	**Entity:** Alameda County managed care plan **Role:** Administer Care Management bundles; partner to design Care Coordination system; Sit on Steering Committee
Medi-Cal Managed Care Health Plan	Kaiser Permanente	Sarita A. Mohanty, MD, MPH, MBA, Regional Executive Director, Medi-Cal Strategy and Operations	**Entity:** Alameda County managed care plan caring for 24,000 Medi-Cal beneficiaries **Role:** Participate in development and implementation of Care Coordination systems and data modifications
Community Partner	Sutter Health Alta Bates Summit Medical Center	Steve O'Brien, MD Chief Medical Executive	**Entity:** Private non-profit hospital system **Role:** Participate in development and implementation of Care Coordination systems and data modifications
Community Partner	Abode Services	Louis Chicoine, Executive Director	**Entity:** CBO providing housing and supportive services **Role:** Partner in delivering housing services
Community Partner	Consumer/ Community Advisory Board (CCAB)	David Modersbach, ACHCHP Grant Manager	**Entity:** Health Care for the Homeless Consumer Board **Role:** Partner in coordinating homeless services
Public Agency / Department	City of Berkeley	Paul Buddenhagen, Director - Health, Housing and Community Services Department	**Entity:** City department overseeing human services **Role:** Partner in coordinating homeless services
Public Agency / Department	City of Fremont	Suzanne Shenfil, Director – City of Fremont Human Services Department	**Entity:** City department overseeing human services **Role:** Partner in coordinating homeless services
Public Agency / Department	City of Oakland	Sara Bedford, Director City of Oakland, Human Services Department	**Entity:** City department overseeing human services **Role:** Partner in coordinating homeless services
Public Agency / Department	EveryOne Home	Elaine de Coligny, Director	**Entity:** Collective Impact Organization/Lead Entity for the HUD Continuum of Care **Role:** Partner in developing and coordinating homeless services; Sit on Steering Committee

Additional Organizations (Optional)	Organization Name	Contact Name and Title	Entity Description and Role in WPC
Public Agency / Department	Alameda County, Information Technology Department	Tim Dupuis, Chief Information Officer	**Entity:** County agency overseeing standardized data systems **Role:** Participate in development and implementation of data sharing system enhancements
Public Agency / Department	Alameda County, Probation Department	LaDonna M. Harris, Chief Probation Officer	**Entity:** County agency supervising sentenced clients on probation **Role:** Participates in linking Probation client data records to the new countywide data access system
Community Partner	Satellite Affordable Housing Associates	Susan Friedland, Executive Director	**Entity:** Non-profit affordable housing provider **Role**: Partner in providing affordable housing and services
Public Agency / Department	Alameda County, Social Services Agency	Lori Cox, Agency Director	**Entity:** County Agency overseeing Social Services **Role**: Administer IHSS program; Sit on Steering Committee

NOTE: Letters of Participation are available upon request.
Please contact Nancy Halloran at nancy.halloran@acgov.org
510-847-3833 (cell)
510-667-3110 (office)

SECTION 2: GENERAL INFORMATION AND TARGET POPULATIONS

2.1. Geographic Area, Community, and Target Population Needs

Overview:

The Alameda County Health Care Services Agency (HSCA) proposes to implement **Alameda County Care Connect (AC^3)** – a wide-ranging initiative building on current programs to create a **system of Whole Person Care that helps high-need patients achieve optimal independence and health.** By 2020, AC^3 will achieve:

- ☐ Improved patient outcomes by connecting housing, integrated physical, mental health, and substance use care, and other critical services through a countywide data-sharing and care coordination system;
- ☐ Sustainable housing solutions for health that maximize the number of Medi-Cal beneficiaries living in healthy, stable homes in the community;
- ☐ Scalable interventions that reduce utilization and have ongoing support from partners; and
- ☐ New payment structures that move managed care organizations (MCOs) and providers toward value-based payment.

AC^3 target populations (defined below) include **homeless people**, **people who are high utilizers of multiple systems (HUMS)**, and an extended circle of people with complex conditions who are receiving **care management** in one system, but actually require **care coordination** that crosses multiple systems. One inspiration was the high number of severely mentally ill patients we identified who were case managed in full service partnerships but had virtually no utilization of primary care medical services.

All three populations will be included in a new **data-sharing and care coordination system**. Patients without a care manager will be eligible for **care management services bundles.** Homeless people will be eligible for **two housing bundles.** Behavioral Health Care Services (BHCS, a part of HCSA) will provide linkage to their network of mental health and substance use disorder (SUD) providers, including **portals to substance use disorder treatment** and **integrated treatment services**.

None of the services under this program are covered by Medi-Cal and all are carefully designed to complement existing services.

Community Need:

AC^3 will be implemented throughout Alameda County, California. To define community need, we began with HSCA's epidemiology unit, then drilled down into population issues with an analysis of cross-walked Alameda Alliance for Health (AAH) and BHCS data. Finally, we interviewed **17 front-line providers and patients** to learn more about the population and how they could be served better. Recurring themes were substance use and mental health treatment access, housing, and revolving door crisis care.

Alameda County contains dramatic disparities in income and health status. People in low-income East Oakland have a life expectancy 15 years shorter than those in the Oakland Hills. Housing is increasingly unaffordable. Among Alameda County residents living in some high poverty neighborhoods, 61% spend over a third of their income on rent and 36% spend over half. Over 10,000 Alameda County residents experience homelessness each year.

Serious mental illness (SMI) and SUD are additional significant factors in avoidable high utilization. Our cross-walked BHCS and Alliance data showed that individuals in high poverty areas visit emergency departments (EDs) for SMI 2.7 times more than those in affluent areas, and rates of ED visits for substance abuse issues are as high as 4,748 per 100,000 ED visits. Analysis of medical and mental health high-acuity, substance use, and criminal justice data revealed that of 6,527 multi-system users in 2015, almost 40% (2,445) were also in jail at some point in 2014.

Existing Efforts & Entity Participation

Alameda County is fortunate to have many healthcare and social service organizations serving its diverse population, including an independent public hospital authority, community-based clinics; HCSA; and two managed care plans. All are separate entities with separate data systems, separate governance, and separate strategic planning. **AC^3 addresses this challenge by creating a backbone organization with a collaborative governance structure that will ultimately include all systems with which patients interact, under the leadership of HCSA.**

Alameda County safety net healthcare institutions have a history of strong collaboration. We have conducted a series of successful local 1115 Waiver implementations and initiated multiple successful small-scale interventions to address complex care needs. This has set the stage for the ambitious countywide WPC initiative we propose.

Key partner entities include:

- Alameda Alliance for Health (AAH) and Anthem BlueCross, two managed care organizations (MCOs) providing services to Alameda County Medi-Cal beneficiaries;
- Alameda Health System (AHS), the public hospital system, with three acute care hospitals, four ambulatory care centers, two skilled nursing facilities, and a psychiatric hospital;
- Community Health Center Network (CHCN), a risk-bearing independent practice association encompassing eight federally-qualified health centers (FQHCs) with 42 sites;
- Behavioral Health Care Services (BHCS), the managed care provider for the severely mentally ill in Alameda County and also the lead agency for the county's substance use treatment services;
- EveryOne Home (EOH), the HUD Continuum of Care organization in Alameda County, currently leading a cross-system effort to move the housing system to a prioritized housing-first approach;
- East Oakland Community Project (EOCP), which operates the County's largest homeless shelter, provides post-acute respite services, and is a leader in homeless & housing services planning; and
- Alameda County's Probation Department, currently implementing AB109 and serving many AC^3'-eligible populations.

The AC^3 infrastructure will enable coordinated care teams to support patients in **accessing the resources and treatment** needed to **reduce avoidable use of crisis and criminal justice systems, and connect patients to preventive services.** The **housing program** will make more supported housing available, and the participation of many systems in the **coordination system** (probation, social services, clinics, behavioral health) will make the needed treatment more accessible.

With regard to **sustainability**, the new data-sharing system will last long past the pilot period. Additional strategies for sustainability include:

- ☐ Return-on-investment analyses and capture of monetized cost savings will be built into the evaluation of the bundles, and participating entities have committed to sustaining successful project components.
- ☐ Investments in the human infrastructure will lead to development of improved workflows, a shared measurement system, and shared language and documentation, all of which will be sustained.
- ☐ A Skills Development and Quality Improvement unit (SQDI) will support training and change management and gather and disseminate learnings for the future.
- ☐ The housing infrastructure investments will continue to benefit patients for many years.

2.2. Communications Plan

The Central Office of the AC^3 backbone organization (see Figure 1) will be responsible for ensuring **strong collaboration, integration, and communications among participating entities**. The key contact for AC^3 will be **Kathleen Clanon, MD**, Medical Director of HCSA. Major program decisions will be made by the following AC^3 committees:

- ▪ The 12-member **Steering Committee** will include executive leaders of the four MCOs (including BHCS and the Drug Medicaid Organized Delivery System (DMC-ODS)), AHS, EveryOne Home, CHCN, Social Services, and representative provider organizations such as East Oakland Community Project. The Steering Committee's Finance Subcommittee will guide contract design, information system development, and sustainability planning and will make **decisions by majority vote**.
- ☐ The 12-15-member **Clinical Implementation Workgroup** brings together program leaders from participating entities to oversee clinical and service standards, quality, and model fidelity; and
- ☐ The 25-30-member **Data and Operations Workgroup** will oversee the details of cross-agency implementation.

The latter two Workgroups will include leaders from the entities described above as well as Probation, Public Health, and at least two consumer representatives from the target populations. These bodies will make **decisions by consensus.** The groups - expanded versions of existing bodies - will **meet monthly during PY2** and at least **quarterly** subsequently. Full staff meetings will take place **semi-annually** in PY2 and **annually** thereafter.

AC3 Organizational Chart (image) – *Please refer to page 48 to view the organizational chart.*

The AC^3 **Communications Office** will provide the Steering Committee with a communications plan that details the schedule and channels for communicating best practices, standards, and successes with providers, beneficiaries, and other stakeholders. **State pilot requirements** will be embedded in all contracts, and any changes will be communicated through bulletins, Workgroups, and official communications.

Sustained communications flow will be the legacy of the data-sharing and care coordination system and human infrastructure. In PY2 the Steering Committee will develop sustainability requirements for maintaining these systems after they are established. Participating entities have committed to sustaining successful project components beyond the pilot period.

Minimizing silos is built into AC^3 (see Figure 3). At the **Service Planning level**, representatives from each sector will collaborate on decisions. At the **Service Administration level,** the four MCOs will align design of contracts for care management and housing services, emphasizing service integration. At the **Service Provider level**, aspiring CB-CMEs and the specialty providers will be forming **multi-sector integrated teams**.

The overall AC^3 service approach revolves around cross-system communication and shared skill sets: aligned methods and priorities; common assessment tools and care plans; shared metrics; documenting in the same system; and case conferencing. The shared data system and the **Skills Development and Quality Improvement (SDQI)** unit create supportive scaffolding for integration. All-staff events and cross-sector trainings will provide opportunities to develop common language and approaches. The SDQI will support **learning for long-term efforts** through quarterly seminars that present results of PDSA work across the system.

2.3.A. Target Populations: Population # 1:

Whole Person Care Coordination Population Definition and Size of Target Population # 1:

AC^3 will provide services to **three** designated target populations. Because of the complex needs of low-income Medi-Cal beneficiaries facing multiple health and life challenges, these populations are not mutually exclusive, but include overlap based on specific conditions and criteria. An early goal of our data integration efforts will be to identify and quantify intersections among these three populations.

Graphic02

- The first target population – the **Care Coordination Population** – is the overarching AC^3 population, encompassing a countywide cohort of high-utilizing, low-income Medi-Cal beneficiaries. It comprises approximately **20,000** individuals who are either a) high users of multiple systems (HUMS); b) homeless; or c) participants eligible for one of several complex care coordination systems in Alameda County.
- The second population comprises a subset of this population who are **High Users of Multiple Systems (HUMS)** not currently enrolled in another complex care system. There were **6,527** HUMS found in available data for 2015.
- The third population is **Homeless Persons**. Our program definition of homeless is described in Section 2.3.C below. There were **10,334** individuals in the Homeless Management Information System (HMIS) in 2015.

All services are designed not to duplicate other services such as Health Homes, but to create a uniform level of care coordination available to all high-utilizers.

The overarching Care Coordination Population is designed to counteract the fragmentation that results from categorical funding streams. It represents an extended circle of individuals with complex conditions who may be receiving **care management** in one system, but actually need **care coordination** that crosses multiple systems. All will benefit from the program's enhanced system-wide service coordination and data sharing approaches.

Including this population in our system is essential. To illustrate, take the point of view of a service provider who has some patients who qualify for existing services, and others who qualify for new AC^3 services. The provider needs a data sharing and care coordination system that works for his or her **entire caseload** of complex care patients. The last thing we want is to create another partial system which only adds complexity and makes ensuring non-duplication more difficult.

Collaborative Process:

HCSA convened over **15** planning and fact-finding meetings involving system leaders, data and planning specialists, and clinicians to identify and define target populations. Data was gathered from many sources, including epidemiological, programmatic and utilization data from public and private agencies. In March and April of 2016, HCSA conducted **17 in-depth key informant interviews** with front-line providers throughout the county, along with leadership interviews covering a wide range of agencies. Interviews explored key issues including how providers define high service utilizers; what programmatic elements served as barriers to and facilitators of patient retention; and priorities for change. Target populations were identified and refined through a group process in April and May 2016 and finalized for the AC^3 application.

Enrollment Cap:

There will not be an enrollment cap for this population. Any eligible patient can be enrolled into the **Care Coordination Population** and their care managers and care team can participate in developing the new standardized care coordination system.

Identification & Outreach Methodology:

Identification of the AC^3 target populations involved complex data sharing and matching involving the Alliance and BHCS, as well as analysis of individual program demographics to estimate overlap in the absence of a master patient index. In the future, the AC^3 data-sharing system will facilitate this process.

As we implement the program, our plan for outreach to the population involves building a database of all enrollees, starting with the groups in the table below, and expanding stepwise to include other data sets such as EMS and Probation, continually resolving permissions and workflow issues. At first we will rely on collaborators to test the workflows using PDSA methods. Once the new system is available, we envision a technical solution that will alert when an eligible person is at point of care.

The estimated size of the Whole Person Care Coordination population combines current known HUMS and homeless with eligibility and enrollment data for **four** current or upcoming complex care coordination programs in our county, with an estimated **31%** overlap among populations, as follows:

County Population / System	Estimated Population
▪ Homeless	10,334
▪ HUMS	6,527
▪ Health Homes Program (projected)	6,500
▪ AHS Complex Care Program	1,500
▪ BCHS Full Service Partnership	780
▪ BCHS Level 1 Service Teams	3,300
Subtotal	**28,941**
Estimated 31% Overlap	8,971
EST. TOTAL PROJECT POPULATION	**20,000**

2.3.B.

Target Populations: Population # 2: High Users of Multiple Systems (HUMS) Definition and Size of Target Population # 2:

The second AC^3 population comprises approximately **6,500** individuals who are identified as **High Users of Multiple Systems (HUMS),** based on a HUMS data analysis conducted by the Alliance and BHCS (there were 6,527 HUMS found in available data for 2015). The Alliance manages about 80% of all Medi-Cal members. For purposes of AC^3, HUMS are defined as Medi-Cal beneficiaries who have come in contact with at least **two** of the following systems within the timeframes listed below, including individuals who received substance use treatment and who have been in the criminal justice system:

Systems	Definition / Inclusion Criteria
1. Medical Crisis / High Acuity Utilization in past 12 months	**a.** Three or more emergency department (ED) visits **OR** **b.** At least one inpatient stay (other than for pregnant women giving birth) **OR** **c.** Recipient of medical sub-acute care **OR** **d.** At least one medical skilled nursing facility (SNF) admission
2. Mental Health High Acuity Utilization/High Need in past 12 months	**a.** Two or more Psychiatric Emergency Services (PES) encounters **OR** **b.** At least one psychiatric inpatient admission **OR** **c.** At least one admission to an Institution for Mental Diseases (IMD) **OR** **d.** A diagnosis of Severe and Persistent Mental Illness (SPMI), defined per BHCS as: **1)** Current assignment to a BHCS Level 1 Service Team; **OR** **2)** Current enrollment in the BHCS FSP program**; OR** **3)** Three or more service episodes with an SPMI diagnosis, with the last episode occurring within the last three (3) years; **OR** **4)** A history of 10 or more SPMI diagnosis episodes since 1991
3. Substance Abuse Treatment Services Recipient in past 12 months	Receipt of at least one substance use disorder (SUD) service
4. Criminal Justice	**a.** At least one discharge from Santa Rita Jail in CY 2014 **OR** **b.** State Prison inmate discharged through AB 109 legislation **OR** **c.** Individuals with a known Person File Number (PFNs) in the Sheriff's Department Data System

Collaborative Process:

The same collaborative process described in section 2.3.A guided the identification of the project's HUMS population. In-depth discussions and data analysis by key staff from the Alliance, BHCS, CHCN, and HCSA yielded the significant finding that high-utilizing members in the psychiatric care system have very little overlap with high-utilizers in the physical health system. This is evidence of **siloed systems**, and no doubt contributes to repeated crisis system utilization and reduced lifespan among the SPMI population.

Enrollment Cap:

The HUMS target population will have an enrollment cap for the Care Management Services Bundle at the following levels: **500, 1200, 1350, and 1500** for PY2-5, respectively. To avoid abrupt cut-offs in enrollment, AC^3 will conduct quarterly spending analyses across all categories to track expenditures per bundle, and will slow down new patient enrollments if needed to ensure that enrollment is open to the neediest patients throughout each program year.

Identification & Outreach Methodology:

The identification and quantification of the project's HUMS population involved a close collaboration between the HCSA, the Alliance, and BHCS that exemplifies the cooperative commitment of the planning team. HCSA brokered a process, including weekly calls, in which the Alliance and BHCS were able to **cross their datasets** to identify patients who were served by both systems and to share utilization data specifically on that mutual population, while ensuring full HIPAA/42CFR compliance. This allowed us to examine utilization data on high-utilizing individuals across multiple systems, including incarceration status and history for patients in the BHCS database. This proved instrumental in defining the scope and needs of the project's HUMS population. Though a one-time process specifically for AC^3 planning, the agreement embodies the complex data sharing that our proposed initiative will foster on a routinized and systematic basis once AC^3 is implemented.

As noted above, our outreach plan involves building a database of all potential enrollees, starting with the groups in the table above, and expanding stepwise to include other data sets such as EMS and Probation, resolving permissions and workflow issues as we add systems. At first we will rely on close collaborators to enroll their patients and test the workflows using PDSA methods. Once the new system is available, we envision a technical solution that will alert when an eligible person is at point of care.

2.3.C. Target Populations: Population # 3: Homeless Persons

Definition and Size of Target Population # 3:

The third AC^3 population consists of an estimated **10,000** Medi-Cal beneficiaries who meet at least one of the HUD category definitions of homelessness as summarized in the table below. There were 10,334 individuals in the Homeless Management Information System (HMIS) in 2015.

Target population #3 also includes individuals who have been in a medical or psychiatric institution, including a skilled nursing facility, for more than 90 days with no community residence to return to, and who wish to and would be able to be discharged to a supported community setting if space were available. We do not yet have a number for this group, as it will require case by case assessment and planning to determine who can safely move into the community.

Category	Definition / Inclusion Criteria
1. Literally Homeless Individuals / Families, including Conditions to the Right	**a.** Place not meant for human habitation **OR** **b.** Living in a shelter **OR** **c.** Exiting an institution where they have resided for 90 days or less **AND** were residing in emergency shelter or place not meant for human habitation before entering institution
2. Individuals / Families Who Will Lose Their Primary Nighttime Residence Within 14 Days, Including Conditions to the Right	**a.** Have no subsequent residence identified **AND** **b.** Lack the resources or support networks needed to obtain other permanent housing
3. Additional Qualifying HUD Homeless categories	**a.** Certain housing-unstable children/youth **b.** Individuals fleeing domestic violence

Collaborative Process:

The same collaborative process described in section 2.3.A guided the identification of the project's homeless population. In addition, the **Housing Solutions for Health** office (HS4H), a joint program of BHCS' Housing Services office and HCSA's Healthcare for the Homeless Program, led the collaborative planning and analysis process for the homeless population.

The planning leveraged the extensive work already underway to address homeless in Alameda County. HS4H worked with Alameda County Housing and Community Development and EveryOne Home, the local backbone organization for housing and homelessness. The EveryOne Home coalition includes multiple stakeholders, including a number of cities, housing authorities, the Sheriff's Department, Veterans Affairs, Social Services, and other key housing providers and stakeholders. We built on their work to define the homeless target population prioritized for services.

In addition, we are building on important existing service partnerships. For instance, AHS is a significant provider in the Health Care for the Homeless program through its Complex Care Program. In addition to providing primary care for the homeless, AHS has partnered with the East Oakland Community Project, the largest homeless shelter in Oakland, to create a 10-bed shelter-based respite care program for homeless persons being discharged from Highland Hospital.

Enrollment Cap:

The homeless target population will have an enrollment cap of **400** patients per year for the Enhanced Housing Transition Service Bundle; a cap of **1050, 1100, 1150,** and **1250** for the Tenancy Sustaining Service Bundle in PY2-5, respectively; and will be prioritized for **150, 300, 350**, and **400** of the Care Management Services Bundles for PY 2-5 respectively. As noted

above, to avoid disruptive enrollment cut-offs, AC^3 will conduct at least quarterly spending analyses across all program categories to track expenditures for bundles, and will slow down new patient enrollments if needed to ensure that enrollment is open to the neediest patients throughout each program year.

Identification & Outreach Methodology:

The estimate of the size of the project's potential homeless service population was derived from data contained in the County's Homeless Management Information System (HMIS). Managed by the Alameda County Community Development Agency (CDA), the HMIS is the region's central database for homelessness populations and service provision. The HMIS allows us to collect, store, and report information about individuals receiving HUD-funded homeless services, and is supported by EveryOne Home, a coalition that includes Housing and Community Development and the 14 cities within the county, nonprofit organizations, and funders, as well as other county departments which provide services to those who are homeless or at risk of homelessness. As of March 2016, a total of **10,334** individuals were included in the database that meet the HUD definition of homelessness, all of whom are persons who had encountered the system by consuming some form of service such as a shelter bed or emergency housing consultation.

SECTION 3: SERVICES, INTERVENTIONS, CARE COORDINATION, & DATA SHARING

3.1.A. Services, Interventions, & Care Coordination: Population # 1: Whole Person Care Coordination Population

Overview of Services and Interventions:

		ELIGIBLE POPULATIONS		
		Whole Person Care Coordination Population ~20,000 people		
		Persons Enrolled in a Local Complex Care Coordination Program	Study Sub-Populations ~15,000 people	
			High Utilizers of Multiple Systems	Homeless
SERVICES	**Data & Care Coordination System** (links care team and identifies lead care manager)	✓	✓	✓
	Housing Service Bundles (to annual funding maximum)	✓**	✓**	✓*
	Care Management Service Bundle (to annual funding maximum)	Already Provided	✓*	✓*

***** If not eligible for the services through another complex care program such as Health Homes Program and Full Service Partnerships

** If Homeless **AND** not eligible for the services listed in (*) above

Services, Interventions, and Care Coordination:

AC[3]'s care coordination system is designed to **radically change** the experience that patients have in receiving care in our systems (see Figure 2). Sections 3.1.B and 3.1.C below review the intensive care management, substance abuse, mental health, and housing interventions we plan for the particularly impacted patients in those targeted subpopulations. The Whole Person Care Coordination target population encompasses **all** patients to be served through the AC[3]

Figure 2: Patient-Centered Workflow for Alameda County Care Connect (AC^3) – ***Please refer to page 50 to view the Figure 2 graphic.***

initiative, including people with complex conditions who are receiving care management in one system, but need care that **crosses multiple systems**.

The **new interventions and strategies we will be testing as part of care coordination** include:

a) **Standardizing patient-facing processes** so that agencies will share consent processes, assessment processes and tools (e.g. PHQ-9), care planning, and patient goal-setting documents. The objective is for us all to speak the same language, share a priority scheme for rationalizing who gets services when, and stop asking patients to repeatedly answer the same questions at each agency.
b) **Improving navigation infrastructure** and tightly integrating housing, so that patients and families get to the right service at the right time. Through this effort, organizations will share triage processes and will know whom to call and what the eligibility policies and processes are for services such as BHCS specialty mental health, Drug Medi-Cal, and housing supports.
c) **Standardizing care team design and adding team capacity** to ensure adequate support for patients and families while preventing worker burnout, including sharing best-practices about designing care teams for complex care management and ensuring adequate staff-to-patient ratios, licensed-to-unlicensed staff ratio, caseload size and mix, step down processes, and other critical components.
d) **Making care coordination resources accessible across agencies**. Currently there is significant redundancy with care managers re-inventing the wheel or having to spend too much time trying to keep resources up-to-date. Patients and families are even more in the dark. A unified care coordination system will make these resources available to all teams.
e) **Creating a data sharing system** that will link providers and patients together across agencies and systems. Currently one system, PreManage-ED, is being piloted in 6 Alameda County EDs. The envisioned AC^3 care coordination data system will go beyond such health system encounters and ultimately will include curated, actionable information about who is working with each patient, when he or she saw them last, what the care plan is, and whom to contact if the patient is in crisis.

Appropriateness of Intervention:

The new care coordination system will have an impact on patients' experience of care across our systems and on the ease and reliability of their access to services. Trust in care systems is a prerequisite for patient engagement in care. As we make our systems more coordinated, more rational, and more predictable, we believe patients and their families will be able to trust their providers more and thus be more likely to be adherent to treatment plans and health and wellness interventions. The proposed transformed care coordination system is largely an infrastructure investment that will have dramatic payoffs in terms of efficiency, improved service planning, and cost of care. However, as detailed in the list above, it has been designed with our target populations in mind.

Infrastructure Needed to Implement:

Four units in the AC^3 backbone organization will be responsible for leading the design, planning, and implementation of AC^3's care coordination system (see Figure 3). First, the Health Care Systems Planning and Improvement unit (HCSPI) will **convene the three workgroups** to develop and pilot our standard tools and processes. **The Care Coordination System Oversight unit** will support that development with expertise in care coordination and managed care, informing the planning design. Then **SDQI coaches** will take those new processes out to the field, train staff, help develop new workflows, and monitor implementation. Finally, the **Financial Oversight** unit will monitor performance and feed process and outcome information back to the Steering Committee. PDSAs at each site will be key in achieving customized implementation of a standardized system.

PDSA Process:

Training and support for **quality improvement** will be provided by the CDQI. Support for PDSAs will come from provider staff's access to regular data reports and from SDQI coaches on-site. PDSAs will be discussed at Quarterly Quality Meetings and fed back into the AC3 Reporting and Analysis unit to feed up to the Steering Committee. Initial PDSAs will likely focus on spreading and refining the standardized assessment tools and care planning documents and process that we will be using. A significant milestone will involve the **approval and implementation of a standard consent process for data-sharing** that will require PDSAs for development and then for implementation across the provider network.

Prior Experience and Linkage to Other Initiatives:

Alameda County has extensive experience in operating and overseeing complex health care improvement initiatives and innovations. The most striking recent success involves the implementation led by HCSA of the **Low-Income Health Program (LIHP**). An analysis of LIHP programs conducted by the UCLA Center for Health Policy Research found that Alameda County had by far the highest percentage of expanded Medi-Cal-eligible patients successfully enrolled in Medi-Cal, with a rate exceeding **90%** of all potential expanded Medi-Cal enrollees.[1] The next highest county had a rate of just over **50%**.

Additional relevant initiatives underway in Alameda County include **PRIME** and **GPP** as well as implementation of the **Health Homes Program**. We have been planning jointly with the public hospital Waiver Implementation Team and have deliberately integrated the interventions, metrics, and decision-making processes of AC^3 to **align with the other waiver programs**. PRIME and GPP will be implemented primarily in the AHS system; AC^3's care coordination system will support the linkage between AHS and the housing, mental health and substance use worlds. The AC^3 care management bundle described below is designed to harmonize with the HHP intervention (though with non-HHP populations) which is both an alignment strategy and a sustainability strategy.

Care Coordination:

The scope of agencies and programs involved in the Alameda County AC^3 ensures our ability to reach virtually all severely impacted Medi-Cal recipients in our region. Our proposed cross-system enhancements will: **a)** allow us to identify our region's entire high-utilizing Medi-Cal population; **b)** track patient utilization across systems; and **c)** ensure coordinated care using single identified care managers. **The direct involvement of so many local health and social service leaders in planning, implementing, and endorsing all facets of AC^3 initiative will be instrumental in ensuring that AC^3 has the needed breadth to make a lasting difference in how we provide care.**

3.1.B.

Services, Interventions, & Care Coordination: Population # 2: HUMS Overview of Services and Interventions:

AC^3 will support a comprehensive range of services and infrastructure improvements designed to improve outcomes and reduce unnecessary utilization of crisis services among high users of multiple systems. This includes a new Care Management Services Bundle; integrated behavioral health system improvements; incentives for providers to build capacity for achieving targeted health outcomes; and portals to link people with substance use disorder (SUD) to treatment to maximize the impact of the new 1115 Drug Medi-Cal treatment expansion.

The aim of the **Care Management Services Bundle** is to ensure that **all** Medi-Cal-eligible HUMS and homeless individuals have access to comprehensive care coordination through a consistent countywide complex care management system. The bundle reflects the requirements of the Health Homes Program Care Management model, but will be available to a different population **not** eligible for HHP. The bundle will include **two tiers –** one for those not facing homelessness, which will have a **1:35** provider-to-patient ratio, and the other for homeless, with a **1:30** ratio. Per-member-per-month (PMPM) rates and target populations are outlined below; detailed calculations are in the budget narrative.

Care Management Services Bundle

1. Tier 1: PMPM $321, Program Year 1 for 350 members; Program Year 3 for 900 members; Program Year 4 for 1000 members; Program Year 5 for 1100 members;
2. Tier 2: PMPM $474, Program Year 1 for 150 members; Program Year 3 for 300 members; Program Year 4 for 350 members; Program Year 5 for 400 members;

The bundle will be administered by **Alameda Alliance for Health** and **Anthem Blue Cross,** and will be provided by a network of Community Based Care Management Entities (CB-CMEs) to be created in anticipation of Alameda County's Health Homes Program starting in 2018. Each MCO will negotiate a contract with HCSA to promote enrollment in the program and to administer the service bundle for its members who are eligible for AC^3, and both HCSA and the

Figure 3: Alameda County Care Connect (AC^3) Concept Map – ***Please refer to page 51 to view the Figure 3 graphic.***

MCOs will ensure that services are not duplicated by any other program, such as the Health Homes Program. AC^3 will work hand-in-hand with the MCOs to identify and build the capacity of CB-CMEs to efficiently and effectively address the needs of the population. **By aligning AC^3 with the structures that will be part of HHP, we will maximize efficiency and strengthen the capacity of both plans to provide complex care coordination and reduce unnecessary utilization.**

Enhanced linkage to SUD treatment will complement upcoming treatment expansion related to the new 1115 Drug Medi-Cal Waiver. These SUD enhancements – described in detail in the budget narrative - include: **1)** A 24/7/365 **Sobering Center** serving individuals who are under the influence of substances for 24 hours; **2) SUD Diversion program** located in a specially-designed collaborative court setting, in which individuals facing criminal charges for drug use and possession can choose to engage in substance abuse treatment in lieu of a jail or prison sentence; **3) CenterPoint Portals to SUD Treatment** program, helping adults on probation with a history of SUD link to treatment and maintain recovery; and **4)** A **Substance Use Residential Helpline** that screens and refers individuals to residential treatment. WPCP will work alongside BHCS to develop protocols for referral and engagement, create standard and routine communication pathways across multiple systems, and include SUD care managers in the new care coordination and data-sharing systems.

AC^3 will also support **integrating behavioral health (IBH) into primary care settings,** including**: 1)** A **Psychiatric Consultation Program** to expand psychiatric service availability at eight local FQHCs, including tele-psychiatry and tele-pharmacy; **2) IBH Care Managers** in the majority of Alameda County FQHCs to improve patient tracking, treatment utilization, and accessibility to primary care and behavioral health services; **3) Providing primary care directly within Behavioral Health Treatment Centers** to facilitate patient health care access and utilization, beginning with the opening of a two-day-per-week medical services clinic at Open Eden Adult Mental Health Services in 2017; and **4)** Building psychiatric workforce capacity by providing clinical education and placements for a **UCSF Psychiatric Fellow** at the BHCS Crisis Response Program or Trust Clinic and by sponsoring a **UC Davis Collaborative Fellowship Program** for primary care providers to receive advanced training in primary care based psychiatry.

AC^3 will also offer **incentives** to improve access to life-saving and preventive treatment for issues that affect the HUMS population, including: **1)** Addressing the local opioid crisis by providing incentives to **31** clinic sites to identify patients with opioid disorder and implement integrated care services for those populations; **2)** Building the capacity of safety net agencies to identify and link to treatment persons with chronic Hepatitis C Virus (this intervention alone could permanently reduce system costs by **curing** HCV cases; **3)** Developing an incentive system to reward the adoption and application of HEDIS measures across the public and community hospital and clinic system; and **4)** Incentivizing safety net agencies to alter systems and workflows to increase appointments available and reduce barriers to obtaining them.

Appropriateness to Population:

Our key informant interviews with front-line providers were very clear that the most critical unmet needs in this population are **housing and access to SUD and mental health treatment**.

Access to primary care was also noted. These findings have guided the development of the AC^3 program.

Effective referral to SUD treatment has been a significant and stubborn problem for primary care, EDs, and other providers in our system. Clients who are in crisis are often ready to make a change in their lives, and being able to access treatment with support is critical at this juncture. Once deciding to initiate treatment, patients need the ongoing support and help with resolving barriers to care that only an effective care manager with a low enough case load can provide.

The availability of **medically assisted treatment (MAT) for addiction** will be a critical service for many in the HUMS population. Like every community in the US, Alameda County is seeing increases in opioid addiction. Deaths from opioid misuse **tripled** between 2005 and 2014, and hospitalizations for opioid-related, non-fatal overdoses increased by over **74%**. Among our 31 safety net clinics and over 500 providers, only eight doctors have X waivers allowing them to prescribe buprenorphine, and none are currently using other MAT interventions. AC^3 will attach powerful incentives for safety net primary care organizations to develop and use MAT as well as non-pharmaceutical treatments for pain and addiction. **This funding is explicitly not for provision of services, but for the building and broadening of primary care provider capacity**.

Prior Experience:

The care coordination bundle builds on and seeks to enhance several local complex care initiatives. One is the **Care Neighborhood** program at **CHCN** which uses intensive care coordination services coupled with strong service linkages to improve patient health and wellness. Another is the **Complex Care Program** at AHS, which utilizes multidisciplinary care management focused on social stabilization, care coordination, and behavioral health to enhance service linkage and promote patient stabilization and wellness. While both programs have been successful, their effectiveness has been hampered by the inability to access and exchange patient-level data with other providers and systems – a problem that will be rectified through the AC^3 initiative.

PDSA Process:

AC^3 will continually utilize PDSA cycles to identify, strategize, and implement quality improvement initiatives at all levels of the system, based on ongoing metric assessment and analysis. Regarding the Care Management Services Bundle, the SDQI and Data Reporting and Analysis units will work with the administering MCOs to identify and address quality issues related to administration and delivery of the bundle. In the case of behavioral health and incentives, SQDI will coach providers to identify areas for improvement in engagement in treatment, and to ensure that reporting and analysis incentives produce meaningful intended results.

Care Coordination:

The Care Management Services Bundle is designed to ensure that Medi-Cal-eligible HUMS and homeless persons in our county who are not currently served by or eligible for other

complex care management programs are able to receive high-quality care coordination services. The bundle will allow us to implement a higher level of comprehensive care coordination that becomes the model across the county that maximizes the value of the data system. In addition, the integrated treatment enhancements described in greater detail in the budget narrative will help providers interrupt the cycles of crisis by providing the right care at the right time.

The Services Bundle will be monitored by HCSA in its capacity as lead entity, with consultation from the Steering Committee. AC^3 staff will lead design of standards and parameters for the new service bundle and HCSA will negotiate a contract with the Alliance and Anthem Blue Cross to administer and distribute bundle services on a PMPM basis. The MCOs will contract with community providers to deliver bundle services following collaboratively developed standards and protocols in accordance with Medi-Cal regulations. Delegated services will be monitored by both MCOs and HCSA to ensure fidelity, adequacy, and accuracy of reporting.

3.1.C.

Services, Interventions, & Care Coordination: Population # 3: Homeless Persons Overview of Services and Interventions:

AC^3 places a strong emphasis on housing assessment, matching to housing opportunities, retention, and support as indispensable elements in helping Medi-Cal populations attain and maintain health and well-being. In Alameda County in 2015, more than **7,800** households sought services because they were homeless or at risk of homelessness, including over **5,900** individuals who self-reported one or more disabling conditions. The literature demonstrates that obtaining safe and secure housing promotes positive outcomes including better utilization of services, better chronic disease management, and reduced mental health disorders. Through the Housing Solutions for Health (HS4H) office, AC^3 will implement **eight** distinct housing support interventions, many drawn from emerging best practices, which will be available to members of the Whole Person Care Coordination Population who meet our program's homeless definition. These interventions will build upon the broad range of housing supports in our region, including the **2,000** supportive units currently coordinated by HCSA staff through the County's Home Stretch program, a pilot initiative of EveryOne Home designed to streamline supportive housing entry.

