HEALTH AND HUMAN SERVICES

Whole Person Care Pilot Application

FINAL REVISED
OCTOBER 20, 2016

Section 1: WPC Lead Entity and Participating Entity Information

1a. Lead Entity Description

Placer County Health and Human Services (HHS) will provide leadership and support for this WPC pilot project. HHS includes Behavioral Health, Public Health, Human Services, and the Public Housing Authority. HHS will be the single point of contact for DHCS and will provide leadership, coordination, and monitoring of the WPC pilot.

1b. Participating Entity Description

- *Managed Care Health Plans*

There are three Medi-Cal Managed Care Plans (MCP) within Placer County: Kaiser; Anthem; and California Health and Wellness (CHW). Two of these MCPs, Anthem Blue Cross and California Health and Wellness, will be active participants in the WPC pilot. Anthem and California Health and Wellness representatives attended all WPC Leadership Committee meetings. In addition, Anthem staff worked closely with the WPC management, administration, and grant-writing team. Both MCPs have had input into the design of the WPC pilot and provided client-level data to the WPC Planning Committee to help understand the potential need for the implementation of the pilot. Their participation in the development of the application demonstrates these organizations' commitment to be actively involved in the WPC Pilot, share data (bidirectional), and participate in achieving the goals and data-sharing vision of the WPC pilot.

The MCPs' role includes continuing to serve on the WPC Leadership Committee, which will meet quarterly. They will identify and engage members; coordinate efforts to ensure members are referred to programs that best meet their needs without duplication of services; and provide health outcomes and utilization data for purpose of program evaluation.

The MCPs will receive pay-for-reporting funding for semi-annual and annual reporting on service utilization data for the WPC pilot.

- *Public Agencies*

Placer County Health and Human Services Department has a highly-functioning, coordinated system of behavioral health care, which includes a Children's System of Care (CSOC), an integrated division comprised of Children's Mental Health and Child Welfare Services, and an Adult System of Care (ASOC), comprised of Behavioral Health, Adult Protective Services, In-Home Support Services (IHSS), and the Public Guardian and Public Administrator. In addition, the Public Health division addresses overall health of the Placer County population and targets those with particular health needs. The target population for the WPC includes adults ages 18 and older. The Public Health Division will take the lead while the ASOC and partner entities will be actively involved in developing, implementing, and evaluating the WPC. The implementation of the WPC will be fully supported across all key HHS divisions. The strong

leadership of HHS and coordinated, integrated ASOC provides an excellent foundation for successfully implementing the vision of the WPC pilot. HHS will continue to serve on the WPC Leadership Committee, identifying individuals and assessing their needs. It will provide collaboration across public and private entities and ongoing care coordination. It will develop a collaborative data-sharing approach to identify common patients, coordinate care, and improve access, as well as evaluate individual and system-level health outcomes.

The Placer County Housing Authority supports the Housing Choice Voucher Program (HCV), formerly known as the Section 8 Voucher Program, a rental assistance program to help low and very low-income families, persons with disabilities, and seniors so that they can live in affordable, safe, and decent housing. This program covers all of Placer County, with the exception of the City of Roseville; the City of Roseville has its own Housing Authority. The Placer County Housing Authority supports local and federal programs to end homelessness. The Housing Authority works to encourage landlords to participate in the HCV Program. The services and vouchers offered by the Housing Authority provide an important resource for WPC in helping to support persons to end the cycle of homelessness. In addition, the Housing Authority works closely with HUD-Veterans Affairs Supportive Housing (HUD-VASH) program that combines the HCV rental assistance with case management and clinical services in collaboration with the Department of Veterans Affairs for homeless veterans. The WPC will work closely and coordinate services with each of these programs to help individuals find safe and stable housing. The Placer County Housing Authority will serve on the WPC Leadership Committee, share data, identify participants, and provide referrals to the services. The Housing Authority will receive pay-for-reporting funding for semi-annual and annual reporting on housing data for the WPC pilot.

The Placer County Probation Department, Adult Supervision Services will be actively involved in the WPC pilot. The Probation Department has a close working relationship with HHS and has developed successful programs in partnership with the Adult and Children Systems of Care Divisions. Outcomes improve when Probation and HHS work together to engage participants; support them in individualized treatment plans; and provide critical services and supports to assist them. This model will be replicated with the Probation Department working closely with the WPC Team to identify inmates who are ready to be released within 90 days who meet WPC target population. The Probation Department will contribute 2.0 FTE Probation Officers and HHS will provide supervision to 1.5 FTE Probation Social Worker Practitioners (funded through the county general fund). One Probation Officer will participate at 0.25 FTE with the Engagement Team, to work out in the community to identify homeless individuals on probation who may benefit from WPC services. This Probation Officer will also work 0.75 FTE with the second 1.0 FTE Probation Officer to help coordinate services with the Comprehensive Complex Care Coordination (CCCC) Team. This collaboration will help coordinate services and support individuals to meet their goals. In addition, there will be 1.5 FTE Probation Social Worker Practitioners to work closely with the Engagement Team and the CCCC Team, to support the goals of the individuals and the WPC pilot. These staff will deliver services to individuals who are within 90 days of release from jail and/or persons on probation who are living in the community. Probation will receive pay-for-reporting funding for semi-annual and annual reporting on probation data for the WPC pilot.

- *Community Partners*

Placer County has a network of community partners that are committed to participating in the WPC pilot:

There are two hospitals in the area that will serve WPC members: Sutter Roseville Medical Center and Sutter Auburn Faith Hospital. Both hospitals have been actively involved in the WPC Leadership Committee meetings and planning phone calls, as well as providing data to the WPC grant-writing team. These two hospitals will identify people in the Emergency Department (ED) and inpatient services who are appropriate for WPC. The hospitals will make referrals to WPC and share data bidirectionally with the WPC Team. The two hospitals will receive WPC pay-for-reporting funding for making these timely referrals to the WPC Team. This collaboration will help achieve the goals of the WPC pilot. Further, Sutter will provide hospital inpatient and emergency department services, as well as continue to share data and serve on the WPC Leadership Committee.

WellSpace Health (WellSpace), a Federally Qualified Health Center (FQHC) has delivered medical services to over 5,000 patients in Placer County for over 24 years. It is a full-service outpatient medical, dental, and behavioral health clinic that offers coordinated health care to its patients. WellSpace is committed to the success of the WPC pilot and has been participating in planning activities, conference calls, and contributing to the design of the WPC application. WellSpace operates the T-3 program. WellSpace will also support the goals of the pilot by creating enhanced access to primary care appointments to WPC members. This strategy will ensure that WPC member receive primary care appointments in a timely manner. WellSpace will receive pay-for-reporting funding for WPC members' timely access to primary care appointments. WellSpace will continue to participate in the WPC Leadership Committee, share data bidirectionally, and improve access to their services for program participants.

Western Sierra Medical Clinic (WSMC), an FQHC, delivers comprehensive primary care services to in Placer County. WSMC offers preventative services and addresses acute and chronic health conditions. WSMC has contributed to the WPC pilot by participating in planning activities and phone calls during the development of the grant. WSMC actively delivers health care services to individuals in Placer County, including WPC members. WSMC will ensure enhanced accessed to primary care for WPC members, share data bidirectionally, and support the evaluation components of the WPC pilot. WSMC will receive pay-for-reporting funding for WPC members' timely access to primary care appointments. WSMC will identify participants; open urgent care access for assigned patients participating in the pilot; share data and referral information; and participate in the WPC Leadership Committee.

Chapa-De Indian Health also operates in the catchment area; has actively participated in the WPC Leadership Committee meetings; provided data to the WPC application; and has been involved in integrating health, mental health, and substance use disorder services. Chapa-De has an exemplary substance use treatment program and will deliver substance use disorder services to WPC members. Chapa-De will ensure enhanced accessed to primary care for WPC members, share data bidirectionally, and support the evaluation components of the WPC pilot. Chapa-De will receive pay-for-reporting funding for WPC members' timely access to primary care

appointments. They will participate on the WPC Leadership Committee; identify participants; open urgent care access for assigned patients participating in the pilot; and share data and referral information.

Advocates for Mentally Ill Housing, Inc. (AMIH) has a critical role in the community and the WPC pilot. AMIH utilizes Peer Counselors to provide outreach to the homeless, provide peer support services to find housing, and help individuals remain in stable living situations over time. AMIH also owns and manages several homes in Placer County, which house persons with a serious mental illness and who recently transitioned from homelessness. The partnership between AMIH and WPC provides an important resource to support WPC members in accessing housing options and remaining stable in their living situation over time. AMIH will provide housing services for WPC individuals who are homeless, and will coordinate services with the WPC Team. AMIH will share data bidirectionally with the WPC Team to achieve positive outcomes.

Community Recovery Resources (CoRR) offers a comprehensive range of recovery-based services, including outpatient substance use and co-occurring treatment services for individuals and families; assessment and services to persons in the criminal justice system; residential services (90 days); and supportive transitional housing. CoRR offers a comprehensive range of quality services. WPC pilot members with substance use and co-occurring disorders will be referred to CoRR for outpatient and residential treatment services, depending on their level of need.

Turning Point Community Programs (Turning Point) is actively involved in delivering a wide range of diverse integrated service programs that are strength-based, wellness- and recovery-focused services to persons with a serious mental illness. Turning Point has been delivering services since 1976 and has programs in over ten counties. Turning Point will meet the needs of WPC members by enrolling high-need WPC clients who have a Serious Mental Illness (SMI) into their Full Service Partnership program and helping link individuals to needed medical care, primary care, and supportive services. The WPC Team will link members to these intensive services when this level of treatment is needed.