Housing-Related Services

1. <u>Enhanced Housing Transition Service Bundle</u>:

AC^3 will implement an **Enhanced Housing Transition Service Bundle** to help high-utilizing Medi-Cal recipients who are not Health Homes eligible identify and secure supportive housing. Bundle services will provide a significantly more intensive level of housing transition support than that available through programs such as Health Homes. The bundle is designed to reach individuals who are **chronically homeless and disabled** and require a high level of support to navigate into housing. Bundle services will be provided by **Housing Navigators** who serve as

homeless advocates, providing intensive care management including housing support plans; addressing housing barriers; housing search and application assistance; and move-in support. Housing Navigators will follow patients for **6 months** post-housed, and will utilize the **Critical Time Intervention (CTI)** model to strengthen each patient's community support networks (www.criticaltime.org).

The Housing Transition Service Bundle will be paid at a per-member-per-month (PMPM) rate of **$323.73** for an estimated **400** individuals per year. The bundle will be administered by **Alameda County Housing Solutions for Health**, which will contract with local homeless CBOs. The program will include an innovative bonus to CBOs when individuals have remained in housing for **6 months** – a key milestone for predicting long-term housing retention.

2. Housing and Tenancy Sustaining Services Bundle:

AC^3 will support a second housing bundle called the **Housing and Tenancy Sustaining Services Bundle,** which provides residency retention services for patients in permanent supportive housing. While the county has funding for 2,000 supportive units, funding for support services within those units is available for only **half** those facilities. The bundle will fill that gap by funding tenancy retention for the remaining **1,000** local patients who are in need of supportive housing. The bundle will support services that include household management; landlord relations coaching; dispute resolution; housing recertification; linkage to services; and updating housing support and crisis plans. The bundle will be administered through the central housing unit at HCSA which will contract with CBOs throughout Alameda County. The bundle will have a PMPM rate of **$211** and will serve approximately **1,000** individuals per year. Bonuses will be paid to CBOs based on patients reaching a critical **24-month** housing retention marker.

3. Skilled Nursing Facility Housing Transitions Program:

A subset of the AC^3 population are residents of **skilled nursing facilities (SNFs)** who do not meet the medical necessity requirement to obtain supportive housing but lack the resources to transition to independent community settings. For these populations, AC^3 will provide intensive housing navigation services that complement the housing bundles described above, through a contract with an experienced CBO providing independent living services. This component will serve a projected **62** SNF residents per year, with a caseload to staff ratio of **25:1.**

4. Street Outreach:

AC^3 will make a one-time investment in **expanded street outreach** with the goal of linking to care **all** unsheltered chronically homeless individuals in Alameda County. The program will contract with CBOs who will in turn hire skilled outreach staff to find persons who are street homeless, build relationships, and link them to whole person care services and housing.

5. **Community Living Facilities Quality Improvement (QI) Program:**

For homeless individuals, a range of housing facilities are available, including residential hotels and board and care facilities. While many AC^3 patients live in such facilities, they are not government regulated and often feature substandard or dangerous living conditions. The AC^3 team researched model programs nationally and identified a San Diego model of a local **Independent Living Association** which has successfully certified nearly **50** owners of community living facilities as providers of clean and safe housing for low-income persons. The program incorporates an online directory, training program, grievance system, and community recognition program. AC^3 will replicate this innovative model by creating an **Alameda County Independent Living Association** which low-income housing operators will be invited to join to improve the quality of their facilities, receive support in filling vacancies, and achieve community recognition. SQDI will assist the new Association with quality management, coordination, and PDSA cycles.

6. **Housing Education and Legal Assistance Program:**

The AC^3 process has identified **legal support** as critical for helping low-income and high-utilizing populations maintain housing. Our program will contract with a qualified legal services CBO to create a new legal services unit dedicated to housing. Innovative program elements include a toll-free number that Medi-Cal beneficiaries can call if they are having housing access or retention problems; maintenance of a small legal service caseload; and housing education workshops in the community.

7. **Flexible Funding Pools – Client and Landlord Funds**:

AC^3 will create **two** specific flexible housing support funds to help high-utilizing patients access and maintain housing. The first is a **Client Move-In Fund** consisting of a $1.4 million per year set-aside from which Housing Navigators can draw to assist patients with move-in expenses such as security deposits, first month's rent, utility deposits, and safety modifications.

The second funding pool is a **Landlord Recruitment and Incentive Fund** whose goal is to expand the pool of low-income housing by providing a cash bonus to landlords who agree to offer their units to low-income subsidy holders. The fund will provide an **initial bonus payment** to landlords and will include a **risk mitigation pool** to pay for unforeseen incidents such as damage to a unit by a patient. The program will include extensive community outreach and recognition events for property holders. The program will also include an **emergency line for landlords** as a way to get help when they are dealing with issues related to high need patients.

8. **Housing Development Pool:**

In support of the County's homeless population, Alameda County Health Care Services Agency will create a **Revolving Housing Development Fund** that does not use Whole Person Care funds, with the goal of significantly increasing the number of permanent supportive housing units in Alameda County. In accordance with STC 114(b), housing pool investments in

housing units or housing subsidies including payment for room and board will not be eligible for WPC Pilot payments unless otherwise identified in CMS Informational Bulletin, 'Coverage of Housing-Related Activities and Services for Individuals with Disabilities. Modeled after a similar fund in Santa Clara County, the housing pool will be overseen by an Advisory Committee appointed in the first year of AC^3 to define the program; market it to potential investors; and develop policies and procedures governing investment and access to funds. The pool will be operated by an intermediary such as Silicon Valley Trust or Enterprise Community Partners – agencies that lend funds, finance development, and build and manage affordable housing. A Review Board will review all lending proposals and score and rank them for funding in accordance with HCSA-established priorities.

The fund will provide loans to support **pre-development, acquisition, or construction** of permanent supportive housing units, with a range of conditions including that a set number of eligible units must be set-aside for households living at or below 30% of Area Median Income (AMI) and that some units be set aside for individuals with SPMI; preferred projects will have 20% or less of the units as permanent supportive housing (PSH) or small projects with 5 or fewer PSH units; and eligible units will provide housing opportunities for high priority homeless individuals or individuals exiting institutions with special needs.

PDSA Process:

AC^3 will utilize PDSA cycles to identify, strategize, and implement quality improvement initiatives at all levels of the system, based on ongoing metric assessment and analysis. In the case of housing, this includes identifying and addressing issues related to housing placement and retention, bundle administration, and homeless outreach.

Care Coordination:

Housing providers will participate in the AC^3 care coordination system. HS4H and the backbone organization will facilitate integration across housing systems. EveryOne Home will serve on planning workgroups.

3.2.A. Data Sharing: Population # 1: Whole Person Care Coordination Population

Data Sharing Overview

- **Data Sharing:** AC^3 will finalize an interagency data sharing protocol during PY2 that allows for the mutual sharing of actionable patient profile information which is patient-centered and adequate to support coordinated care across multiple systems. AC^3 will utilize the **Continuity of Care Document (CCD)** as a base framework for interoperability of clinical data by allowing physicians to send electronic medical information to other providers without loss of meaning and for purposes of improving patient care. The CCD is an XML-based markup standard intended to specify the encoding, structure, and semantics of a patient summary clinical document for exchange. All AC^3 entities will

agree to a roster of data elements capable of being shared and mutually modified using the **Common Meaningful Use (MU) Data Set** as a base format. Provider entities participating in the data pilot will include, at minimum, BHCS, EMS, and Housing and Community Development, along with CHCN and Alameda Health System.

Bi-directional data sharing will also take place with the managed care plan (MCP) partners, (the Alliance and Anthem Blue Cross). In one direction, MCPs will provide basic client information that identifies their respective patient population eligible for WPCP program services. This information will support development and management of a master patient index that will be used under the WPC data sharing system. In the other direction, MCPs can query on shared information within the data sharing system (e.g., utilization, enrollment, etc.) and schedule regularly-generated comprehensive reports on services delivered by WPCP providers to their clients. As services and partners expand (e.g., Probation), MCPs can potentially begin to receive data that will continue to supplement a complete patient profile and improve the holistic approach to managed care.

Dedicated IT and Health Data Analyst resources will be assigned to MCP partners during the WPC pilot; they will be responsible for the upload and download of information used in the data sharing system. Again, specific workflow processes and reporting format/ requirements will be initially determined during the PY2 planning phase and improved upon via PDSA cycles throughout the pilot.

☐ **Infrastructure Evolution:** During the initial pilot phases, participating entities will use existing data sharing processes and workflows while low-tech / high security solutions such as secure sharing of care plans and visit information are developed and implemented. PDSAs during this phase will focus on improving process workflows and will inform technical and functional specifications for a larger, more comprehensive data exchange system. A **consent process** to address 42CFR regulations will be built into the workflow.

☐ **Tools to Support Data Sharing:** Specific tools will be assessed during the pilot; our project will likely utilize a **centralized, query-based model** for exchanging data that employs middleware - software to "glue together" separate existing programs. A **dedicated server and data repository** supported by reporting tools (e.g., Emanio, Tableau) will house this information and support reporting requirements and metrics monitoring throughout the course of the pilot. **Care management applications** (e.g., Maestro, Symphony) will be used by care managers and other end users.

☐ **Existing Capabilities:** HCSA has begun a data exchange feasibility assessment and formed a **Data Sharing Workgroup**. The IS departments of AHS, AAH, CHCN, and BHCS are participating so far; this group will expand to include other data systems. Some partner entities are participating in a pilot of PreManage ED. This pilot will be folded into the feasibility assessment, although the system we design will reach beyond the ED. Many

major IS changes are underway locally, making this an ideal time for a comprehensive planning process to promote synergy and prevent major investments in conflicting systems.

Timeline & Implementation Plan:

☐ **Program Year 1: Assess/Plan/Prepare**

- Staff Data Sharing and Analysis unit
- Survey database systems, consent requirements, and workflows of partner entities
- Identify data elements to be exchanged
- Implement QA / Data Cleaning protocols
- Identify and begin procuring vendor
- Develop, test, and train for data sharing
- Confirm HIPAA/42CFR-compliant data sharing agreements

☐ **Program Year 2: Build**

- Procure vendors
- Develop custom reports and tools
- Train users and provide in-house technical support

☐ **Program Year 3: Deploy**

- Go live
- Test / Iterate

☐ **Program Year 4: Scale-Up/Plan for Sustainability**

- Identify systems to be added after pilot period
- Ensure HIPAA and 42CFR compliant data sharing agreements are in place for new participants
- Develop custom reports and tools
- Train new end-users

Building Sustainable Infrastructure:

While the majority of design, buildout, and implementation of the enhanced data system will be carried out during the pilot period, we will estimate continuation costs and evaluate cost savings realized through the pilot to develop a realistic sustainability plan that includes support for ongoing system enhancements.

Data Governance Approach:

The data program will be overseen by a AC^3 Data Sharing and Analysis Department headed by an Executive Director and supported by an IS/IT Director, a Database Administrator, IS and IT Analysts, Legal Counsel, and a Data Exchange Operations Director overseeing a staff of analysts and designers. The Department will be under the supervision of the AC^3 central office.

Challenges:

The AC^3 Data Sharing Workgroup conducted interviews with **22** representatives of **7** key stakeholder agencies and identified barriers and challenges which AC^3 will address. These include: a) the cost and resources needed to develop and implement the data system; b) the need for clear guidance regarding data sharing; d) fragmented systems and disparate levels of technological maturity; and e) fear of culture change and potential resistance to workflow and procedures changes.

3.2.B. Data Sharing: Population # 2: HUMS

The description of data sharing in Section 3.2.A also applies to the HUMS population. A particular data system challenge affecting the HUMS population is the need to reach beyond health-related organizations to other sectors, such as criminal justice, social services, and probation, which have their own regulations and technical requirements. We will resolve this by including IS leadership and experts from those sectors in the Steering Committee and Data and Operations Work Group. The inclusion of SUD services, with the heightened confidentiality requirements, has also been identified as a special challenge in working with this group.

Data Sharing Overview

- ☐ **Data Sharing:** As noted above, AC^3 will finalize an interagency data sharing protocol during PY2 that allows for the mutual sharing of actionable patient profile information which is patient-centered and adequate to support coordinated care across multiple systems. AC^3 will utilize the **Continuity of Care Document (CCD)** as a base framework for interoperability of clinical data by allowing physicians to send electronic medical information to other providers without loss of meaning and for purposes of improving patient care. The CCD is an XML-based markup standard intended to specify the encoding, structure, and semantics of a patient summary clinical document for exchange. All AC^3 entities will agree to a roster of data elements capable of being shared and mutually modified using the **Common Meaningful Use (MU) Data Set** as a base format. Entities participating in the data pilot will include, at minimum, BHCS, EMS, and Housing and Community Development, along with CHCN, Alameda Health System, and the Alliance.

- ☐ **Infrastructure Evolution:** During the initial pilot phases, participating entities will use existing data sharing processes and workflows while low-tech / high security solutions such as secure sharing of care plans and visit information are developed and implemented.

PDSAs during this phase will focus on improving process workflows and will inform technical and functional specifications for a larger, more comprehensive data exchange system. A **consent process** to address 42CFR regulations will be built into the workflow.

- ☐ **Tools to Support Data Sharing:** Specific tools will be assessed during the pilot; our project will likely utilize a **centralized, query-based model** for exchanging data that employs middleware - software to "glue together" separate existing programs. A **dedicated server and data repository** supported by reporting tools (e.g., Emanio, Tableau) will house this information and support reporting requirements and metrics monitoring throughout the course of the pilot. **Care management applications** (e.g., Maestro, Symphony) will be used by care managers and other end users.

- ☐ **Existing Capabilities:** HCSA has begun a data exchange feasibility assessment and formed a **Data Sharing Workgroup**. The IS departments of AHS, AAH, CHCN, and BHCS are participating so far; this group will expand to include other data systems. Some partner entities are participating in a pilot of PreManage ED. This pilot will be folded into the feasibility assessment, although the system we design will reach beyond the ED. Many major IS changes are underway locally, making this an ideal time for a comprehensive planning process to promote synergy and prevent major investments in conflicting systems.

Timeline & Implementation Plan:

See Timeline in Section 3.2.A above

Building Sustainable Infrastructure:

While the majority of design, buildout, and implementation of the enhanced data system will be carried out during the pilot period, we will estimate continuation costs and evaluate cost savings realized through the pilot to develop a realistic sustainability plan that includes support for ongoing system enhancements.

Data Governance Approach:

The data program will be overseen by a AC^3 Data Sharing and Analysis Department headed by an Executive Director and supported by an IS/IT Director, a Database Administrator, IS and IT Analysts, Legal Counsel, and a Data Exchange Operations Director overseeing a staff of analysts and designers. The Department will be under the supervision of the AC^3 backbone organization.

Challenges:

The AC^3 Data Sharing Workgroup conducted interviews with **22** representatives of **7** key stakeholder agencies and identified barriers and challenges which AC^3 will address. These include: a) the cost and resources needed to develop and implement the data system; b) the need for clear guidance regarding data sharing; d) fragmented systems and disparate levels of

technological maturity; and e) fear of culture change and potential resistance to workflow and procedures changes.

3.2.C. Data Sharing: Population # 3: Homeless Persons

The description of data sharing in Section 3.2.A also applies in full to the homeless population. In addition, a particular challenge for our work with homeless populations is that, because we may have only intermittent contact with potential enrollees, the information in the system will have to be current and useful or we may miss a chance to engage an individual. To keep information current, we will want to allow **as many team members as possible** to write in the system, although that could also potentially have a negative impact on data security and quality. This tension is a particular challenge with respect to this population.

Data Sharing Overview

- ☐ **Data Sharing:** As noted above, AC^3 will finalize an interagency data sharing protocol during PY2 that allows for the mutual sharing of actionable patient profile information which is patient-centered and adequate to support coordinated care across multiple systems. AC^3 will utilize the **Continuity of Care Document (CCD)** as a base framework for interoperability of clinical data by allowing physicians to send electronic medical information to other providers without loss of meaning and for purposes of improving patient care. The CCD is an XML-based markup standard intended to specify the encoding, structure, and semantics of a patient summary clinical document for exchange. All AC^3 entities will agree to a roster of data elements capable of being shared and mutually modified using the **Common Meaningful Use (MU) Data Set** as a base format. Entities participating in the data pilot will include, at minimum, BHCS, EMS, and Housing and Community Development, along with CHCN, Alameda Health System, and the Alliance.

- ☐ **Infrastructure Evolution:** During the initial pilot phases, participating entities will use existing data sharing processes and workflows while low-tech / high security solutions such as secure sharing of care plans and visit information are developed and implemented. PDSAs during this phase will focus on improving process workflows and will inform technical and functional specifications for a larger, more comprehensive data exchange system. A **consent process** to address 42CFR regulations will be built into the workflow.

- ☐ **Tools to Support Data Sharing:** Specific tools will be assessed during the pilot; our project will likely utilize a **centralized, query-based model** for exchanging data that employs middleware - software to "glue together" separate existing programs. A **dedicated server and data repository** supported by reporting tools (e.g., Emanio, Tableau) will house this information and support reporting requirements and metrics monitoring throughout the course of the pilot. **Care management applications** (e.g., Maestro, Symphony) will be used by care managers and other end users.

☐ **Existing Capabilities:** HCSA has begun a data exchange feasibility assessment and formed a **Data Sharing Workgroup**. The IS departments of AHS, the Alliance, CHCN, and BHCS are participating so far; this group will expand to include other data systems. Some partner entities are participating in a pilot of PreManage ED. This pilot will be folded into the feasibility assessment, although the system we design will reach beyond the ED.

Timeline & Implementation Plan:

See Timeline in Section 3.2.A above

Building Sustainable Infrastructure:

While the majority of design, buildout, and implementation of the enhanced data system will be carried out during the pilot period, we will estimate continuation costs and evaluate cost savings realized through the pilot to develop a realistic sustainability plan that includes support for ongoing system enhancements.

Data Governance Approach:

The data program will be overseen by a AC^3 Data Sharing and Analysis Department headed by an Executive Director and supported by an IS/IT Director, a Database Administrator, IS and IT Analysts, Legal Counsel, and a Data Exchange Operations Director overseeing a staff of analysts and designers. The Department will be under the supervision of the AC^3 backbone organization.

Challenges:

The AC^3 Data Sharing Workgroup conducted interviews with **22** representatives of **7** key stakeholder agencies and identified barriers and challenges which AC^3 will address. These include: a) the cost and resources needed to develop and implement the data system; b) the need for clear guidance regarding data sharing; d) fragmented systems and disparate levels of technological maturity; and e) fear of culture change and potential resistance to workflow and procedures changes.

SECTION 4: PERFORMANCE MEASURES, DATA COLLECTION, QUALITY IMPROVEMENT, & ONGOING MONITORING

4.1. Performance Measures, Universal Metrics, Variant Metrics

Performance Measures Overview:

AC^3 performance measures will track progress and outcomes using both universal and variant metrics. These metrics will allow the program to: a) track progress in relation to patient care enhancement, improved patient care outcomes, and systems change and integration; b) identify areas for program improvement; and c) identify cost savings to support program

activities and interventions over the long term. The chart below provides an overview of performance measures, detailed in the attached full metric table, including projected four-year performance targets where appropriate.

<table>
<tr><th rowspan="2">Performance Measures</th><th colspan="5">Projected Annual Targets</th></tr>
<tr><th>Performance Benchmark</th><th>Year 2</th><th>Year 3</th><th>Year 4</th><th>Year 5</th></tr>
<tr><td colspan="6">Universal Measures</td></tr>
<tr><td colspan="6">Health Outcomes Measures</td></tr>
<tr><td>▪ ED Visits</td><td>91 ER Visits / 1,000 Member Months</td><td rowspan="4">5% Reduction of Gap Between Baseline and Benchmark</td><td rowspan="4">10% Reduction Over Previous Year</td><td rowspan="4">10% Reduction Over Previous Year</td><td rowspan="4">10% Reduction Over Previous Year</td></tr>
<tr><td>▪ Inpatient Utilization</td><td>32 IP Admits / 1,000 Member Months</td></tr>
<tr><td>▪ Follow-Up After Mental Health Hospitalization</td><td>30-Day: 63.0%
7-Day: 43.9%</td></tr>
<tr><td>▪ Engagement in Alcohol / Drug Treatment</td><td>Initiation: 38.8%
Engagement: 11.3%</td></tr>
<tr><td colspan="6">Administrative Measures</td></tr>
<tr><td>▪ Proportion of Beneficiaries with Comprehensive Care Plan</td><td>100%</td><td>Define Baseline</td><td>20% Reduction of Gap Between Baseline and Benchmark</td><td>20% Reduction Over Previous Year</td><td>20% Reduction Over Previous Year</td></tr>
<tr><td>▪ Care Coordination Infrastructure Enhancement</td><td colspan="5" rowspan="2">Policies, procedures, monitoring and improvement plans will be submitted.</td></tr>
<tr><td>▪ Data Infrastructure Enhancement</td></tr>
</table>

Performance Measures	Projected Annual Targets				
	Performance Benchmark	Year 2	Year 3	Year 4	Year 5
Variant Measures					
▪ **High Blood Pressure Control**	70%	5% Reduction of Gap Between Baseline and Benchmark	10% Reduction Over Previous Year	10% Reduction Over Previous Year	10% Reduction Over Previous Year
▪ **12-Month Depression Remission** ▪ **Suicide Risk Assessment Among SPMI**	None	5% Improvement Over Baseline	10% Improvement Over Prior Year	10% Improvement Over Prior Year	10% Improvement Over Prior Year
▪ **Percent in Less Restrictive and More Independent Housing**	Combined Score of 2,000 (Unique AC Metric)	60% Increase in Composite Score	60% Increase in Composite Score	60% Increase in Composite Score	60% Increase in Composite Score
▪ **Percent in Housing After 6 Months**	85% at 12 Months	5% Improvement Over Baseline	10% Improvement Over Prior Year	10% Improvement Over Prior Year	10% Improvement Over Prior Year
▪ **New Housing Placements**	65% of Homeless Become Permanently Housed	5% Improvement Over Baseline	10% Improvement Over Prior Year	10% Improvement Over Prior Year	10% Improvement Over Prior Year
▪ **Single Care Manager Assignment**	100% Assignment	80% Assignment	90% Assignment	100% Assignment	100% Assignment
▪ **MH Follow-Up to PES Visit**	None	5% Reduction of Gap Between Baseline and Benchmark	10% Reduction Over Previous Year	10% Reduction Over Previous Year	10% Reduction Over Previous Year

Overarching Vision of Performance Measures:

The universal and variant performance measures were selected to provide **at least one** key measure for each major component of whole person care: crisis services utilization; mental health; SUD; comprehensive care coordination; physical health; and housing. With these data, AC^3 will monitor progress toward our vision of enabling high-need patients to achieve their optimal level of independence and health.

Tracking & Documentation Plan:

Data will be collected and analyzed by the Reporting and Analysis group, with the oversight of the Executive Director of the Data Exchange unit (see Section 4.2). Project sites will continually enter data which will be collected and aggregated in a data repository (see Figure 4). All service providers will report necessary data on patients and service utilization while MCOs will report on utilization of services provided by their network (e.g., ED visits throughout the system) and on the Care Management service bundles. The HS4H office will ensure housing providers report on housing bundles and services.

The Reporting and Analysis group will write monitoring process guidelines and reporting standards; review and approve data monitoring reports; and conduct detailed analyses of data for tracking patient outcomes. Quality of data is essential so locally-based analyst teams will support major sites for reporting integrity and quality.

A management analyst in the AC^3 Director's office will work with the Reporting and Analysis group to track overall reporting and will manage the mid-year and annual reporting process to DHCS. The Financial Oversight unit of the backbone organization will track and analyze system-wide program financial and utilization data, with the ultimate aim of documenting cost and savings impact.

4.1.a Universal Metrics

The Alameda County AC3 will track and report universal metrics for the following two categories, as detailed in the table below.

☒ **Health Outcomes Measures**
☒ **Administrative Measures**

See attached **Universal Metrics Table.**

4.1.B. Variant Metrics Table- See Separate Document

4.2. Data Analysis, Reporting, & Quality Improvement

Plan for Data Collection, Reporting, & Analysis:

The AC^3 backbone organization will be responsible for negotiating agreements with County agencies, MCOs, and community-based providers that include requirements related to data collection, reporting, and quality assurance. Direct data functions and required reporting will be overseen by the Data Exchange unit and its governing body, which will establish data priorities, objectives, and accountability targets for participating providers. Day-to-day oversight of data collection and reporting will lie with the unit's Data Reporting and Analysis group, which will partner closely with sites to implement standardized data collection procedures; provide on-site training, support, and TA; and ensure collaborative problem-solving.

The chart on the following page outlines the basic AC^3 data reporting, analysis, and feedback relationships (see Figure 4). Data will be reported from all participating sites using new standardized procedures and collected and aggregated at a centralized data repository using matching and data standardization tools. For both tracking and reporting purposes, the AC^3 Reporting and Analysis group will analyze patient and service data using one or more reporting and analysis tools (e.g., Tableau, Emanio). Meanwhile, providers will be able to access data via an enhanced care management application (e.g., Symphony, EDIE, PreManage). This will allow providers access to a comprehensive snapshot of services utilized by a member across all participating sites.

Data Sources & Timeline:

During program year 2 - the first implementation year - the Data Exchange unit's IS / IT System Development group will partner with providers and the Reporting and Analysis group to develop data collection and reporting methodologies that build upon the existing EHR systems at each agency. A team of full-time Health Data Analysts and IT analysts will be out-based at provider organizations (one team per major organization) to support data transformation and promote collaborative innovation. During this formative phase, while long-term data exchange solutions are being planned and assessed, providers will focus on process workflows and begin data exchange using a low-tech solution such as MS Excel Exchange or MS Access Database.

Beginning in late year 3 / early year 4, providers will begin providing patient data following standardized cross-system procedures. This includes entering enhanced patient demographic, service, and conditions data while updating patient notes. The Permissions Monitoring group of the Data Exchange unit will be responsible for development Memoranda of Understanding and Business Associate Agreements with partner entities in the pilot, including agreements to comply with HIPAA/42CFR regulations. Support and TA will be provided by the Reporting and Analysis group, which will regularly examine and analyze data and will prepare aggregate reports on a quarterly or semi-annual basis.

QI & Change Management:

AC^3 will establish a **Skills Development and Quality Improvement (SDQI) unit** to oversee both training and quality improvement activities. The SDQI unit will enhance provider care coordination capacity by introducing and rolling out new care coordination protocols, new care management packages, associated data management training, and appropriate privacy rules. The unit will also monitor process and outcome data in order to design PDSA cycles that enhance the system.

QI and change management oversight for the AC^3 will take place on several levels. The Health Care Systems Planning and Improvement (HCSPI) unit will focus on the establishment of a countywide Whole Person Care Coordination system infrastructure and will conduct PDSA cycles related to enhanced care management approaches; implementation of network service bundles; and system-wide reorganization and integration. The Care Coordination System Oversight unit (CCSO) will develop and monitor regulatory standards for AC^3 and align program design with Medi-Cal benefits requirements. Financial Oversight and Contracting will oversee contracts, document deliverables, and implement result-based accountability, conducting PDSA cycles related to reporting accuracy, timely expenditure of funds, and Results Based Accountability (RBA) adoption. As noted above, the Data Reporting and Analysis group of the Data Exchange unit will feed information to this process. Meanwhile, the Communications and Change Management group will play a key role in supporting change management by convening cross-site meetings; facilitating information-sharing; and sharing project successes and advancements to retain focus on overarching goals.

Adjustments & Changes:

Because the AC^3 initiative will implement a new approach to the way in which crisis services are organized, delivered, monitored, and tracked, a continual process of self-assessment, process and outcomes monitoring, and programmatic adaptation and readjustment will be integral to the program implementation process. The project's overarching governing bodies will review project data and focus on change management and the ongoing adaptation of interventions to respond to emerging challenges and opportunities, including the Operations Workgroup which will conduct cross-organizational problem-solving and the Clinical Integration Workgroup which will keep the program focused on **individual patient experience** and the utilization of PDSA cycles at all levels of the system. Basic quantitative data will provide information on patient utilization of services, including distribution of service bundles and implementation of enhanced care coordination and data systems. Qualitative data will provide input on key implementation aspects of the program such as how frequently providers are updating patient information; how patient data is being accessed and used across the system; how successful the program is in ensuring a lead care manager for each patient, who is fluent in multiple systems; and how the AC^3 is impacting outcome indicators such as patient housing status and utilization of crisis systems. AC^3 planning bodies will review data to identify gaps and barriers and target priority issues for PDSA quality improvement. Providers and patients will play an integral role in project monitoring by serving as active partners in the AC^3 initiative, providing feedback and input on how systems can be improved and enhanced.

Figure 4: Proposed AC[3] Data Exchange Workflow *– Please refer to page 52 to view the Figure 4 graphic.*

4.3 Participant Entity Monitoring

Monitoring is the responsibility of the AC^3 backbone organization, and a total of **7.5 FTE staff** have been designated specifically for financial and program monitoring. Clinical monitoring and complaints and grievances monitoring for agencies administering the Case Management Bundle have been delegated to the MCOs as part of their bundle administration responsibilities.

The **process of monitoring** will begin with a series of meetings with participating entities to agree on process and outcome metrics for each service that will make up the total matrix of WPC deliverables. HCSA has extensive experience in this; as of May 2016, we had converted **33** direct service contracts in mental health services, primary care, and preventative care to metrics-driven reporting as part of our Results Based Accountability (RBA) work. Metrics will include financial monitoring, volume, and value measures and will need to be reportable as electronic files. The Steering Committee will review and vote on the metrics schemes, including what will constitute “red flags”. The AC^3 Central Office will support the Steering Committee in developing these limits and will report on overall system performance.

Once contracts are executed and service begins, **monthly reports on results** will flow into a dashboard program such as IMPACT, which is currently used by HCSA’s RBA program. Both the participating organizations AC^3 staff will be able to view this progress. Contracts will include requirements for agencies to perform at least one PDSA per quarter based on that agency’s specific results. PDSAs will be shared at **Quarterly Quality Meetings** organized by the SDQI unit.

The SDQI has primary responsibility for providing **training and technical assistance** on AC^3 tools and systems. A staff of Coaches/Monitors is included in the SDQI who will visit downstream provider agencies at least quarterly to provide onsite coaching and assist in spreading successful ideas from one organization to another.

If an agency shows poor performance on their contract metrics, a **special technical assistance visit** will be scheduled and a **corrective action plan** will be developed that must be signed off on by the BBO monitoring staff. If satisfactory improvement does not occur and the agency has fallen below the “red flag” performance limits as determined by the Steering Committee, the agency will be put on notice and a plan of correction developed. If the plan of correction is not followed, the contract will be terminated. Final decisions on terminations will be made within the AC^3 backbone organization, consistent with procurement and monitoring processes that are already used by HCSA.

SECTION 5. FINANCING

5.1. Financing Structure

Financing Structure Description:

☐ **Pilot Payment Distribution:** As shown in the Funding Diagram, the AC^3 backbone organization will oversee and track the distribution of infrastructure, service bundles, and pay for outcomes funds to the participating MCOs (AAH, Anthem, BHCS, and M-C ODS) and Alameda Housing Solutions for Health (AH4H) as well as infrastructure and incentive payments for downstream contractors and providers.

- **Oversight / Governance:** The backbone organization will manage the IGT to DHCS and will secure the funds commensurate with deliverable achievement. On a monthly then quarterly basis, the BBO will convene the AC^3 Governing Board to review the budget, progress toward deliverables and performance goals, and approve all funds distributions, including any revisions based on PDSA cycles. Prior to each Governing Board meeting, the Finance Subcommittee Chair and AC^3 staff will prepare a Budget Report detailing all expenditures and deliverables completion. The Budget Report will also reflect a summary of AC^3 staff's quarterly check-in calls with all entities receiving AC^3 funds to review metrics, plan PDSA sessions to improve program effectiveness using collected data and ensure that payments are sufficient to provide defined services.

Payment Timeline, Structure, Process, Tracking, Needed Changes, and Planning for Sufficiency:

☐ **Care Management and Housing Services Bundles:** On a quarterly basis, the BBO will prospectively distribute Care Management Services Bundle payments to the two distributing MCOs and Housing Transitions and Housing Sustaining Service Bundle payments to HS4H for the projected number of individuals to be served during that upcoming time period. If fewer individuals are served during the period, the next payment will be adjusted downward accordingly. The two MCOs will contract with CB-CMEs to provide Health Home-like care coordination and care management services for AC^3-enrolled individuals not receiving such services through other programs. Payment adjustments will be made based on actual participation, in order to ensure bundle administrators are paid based on actual expenses. HS4H will use its funds to issue year-long contracts with four option years to CBOs with demonstrated track records and experience delivering housing transition and housing sustaining services. Option years will be contingent on satisfactory performance.

- **Client Move-In Fund:** HCSA will fund a Basic Client Move-In Fund annually as a service delivery infrastructure investment. HS4H will oversee contractors to use these funds for discrete, one-time, allowable costs such as first month's rent and security deposit.

- ☐ **Paying for Outcomes and Incentives:** AC^3 incentives and Pay for Outcomes structures are designed to incentivize attainment of and performance beyond desired thresholds, aligning with research on the effectiveness of rewarding improvement as well as excellence. AC^3 will oversee and track the distribution of incentives and Pay for Outcomes as described in the budget narrative. One month after reports are submitted by MCOs and HS4H, AC^{3}will make payments for achievement of outcomes per agreed-upon targets and performance beyond targets. AC^3 will also provide incentive payments for downstream providers and contractors based on achievement of defined outcomes.

- **Preparing for Value Based Payments:** The program's financing design will prepare MCOs, HS4H, contractors, and CB-CMEs for a future of value-based care in several ways. The vision of AC^3 communicates a clear message regarding the need to enhance reporting and expect increasing accountability for outcomes. Introducing incentives into housing service provider contracts will also represent the first time Alameda County has used "Pay for Success" strategies with these contractors. Additionally, structuring service bundles as PMPM payments with concurrent accountability for tracking, reporting, and receiving payments for outcomes is a significant departure from fee-for-service payments, which incentivize volume of specific services but not necessarily quality of care, giving providers the necessary flexibility to provide the services that patients need within the parameters of clear service expectations and desired outcomes. Finally, by selecting decreasing ED visits and follow-up after MH hospitalization as two key Pay for Outcomes measures, AC^{3}will advance the goal of driving down inappropriate hospital care and readmissions and moving toward value-based payments.

5.2. Funding Diagram – See page 53 (graphic06) to view the funding diagram.

5.3 Non-Federal Share

The non-federal share is provided by Alameda County Health Care Services and its Behavioral Health Care Services Department.

5.4

Non-Duplication of Payments and Federal Financial Participation Relationship Between AC^3 and Service Provision:

Since the Coverage Initiative, California's first 1115 waiver of 2005-2010, Alameda County Health Care Services Agency and its Behavioral Health Care Services Department have been working to move the healthcare system toward integrated whole-person, data-guided, evidence-based care. With the Bridge to Reform, that movement accelerated, and principles of value-based care were incorporated into our programs and contracts. The AC^3 opportunity will allow Alameda to further accelerate and better coordinate ongoing efforts in behavioral health/primary care integration, including addressing substance use and Hepatitis C within

primary care, and to fill important gaps (e.g., housing transitions and sustaining services) in service provision in Alameda County.

The AC^3 program is designed to build on the existing service infrastructure. In our planning process, we thoroughly scanned the delivery landscape to identify partners and programs serving Medi-Cal beneficiaries and service and infrastructure gaps. The AC^3 program builds on the existing service infrastructure to create a coherent and efficient countywide system.

Compliance with STC 113 and Ensuring Medi-Cal-Only Beneficiaries:

Program services have been carefully constructed to ensure they will only be received by Medi-Cal beneficiaries and do not include services covered or reimbursed by Medi-Cal, including new services under Health Homes and the Drug Medi-Cal Organized Delivery System. All AC^3 activities are for infrastructure or services for the target populations, and are aimed at improving integration, reducing unnecessary utilization of services, and improving health outcomes. HCSA administration is familiar with the regulations for IGTs and will work closely with the Financial Oversight and Contracting unit to ensure that non-federal share is not derived from impermissible sources.

Through our Data Reporting and Analysis unit we will ensure that patients' source of payment is identified in reporting. The staff of the Financial Oversight and Contracting unit will write contracts to ensure that requirements are clear to contractors. The two units will work together to ensure that payments are made only for services provided to Medi-Cal beneficiaries and that no Medi-Cal services are paid for with AC^3 funds.

Ensuring non-duplication of Medi-Cal Targeted Case Management

The vast majority of AC3 activities will not qualify for Medi-Cal's targeted case management ("TCM") benefit.