Pacific Education Services (PES) provides substance use disorder treatment programs and services to offenders to reduce recidivism and improve public safety. The program coordinates services with drug diversion and custody programs in Placer County Sheriff and Probation Departments. PES managers have been involved in the planning and development of the WPC application. WPC members will be linked to PES services as needed to help them achieve their goals.

The Gathering Inn offers a range of programs and services to help individuals overcome the issues causing homelessness and successfully transition to a stable housing situation. The Gathering Inn operates two points of entry, one in Auburn and one in Roseville. Individuals may use the showers and lockers, clean their clothes, and have a safe place to relax. Case management services are provided to link individuals to healthcare, mental health, 12-step, and employment opportunities. In the evening, individuals are transported by bus to one of many

churches to receive dinner, participate in social activities, and to sleep inside. WPC will link members to these services.

The Gathering Inn also offers an Interim Care Program (ICP) funded by Sutter Roseville Medical Center. The ICP is a 5-bed 24/7 program that is open to persons who are recovering after being discharged from the hospital and need support managing health conditions. The Gathering Inn Director has been involved in the planning and development of the WPC application. This program provides support while the individual is transitioning back into the community and obtaining housing. This program is an important part of the continuum of services and WPC members will be linked to these services. The Gathering Inn will share bidirectional data with the WPC pilot. It also anticipated that The Gathering Inn will be funded by WPC to deliver the WPC Respite Services.

Volunteers of America (VOA) operates one of the homeless shelters in Placer County. This program will provide shelter services to persons who are homeless, including those with addiction and/or other crises and support access to services. WPC and VOA will collaborate to link WPC individuals to needed services.

Homeless Resource Council of the Sierras (HRCS) provides funding recommendations for local providers in Placer and Nevada Counties. These funds are administered by the Department of Housing and Urban Development (HUD) and are awarded through the Continuum of Care (CoC) competition. The CoC approach is designed to encourage coordination of housing and service providers on a local level and to develop a continuum of care. The continuum includes outreach, emergency shelter, transitional housing, and permanent and supportive housing. WPC and HRCS will collaborate to link WPC members to services and help to engage this high-need population.

Sierra Foothills AIDS Foundation provides comprehensive support services to people living with HIV or AIDS and their families, and provides education and prevention services to the general public, including free HIV testing. They play a unique role for our homeless target population by providing housing assistance and referrals, a food closet, and emergency financial assistance. WPC members will be linked to the AIDS Foundation for services as needed.

Sierra Mental Wellness Group is an organizational provider that contracts with Placer County to provide crisis response services after business hours and 24/7 on weekends and holidays. This program will work closely with WPC members who call the crisis line and need supportive services. This program will link WPC members to the WPC Team to help resolve the immediate crisis and coordinate services to help reduce ED visits and hospitalizations.

Placer Independent Resource Services (PIRS) advocates for the rights of people with disabilities; educates the community about disability issues; and provides services to persons with disabilities to live independent, productive lives. PIRS has a focus on wellness and behavioral health, which is a major focus for the homeless target population. WPC members will be linked to PIRS services to help develop independent living skills to support a healthy lifestyle and permanent housing solution.

1.1 Whole Person Care Pilot Lead Entity and Contact Person

Organization Name	Placer County Health and Human Services Department (HHS)
Type of Entity	Behavioral Health, Public Health, Human Services, and the Public Housing Authority
Contact Person	Jeff Brown
Contact Person Title	Director
Telephone	(530) 745-3141
Email Address	jbrown@placer.ca.gov
Mailing Address	Placer County Health and Human Services Department 3091 County Center Dr., Ste. 290 Auburn, CA 95603

1.2 Participating Entities

Required Organizations:

Required Organizations	Organization Name	Contact Name and Title	Entity Description and Role in WPC
a. Medi-Cal Managed Care Health Plan	Anthem Blue Cross	Janet Paine, Interim Network Relations Manager, North / Program Manager	Develop strategies for integrating services; providing transportation, case management, and mild-to-moderate mental health treatment; coordinating health care services to common patients; share data with WPC and develop strategies for using data bidirectionally to support the WPC goals; develop the infrastructure to collaborate and integrate health services
	California Health and Wellness	Reina Hudson, Manager of Community Programs	Develop strategies for integrating services; provide transportation, case management, and mild-to-moderate mental health treatment; coordinate health care services to common patients; share data with WPC and develop strategies for using data bidirectionally to support the WPC goals; develop the infrastructure to collaborate and integrate health services
b. Health and Human Services Department (HHS)	HHS: Public Health	Robert Oldham, M.D., Health Officer/ Division Director	Provide leadership and oversight of public healthcare services, including nursing and coordination of care across WPC entities.
	HHS: Human Services	Linda Patterson, Division Director	Assist individuals with access to public assistance benefits, including Medi-Cal
	HHS: Placer Co. Housing Authority	Linda Patterson, Director of Placer County Housing Authority	Work to create access to the Housing Choice Voucher program for homeless individuals and will work with the Department of Veterans Affairs to use VASH vouchers to house our homeless veteran population

Required Organizations	Organization Name	Contact Name and Title	Entity Description and Role in WPC
c. Specialty Mental Health Agency/ Department	HHS: Adult System of Care	Maureen Bauman, Director of Adult System of Care	Provide mental health and substance abuse disorder treatment; coordinate data collection and evaluation activities for WPC; develop and implement strategies to share data bidirectionally with the Managed Care Plans and other entities to achieve the WPC goals and outcomes.
d. Public Agency/ Department	County of Placer Probation Department	Marshall Hopper, Chief Probation Officer	Deploy two probation officers to work exclusively with the county's homeless population; collaborate with WPC activities; share data; identify participants; provide referrals to the services; support pilot activities
e. Community Partner #1	Sutter: Roseville Medical Center & Auburn Faith Hospital	Kelly Brink, Coordinator, Community Benefit	Hospital Inpatient services and Emergency Department; shares data bidirectionally with the Managed Care Plans and other entities to achieve the WPC goals and outcomes.
f. Community Partner #2	WellSpace Health	Jonathan Porteus, CEO	Federally Qualified Health Center; shares data bidirectionally with the Managed Care Plans and other entities to achieve the WPC goals and outcomes.
g. Community Partner #3	Western Sierra Medical Clinic (WSMC)	Scott McFarland, CEO	Federally Qualified Health Center; shares data bidirectionally with the Managed Care Plans and other entities to achieve the WPC goals and outcomes.
h. Community Partner #4	Chapa-De Indian Health	Lisa Davies, Executive Director	Indian Health Outpatient Services; shares data bidirectionally with the Managed Care Plans and other entities to achieve the WPC goals and outcomes.

Additional Support Organizations:

Additional Support Organizations	Organization Name	Contact Name and Title	Entity Description and Role in WPC
i. Community Partner #5	Advocates for Mentally Ill Housing, Inc. (AMIH)	Jennifer Price, Executive Director	Deliver housing services; share data on WPC clients; participate on WPC Leadership Committee
j. Community Partner #6	Community Recovery Resources (CoRR)	Warren Daniels, Executive Director	Deliver substance use disorder services; co-occurring services; share data on WPC clients; participate on WPC Leadership Committee
k. Community Partner #7	Turning Point Community Programs	Jennifer Wellenstein, Interim Program Director	Deliver mental health and substance use disorder services; implement Full Service Partnership services; share data on WPC clients; participate on WPC Leadership Committee
l. Community Partner #8	Pacific Education Services (PES)	Walter Stockman, President	Deliver substance use disorder services; share data on WPC clients; participate on WPC Leadership Committee
m. Community Partner #9	The Gathering Inn	Keith Diederich, Executive Director	Operate Shelter; deliver Interim Care Program services; share data on WPC clients; participate on WPC Leadership Committee
n. Community Partner #10	Volunteers of America (VOA)	Leo McFarland, President & CEO	Operate Shelter; share data on WPC clients; participate on WPC Leadership Committee
o. Community Partner #13	Homeless Resource Council of the Sierras	Susan Farrington, Executive Director	Coordinate services for homeless and WPC; provide strategic planning; participate on WPC Leadership Committee
p. Community Partner #14	Sierra Foothills AIDS Foundation	Susan Farrington, Executive Director	Coordinate services for homeless and WPC; provide strategic planning; participate on WPC Leadership Committee
q. Community Partner #15	Sierra Mental Wellness Group	Jon Kerschner, Executive Director	Deliver mental health crisis intervention services; share data on WPC clients; participate on WPC Leadership Committee
r. Community Partner #16	Placer Independent Resource Services (PIRS)	Susan L. (Tink) Miller, Executive Director	Deliver independent living services; peer advocacy and support; participate on WPC Leadership Committee

1.3 Letters of Participation and Support

- Letters of Participation from pilot entities, which indicate a commitment to participate in the WPC pilot, are included as Attachment 1.

- Letters of Support from participating providers and other relevant stakeholders in the geographic area of the WPC pilot are included as Attachment 2.

Section 2: General Information and Target Population

2.1 Geographic Area, Community, and Target Population Needs

Placer County is a rural county with a population of 367,309 located east of Sacramento. The county has a total area of 1,502 square miles and stretches from the suburbs of Sacramento to Lake Tahoe and the Nevada border.