The majority of AC3 services that could appear to potentially overlap with TCM are organized as service bundles, and thus depart significantly from the encounter-based structure of TCM. Moreover, the service bundles are much more intensive than the services provided through TCM, and include a more robust scope of care support and coordination activities which are distinct from and outside the TCM benefit. For instance, the Care Management Service Bundles include health and self-management promotion, disease specific education, transitional care to assist patients in moving between different service levels, family and caregiver support, peer support, and creating a personalized resource guide. Modes and locations of interactions go well beyond the typical TCM face-to-face office visit. Providers will meet with patients at hospital, home and other locations, and accompany them to appointments. Communication methods may include calls, texts, and social media, and are not limited to the traditional TCM encounters.

Our planned housing-related service bundles are both more narrowly focused than TCM, and include direct social and housing services that would not be recognized as TCM services, such as searching for housing, communicating with landlords, ensuring a safe living environment, environmental modifications, coordinating moves, landlord & tenant education & training, coaching on landlord relationships, dispute resolution, eviction prevention, etc.

In the case of our proposed fee for service deliverables, for instance, substance use treatment portals and clinic-based navigation, the encounters are more limited than required for TCM reimbursement, and workers do not meet the education/experience requirements. Therefore these services would not be eligible for reimbursement under TCM.

For these reasons, we have concluded that the vast majority of WPC Pilot activities will not duplicate services available through Medi-Cal TCM. However, in response to concerns of duplication of payment, we have applied a TCM budget adjustment to the programs that could potentially be TCM eligible, to reduce our request for WPC funds. Each TCM budget adjustment can be found in the corresponding service description.

Qualification for Bonus Points:

AC^3 addresses **all** key priority bonus point elements in the WPC application, including the following:

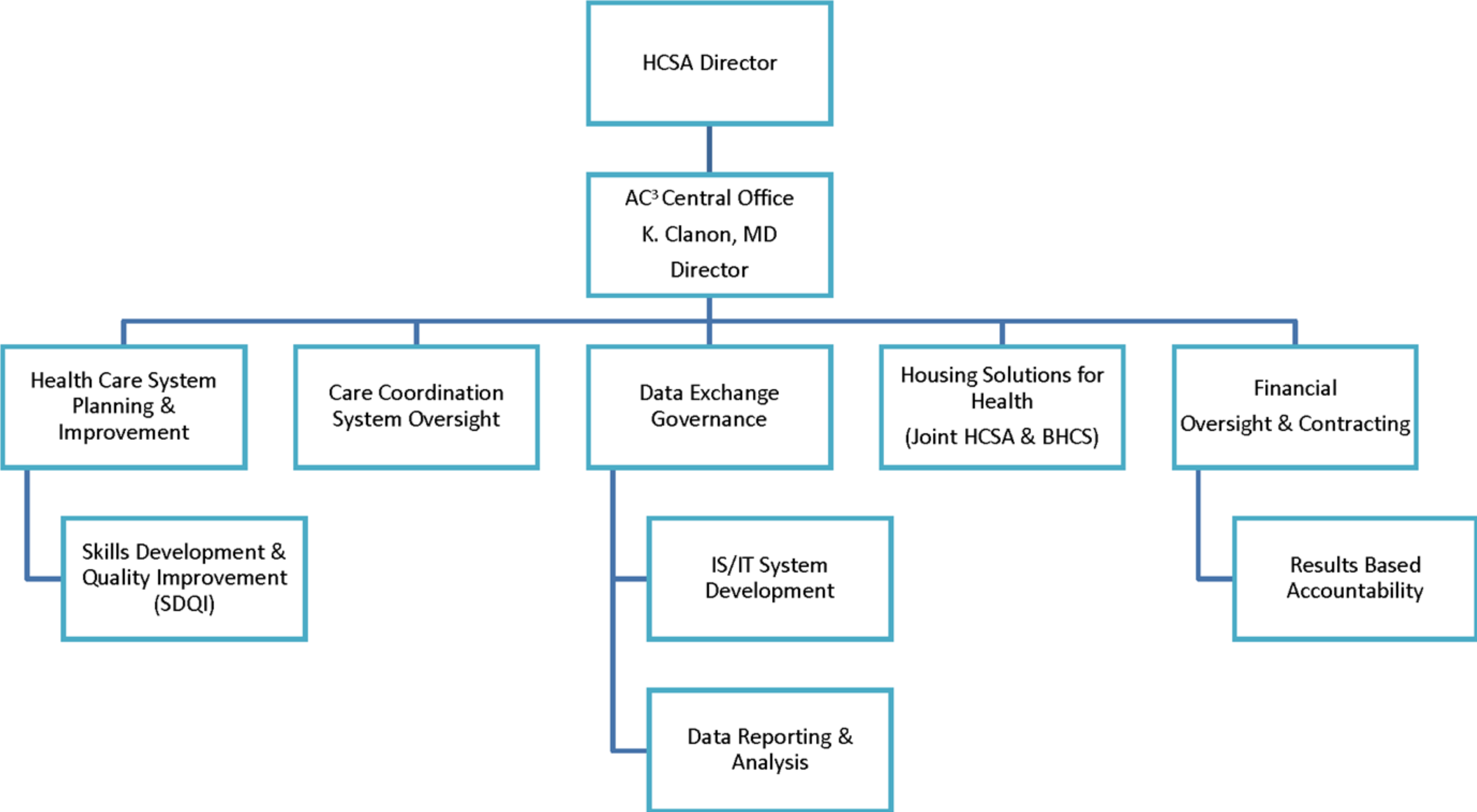
☐ **More than one participating managed care plan:** AC^3 involves **two** managed care plans: Alameda Alliance for Health and Anthem BlueCross 5 points);

☐ **More than two participating community partners:** AC^3 involves **seven** community partners as listed in Table 1.2 (5 points); and

☐ **Creative interventions**: AC^3 incorporates a myriad of innovative approaches to system change and results-based outcomes, including:

- Incentive payments to housing agencies for reaching 5-month and 24-month housing retention milestones;
- Creation of an Independent Living Association comprised of owners of low-income housing;
- A Landlord Recruitment and Incentive Fund offering bonuses to landlords who open new low-income units;
- Incentives to community clinics to increase opioid assessment and treatment;
- Creation of a Substance Use Residential Helpline to facilitate patient access to residential treatment; and
- Building Results Based Accountability into contract language to formalize evidence-based and outcome-oriented performance. (5 points)

AC3 Organizational Chart (image) – *graphic 01*



AC3 Target Populations – graphic 02

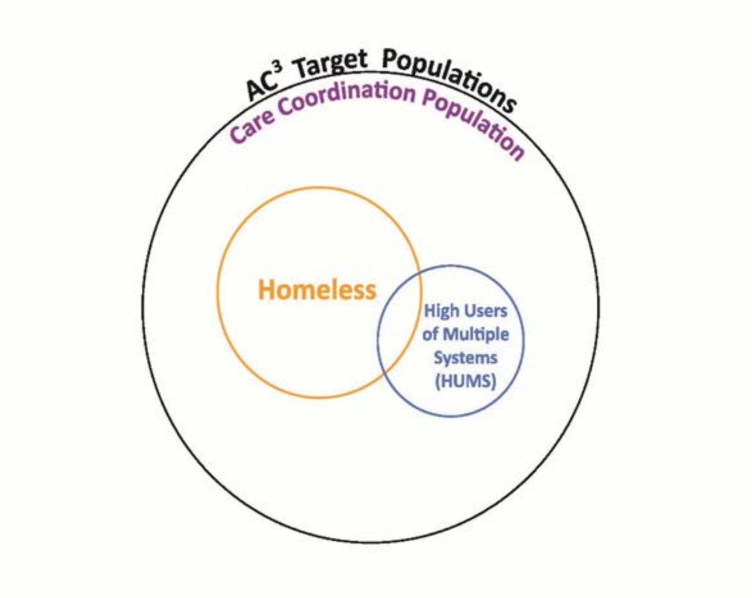


Figure 2: Patient-Centered Workflow for Alameda County Care Connect (AC3) *graphic 03*

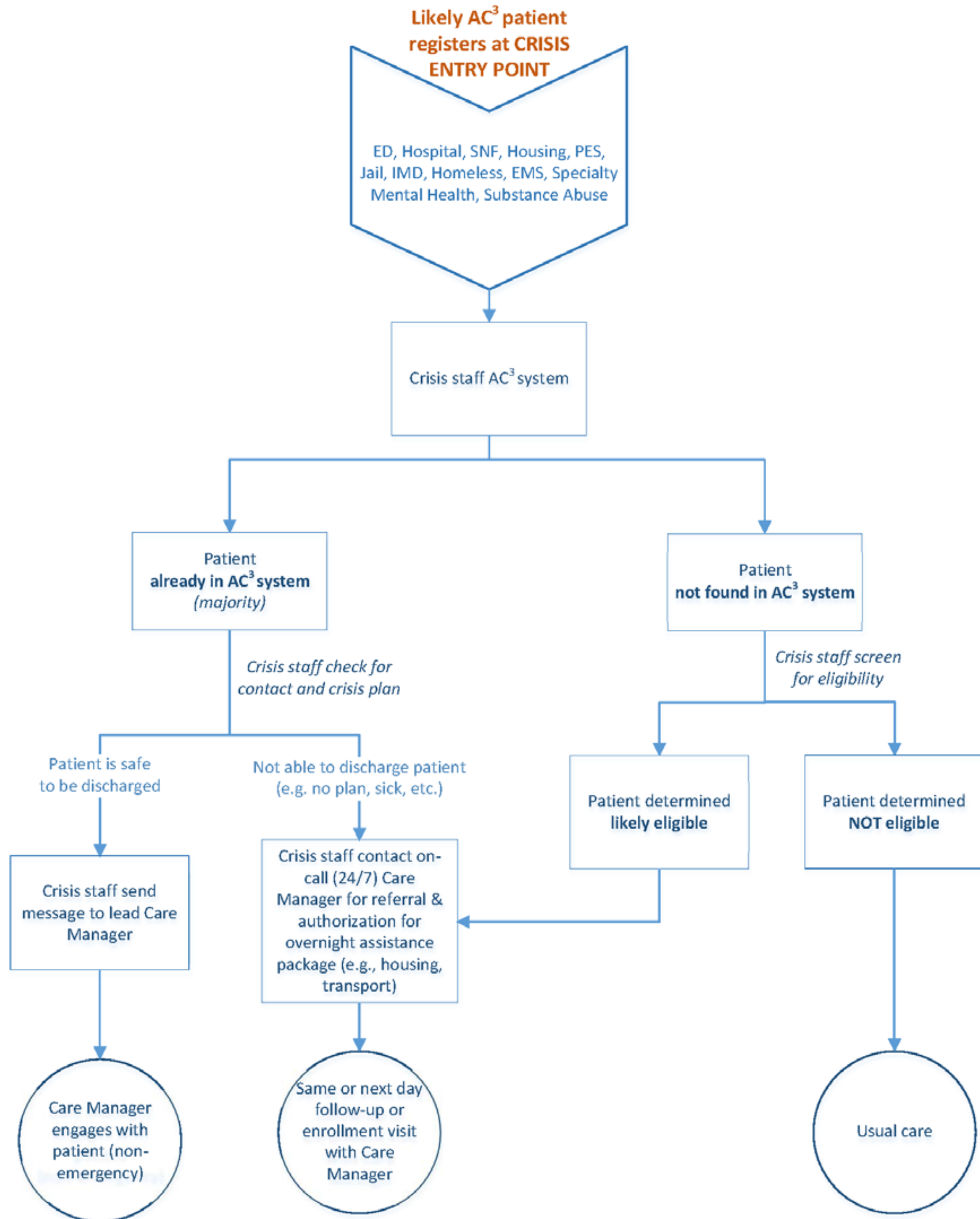
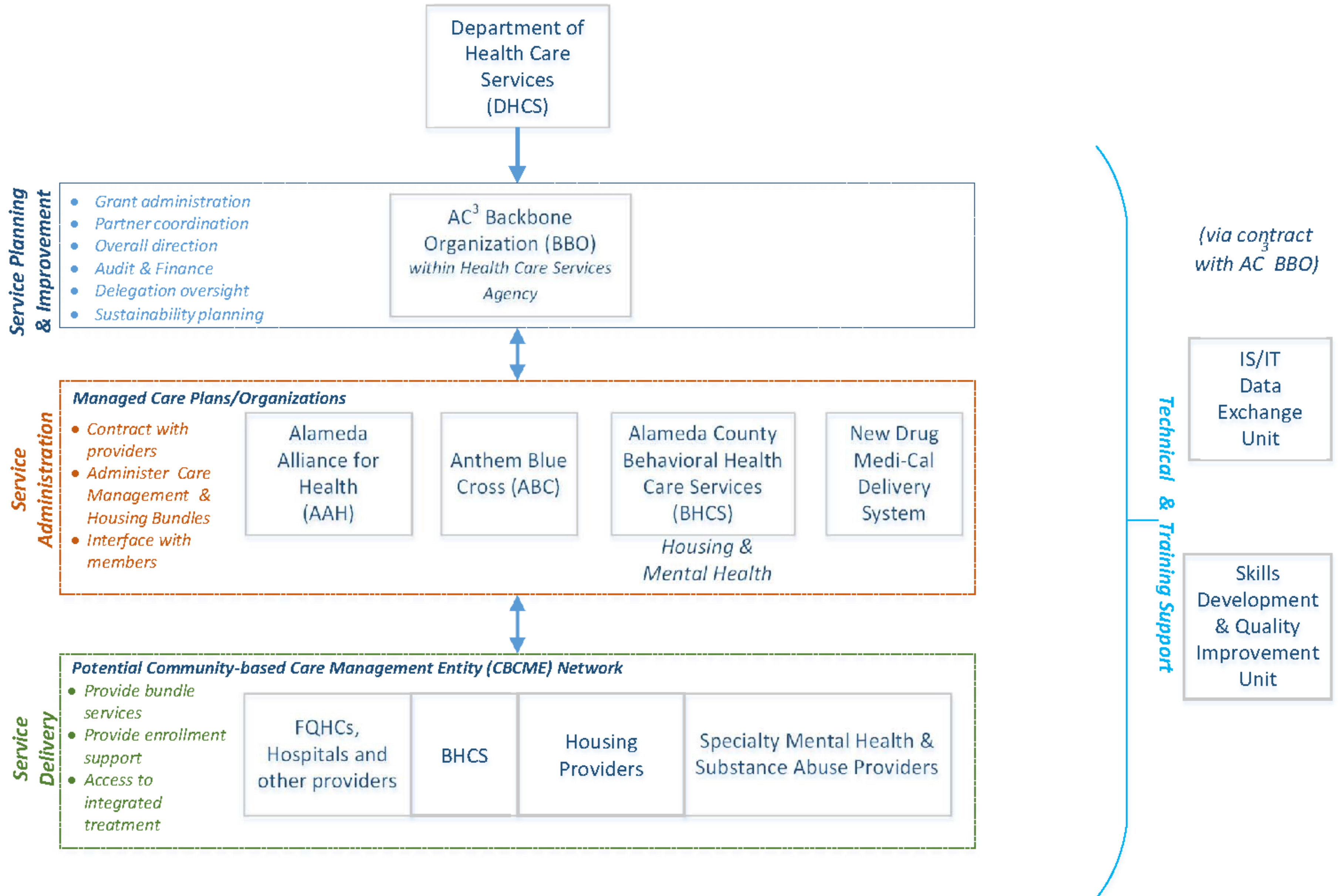


Figure 3: Alameda County Care Connect (AC3) Concept Map – *graphic 04*



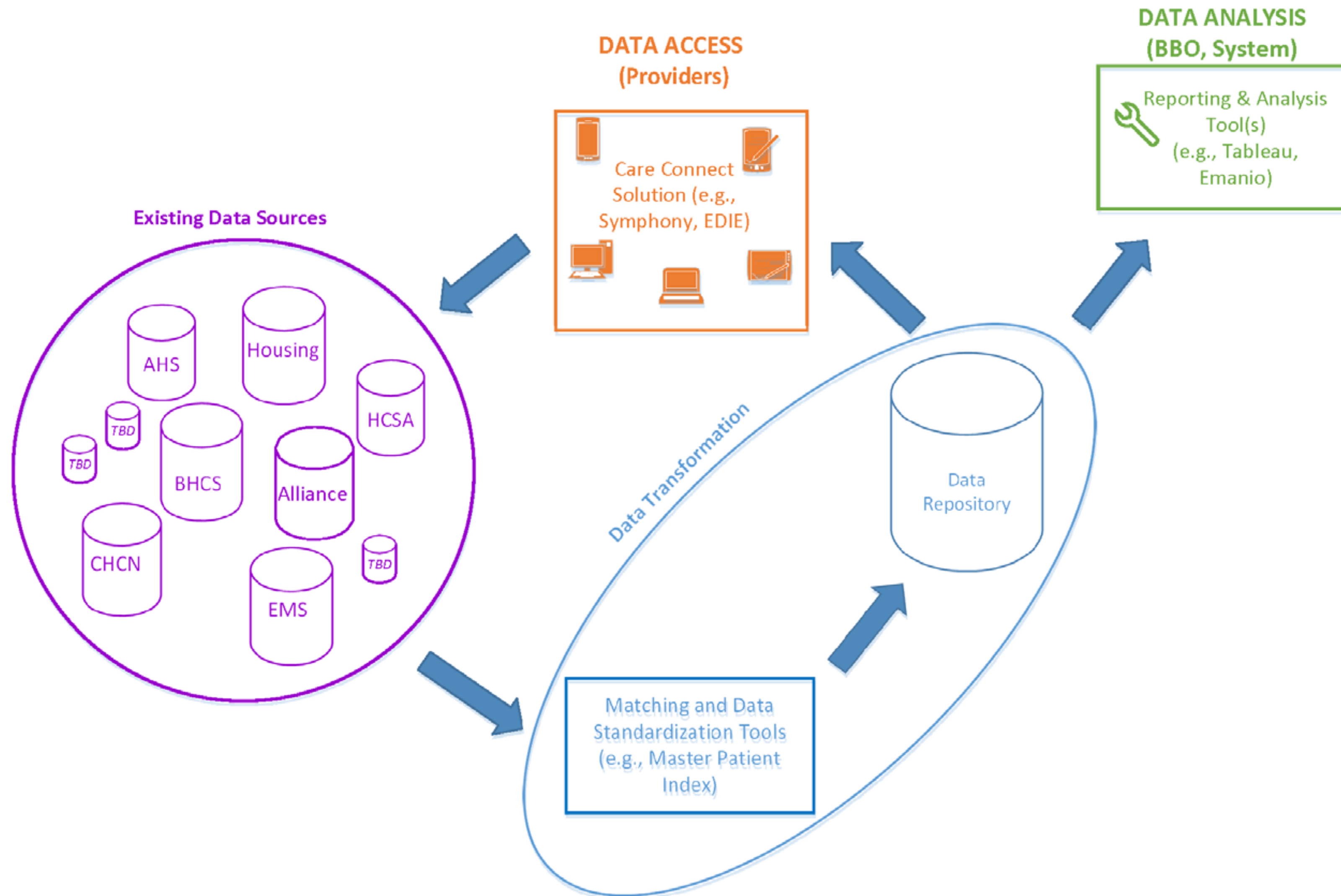
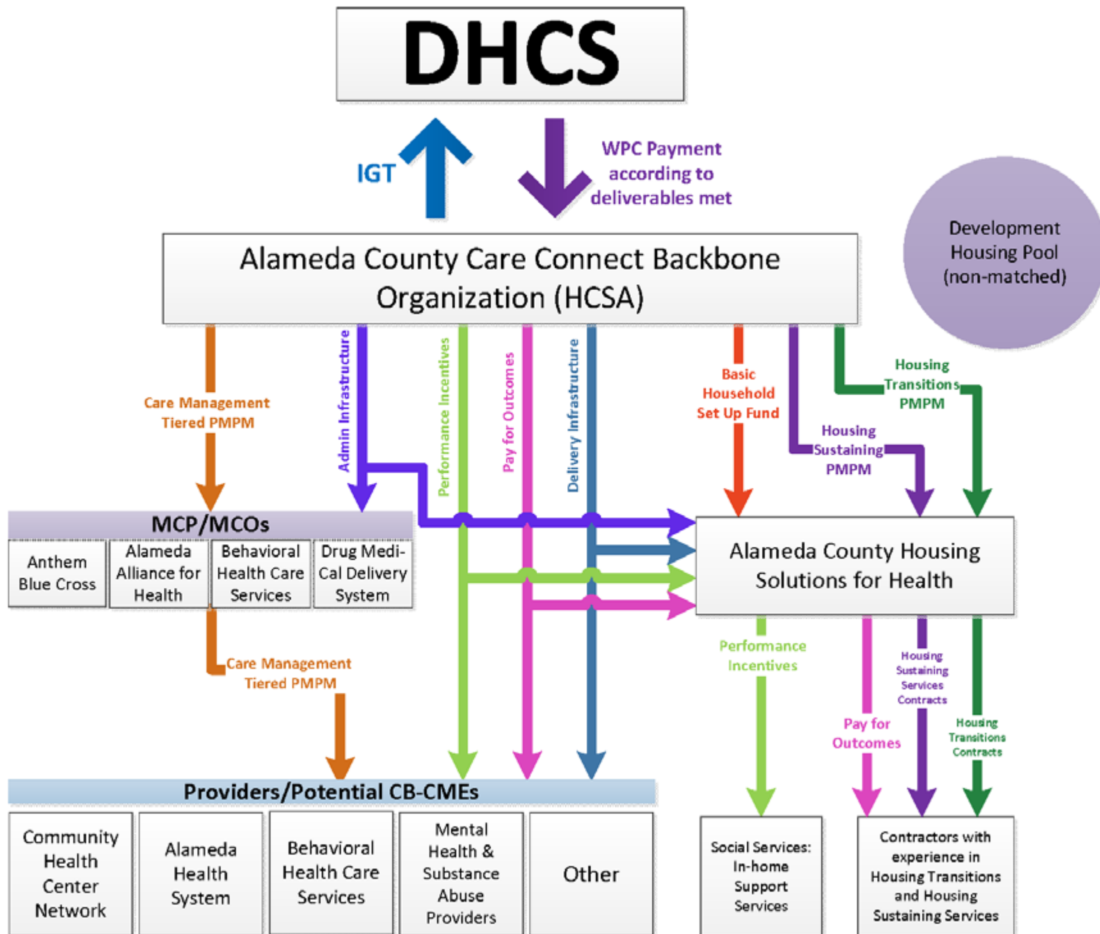


Figure 4: Proposed AC3 Data Exchange Workflow - graphic 05
DATA ANALYSIS
(BBO, System)
Reporting & Analysis Tool(s) (e.g., Tableau, Emanio)
DATA ACCESS
(Providers)
Care Connect Solution (e.g., Symphony, EDIE)
Existing Data Sources
AHS
Housing
HCSA
TBD
TBD
BHCS
Alliance
CHCN
EMS
TBD
Data Transformation
Data Repository
Matching and Data Standardization Tools (e.g., Master Patient Index)


DHCS
IGT
WPC Payment according to deliverables met
Development Housing Pool (non-matched)
Alameda County Care Connect Backbone Organization (HCSA)
Care Management Tiered PMPM
Admin Infrastructure
Performance Incentives
Pay for Outcomes
Delivery Infrastructure
Basic Household Set Up Fund
Housing Sustaining PMPM
Housing Transitions PMPM
MCP/MCOs
Anthem Blue Cross
Alameda Alliance for Health
Behavioral Health Care Services
Drug Medi-Cal Delivery System
Alameda County Housing Solutions for Health
Care Management Tiered PMPM
Performance Incentives
Housing Sustaining Services Contracts
Pay for Outcomes
Housing Transitions Contracts
Providers/Potential CB-CMEs
Community Health Center Network
Alameda Health System
Behavioral Health Care Services
Mental Health & Substance Abuse Providers
Other
Social Services: In-home Support Services
Contractors with experience in Housing Transitions and Housing Sustaining Services

AC^3 Metrics

Group	Type	Metric Description	Numerator	Denominator	Benchmark	Target year 2	Target year 3	Target year 4	Target year 5	SOURCE
Universal	Outcome	Ambulatory Care – Emergency Department Visits (HEDIS)	Count of visits	AC3 Population	91 ER visits/1,000 member months	5% reduction of gap between baseline and benchmark	10% reduction of gap between previous year and benchmark	10% reduction of gap between previous year and benchmark	10% reduction of gap between previous year and benchmark	Benchmark Source: DHCS Medi-Cal Managed Care Performance Dashboard, March 2016 release, SPD rate
Universal	Outcome	Inpatient Utilization-General Hospital/Acute Care (IPU) (HEDIS)	Count of admits	AC3 Population	32 IP admits/1,000 member months	5% reduction of gap between baseline and benchmark	10% reduction of gap between previous year and benchmark	10% reduction of gap between previous year and benchmark	10% reduction of gap between previous year and benchmark	Benchmark Source: DHCS Medi-Cal Managed Care Performance Dashboard, March 2016 release, SPD rate

AC^3 Metrics

Group	Type	Metric Description	Numerator	Denominator	Benchmark	Target year 2	Target year 3	Target year 4	Target year 5	SOURCE
Universal	Outcome	Follow-up After Hospitalization for Mental Illness (FUH) (HEDIS)	30-Day Follow-Up: An outpatient visit, intensive outpatient visit or partial hospitalization with a mental health practitioner within 30 days after discharge. Include outpatient visits, intensive outpatient visits or partial hospitalizations that occur on the date of discharge. 7-Day Follow-Up: Same measure, at 7 days.	AC3 eligible patients 6 years and older as of the date of discharge who were discharged from an acute inpatient setting (including acute care psychiatric facilities) with a principal diagnosis of mental illness during the first 11 months of the measurement year (e.g., January 1 to December 1).	National Medicaid Average: 30-Day Follow-up: 63.0% 7-Day Follow-up: 43.9%	5% reduction of gap between baseline and benchmark	10% reduction of gap between previous year and benchmark	10% reduction of gap between previous year and benchmark	10% reduction of gap between previous year and benchmark	Benchmark Source: NCQA State of Health Care Quality 2015 Report, 2014 Medicaid Rates http://www.ncqa.org/report-cards/health-plans/state-of-health-care-quality/2015-table-of-contents/follow-up

AC^3 Metrics

Group	Type	Metric Description	Numerator	Denominator	Benchmark	Target year 2	Target year 3	Target year 4	Target year 5	SOURCE
Universal	Outcome	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET) (HEDIS)	Initiation of AOD Dependence Treatment: Initiation of AOD treatment through an inpatient admission, outpatient visit, intensive outpatient encounter or partial hospitalization within 14 days of the index episode start date. Engagement of AOD Treatment: Initiation of AOD treatment and two or more inpatient admissions, outpatient visits, intensive outpatient encounters or partial hospitalizations with any AOD diagnosis within 30 days after the date of the Initiation encounter (inclusive).	AC3 eligible patients age 13 years of age and older who were diagnosed with a new episode of alcohol or other drug dependency (AOD) during the first 10 and ½ months of the measurement year (e.g., January 1-November 15).	National Medicaid Average: Initiation: 38.8% Engagement: 11.3%	5% reduction of gap between baseline and benchmark	10% reduction of gap between previous year and benchmark	10% reduction of gap between previous year and benchmark	10% reduction of gap between previous year and benchmark	NCQA State of Health Care Quality 2015 Report, 2014 Medicaid Rates http://www.ncqa.org/report-cards/health-plans/state-of-health-care-quality/2015-table-of-contents/alcohol-treatment

AC^3 Metrics

Group	Type	Metric Description	Numerator	Denominator	Benchmark	Target year 2	Target year 3	Target year 4	Target year 5	SOURCE
Universal	Administrative	Proportion of participating beneficiaries with a comprehensive care plan, accessible by the entire care team, within 30 days of: 1. Enrollment into the WPC Pilot 2. The beneficiary's anniversary of participation in the Pilot (to be conducted annually).	Number of patients in the denominator who had a comprehensive care plan, accessible by the entire care team, within 30 days of: 1. Enrollment into the WPC Pilot 2. The beneficiary's anniversary of participation in the Pilot (to be conducted annually).	AC3 population that is receiving one or more of the WPCP service bundles	100%	Define baseline as enrollment system is up and running	20% reduction in gap between PY2 rate and 100% target	20% reduction in gap between PY3 rate and 100% target	20% reduction in gap between PY4 rate and 100% target	
Universal	Administrative	Care coordination, case management, and referral infrastructure.	Policies and Procedures for care coordination, case management, and referral processes will be submitted to DHCS, including communication structure between the participating entities. Monitoring procedures for these policies, compilation and analysis plan for the findings, and a modification plan for the policies and procedures will also be submitted.							
Universal	Administrative	Data and information sharing infrastructure.	Policies and Procedures for data and information sharing across all participating entities to provide streamlines care coordination, case management, monitoring, and strategic improvements will be submitted to DHCS. Monitoring procedures for these policies, compilation and analysis plan for the findings, and a modification plan in accordance with PDSA for the policies and procedures will also be submitted.							

AC^3 Metrics

Group	Type	Metric Description	Numerator	Denominator	Benchmark	Target year 2	Target year 3	Target year 4	Target year 5	SOURCE
Variant	Outcome	Controlling high blood pressure (HEDIS)	Within the denominator, whose BP was adequately controlled during the measurement year based on the following criteria: • Members 18–59 years of age whose BP was <140/90 mm Hg. • Members 60–85 years of age with a diagnosis of diabetes whose BP was <140/90 mm Hg. • Members 60–85 years of age without a diagnosis of diabetes whose BP was <150/90 mm Hg	Patients 18 to 85 years of age by the end of the measurement year who had at least one outpatient encounter with a diagnosis of hypertension (HTN) during the first six months of the measurement year.	National Medicaid 90th percentile 2015: 70%	5% reduction of gap between baseline and benchmark	10% reduction of gap between previous year and benchmark	10% reduction of gap between previous year and benchmark	10% reduction of gap between previous year and benchmark	NCQA HEDIS Measure: Controlling High Blood Pressure NCQA State of Health Care Quality 2015 Report, 2014 Medicaid Rates http://www.ncqa.org/report-cards/health-plans/state-of-health-care-quality/2015-table-of-contents/controlling-high-blood-pressure

AC^3 Metrics

Group	Type	Metric Description	Numerator	Denominator	Benchmark	Target year 2	Target year 3	Target year 4	Target year 5	SOURCE
Variant	Outcome	WPC Pilots utilizing the PHQ-9 shall report the Depression Remission at Twelve Months (NQF 0710) metric	Adults who achieved remission at twelve months as demonstrated by a twelve month (+/- 30 days) PHQ-9 score of less than five	AC3 population aged 18 and older with a diagnosis of major depression or dysthymia and an initial (index) PHQ-9 score greater than nine during an outpatient encounter.	None available	5% improvement over baseline	10% improvement over prior year	10% improvement over prior year	10% improvement over prior year	NQF 0701 Depression Remission at Twelve Months http://www.qualityforum.org/QPS/0710
Variant	Outcome	WPC Pilots including a severely mentally ill (SMI) target population shall report the Adult Major Depression Disorder (MDD): Suicide Risk Assessment (NQF 0104)	Patients who had suicide risk assessment completed at each visit	All patients aged 18 years and older with a new diagnosis or recurrent episode of Major Depressive Disorder (MDD)	None available	5% improvement over baseline	10% improvement over prior year	10% improvement over prior year	10% improvement over prior year	NQF 0104 Adult Major Depressive Disorder (MDD): Suicide Risk Assessment http://www.qualityforum.org/QPS/0104

AC^3 Metrics

Group	Type	Metric Description	Numerator	Denominator	Benchmark	Target year 2	Target year 3	Target year 4	Target year 5	SOURCE
Variant	Housing	Less restrictive and more independent housing setting (unique AC metric)	Living situation status (cumulative score) annually for all AC3 patients receiving housing transitions and/or tenancy sustaining services	Living situation status (cumulative score) at enrollment for all AC3 patients receiving housing transitions and/or tenancy sustaining services	score of approx. 2,000 (400 participants with a score of 5 or lower)	60% increase in composite score (avg. increase from 5 to 8)	60% increase in composite score (avg. increase from 5 to 8)	60% increase in composite score (avg. increase from 5 to 8)	60% increase in composite score (avg. increase from 5 to 8)	Innovative Alameda County Measure, supported by the Olmstead decision related to the Americans with Disabilities Act that individuals with disabilities should be supported to live in the least restrictive and most integrated setting that is appropriate to meet their needs. Uses HUD housing categories (included in the HMIS data intake) scored 0-14. Report on cohort status based on years of housing services received compared to baseline. * death or

AC^3 Metrics

Group	Type	Metric Description	Numerator	Denominator	Benchmark	Target year 2	Target year 3	Target year 4	Target year 5	SOURCE
Variant	Housing	% of participants who remain in housing after 6 months	Number of participants in housing over 6 months	Number of participants in housing for at least 6 months	HUD Performance Measure 85% at 12 months	5% improvement over baseline	10% improvement over prior year	10% improvement over prior year	10% improvement over prior year	https://www.hudexchange.info/programs/coc/system-performance-measures/ *death or disenrollment will result in lowering the denominator
Variant	Housing	# of new housing placements/participants served (HUD)	AC3 patients receiving housing transition services who were permanently housed (as defined by HUD categories 7-14)	AC3 patients receiving housing transition services	HUD Performance Measure 65% of individuals who are homeless become permanently housed	5% improvement over baseline	10% improvement over prior year	10% improvement over prior year	10% improvement over prior year	https://www.hudexchange.info/programs/coc/system-performance-measures/ * death or disenrollment will result in lowering the denominator

AC^3 Metrics

Group	Type	Metric Description	Numerator	Denominator	Benchmark	Target year 2	Target year 3	Target year 4	Target year 5	SOURCE
Variant	Administrative	Care coordination assignment	Those with assignment	AC3 population that are receiving one or more of the AC3 service bundles	100% assignment	80% assignment	90% assignment	100% assignment	100% assignment	University of Washington, Coordinated Care Collaborative, Advancing Integrated Mental Health Solutions (AIMS) Center

AC^3 Metrics

Group	Type	Metric Description	Numerator	Denominator	Benchmark	Target year 2	Target year 3	Target year 4	Target year 5	SOURCE
Variant	Outcome	Follow up After PES Visit for Mental Health	30-Day Follow-Up: An outpatient visit, intensive outpatient encounter or partial hospitalization, with any practitioner, with a primary diagnosis of mental health disorder within 30 days after the ED visit. Include outpatient visits, intensive outpatient visits or partial hospitalizations that occur on the date of the ED visit. 7-Day Follow-Up Same measure, at 7 days.	AC3 Population with ED visit (ED Value Set) with a primary diagnosis of mental illness	None published yet	5% reduction of gap between baseline and benchmark	10% reduction of gap between previous year and benchmark	10% reduction of gap between previous year and benchmark	10% reduction of gap between previous year and benchmark	Proposed HEDIS 2017 Measure https://www.ncqa.org/Portals/0/PublicComment/HEDIS2017/3.%20FUM%20Materials.pdf

WPC Budget Template: Summary and Top Sheet			
WPC Applicant Name:	Alameda County Health Care Services Agency		
	Federal Funds *(Not to exceed 90M)*	**IGT**	**Total Funds**
Annual Budget Amount Requested	28,345,340	28,345,340	56,690,680
PY 1 Budget Allocation (Note PY 1 Allocation is predetermined)			
PY 1 Total Budget	56,690,680		
Approved Application (75%)	42,518,010		
Submission of Baseline Data (25%)	14,172,670		
PY 1 Total Check	OK		
PY 2 Budget Allocation			
PY 2 Total Budget	56,690,680		
Administrative Infrastructure	11,209,652		
Delivery Infrastructure	2,044,367		
Incentive Payments	27,969,286		
FFS Services	9,166,713		
PMPM Bundle	3,866,006		
Pay For Reporting	1,414,656		
Pay for Outomes	1,020,000		
PY 2 Total Check	OK		
PY 3 Budget Allocation			
PY 3 Total Budget	56,690,680		
Administrative Infrastructure	9,746,652		
Delivery Infrastructure	2,103,465		
Incentive Payments	25,969,284		
FFS Services	9,221,052		
PMPM Bundle	8,008,913		
Pay For Reporting	621,314		
Pay for Outomes	1,020,000		
PY 3 Total Check	OK		
PY 4 Budget Allocation			
PY 4 Total Budget	56,690,680		
Administrative Infrastructure	8,648,711		
Delivery Infrastructure	2,019,367		
Incentive Payments	24,769,285		
FFS Services	9,221,052		
PMPM Bundle	8,612,265		
Pay For Reporting	1,500,000		
Pay for Outomes	1,920,000		
PY 4 Total Check	OK		
PY 5 Budget Allocation			
PY 5 Total Budget	56,690,680		
Administrative Infrastructure	9,217,187		
Delivery Infrastructure	2,019,367		
Incentive Payments	22,969,284		
FFS Services	9,221,052		
PMPM Bundle	9,215,619		
Pay For Reporting	1,693,171		
Pay for Outomes	2,355,000		
PY 5 Total Check	OK		

ALAMEDA HEALTH CARE SERVICES AGENCY

CATEGORY 1c: INFRASTRUCTURE DEVELOPMENT | Incentive Payments for Downstream Providers

#1 Rationale--Timely Adoption of AC^3 System

Significant collaborative work will be facilitated by the backbone organization and Capacity Development Institute to develop standardized tools, processes, and workflows across all AC^3 participating agencies for patient enrollment, gathering consent, care coordination, and increased fluency in all service areas such as physical health, behavioral health, and housing. These processes must then be learned through training and put into action on the front lines of care. These payments will incentivize critical organizations to participate in the collaborative development process to increase community buy-in, for a majority of impacted staff to quickly take in the training, and to adopt the system of tools and processes. Testing the processes and collaborative improvement through PDSA work is included. The development process will be incentivized at the organization level, but the training participation and a system adoption must be incentivized at the clinic level as each will have its own unique challenges to put this system in place. We anticipate 30 provider organizations would be eligible for this incentive in the development stage at $100,000 per agency; and 50 sites for the staff training and adoption phases at $100,000 per site over the life of the pilot.

	Total Max Amount of Funding			
	PY2	**PY3**	**PY4**	**PY5**
Incentive Payments				
Deliverables				
1. At least one representative from each provider organization will attend each monthly meeting throughout PY2 to develop standard care management definitions, outcomes, models as part of the care coordination system; includes gathering feedback at their home organization between meetings and bringing fruitful content to each discussion (anticipating 30 provider organizations; $100,000 each)	$ 3,000,000			
2. Clinic sites to secure time and complete training of at least two of their designated employees involved in care coordination to operationalize the new standardized care coordination system, including webinar participation, creating and searching for care plans with test patients, sending issues encountered to the appropriate BBO staff, etc. (anticipating 50 provider organization sites; $100,000 each; total of $5,000,000 over pilot)	$ 1,000,000	$ 3,000,000	$ 1,000,000	
3. Clinic sites to provide evidence of adoption and use of the tools of the new standardized care coordination system including written workflow, 10 written anecdotes about the experience of using the system for patient care, and reported number of clients each month for six months whose care was shaped by the new system (estimating 50 provider organization sites; $100,000 each; $5,000,000 over pilot)		$ 2,000,000	$ 3,000,000	
Total amount available for Timely Adoption of AC^3 System incentives	**$ 4,000,000**	**$ 5,000,000**	**$ 4,000,000**	**$ -**

#2 Rationale-Care Management Services Bundles

AC3 is building on the framework and network that will be developed in Alameda County for the ACA 2703 Health Homes Program. The pilot will offer the same set of services to a broader population, broken into two rate tiers to account for differing complexity and challenge. In this way, AC3 will enable faster PDSA improvements among the network of Community Based Care Management Entities (CB-CMEs) by flowing additional people through that enrollment and care management pathway. The unified enrollment process will ensure that participants are signed up for services whether through Health Homes or AC3 but not both. The core Care Management service bundle is a testing venue for implementing the supports of the standardized Care Coordination System and the data sharing system. The Care Management Bundles will be administered by the Managed Care Plans so as to align with the administration of the Health Homes Program benefit.

A participant is determined eligible for the Care Management Service Bundle by the Managed Care Plan in its service bundle administration role if the patient 1) meets the criteria of the High Users of Multiple Systems and/or the Homeless AC3 target population(s), 2) is confirmed not to be enrolled in any other comprehensive Case Management program available in the county, 3) has evidence of medical complexity that can be impacted by Care Management Services (to be determined by the Managed Care Plan), and 4) has evidence of issues related to social determinants of health. The Tier 1 bundle will be the default service package unless a client has a Serious Mental Illness and/or is homeless, in which case the client will be enrolled in the Tier 2 bundle. The care manager to participant ratio is 1 care manager to 35 patients for Tier 1, and 1 care manager to 30 patients for Tier 2.

The goal of the Care Management Service Bundle is to stabilize the patient's medical, behavioral, and social needs to a point where they can be managed through the system's basic "usual care" coordination between providers, as enhanced by the data sharing platform to be developed through the implementation of AC3. The intent is to support clients with the Care Management Service Bundle until they can be safely "graduated" (and thus disenrolled) from this intensive support: for instance, if the client is successfully meeting their wellness goals, is engaged in self-care, and has been connected with all needed and available resources. Clients may also be disenrolled from the bundle for other reasons such as 1) they cannot be reached for over 60 days, 2) the patient no longer wishes to engage in progressing toward wellness goals, and/or 3) staff is no longer safe interacting with the client. The average duration for Tier 1 services is expected to be six months and the average duration of services for Tier 2 case management is 12 months. The durations are based on historical experience of delivering care management interventions of various kinds in Alameda County.

As there are a limited number of Care Management Service Bundle slots and therefore an enrollment cap, a waitlist for both Tiers 1 and 2 will be established and administered by the Managed Care Plan as a part of their bundle administration activities, described in Deliverable #37. The Managed Care Plan staff will take in referrals for this bundle from the network of providers participating in the pilot and will maintain and work that list in multiple ways such as the following:

1. Regularly update information on waitlisted individuals based on administrative data and reports from providers.
2. Partner with providers to manage referrals and help triage waitlisted individuals and prioritize those most likely to benefit from the service bundles.
3. Remove and add individuals to the waitlist as necessary.
4. Review referral criteria with providers on a regular basis to ensure quality referrals and minimize duplication of services.
5. Assess caseloads periodically to determine if the service bundles are continuing to have a positive contribution towards clients' health and service utilization. Clients may either continue to be enrolled, or stepped down and disenrolled.

As clients are disenrolled, Alameda County will outreach to new individuals on the waitlist.

Clients are eligible for only one AC3 service bundle at a time, and would only receive additional AC3 discrete services if those services were not covered by their current service bundle. For example, clients are anticipated to flow into the Tier 1 Care Management Service bundle directly through provider referral, at the close of a Housing Transitions Service Bundle, or at the close of a Tier 2 Care Management Service Bundle, should the additional intensity of the second tier no longer be needed. Clients may flow into the Tier 2 Care Management Service bundle at the close of Housing Outreach Discrete Services, and out of Tier 2 Care Management services when successfully stabilized or when only Tier 1 services are needed. Discrete Services such as Housing Education and Legal Assistance and Substance Use Disorder Treatment supports are not included in the Care Management Service Bundle and therefore may be provided in addition to that bundle.

The Care Management service bundles will not duplicate TCM services. The bundles are much more intensive than the services provided through TCM, and include a more robust set of care support and coordination activities which is distinct from and outside the TCM benefit. Services include health and self-management promotion, disease specific education, transitional care to assist patients in moving between different service levels, family and caregiver support, peer support, and creating a personalized resource guide. Modes and locations of interactions go well beyond the typical TCM face-to-face office visit. Providers will meet with patients at hospital, home and other locations, and accompany them to appointments. Communication methods may include calls, texts, and social media, in addition to the traditional TCM encounters.

In addition, clients served will be monitored to ensure that comprehensive case management services provided through the Whole Person Care pilot program are not claimed under the TCM program and vice versa. Finally, we have applied a TCM budget adjustment to reduce our request for WPC funds. We have assumed approximately 20% of the population will be adequately served by TCM, and 80% will need the more robust services included in the Care Management Service Bundle. Therefore we are reducing our budget by 20%.

#2 Rationale-Care Management Services Bundles

Service Bundle	$$ per Month	PY2 # Mo.	PY2 # Mbrs	PY2 Total	PY3 # Mo.	PY3 # Mbrs	PY3 Total	PY4 # Mo.	PY4 # Mbrs	PY4 Total	PY5 # Mo.	PY5 # Mbrs	PY5 Total
Care Management Services Tier 1	$ 320.95	6	438	$ 842,500	6	1125	$ 2,166,429	6	1250	$ 2,407,143	6	1375	$ 2,647,857
Reduced by 20% to account for those adequately managed by TCM.	$ 320.95	6	350	$ 674,000	6	900	$ 1,733,143	6	1000	$ 1,925,714	6	1100	$ 2,118,286
Care Management Services Tier 2	$ 473.96	12	188	$ 1,066,400	12	375	$ 2,132,800	12	438	$ 2,488,267	12	500	$ 2,843,733
Reduced by 20% to account for those adequately managed by TCM.	$ 473.96	12	150	$ 853,120	12	300	$ 1,706,240	12	350	$ 1,990,613	12	400	$ 2,274,987
TOTAL (Sum of adjusted lines)				**$ 1,527,120**			**$ 3,439,383**			**$ 3,916,328**			**$ 4,393,272**

(Column group header: Total Max Amount of Funding)

Care Management Services Tier 1: Medically Complex, Social Determinants of Health issues	Units	Annual Cost per Unit	Salaries	28% benefits	Total
Staffing					
CHW	1	$ 45,000	$ 45,000	$ 12,600	$ 57,600
LCSW	0.25	$ 80,000	$ 20,000	$ 5,600	$ 25,600
RN	0.25	$ 90,000	$ 22,500	$ 6,300	$ 28,800
Indirect at 5%	1.5				$ 5,600
HR/Admin/Support Staff					$ 5,600
Staff Training					$ 2,240
Insurance					$ 2,240
Cell Phones					$ 1,120
Caseload: 35 people for 6 months (420 member months)					
Operations					
Non-medical transportation estimating 6 trips @ $20/each per 12 member months for 420 member months					$ 4,200
Travel for Care Team					$ 1,800
TOTAL					**$ 134,800**

#2 Rationale-Care Management Services Bundles					
	Members	Member Months			Cost / MM = PMPM rate
Member Months	**70**		**420**		**$ 320.95**
Care Management Services Tier 2: Medically Complex, Social Determinants of Health issues, SMI and/or Homeless	**Units**	**Annual Cost per Unit**	**Salaries**	**28% benefits**	**Total**
Staffing					
CHW	1	$ 45,000	$ 45,000	$ 12,600	$ 57,600
LCSW	0.5	$ 80,000	$ 40,000	$ 11,200	$ 51,200
RN	0.3	$ 90,000	$ 27,000	$ 7,560	$ 34,560
Indirect at 5%	1.8				$ 7,168
HR/Admin/Support Staff					$ 7,168
Staff Training					$ 2,867
Insurance					$ 2,867
Cell Phones					$ 1,434
Caseload: 30 people for 12 months (360 member months)					
Operations					
Non-medical transportation estimating 6 trips @ $20/each per 12 member months for 360 member months					$ 3,600
Travel for Care Team					$ 2,160
TOTAL					**$ 170,624**
	Members	Member Months			Cost / MM = PMPM rate
Member Months	**30**		**360**		**$ 473.96**

ALAMEDA HEALTH CARE SERVICES AGENCY

CATEGORY 3b: REPORTING AND QUALITY | Pay for Metric Outcome Achievement

#3 Rationale - Emergency Department Visits

Payment to incentivize improvement on Universal Outcome metric Ambulatory Care - Emergency Department Visits (HEDIS). This incentive would be targeted toward work with provider agencies providing care management to at least 50 people eligible in the AC^3 population, including crisis responders such as the mobile crisis team. Consistent contact and strong relationships with the care manager will provide a pathway other than the Emergency Department to get a client's urgent needs met. We will prioritize eligibility for this incentive for the tweleve (PY4) and thirteen (PY5) provider organizations that have the most improvement to be made toward the benchmark and the largest liklihood for impact. We are budgeting an average of $75,000 per agency per year to garner the necessary attention to this goal. We anticipate that significant improvement will require the prior implementation of the care coordination system and data sharing system, so this “Pay for Outcome” incentive is made available only in Program Years 4 and 5.

		Total Max Amount of Funding			
		PY2	PY3	PY4	PY5
Incentive Payments					
Metric Reported	**Entity Receiving Payment**				
1. Pay for Outcome funds will be paid each budgeted year to organizations that show a 10% decrease in the gap between benchmark/goal for this Universal Outcome Metric (91 ER Visits/1,000 member months) and that clinic site's performance on the metric during the prior year	Provider Organizations providing Care Management - 12 for PY4 and 13 for PY5 (average of $75,000 per organization)			$ 900,000	$ 975,000

#4 Rationale - Follow Up After Hospitalization for Mental Illness

Payment to incentivize improvement on Universal Outcome metric Follow-up after hospitalization for mental illness (HEDIS). Improvement on this measure will take participation from both the psychiatric hospital and the receiving outpatient specialty mental health providers, overcoming different communication and workflow challenges and creating stronger connections to ease clients from acute care to supportive outpatient care. In order to attach enough dollars to garner attention to this work, we have allocated $300,000 to the Psychiatric Hospital in each of PY2-5 to sustain their attention for ensuring they send the necessary information to the outpatient providers necessary for a successful transition out of acute care. In addition, we have budgeted an average of $30,000 for each of 20 major specialty outpatient mental health providers that care for a minimum of 50 people eligible in the AC^3 population to significantly shift expectations of a consistent information flow from the psychiatric hospital and to incentivize quick response to that outreach.

		Total Max Amount of Funding			
		PY2	PY3	PY4	PY5
Incentive Payments					
Metric Reported	**Entity Receiving Payment**				
1.Pay for Outcome funds will be paid each budgeted year to organizations that show a 10% decrease in the gap between benchmark/goal for this Universal Outcome Metric (63.0% 30-day follow up; 43.9% 7-day follow up) and that clinic site's performance on the metric the prior year	Psychiatric Hospital	$ 300,000	$ 300,000	$ 300,000	$ 300,000
	Specialty Outpatient Mental Health Providers - 20 ($30,000 each)	$ 600,000	$ 600,000	$ 600,000	$ 600,000
	TOTAL	**$ 900,000**	**$ 900,000**	**$ 900,000**	**$ 900,000**

#5: Rationale--Housing Solutions for Health

Alameda County Housing Solutions for Health (HS4H) is the HCSA entity overseeing AC[3] housing and homeless services. Housing Solutions for Health includes staff from BHCS Housing Services Office, and Health Care for the Homeless, including staff assigned to the Home Stretch program. Staff in this unit support coordinating access to permanent supportive housing countywide, manage a broad range of health care services provided to individuals experiencing homelessness, develop, plan, and organize the activities associated with the identification, development and operation of housing and housing support services for clients with serious mental illness, and establish and integrate housing related plans and policies for the use of the Mental Health Services Act (MHSA) and other similar funding. All positions listed below are funded via MHSA. 100% of FTE listed below are dedicated to the AC3 Whole Person Care pilot.

				Budget			
				PY2	PY3	PY4	PY5
Staffing							
	FTE	**Salary & benefits**	**Role/responsibility**				
Housing Services Administrator	0.9	$ 188,292	Director of Housing Services Office; directs activities related to housing and housing support services for clients with SMI	$ 160,048	$ 160,048	$ 160,048	$ 160,048
Secretary	0.9	$ 76,489	Supports housing activities and documentation for clients in the Housing Services Office	$ 65,015	$ 65,015	$ 65,015	$ 65,015
Administrative Specialist II	0.9	$ 122,772	Supports housing activities and support services for Housing Services Office	$ 104,356	$ 104,356	$ 104,356	$ 104,356
Behavioral Health Clinical Supervisor	0.9	$ 155,626	Oversees day to day clinical operations of Housing Services Office's client supportive services	$ 132,282	$ 132,282	$ 132,282	$ 132,282
Rehabilitation Counselor	0.9	$ 114,192	Provides counseling services to clients in MHSA-funded housing programs	$ 97,063	$ 97,063	$ 97,063	$ 97,063
BHCS Housing Resource Specialist	0.9	$ 131,333	Provides clinical consultation and mental health orientation, review and evaluation functions to Residential Care Providers	$ 111,633	$ 111,633	$ 111,633	$ 111,633

#5: Rationale--Housing Solutions for Health							
Home Stretch Coordinator (Sr. Program Specialist)	1.0	$ 143,364	Oversees prioritization and coordinates access to permanent supportive housing units countywide for all chronically homeless high need individuals	$ 143,364	$ 143,364	$ 143,364	$ 143,364
Housing Navigation Coordinator (Program Specialist)	1.00	$ 135,314	Provides program planning, coordination, training/technical assistance, and review/evaluation functions for Home Stretch Housing Navigators	$ 135,314	$ 135,314	$ 135,314	$ 135,314
Home Stretch Administrative Assistant	1.00	$ 95,659	Provides administrative, operational and procedural support to Home Stretch and Alameda County Health Care for the Homeless	$ 95,659	$ 95,659	$ 95,659	$ 95,659
SUBTOTAL (Staff)	**7.10**			**$ 1,044,735**	**$ 1,044,735**	**$ 1,044,735**	**$ 1,044,735**
Operations							
Item	**Cost per FTE**		**Description**				
Computers and Equipment	$ 357		PY2-PY5 allocate 5 computers/year	$ 2,536	$ 2,536	$ 2,536	$ 2,536
Software	$ 119		Specialized software license (MS Project, Visio, Adobe Distiller), yearly license & maintenance fees	$ 845	$ 845	$ 845	$ 845
Cell phones	$ 476		Verizon - voice and data	$ 3,381	$ 3,381	$ 3,381	$ 3,381
VPNs	$ 476		Verizon - USB remote access USB modem	$ 3,381	$ 3,381	$ 3,381	$ 3,381

#5: Rationale--Housing Solutions for Health							
Mailing & Postage	$ 167		Postage for internal/external communications, newsletters, courier services	$ 1,183	$ 1,183	$ 1,183	$ 1,183
Travel	$ 1,429		Travel and accommodations for out-of-town conferences, events	$ 10,143	$ 10,143	$ 10,143	$ 10,143
Mileage	$ 714		Work travel to meetings, conf, outreach events, etc.	$ 5,071	$ 5,071	$ 5,071	$ 5,071
Training	$ 1,667		Conference and training registration for Administrative staff	$ 11,833	$ 11,833	$ 11,833	$ 11,833
Food	$ 1,905		Catered food for outreach and training meetings	$ 13,524	$ 13,524	$ 13,524	$ 13,524
Outside printing	$ 1,429		Brochures, posters, education/training materials	$ 10,143	$ 10,143	$ 10,143	$ 10,143
Office Supplies	$ 714		Office supplies for administrative staff and on-going office supplies	$ 5,071	$ 5,071	$ 5,071	$ 5,071
Office Expenses	$ 286		Room rental fees for trainings, meetings, and events, ATT phone conference services, non-office expenses (Ergonomic equipment and assessments)	$ 2,029	$ 2,029	$ 2,029	$ 2,029
Transportation	$ -		N/A	$ -	$ -	$ -	$ -
Furniture	$ 476		Cubicle/office and conference and breakroom, yearly maintenance	$ 3,381	$ 3,381	$ 3,381	$ 3,381

#5: Rationale--Housing Solutions for Health							
Communications	$ 238		Phone system (phones, data racks, network drops, cabling, and installation) yearly maintenance	$ 1,690	$ 1,690	$ 1,690	$ 1,690
Office set-up	$ 238		Moving Expenses for Property & Salvage	$ 1,690	$ 1,690	$ 1,690	$ 1,690
Rent / Lease (of copiers)	$ 857		Konica lease of multi-functional devices (scan, copier, fax, and printer). $9K/machine/year. 2 machines	$ 6,086	$ 6,086	$ 6,086	$ 6,086
Rent / Lease (of building/space)	$ 12,476		Based on actuals. BMD Charges, total square feet ($38.67/ft^2), annual space cost/employee.	$ 88,581	$ 88,581	$ 88,581	$ 88,581
SUBTOTAL (Operations)				**$ 170,569**	**$ 170,569**	**$ 170,569**	**$ 170,569**
Total Housing Solutions for Health Administrative Infrastructure				**$ 1,215,304**	**$ 1,215,304**	**$ 1,215,304**	**$ 1,215,304**

ALAMEDA HEALTH CARE SERVICES AGENCY

CATEGORY 2b: SERVICES AND INTERVENTIONS | Bundled PMPM Services

#6: Rationale--Skilled Nursing Facility Transition Bundle

The Skilled Nursing Facility Transitions Bundle is for intensive housing navigation services offered to AC3 patients who are residents of SNFs who do not meet medical necessity requirements, but lack the resources to transition into a more independent community setting. By moving people from institutional to community settings, AC3 will improve patients' quality of life while reducing state/federal expense. Through shared data and care management teams, we can identify patients at risk of extended stays in nursing facilities, offering home and community-based services to prevent unnecessary nursing facility admissions and to shorten durations of stay. Services offered would include those under the Housing Transition Service Bundle, but would be administered specifically by East Bay Innovations (Community Care Transitions Program--CCT), to ensure resources focus on this subpopulation of patients who would benefit from a less costly level of care. Budget is based on serving 62 clients per year, with a caseload to staff ratio of 25:1 (consistent with housing navigation service bundle ratios). Average cycle time for services is 12 months at which point an individual should be stably housed and exiting the bundle. A review will be done of any patient not stably housed at the 12 month mark to determine if services are achieving impact or if the patient should be exited from the service bundle and linked back to care coordination to determine a new service plan.

Housing Navigators serve as the homeless individual's advocate throughout the housing process and provide a range of intensive housing services that include tenant screening, assessment, and presenting options; developing a housing support plan and crisis plan; searching for housing and assisting with applications; non-medical transportation to ensure access to housing options; identifying and securing resources for one-time move-in expenses; ensuring living environment is safe and ready for move-in; coordination of the move; and establishing procedures and contacts to retain housing.

Eligibility qualifications for this bundle include AC3 patients currently residing in SNF's who no longer meet medical necessity, where a determination has been made that they would benefit from a lower level of care in a community setting. Individuals must also meet the HUD definition of homelessness prior to entry in the SNF, and be facing homelessness upon exit from the SNF to receive this intensive level of housing services. Individuals receiving this bundle will be identified as openings become available, in collaboration with SNF and hospital staff so that eligible patients are prioritized in real time relative to other patients at the facility. Individuals who could better be served in a community setting will be identified using best practices emerging from the CCT program, and access to these services will function more as an active registry of current SNF patients versus a waiting list employing first-come-first-served strategies. There will be no duplication of service bundles in AC3, so any individual enrolled in this bundle will not be simultaneously enrolled in another. However, it is possible by design that once someone is stepped-down in the community, they may eventually be enrolled in a care management (tier 1) bundle should the need for additional intensive supports be needed. Similarly, it is possible that clients exiting SNFs might be matched to permanent supportive housing opportunities and subsequently enroll in the tenancy sustaining services bundle if appropriate.

The SNF transition service bundle will not duplicate TCM services. The intensive housing navigation services are more narrowly focused than TCM, and, as described above, include direct services that would not be recognized as TCM services. To be certain there is no duplication of billing, clients served will be monitored to ensure that services provided through the Whole Person Care pilot program are not claimed under the TCM program and vice versa.

#6: Rationale--Skilled Nursing Facility Transition Bundle													
		Total Max Amount of Funding											
		PY2			PY3			PY4			PY5		
Service Bundle	$$ per Month	# Mo.	# Mbrs	Total	# Mo.	# Mbrs	Total	# Mo.	# Mbrs	Total	# Mo.	# Mbrs	Total
Skilled Nursing Facility Transitions	$ 315.39	12	62	**$ 234,650**	12	62	**$ 234,650**	12	62	**$ 234,650**	12	62	**$ 234,650**

SNF BUNDLE:	Units		Annual Cost per Unit	Total
Staffing				
Housing Navigator (Care Manager) Salary	2.5	Care management, transition services into stable housing setting	$ 60,000	$ 150,000
Housing Navigator Benefits @ 28%	2.5		$ 16,800	$ 42,000
Indirect Staff Costs @ 5%	2.5	Indirect costs for organizational overhead	$ 3,840	$ 9,600
Operations				
Office Supplies & equipment	2.5	Consumable office supplies and office equipment usage (fax, copier, telephone, computer)	$ 500	$ 1,250
Travel (20mi/trip*10 trip/mo*12mo*.55)	2.5	Staff travel per FTE: 20 miles/trip at 10 trips/mo at $.55/mile	$ 1,320	$ 3,300
Office Space & Utilities	n/a	facility costs including office space, utilities	$ 19,200	$ 19,200
Other Expenses				
Enhanced Care Coordination Incentives			$ 150	$ 9,300
TOTAL			**$ 101,810**	**$ 234,650**
	Members	Member Months		Cost / MM = PMPM rate
Member Months	**62**	**744**		**$ 315.39**

#7: Rationale--Outreach Services

Proposed funding for an expansion of outreach services with a countywide goal of reducing homelessness which will decrease long-term outreach service needs post AC3 pilot. The budget for these services is based on providing services to current homeless count estimates of 2,500 unsheltered individuals in Alameda County. Each outreach team member (1 FTE) can reach approximately 125 individuals, thereby requiring 20 FTE. Local funding currently funds approx. 12 FTE, therefore an expansion of 8 FTE system-wide is needed to serve an additional 1,000 individuals. Outreach positions (Community Health Outreach Workers and Peer Support Specialists) provide a workforce development opportunity to identify AC3 patients who, with training and support, can be identified for AC3 Outreach positions and it is a local priority to wed AC3 service expansion opportunities with employment services to AC3 patients. Services provided under Outreach include non-MAA billable activities including coordination, data sharing, collateral service time spent on behalf of patients. AC3 funding will be leveraged to ensure complete outreach services can be provided in a comprehensive and diagnostically-neutral manner. Services will be contracted out to local CBOs that currently provide outreach services to homeless individuals, and will be awarded to multiple eligible vendors covering the full geographical area. Contracts will be Fee for Service, utilizing an hourly rate for outreach time spent, with an estimated 65% time engaged in direct client contact (i.e. conducting street outreach), and remaining 35% time spent providing follow-up and linkage services on behalf of clients and other administrative duties. Clients receiving fee for service outreach services will be connected to AC3 service bundles as indicated. Once enrolled in a service bundle, individual outreach services will discontinue as the goal of outreach is to engage street homeless individuals so that they can access intensive health care and housing services. Once they are engaged and connected with service providers under AC3, outreach activities will not be required for that individual.

					Budget			
					PY2	PY3	PY4	PY5
Discrete Services		**Annual Budget**						
Service	**Frequency**	**Type of Unit**	**# Units**	**$ per Unit**				
Outreach: direct services	Daily (65%)	Hours	10816	41.40	$ 447,798	$ 447,798	$ 447,798	$ 447,798
Outreach: administrative/indirect services	Daily (35%)	Hours	5824	41.40	$ 241,122	$ 241,122	$ 241,122	$ 241,122
TOTAL	**1.0**		**16640**		**$ 688,920**	**$ 688,920**	**$ 688,920**	**$ 688,920**
TOTAL AC3 FUNDED (ADJUSTED FOR 50% SERVICES MAA BILLABLE)					**$ 344,460**	**$ 344,460**	**$ 344,460**	**$ 344,460**

SERVICE:				
Staffing	**FTE**	**Salary & benefits**		**Notes/Description**
Community Health Worker Salary	8	$ 50,000	$ 400,000	Provide outreach services to unsheltered individuals
CHW benefits (@28%)	8	$ 14,000	$ 112,000	
Indirect Staff Costs @ 5%	8	$ 3,200	$ 25,600	
SUBTOTAL (Staff)	8	$ 67,200	**$ 537,600**	
Operations				
Staff Travel	8	$ 2,640	$ 21,120	Staff travel per month: 20 sites visited/month @ 20 miles/trip at $.55/mile
Office Supplies & equipment	8	$ 500	$ 4,000	Consumable office supplies and office equipment usage (fax, copier, telephone, computer)
Office Space & Utilities	n/a	$ 51,200	$ 51,200	facility costs including office space, utilities

Other Expenses						
Enhanced Care Coordination Incentives	1000	$ 75		$ 75,000		
SUBTOTAL (Operations)		$ 54,415		**$ 151,320**		
TOTAL		$ 121,615		**$ 688,920**		

ALAMEDA HEALTH CARE SERVICES AGENCY

CATEGORY 2a: SERVICES AND INTERVENTIONS | Discrete Services

#8: Rationale--Housing Education & Legal Assistance

The creation of a medical-legal partnership for AC[3] patients that focuses on legal needs around housing will ensure that barriers to getting housed and remaining housed are addressed. Prevention of individuals (re)entering the homeless system is far less expensive than providing health care services to homeless individuals and navigating them back to permanent housing. The goal is to provide housing problem-solving as a complement to housing transition and tenancy sustaining services, and to provide legal expertise when needed. The Housing Education & Legal Assistance program will provide educational workshops and open office hours at housing resource centers countywide and will host a 1-800 hotline for Medi-Cal beneficiaries with a housing problem. The program will also have the ability to address issues requiring more in-depth legal assistance. It is estimated that 90% of those served will be AC[3] participants, and the remaining 10% are excluded from AC[3] costs, as they are most likely undocumented individuals. Services will be contracted out (via RFP) to one centralized entity (CBO), assuming ability to provide services countywide. Otherwise, regional contracts may be awarded. Eligible CBOs will be those that currently provide legal assistance services to the safety net. Contracts will be Fee for Service, utilizing service rates for 3 basic categories of work as outlined below. Eligible individuals receiving these services may simultaneously be enrolled in an AC3 service bundle, as these discrete services must be provided by an attorney and are outside the scope of any service bundle. We anticipate that providers of service bundles will help facilitate linkage to this discrete legal service when indicated for their clients.

					Budget			
					PY2	PY3	PY4	PY5
Discrete Services		**Annual Budget**						
Service	**Frequency**	**Type of Unit**	**# Units**	**$ per Unit**				
1- Centralized Call Center	ongoing operation of 1-800 number to triage housing crises	cases routed through call center	1470	PY2: $112.21 to cover start-up costs; PY3-5: $85	164,950	124,950	124,950	124,950
Adjusted for 90% AC3 Participants			**1470**	**PY2: $100.99 to cover start-up costs; PY3-5: $76.50**	**148,455**	**112,455**	**112,455**	**112,455**
2- Housing Education Workshops	biweekly at each (6) Housing Resource Center	session/ workshop	156	499.88	77,982	77,982	77,982	77,982
Adjusted for 90% AC3 Participants			**156**	**450**	**70,184**	**70,184**	**70,184**	**70,184**
3- Individual Legal Assistance	approx. 300 clients served annually	client case	300	1950	585,000	585,000	585,000	585,000
Adjusted for 90% AC3 Participants			**300**	**1755**	**526,500**	**526,500**	**526,500**	**526,500**
Total (Sum of 90% adjusted lines)					**$ 745,139**	**$ 709,139**	**$ 709,139**	**$ 709,139**

#8: Rationale--Housing Education & Legal Assistance								

#8: Rationale--Housing Education & Legal Assistance								
Budget Background								
SERVICE:								
Staffing	**FTE**	**Salary & benefits**			**Notes/Description**			
Staff Attorney Salary	6	$ 75,000		$ 450,000	Housing legal assistance and problem solving; facilitate educational groups/workshops			
Staff Attorney Benefits @28%	6	$ 21,000		$ 126,000				
Admin Support Salary	1	$ 50,000		$ 50,000	Manage call center data on all callers, outcomes of conversation, referrals made, reporting on program, document processing for patient etc.			
Admin Support Benefits @28%	1	$ 14,000		$ 14,000				
Indirect Staff Costs @ 5%	5%	$ 32,000		$ 32,000	Indirect costs for organizational overhead			
SUBTOTAL (Staff)				**$ 672,000**				
Operations					**Notes/Description**			
Staff Travel	6	$ 3,432		$ 3,432	Staff travel per week to housing resource centers: 6 sites visited (1 FTE per site)/week @ 20 miles/trip at $.55/mile			
Office Supplies & equipment	7	$ 500		$ 3,500	Consumable office supplies and office equipment usage (fax, copier, telephone, computer)			
Office Space & Utilities	n/a	$ 64,000		$ 64,000	facility costs including office space, utilities			
Enhanced Care Coordination Incentives		$ 7,500		$ 45,000				
Other Expenses								
Call Center Data Support	100%	$ 40,000		$ 40,000	One-time expense. Off the shelf software package or other database support to host call center information on all callers			
Contracts								
(100% of AC^{3} budgeted amount passed through to CBO contractors)								
SUBTOTAL (Operations/non-labor)				**$ 155,932**		*excludes one-time call center expense*		
					PY2	**PY3**	**PY4**	**PY5**
TOTAL				**$ 827,932**	**$ 827,932**	**$ 787,932**	**$ 787,932**	**$ 787,932**
TOTAL-- AC^{3} FUNDED (ADJUSTED FOR 90% SERVICES to AC^{3} PARTICIPANTS)				**$ 745,139**	**$ 745,139**	**$ 709,139**	**$ 709,139**	**$ 709,139**

#9: Rationale--Community Living Facilities QI Infrastructure Development

Community living facilities (CLFs) have no established oversight, resulting in a lack of reliable information about the current state, and little insight into their standards of operation. Questions of quality and availability need to be addressed countywide to better understand, expand, and improve a range of housing options for individuals with extremely low incomes and disabilities, often exiting from institutions or the streets. AC3 includes an expanded range of housing stock- licensed Board and Cares, Residential Care Facilities for the Elderly, Adult Residential Facilities, recovery residences, residential hotels, including unlicensed Room and Boards. The intent of the Community Living Facilities QI Program is to create a system and develop infrastructure so that the county can begin providing oversight of these types of facilities. Administrative staff will coordinate and provide information about CLF's and their availability through an online directory; the website will provide resources in support of CLF operators, residents, and the community. Staff will develop a system that promotes high quality standards, consultation to operators, education and training resources, and will implement peer review and accountability mechanisms so that the system holds itself accountable to higher standards of housing and care. Administrative staff will also be available to help facilitate a grievance process between operators and residents through a community-led process. A similar program in San Diego (operated by the Independent Living Association) spends approx. $450,000 per year to manage less than 50% of the total CLF inventory that we would expect to manage in Alameda County. Therefore, our county costs are to scale with affected CLF's. The CLF QI Program will be administered via contracted staff to build infrastructure and provide support to the community so that these standards and accountability mechanisms create permanent systems-change beyond the AC3 pilot.

				Budget			
				PY2	PY3	PY4	PY5
Staffing							
	FTE	**Salary & benefits**	**Role/responsibility**				
Program Director Salary	1	$ 85,000	Strategic Planning. Marketing.	$ 85,000	$ 85,000	$ 85,000	$ 85,000
Program Manager Salary	1	$ 65,000	Daily operations of program. Monitoring and reporting on QI components of facilities.	$ 65,000	$ 65,000	$ 65,000	$ 65,000
Program Assistant Salary	2	$ 50,000	Assistance organizing training events; supporting data collection	$ 100,000	$ 100,000	$ 100,000	$ 100,000
Database Administrator	1	$ 75,000	Database creation & support for online directory and website	$ 75,000	$ 75,000	$ 75,000	$ 75,000
Facility Inspectors/ Certification Staff	2	$ 65,000	Create and enforce standards; complete certifications on residences; provide trainings to operators of CLF's on meeting standards	$ 130,000	$ 130,000	$ 130,000	$ 130,000
Staff Benefits at 28%	1	$ 127,400		$ 127,400	$ 127,400	$ 127,400	$ 127,400
SUBTOTAL (Staff)				**$ 582,400**	**$ 582,400**	**$ 582,400**	**$ 582,400**

#9: Rationale--Community Living Facilities QI Infrastructure Development							
Operations							
Staff Travel	2	$ 1,144	Staff travel per year to visit facilities (2 FTE) @ 2/wk, 20 miles total, $.55/mile	$ 2,288	$ 2,288	$ 2,288	$ 2,288
Office Supplies & equipment	7	$ 500	Consumable office supplies and office equipment usage (fax, copier, telephone, computer)	$ 3,500	$ 3,500	$ 3,500	$ 3,500
Office Space & Utilities	n/a	$ 58,240	Facility costs including office space, utilities	$ 58,240	$ 58,240	$ 58,240	$ 58,240
Marketing & Communications	1	$ 75,000	Marketing/promotional budget to recruit CLF operators into the program	$ 75,000	$ 75,000	$ 75,000	$ 75,000
Operator & Resident Training Events/Activities	12	$ 2,500	Cost to host monthly training/seminars on improving quality of facilities and care	$ 30,000	$ 30,000	$ 30,000	$ 30,000
Contracts		**Total**	**Description**				
(100% of AC^3 budgeted amount passed through to single entity contractor to operate program)							
Other Expenses	**% of component costs**	**Total**	**Description**				
Data System Support	100%	$ 50,000.00	Online directory/database software; website creation & hosting	$ 75,000	$ 50,000	$ 50,000	$ 50,000
Program Evaluation	100%	$ 50,000.00	Evaluation of year 1 QI program and impact on community living facilities	$ -	$ 50,000	$ -	$ -
Indirect Costs	5%	$ 29,120.00	Indirect costs for organizational support and infrastructure	$ 29,120	$ 29,120	$ 29,120	$ 29,120
SUBTOTAL (Operations)				**$ 273,148**	**$ 298,148**	**$ 248,148**	**$ 248,148**
TOTAL				**$ 855,548**	**$ 880,548**	**$ 830,548**	**$ 830,548**

#10: Rationale--Client Move-In & Landlord Funds

Flexible client funding to be accessed by housing navigators will support the work in the Housing Transition Service Bundle for elements necessary to enable a person to establish a basic household that does not constitute room and board. These elements include: security deposits; set-up fees for utilities or service access, first month coverage of utilities, including telephone, electricity, heating, and water; essential household furnishings & moving expenses required to occupy and use a community domicile, including furniture, window coverings, food prep items, and bed/bath linens; first month's rent; services necessary for the individual's health and safety, such as pest eradication and one-time cleaning prior to occupancy; home modifications, such as an air conditioner or heater; and other medically necessary services, such as hospital beds and Hoyer lifts, to ensure access and reasonable accommodations. Funding is structured as fee for service (with the unit of service being client move-in, and with the fee based on months to permanent housing), and encourages both patient & housing navigator: the max amount made available to those clients and housing navigators obtaining permanent housing within 4 months is $3600; $2400 max available for those obtaining permanent housing within 8 mos.; $1200 within 12 months. The total number served, if all households obtain permanent housing within 4 months, is 400 households. Months is defined as time from assignment to housing navigator to signing a lease (or ready to sign lease if fund $ is made available for deposit).