Placer County is in an excellent position to implement the Whole Person Care pilot. This project would create the infrastructure, leadership, and interagency collaboration to implement an effective, county-level safety net to better manage whole person needs. Currently, there is no systematic method for sharing data across the entities involved in the WPC to identify and refer persons who utilize ED and/or hospitalizations inappropriately. High-risk persons with multiple needs, including chronic health conditions, mental health and substance use disorders, and/or homelessness, often have multiple needs and frequently utilize services when in a crisis, at the highest level of care in the ED and/or hospitalization. As a result, the provider delivering services only responds to the immediate crisis, and does not have the time or accountability to coordinate services across entities. When the crisis is resolved, the individual is discharged, and the individual returns to the community until the next crisis occurs. This cycle may contribute to repeat admissions to higher levels of care.

In addition, there is no formal process for identifying high-need individuals, systematically assessing their complex needs, and coordinating services across entities. As a result, there is little accountability or incentives for coordinating care and identifying the needs of the individual to deliver whole person care. This model of silo services and minimal coordination creates opportunities for the WPC pilot. There is a need for a county-wide system of care, with an active and functioning WPC Leadership Committee and Multi-Disciplinary Team (MDT) that is accountable to coordinate services and continually identify opportunities to improve access, quality of care, cost-effectiveness, and outcomes.

Individuals enrolled in the WPC pilot will meet the criteria for one or more of the target populations: 1) high-risk, high-utilizing Medi-Cal beneficiaries who have repeated incidents of avoidable ED or hospital readmissions; 2) two or more chronic health conditions; 3) a Serious Mental Illness (SMI) and/or Substance Use Disorder (SUD); 4) homeless or at risk of homelessness; and/or 5) scheduled for release from jail and meets target population criteria. The participating entities will contribute to collaborative, bidirectional data sharing and outcomes.

The WPC pilot will develop four (4) bundled programs to serve the identified target populations: 1) Engagement Team; 2) Comprehensive Complex Care Coordination (CCCC) Team; 3) Medical Respite Care Program; and 4) Housing Services.

The WPC will build and strengthen the existing system by bringing representatives from partner entities to form the WPC Leadership Committee. The WPC Leadership Committee will discuss and implement the vision of coordination and collaboration; review data and outcomes; and identify opportunities to improve services.

The development of an enhanced Information Technology (IT) infrastructure to improve communication and data sharing will support the implementation strategies of the WPC pilot. HHS will utilize Emergency Department Information Exchange (EDIE), a software program that has been developed by Collective Medical Technologies, to collect data from the hospitals and EDs; notify ED clinicians; and create the capacity to identify WPC members to promote coordination of services and identify new referrals.

WPC entities will also develop the capacity to share data on a monthly basis, and submit the data to HHS, the lead agency, to review ongoing services; collect labs for tracking health outcomes; and promote care coordination. WPC entities will have access to updates on client data and information, to the extent allowed by federal law. Outcomes will be reviewed monthly to systematically monitor service access, implementation, and coordination.

The pilot will utilize incentive payments to help support entities to report data in a timely manner on key metrics, outcomes, and timely access to services. The WPC will identify strategies for supporting apartment landlords to create access for WPC members and to create the support to WPC members to help improve the stability of living situations for these high-risk individuals, over time.

The WPC Managed Care Plans provided data on persons who had six (6) or more encounters in a twelve-month period to help demonstrate the need for the WPC pilot and the ability to share data. Preliminary cohort data (February 2015 – January 2016) from Sutter Auburn Faith Hospital and Sutter Roseville Medical Center shows that across the two hospitals there were 426 patients who had 3,746 ED or hospital encounters, for an average of 8.8 encounters per patient. Of these 3,746 encounters, 177 were children, which is only 5% of the high user population. This data shows that 95% of the highest users of the ED were adults and older adults, the age group that will be served by this WPC pilot.

The Sutter data showed that of the 3,746 encounters, 3,339 were encounters in the ED (89%). The average number of ED visits per patient was 7.83 visits. This data clearly demonstrates that there are opportunities to improve coordination of care and link individuals to services.

In examining the chronic health conditions of these individuals, the most prevalent conditions included: hypertension (32.7%); hyperlipidemia (18.7%); diabetes (21%); and COPD (9%). Mental health conditions (38.8%) and substance use disorders (8%) were also frequently reported as the primary diagnosis for admission to the ED.

The ASOC serves a large number of persons with an SMI. Of the 3,993 persons served in 2014/15, 3,043 (76%) were adults or older adults. Of these adults, 349 are served in the Full Service Partnership program. Approximately 21% of these clients are homeless at any one time.

Homelessness continues to be a high priority in Placer County. Factors that contribute to chronic homelessness include the high cost of living in Placer County. As a bedroom county near Sacramento, the county population has increased from 175,477 to 375,391 in the past 25 years (a 114% increase). As a result, the rental vacancy rate is 2%. This situation impacts the availability of low-cost housing and contributes to an increase in homelessness.

2.2 Communication Plan

The Placer County HHS is the lead entity and provides leadership, coordination, oversight, and overall accountability to the WPC pilot. An ongoing WPC Leadership Committee, comprised of representatives for all participating entities, has the decision-making responsibility to work collaboratively to ensure access to WPC partners; support their staff to participate in ongoing WPC meetings and deliver timely, coordinated services; and share data to develop the infrastructure to measure service utilization and outcomes over time. The WPC Leadership Committee will initially meet at least monthly to discuss implementation strategies; refine the initial design and coordination of services; develop strategies for enhanced data sharing; and resolve issues to be responsive to needed modifications and suggest new solutions. Outcome data will be reviewed, and input on opportunities to make system modifications to improve outcomes will be discussed.

The WPC Leadership Committee will continue to meet throughout the 5-year WPC Pilot and beyond, to persistently work together to discuss implementation strategies, needs and successes, and refine services. The data sharing and review of system and client outcome reports will inform planning and implementation activities, as well as review key system and beneficiary outcomes. This data will document roles and responsibilities; points of access; barriers to services; opportunities to modify implementation activities; and celebrate successes. The ability to evaluate which services are cost-effective and have an impact on utilization of high-cost services will also support and sustain the infrastructure beyond the 5-year pilot.

In addition to the WPC Leadership Committee, we will implement a WPC Multi-Disciplinary Team (MDT) that will meet several times a month to coordinate services; discuss clients; manage each client's Tailored Plan of Care; and share resources to strengthen client- and system-level data. This Team will be comprised of WPC staff and entity staff at critical points of service who can help design day-to-day implementation strategies; address barriers and resolve line issues; and identify system-level issues that need to be discussed at the WPC Leadership Committee. Data will be available to both the WPC Leadership Committee and the WPC MDT to continually assess points of access; develop strategies for engaging and maintaining clients; review timely access to services; and support the delivery of cost-effective services for maximizing resources. Data will also be regularly shared between the Managed Care Plans and the WPC Team to review access, service utilization, and outcomes. Policies and procedures will be developed and implemented across the WPC entities to outline target population; service coordination; communication; and data collection and reporting.

Data from the WPC pilot will also be shared at community meetings, including monthly meetings with the Placer Collaborative on Homelessness and bi-monthly meetings of the Homeless Resource Council of the Sierras.

2.3 Target Population(s)

As a medium-sized county, the Placer County WPC Leadership Committee reviewed data from a number of the participating entities and determined that it was important to include several target populations to meet the needs of this small county. By including persons who meet various target population criteria, the WPC pilot will be able to serve more people and identify strategies that are effective with different populations. In addition, it is anticipated that many of the individuals will meet several of these criteria.

It is estimated that approximately 150 individuals will be served per year, with an estimated unduplicated count of 450 across the five years. Some of the individuals served will have complex health and behavioral health conditions and require multi-year services. Others may need only a few months of services to become stable and linked to community services. Individuals enrolled in the WPC pilot will be adults ages 18+ and may include persons who meet one or more of the following criteria: 1) a history of repeated incidents of avoidable ED use and hospital readmissions; 2) two or more chronic health conditions; 3) a mental health diagnosis and/or substance use disorder; 4) currently homeless or at risk of homelessness; and/or 5) scheduled for release from jail and who meet the WPC target population criteria. All individuals will be eligible for Medi-Cal services and enrolled with benefits as quickly as possible. Each population is described below.

1) A history of repeated incidents of avoidable Emergency Department use and hospital readmissions:

There are two Sutter Hospitals that are participating in the WPC pilot: Sutter Roseville Medical Center and Sutter Auburn Faith Hospital. Managers from Sutter have been actively involved in the WPC Leadership Committee planning meetings, as well as producing data for an initial analysis of the target population. The summary data on adults ages 18+ was helpful in identifying the top 5% of their service population in terms of cost of services. This information provided an overview of patients who may have avoidable ED visits and/or hospitalizations, who could benefit from collaborative services and systematic coordination across multiple systems.

It is anticipated that approximately 60 out of 150 (40%) per year of the adults ages 18+ referred and enrolled in the WPC each year will be persons who have a high number of avoidable ED and/or hospitalizations. While it is difficult to assess the number of persons with avoidable hospitalization from the initial data and who would benefit from the WPC pilot, the WPC MDT will work closely with ED and hospital discharge social workers to identify the highest-need individuals who are appropriate for WPC service coordination and linkage to community services. It is anticipated that all persons referred to the WPC will be Medi-Cal beneficiaries.