Flexible landlord funding will be used to engage landlords in offering supportive housing units with subsidies. These funds are not made available directly to providers, but to a centralized organization working under contract to help recruit landlords to expand pool of available affordable housing units countywide. Goal is to recruit landlords and centrally manage at least 50% of our shelter plus care capacity (approx. 600 units). Funds would be used for: recruitment efforts, including marketing campaigns; support services to landlords, including a 24/7 emergency line; housing locator assistance; potential master leasing; and risk mitigation to landlords in order to encourage private landlords to accept housing subsidies. Together, these funds will benefit AC^3 patients countywide by ensuring funds are available to move-in once housing is found, and by increasing the pool of landlords willing to take affordable housing subsidies. Both funds will be managed by a single third party entity, awarded contract via RFP process.

					Budget			
					PY2	PY3	PY4	PY5
Discrete Services			**Annual Budget**					
Service #1: Client Move-In Fund	**Frequency**	**Type of Unit**	**Max # Units**	**$ per Unit**				
1. Obtain permanent housing	w/in 4 mos.	months to housing	400	3600.00	1,440,000	1,440,000	1440000	1440000
2. Obtain permanent housing	w/in 8 mos.	months to housing		2400.00	-	-	-	-
3. Obtain permanent housing	w/in 12 mos.	months to housing		1200.00				
TOTAL			**400**		**$ 1,440,000**	**$ 1,440,000**	**$ 1,440,000**	**$ 1,440,000**
Service #2: Housing Locator/Landlord Fund	**Frequency**	**Type of Unit**	**Max # Units**	**$ per Unit**				
1. Landlord Recruitment & Management Fee	n/a	housing unit	600	1257.50	754,500	754,500	754,500	754,500
2. Risk Mitigation Fund	n/a	housing unit	600	700.00	420,000	420,000	420,000	420,000
TOTAL			**600**		**$ 1,174,500**	**$ 1,174,500**	**$ 1,174,500**	**$ 1,174,500**
TOTAL					**$ 2,614,500**	**$ 2,614,500**	**$ 2,614,500**	**$ 2,614,500**

SERVICES:					
Contracts		**Total**		**Annual**	**Notes/Description**
		(100% of AC[3] budgeted amount passed through to single entity contractor to operate program)			
Other Expenses	**% of component costs**	**Total**			
Basic Household Set-Up Fund (Patient Fund)		$ 1,440,000		$ 1,440,000	Funding made available to support client move-in expenses (see Service #1 above)
Landlord Recruitment & Management Fee				$ 630,000	Funding to support landlords, including contracted agency staff cost to provide 24/7 landlord support hotline, coordination with service providers & subsidy payers, HQS,
Risk Mitigation Fund				$ 420,000	Eviction Prevention Services (fund to cover property damage after deposit is applied; unit
Indirect/Overhead Cost				$ 124,500	Overhead fee for managing funds
TOTAL				**$ 2,614,500**	

ALAMEDA HEALTH CARE SERVICES AGENCY

CATEGORY 1c: INFRASTRUCTURE DEVELOPMENT | Incentive Payments for Downstream Providers

#11: Rationale--IHSS Rapid Intake

In-Home Supportive Services (IHSS), a unit within Alameda County Social Services Agency, can keep Medi-Cal clients in the community and out of costly and inappropriate institutional care while enhancing social supports for clients who choose family or friends to provide care. **An expedited intake unit that has established processes to serve recently homeless clients is needed to make these services available to newly housed clients.** One time achievement payment will be awarded for reaching the threshold of expediting intake for AC^3 patients referred for In Home Support Services (IHSS). Upon demonstration of 5 AC^3 patients receiving expedited IHSS services, as defined by an average 3-5 day processing time upon referral to the IHSS unit and determination of services, IHSS will receive the one-time payment to reimburse first year expenses for establishing expedited intake unit.

		Total Max Amount of Funding			
		PY2	**PY3**	**PY4**	**PY5**
Incentive Payments					
Deliverables being encouraged	**Metric**				
1 IHSS rapid intake unit established	5 recently homeless AC3 patients have received expedited IHSS services through this process, as defined by an average 3-5 day			$ 200,000	
Total amount available for deliverables				$ 200,000	

CATEGORY 2b: SERVICES AND INTERVENTIONS | Bundled PMPM Services

Goal: To provide flexibility to CB-CMEs to do what it takes to get an individual transitioned from a higher level of care/institutionalization into a safe, secure and sustainable lower level of care in the community, and to ensure individuals can sustain a successful transition into housing. Not all services will be required by every enrollee but some enrollees (chronically homeless and disabled) will require a significantly more intensive level and/or duration of service to make a successful transition.

#12a: Rationale-- Enhanced Housing Transition Service Bundle

The Enhanced Housing Transition Service Bundle is for intensive housing navigation services offered to chronically homeless AC3 patients, with staff ratios of approximately 25:1. Housing Navigators serve as the homeless individual's advocate throughout the housing process and provide a range of housing services that include tenant screening, assessment, and presenting options; developing a housing support plan and crisis plan; searching for housing and assisting with applications; non-medical transportation to ensure access to housing options; identifying and securing resources for one-time move-in expenses (via access to the Client Move-In Fund presented under Delivery Infrastructure); ensuring living environment is safe and ready for move-in; coordination of the move; and establishing procedures and contacts to retain housing. Housing Transition Services will emphasize building up community supports including connections to family when possible, addressing housing barriers, and connecting clients to Housing Resource Centers (hubs) to ensure access to resources. Housing Navigators follow a Critical Time Intervention (CTI) model and work with clients on average for 12 months to ensure an overlap in services post-housing, as part of the handoff to the Tenancy Sustaining Services Provider. Goal is to have housing navigation capacity for 600 individuals (County's estimate of chronically homeless and disabled individuals). Current local funding covers 200 individuals. AC3 goal is to add 16 FTE to serve an additional 400 individuals to meet capacity.

Average cycle time for services is 12 months at which point an individual should be stably housed and exiting the bundle. A review will be done of any individual not stably housed at the 12 month mark to determine if services are achieving impact or if the individual should be exited from the service bundle and linked back to care coordination to determine a new service plan. As referenced, eligibility requirements for this bundle include chronic homelessness (using the HUD definition), disabled (included in HUD's definition of chronic homelessness), and high need (as defined by our Continuum of Care and in alignment with our Coordinated Entry prioritization. High need determination includes either 1-a qualifying score on the VI-SPDAT; 2-frequent utilization of emergency health care; 3- frequent contact with law enforcement; or 4-having a qualifying medical or mental health diagnosis). Because this is an intensive service prioritized for chronically homeless and high need, individuals eligible for this service will be identified through the Home Stretch registry- the county's by-name list that prioritizes individuals to permanent supportive housing resources. The Home Stretch registry serves as a waiting list for this service bundle. Accordingly, as housing navigation slots become available, caseloads will be filled by individuals in the top priority group from this registry. Housing Transition Service Bundles will be administered via Alameda County Housing Solutions for Health to homeless service providers (CBOs) with an eye toward potentially transferring administration to the Managed Care Plans over time for fully integrated care. There will be no duplication of service bundles in AC3, so any individual enrolled in this bundle will not be simultaneously enrolled in another. However, it is possible by design that once someone is permanently housed in the community, they may eventually be enrolled in a care management (tier 1) bundle should the need for additional intensive supports be needed. Also, it is highly likely that clients exiting the Housing Transition Services Bundle will be matched to permanent supportive housing opportunities and subsequently enroll in the tenancy sustaining services bundle if appropriate. It is also likely that clients identified and billed for under the Fee for Service Outreach program will subsequently flow into this service bundle, at which point they will no longer receive FFS outreach services.

The Enhanced Housing Transition Service Bundle will not duplicate TCM services. The intensive housing navigation services are more narrowly focused than TCM, and include services that would not be recognized as TCM services, such as searching for housing, communicating w landlords, ensuring a safe living environment, environmental modifications, coordinating moves, etc. To be certain there is no duplication of billing, clients served will be monitored to ensure that services provided through the Whole Person Care pilot program are not claimed under the TCM program and vice versa.

12b Rationale-- Housing & Tenancy Sustaining Supportive Service Bundle

Supportive housing is a cost-effective approach that combines deeply affordable housing (20% of area median income or below) with supportive services (housing & tenancy sustaining services) to help people with disabilities live with stability, autonomy, and dignity. The goal is to fund sustaining services for all permanent supportive housing opportunities available in the county. Services are currently funded locally for approximately half of the 2000 units/opportunities we currently have in Alameda County and we anticipate 50 more units coming online each year through our HUD funding package, development through the Housing Pool, and potential resources such as the County Housing Bond and No Place Like Home proposals (if passed). Therefore, an expansion of services is proposed for 1,050 units, utilizing a client:care management ratio of 40:1 (resulting in 26 additional FTE). Housing activities and services in this bundle include: identification and intervention for behaviors that may jeopardize housing; landlord & tenant education; coaching on relationships with landlords; dispute resolution assistance; advocating and linking to eviction-prevention community resources including the WPC-proposed Housing Education & Legal Assistance Program; assistance with housing recertification; updating housing support & crisis plans; and training in good tenancy and support in household management skills. Services are offered using housing-first evidence-based practices, and include linking individuals to employment services through Behavioral Health Care Services' Individual, Placement, and Support (IPS) employment project. These services should support individuals to maintain housing and ensure they have the necessary tools to integrate into their communities, focusing on the core values of health, home, purpose, and community.

Housing and Tenancy Sustaining Service Bundles will be administered via Alameda County Housing Solutions for Health to homeless service providers (CBOs) with an eye toward potentially transferring administration to the Managed Care Plans over time for fully integrated care. Eligibility requirements for this bundle include chronically homeless (HUD definition) high need individuals (per local definition outlined in the Enhanced Housing Transition Bundle above) who have been matched to a permanent supportive housing opportunity where the housing services are a required component to housing. Therefore, beneficiaries may first be enrolled in the Enhanced Housing Transition Bundle to help them navigate to permanent housing, but once matched to PSH, they would exit that bundle and be eligible for enrollment in the Tenancy Sustaining Services Bundle. These services are designated to permanent supportive housing units and these set aside PSH units are filled through the County's Home Stretch registry (prioritized by-name list matching chronically homeless, high need individuals to permanent supportive housing opportunities). Therefore, once capacity is reached, any turnover in slots (as individuals stabilize and require less ongoing care) will be filled by individuals who are matched to permanent supportive housing from the Home Stretch registry. Thus, the Home Stretch registry serves as a waiting list for this service bundle. There will be no duplication of service bundles in AC3, so any individual enrolled in this bundle will not be simultaneously enrolled in another. It is possible (and by design) that many individuals coming into this bundle will be transferring from Housing Transition Service Bundle or SNF Transition Service Bundle, if they are matched to a permanent supportive housing opportunity.

		Total Max Amount of Funding											
		PY2			PY3			PY4			PY5		
Service Bundle	**$$ per Month**	**# Mo.**	**# Mbrs**		**# Mo.**	**# Mbrs**	**Total**	**# Mo.**	**# Mbrs**	**Total**	**# Mo.**	**# Mbrs**	**Total**
Enhanced Housing Transition	$ 323.73	6	400	$ 776,952	12	400	$ 1,553,904	12	400	$ 1,553,904	12	400	$ 1,553,904
Housing & Tenancy Sustaining Services	$ 210.68	6	1050	$ 1,327,284	12	1100	$ 2,780,976	12	1150	$ 2,907,384	12	1200	$ 3,033,792
TOTAL				**$ 2,104,236**			**$ 4,334,880**			**$ 4,461,288**			**$ 4,587,696**

BUNDLE 1:	Units		Annual Cost per Unit	Total
Staffing				
Housing Navigator (Care Manager) Salary	16		$ 60,000	$ 960,000
Housing Navigator Benefits @ 28%	16		$ 16,800	$ 268,800
Indirect Costs @ 5%	16		$ 3,840	$ 61,440
Operations				
Office Supplies & equipment	16		$ 500	$ 8,000
Office Space & Utilities	16		$ 7,680	$ 122,880
Travel (20mi/trip*25 trip/mo*12mo*.55)	16		$ 3,300	$ 52,800
Other Expenses				
Enhanced Care Coordination Incentives	16		$ 5,000	$ 80,000
TOTAL			**$ 97,120**	**$ 1,553,920**
	Members	Member Months		Cost / MM = PMPM rate
Member Months	**400**	**4800**		**$ 324**

BUNDLE 2:	Units		Annual Cost per Unit	Total
Staffing				
Supportive Housing Case Manager Salary	26		$ 60,000	$ 1,560,000
Supportive Housing Case Manager Benefits @28%	26		$ 16,800	$ 436,800
Indirect Costs @ 5%	26		$ 3,840	$ 99,840
Operations				
Office Supplies & equipm	26		$ 500	$ 13,000
Office Space & Utilities	26		$ 7,680	$ 199,680
Travel (20mi*480 trips (40 clients monthly)*.55)	26		$ 5,280	$ 137,280
Other Expenses				
Enhanced Care Coordination Incentives	26		$ 8,000	$ 208,000

TOTAL			**$ 102,100**	**$ 2,654,600**
	Members	Member Months		Cost / MM = PMPM rate
Member Months	**1050**	**12600**		**$ 211**

ALAMEDA HEALTH CARE SERVICES AGENCY

#13: CATEGORY 3b: REPORTING AND QUALITY | Pay for Metric Outcome Achievement

#13: Rationale--Stably Housed

Data indicate that once someone is stably housed at 6 months, their likelihood of remaining housed over the long run increases. Enterprise and the Center for Outcomes Research and Education (CORE) released a 2016 report (*Health in Housing: Exploring the Intersection Between Housing and Health Care*) finding that after moving into affordable housing, Medicaid costs were lower by approximately $48/resident/month. Accordingly, option one would be to pay the $50 savings per month for the first 6 months to the entity providing the housing navigation services to help house someone. This aligns with our Housing Navigation model which includes the Housing Navigator providing transition services up to 6 months post housing as the individual receives a warm handoff to the tenancy sustaining services provider. For tenancy sustaining services, HUD has established 24 months as the outer limit for the housing retention risk period (0-6 mos; 6-24 mos), therefore our next benchmark is to fund housing stability as an outcome at 24 months. Payments will be administered by Alameda County Housing Solutions for Health, to homeless service providers (CBOs) via contract. 'Stably housed' at each time interval is defined by the individual remaining in either the same permanent housing situation or moving to an equal or improved independent living situation per HUD's scale (points range from 0-14; any residential type that is a 9 or above is considered permanent, with increasing independence as one moves up the scale). Payments will be triggered based on 6 and 24 months from the lease date and will be provided to the community-based organization whose staff provided the housing navigation services (at 6 months) and tenancy sustaining services (at 24 months).

			Total Max Amount of Funding			
EXAMPLE OF HOW PAY FOR METRIC OUTCOME ACHIEVEMENT WOULD BE ADMINISTERED:			**PY2**	**PY3**	**PY4**	**PY5**
Incentive Payments						
Metric Reported	**Entity Receiving Payment**					
1. Stably housed at 6 mos		housing navigator entity (CB-CME)	$120,000	$120,000	$120,000	$120,000
2. Stably housed at 24 mos		tenancy sustaining services provider (CBO's)	$ -	$ -	$ -	$ 360,000
Total amount available for deliverables			$120,000	$120,000	$120,000	$480,000

Calculations for determining payment level

Example: Pay for Outcome to Housing Navigation Services Provider

Potential 400 outcomes at each time interval during AC[3], for those AC[3] patients that are in Permanent Supportive Housing.

Stably housed **(see definition above)** at 6 months = $50/month Medicaid savings = $300

Outcome	**Unit Max**	**Cost Per Unit**	**Total**
stably housed at 6 mos	400	$ 300	$ 120,000
stably housed at 6 mos	400	$ 300	$ 120,000
stably housed at 6 mos	400	$ 300	$ 120,000
stably housed at 6 mos	400	$ 300	$ 120,000
			$ 480,000

Example: Pay for Outcome to Tenancy Sustaining Services Provider

Potential 400 outcomes at highest interval during AC[3]. Turnover in current PSH around 20% (400 units come online/available each year)

Stably housed **(see definition above)** at 24 mos = $50/month Medicaid savings realized between 6-24 mos = 18 mos @ $50 = $900

Outcome	**Unit Max**	**Cost Per Unit**	**Total**
stably housed at 24 mos	0	$ 900	$ -
stably housed at 24 mos	0	$ 900	$ -
stably housed at 24 mos	0	$ 900	$ -
stably housed at 24 mos	400	$ 900	$ 360,000
			$ 360,000

ALAMEDA HEALTH CARE SERVICES AGENCY

SAMPLE BUDGET NARRATIVE TEMPLATE

CATEGORY 2a: SERVICES AND INTERVENTIONS | Discrete Services

#14 Rationale--Sobering Center

Through a contract with BHCS, Horizon Services will operate a Sobering Center 24/7/365, providing a monitored environment for patient who are under the influence of substances and need a behavioral health intervention to achieve stability. Patients will rest at the Center for less than 24 hours. The aim is to ensure the safety of the individual and the community; once the person is sober, they will receive an assessment and encouragement with a warm handoff to the Detox Center that is located next door to the Sobering Center, providing low-barrier transition to treatment. The Sobering Center services will include 24/7/365 transportation services; on request from hospitals, crisis teams, etc., EMTs will pick up patients and bring them to the Center. The Sobering Center is expected to have an average of 17 clients per day in PY2, and to grow by 10% in PY3. We assume 80% of clients will be eligible, or an average of 14 patients per day.

The AC3 program will work in concert with the re-design of the SUD system of care that is underway thanks to the Drug Medi-Cal Waiver Organized Delivery System. Sobering Center services will be significantly expanded, and SUD treatment services will be better integrated into the network of services needed by the patients. Staff will participate in trainings to communicate effectively with providers in different systems, such as psychiatric emergency, primary care, housing, police, emergency departments, etc. Staff will also be trained in the use of AC3 data sharing system and will identify and communicate with members of the patient's care team. Staff from other systems will be trained in how to refer to the Sobering Center.

Encounters are defined as a bed day, which is a stay at the Sobering Center as described above. Stays are <24 hours, but note one person could potentially be admitted more than once in a year, so these are not unduplicated persons.

					Budget			
					PY2	PY3	PY4	PY5
Discrete Services								
Service	**Frequency**	**Type of Unit**	**# Units**	**$ per Unit**				
Sobering Center	daily	Bed day	5110	$ 239.21	$ 1,222,357	$ 1,222,357	$ 1,222,357	$ 1,222,357
TOTAL					**$ 1,222,357**	**$ 1,222,357**	**$ 1,222,357**	**$ 1,222,357**

Sobering Center Budget							
Staffing	**FTE**	**Salary & benefits**	**Role/responsibility**				
Program Director	0.5	$ 119,653	Directs and oversees Sobering Center activities and has ultimate responsibility for contracted services. Represents the Center in local planning and coordinating efforts.	$ 56,889	$ 56,889	$ 56,889	$ 56,889
Deputy Director	0.5	$ 79,098	Directs Center schedule; supervises key staff; ensures adherence to relevant regulations and policies.	$ 37,607	$ 37,607	$ 37,607	$ 37,607
Office Mgr	0.5	$ 62,818	Coordinates staff scheduling and manages accounting and reporting.	$ 29,867	$ 29,867	$ 29,867	$ 29,867
IS Dept	0.5	$ 43,658	Oversees and troubleshoots IS system; assists with data analysis and the preparation of reports.	$ 20,757	$ 20,757	$ 20,757	$ 20,757
Nurse Coordinator	0.8	$ 98,714	LVN overseeing and providing direct client support services.	$ 78,971	$ 78,971	$ 78,971	$ 78,971
Sober Program Asst	1.0	$ 74,783	Supervises, supports, and helps train patient service staff.	$ 74,783	$ 74,783	$ 74,783	$ 74,783
Svc Coordinator	1.0	$ 65,809	Certified treatment provider	$ 65,809	$ 65,809	$ 65,809	$ 65,809
Detox Asst Level 3	4.2	$ 60,008	Entry level treatment provider with certification	$ 252,033	$ 252,033	$ 252,033	$ 252,033
Detox Asst Level 2	3.2	$ 53,833	Monitors patient condition; prepares food on-site; assists patients with issues and problems	$ 172,266	$ 172,266	$ 172,266	$ 172,266
Detox Asst Level 1	2.0	$ 46,974	Acts primarily as driver for Center patients	$ 93,948	$ 93,948	$ 93,948	$ 93,948
Health Tech	4.2	$ 53,691	Certified EMT providing client transport and emergency services	$ 225,503	$ 225,503	$ 225,503	$ 225,503

Office Asst	2.0	$ 56,835	Provides administrative staff support including data managemment, file protection, and receptionist services		$ 113,671	$ 113,671	$ 113,671	$ 113,671
Relief	n/a	n/a	Coverage for staff during absences		$ 125,901	$ 125,901	$ 125,901	$ 125,901
					$ -	$ -	$ -	$ -
					$ -	$ -	$ -	$ -
SUBTOTAL (Staff)	**20**				**$ 1,348,006**	**$ 1,348,006**	**$ 1,348,006**	**$ 1,348,006**
Operations								
Enhanced Care Coordination		$ 50,600			$ 50,600	$ 50,600	$ 50,600	$ 50,600
Insurance		$ 10,460	Covers insurance costs related to Center		$ 10,460	$ 10,460	$ 10,460	$ 10,460
Other Components		$ 46,121	Other misc, e.g. Office, maintenance, depreciation, etc.		$ 46,121	$ 46,121	$ 46,121	$ 46,121
SUBTOTAL (Operations)		**$ 107,181**			**$ 107,181**	**$ 107,181**	**$ 107,181**	**$ 107,181**
TOTAL Direct					**$ 1,455,187**	**$ 1,455,187**	**$ 1,455,187**	**$ 1,455,187**
Indirects	5%				$ 72,759	$ 72,759	$ 72,759	$ 72,759
TOTAL					**$ 1,527,946**	**$ 1,527,946**	**$ 1,527,946**	**$ 1,527,946**
TOTAL-- AC^3 FUNDED (ADJUSTED FOR 80% SERVICES TO ELIGIBLE POPULATION)					**$ 1,222,357**	**$ 1,222,357**	**$ 1,222,357**	**$ 1,222,357**

CATEGORY 2a: SERVICES AND INTERVENTIONS | Discrete Services

#15 Rationale--SUD Diversion

SUD Diversion program is located in a specially-designed collaborative court setting, in which all members of the court team use the power of positive reinforcement to support clients in achieving their recovery-oriented goals. Individuals facing criminal charges for drug use and possession can choose to engage in substance abuse treatment in lieu of a jail or prison sentence, and in some instances may even get their charges dismissed. The program is a cross-agency collaboration of BHCS and the Superior Court of Alameda County that links the criminal justice system with community-based SUD treatment providers. It offers a path to recovery from addiction and an effective diversion from repeated cycling through the criminal justice system.

The primary functions of this program are to assess each participant's SUD and any co-occurring mental health disorders, refer them to treatment, encourage them to engage in and complete treatment, and thereby reduce drug-related criminal activity. The program provides comprehensive supervision, drug testing, and immediate sanctions and incentives. Clients must attend community-based substance use treatment and recovery activities and make regular court appearances as required by the SUD diversion program. Using American Society of Addiction Medicine (ASAM) criteria, each client is referred to the appropriate level of treatment and recovery support services (outpatient and residential treatment, NA/AA meetings, etc.), all of which are accompanied by regular urinalysis drug testing. Clients are also referred to services such as mental health, primary medical care, education, and vocational training / job placement services.

Approximately 250 people per year will participate in the SUD Diversion / program. We estimate at least 80% will be eligible for WPC, or 200 per year. As part of AC3, eligible clients of the SUD Diversion program can be enrolled in the AC3 system and will be better connected to the wide range of services needed to achieve and maintain sobriety.

Level of service varies based on the client's stage in recovery. Encounters are defined as 1) Initial assessment: averages 1 hour; 2) Court visit encounters: Clients each report personally to the Court, then observe their peers interacting with the judge. Encounters can range from 15 minutes (for clients who are well established in recovery and employed) to several hours; frequency and length of visits depends on client's stage in recovery; we estimate one hour per encounter; 3) Drug testing+ care manager contact: initially occurs once per week; later in treatment occurs once every 2 months; averages approximately 15 minutes.

					Budget			
					PY2	PY3	PY4	PY5
Discrete Services								
Service	**Frequency**	**Type of Unit**	**# Units (hours)**	**$ per Unit**				
SUD Diversion	One per client	Assessment (~1 hr)	200	$ 229.29	$ 45,858	$ 45,858	$ 45,858	$ 45,858
SUD Diversion	1-2 times per month	Court visit encounters (est avg 1 hr)	1,718	$ 229.29	$ 393,918	$ 393,918	$ 393,918	$ 393,918
SUD Diversion	Weekly / bi-monthly	Drug testing with Care Manager contact (4@15 min ea.)	540	$ 229.29	123,816	123,816	123,816	123,816
TOTAL			**2,458**	**$ 229.29**	**$ 563,591**	**$ 563,591**	**$ 563,591**	**$ 563,591**

SUD Diversion Budget (MOU with Alameda County Superior Court)							
Staffing	**FTE**	**Salary & benefits**	**Role/responsibility**				
Principal Analyst (Division Chief)	1	$ 135,720	Oversees SUD Diversion program operations; supervsises staff; sets policies and procedures in collaboration with the Superior Court of Alameda County.	$ 135,720	$ 135,720	$ 135,720	$ 135,720
Substance Abuse Assessment Specialists	4	$ 81,576	Specialists provide one-on-one client counseling, assessment, referrals, and development of care plan. Monitors client adherence to care plan and responds to issues as they arise.	$ 326,304	$ 326,304	$ 326,304	$ 326,304
Management Analyst	0.7	$ 122,721	Tracks services, expenditures, and data related to the SUD Diversion program and provides reports to the Superior Court on client caseloads and adherence rates.	$ 85,905	$ 85,905	$ 85,905	$ 85,905
Division Secretary	0.5	$ 98,623	Provides high-level adminstrative support to the SUD Diversion program, including coordinating schedules, maintaining records, and preparing reports	$ 49,312	$ 49,312	$ 49,312	$ 49,312
SUBTOTAL (Staff)	**6**			**$ 597,240**	**$ 597,240**	**$ 597,240**	**$ 597,240**

Operations								
Client Transportation		$ 17,600			$ 17,600	$ 17,600	$ 17,600	$ 17,600
Drug Testing		$ 54,912			$ 54,912	$ 54,912	$ 54,912	$ 54,912
Drug testing Kits		$ 8,900			$ 8,900	$ 8,900	$ 8,900	$ 8,900
Treatment Facilty Progress Rpts		$ 5,200			$ 5,200	$ 5,200	$ 5,200	$ 5,200
Travel and Stakeholder meetings		$ 6,488			$ 6,488	$ 6,488	$ 6,488	$ 6,488
Training		$ 6,500			$ 6,500	$ 6,500	$ 6,500	$ 6,500
Office Supplies		$ 7,649			$ 7,649	$ 7,649	$ 7,649	$ 7,649
SUBTOTAL (Operations)		**$ 107,249**			**$ 107,249**	**$ 107,249**	**$ 107,249**	**$ 107,249**
TOTAL Direct					**$ 704,489**	**$ 704,489**	**$ 704,489**	**$ 704,489**
TOTAL-- AC^3 FUNDED (ADJUSTED FOR 80% SERVICES TO ELIGIBLE POPULATION)					**$ 563,591**	**$ 563,591**	**$ 563,591**	**$ 563,591**

CATEGORY 2a: SERVICES AND INTERVENTIONS | Discrete Services

#16 Rationale--Portals to Substance Use Disorder Treatment

The AC3 program will work in concert with the re-design of the SUD system of care that is underway thanks to the Drug Medi-Cal Waiver Organized Delivery System. The SUD portals are a new service designed to link people with addiction disorders to appropriate services, using American Society of Addiction Medicine (ASAM) criteria.

a. Linkage to SUD treatment – probation

The goal of the **Criminal Justice Care Management portal operated by CenterPoint is to help adults who are on probation under AB109 status** and who have a history of SUD to establish and maintain recovery from substance use, and attain stabilization, increase self-sufficiency, and improve quality of life; to reduce recidivism into the criminal justice system; and to develop cognitive and behavioral coping skills to prevent relapse. Through this program, assessment specialists and care managers are located throughout the county at Probation offices and SUD treatment sites. Using an ASAM assessment tool, they conduct screening, assessment and referral to treatment for clients as they re-enter the community.
We are projecting an estimated 80% of clients served will qualify for WPC.
Encounters are defined as hours of assessment and referral provided. Initial assessments average one hour; re-assessments average 1.5 hours. Approximately 70% of clients referred enter treatment and receive re-assessments.

b. Substance Use Residential Helpline

Through the new DMC organized delivery system, Alameda County will be establishing a countywide screening and referral service for SUD residential treatment and for recovery residence plus outpatient treatment (RROT). To make these Drug Medi-Cal-funded treatment services successful, expanded delivery infrastructure is needed. AC3 will include establishment of a Helpline (not eligible for or funded by Medi-Cal) to ensure that clients are appropriately referred to and get access to SUD residential treatment or recovery residences. The Helpline will provide screening and assessment to determine appropriate level of care placements, using an ASAM assessment tool. They will facilitate referral and effective hand-off with service providers, and periodically conduct re-assessments and recommendations to treatment service providers.

As part of the AC3 program, staff will use the AC3 System to collaborate with other members of the patient's care team to identify a lead care coordinator and to contribute to a common care plan. The program will participate in designing and implementing the new standardized AC3 System that will be developed by the AC3 program.

We are projecting an estimated 80% of clients served will qualify for WPC.
Encounters are defined as 1) hours of information, screening & referral provided through the Helpline; and 2) hours of in-person assessment and re-assessment. Assessments take place at Centerpoint offices, and the reassessments take place on-site at Residential Treatment facilities and Recovery Residences. They average 1.5 hrs per visit including transportation, documentation, and follow-up communication in person or by phone with the treatment provider. An estimated 675 eligible clients will be served.

We have determined there is no potential duplication with TCM in this service. The encounters are more limited than required for TCM reimbursement, and the staff are not trained case managers and only do SUD assessments and referrals. Therefore these services would not be eligible for reimbursement under TCM.

					Budget			
					PY2	PY3	PY4	PY5
Discrete Services								
Service	**Frequency**	**Type of Unit**	**# Units (hours)**	**$ per Unit**				
a. Linkage to SUD treatment – probation	1-2 visits per client	Assessment and reassessments	540	$ 154.99	$ 83,696	$ 83,696	$ 83,696	$ 83,696
b. Substance Use Residential Helpline	n/a	Helpline info, screening and referrals	350	$ 154.99	$ 54,248	$ 54,248	$ 54,248	$ 54,248
	two 90 min visits per client	In-person assessments & reassessments of clients in residential tx	2025	$ 154.99	$ 313,862	$ 313,862	$ 313,862	$ 313,862
TOTAL			**2,915**	**$ 154.99**	**$ 451,806**	**$ 451,806**	**$ 451,806**	**$ 451,806**
Portals to Substance Use Disorder Treatment (Contract with CenterPoint)								
Staffing	**FTE**	**Salary & benefits**	**Role/responsibility**					
Assessment Specialist /Program manager	1	$ 72,050	Oversees and coordinates day-to-day operations of the CenterPoint Portals program while providing direct patient assessment and support services and supervising and supporting project staff		$ 72,050	$ 72,050	$ 72,050	$ 72,050
Assessment Specialist	2	$ 60,260	Specialists provide direct patient assessment, support, care plan development, linkage, and follow up services to persons on Probation with SUD histories		$ 120,520	$ 120,520	$ 120,520	$ 120,520
Care Managers	2	$ 52,400	Case Managers suport the CenterPoint Portals Assessment Specialists by tracking patient care plans, respond to patient inquiries, and following-up to ensure linkages are met		$ 104,800	$ 104,800	$ 104,800	$ 104,800

Data Analyst	1	$ 49,780	Coordinates overall data collection, tracking, and reporting for the CenterPoint Portals program	$ 49,780	$ 49,780	$ 49,780	$ 49,780
SUBTOTAL (Staff)	**6**			**$ 347,150**	**$ 347,150**	**$ 347,150**	**$ 347,150**
Operations							
Office Expense		$ 20,000	Provides support for office space rental for 6.0 full-time project staff	$ 20,000	$ 20,000	$ 20,000	$ 20,000
Utilities		$ 15,800	Covers utility costs related to space rental	$ 15,800	$ 15,800	$ 15,800	$ 15,800
Communications		$ 20,000	Includes costs of wireless linkages, telephones, and other communications services	$ 20,000	$ 20,000	$ 20,000	$ 20,000
Transportation		$ 20,914	Supports cost of monthly transportation by project staff as needed to out-based client service locations at Probation and in local CBOs	$ 20,914	$ 20,914	$ 20,914	$ 20,914
Professional & Spec. Services*		$ 10,000	Include subcontract costs related to legal consultation, materials production, and insurance requirements	$ 10,000	$ 10,000	$ 10,000	$ 10,000
Insurance		$ 11,000	Covers costs related to both facilty and travel-related insurance	$ 11,000	$ 11,000	$ 11,000	$ 11,000
Structure		$ 84,000	Covers structural costs related to the new proposed helpline, including furnishings and basic supplies	$ 84,000	$ 84,000	$ 84,000	$ 84,000
Equipment		$ 9,000	Includes cost of establishing basic helpline infrastructure including telephones, printers and computers, etc.	$ 9,000	$ 9,000	$ 9,000	$ 9,000
SUBTOTAL (Operations)		**$ 190,714**		**$ 190,714**	**$ 190,714**	**$ 190,714**	**$ 190,714**

TOTAL Direct					**$ 537,864**	**$ 537,864**	**$ 537,864**	**$ 537,864**
Indirects	5%				$ 26,893	$ 26,893	$ 26,893	$ 26,893
TOTAL					**$ 564,757**	**$ 564,757**	**$ 564,757**	**$ 564,757**
TOTAL-- AC^3 FUNDED (ADJUSTED FOR 80% SERVICES TO ELIGIBLE POPULATION)					**$ 451,806**	**$ 451,806**	**$ 451,806**	**$ 451,806**

ALAMEDA HEALTH CARE SERVICES AGENCY

CATEGORY 1c: INFRASTRUCTURE DEVELOPMENT | Incentive Payments for Downstream Providers

#17 Rationale--Capacity Development Incentives for Physical Health Providers - Opioid

In Alameda County, deaths from opioid misuse tripled between 2005 and 2014, and hospitalizations for opioid-related, non-fatal overdoses increased by over 74 percent. Only 8 doctors among our 31 safety net clinics and over 500 providers have X waivers allowing them to prescribe buprenorphine and none are currently using other Medication-Assisted Treatment (MAT) interventions. In an effort to reduce prescription opioid misuse and abuse, AC^3 will attach powerful incentives for safety net primary care organizations to develop and use the MAT as well as non-pharmaceutical treatments for pain and addiction. Provider organizations will first be supported in using population health records to identify patients with suspected opioid use disorder, and then to build their capacity for integrated care of those patients in the primary care setting and with critical partners in behavioral health, alternative therapies, and supportive services, such as acupuncture, physical therapy, chiropractic services, counseling, exercise, meditation, yoga, etc. This funding is explicitly not for provision of services, but for the building and broadening of primary care provider capacity. The development of this capacity will provide enhanced integrated care for AC^3 patients, many of whom experience addiction to opioids. Additionally, we believe there is built-in sustainability for this integrated care capacity, given that the visits and medications are supported by expanded payment programs. The incentive funds will be made available across 31 participating clinic sites, scaled relative to clinic size.

The initial effort in PY2 will be the most significant to get the providers trained and certified, to establish workflows for buprenorphine and other MAT therapies and to reach agreement on which chronic opioid-using patients should be approached about switching to safer therapies. Overcoming provider concern and resistance to adopting this clinical capacity will be a hurdle, so significant incentive payments are made available in this first year to ensure progress and successful implementation. The following program years will require continued strong attention to improvements in these processes via PDSA cycles so as to increase population penetration, but not quite as much as in PY2. Across all years, it is significantly more difficult to move change and garner necessary attention at the very large and complex public hospital and clinic system compared to the community clinic sites, espcially with multiple competing priorities, so significantly more incentive dollars are allocated for those provider organization sites.

		Total Max Amount of Funding			
		PY2	PY3	PY4	PY5
Incentive Payments					
Deliverables being encouraged	**Entities eligible**				
1. Provide written evidence of the development and strengthening of workflows, documentation standards, follow up strategies, and anecdotal provider experience of performing screening for opioid dependence and treatment with Buprenorphine as MAT	Community Primary Care Sites - 27 $117,191 each	$ 3,164,153			
	Public Hospital and Clinic System Primary Care Sites - 4 $1,343,944 each	$ 5,375,778			

#17 Rationale--Capacity Development Incentives for Physical Health Providers - Opioid					
2. Increase volume of AC^3 patients treated for opioid dependence. Incentive funds will be paid each budgeted year to provider organization sites that show a 10% decrease in the gap between target treatment rate negotiated with each provider agency during PY2 (and revised annually if needed) and that clinic site's performance the prior year.	Community Primary Care Sites - 27 $58,314 each		$ 1,574,469	$ 1,574,469	$ 1,574,469
	Public Hospital and Clinic System Primary Care Sites - 4 $695,963 each		$ 2,783,852	$ 2,783,852	$ 2,783,852
3. Provide written evidence of the site-specific pilot design and implementation to provide and/or refer patients to non-medication therapies to treat opioid dependence (PY3), the scaling up of these services and/or referrals to meet the full client load potentially in need of them (PY4), and the improvement of that system using at least one PDSA (PY5)	Community Primary Care Sites - 27 $18,519 each		$ 500,000	$ 500,000	$ 500,000
	Public Hospital and Clinic System Primary Care Sites - 27 $200,000 each		$ 800,000	$ 800,000	$ 800,000
TOTAL		**$ 8,539,931**	**$ 5,658,321**	**$ 5,658,321**	**$ 5,658,321**

ALAMEDA HEALTH CARE SERVICES AGENCY

CATEGORY 1b: INFRASTRUCTURE DEVELOPMENT | Delivery Infrastructure

#18a Rationale---Psychiatric Consultation for Primary Care Providers

AC^3 patients benefit from strong integration between primary care, mental health services, and substance abuse treatment to remove barriers for accessing appropriate care at the right place and the right time. Therefore, AC^3 will support Alameda County Behavioral Health Care Services (BHCS) to provide a Psychiatric Consultation Program to eight of Alameda County's Federally Qualified Health Centers and two HIV Specialty Care Health Centers. The BHCS Psychiatric Consultants will provide consultation services only to primary care providers and behavioral health clinicians needing support in the diagnosis and treatment of mental health and substance use conditions. These psychiatric consultation services are not providing care to clients, and are therefore not billable by BHCS, the FQHCs, or the HIV Health Centers to Medi-Cal or Ryan White. Please see deliverable #18b in Discrete Services for complete rationale for this program overall.

Specific deliverables include:

-- Equipment for nine clinics and two central BHCS sites to enable timely tele-psychiatry and tele-pharmacy services for primary care and behavioral health providers serving the AC^3 target population (homeless, SMI, and SUD clients). The Tele-Pharmacy service will be provided by the Senior Clinical Pharmacist. The Tele-Psychiatry services will be provided by the members of the current Psychiatric Consultation Team at eight FQHCs in Alameda County. These services will help eliminate barriers to timely treatment and assessment of chronic health conditions for AC^3 patients.

				Budget			
				PY2	PY3	PY4	PY5
Infrastructure Expenses	**% of component costs**	**Total**	**Description**				
Equipment necessary to provide Tele-Pharmacy/Psychiatry		$ 34,098	9 Life-size Icon 400 Systems for 9 FQHC Clinics: $2,500 each x 9 = $22,500 2 Life-size Icon 600 Systems for BHCS Tele Conferencing Office: $5,799 each x 2=$11,598		$ 34,098		
TOTAL				**$ -**	**$ 34,098**	**$ -**	**$ -**

ALAMEDA HEALTH CARE SERVICES AGENCY

CATEGORY 2a: SERVICES AND INTERVENTIONS | Discrete Services

#18b Rationale---Psychiatric Consultation for Primary Care Providers

AC^3 patients benefit from strong integration between primary care, mental health services, and substance abuse treatment to remove barriers for accessing appropriate care at the right place and the right time. Therefore, AC^3 will support Alameda County Behavioral Health Care Services (BHCS) in providing a Psychiatric Consultation Program to eight of Alameda County's Federally Qualified Health Centers and two HIV Specialty Care Health Centers. **The BHCS Psychiatric Consultants will provide consultation services only to primary care providers and behavioral health clinicians** needing support in the diagnosis and treatment of mental health and substance use conditions. They will also be available upon request to provide assistance and troubleshooting for clinicians on getting patients into BHCS specialty mental health services or substance use treatment and recovery services. The Psychiatric Consultants help primary care providers and behavioral health clinicians with recommendations regarding alternative treatments and medication management for patients presenting diagnostic or therapeutic challenges. The Psychiatric Consultants also provide psychiatric educational trainings and medication updates to the primary care and behavioral health staff at scheduled Quality Improvement activities and in-service education presentations. All of these activities will build up the capacity of primary care and behavioral health providers at clinics serving AC^3 clients. **These psychiatric consultation services are not providing care to clients, and are therefore not billable by BHCS, the FQHCs, or the HIV Health Centers to Medi-Cal or Ryan White.**

Specific deliverables include:
-- The development of a resource collection of educational training presentations (both Mental Health and SUD topics) for FQHC primary care providers and behavioral health clinicians that build on the trainings presented at the primary care psychiatry program by UC Davis, Psychiatry Department.
-- The participation of Psychiatric consultants in the planning process of the data sharing initiative of the Pilot so that the new technology and workflow systems meet requirements for helping SMI patients get timely access to primary care and SUD providers.
-- Working with the FQHC Medical Directors and BH Directors, Psychiatric Consultants will provide two in-service trainings to primary care clinical staff on how to use screening and tracking tools (PHQ9 , PHQ2, and UNCOPE) in the diagnosis, tracking of a patient's depression severity, and monitor improvement of specific symptoms with treatment.
-- Hiring a Consulting Pharmacist to support the FQHCs and the 5 County operated Adult Community Support Centers, particularly their primary care providers, behavioral health clinicians, patients, and patient family members with medication education, proper prescribing of opiates and psychotropic medications. This will help to expand the impact of the Consulting Psychiatrists.
-- Planning, developing, and implementing Tele-Psychiatry and Tele-Pharmacy systems through Behavioral Health Care Services to provide Safety Net Behavioral Health Clinicians and Primary Care Providers serving the AC^3 target population (homeless, SMI, and SUD clients) timely access to psychiatric and pharmacy consultation services, including drug therapy monitoring consultation, provider consultation on patient counseling, prior authorization and refill authorization for prescription drugs, and monitoring of formulary compliance with the prescribing of psychotropic medications. The Tele-Pharmacy service will be provided by the Senior Clinical Pharmacist. The Tele Psychiatry services will be provided by the members of the current Psychiatric Consultation Team at eight FQHCs in Alameda County. These services will help eliminate barriers to timely treatment and assessment of chronic health conditions for AC^3 patients.
-- Conducting a needs assessment of the need for additional Psychiatric Consultants in the FQHCs in Alameda County, develop a written plan for recruitment and retention of at least 5 new Psychiatric Consultants with SUD skills to work collaboratively with certified Substance Abuse Counselors in the primary care setting.
-- Producing a written report on the effect of placing Psychiatric Consultants in Primary Care services on reducing the level of chronic physical and behavioral health conditions among the WPCP target population

					Budget			
					PY2	PY3	PY4	PY5
Discrete Services								
Service	**Frequency**	**Type of Unit**	**# Units**	**$ per Unit**	**Note: Pharmacist at 0.5 FTE in PY2*			
Individual Curbside Consults	9 / week / FTE	Case Consult	4,050 curbside consults per year (50 weeks) over all 8 Psychiatrists and 1 Pharmacist (3,825 for PY2, 8.5 FTE)	$73.34 ($73.72 PY2)	$281,980	$297,037	$297,037	$297,037
Individual Consultation Chart Review	9 / week / FTE	Case Consult	4,050 chart reviews per year (50 weeks) over all 8 Psychiatrists and 1 Pharmacist (3,825 for PY2, 8.5 FTE)	$73.34 ($73.72 PY2)	$281,980	$297,037	$297,037	$297,037
One on one staff meetings	12 / week / FTE	Case Consult	5,400 group consultations per year (50 weeks) over all 8 Psychiatrists and 1 Pharmacist (5,100 for PY2, 8.5 FTE)	$55.01 ($58.75 PY2)	$281,980	$297,036	$297,036	$297,036
Elbow Support: Non-reimbursable client face-to-face contact alongside primary provider	2.8 / week / FTE	Case Consult	1,260 non-reimbursable client contacts per year (50 weeks) over all 8 Psychiatrists and 1 Pharmacist (1,190 for PY2, 8.5 FTE)	$471.49 ($503.54 PY2)	$563,960	$594,073	$594,073	$594,073
Training Presentation for clinic providers	.5 / week / FTE	Presentation	225 presentations per year (50 weeks) over all 8 Psychiatrists and 1 Pharmacist (213 in PY2, 8.5 FTE)	$1320.16 ($1409.90 PY2)	$281,980	$297,036	$297,036	$297,036
TOTAL					**$ 1,691,880**	**$ 1,782,219**	**$ 1,782,219**	**$ 1,782,219**

Psychiatric Consultation for Primary Care Providers Budget Staffing							
	FTE	Salary & benefits	Role/responsibility				
Psychiatrists	5.0	$ 284,742	Provide Psychiatric consultation to primary care providers and behavioral health clinicians in FQHCs, provide specialized consultation on medication and diagnosis of psychiatric concerns, provide training to primary care providers and behavioral health clinicians to increase their comfort with prescribing psychotropic drugs. Collaboratively develop and refine the program with BHCS leadership to tailor support to needs of the receiving providers.	$ 1,423,710	$ 1,423,710	$ 1,423,710	$ 1,423,710
Director of Integrated Care Services	0.3	$ 187,356	Plans, organizes, and implements the agency's integrated behavioral health services, interacts with FQHC and specialty mental health clinics and SUD providers to ensure timely access of physical health services for SMI and SUD populations	$ 62,452	$ 62,452	$ 62,452	$ 62,452
BH Medical Director	0.1	$ 334,757	Plans and directs the integrated care services and how they interface with the County's physical health system and the contracted mental health providers providing psychiatric support services, provides consultation to staff, provides education for providers, acts as liaison to other service systems	$ 33,476	$ 33,476	$ 33,476	$ 33,476
Admin assistant	0.3	$ 95,658	Provide support to program mangers as well as related staff, program operation, and service delivery	$ 31,886	$ 31,886	$ 31,886	$ 31,886
Management Analyst	0.3	$ 139,401	Plans, designs, and conducts data collection studies that measure the impact of behavioral health programs of patient care of clients with serious mental illness, analyze data with statistical techniques where appropriate to evaluate program services	$ 46,467	$ 46,467	$ 46,467	$ 46,467
Pharmacist	1.0 (.5 in PY2; 1.0 in PY3-5)	$ 180,678	The BHCS Senior Pharmacy Consultant provides timely education, counseling, and follow up for primary care providers, behavioral health clinicians , and patients initiated on new psychotropic medications. The Senior Pharmacy Consultant also collaborates with psychiatrist, behavioral health clinicians, and primary care providers in the evaluation and discussion of optimal treatment strategies for patients presenting diagnostic or therapeutic challenges.	$ 90,339	$ 180,678	$ 180,678	$ 180,678
Operations							
Office supplies and equipment, staff training	$500/FTE			$ 3,050	$ 3,050	$ 3,050	$ 3,050
TOTAL				**$ 1,691,380**	**$ 1,781,719**	**$ 1,781,719**	**$ 1,781,719**

#19 Rationale--- Integrated Behavioral Health Care Coordinators at FQHCs

With the goal of improving continuity of care for AC[3] patients with SMI needing access to primary care services after hospitalizations, we plan to provide a Behavioral Health Care Coordinator in the majority of Alameda County FQHCs. These BH Care Coordinators will help to improve patient tracking, treatment utilization, and accessibility to primary care and behavioral health services for Alameda County residents. They will ensure timely follow-up by assisting with scheduling appointments, and securing patient health information and data for the primary care and behavioral health follow-up appointment within 30 days of discharge.
-- Twelve Care Coordinators will be hired and retained at eight FQHCs to assist patients, behavioral health clinicians, and primary care providers with timely access to care and ensure accurate processing of patient health information
-- A written report will be completed on the impact of BH Care Coordinators upon the Safety Net System in Alameda County by ensuring receipt of essential patient health information for providers and assisting patients in getting more timely access to health care services.

We have determined there is no potential duplication with TCM in this service. IBH care coordinators are not trained case managers, and do not perform the TCM functions; they do not do assessments, develop care plans, or do referrals. The IBH care coordinators provide services associated with the specific clinic they work in, such as facilitating referrals, assisting with scheduling appointments, and securing patient health information and data.

					Budget			
					PY2	PY3	PY4	PY5
Discrete Services								
Service	**Frequency**	**Type of Unit**	**# Units**	**$ per Unit**				
Care Coordination Services, including internal and external referrals	70 / month / FTE	Completed care coordination service for a patient	10,080 completed care coordination services per year over all 12 FTE	$ 102.43	$ 1,032,457	$ 1,032,457	$ 1,032,457	$ 1,032,457
TOTAL					**$ 1,032,457**	**$ 1,032,457**	**$ 1,032,457**	**$ 1,032,457**

Integrated Behavioral Health Care Coordinators at FQHCs Budget
Staffing

	FTE	Salary & benefits	Role/responsibility				
Director of Integrated Care Services	0.3	$ 187,356	Plans, organizes, and implements the agency's integrated BH health services, interacts with FQHC and specialty mental health clinics and SUD providers to ensure timely access of physical health services for SMI and SUD populations	$ 62,452	$ 62,452	$ 62,452	$ 62,452
BH Medical Director	0.1	$ 334,757	Plans, directs the integrated care services and how they interface with the County's physical health system and the contracted mental health providers providing psychiatric support services, provides consultation to staff, provides education for providers, acts as liaison to other service systems	$ 33,476	$ 33,476	$ 33,476	$ 33,476
Program Manager for integrated care services (Project Manager)	0.5	$ 132,419	Ensure timely processing of contracts, implementation of the services, plan and evaluate result of services, administer budgets, monitor achievement of contract goals, provide technical assistance to providers as needed	$ 66,209	$ 66,209	$ 66,209	$ 66,209
Admin assistant	0.3	$ 95,658	Provide Support to program mangers as well as related staff, program operation, and service delivery	$ 31,886	$ 31,886	$ 31,886	$ 31,886
Management Analyst	0.3	$ 139,401	Plan, design, and conduct data collection studies that measure the impact of behavioral health programs of patient care of clients with serious mental illness, analyze data with statistical techniques where appropriate to evaluate program services	$ 46,467	$ 46,467	$ 46,467	$ 46,467
SUBTOTAL (Staff)				**$ 240,490**	**$ 240,490**	**$ 240,490**	**$ 240,490**
Operations							
Office supplies and equipment, staff training	$500/FTE			$ 800	$ 800	$ 800	$ 800
Contracts		**Total**	**Description**				
Contracts for FQHCs to fund 12 full time care coordinators to improve patient tracking, treatment utilization, with focus on both mental health, substance abuse, and physical health for high utilizer populations				$ 791,167	$ 791,167	$ 791,167	$ 791,167
Other Expenses	**% of component costs**	**Total**	**Description**				
SUBTOTAL (Operations)				**$ 791,967**	**$ 791,967**	**$ 791,967**	**$ 791,967**
TOTAL				**$ 1,032,457**	**$ 1,032,457**	**$ 1,032,457**	**$ 1,032,457**

#20a Rationale---Behavioral Health Medical Home Infrastructure Operation

In some cases, AC3 patients may desire or may be best suited to have their complete integrated care rooted in a behavioral health clinic instead of a traditional primary care FQHC. In order to ensure timely access to preventive health services and primary care for clients in this category, AC^3 will support the expansion of infrastructure capacity and the non-clinical infrastructure operations, management, and improvement of primary care services made available within Behavioral Health Treatment Centers in strategic locations. These Centers focus on serving the AC^3 high need SMI clients who are high utilizers of the EDs and have costly hospitalizations due to costly chronic health conditions and barriers to primary care. Specific deliverables include:

-- Open Eden Adult Mental Health, Community Support Center PATH Clinic by June 30, 2017, offering primary care services two days per week to enrolled program participants.

-- Expand Eden Adult Mental Health, Community Support Center PATH Primary Care Clinic to three days per week by March 31, 2018, offering health/wellness education activities, and tobacco education and smoking cessation classes 2 days per week to enrolled program participants.

-- Offer to enrolled patients at Eden Adult Community Support Center on-site SUD counseling and recovery groups to help them address the impact that AOD issues are having on their physical and mental health.

-- Expand Eden Adult Mental Health, Community Support Center PATH Primary Care Clinic to four days per week by December 29, 2020.

				Budget			
				PY2	PY3	PY4	PY5
Staffing							
	FTE	**Salary & benefits**	**Role/responsibility**				
BH Medical Director	0.1	$ 334,757	Assists the BHCS Director of Integrated Care in the building of collaborative relationships with primary care entities through planning expansion of AC^3 infrastructure capacity for medical services in BHCS Mental Health Centers. Monitors the delivery of integrated care services in the County-operated Mental Health Clinics, and how they are interfacing with the County's Specialty Care psychiatry providers, hospital providers, and physical health system providers. The Medical Director also provides consultation to clinicians and education to BHCS staff and providers to promote integration, and acts as liaison to other service systems	$ 33,476	$ 33,476	$ 33,476	$ 33,476

Director of Integrated Care Services	0.3	$ 187,356	Responsible for the visioning, planning, organizing, and implementation of the AC^3 integrated BH primary care services in mental health centers, interacts with FQHCs and specialty mental health clinics and SUD providers to develop robust infrastructure that ensures timely access of physical health services for SMI and SUD populations. The Director is also the liaison to other health and social service systems to identify additional infrastructure needs.	$ 62,452	$ 62,452	$ 62,452	$ 62,452
Financial Services Specialist	0.2	$ 75,513	Provides timely monthly and quarterly financial reports for the BHCS integrated care services to ensure the development of the AC^3 infrastructure of the Behavioral Health Medical Homes is progressing on target. Assist in the preparation of budgets and expenditure reports.	$ 15,102.60	$ 15,102.60	$ 15,102.60	$ 15,102.60
Program Manager for integrated care services (Project Manager)	0.5	$ 132,419	Ensures timely processing of contracts for AC^3 operations and infrastructure development. Assists the Director of Integrated Care to plan and evaluate results of the Behavioral Health Medical Home infrastructure development. Administers budgets, monitors achievement of contract goals, provides technical assistance to providers as needed.	$ 66,209	$ 66,209	$ 66,209	$ 66,209
Admin assistant	0.3	$ 95,658	Provides administrative support to the staff of the BHCS Integrated Care Services on AC^3 infrastructure development. Supports related staff in the Office of the Medical Director to ensure timely completion of operational goals.	$ 31,886	$ 31,886	$ 31,886	$ 31,886

Management Analyst	0.3	$ 139,401	Works collaboratively with infrastructure staff. Plans, designs, and conducts data collection studies that measure the impact integrated services enabled by infrastructure development, analyzes data with statistical techniques where appropriate to evaluate effectiveness and opportunities for improvement. Sets up analytical studies and surveys to measure impact of infrastructure and integrated care on improving access to physical health services and improved health indicators.	$ 46,468	$ 46,468	$ 46,468	$ 46,468
SUBTOTAL (Staff)				**$ 255,594**	**$ 255,594**	**$ 255,594**	**$ 255,594**

Operations							
Office supplies and equipment, staff training	$500/FTE			$ 900	$ 900	$ 900	$ 900
Contracts		**Total**	**Description**				
LifeLong Medical Care		$ 137,655	To provide the non-clinical administrative staffing to operate the infrastructure of a full time satellite primary care clinic service in a BHCS Mental Health Center serving SMI clients in Oakland. The non-clinical staff includes a fulltime Clinic Coordinator, a fulltime Data Coordinator/Admin Assistant, and the part time operational supervision by an Associate Director. The contracted non-clinical staff are integrated with County counterparts to administer clinic operations. The staff is also responsible for ensuring that scheduling and referral processes and infrastructure are in place and effective, making improvements as needed. None of the above non-medical services provided in the BHCS, Oakland PATH Clinic are billable to Medi-Cal.	$ 137,655	$ 137,655	$ 137,655	$ 137,655

Tri-City Health Center		$ 103,500	To provide the non-clinical administrative staffing to operate the infrastructure of a full time satellite primary care clinic service in a BHCS Mental Health Center serving SMI clients in Fremont. The non-clinical staff includes part time Administrative Oversight for clinic infrastructure operations, a fulltime Data Coordinator/Admin Assistant, and the part time operational supervision by an Associate Director. The contracted non-clinical staff are integrated with County counterparts to administer clinic operations. The staff is also responsible for ensuring that scheduling and referral processes and infrastructure are in place and effective, making improvements as needed. None of the above non-medical services provided in the BHCS, Oakland PATH Clinic are billable to Medi-Cal.	$ 103,500	$ 103,500	$ 103,500	$ 103,500
SUBTOTAL (Operations)				**$ 242,055**	**$ 242,055**	**$ 242,055**	**$ 242,055**
TOTAL				**$ 497,649**	**$ 497,649**	**$ 497,649**	**$ 497,649**

#20b Rationale---Behavioral Health Medical Homes - Discrete Services Nurse Care Coordinators

In order to ensure timely access to preventive health services and primary care for those AC^3 patients who desire and are best suited to have their care rooted in a behavioral health clinic, AC^3 will support nurse care coordination made available within the BH Treatment Centers in strategic locations, focusing on serving the high need SMI residents who are high utilizers of the EDs and have costly hospitalizations due to costly chronic health conditions and barriers to primary care.

The clinic-based services provided by the Behavioral Health Nurse Care Coordinators are generally more narrow in scope than those of TCM, and the staff have not been trained for TCM. **However, to account for any potential overlap we have applied a budget adjustment to reduce our request for WPC funds.** We have assumed approximately 25**%** of the population will be served by TCM, and 75**%** will be served by the BH medical home nurse care coordinators. Therefore we are reducing our budget by 25**%.** In addition, clients served will be monitored to ensure that services provided through the Whole Person Care pilot program are not claimed under the TCM program and vice versa.

					Budget			
					PY2	PY3	PY4	PY5
Discrete Services								
Service	**Frequency**	**Type of Unit**	**# Units**	**$ per Unit**				
New Referrals	20 / month / FTE	Coordination Service	720 referrals per year over 3 FTE	$154.35	$111,129	$111,129	$111,129	$111,129
Adjusted to 75% for potential TCM overlap:			540 referrals per year over 3 FTE	$154.35	$83,347	$83,347	$83,347	$83,347
Care Coordination Meetings with Primary Care	4 / month / FTE	Coordination Service	144 meetings per year over 3 FTE	$425.78	$61,313	$61,313	$61,313	$61,313
Adjusted to 75% for potential TCM overlap:			108 meetings per year over 3 FTE	$425.78	$45,984	$45,984	$45,984	$45,984
Clinic Debrief Sessions with Primary Care Team	16 / month / FTE	Coordination Service	567 sessions per year over 3 FTE	$425.78	$241,418	$241,418	$241,418	$241,418
Adjusted to 75% for potential TCM overlap:			At least 425.25 sessions per year over 3 FTE	$425.78	$181,064	$181,064	$181,064	$181,064
Care Coordination meetings with Psychiatrists	2 / month / FTE	Coordination Service	72 meetings per year over 3 FTE	$425.78	$30,656	$30,656	$30,656	$30,656
Adjusted to 75% for potential TCM overlap:			54 meetings per year over 3 FTE	$425.78	$22,992	$22,992	$22,992	$22,992
TOTAL (Sum of 75% adjusted lines)					**$ 333,387**	**$ 333,387**	**$ 333,387**	**$ 333,387**
Behavioral Health Medical Homes - Discrete Services Budget								
Staffing								
	FTE	**Salary & benefit**	**Role/responsibility**					
Nurse Care Coordinators	3	$ 147,672	Provide nursing case management and assessment, monitor patients for significant or serious changes, ensure documentation of interventions, track referrals to specialty care, coordinate with other providers and community agencies, assist patients in accessing health care providers and services		$ 443,016	$ 443,016	$ 443,016	$ 443,016
Operations								
Office supplies and equipment, staff training	$500/FTE				$ 1,500	$ 1,500	$ 1,500	$ 1,500
TOTAL					**$ 444,516**	**$ 444,516**	**$ 444,516**	**$ 444,516**

#20c Rationale---Behavioral Health Medical Homes - Discrete Services Patient Navigators

In order to ensure timely access to preventive health services and primary care for those AC^3 patients who desire and are best suited to have their care rooted in a behavioral health clinic, AC^3 will support patient navigation made available within the BH Treatment Centers in strategic locations, focusing on serving the high need SMI residents who are high utilizers of the EDs and have costly hospitalizations due to costly chronic health conditions and barriers to primary care.

We have determined there is no potential duplication with TCM in this service. IBH navigators are not trained case managers, and do not perform the TCM functions: they do not do assessments, develop care plans, or do referrals. The IBH navigators provide services associated with the specific clinic they work in, and the services they provide are generally not included in TCM, such as peer counseling and supporting primary care teams.

					Budget			
					PY2	PY3	PY4	PY5
Discrete Services								
Service	**Frequency**	**Type of Unit**	**# Units**	**$ per Unit**				
Care Coordination Meetings with Primary Care	4 / month / FTE	Navigation Service	144 meetings per year over 3 FTE	$ 343.90	$49,521	$49,521	$49,521	$49,521
Adjusted to 75% for potential TCM overlap:			108 meetings per year over 3 FTE	$343.90	$37,141	$37,141	$37,141	$37,141
Assist with transport referrals	16 / month / FTE	Navigation Service	567 referrals per year over 3 FTE	$ 131.01	$74,282	$74,282	$74,282	$74,282
Adjusted to 75% for potential TCM overlap:			At least 425.25 referrals per year over 3 FTE	$131.01	$55,712	$55,712	$55,712	$55,712
Coordinate Health and Wellness Classes	16 / month / FTE	Coach/ Counseling Service	567 classes/activities coordinated per year over 3 FTE	$ 131.01	$74,282	$74,282	$74,282	$74,282
Adjusted to 75% for potential TCM overlap:			At least 425.25 classes/activities per year over 3 FTE	$131.01	$55,712	$55,712	$55,712	$55,712
Care Coordination meetings with Psychiatrists	2 / month / FTE	Coordination Service	72 meetings per year over 3 FTE	$ 343.90	$24,761	$24,761	$24,761	$24,761
Adjusted to 75% for potential TCM overlap:			54 meetings per year over 3 FTE	$343.90	$18,571	$18,571	$18,571	$18,571
TOTAL (Sum of 75% adjusted lines)					**$ 167,135**	**$ 167,135**	**$ 167,135**	**$ 167,135**
Behavioral Health Medical Homes - Discrete Services Budget								
Staffing								
	FTE	**Salary & benefit**	**Role/responsibility**					
Patient Navigators/ Community Health Workers	3	$ 73,782	Provide individual and group peer support counseling for patients to get to medical services and participation in health and wellness related activities; provide assistance with care coordination and work with primary care team as needed to support activation of treatment plans for the patient; work with patients and family members		$ 221,346	$ 221,346	$ 221,346	$ 221,346
Operations								
Office supplies and equipment, staff training	$500/FTE				$ 1,500	$ 1,500	$ 1,500	$ 1,500
TOTAL					**$ 222,846**	**$ 222,846**	**$ 222,846**	**$ 222,846**

#21 Rationale---Training and Workforce Development

It is critical to build the skill set of the Alameda County behavioral health and primary care workforce, and to draw skilled new providers toward local provider agencies that serve AC^3 patients, so that they are prepared to provide high quality and culturally responsive care management services to complex AC^3 patients who are high utilizers of health and social services due to multiple chronic health conditions. Training and workforce development will include:

-- Providing clinical education and experience to a selected UCSF Psychiatric Fellow at the BHCS Crisis Response Program or the Trust Clinic. Up to two candidates from the UCSF School of Psychiatry will be selected to be Fellows in either of these two settings. In PY4 and 5, a fellowship position will also be available in the Psychiatric Consultation team providing resources for primary care and behavioral health clinicians at the FQHCs.

-- Sponsoring UC Davis' Collaborative Fellowship Program for primary care providers to receive advanced training in primary care based psychiatry. 9 Primary Care Providers will be enrolled each year (PY2-5) from the Alameda County FQHCs that serve the AC^3 population in a 12 month UC Davis Collaborative for Primary Care Psychiatry Program.

				Budget			
				PY2	PY3	PY4	PY5
Staffing							
	FTE	**Salary & benefits**	**Role/responsibility**				
Workforce Education & Training Manager	0.2	$ 164,592	The BHCS WET Manager is responsible for the planning, development, and leadership of the administration of the workforce, education, and training programs serving mental health and substance staff in the Specialty Behavioral Health System. Develops and evaluates workforce development programs and training services that will improve the skills and competence of staff serving individuals and families impacted by mental illness and substance use disorders.	$ 32,918	$ 32,918	$ 32,918	$ 32,918
Admin Assistant	0.2	$ 93,161	Provide administrative support to program managers and related staff in the timely delivery of workforce development training programs and services to the BHCS employees and contract providers.	$ 18,632	$ 18,632	$ 18,632	$ 18,632

Admin Specialist II	0.2	$ 114,978	Assists in the planning and conducting of operational studies and makes recommendations. Represents the program as a liaison with other County departments, representatives of other public and private organizations, program participants and the public.	$ 22,996	$ 22,996	$ 22,996	$ 22,996
Financial Services Specialist II	0.1	$ 114,978	Provides timely monthly and quarterly financial reports for the BHCS integrated care services. Assist in the preparation of budgets and expenditure reports.	$ 11,498	$ 11,498	$ 11,498	$ 11,498
Training Officer	0.1	$ 156,761	Responsible for the planning, coordination, and development of the training programs that meets the standards, objectives, and policies of BHCS. Collaborates with staff, CBOs, stakeholders, and consultants to identify effective training strategies that address the organization's goals and objectives. Contract with vendors and identifies evidence based practices resources.	$ 15,676	$ 15,676	$ 15,676	$ 15,676
SUBTOTAL (Staff)				**$ 101,720**	**$ 101,720**	**$ 101,720**	**$ 101,720**

Operations							
Office supplies and equipment, staff training	$500/FTE			$ 400	$ 400	$ 400	$ 400
Contracts		**Total**	**Description**				
Alameda Health Consortium contract		$ 450,000	Sponsorship of 9 primary care providers each Program Year to participate in a 12 month intensive training fellowship program to develop behavioral health skills, supporting integrated care at medical homes where AC^3 patients are served	$ 450,000	$ 450,000	$ 450,000	$ 450,000
UCSF		$ 139,050	Sponsorship of two Psychiatry fellows from UC San Francisco to learn and support the infrastructure of the TRUST Clinic, Crisis Response, and/or Psychiatric consultation team that serves AC^3 patients	$ 139,050	$ 139,050	$ 139,050	$ 139,050
SUBTOTAL (Operations)				**$ 589,450**	**$ 589,450**	**$ 589,450**	**$ 589,450**
TOTAL				**$ 691,170**	**$ 691,170**	**$ 691,170**	**$ 691,170**

ALAMEDA HEALTH CARE SERVICES AGENCY

CATEGORY 1c: INFRASTRUCTURE DEVELOPMENT | Incentive Payments for Downstream Providers

#22 Rationale--Capacity Development Incentives for Physical Health Providers - Hepatitis C

To test the care coordination changes we are putting in place, we will need a clinical use case. The new linkages will not be completely tested, and the new interventions not deeply understood among our clinical provider partners unless we can harness them to a health outcome that is important, common in our target populations, measureable both in terms of health impact and in terms of cost savings and of clear life-saving benefit. Hepatitis C meets all of those criteria and will be our Care Coordination Test Case. We chose HCV for our system wide test case for several reasons:

1. HCV is disproportionately experienced by the low income vulnerable populations targeted by AC^3, particularly those who are homeless or who suffer from substance abuse.
2. Alameda County has the fifth highest rate of newly reported chronic Hepatitis C Virus (HCV) cases among local health jurisdictions in the state. Among a group of 4 clinic organizations in our network who have reported data on HCV, only 20-29% of patients in the birth cohort had ever been tested for HCV and the percentage found to be positive of those tested was 10%.
3. HCV can be lethal, and especially for those already suffering from cirrhosis, diagnosis and treatment are literally life-saving.
4. The new HCV treatments are more than twice as effective as old regimens, with a cure rate over 90% in our pilot sites.
5. The new therapies are also by far the highest cost treatment commonly encountered in a primary care setting, so supporting vulnerable populations in adherence to this treatment is a crucial task for stewardship of resources.
6. Availability of HCV treatment in specialty GI clinics is severely limited; the one GI specialty clinic in our safety net system has a waiting list over 8 weeks long and most HCV patients are not being referred.

Building capacity for successful HCV treatment in primary care settings will require coordination with mental health, substance abuse and social supports. Incentives will be made available to safety net medical provider agencies to build up their capacity to provide this lifesaving service to low-income residents in the primary care setting, removing barriers of referral and provision of integrated high quality treatment for AC3 patients. The incentive payments do not pay for the treatment itself. The amount of incentive funds was determined by the likelihood of impact and then tied to organization size; 31 primary care sites will be eligible, 4 of which are associated with the large Public Hospital and Clinic System. The initial effort in PY2 will be the most significant, in order to get the policies and workflows off the ground and into action, and so significant incentive payments are made available in this first year to ensure progress and successful implementation. The following program years will require continued strong attention to improvements in these processes via PDSA cycles so as to increase population penetration, becoming more difficult to close in on the target screening and treatment rates as time goes by, but not quite as much as in PY2. Across all years, it is significantly more difficult to move change and garner necessary attention at the extremely complex public hospital and clinic system compared to the community clinic sites, espcially with multiple competing priorities, so significantly more incentive dollars are allocated to those provider organization sites.

		Total Max Amount of Funding			
		PY2	PY3	PY4	PY5
Incentive Payments					
Deliverables being encouraged	**Entities eligible**				
1. Provide written evidence of the development and strengthening of workflows, documentation standards, follow up strategies, and anecdotal provider experience of performing screening and treatment for Hepatitis C	Community Primary Care Sites - 27 $121,076 each	$ 3,269,051			
	Public Hospital and Clinic System Primary Care Sites - 4 $1,343,944 each	$ 5,375,778			
2. Increase volume of AC[3] patients screened and treated for Hepatitis C. **PY3:** Incentive funds will be paid to those sites that show a 10% decrease in PY3 of the gap between target treatment rate negotiated with each provider agency during PY2 and that clinic site's performance in PY2. **PY4:** Community primary care sites will be paid to maintain treatment rate achieved during PY3. Public Hospital primary care sites will be paid an incentive when another 10% decrease is achieved in the gap between target treatment rate negotiated in PY2 and performance in PY3. **PY5:** Incentive funds will be paid to Community Primary Care sites that show a 10% decrease in PY5 of the gap between target treatment rate negotiated with each provider agency during PY2 and that clinic site's performance in PY4. Incentive funds will be paid to Public Hospital primary care sites that show a **20%** decrease in PY5 of the gap between target treatment rate negotiated with each provider agency during PY2 and that clinic site's performance in PY4.	Community Primary Care Sites - 27 $43,680 each (PY3); $14,051 each (PY4 - maintenance); $51,088 each (PY5 - improvement push)		$ 1,179,367	$ 379,367	$ 1,379,367
	Public Hospital and Clinic System Primary Care Sites - 4 $395,963 each (PY3); $495,963 each (PY4); $845,963 each (PY5)		$ 1,583,852	$ 1,983,852	$ 3,383,852
Total		**$ 8,644,829**	**$ 2,763,219**	**$ 2,363,219**	**$ 4,763,219**

#23 Rationale--Capacity Development Incentives for Physical Health Providers - HEDIS

HEDIS Measures are increasingly the performance metrics of choice among Alameda County's managed care plans and care providers alike. AC3 would like to see improvement in these quality measures across the community primary care practices and public hospital and clinic system to increase the value of care received by AC3 patients. For the provider agencies, this includes gathering staff buy-in, data collection and reporting, and embracing PDSA improvement cycles taught by the AC3 BBO. Baseline data for the broad HEDIS measure set are being collected and analyzed now by the AC3 partner managed care plans. Once that data is available, we will collaboratively select measures for incentivization through an assessment of impact, significance to the MCPs, and the size of the gap from national benchmarks. This work will also routinize a reliance on data to drive attention and effort to quality areas most in need of improvement. The amount of incentive funds was determined by the likelihood of impact and then tied to organization size; 31 primary care sites will be eligible, 4 of which are associated with the large Public Hospital and Clinic System. Across all years, it is significantly more difficult to move change and garner necessary attention at the very complex public hospital and clinic system compared to the community clinic sites, especially with multiple competing priorities, so significantly more incentive dollars are allocated to those provider organization sites.