Individuals who meet these high-utilization criteria have multiple health conditions; have a history of non-compliance with medications; and have difficulty accessing primary care services to help manage their health condition(s). These individuals will greatly benefit from the intensive, supportive coordinated services provided by the WPC CCCC Team.

Those who need ongoing support to manage their health conditions upon discharge from a Sutter hospital will be linked to The Gathering Inn-ICP and/or the WPC Medical Respite program,

where they can stay for up to 30 days (and renewed stays for up to 90 days); have a safe, clean, supportive environment to learn how to care for their health; and have supportive services. WPC members who need housing transition services will be referred to the WPC Housing Services program.

The T-3 program, operated by WellSpace, has been funded by Sutter for the past several years, to provide continuity of care following discharge from a Sutter hospital. This program will also be available to provide services to WPC members who need a high level of support following discharge from the hospital.

2) Two or more chronic health conditions:

Adults ages 18+ with two or more chronic health conditions describes the majority of the persons served by the WPC pilot. Chronic diseases and conditions, such as heart disease, stroke, cancer, type 2 diabetes, obesity, arthritis, and COPD, are among the most common, costly, and preventable of all health conditions. Therefore, it is anticipated that approximately 120 of the 150 (80%) of enrolled individuals will have two or more chronic health conditions. These individuals will have Medi-Cal and/or eligible to be enrolled in Medi-Cal. In addition, many of these individuals will have a history of non-adherence with medications, and may have difficulty accessing primary care services to help manage their health condition(s). It is anticipated that many of these individuals will also meet other target population criteria, including having a mental health and/or substance use disorder; at risk of homelessness; and/or having multiple avoidable hospitalizations.

Data used in this methodology included outpatient data from Anthem Blue Cross. This data provided information on the number of members who have two or more chronic health diagnoses, including heart disease, diabetes, COPD, unmanaged cholesterol, obesity, and high blood pressure. In addition, data from HHS-ASOC was reviewed to obtain information on persons with a Serious Mental Illness (SMI) and/or Substance Use Disorder (SUD). This data was examined to identify persons who also have a diagnosis of a chronic health condition. The data also was also analyzed to identify BH clients who are enrolled in a Managed Care Plan, which provided valuable information on the number of persons who could benefit from WPC care coordination.

In addition to receiving services through the CCCC Team, individuals enrolled in the WPC pilot who also have an SMI will be supported to access the Health 360 Project, a SAMHSA-funded grant that supports individuals to learn how to manage their health conditions and receive services from the Health 360 staff. The collaboration and shared resources between the WPC pilot and Health 360 will promote positive health outcomes and demonstrate the effectiveness of health care integration on producing positive health outcomes.

3) A mental health and/or substance use disorder:

Persons with an SMI and/or SUD who are ages 18 and older, have Medi-Cal, and/or are eligible to be enrolled in Medi-Cal are included in the target population for WPC. It is also anticipated that many of these individuals will meet other target population criteria, including having chronic

health conditions and/or homeless or at risk of homelessness. In addition, these individuals will have a history of non-adherence with medications, and have difficulty accessing primary care services to help manage their health condition(s).

Data used in this methodology included information from HHS Behavioral Health. This data was examined to identify persons who have Medi-Cal and receive mental health and/or substance use treatment services. Persons who are homeless were also identified in this data set, and service utilization patterns were reviewed as well.

The Placer HHS ASOC Avatar data shows that there was a total of 3,993 clients who received mental health services in FY 2014/15. Seventy-six percent (76%) were adults and older adults (N=3,043). Of these adults, 189 qualified for Full Service Partnership services and 72 of the 189 FSP were homeless at admission (38%). Service utilization was reviewed to assess current services, including crisis and psychiatric hospitalizations. Persons who are homeless or at risk of homelessness and have other risk factors will be referred to the WPC pilot. The mental health service utilization data shows that across the 3,993 persons who received mental health services in FY 2014/15 received a total of 40,634 hours of services. This data averages to 10.18 hours of mental health service per person per year.

Data was also available for persons who received psychiatric inpatient services in FY 2014/15. There were 564 adults who received psychiatric inpatient hospitalizations for a total of 7,992 days. This data averages to 14.17 days per person. Persons with four (4) or more crisis services in a year, one (1) or more psychiatric hospitalizations, and/or four or more inappropriate hospitalizations in a year will be referred to the WPC pilot. The percent of persons who are discharged from a psychiatric hospital and have a follow-up appointment is a high priority outcome of the WPC project.

Data was available for persons with a substance use disorder (SUD). There were 1,036 client admissions reported in CalOMS and 727 individuals reported by the Placer ASOC programs.

Individuals enrolled in the WPC pilot will be supported to access the Health 360 Project, to learn how to manage their health conditions and receive support services from the Health 360 staff.

It is anticipated that 105 of the 150 (70%) individuals annually served in WPC will have an SMI and/or SUD. The majority will have two or more chronic health conditions, and 40% or more will be at risk of homelessness. Individuals enrolled in the WPC pilot will be supported to access the Health 360 Project, to learn how to manage their health conditions and receive support services from the Health 360 staff.

4) Currently homeless or at risk of homelessness:

These adults ages 18+ will have Medi-Cal and/or eligible to be enrolled in Medi-Cal, and are currently homeless or are at imminent risk of homelessness. It is also anticipated that many of these individuals will meet other target population criteria, including having an SMI and/or SUD and/or two or more chronic health conditions.

Data used in this methodology included data from HHS Behavioral Health. This data was examined to identify persons who receive mental health and/or substance use services and who are homeless. This data shows that 38% of the highest need mental health clients were homeless at the time of admission to services.

County-wide, a recent study on homelessness showed that there were 540 individuals who were homeless in Placer (Marbut, 2015). Of the homeless population, 40% were chronically homeless, 30% SMI, 32% chronic substance abuse, 28% victims of domestic violence, 8% veterans, and 7% former foster youth. While overall homelessness was decreased in Placer County, the overall chronic numbers have increased, and the Placer homeless community is becoming dramatically more chronic. The National Point in Time Count (PITC) shows the national percent of chronic homelessness was 14.5%; California's rate is 24.7%; and Placer's is 40%. This rate is nearly three times the national average and double the state (Marbut, 2015).

The Marbut study also found that Placer County lacks "strategic interaction and connectivity – there was no Placer System." For example, the homeless individuals seek food, however the opportunity to link them to other resources at food banks, etc., is missed. "Services are not integrated and seldom coordinated." The development of the WPC pilot will help address this finding and provide systematic engagement to the homeless, engage them in services, address their chronic health conditions, mental health and substance use disorders, and support them to achieve positive outcomes.

It is anticipated that 50 of the 150 individuals (33%) of WPC members will be enrolled in WPC Housing Services. These housing services will assist WPC members to obtain housing and sustain housing over time.

5) Scheduled for release from jail and also meet at least one WPC target population criteria:

The Probation Department has dedicated 2.0 FTE Probation Officers to work closely with the 1.5 FTE HHS Social Work Practitioners. These specialists will work closely with the WPC Team to identify individuals who are within 90 days of scheduled release from jail and who also meet one or more of the WPC target population criteria. The Probation Officer will identify those individuals who are interested in working with the WPC Team to receive the support needed to transition back to the community. Probation will work closely with the Engagement Team and the CCCC Team to engage WPC members in services; conduct a full assessment; and develop a Tailored Plan of Care to identify goals for recovery and wellness. This strategy will include support in obtaining benefits, housing, employment, and health care to help WPC members remain living in the community. It is estimated that the between 10 and 20 individuals from the jail will be referred to WPC each month.

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

3.1 Services, Interventions, and Care Coordination

The WPC pilot develops the infrastructure, leadership, and interagency collaboration to implement an effective, county-level safety net to better manage whole person needs. Persons with multiple needs, including chronic health conditions, mental health and substance use disorders, and/or homelessness, often have multiple needs and only utilize services when in a crisis. As a result, the immediate service provider only responds to the immediate crisis, and does not have the time, or accountability, to coordinate services across entities. The crisis is resolved, the individual discharged, and the individual returns to the community until the next crisis at the same entity or at another entity.

As a result, there is little accountability or time for coordinating care across agencies to identify all of the needs of the individual and develop a Tailored Plan of Care to deliver whole person care. The current model of silo services and minimal coordination across entities creates opportunities for the WPC pilot.

The WPC pilot has identified four (4) funding bundles to support the implementation of the WPC pilot and achieve positive outcomes. These bundles include: 1) Engagement; 2) Comprehensive Complex Care Coordination (CCCC); 3) Medical Respite Care Program (Medical Respite); and 4) Housing Services. The majority of persons receiving WPC services will be enrolled in the CCCC. As appropriate, WPC members will be referred to the Medical Respite program and/or Housing Services. In addition, other programs offered by providers will be utilized, as appropriate, to meet the needs of the individual. These include, but are not limited to, the following: The Gathering Inn Intensive Care Program; Sutter/WellSpace T3 program; primary care; Community Recovery Resources (CoRR); and other specialty services. The WPC pilot will implement a county-wide system of care, with an active and functioning WPC Leadership Committee and WPC MDT that is accountable to coordinate services on an ongoing basis and continually identify opportunities to improve access; quality of care; cost-effectiveness; and outcomes. All four funding bundles will serve two or more of the target populations.