		Total Max Amount of Funding			
		PY2	PY3	PY4	PY5
Incentive Payments					
Deliverables being encouraged	**Entities eligible**				
1. Improve performance on a growing set of HEDIS measures selected in partnership with the Managed Care Plans, measured by reducing the gap between the NCQA benchmark for our Region IX and performance for AC3 beneficiaries the prior year by at least 10% each year PY3-5. One measure will be selected for improvement during PY3, a second will be added for PY4, and a third will be added for PY5.	Community Primary Care Sites - 27 $80,717 each		$ 2,179,367	$ 2,179,367	$ 2,179,367
	Public Hospital and Clinic System Primary Care Sites - 4 $895,963 each		$ 3,583,852	$ 3,583,852	$ 3,583,852
TOTAL		**$ -**	**$ 5,763,219**	**$ 5,763,219**	**$ 5,763,219**

#24 Rationale--Capacity Development Incentives for Physical Health Providers - Access

Timely access to primary care appointments is a critical component of integrated Whole Person Care, and has been an ongoing challenge in Alameda County's safety net. Although some of our clinic organizations have new and return appointment times within a 10 day benchmark, those with the highest percentage of homeless patients and HUMS uniformly have Third Next Available Appointment (TNAA) times outside that window, ranging from 3 weeks to more than 12. At the Highland outpatient clinic and Eastmont Wellness Center, the two medical homes in Alameda County that provide care to the highest percentage of HUMS, TNAA times are over 90 days and 48 days respectively. Past attempts to purchase expedited access for homeless or SPMI patients to primary care assignment have been problematic to implement and unreliable in terms of application. Therefore, AC^3 will provide incentives to safety net provider agencies to alter systems and workflows so as to increase the appointments available and reduce barriers for patients to obtain them. AC^3 will encourage the collaborative development of measurement strategies and prioritization of improvement tasks. Improvement goals are defined as a reduction of the TNAA gap between baseline and the goal of 10 days by at least 10%.

The Public Hospital and Clinic System experiences the most significant wait times across the County, and also is one of the largest providers of care and has the most complex patient flow, revenue, and administrative landscape to be navigated in order to make improvements. Improvements in access will require changes on many levels of the organization, some of which are clear and some that will require rigorous investigation of the root causes. Therefore, significant dollars have been allocated per site in that system for this incentive to garner the required attention for improvement. This is also an opportunity to expand innovative practices such as eConsult to improve access to specialty care services.

		Total Max Amount of Funding			
		PY2	**PY3**	**PY4**	**PY5**
Incentive Payments					
Deliverables being encouraged					
1. Performance incentive to reduce Third Next Available Appointment by at least 10% of the gap between the goal of 10 days and the rate the prior year each year, or provide evidence of increased numbers of Convenient Care visits easily available when an AC3 client requests it	Select Community-based Primary Care Organizations - 5 $343,750 each organization	$ 1,718,748	$ 1,718,748	$ 1,718,748	$ 1,718,748
2. Performance incentive to reduce Third Next Available Appointment by at least 10% of the gap between the goal of 10 days and the rate the prior year, each year.	Public Hospital and Clinic System Sites - 4 $895,963 each, PY3-5		$ 3,583,852	$ 3,583,852	$ 3,583,852
TOTAL		**$ 1,718,748**	**$ 5,302,600**	**$ 5,302,600**	**$ 5,302,600**

#25 Rationale--Capacity Development Incentives for Physical Health Providers (Population Health)

In an effort to continue transformation of Alameda County's safety net into patient and family centered system of care that promotes wellness, eliminates disparities and optimizes health, the public hospital system will develop the ability to enter into Risk Based Global Prospective Payment contracts at a population level. AC^3 will enhance its key competencies in specific areas of care delivery – Ambulatory Clinics, Acute Care, Behavioral Health, and Post-Acute Care – and supplement the Continuum of Care through contractual relationships with other providers. The system will be supported with a state of the art integrated technology platform, consolidated financial systems, and human resource systems characterized by a Culture of Accountability, providing the public hospital system with the nimbleness to respond rapidly to opportunities and a changing environment.

		Total Max Amount of Funding			
		PY2	PY3	PY4	PY5
Incentive Payments					
Deliverables being encouraged					
1. Implement a population management system through a third party vendor	Public Hospital and Clinic System	$ 583,852			
2. Provide evidence of management reports enabled by the population management system tailored to tiers of medical complexity of AC^3 patients	Public Hospital and Clinic System	$ 1,000,000			
3. Identification and implementation of a minimum of three outreach specific programs (“Population Initiatives”) informed by those risk-tiered population management reports, defined as percentage rates	Public Hospital and Clinic System	$ 1,000,000			
4. Evidence of improvement on at least two of those Population Initiatives by at least 10% over baseline	Public Hospital and Clinic System	$ 1,000,000			
TOTAL		**$ 3,583,852**			

ALAMEDA HEALTH CARE SERVICES AGENCY

CATEGORY 1a: INFRASTRUCTURE DEVELOPMENT | Administrative Infrastructure - Governance for Data Exchange Unit

#26 Rationale-Governance for Data Exchange Unit

The Governance group of the Data Exchange Unit will oversee the workplan and vision for building the Data Exchange Unit. This group will also set priorities, establish accountability and manage the budget for the Data Exchange Unit. It will review and approve regular data monitoring reports required by funder prior to submission, approve recommendations for information system (IS) solutions for day-to-day exchange and reporting, etc., and report and interface with the backbone organization and Steering Committee. The Governance Group will also provide general administrative support to the unit. This group represents the core Executive Leadership, governance and administrative support function of the unit.

The Data Exchange unit is designed to be a contracted unit that is 100% dedicated to WPC Pilot activities only. Stakeholder interviews conducted during the assessment and development of the WPCP program and proposal identified that having locally-based resources to support this work is a key facilitator to successful data exchange. The Data Exchange unit was designed specifically to provide this as well as to establish a consistent and sustainable support structure through the life of the pilot.

						Budget			
						PY2	PY3	PY4	PY5
Staffing (ALL CONTRACTS)									
Title	**FTE**	**Base Salary**	**% bene**	**Contract Amount**	**Role/responsibility**				
Executive Director, Data Transformation	1.0	$ 250,000	1.20	$ 300,000	This position reports to AC[3] executive leadership and will oversee and set priorities as well as establish accountability and manage the budget for the Data Sharing & Analysis Department. This position will review and approve regular data monitoring reports required by funder prior to submission, approve recommendations for information system (IS) solutions for day-to-day exchange and reporting, etc., and interface with the Steering Committee.	$ 300,000	$ 300,000	$ 300,000	$ 300,000
Executive Assistant	1.0	$ 95,000	1.20	$ 114,000	This position will provide administrative support to the Executive Director of Data Transformation (e.g., meeting support, scheduling, etc.).	$ 114,000	$ 114,000	$ 114,000	$ 114,000
Sr. Administrative Assistant	1.0	$ 80,000	1.20	$ 96,000	This position will provide administrative support to the Data Sharing and Analysis Unit.	$ 96,000	$ 96,000	$ 96,000	$ 96,000
SUBTOTAL (Staff)	**3.0**	**$ 425,000**	**1.20**	**$ 510,000**		**$ 510,000**	**$ 510,000**	**$ 510,000**	**$ 510,000**
Operations									
Contracts *(see Staffing)*				**Total**	**Description**				
Other Expenses	**$ Per FTE**			**Total**	**Description**				
Computers and Equipment	$ 1,000			$ 3,000		$ 3,000	$ -	$ -	$ -
Software	$ 500			$ 1,500		$ 1,500	$ 1,500	$ 1,500	$ 1,500
Mailing	$ -			$ -		$ -	$ -	$ -	$ -
Postage	$ -			$ -		$ -	$ -	$ -	$ -

Mileage	$ 1,000			$ 3,000		$ 3,000	$ 3,000	$ 3,000	$ 3,000
Travel	$ 1,000			$ 3,000		$ 3,000	$ 3,000	$ 3,000	$ 3,000
Training	$ -			$ -		$ -	$ -	$ -	$ -
Convenings	$ 500			$ 1,500		$ 1,500	$ 1,500	$ 1,500	$ 1,500
Food	$ 500			$ 1,500		$ 1,500	$ 1,500	$ 1,500	$ 1,500
Outside printing	$ 500			$ 1,500		$ 1,500	$ 1,500	$ 1,500	$ 1,500
VPNs	$ 500			$ 1,500		$ 1,500	$ -	$ -	$ -
Cell phones (equipment)	$ 500			$ 1,500		$ 1,500	$ -	$ -	$ -
Cell phones (service)	$ 600			$ 1,800		$ 1,800	$ 1,800	$ 1,800	$ 1,800
Office Supplies	$ 500			$ 1,500		$ 1,500	$ 1,500	$ 1,500	$ 1,500
Office Expenses (utilities, etc.)	$ 100			$ 300		$ 300	$ 300	$ 300	$ 300
Rent / Lease	$ 3,000			$ 9,000	Annual Total	$ 9,000	$ 9,000	$ 9,000	$ 9,000
SUBTOTAL (Operations)	**$ 10,200**			**$ 30,600**		**$ 30,600**	**$ 24,600**	**$ 24,600**	**$ 24,600**
TOTAL (Group 1)				**$ 540,600**		**$ 540,600**	**$ 534,600**	**$ 534,600**	**$ 534,600**

CATEGORY 1a: INFRASTRUCTURE DEVELOPMENT | Administrative Infrastructure - IS/IT Systems Development for Data Exchange Unit

#27 Rationale-IS/IT Systems Development for Data Exchange Unit

The IS/IT System Development group of the Data Exchange Unit will oversee and set priorities for the IS/IT team of analysts and database administrator. The group will identify at least 2-3 potential vendors and will select and manage the vendor who will build the technology to support the Data Exchange Unit during the pilot. The IS/IT Development group will oversee the following:

- Development of an IS solution for day-to-day data exchange and reporting as well as monitoring processes
- Guidance on reporting standards, management and monitoring data receipt, data quality assurance, and processing of data from multiple data sources for reporting and care coordination purposes
- Development, implementation and maintenance of the database system architecture to support care coordination solutions
- Development of queries to extract data per state required format and execution of data mining activities including automation of data quality assurance efforts
- Implementation and maintenance of dedicated onsite technical support
- Partnerships with locally-based health data analysts to ensure technical requirements are met in a timely manner and all systems can talk to one another

After the development and implementation of the Data Exchange Unit, the focus of this group will be on driving down cycle times to deliver tested, ready-to-deploy interfaces using available tools, and to create logical workflows and alerts to notify of bottlenecks in the exchange process. This group represents the core IT development and support function of the unit.

The Data Exchange unit is designed to be a contracted unit that is 100% dedicated to WPC Pilot activities only. The data exchange unit will be responsible for setting the strategic direction of the IT project, developing and managing the workplan for design and implementation, as well as defining system and functional requirements for the IT solution. They will partner with a vendor who will develop the actual IT solution using a combination of off-the-shelf and customizable products and collaborate with in-house staff to build technical capacity to support the project long-term.

The data exchange unit is designed to provide both planning and implementation support throughout the full life of the pilot. While some of the group's activities may shift as the data exchange environment and tools evolve (particularly between pilot years 3 and 4), data sharing objectives will generally remain the same. The unit will also support participating agencies in making the internal workflow and capacity changes that are essential to successful transformation. Therefore, a steady level of support staffing is required for all 4 years in order for data exchange to be effectively implemented and supported.

Data exchange activities will address two needs simultaneously: a "low-tech" solution that enables data sharing to commence in PY2 (described in deliverable #29 and on p. 66-67 of the application), and assessment and planning for a "hi-tech" data exchange solution to be implemented in PYs 4 and 5. Data from different delivery systems are to be shared using the proposed model shown on application p.85. Initial planning for the "hi-tech" solution will explore infrastructure options where select data from various key delivery systems are uploaded into a limited yet centralized data repository (e.g., a hybrid federated data model, etc.). Ideally, users can then query on this data repository for specific patient data to receive information directly or in some combined format (e.g., customized report, etc). The low-tech methods for exchanging data across systems will involve developing protocols for exchanging critical data via, e.g., frequent exchanges of flat files and reports.

Pilot years 2 and 3: Activities will focus heavily on assessment and planning for the "hi-tech" data exchange solution that includes architecture to facilitate inter-delivery system connectedness, interoperability, and ideally enables the bi-directional sharing of data. Under the direction of the Executive Director, the core IT group will conduct activities necessary for determining and defining clinical workflows, system and functional requirements as well as supporting IT infrastructure needs with a more robust IT solution (e.g., use case group, vendor review and selection, data cleaning and preparation).

Pilot years 4 and 5: Once a more robust IT solution is in place and internal capacity is built, the core IT group's activities will shift from planning and implementation to ongoing database maintenance and support (particularly around work that is typically resource intensive such as duplicate data management and assisting providers as utilization of technology increases at the point-of-care). The IT Project Manager and Database Architect's roles will either dissolve or be reduced to on an as-needed basis. Activities for the data exchange operations group and locally-based analysts will remain the same except they will be trained to use a "hi-tech" solution to support their data exchange needs.

(See p. 85 of the application for a diagram depicting this data flow).

						Budget			
						PY2	PY3	PY4	PY5
Staffing (ALL CONTRACTS)									
Title	**FTE**	**Base Salary**	**% bene**	**Contract Amount**	**Role/responsibility**				
IS/IT Director	1.0	$ 175,000	1.20	$ 210,000	This position reports to the Executive Director of Data Transformation and will be respoinsible for overseeing and setting priorities for the IS/IT team of analysis and the database administrator and analyst. This position will also work with the IS/IT project manager (during initial years of setup) to ensure successful implementation of the data exchange system. This role is also responsible for identifying and recommending the IS solutions to support the data exchange process and reporting.	$ 210,000	$ 210,000	$ 210,000	$ 210,000
IS/IT Project Manager	1.0	$ 150,000	1.20	$ 180,000	This position works with the IS/IT Director to develop, monitor, implement and evaluate implementation plan for IS solutions.	$ 150,000	$ 150,000	$ -	$ -
Database Architect	1.0	$ 175,000	1.20	$ 210,000	This position works closely with the Database Administrator and Sr. Data Visualization Designer to design and recommend system architecture and establish database standards. Post PY3, this position will be contracted on an as needed basis.	$ 175,000	$ 175,000	$ -	$ -
Database Administrator	1.0	$ 125,000	1.20	$ 150,000	This position reports to the Executive Director of Data Transformation and manages the receipt, quality assurance and processing of data from the various data sources. This position will also develop and maintain the system architecture and workflow documentation.	$ 150,000	$ 150,000	$ 150,000	$ 150,000

Senior Interface Architecture/Developer	1.0	$ 125,000	1.20	$ 150,000	This position reports to the IS/IT Director and leads the architecture and development of all Interfaces in the data exchange system (including development, testing, implementing of custom interfaces). This position will focus on driving down cycle times to deliver tested, ready-to deploy interfaces using available tools, create workflows and alerts to notify of bottlenecks, and develop and enforce Standard Operating Procedures for interface development.	$ 150,000	$ 150,000	$ 150,000	$ 150,000
Interface Analyst/Developer	1.0	$ 95,000	1.20	$ 114,000	This position reports to the Sr. Interface Architect/Developer and will analyze interface requirements, develop/test/document and implement standards, troubleshoot and identify issues, and follow and support enhancement of Standard Operating Procedures.	$ 114,000	$ 114,000	$ 114,000	$ 114,000
IT Analyst (locally-based)	4.0	$ 95,000	1.20	$ 456,000	This position reports to the IS/IT Director and is dedicated onsite support for participating entities in the pilot. This position will provide onsite technical support to ensure technical requirements are met in a timely manner, set-up and ensure that connections between the central repository and local systems are successful, support automation of data QA efforts (initial) and coordinate with the Health Data Analyst to ensure business needs are met in a timely manner.	$ 456,000	$ 456,000	$ 456,000	$ 456,000
IT Analyst	1.0	$ 95,000	1.20	$ 114,000	This position reports to the Database Administrator and has the primary function of developing queries to extract data per the state required format. This position will also develop queries for custom reporting/data mining activities.	$ 114,000	$ 114,000	$ 114,000	$ 114,000
SUBTOTAL (Staff)	**11.0**	**$ 1,035,000**	**1.20**	**$ 1,584,000**		**$ 1,519,000**	**$ 1,519,000**	**$ 1,194,000**	**$ 1,194,000**
(Staff, post PY3)	9								

Operations									
Contracts *(see Staffing)*				**Total**	**Description**				
Other Expenses	**$ Per FTE**			**Total**	**Description**				
Computers and Equipment	$ 1,000			$ 11,000		$ 11,000	$ -	$ -	$ -
Software	$ 500			$ 5,500	Reduce costs by 2 FTE PY4-5	$ 5,500	$ 5,500	$ 4,500	$ 4,500
Mailing	$ -			$ -		$ -	$ -	$ -	$ -
Postage	$ -			$ -		$ -	$ -	$ -	$ -
Mileage	$ 1,000			$ 11,000	Reduce costs by 2 FTE PY4-5	$ 11,000	$ 11,000	$ 9,000	$ 9,000
Travel	$ 1,000			$ 11,000	Reduce costs by 2 FTE PY4-5	$ 11,000	$ 11,000	$ 9,000	$ 9,000
Training	$ -			$ -		$ -	$ -	$ -	$ -
Convenings	$ 500			$ 5,500	Reduce costs by 2 FTE PY4-5	$ 5,500	$ 5,500	$ 4,500	$ 4,500
Food	$ 500			$ 5,500	Reduce costs by 2 FTE PY4-5	$ 5,500	$ 5,500	$ 4,500	$ 4,500
Outside printing	$ 500			$ 5,500	Reduce costs by 2 FTE PY4-5	$ 5,500	$ 5,500	$ 4,500	$ 4,500
VPNs	$ 500			$ 5,500		$ 5,500	$ -	$ -	$ -
Cell phones (equipment)	$ 500			$ 5,500		$ 5,500	$ -	$ -	$ -
Cell phone (service)	$ 600			$ 6,600		$ 6,600	$ 6,600	$ 5,400	$ 5,400
Office Supplies	$ 500			$ 5,500	Reduce costs by 2 FTE PY4-5	$ 5,500	$ 5,500	$ 4,500	$ 4,500
Office Expenses (utilities, etc.)	$ 100			$ 1,100		$ 1,100	$ 1,100	$ 1,100	$ 1,100
Rent / Lease	$ 3,000			$ 33,000	Annual Total	$ 33,000	$ 33,000	$ 33,000	$ 33,000
SUBTOTAL (Operations)	**$ 10,200**			**$ 112,200**	**Total for PY2&3; reduce costs by 2 FTE post-PY3**	**$ 112,200**	**$ 90,200**	**$ 80,000**	**$ 80,000**
TOTAL (Group 2)				**$ 1,696,200**		**$ 1,631,200**	**$ 1,609,200**	**$ 1,274,000**	**$ 1,274,000**

#28 Rationale - Permissions Monitoring for Data Exchange Unit

The **Permissions Monitoring** group of the Data Exchange Unit will primarily be responsible for reviewing and approving memorandums of understanding (MOUs), business associate agreements (BAAs) between participating partner entities in the pilot, and all permissions, policies and procedures related to HIPAA compliance affecting or impacted by the pilot. **This group represents the core permission monitoring function of the unit.**

The Permissions Monitoring unit is designed to be a contracted unit that is 100% dedicated to WPC Pilot activities only.

						Budget			
						PY2	PY3	PY4	PY5
Staffing (ALL CONTRACTS)									
Title	**FTE**	**Base Salary**	**% bene**	**Salary & benefits***	**Role/responsibility**				
Legal Counsel (PY2-3)	1.0	$ 150,000	1.20	$ 180,000	This position will report to the Executive Director of Data Transformation and be primarily responsible for ensuring permissions and documentation is in place to ensure compliance with data exchange regulatory guidelines. This position will be reduced to 0.5 FTE PY4-5.	$ 180,000	$ 180,000	$ -	$ -
Legal Counsel (PY4-5)	0.5	$ 150,000	1.20	$ 90,000		$ -	$ -	$ 90,000	$ 90,000
SUBTOTAL (Staff)	**1**	**$ 150,000**	**1.20**	**$ 135,000**		**$ 180,000**	**$ 180,000**	**$ 90,000**	**$ 90,000**
Operations									
Contracts *(see Staffing)*				**Total**	**Description**				
Other Expenses	**$ Per FTE**			**Total**	**Description**				
Computers and Equipment	$ 1,000			$ 1,000		$ 1,000	$ -	$ -	$ -
Software	$ 500			$ 500		$ 500	$ 500	$ 500	$ 500
Mailing	$ -			$ -					
Postage	$ -			$ -					
Mileage	$ 1,000			$ 1,000	Reduce cost by 0.5 FTE PY4-5	$ 1,000	$ 1,000	$ 500	$ 500
Travel	$ 1,000			$ 1,000	Reduce cost by 0.5 FTE PY4-5	$ 1,000	$ 1,000	$ 500	$ 500
Training	$ -			$ -					
Convenings	$ 500			$ 500	Reduce cost by 0.5 FTE PY4-5	$ 500	$ 500	$ 250	$ 250
Food	$ 500			$ 500	Reduce cost by 0.5 FTE PY4-5	$ 500	$ 500	$ 250	$ 250
Outside printing	$ 500			$ 500	Reduce cost by 0.5 FTE PY4-5	$ 500	$ 500	$ 250	$ 250
VPNs	$ 500			$ 500		$ 500	$ -	$ -	$ -
Cell phones (equipment)	$ 500			$ 500		$ 500	$ -	$ -	$ -
Cell phones (service)	$ 600			$ 600		$ 600	$ 600	$ 600	$ 600
Office Supplies	$ 500			$ 500		$ 500	$ 500	$ 500	$ 500
Office Expenses (utilities)	$ 100			$ 100		$ 100	$ 100	$ 100	$ 100
Rent / Lease	$ 3,000			$ 3,000	Annual cost	$ 3,000	$ 3,000	$ 3,000	$ 3,000
SUBTOTAL (Operations)				**$ 10,200**		**$ 10,200**	**$ 8,200**	**$ 6,450**	**$ 6,450**
TOTAL (Group 3)				**$ 145,200**		**$ 190,200**	**$ 188,200**	**$ 96,450**	**$ 96,450**

CATEGORY 1a: INFRASTRUCTURE DEVELOPMENT | Administrative Infrastructure - Data Reporting & Analysis for Data Exchange Unit

#29 Rationale-Data Reporting & Analysis for Data Exchange Unit

The Data Reporting & Analysis group of the Data Exchange Unit will provide regular reporting and feedback to the Executive Director of Data Transformation. The group will develop monitoring processes, provide guidance on reporting standards, work closely with Database Architect and Database Administrator to design analytic plans that feasibly support business and reporting needs, direct the work of local health data analysts, locally-based Health Data Analysts and Sr. Business analyst to support reporting and monitoring needs, maintain the portfolio of final reports, coordinate with IS/IT Analyst to ensure technical needs are met in timely manner, conduct detailed analyses of data for tracking patient/client outcomes (and understanding complex relationships across the population), work with the Permissions Monitoring group to draft policies & procedures (e.g., standard operating procedures) for legal counsel review, and partner with the Capacity Development Institute to developed trainings for end users on use of the data exchange system and workflows. This group represents the core reporting and analysis function for the unit.

Pilot years 2 and 3: In parallel to the work described in deliverable #27, care providers and case managers will exchange data across partner entities in a “low-tech” environment (e.g., slightly modified version of existing data exchange methods, frequent exchanges of flat files and resource-intensive reports, etc). Workflow processes will be refined through PDCA cycles. This work will be led by the Data Exchange Operations Director and supported by locally-based IT and Health Data analysists as well as a Sr. Operations Business Analyst, Data Visualization staff and locally-based Health Data Analysts. (See p. 85 of the application for a diagram depicting this data flow). Care providers and case managers will use a "hi-tech" method for exchanging data once an information system is put in place (estimated PYs 4 and 5).

The Data Reporting and Analysis unit is designed to be a contracted unit that is 100% dedicated to WPC Pilot activities only.

						Budget			
						PY2	PY3	PY4	PY5
Staffing (ALL CONTRACTS)									
Title	**FTE**	**Base Salary**	**% bene**	**Salary & benefits***	**Role/responsibility**				
Data Exchange Operations Director	1.0	$ 175,000	1.20	$ 210,000	This position primarily reports to the Executive Director of Data Transformation and will develop the data monitoring process and provide guidance on reporting standards. This position will also set priorities and manage resources for the group of system and business analysts, data visualization designers and trainers.	$ 210,000	$ 210,000	$ 210,000	$ 210,000
Sr. Data Visualization Designer	1.0	$ 110,000	1.20	$ 132,000	This position will work closely with the Database Architect and Database Administrator to design analytic plans that feasibly support business and reporting requirements. This position will also direct the work of local health data analysts to ensure the appropriate data are being captured. This position will generate and prepare analysis results from locally-based Health Data Analysts and Sr. Business Analyst for end-users (both required and ad hoc requests) and will be the primary contact for the portfolio of reports.	$ 132,000	$ 132,000	$ 132,000	$ 132,000

	2.0	$ 110,000	1.20	$ 264,000	This position will report to the Sr. Data Visualization Designer and willprovide dedicated onsite support to ensure business requirements are met in a timely manner. This position will conduct detailed analyses of data for tracking patient/client outcomes, troubleshoot data quality, cleansing and prep needs, manage ongoing and ad hoc data reporting, and coordinate workflows with their IS/IT Analyst counterpart to ensure technical needs are met in a timely manner.	$ 264,000	$ 264,000	$ 264,000	$ 264,000
Health Data Analyst	2.0	$ 110,000	1.20	$ 264,000		$ 264,000			
Sr. Operations Business Analyst	1.0	$ 110,000	1.20	$ 132,000	This position reports directly to the Data Exchange Operations Director and acts as an executive consultant to support various needs within the Data Reporting & Analysis and Permissions group (e.g., draft policies & procedures for legal counsel review, develop QA reports for Executive Director and Steering Committee, etc.).	$ 132,000	$ 132,000	$ 132,000	$ 132,000
Trainers	0.5	$ 110,000	1.20	$ 66,000	This position will partner with the Capacity Development Institute to develop and train system end users and carry out PDSA processes.	$ 66,000			
*Assume 20% of base salary for benefits									
SUBTOTAL (Staff)	**7.5**			**$ 1,068,000**		**$ 1,068,000**	**$ 738,000**	**$ 738,000**	**$ 738,000**

Operations									
Contracts *(see Staffing)*				**Total**	**Description**				
Other Expenses	**$ Per FTE**			**Total**	**Description**				
Computers and Equipment	$ 1,000			$ 7,500		$ 7,500	$ -	$ -	$ -
Software	$ 500			$ 3,750		$ 3,750	$ 3,750	$ 3,750	$ 3,750
Mailing	$ -			$ -		$ -	$ -	$ -	$ -
Postage	$ -			$ -		$ -	$ -	$ -	$ -
Mileage	$ 1,000			$ 7,500		$ 7,500	$ 7,500	$ 7,500	$ 7,500
Travel	$ 1,000			$ 7,500		$ 7,500	$ 7,500	$ 7,500	$ 7,500
Training	$ -			$ -		$ -	$ -	$ -	$ -
Convenings	$ 500			$ 3,750		$ 3,750	$ 3,750	$ 3,750	$ 3,750
Food	$ 500			$ 3,750		$ 3,750	$ 3,750	$ 3,750	$ 3,750
Outside printing	$ 500			$ 3,750		$ 3,750	$ 3,750	$ 3,750	$ 3,750
VPNs	$ 500			$ 3,750		$ 3,750	$ -	$ -	$ -
Cell phones (equipment)	$ 500			$ 3,750		$ 3,750	$ -	$ -	$ -
Cell phones (service)	$ 600			$ 4,500		$ 4,500	$ 4,500	$ 4,500	$ 4,500
Office Supplies	$ 500			$ 3,750		$ 3,750	$ 3,750	$ 3,750	$ 3,750
Office Expenses	$ 100			$ 750		$ 750	$ 750	$ 750	$ 750
Rent / Lease	$ 3,000			$ 22,500		$ 22,500	$ 22,500	$ 22,500	$ 22,500
SUBTOTAL (Operations)	**$ 10,200**			**$ 76,500**		**$ 76,500**	**$ 61,500**	**$ 61,500**	**$ 61,500**
TOTAL (Group 4)				**$ 1,144,500**		**$ 1,144,500**	**$ 799,500**	**$ 799,500**	**$ 799,500**

ALAMEDA HEALTH CARE SERVICES AGENCY

CATEGORY 1c: INFRASTRUCTURE DEVELOPMENT | Incentive Payments for Downstream Providers

#30 Rationale--Capacity Development Incentives for Physical Health Providers - Data Quality Improvements

The public hospital system and its associated clinics are a major provider not only of primary care, but also specialty care, inpatient care, and emergency services for the AC^3 population. To achieve the seamless care coordinating and data sharing goals of the AC^3, it is essential that the data provided by this critical organization is complete, of extremely high quality, and available in a timely manner. AC^3 will incentivize this organization regarding data cleaning, quality assurance, and improving data integrity around key fields that enable providers and care managers to make the necessary connections to administer appropriate, timely, and efficient care and referrals. Specific incentive areas will include:

-- Timely data submission to the overarching data sharing system connecting providers across the County caring for AC3 patients, throughout the stages of that system's development

-- Increased accuracy of collecting housing status at time of visit, particularly for psychiatric encounters. This too includes development, testing, implementation, and improvement of a protocol through PDSA processes.

-- Consistent identification of the primary care provider and medical home for every AC^3 patient who receives any type of care from the public hospital and clinic system, visible in their EHR to all departments in the organization. This applies to those AC^3 beneficiaries who are assigned inside and outside of the organization. Steps include development, testing, implementation, and improvement of a protocol to assign PCP and medical home that is understood and used across all department through PDSA processes.

		Total Max Amount of Funding			
		PY2	**PY3**	**PY4**	**PY5**
Incentive Payments					
Deliverables being encouraged					
1. Timely data submission (monthly, unless frequency determined to be otherwise through data sharing system planning)	Public Hospital and Clinic System	$ 481,926	$ 481,926	$ 481,926	$ 481,926
2. Provide evidence of improvement in collection and electronic documentation of housing status by reducing the percentage of patients seen with housing status as "unknown" by at least 20% over the prior year in PY2 for the psychiatric hospital, and then by all four ambulatory sites for PY3-5 by at least 10% over the prior year	Public Hospital and Clinic System	$ 1,000,000	$ 500,000	$ 500,000	$ 500,000
3. Provide evidence of improvement in collection and electronic documentation of Primary Care Provider and Primary Care Medical home, whether inside or outside of the public hospital and clinic system, by reducing the percentage of those patients seen with these EHR fields that are blank or "unknown" by at least 10% compared to the prior year	Public Hospital and Clinic System		$ 500,000	$ 500,000	$ 500,000
TOTAL		**$ 1,481,926**	**$ 1,481,926**	**$ 1,481,926**	**$ 1,481,926**

ALAMEDA HEALTH CARE SERVICES AGENCY

CATEGORY 1a: INFRASTRUCTURE DEVELOPMENT | Administrative Infrastructure

#31 Rationale-- AC^3 Back Bone Organization (BBO)

Infrastructure for the back bone organization (BBO) performs centralized program management, including biannual reporting (compiling, auditing, and making reports) and communication with the California Department of Health Care Services (DHCS). The BBO develops and supports a culture of mutual accountability and collaboration with approximately 50 partner entities or downstream providers. The BBO assembles a network of downstream providers that represents 80% of our target populations. The central program management office will provide a mechanism for partnership entity consultation through committees and work groups. There will be four governance entities managed through the BBO: 1) a governance group directed toward ensuring performance of AC3, 2) a Steering Committee (SC) , 3) an Operations Work Group (OWG) to conduct cross-organizational problem solving, and 4) a Clinical Integration Work Group (CIWG) designed to keep the program focused on patient experience and Plan Do Study Act (PDSA) cycles. Each of these groups is based on an existing working group that will be enhanced to include and focus on the AC3. The BBO will lead planning, collect consumer input, and manage consumer involvement at a high level. Core program standards are required for the implementation of standardized care management protocols with AC3 target populations in multiple sites. The SC and CIWG will develop core program standards in consultation with subject matter experts (SMEs). Partner entities will receive training on care management protocols and Results Based Accountability (RBA) through the efforts of the Skill Development and Quality Improvement (SDQI) division.

The BBO is a dedicated unit, designed to ensure the intensive investment in whole person care is successful and has lasting impact. 100% of FTE listed below are dedicated to the AC3 whole person care pilot. With the exception of the Medical Director, all positions are new hires.

				Budget			
				PY2	PY3	PY4	PY5
Staffing							
	FTE	**Salary & benefits**	**Role/responsibility**				
AC^3 Director (Medical Director)	0.75	$ 212,438	Clinical oversight, direction, and management of all aspects of program. Clinical oversight, direction, and management of all aspects of program	$ 212,438	$ 212,438	$ 212,438	$ 212,438
Deputy Director	1	$ 202,500	Supervises Program Development Director; leads partner entity consultation; responsible for overall coordination of interlocking change efforts. Responsible for oversight and management of program areas	$ 202,500	$ 202,500	$ 202,500	$ 202,500
Administrative Assistant	1	$ 96,000	Administrative support of Medical Director and Deputy Director	$ 96,000	$ 96,000	$ 96,000	$ 96,000
Scheduler	1	$ 75,000	Maintain schedule for team and partner meetings	$ 75,000	$ 75,000	$ 75,000	$ 75,000
Management Analyst	1	$ 186,000	Project management and continuous tracking of AC^3 activities and objectives. Supports grant monitoring and both narrative and quantitative aspects of grant reporting.	$ 186,000	$ 186,000	$ 186,000	$ 186,000

Community Relations and Member Outreach Program Specialist	1	$ 135,000	Manages and collects consumer input via attendance at consumer committee meetings, organizing focus groups, and other consumer engagement activities	$ 135,000	$ 135,000	$ 135,000	$ 135,000
Information Systems Specialist	1	$ 120,000	Technical support for BBO staff	$ 120,000	$ 120,000	$ 120,000	$ 120,000
Recruitment Specialist	1	$ 148,824	Coordination of recruitment functions	$ 148,824	$ 148,824	$ 148,824	$ 148,824
Human Resources Technician	1	$ 103,500	Assistance with hiring process	$ 103,500	$ 103,500	$ 103,500	$ 103,500
Specialist Clerk II	1	$ 77,805	Recruitment for staffing AC^3--go to 50% FTE in PY 4&5	$ 105,000	$ 105,000	$ 52,500	$ 52,000
SUBTOTAL (Staff)	**9.75**	**1,357,067**		**$ 1,384,262**	**$ 1,384,262**	**$ 1,331,762**	**$ 1,331,262**
Operations							
Contracts		**Total**	**Description**				
Other Expenses	**$ Per FTE**	**Total**	**Description**				
Computers and Equipment							
Software							
Mailing							
Postage							
Mileage							
Travel							
Training							
Convenings							
Food							
Outside printing							
VPNs							
Cell phones							
Office Supplies							
Office Expenses							
Rent / Lease							
SUBTOTAL (Operations)							

TOTAL							
				Budget			
				PY2	PY3	PY4	PY5
Other Expenses							
HR Expenses		$ 50,000					
	$ Per FTE	**Description**					
One-time Start-up Operations Budget							
Computers and Equipment	$ 1,214	Computers		$ 11,839.29			
Software	$ 1,071	Specialized software license (MS Projct, Visio, Adobe Distiller).		$ 10,446.43			
Office Supplies	$ 952	Initial offices supplies for admin staff and on-going offices supplies		$ 9,285.71			
Furniture	$ 7,524	Cubicle/office configuration for staff. Design, furniture, installation. $7K/FTE; plus Conference and Breakroom,		$ 73,357.14			
Communications	$ 1,429	Set-up and phone system (phones, data racks, network drops, cabling, and installation)		$ 13,928.57			
Office set-up	$ 238	Moving Expenses for Property & Salvage		$ 2,321.43			
SUBTOTAL (Start-up Operations)	**$ 12,429**			**$ 121,178.57**			

Ongoing Operations Budget	$ Per FTE	Description				
Computers and Equipment	$ 357	PY2-PY5 allocate 5 computers/year	$ 3,482	$ 3,482	$ 3,304	$ 3,304
Software	$ 119	Specialized software license (MS Project, Visio, Adobe Distiller). Yearly license & maintanence fees	$ 1,161	$ 1,161	$ 1,101	$ 1,101
Cell phones	$ 476	Verizon - voice and data	$ 4,643	$ 4,643	$ 4,405	$ 4,405
VPNs	$ 476	Verizon - USB remote access USB modem	$ 4,643	$ 4,643	$ 4,405	$ 4,405
Mailing & Postage	$ 167	Postage for internal/external communications, newsletters, courier services	$ 1,625	$ 1,625	$ 1,542	$ 1,542
Travel	$ 1,429	Travel and accomodations for out-of-town conferences, events	$ 13,929	$ 13,929	$ 13,214	$ 13,214
Mileage	$ 714	Work travel to meetings, conf, outreach events, etc	$ 6,964	$ 6,964	$ 6,607	$ 6,607
Training	$ 1,667	Conference and training registration for Admin staff	$ 16,250	$ 16,250	$ 15,417	$ 15,417
Food	$ 1,905	Catered food for outreach and training meetings	$ 18,571	$ 18,571	$ 17,619	$ 17,619
Outside printing	$ 1,429	Brochures, posters, education/training materials	$ 13,929	$ 13,929	$ 13,214	$ 13,214
Office Supplies	$ 714	Offices supplies for admin staff and on-going offices supplies	$ 6,964	$ 6,964	$ 6,607	$ 6,607
Office Expenses	$ 286	Room rental fees (for training, meeting/events), ATT phone conf services, non-office expenses (Ergo equipment, assessments)	$ 2,786	$ 2,786	$ 2,643	$ 2,643
Transportation	$ -	N/A				
Furniture	$ 476	Cubicle/office and Conference and Breakroom, Yearly maintanence	$ 4,643	$ 4,643	$ 4,405	$ 4,405
Communications	$ 238	Phone system (phones, data racks, network drops, cabling, and installation) yearly maintanence	$ 2,321	$ 2,321	$ 2,202	$ 2,202
Office set-up	$ 238	Moving Expenses for Property & Salvage	$ 2,321	$ 2,321	$ 2,202	$ 2,202
Rent / Lease (of copiers)	$ 857	Konica lease of multi-functional devices (scan, copier, fax, and printer). $9K/machine/year. 2 machines	$ 8,357	$ 8,357	$ 7,929	$ 7,929
Rent / Lease (of building/space)	$ 12,476	Based on actuals. BMD Charges, total sq feet ($38.67/sq ft). Annual space cost/Employee	$ 121,643	$ 121,643	$ 115,405	$ 115,405
SUBTOTAL (Ongoing Operations)	**$ 24,024**		**$ 234,232**	**$ 234,232**	**$ 222,220**	**$ 222,221**
			PY2 includes "HR expenses" @ 50,000			
TOTAL BBO			**$ 1,789,672**	**$ 1,618,494**	**$ 1,553,982**	**$ 1,553,483**

#32 Rationale - Health Care System Planning and Improvement (HCSPI)

The Health Care System Planning and Improvement (HCSPI) division is focused on the establishment of an infrastructure for the AC3. HCSPI collaborates with Managed Care Plans (MCPs) & Provider Affairs and is responsible for organizing the cross-organizational cooperation necessary for the development of: 1) the CB-CME network and associated service bundles, 2) the care coordination system and 3) crisis system reorganization efforts. HCSPI oversees communications and works with MCPs to monitor contracts.