1. Engagement: One of the greatest issues and barriers to service for the WPC pilot target population is trust, access to care, and continuity of care. The Engagement Team will be comprised of a Nurse; two Peer Advocates; a part-time Clinician with a specialization in co-occurring disorders; and a part-time Probation Officer. The majority of persons referred (estimated 150 per year) to the WPC pilot will receive initial, welcoming services from the Engagement Team. Persons receiving services from the Engagement Team will meet any of the WPC target population criteria. The individual may be homeless and mentally ill. Other individuals will be referred from other entities and have chronic health conditions and/or multiple Emergency Department visits and/or avoidable hospitalizations.

   The Engagement Team will visit the shelters, homeless camps, and other known areas where individuals live in the community. This Team will have skills in motivational

interviewing and a vision of wellness and recovery. The Engagement Team will have the time and patience to greet people where they live; offer enhanced engagement and care coordination services; visit repeatedly to touch base; and provide whatever it takes to build trust and engage the individual in accessing services.

The Engagement Team activities will build trust and offer initial engagement services. The goal is to engage and motivate participants so they are willing to enroll in the WPC program.

The Nurse will be available to provide consultation on immediate health conditions and provide valuable resources to help engage the individual in services. As a supportive relationship is developed, the individual will develop the trust needed to access services and obtain the needed support to meet their needs.

Persons referred by the hospitals, EDs, and/or primary care may also make referrals to the Engagement Team. This primary point of contact would be accountable for linking the individual to needed services and have responsibility for continuity of care, when linking to other services, including WPC.

The Peer Advocate/case manager will make a warm handoff to the CCCC Team, when appropriate, to sustain the initial trusting relationship developed. This shared responsibility will also help ensure that the individual is faithful to the Tailored Plan of Care that is jointly developed with him/her, the Engagement Team and the CCCC. This model will promote positive outcomes as there is a single point of accountability and oversight.

Once the person is engaged, the individual will be linked to the CCCC Team for ongoing services. Once linked and the Tailored Plan of Care is developed, the individual will be closed to the Engagement Team. It is anticipated that the length of stay with the Engagement Team will average two (2) months, with a range of one (1) to four (4) months.

Homeless individuals often do not trust people who come to "help" them. When the Engagement Team is able to address some of the homeless individual's immediate, basic needs, a trusting relationship begins to be developed.

Engagement services include screening and assessment, case management, linkage to appointments including providing transportation, as needed, medication reconciliation, and nursing/health care for any health conditions. Individuals will be linked / supported to obtain needed paperwork for applying for entitlements (birth certificate, ID, free phone).

2. Comprehensive Complex Care Coordination (CCCC): The WPC pilot will work with the most complex individuals and develop a system across entities to quickly identify persons who meet the criteria for WPC, ensuring a timely referral to the CCCC Team. The CCCC Team will coordinate with the Engagement Team to offer a warm handoff and

engage the individual, continuing to develop a trusting relationship, and offering support needed, so that the individual can access services. Whenever possible, the CCCC team will utilize a "master case management" concept, where one case manager / peer advocate is assigned to the person to build a trusting relationship with the individual. This model will help advocate for and support the member throughout the delivery of WPC services, and will help support outcomes, improve communication and accountability, and support integration of services across WPC entities. The majority of WPC members will be served by the CCCC Team.

It is expected that the majority of enrolled individuals (estimated 140 per year) will be eligible for the CCCC if they meet the target population of the WPC program. If a person has a good support system and can quickly change their behavior to improve their health they would have an abbreviated length of time in this service. However, we are expecting that most persons enrolled with need assistance in multiple areas in order to be successful in this program and will be enrolled in this service level until they exit the program. Eligibility criteria for the CCCC Team includes one or more of the target populations: 1) high-risk, high-utilizing Medi-Cal beneficiaries who have repeated incidents of avoidable ED or hospital readmissions; 2) two or more chronic health conditions; 3) a Serious Mental Illness (SMI) and/or Substance Use Disorder (SUD); 4) homeless or at risk of homelessness; and/or 5) scheduled for release from jail and meets target population criteria.

The CCCC Team will utilize a comprehensive Health Assessment tool to measure several aspects of the individual's life, including health, mental health, substance use, housing, service utilization, medications, and social support network. This tool will help assess and identify the most critical needs and expedite access to services. A Tailored Plan of Care will be developed with each WPC member within the first 30 days to provide a blueprint for needed services; identification of involved entities; a timeline for accessing services; and identified outcomes to meet each individual's needs.

The CCCC Team is comprised of a Nurse; Case Manager(s); a Clinician with expertise in co-occurring disorders; and two Peer Advocates. In addition, the Probation Officers and Social Work Practitioners will coordinate services with the CCCC Team to support individuals released from the jail and needing support in returning to the community. A pharmacist will be on contract to help members understand their medications, provide support in reconciling medications between entities, and provide expertise in medication compliance.

The CCCC Team will offer the core array of services including a full assessment of health, mental health, substance use, and housing needs. Following the assessment, the CCCC Team will help the individual develop a Tailored Plan of Care, identifying personal goals and services that will support him/her in achieving their goals. Other core services offered by the CCCC Team include mental health and/or substance use treatment services, case management, Peer Advocacy services, linkage to appointments including providing transportation, as needed, medication reconciliation, and nursing/health care for any health conditions.

WPC members will be encouraged to participate in various health management activities, including psycho-education training on Diabetes Management; COPD; Obesity – Body Mass index > 25); Hypertension; Hyperlipidemia; and other chronic health conditions. Individuals will also be supported to develop alternatives to helping them manage their pain. Individuals will be supported to adhere to the prescribed medications, with support in understanding each medication, potential side effects, and development of Medication Boxes or pill packets to help them manage their daily requirements.

The pharmaceutical medications in the Medication Boxes or pill packets are paid for by Medi-Cal. The utilization of medication boxes and/or pill bubble packets produced by the pharmacy help the member know the time and day to take the medication, as prescribed. This practice supports adherence to prescribed medications. The medication boxes also allow staff to quickly see if the member has been taking their medications, as prescribed. Adherence to medications is an important component to wellness and recovery.

In addition, health activities will be offered, in coordination with our SAMHSA-funded Health 360 project, including Stress Management; Walking groups; Symptom Management groups; Activities of Daily Living including nutrition; cooking; shopping; shopping; laundry; etc. As needed, WPC members will be supported in utilizing medical supplies to address non-urgent conditions.

Individuals will also be linked / supported to obtain needed paperwork for applying for entitlements (birth certificate, ID, free phone, CalFresh, housing vouchers, and other benefit programs) to meet their needs.

The WPC pilot will also build upon existing services and supports available from different entities, to fund services at critical points of entry to improve access and respond to the immediate needs of individuals. For example, Sutter Hospital funds WellSpace FQHC to operate the T-3 program. The T-3 team works closely with individuals being discharged from Sutter hospital and provides case management services to high-need individuals in the county who require additional support to access Primary Care services. The T-3 program helps to engage individuals in community services and help divert individuals from using the ED and inpatient hospitalization for routine health care. The T-3 program will be an excellent resource for the WPC Team, and will work closely to coordinate service for WPC members and/or make referrals to the WPC CCCC Team for ongoing coordination services, as needed.

Once the individual is stable, fully engaged in ongoing services, actively participating in supportive services, and shows a reduction in their presenting problems (frequent ED and/or hospitalizations; management of chronic health conditions), the individual will be linked to the ASOC or other health care organizations for ongoing health, mental health and/or substance use disorder treatments services. It is anticipated that most individuals will receive services from the CCCC Team for an average of 10 months, with a range from 4 months to over 2 years.

3. Medical Respite Program: The WPC pilot will also fund a bundled Medical Respite program. This program will be a 5-bed home-like facility for persons who may be frequently hospitalized for two or more health conditions; have frequent ED visits for routine health conditions; and/or need help in managing their chronic health conditions in a clean, safe environment. Some of the persons served in this program may have an SMI and/or SUD.

   This program will provide post-hospital medical care to WPC members who are homeless, in an unstable living situation, and/or too ill or frail to recover from physical illness/injury in their usual living environment (but not ill enough to be treated in a hospital or skilled nursing facility). The Medical Respite program is a short-term (up to 28 days), 24/7 program that supports the individual to recover in a safe environment while accessing medical care and supportive services. Persons enrolled in the Medical Respite Program may also be concurrently enrolled in the CCCC Team for ongoing, supportive services.

   The Medical Respite Program will have one LVN on staff, to support the medical needs of guests. In addition, CCCC Team nurses will visit the Medical Respite program on a daily basis to provide ongoing support, education, and training to WPC members to help them manage their health, make positive choices, and improve health outcomes. Medical Respite staff will support individuals to access ongoing services to meet identified needs; obtain benefits; and coordinate services with other entities to meet the goals outlined on the individual's Tailored Plan of Care.

   Individuals will receive core services including referral and linkage; treatment planning; case management; transportation to appointments; medication support and medication reconciliation; nursing care for acute and chronic health conditions; and linkage to other services, including housing services. Activities will include some or all of the following: medication reconciliation; medication management including learning to use medication boxes/packets; support and training to manage health conditions, management of mental health and/or substance use symptoms; and activities of daily living skills, including how to care for wound care/health conditions.

   Individuals will also be linked to Health Management Education Activities (Individual or Group) including Diabetes Management; COPD; Obesity – Body Mass Index > 25; Hypertension; Hyperlipidemia; Etc. and Stress Management groups and Walking/ Nutrition groups. For individuals who enter the WPC Pilot through the Medical Respite Team, he/she will be referred to the CCCC Team to access ongoing services to help sustain positive outcomes following discharge, when the individual is living in the community. All individuals discharged from the Medical Respite Team will receive ongoing services from the CCCC Team until their symptoms are stable and they can be linked to the ASOC or other health care organizations for ongoing services.

   Individuals utilizing the Medical Respite Program will have an anticipated length of stay of 28 days. However, members with ongoing medical respite needs beyond the anticipated 28-day length of stay will have the opportunity to apply to extend their stay

every 28 days for a maximum total stay of 90 days. It is anticipated that most individuals will receive services from the Medical Respite Team for an average of three (3) weeks, with an average of two (2) weeks to three (3) months, depending upon improvement in their chronic health condition.

4. Housing Services: The Housing Services will be bundled and provide comprehensive housing services to WPC members who are homeless or at risk of homelessness (estimated 50 persons per year). These housing transition services will assist the individual to obtain housing and develop daily living skills to support them to remain stable in their new living situation. Housing Services will include conducting a housing assessment; developing an individualized housing support plan; assisting with the housing application; identifying and securing available resources to assist with subsidizing rent including timely applications to the Placer County's Housing Authority Housing Choice Voucher Program and the Veterans Administration/Housing Authority's VASH Voucher program; identifying and securing resources to cover expenses, such as security deposit, moving costs, furnishing, environmental modifications, and other one-time expenses; and developing a housing support crisis plan to that includes prevention and early intervention services when housing is jeopardized.

   Persons who are eligible for Housing Services will meet the WPC target population and are currently homeless or at risk of homelessness. The Housing Services will be specifically tailored for each individual participant based on their Tailored Plan of Care. The services include three aspects of work: 1) the intensive work necessary for someone who is homeless to become "housing ready;" 2) the identification and removal of barriers that keep a particular individual from housing (bad credit, outstanding bills to utility companies, lack of funds for 1st and last month rent; and 3) the ongoing work with landlords or potential landlords to increase rental property availability specifically for the target population.

   The Housing Services program also supports individual to maintain tenancy once housing is secured. This approach includes identifying behaviors that may jeopardize housing, such as late payments and violating terms of the lease; coaching on developing relationships with the landlord and roommates; assisting in resolving disputes with landlords and/or neighbors to reduce the risk of eviction; and coordinating with the crisis plan and other WPC services, to address exiting or recurring housing retention barriers.

   Housing options are challenging in Placer County and this program is designed to have a dedicated service to better address the achievement of housing by developing expertise and focus on this particular issue. The coordination between the CCCC and Housing Services will be outlined for each participant so that there is no duplication of effort or resources.

   Placer County will utilize existing resources to support the housing of persons in the WPC program. These resources include Advocates for Mentally Ill Housing (AMIH) who with the Adult System of Care support individuals with serious mental illness who

are homeless with Housing and Urban Development (HUD) funded vouchers, HUD supported housing and new funding for rapid re-housing vouchers.

It is anticipated that individuals will receive Housing Services for approximately nine (9) months, with a range of six (6) months to two (2) years. Once the individual is placed in a safe living situation and is stable for a few months, he/she may be linked to the CCCC Team and/or continue to receive CCCC Team services, as needed, to meet the goals of their Tailored Plan of Care.

Additional Resources:

In addition to the four identified bundled programs, the WPC will develop the administrative infrastructure and capacity to provide leadership, management, and coordination to ensure the success of the WPC pilot. This strategy will include the development of clear admission and discharge criteria for the WPC target population and related bundled programs, the referral process, and training on making a referral. The development of the capacity to share "real time" bidirectional data through Epic and Avatar will create the capacity to quickly identify high-risk, high-need individuals. This strategy will also include the capacity to share service utilization data on enrolled WPC members and track outcomes at admission and throughout the project.

The WPC services will also be coordinated with existing services to improve access and support outcomes. The WPC pilot will coordinate with the Behavioral Health Crisis Services providers (Sierra Mental Wellness Group and Placer County Adult System of Care) and the Placer County Mobile Crisis Team to quickly identify persons who could benefit from WPC services and make the appropriate referral, as well as immediately recognizing current WPC members, to link them to the CCCC Team for support and linkage to needed services and supports.

In addition, incentive payments will be made to hospitals, EDs, and medical clinics. The Hospital incentive will be paid directly to the hospital when they notify and coordinate with the WPC staff that a WPC member or eligible member has arrived at the hospital. The Medical Clinic incentive will be paid directly to the primary care clinics that reserve one hour per week in their schedule for a primary care visit so that WPC members can be seen within seven days. These incentive payments will help to support appropriate referrals to WPC, as well as creating access to primary care clinics to ensure timely appointments for WPC members who need urgent health care.

These incentive payments are tied directly to the specific, measurable goals. The primary care provider will be paid a rate no more than 50% of the FQHC rate for one encounter for each person who is referred to the FQHC and seen within seven (7) days. This strategy will help to improve access to primary care and ensure that WPC members receive health care services in a timely manner. By linking incentive payments to the measurable goal of access to services for each member, we can ensure both client level outcomes, and system improved performance.

WPC will also utilize programs to meet the needs of persons with substance use disorders and co-occurring mental health and substance use disorders. These programs include Placer County Adult System of Care, Community Recovery Resources (CoRR), PES, and Turning Point.

The Probation Social Work practitioners will also be available to facilitate groups (psycho-educational and evidenced-based practices) and provide individual therapy with WPC Probation members to further support the development of coping skills, supporting overall health and wellness for the WPC members. Probation officers will monitor and support WPC Probation members to ensure that they are adhering to their terms and conditions, and help support the goals of the WPC program.

3.2 Data Sharing

During the planning phase of the application, several of our partner organizations provided data on the high utilizers in their systems. These entities analyzed raw data and provided summary data to the WPC Leadership Committee and the grant-writing team to provide an initial idea of the number of persons who meet the WPC criteria. This information helps identify the need in the community for WPC services. In addition, HHS and the Managed Care Plans reviewed data on individuals using mental health services who were covered by the MCPs. This data provided information to understand the health service utilization patterns for persons with an SMI, as well as highlighted the potential need and intensity of services utilized across the health care continuum. This data helps to plan WPC services to meet the complex needs of individuals who meet the WPC pilot criteria.

The WPC will develop the infrastructure and bidirectional data sharing capacity to fully implement the WPC. Each person enrolled in the WPC will sign a Release of Information form to allow data sharing across the WPC entities and with the Managed Care Plans. This strategy will create the core foundation needed for sharing Personal Health Information/Personal Information (PHI/PI) between entities, developing the capacity to make referrals and share service utilization and outcome data across WPC partners. All WPC entities will comply with all applicable state and federal laws surrounding confidentiality, privacy, and security of PHI/PI.

The Sutter Hospitals have implemented Epic as their EHR software while the local health care organizations utilize other EHR, such as e-clinical works. The WPC will fund the capacity to develop/expand a "CURES-like" system to identify individuals who are current WPC members or who meet the criteria for referral to WPC. For example, this enhanced system will have the capacity to identify persons who are served in the ED four (4) or more times in a 12-month period. These individuals will be highlighted for review by an ED nurse. If the nurse determines that several of the ED visits are "avoidable," the nurse will refer the individual to the CCCC Team for assessment. Similarly, individuals who have four (4) or more hospitalizations in a twelve-month period will be highlighted for review by a hospital nurse/discharge planner, or if the person has one or more psychiatric hospitalizations. If it is determined that the hospitalizations are "avoidable," the individual will be referred to CCCC for assessment.

Collective Medical Technologies developed software named EDIE. This program collects data from all EDs, and potentially other WPC entities, and packages that data into actionable insights and then delivers those insights to ED clinicians via real-time notification immediately when they are needed. The WPC pilot will further investigate this program and determine if it could provide the tools needed to track WPC members across services and notify the WPC Team when an individual comes into the ED or is hospitalized, either for physical health or psychiatric

services. EDIE matches the patient within the database, analyzes them against targeted criteria specific to the WPC guidelines, and if the patient meets any one of the criteria, EDIE automatically pushes an alert to the WPC Team. These alerts surface critical information immediately, including known care providers, a WPC Member's Tailored Plan of Care, any recent security related events, and a member's ED visit history. This information would offer providers instant decision support and the information needed to impact a better outcome. (Collective Medical Technologies website for EDIE: http://collectivemedicaltech.com/)

The Probation Department will also be trained to identify individuals who are within 90 days of release from the jail, and meet WPC criteria, including crisis and/or hospitalizations, chronic health conditions, and homeless or at risk of homelessness upon discharge. The Probation staff will make referrals to the CCCC Team for assessment and supportive services.

Data-sharing tools will be developed as the WPC pilot is implemented. Each entity has a different data system and different organizational policies on data sharing. The first year of the WPC pilot will include developing the infrastructure to share data; create a shared Release of Information form that meets the legal requirements of all entities; and develop a Memorandum of Understanding. Sharing Meaningful Use data and patient specific information electronically will be developed over the life of the pilot. In the interim, the HHS will be the lead agency for collecting and analyzing the shared data and ensure that all state and federal regulations concerning confidentiality are followed.