100% of FTE listed below are dedicated to the AC3 whole person care pilot. All positions are new hires.

				Budget			
				PY2	PY3	PY4	PY5
Staffing							
	FTE	**Salary & benefits**	**Role/responsibility**				
Program Development Director	1	$ 181,500	Responsible for managing the AC^3 care coordination system and CB-CME network, crisis system reorganization, and communications efforts. Manages strategic planning, partnership development, and capacity development	$ 181,500	$ 181,500	$ 181,500	$ 181,500
Administrative Assistant	1	$ 96,000	Administrative support for Program Development Director	$ 96,000	$ 96,000	$ 96,000	$ 96,000
Senior management analyst	1	$ 147,000	Responsible for crisis system reorganization deliverables, coordinating resources and ensuring alignment	$ 147,000	$ 147,000	$ 147,000	$ 147,000
Outreach Coordinator	1	$ 127,500	Outreach and input coordination as part of crisis system reorganization	$ 127,500	$ 127,500	$ 127,500	$ 127,500
SUBTOTAL (Staff)	**4**	**$ 552,000**					
Operations							
One-time Start-up Operations Budget	**$ Per FTE**	**Description**					
Computers and Equipment	$ 1,214	Computers		$ 4,857			
Software	$ 1,071	Specialized software license (MS Projct, Visio, Adobe Distiller).		$ 4,286			
Office Supplies	$ 952	Initial office supplies for admin staff and on-going office supplies		$ 3,810			
Furniture	$ 7,524	Cubicle/office configuration for staff. Design, furniture, installation. $7K/FTE; plus Conference and Breakroom,		$ 30,095			
Communications	$ 1,429	Set-up and phone system (phones, data racks, network drops, cabling, and installation)		$ 5,714			
Office set-up	$ 238	Moving Expenses for Property & Salvage		$ 952			
SUBTOTAL (Start-up Operations)	**$ 12,429**			**$ 49,714**			

			Budget			
			PY2	PY3	PY4	PY5
Ongoing Operations Budget	**$ Per FTE**	**Description**				
Computers and Equipment	$ 357	PY2-PY5 allocate 5 computers/year	$ 1,429	$ 1,429	$ 1,429	$ 1,429
Software	$ 119	Specialized software license (MS Projct, Visio, Adobe Distiller). Yearly license & maintanence fees	$ 476	$ 476	$ 476	$ 476
Cell phones	$ 476	Verizon - voice and data	$ 1,905	$ 1,905	$ 1,905	$ 1,905
VPNs	$ 476	Verizon - USB remote access USB modem	$ 1,905	$ 1,905	$ 1,905	$ 1,905
Mailing & Postage	$ 167	Postage for internal/external communications, newsletters, courier services	$ 667	$ 667	$ 667	$ 667
Travel	$ 1,429	Travel and accomodations for out-of-town conferences, events	$ 5,714	$ 5,714	$ 5,714	$ 5,714
Mileage	$ 714	Work travel to meetings, conf, outreach events, etc	$ 2,857	$ 2,857	$ 2,857	$ 2,857
Training	$ 1,667	Conference and training registration for Admin staff	$ 6,667	$ 6,667	$ 6,667	$ 6,667
Food	$ 1,905	Catered food for outreach and training meetings	$ 7,619	$ 7,619	$ 7,619	$ 7,619
Outside printing	$ 1,429	Brochures, posters, education/training materials	$ 5,714	$ 5,714	$ 5,714	$ 5,714
Office Supplies	$ 714	Offices supplies for admin staff and on-going offices supplies	$ 2,857	$ 2,857	$ 2,857	$ 2,857
Office Expenses	$ 286	Room rental fees (for training, meeting/events), ATT phone conf services, non-office expenses (Ergo equipment, assessments)	$ 1,143	$ 1,143	$ 1,143	$ 1,143
Transportation	$ -	N/A				
Furniture	$ 476	Cubicle/office and Conference and Breakroom, Yearly maintanence	$ 1,905	$ 1,905	$ 1,905	$ 1,905
Communications	$ 238	Phone system (phones, data racks, network drops, cabling, and installation) yearly maintanence	$ 952	$ 952	$ 952	$ 952
Office set-up	$ 238	Moving Expenses for Property & Salvage	$ 952	$ 952	$ 952	$ 952
Rent / Lease (of copiers)	$ 857	Konica lease of multi-functional devices (scan, copier, fax, and printer). $9K/machine/year. 2 machines	$ 952	$ 952	$ 952	$ 952
Rent / Lease (of building/space)	$ 12,476	Based on actuals. BMD Charges, total sq feet ($38.67/sq ft). Annual space cost/Employee	$ 49,905	$ 49,905	$ 49,905	$ 49,905
SUBTOTAL (Ongoing Operations)	**$ 24,024**		**$ 93,619**	**$ 93,619**	**$ 93,619**	**$ 93,619**

Contracts		**Total**	**Description**				
Other Expenses	**$ Per FTE**	**Total**	**Description**				

Computers and Equipment							
Software							
Mailing							
Postage							
Mileage							
Travel							
Training							
Convenings							
Food							
Outside printing							
VPNs							
Cell phones							
Office Supplies							
Office Expenses							
Rent / Lease							
SUBTOTAL (Operations)							
TOTAL HCSPI				**$ 695,333**	**$ 645,619**	**$ 645,619**	**$ 645,619**

#33 Rationale--Communications and Change Management

The communications and change management team will be responsible for internal and external communication and will build consensus and awareness around the vision of AC3. The communications manager will manage social media, produce materials as models are refined, and harvest information for dissemination to external partners. Regular multi-channel communication between and among provider organizations and partner entities will promote understanding of the program's vision, aid in change management efforts, furnish relevant updates on progress and program strategy, and disseminate local best practices. The communications team will serve to develop a network-wide sense of participation in an important and transformative program.

100% of FTE listed below are dedicated to the AC3 whole person care pilot. All positions are new hires.

				Budget			
				PY2	PY3	PY4	PY5
Staffing							
	FTE	**Salary & benefits**	**Role/responsibility**				
Communications Manager	1	$ 130,500	Oversees internal and external communication; builds consensus and awareness around vision of AC^3, manages social media, produces materials as models are refined, and harvests information for dissemination to external partners	130,500	130,500	130,500	130,500
Communications Assistant	0.5	$ 61,000	Assistant to Communications Manager	$ 61,000	$ 61,000	$ 61,000	$ 61,000
SUBTOTAL (Staff)		**$ 191,500**		**$ 191,500**	**$ 191,500**	**$ 191,500**	**$ 191,500**

One-time Start-up Operations Budget	**$ Per FTE**	**Description**	PY2	PY3	PY4	PY5
Computers and Equipment	$ 1,214	Computers	$ 1,821			
Software	$ 1,071	Specialized software license (MS Project, Visio, Adobe Distiller).	$ 1,607			
Office Supplies	$ 952	Initial offices supplies for admin staff and on-going offices supplies	$ 1,429			
Furniture	$ 7,524	Cubicle/office configuration for staff. Design, furniture, installation. $7K/FTE; plus Conference and Breakroom,	$ 11,286			
Communications	$ 1,429	Set-up and phone system (phones, data racks, network drops, cabling, and installation)	$ 2,143			
Office set-up	$ 238	Moving Expenses for Property & Salvage	$ 357			
SUBTOTAL (Start-up Operations)	**$ 12,429**		**$ 18,643**			

Ongoing Operations Budget	$ Per FTE	Description				
Computers and Equipment	$ 357	PY2-PY5 allocate 5 computers/year	$ 536	$ 536	$ 536	$ 536
Software	$ 119	Specialized software license (MS Projct, Visio, Adobe Distiller). Yearly license & maintanence fees	$ 179	$ 179	$ 179	$ 179
Cell phones	$ 476	Verizon - voice and data	$ 714	$ 714	$ 714	$ 714
VPNs	$ 476	Verizon - USB remote access USB modem	$ 714	$ 714	$ 714	$ 714
Mailing & Postage	$ 167	Postage for internal/external communications, newsletters, courier services	$ 250	$ 250	$ 250	$ 250
Travel	$ 1,429	Travel and accomodations for out-of-town conferences, events	$ 2,143	$ 2,143	$ 2,143	$ 2,143
Mileage	$ 714	Work travel to meetings, conf, outreach events, etc	$ 1,071	$ 1,071	$ 1,071	$ 1,071
Training	$ 1,667	Conference and training registration for Admin staff	$ 2,500	$ 2,500	$ 2,500	$ 2,500
Food	$ 1,905	Catered food for outreach and training meetings	$ 2,857	$ 2,857	$ 2,857	$ 2,857
Outside printing	$ 1,429	Brochures, posters, education/training materials	$ 2,143	$ 2,143	$ 2,143	$ 2,143
Office Supplies	$ 714	Offices supplies for admin staff and on-going offices supplies	$ 1,071	$ 1,071	$ 1,071	$ 1,071
Office Expenses	$ 286	Room rental fees (for training, meeting/events), ATT phone conf services, non-office expenses (Ergo equipment, assessments)	$ 429	$ 429	$ 429	$ 429
Transportation	$ -	N/A				
Furniture	$ 476	Cubicle/office and Conference and Breakroom, Yearly maintanence	$ 714	$ 714	$ 714	$ 714
Communications	$ 238	Phone system (phones, data racks, network drops, cabling, and installation) yearly maintanence	$ 357	$ 357	$ 357	$ 357
Office set-up	$ 238	Moving Expenses for Property & Salvage	$ 357	$ 357	$ 357	$ 357
Rent / Lease (of copiers)	$ 857	Konica lease of multi-functional devices (scan, copier, fax, and printer). $9K/machine/year. 2 machines	$ 1,286	$ 1,286	$ 1,286	$ 1,286
Rent / Lease (of building/space)	$ 12,476	Based on actuals. BMD Charges, total sq feet ($38.67/sq ft). Annual space cost/Employee	$ 18,714	$ 18,714	$ 18,714	$ 18,714
SUBTOTAL (Ongoing Operations)	**$ 24,024**		**$ 36,036**	**$ 36,035**	**$ 36,035**	**$ 36,035**
TOTAL Communications and Change Management			**$ 246,178**	**$ 227,535**	**$ 227,535**	**$ 227,535**

#34 Rationale - Care Coordination System Oversight (CCSO)

Care Coordination System Oversight (CCSO) is responsible for the production and monitoring of regulatory standards for AC3, via collaboration with Managed Care Plans (MCPs) and Provider Affairs. The convening of associated work groups is supported by HCSPI. The overall goal for CCS division is to align program design with Medi-Cal benefit requirements. This division is responsible for keeping the AC3 program up to date with regulatory and payment changes. In order to ensure patient connection with provider organizations, 24-hour on-call face-to-face services for AC3 patient who present in crisis will be provided under this division. CCS is also responsible for the development and refinement of the AC3 care management model. This will include delegation oversight as well as oversight of patient complaint and grievance processes at the MCPs. This division also serves to build the Health Care Services Agency's expertise to be able to effectively monitor the Managed Care system.

100% of FTE listed below are dedicated to the AC3 whole person care pilot. All positions are new hires.

				Budget			
				PY2	PY3	PY4	PY5
Staffing							
	FTE	**Salary & benefits**	**Role/responsibility**				
Care Coordination System Oversight Director	1	181,500	Responsible for managing relationships with MCPs and Provider Affairs	181,500	181,500	181,500	181,500
Administrative Assistant	0.5	64,000	Administrative support for the Care Coordination Services Director	64,000	64,000	64,000	64,000
Delivery Oversight Manager	1	$ 120,000	Reviews data and conducts field visits	$ 120,000	$ 120,000	$ 120,000	$ 120,000
SUBTOTAL (Staff)	**2.5**	**$ 365,500**		**$ 365,500**	**$ 365,500**	**$ 365,500**	**$ 365,500**
Operations							
24/7/365 On-Call Connection to Care Coordination		Supplement existing Community Health Worker staff at a CB-CME-like entity to provide this service. 6,656 overnight/weekend/holiday hours at $4.40/hour		$29,286	$29,286	$29,286	$29,286
One-time Start-up Operations Budget	**$ Per FTE**	**Description**					
Computers and Equipment	$ 1,214	Computers		$ 3,036			
Software	$ 1,071	Specialized software license (MS Projct, Visio, Adobe Distiller).		$ 2,679			
Office Supplies	$ 952	Initial offices supplies for admin staff and on-going offices supplies		$ 2,381			
Furniture	$ 7,524	Cubicle/office configuration for staff. Design, furniture, installation. $7K/FTE; plus Conference and Breakroom,		$ 18,810			
Communications	$ 1,429	Set-up and phone system (phones, data racks, network drops, cabling, and installation)		$ 3,571			
Office set-up	$ 238	Moving Expenses for Property & Salvage		$ 595			

SUBTOTAL (Start-up Operations)	$	12,429		$	31,071	

Ongoing Operations Budget	$ Per FTE	Description				
Computers and Equipment	$ 357	PY2-PY5 allocate 5 computers/year	$ 893	$ 893	$ 893	$ 893
Software	$ 119	Specialized software license (MS Project, Visio, Adobe Distiller). Yearly license & maintanence fees	$ 298	$ 298	$ 298	$ 298
Cell phones	$ 476	Verizon - voice and data	$ 1,190	$ 1,190	$ 1,190	$ 1,190
VPNs	$ 476	Verizon - USB remote access USB modem	$ 1,190	$ 1,190	$ 1,190	$ 1,190
Mailing & Postage	$ 167	Postage for internal/external communications, newsletters, courier services	$ 417	$ 417	$ 417	$ 417
Travel	$ 1,429	Travel and accomodations for out-of-town conferences, events	$ 3,571	$ 3,571	$ 3,571	$ 3,571
Mileage	$ 714	Work travel to meetings, conf, outreach events, etc	$ 1,786	$ 1,786	$ 1,786	$ 1,786
Training	$ 1,667	Conference and training registration for Admin staff	$ 4,167	$ 4,167	$ 4,167	$ 4,167
Food	$ 1,905	Catered food for outreach and training meetings	$ 4,762	$ 4,762	$ 4,762	$ 4,762
Outside printing	$ 1,429	Brochures, posters, education/training materials	$ 714	$ 714	$ 714	$ 714
Office Supplies	$ 714	Offices supplies for admin staff and on-going offices supplies	$ 1,786	$ 1,786	$ 1,786	$ 1,786
Office Expenses	$ 286	Room rental fees (for training, meeting/events), ATT phone conf services, non-office expenses (Ergo equipment, assessments)	$ 714	$ 714	$ 714	$ 714
Transportation	$ -	N/A				
Furniture	$ 476	Cubicle/office and Conference and Breakroom, Yearly maintanence	$ 1,190	$ 1,190	$ 1,190	$ 1,190
Communications	$ 238	Phone system (phones, data racks, network drops, cabling, and installation) yearly maintanence	$ 595	$ 595	$ 595	$ 595
Office set-up	$ 238	Moving Expenses for Property & Salvage	$ 595	$ 595	$ 595	$ 595
Rent / Lease (of copiers)	$ 857	Konica lease of multi-functional devices (scan, copier, fax, and printer). $9K/machine/year. 2 machines	$ 2,143	$ 2,143	$ 2,143	$ 2,143
Rent / Lease (of building/space)	$ 12,476	Based on actuals. BMD Charges, total sq feet ($38.67/sq ft). Annual space cost/Employee	$ 31,190	$ 31,190	$ 31,190	$ 31,190
SUBTOTAL (Ongoing Operations)	**$ 24,024**		**$ 57,202**	**$ 57,201**	**$ 57,201**	**$ 57,201**

Contracts		Total	Description				
Regulatory compliance SME		$ 75,000	Provides subject matter expertise on Regulatory Compliance and strategic business planning	$ 75,000	$ 75,000	$ 75,000	$ 75,000
Care management SME		$ 75,000	Provides subject matter expertise on Care Management	$ 75,000	$ 75,000	$ 75,000	$ 75,000
Other Expenses	**$ Per FTE**			**Total**			
Computers and Equipment	$ 1,000			$ 2,000	$ 2,000	$ 2,000	$ 2,000
Software	$ 500			$ 1,000	$ 1,000	$ 1,000	$ 1,000
Mailing	$ -			$ -			
Postage	$ -			$ -			
Mileage	$ 1,000			$ 2,000	$ 2,000	$ 2,000	$ 2,000
Travel	$ 1,000			$ 2,000	$ 2,000	$ 2,000	$ 2,000
Training	$ -			$ -			
Convenings	$ 500			$ 1,000	$ 1,000	$ 1,000	$ 1,000
Food	$ 500			$ 1,000	$ 1,000	$ 1,000	$ 1,000
Outside printing	$ 500			$ 1,000	$ 1,000	$ 1,000	$ 1,000
VPNs	$ 500			$ 1,000	$ 1,000	$ 1,000	$ 1,000
Cell phones (equipment)	$ 500			$ 1,000	$ 1,000	$ 1,000	$ 1,000
Cell phones (service)	$ 600			$ 1,200	$ 1,200	$ 1,200	$ 1,200
Office Supplies	$ 500			$ 1,000	$ 1,000	$ 1,000	$ 1,000
Office Expenses (utilities, etc.)	$ 100			$ 200	$ 200	$ 200	$ 200
Rent / Lease	$ 3,000			$ 6,000	$ 6,000	$ 6,000	$ 6,000
SUBTOTAL (Operations)	**$ 10,200**			**$ 20,400**	**$ 20,400**	**$ 20,400**	**$ 20,400**
TOTAL CCSO		**$ 515,500**		**$ 653,460**	**$ 622,387**	**$ 622,387**	**$ 622,387**
Other Expenses	**$ Per FTE**	**Total**	**Description**				
Computers and Equipment							
Software							
Mailing							
Postage							
Mileage							
Travel							
Training							
Convenings							
Food							
Outside printing							
VPNs							
Cell phones							
Office Supplies							
Office Expenses							

Rent / Lease							
SUBTOTAL (Operations)							

#35 Rationale--Financial Oversight and Contracting

Financial oversight of the AC3 Pilot Program will include documenting deliverables, overseeing contracts, converting contracts to reflect Results Based Accountability (RBA) and monitoring return on investment for care management interventions. Careful analysis of these elements of the program will enable the sustainability of services past the period of the grant. RBA staff functions include facilitating meetings, development of a set of RBA trainings and materials, development of technical assistance materials, communication plan, monitoring of progress across the collaboration, maintaining communication with partners engaged in implementation and overall management of the planning, implementation and evaluation efforts. This office will also ensure that regulations IGT and federal financial participation are met. Operations costs for RBA positions are covered through another source and are not included in the budget below. The operations costs are calculated for the 3.5 non-RBA FTE staff.

100% of FTE listed below are dedicated to the AC3 whole person care pilot. With the exception of RBA part-time FTE, all positions are new hires.

Staffing

	FTE	Salary & benefits	Role/responsibility				
Financial Services Specialist	1	$ 135,000	Responsible for building County-wide capacity for value-based contracts. Coordinates AC^3 with existing finance and administrative units	$ 135,000	$ 135,000	$ 135,000	$ 135,000
Program Financial Specialist	1	$ 135,000	Contract procurement and expediting of contracts	$ 135,000	$ 135,000	$ 135,000	$ 135,000
Administrative Services Specialist	0.5	$ 60,000	Administrative support for Finance functions	$ 30,000	$ 30,000	$ 30,000	$ 30,000
Business and Financial Analyst	1	$ 116,000	Responsible for tracking and analyzing program financial impacts and outputs. Cost effectiveness and other financial efficiency measures, along with calculating ROI. Knowledgable of Medi-Cal managed care regulatory codes.	$ 116,000	$ 116,000	$ 116,000	$ 116,000
RBA Positions							
CAPE Director (RBA)	0.05	$ 7,628	Planning, broad guidance of the alignment with Accountability Initiative	$ 7,628	$ 3,051		
Supervising Program Specialist (RBA)	0.3	$ 40,611	Lead and direct the day to day activities for program planning, implementation, and support for RBA adoption. This includes facilitating meetings, development of a set of RBA trainings and materials, development of technical assistance materials, communication plan, monitoring of progress across the collaboration, maintaining communication with partners engaged in implementation and overall management of the planning, implementation and evaluation efforts	$ 40,611	$ 13,537		
Program Specialist (2) (RBA)	1	$ 122,590	Assist in the development of trainings and materials, conduct trainings, provide technical assistance, coordinating implementation and communication efforts, and other activities as needed	$ 122,590	$ 61,295		

IT Systems Specialist* (RBA)	0.2	$ 24,518	Assist in the designing of the IT infrastructure for data management and sharing as well as develop protocols to ensure data integrity and accuracy	$ 61,295	$ 24,518		
Admin Specialist (RBA)	0.2	$ 18,529	Providing general support for activities and coordination of meetings	$ 46,324	$ 18,529		
Supervising Management Analyst* (RBA)	0.2	$ 27,074	Identification of data analysis needs, develop and oversee the alignment of a value based framework with the implementation of the data development plan, and provide necessary analysis and recommendations for decision making process	$ 27,074	$ 27,074		
SUBTOTAL (Staff)	**5.45**	**$ 686,950**		**$ 721,522**	**$ 564,004**	**$ 416,000**	**$ 416,000**
Operations							
One-time Start-up Operations Budget	**$ Per FTE**	**Description**					
Computers and Equipment	$ 1,214	computers		$ 4,250.0			
Software	$ 1,071	Specialized software license (MS Projct, Visio, Adobe Distiller)		$ 3,750.0			
Office Supplies	$ 952	Initial offices supplies for admin staff and on-going offices supplies		$ 3,333.33			
Furniture	$ 7,524	Cubicle/office configuration for staff. Design, furniture, installation. $7K/FTE; plus Conference and Breakroom		$ 26,333.33			
Communications	$ 1,429	Set-up and phone system (phones, data racks, network drops, cabling, and installation)		$ 5,000.0			
Office set-up	$ 238	Moving Expenses for Property & Salvage		$ 833.33			
SUBTOTAL (Start-up Operations)	**$ 12,429**			**$ 43,500.0**			

Mailing						
Postage						
Mileage						
Travel						
Training						
Convenings						
Food						
Outside printing						
VPNs						
Cell phones						
Office Supplies						
Office Expenses						
Rent / Lease						
SUBTOTAL (Operations)						
Ongoing Operations Budget	**$ Per FTE**	**Description**				
Computers and Equipment	$ 357	PY2-PY5 allocate 5 computers/year	$ 1,250	$ 1,250	$ 1,250	$ 1,250
Software	$ 119	Specialized software license (MS Projct, Visio, Adobe Distiller). Yearly license & maintanence fees	$ 417	$ 417	$ 417	$ 417
Cell phones	$ 476	Verizon - voice and data	$ 1,667	$ 1,667	$ 1,667	$ 1,667
VPNs	$ 476	Verizon - USB remote access USB modem	$ 1,667	$ 1,667	$ 1,667	$ 1,667
Mailing & Postage	$ 167	Postage for internal/external communications, newsletters, courier services	$ 583	$ 583	$ 583	$ 583
Travel	$ 1,429	Travel and accomodations for out-of-town conferences, events	$ 5,000	$ 5,000	$ 5,000	$ 5,000
Mileage	$ 714	Work travel to meetings, conf, outreach events, etc	$ 2,500	$ 2,500	$ 2,500	$ 2,500
Training	$ 1,667	Conference and training registration for Admin staff	$ 5,833	$ 5,833	$ 5,833	$ 5,833
Food	$ 1,905	Catered food for outreach and training meetings	$ 6,667	$ 6,667	$ 6,667	$ 6,667
Outside printing	$ 1,429	Brochures, posters, education/training materials	$ 5,000	$ 5,000	$ 5,000	$ 5,000
Office Supplies	$ 714	Offices supplies for admin staff and on-going offices supplies	$ 2,500	$ 2,500	$ 2,500	$ 2,500
Office Expenses	$ 286	Room rental fees (for training, meeting/events), ATT phone conf services, non-office expenses (Ergo equipment, assessments)	$ 1,000	$ 1,000	$ 1,000	$ 1,000
Transportation	$ -	N/A				
Furniture	$ 476	Cubicle/office and Conference and Breakroom, Yearly maintanence	$ 1,667	$ 1,667	$ 1,667	$ 1,667

Communications	$ 238	Phone system (phones, data racks, network drops, cabling, and installation) yearly maintanence	$ 833	$ 833	$ 833	$ 833
Office set-up	$ 238	Moving Expenses for Property & Salvage	$ 833	$ 833	$ 833	$ 833
Rent / Lease (of copiers)	$ 857	Konica lease of multi-functional devices (scan, copier, fax, and printer). $9K/machine/year. 2 machines	$ 3,000	$ 3,000	$ 3,000	$ 3,000
Rent / Lease (of building/space)	$ 12,476	Based on actuals. BMD Charges, total sq feet ($38.67/sq ft). Annual space cost/Employee	$ 43,667	$ 43,667	$ 43,667	$ 43,667
SUBTOTAL (Ongoing Operations)	**$ 24,024**		**$ 84,083**	**$ 84,084**	**$ 84,084**	**$ 84,084**
TOTAL			**$ 849,105**	**$ 648,088**	**$ 500,084**	**$ 500,084**

#36 Rationale--Skills Development and Quality Improvement (SDQI) [Contracted Services]

The Skills Development and Quality Improvement (SDQI) division is responsible for training development and skill development at approximately 50 downstream provider entities (these may include multiple sites belonging to one parent organization). Partner entities include physical health providers (hospitals, psychiatric in-and outpatient services, and Emergency Departments), behavioral health providers, substance use facilities, homeless services providers, and financial assistance providers. Based on an initial assessment of appropriate organizations in Alameda County, over the course of the 5-year grant period the SDQI will provide 75 trainings to 680 individuals and serve 50 partner entities belonging to approximately 6 parent organizations. The SDQI division will enhance MCP capacity for care coordination by introducing and rolling out new care coordination protocols, new care management packages, privacy and HIPAA, and associated data management training for providers. HCSA's Results Based Accountability (RBA) office will provide multiple RBA trainings to downstream providers over the course of the grant period. The SDQI will strengthen the human infrastructure in Alameda County; building the capacity of care managers to do Whole Person Care will result in a more skilled and integrated workforce doing care coordination and care management for our target populations. Downstream providers will be more prepared to provide Whole Person Care to other target populations including Health Homes populations.

The Skills Development and Quality Improvement unit is designed to be a contracted unit that is 100% dedicated to WPC Pilot activities only. All positions are new hires.

Staffing

FTE	**Salary & benefits**	**Role/responsibility**				
			Budget			
			PY2	PY3	PY4	PY5
Contracts	**Total**	**Description**				
SDQI Director (1 FTE in PY2; .75 in PY3; .5 in PY4; and .75 in PY5)	$ 135,000	Responsible for overseeing all aspects of SDQI	$ 135,000	$ 101,250	$ 67,500	$ 101,250
Administrative Assistant (1 FTE in PY2; .75 in PY3; .5 in PY4; .75 in PY5)	$ 96,000	Administrative support for SDQI Director and Training Director	$ 96,000	$ 72,000	$ 48,000	$ 72,000
Training Director (1 FTE in PY2; .75 in PY3; .5 in PY4; and .75 in PY5)	$ 135,000	Oversees and directs the development, implementation, and evaluation of SDQI programs and curriculum development	$ 135,000	$ 101,250	$ 67,500	$ 101,250
Curriculum Development Assistant	$ 75,000	Assist the Training Director	$ 75,000	$ 56,250		
Learning Technology SME	$ 100,000	Convert curriculum content into enduring materials e.g. online courses and modules	$ 100,000	$ 50,000	$ 50,000	$ 100,000
Materials Production Manager	$ 90,000	Creates print, online, and video training materials	$ 90,000	$ 67,500		$ 67,500
Trainer/Coach (8 consultants in PY2; 3 in PY3; 2 in PY4; and 5 in PY5)	$ 693,000	Deliver trainings; "train the trainer" in order to make use of existing training resources. Provide technical expertise to downstream providers in consultative and coaching capacity. Train partner entity staff in real time on model fidelity, PDSA execution, and dissemination of evolving best practices. Responsible for promoting sustainability and proper accounting in CBOs.	$ 693,000	$ 433,125	$ 173,250	$ 433,125
Resource Manager (1 FTE in PY1; .5 in PY3; .5 in PY4; and 1 in PY5)	$ 97,500	Quality monitor, content expert, design and run PDSA cycles pertaining to referral system	$ 97,500	$ 48,500	$ 48,500	$ 97,500
SUBTOTAL (Contracts)	**$ 1,421,500**		**$ 1,421,500**	**$ 929,875**	**$ 454,750**	**$ 972,625**

Operations							
	$ Per FTE			**Total**			
Computers and Equipment	1,000			$ 15,000	$ 9,750	$ 4,500	$ 10,000
Software	500			$ 8,000	$ 4,875	$ 2,250	$ 5,000
Mailing	-						
Postage	-						
Mileage	1,000			$ 15,000	$ 9,750	$ 4,500	$ 10,000
Travel	1,000			$ 15,000	$ 9,750	$ 4,500	$ 5,000
Training	-						
Convenings	500			$ 7,500	$ 4,875	$ 2,250	$ 5,000
Food	500			$ 7,500	$ 4,875	$ 2,250	$ 5,000
Outside printing	500			$ 7,500	$ 4,875	$ 2,250	$ 5,000
VPNs	500			$ 7,500	$ 4,875	$ 2,250	$ 5,000
Cell phones (equipment)	500			$ 7,500	$ 4,875	$ 2,250	$ 5,000
Cell phones (service)	600			$ 9,000	$ 5,850	$ 2,700	$ 6,000
Office Supplies	500			$ 8,000	$ 4,875	$ 2,250	$ 5,000
Office Expenses (utilities, etc.)	100			$ 1,500	$ 975	$ 450	$ 1,000
Rent / Lease	3,000			$ 45,000	$ 29,250	$ 13,500	$ 30,000
Total	**10,200**	(per FTE per year)					
TOTAL				$ 154,000	$ 99,450	$ 45,900	$ 97,000
	$ (693,000)						
TOTAL SDQI		**$ 1,421,500**		**$ 1,575,500**	**$ 1,029,325**	**$ 500,650**	**$ 1,069,625**

ALAMEDA HEALTH CARE SERVICES AGENCY

CATEGORY 1a: INFRASTRUCTURE DEVELOPMENT | Administrative Infrastructure - Care Management Service Bundle Administration

#37 Rationale - Care Management Service Bundle Administration

AC^3 is building on the framework and network that will be developed in Alameda County for the ACA 2703 Health Homes Program. The Care Management Bundles will be administered by the Managed Care Plans so as to align with the administration of the Health Homes Program benefit and ensure no duplication. The Managed Care Heath Plans will employ the team of staff required to oversee , assess, analyze, and troubleshoot client assignment and graduation to and from a service bundle. The activities are the same regardless of the number of the number of bundles administered, thus the flat annual fee.

As a part of these administration activities, the Managed Care Plan will establish and administer a waiting list for those eligible for Care Management Bundle when all slots are filled. Details of this work are described in the Deliverable #2 Care Management Service Bundle Budget Narrative.

Item	PY2	PY3	PY4	PY5
Flat Fee for Administering Care Management Bundle Tiers 1 and 2 (Alameda Alliance)	$ 678,600	$ 678,600	$ 678,600	$ 678,600
TOTAL	**$ 678,600**	**$ 678,600**	**$ 678,600**	**$ 678,600**

Alameda Alliance for Health - Annual Costs for Administering the Care Management Bundle

Role/Title	# FTEs	Rate (Annual)	Salary	Benefits (30%)	Total Annual Compensation
Compliance/Clinical Oversight	0.75	$ 97,000	$ 72,750	$ 21,825	$ 94,575
RN	0.75	$ 97,000	$ 72,750	$ 21,825	$ 94,575
MSW	0.75	$ 68,000	$ 51,000	$ 15,300	$ 66,300
Health Navigator	1.00	$ 73,000	$ 73,000	$ 21,900	$ 94,900
HealthCare/Reporting Analyst	1.00	$ 85,000	$ 85,000	$ 25,500	$ 110,500
WPC Program Administrator	0.75	$ 80,000	$ 60,000	$ 18,000	$ 78,000
G&A Coordinator	0.25	$ 50,000	$ 12,500	$ 3,750	$ 16,250
Financial Analyst	0.50	$ 80,000	$ 40,000	$ 12,000	$ 52,000
IT Analyst	0.50	$ 110,000	$ 55,000	$ 16,500	$ 71,500
TOTAL	**6.25**	**$ 740,000**	**$ 522,000**	**$ 156,600**	**$ 678,600**

ALAMEDA HEALTH CARE SERVICES AGENCY

CATEGORY 3a: REPORTING AND QUALITY | Pay for Metric Reporting

#38 Rationale - Pay for Reporting

Pay for Reporting payments will be used to incentivize problem solving and long term commitment to the vision of a connected care coordination and data sharing system.

1: **PHQ-9** results are not typically reported in health plan claims data, so AC3 will be dependent on the provider agencies themselves for this data. Although current systems allow for funneling PHQ-9 results up to the lead agency for aggregate reporting, many organizations that will be providing primary care to AC3 beneficiaries are currently considering a change in Electronic Medical Record software, or may be considering a change over the course of the pilot. Pay for reporting dollars will be passed down to these provider organizations during the last two years of the pilot upon successful reporting of this variant metric, incentivizing these partners to ensure that any electronic system change will still allow for PHQ-9 result extraction.

2: **Initiation & Engagement of AOD treatment -** Substance Use Disorder treatment is a special category of patient health information with additional legal protections. The workflow and data flow to report this information in a way that is both accurate and adheres to required legal safeguards is complex and will need to be worked out collaboratively between the lead entity and Behavioral Health Care Services which currently houses this data. Therefore, funds to support and incentivize this work are set aside for both departments during PY2. Then, in PY4 and 5, dollars are made available to incentivize the retention of those structures in light of new electronic health record system considerations as noted in #1 above.

3 and 4: **Care Coordination Assignment and Care Plan -** The lead entity will hold primary responsibility to ensure that each AC3 enrollee has an assigned care coordinator and that their care plan is accessible to their entire care team. We anticipate that gathering information on these processes will in itself be challenging; having on-going data will be essential to the PDSA process and meeting these critical targets. There will be both technical and relational challenges between organizations that must collaborate to succeed. These dollars will incentivize ongoing troubleshooting and will support any unexpected financial outlay necessary to link important partners to report on these metrics.

5: **Emergency Department Visits -** The lead entity will be responsible for facilitating collaboration beween all involved partners to ascertain accurate numerators and denominators for all universal and outcome metrics as they pertain to AC3's three target populations, represeted here by the emergency department utilization outcome metric. These PY2 funds will incentivize creative problem solving to put these reporting structures in place rapidly. The additional PY5 funds will incentivize the retention of those structures in light of new electronic health record system considerations as noted in #1 above.

		Total Max Amount of Funding			
		PY2	PY3	PY4	PY5
Incentive Payments					
Metric Reported	**Entity Receiving Payment**				
1 Depression Remission (PHQ-9)	Provider Organizations - 30 (PY4: average $15,000 each; PY5: average $16,667 each)			$450,000	$500,000
2 Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	Lead Entity	$150,000		$150,000	$150,000
	Behavioral Health Care Services	$200,000		$200,000	$200,000
3 Care coordination assignment	Lead Entity	$350,000	$311,314	$350,000	$350,000
4 Comprehensive care plan accessible to entire care team	Lead Entity	$350,000	$310,000	$350,000	$350,000
5 Emergency Department Visits	Lead Entity	$364,656			$143,171
Total amount available for deliverables		**$1,414,656**	**$621,314**	**$1,500,000**	**$1,693,171**