Placer County ASOC and the Managed Care Plans currently have a process for exchanging data to identify shared clients and services. The WPC Pilot will create the opportunity to enhance this process and develop a bidirectional data sharing protocol to be able to analyze access, service utilization, cost-effectiveness, and outcomes for WPC. This approach will greatly enhance management support activities and help improve services for the target population(s).

There are many challenges in achieving the goals of the WPC Project. To aid the development of the capacity to routinely share data across agencies and review it regularly to continuously evaluate system strengths and areas of improvement, all entities will be involved and responsible for identifying resources needed to effect change and achieve positive outcomes for WPC members. Each WPC entity is invested in working together to meet these challenges and create the capacity to better meet the needs of high-risk individuals and provide cost-effectives services. Obtaining this level of coordination and integration of data sharing will be an ongoing process. Through regular Leadership and MDT meetings to review access, service utilization, and outcome data; discuss opportunities to strengthen services; and implement modifications to the system using a PDSA model of change, the WPC pilot will begin to break down service silos and cultural norms, and strengthen the safety net for the highest-need individuals in the system.

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

4.1 Performance Measures

Pay for Outcomes Metrics:

- Universal Metric – 70% of WPC members with a primary diagnosis of mental illness who are seen in the emergency department will have a CCCC visit within 7 days.

- Universal Metric – 80% of WPC members with a Serious Mental Illness (SMI) will receive a CCCC service following discharge from a psychiatric hospital within 30 days.

- Universal Metric – 70% of WPC members will have a completed assessment and Tailored Plan of Care within 30 days of enrollment to WPC. (Tailored Plan of Care is accessible to all WPC entities.)

- Variant Metric – Percent of WPC members discharged from Index Hospital Stay who are not re-hospitalized within the next 30 days. Goal: 55% (Year 2), 60% (Year 3); 65% (Year 4); 70% (Year 5).

Performance measures will be collected from each entity, as well as generated from data collected from the WPC pilot. Service utilization and outcome measures will be collected for each person enrolled in WPC. These performance measures will be briefly outlined below. The WPC pilot does not have distinct and different treatment interventions for each target population. As a result, there will be consistency in the performance measures collected across persons served by various entities.

Each person referred to the WPC will receive a screening and an assessment. This approach will provide both basic demographic information and identify health, mental health, substance use, and homelessness status at the time of referral. Outcome instruments will be utilized to measure symptoms, such as depression and suicide risk.

Specific progress on health conditions will be monitored, depending upon the individual's presenting problems. For example, the assessment may include a Health Survey tool to collect information on health conditions, such as diabetes, hypertension, cardiovascular disease, substance use, tobacco use, and other indicators. Indicators including weight, height, blood pressure, blood glucose, and lipid profile, and medications will also be collected.

Service utilization data will be collected for each WPC entity that is involved in the individual's care, such as hospitals, psychiatric hospitals, ED, crisis and mobile crisis, and each service provider (e.g., mental health outpatient, substance use treatment, primary care, and specialty

services), whenever possible. Data will be obtained from the Engagement Team, CCCC Team, Housing Services, and Medical Respite WPC programs, and will include hospital and psychiatric hospital readmission and discharge dates, as well as time to first service in the community. Bidirectional data sharing between WPC and the Managed Care Plans will be implemented to understand service utilization and cost-effectiveness of the WPC pilot and identify opportunities to improve services.

Individual performance measures will be collected at admission, periodically, and at discharge for each client enrolled in the program. These measures may include employment, arrest history, and living situation. Timeliness to services following a psychiatric inpatient hospitalization will also be reviewed. This outcome will be closely monitored to ensure timely access to the WPC. The evaluation activities will meet the WPC performance measurement system requirements.

A WPC Outcome Dashboard will be developed to identify the number of persons served by each program each month, and cumulatively; services delivered; and key outcomes. The WPC data will be used to continually inform the WPC Leadership Committee and others of the effectiveness of the interventions; the hospitalized or use the ED; and the number successfully housed. The WPC Leadership and MDT will closely monitor outcomes to examine the effectiveness of services; monitor cost; identify barriers; develop solutions; and celebrate successful outcomes using a Plan Do Study Act (PDSA) model.

Through review of data, the WPC Team can quickly identify access points; timeliness of services; length of services; inappropriate admissions to ED and/or hospitals; and length of stay. The Housing Services program will provide information on the number of people housed, length of time in the living situation, and reasons for movement to another home. Similarly, the Medical Respite program will monitor the number in the program; length of stay; improvement in health condition(s); the number who are re-admitted to the hospital or ED; and the number successfully linked to housing and services at discharge.

The analysis of system-level and person-level performance data is conducted on an ongoing basis. Data reports will be produced and distributed to the WPC Leadership Committee, MDT, and others on a regular basis. Review of evaluation data creates the opportunity to quickly recognize when the system is coordinating care, making referrals in a timely manner, and demonstrating improved outcomes. It is also valuable to know when a client's medical needs are going untreated, or when health conditions require a change in treatment, so additional support can be implemented to meet those needs.

4.1.a Universal Metrics

By checking the boxes below, Placer HHS acknowledges that all WPC pilots must track and report the following universal metrics:

☒ Health Outcomes Measures
☒ Administrative Measures

- Health Outcomes: Ambulatory Care: Emergency Department Visits, including utilization of PDSA with measurement and necessary changes at least quarterly
    - Health Outcomes: Follow-Up after Emergency Department Visit for Mental Illness. 70% of WPC members with a primary diagnosis of mental illness who are seen in the emergency department will have a CCCC visit within 7 days.
    - Health Outcomes: Follow-Up after Emergency Department Visit for Alcohol and Other Drug Dependence. 10% of WPC members with a primary diagnosis of alcohol and other drug (AOD) dependence, who are seen in the emergency department, had a CCCC visit within 7 days.

- Health Outcomes: Inpatient Utilization: General Hospital/Acute Care, including utilization of PDSA with measurement and necessary changes at least quarterly
    - Health Outcomes: Follow-up After Hospitalization for Mental Illness. 80% of WPC members with a Serious Mental Illness (SMI) will receive a CCCC service following discharge from a psychiatric hospital within 30 days.

- Health Outcomes: Initiation and Engagement of Alcohol and Other Drug Dependence Treatment
    - 85% of WPC members with an identified SUD who are referred to AOD treatment
    - 40% of WPC members with an identified SUD who receive AOD treatment services

- Administrative: Comprehensive Care Plan. Proportion of participating beneficiaries with a comprehensive care plan, accessible by the WPC Team, within 30 days of:
    - Enrollment into the WPC pilot: 70% of WPC enrolled members will have a completed assessment and Tailored Plan of Care within 30 days of enrollment to WPC (Tailored Plan of Care is accessible to all WPC entities).
    - Annual Re-Assessment: 85% of WPC enrolled members have a re-assessment and updated Tailored Plan of Care after 12 months of WPC services (updated Tailored Plan of Care is accessible to all WPC entities).

- Administrative: Care Coordination, Case Management, and Referral Infrastructure. Measured by:
    - Submission of documentation demonstrating the establishment of care coordination, case management, and referral policies and procedures across the WPC pilot lead and all participating entities which provide for streamlined case management.

        - WPC Leadership will develop shared policies and procedures, review semi-annually, and utilize the PDSA model to modify and implement changes across entities.

- Administrative: Data and Information Sharing Infrastructure. Measured by:
    - Submission of documentation demonstrating the establishment of data and information sharing policies and procedures across the WPC pilot lead and all participating entities
        - 80% of WPC contract providers implement EDIE and/or other data collection processes to document access, quality, cost effectiveness, and outcomes.

4.1.b Variant Metrics

Variant Metrics Table for All Target Populations

Variant Metric	Description	PY 2	PY 3	PY 4	PY 5
Metric #1: Administrative: County Metric	Percent of protocols developed and implemented for special care coordination referrals to providers. Percent of protocols reviewed annually for continuous quality improvement.	85%	90%	95%	100%
Metric #2: Health Outcomes: 30-day All Cause Readmissions	Percent of WPC members discharged from Index Hospital Stay who are not re-hospitalized within the next 30 days.	55%	60%	65%	70%
Metric #3: Health Outcomes: Required for Pilots using PHQ-9	Percent of WPC enrolled members (ages 18+) with a diagnosis of major depression or dysthymia and an initial PHQ-9 score greater than 9 (during an outpatient encounter) who achieved remission at 12 months, as demonstrated by a PHQ-9 score of less than 5.	-	15%	20%	25%
Metric #4: Health Outcomes: Required for Pilots with SMI Target Population	Health Outcomes - Required for Pilots with SMI Target Population: Percent of WPC enrolled members (ages 18+) with a new diagnosis or recurrent episode of Major Depressive Disorder who had a suicide risk assessment completed at each clinical visit (as measured by the Assessing and Managing Suicide Risk (AMSR) instrument).	50%	55%	60%	65%
Metric #5: Housing: Housing Services	Percent of homeless receiving housing services in PY that were referred for housing services.	70%	75%	80%	85%
Other Metric (optional)	Medical Respite Care: Percent of enrolled WPC members who receive services at the Medical Respite Program and show improvement in their physical health condition at the time of discharge.	40%	45%	50%	55%

4.2 Data Analysis, Reporting, and Quality Improvement

The Placer County WPC pilot is in an excellent position to collect, report, and analyze data to continually evaluate access, quality, cost-effectiveness, and outcomes. In writing this application, data was collected, analyzed, and utilized to document the need for the pilot. Several of the participating entities, including Managed Care Plans, provided data on high utilizers in their system. This data was used to understand the target populations that could benefit from an integrated WPC ASOC. The willingness of these different entities to share data to support the WPC application clearly illustrates the level of commitment to this pilot.

Throughout the project, data will be collected on all persons referred to the WPC, including basic demographic information, referral source, and timeliness of response to the referral. Upon referral, the Engagement Team and/or the CCCC Team will screen the individual and determine if WPC can meet their needs.

If the individual could benefit and is interested in becoming involved with the WPC, a comprehensive assessment will be conducted to identify each individual's needs. The assessment may include a number of different instruments and surveys. For example, if the person is suicidal, the Assessing and Managing Suicide Risk (AMSR) model will be used at admission and periodically throughout enrollment in WPC to assess the person's level of risk. In addition, every person will be administered the PHQ-9 at assessment to evaluate for depression and other mental health symptoms.

Other components of the assessment may include a Health Survey tool to collect information on existing health conditions, including diabetes, hypertension, cardiovascular disease, substance use, diet, nutrition, and exercise habits. In addition, health indicators including weight, height, blood pressure, blood glucose, and lipid profile will be collected, as well as information on medication history and current usage.

Each individual enrolled in WPC will sign a Universal Release of Information and Informed Consent, so that information can be shared across all entities involved in the WPC. Service utilization data will be collected for each WPC entity who is involved in the individual's care. Service utilization data will be collected from each WPC service provider. Data will also be obtained from the Engagement Team, CCCC Team, Housing Services, and Medical Respite programs. This data will include hospital and psychiatric hospital admission and discharge dates; admission and treatment diagnosis; procedure codes; and duration of services. Data will be collected on each WPC member (whenever possible) for 12 months prior to WPC enrollment, periodically, and at discharge. Data from EDIE, when available, will be utilized to identify referrals to WPC, as well as notify the WPC Team when a member has been admitted to the ED or hospital.

Performance measures will be collected at admission, periodically, and at discharge for each WPC member. Timeliness to services following a psychiatric inpatient hospitalization will also be reviewed. This system outcome will be closely monitored to ensure timely access to the WPC. The evaluation activities will meet or exceed the WPC state data requirements.

A WPC Outcome Dashboard will be developed to quickly identify the number of persons served by each program each month, and cumulatively; services delivered; and key outcomes (e.g., time to first appointment, improved health, mental health, substance use treatment outcomes, and housing).

The WPC data will be used to continually inform the WPC Leadership Committee, the MDT, and CCCC of the effectiveness of the interventions; the number of people who are hospitalized or use the ED; and the number of persons who are successfully housed. The WPC Leadership and MDT will closely monitor key indicators and outcomes to examine the effectiveness of services; monitor cost; identify barriers; develop solutions; and celebrate successful outcomes using a Plan Do Study Act (PDSA) model.

The analysis of system-level and person-level performance data is conducted on an ongoing basis. Data reports will be produced and distributed to the WPC Leadership Committee, MDT, and others on a regular basis. Periodic review of evaluation data creates the opportunity to quickly recognize when the system is coordinating care, making referrals in a timely manner, and demonstrate improved client outcomes. Data from the Managed Care Plans will provide valuable information on service utilization on hospitalizations and outpatient health care services.

Through frequent use of data, data reports, the Outcome Dashboard, and monitoring of WPC member's health indicators, the WPC Teams can quickly identify a number of key indicators. For persons who are homeless, Housing Services will provide information on the number of people housed, length of time in the living situation, and reasons for movement to another home. Similarly, the Medical Respite program will monitor the number of persons in the program, length of stay, improvement in health condition(s), the number of persons who are re-admitted to the hospital or ED, and the number successfully linked to housing.

The WPC will also implement an Evaluation/Quality Improvement (QI) Committee to review ongoing data, analyze data, and utilize the Outcome Dashboard to provide timely, useful data to the WPC Leadership and MDT committee. The QI Committee will also obtain data from the fiscal department to manage resources, analyze the cost-effectiveness of services, and ensure that programs remain within budgeted allocations. Data from the Managed Care Plans will also provide important information on costs of services, as well as provide feedback to the Managed Care Plans on individual outcomes.

The WPC Leadership, MDT, and QI Committee will ensure that data is used as a feedback tool to closely monitor key indicators and outcomes to examine the effectiveness of programs, monitor costs, identify barriers to services, develop solutions, and celebrate successful outcomes using the PDSA model to continuously improve access and services. The use of data also helps to continuously improve the quality and quantity of services to ensure that we are meeting the needs of the WPC members and our community. In addition, outcome data is used to inform WPC leaders about the need to develop, coordinate, and modify services to improve client and system-level outcomes. The result will be healthy outcomes for our clients and communities.

4.3 Participant Entity Monitoring

Placer County HHS provides the leadership, oversight, and ongoing monitoring activities to ensure the successful implementation of the WPC pilot. HHS will be responsible for developing a data model to collect core data, client and system outcomes, and program deliverables from all entities. In addition, HHS will draft policies and procedures on timely data collection, reporting, quality indicators, and outcome measures. These policies and procedures will be reviewed and implemented with the WPC Leadership Committee to create a collaborative process for systematically developing, collecting, reporting, analyzing, and rewarding performance.

HHS will also provide technical assistance to all entities to ensure that data is collected consistently and reliably, and reported in a timely manner. Data reports will be developed and shared with each entity prior to sharing with the WPC Leadership Committee, to reduce any errors and/or omissions in the data.

Client, service, and outcome data will be utilized on an ongoing basis to review each entity's performance; timeliness of access to services; referrals to services; and client- and system-level outcomes. Entities will receive performance incentives for timely referral, access, and outcomes. If an entity has difficulties submitting data, has ongoing barriers to services, and/or does not achieve planned outcomes, HHS will provide additional technical assistance to remedy the issues. If the entity's performance does not improve with additional support, sanctions and/or contract termination will be implemented, depending upon the extenuating circumstances.

In addition to closely monitoring data submission, core performance outcomes will be reviewed to ensure access to health, mental health, substance use treatment, housing, and medical respite services. Quality of care and cost-effectiveness will also be measured, along with surveys regarding the member's perception of care. Barriers to service will be monitored and problem solving and technical assistance will be provided to individual entities, as well as engaging the WPC Leadership Committee to develop solutions to improve performance.

HHS and partner entities have experience in developing processes that can address conflicts and disputes through on-going review resulting in course correction as necessary. An example is the 5150 MOU in Placer that involves multiple entities that transport; provide medical clearance; assess for 5150; provide crisis intervention; and hospitalize. The MOU provides descriptions about the roles and responsibilities of each entity. The MOU is revised approximately every 5 years and is used to discuss situations when a staff from one entity did not follow the protocol. The document holds the agreement about what is expected, so that in quarterly meetings, a review can occur and entities can review situations that went awry and assist their staff to course-correct for future situations. Placer envisions a similar document to be developed and updated throughout the WPC pilot. As the WPC Leadership Committee implements services, this MOU can be developed to clarify expectations that will work well with the regular meetings to problem solve and course correct when things will not go as planned.

Section 5: Financing

5.1 Financing Structure

The Placer County Health and Human Services (HHS) WPC pilot program is designed to maximize resources by utilizing a cross-entity service delivery model. It includes services offered by a highly effective and efficient team of trained county staff for the activities the county performs well, and services offered by contracted community providers with proven track records for successful service delivery for the activities that are better served within the community.

The WPC Team has built a financing structure that looks to maximize resources by leveraging funds outside of the WPC grant while also connecting with and/or expanding existing programs, wherever possible. For the activities identified as current service gaps, the WPC Team will access the WPC grant funds as appropriate. To access these funds, the team will utilize the bundled services payment structure.

The WPC has identified four bundles to categorize services offered to the target populations. These four bundles include Engagement; Comprehensive Complex Care Coordination (CCCC); Medical Respite, and Housing. Each bundled program has unique costs attributable to the specific services and activities being performed within the bundle. These costs were divided by the anticipated number of members served to arrive at the required per-member-per-month (PMPM) rate (detail included in section 5.5 below). The costs associated with county-operated services will initially be paid by county general funds, with those county funds then being reimbursed once the revenue is received from DHCS. The costs associated with contracted services will be paid through a monthly invoicing process initially using county funds, with those county funds then being reimbursed once the revenue is received from DHCS. In this way, the county will assume the risk by paying for all expenses upfront, with the expectation that the WPC funds drawn down at year end will be sufficient to provide reimbursement back to the county for the services already provided.

The financing structure also includes the use of incentive, reporting, and outcomes payments to partnering entities within Placer County who will all contribute to make the WPC pilot program a success. Pay for performance is a relatively new contracting model to most of the community providers in the county, so this introduction will serve a critical first step for launching a more long-term transition to contract performance reimbursement strategies.

All program payments will be tracked in the county's existing financial software system. This system allows for the use of multiple coding options that will ensure all WPC pilot payments are accurately classified for reimbursement. As the lead entity, HHS will assign the oversight and governance for all financial aspects of the WPC pilot program to its Administrative Services Division.

5.2 Funding Diagram

Attachment 3 demonstrates how the WPC grant funds would flow from DHCS. To summarize, funds will flow from DHCS to Placer County HHS Administrative Services Division. Once received, HHS Administrative Services will journal the revenue to the other HHS Divisions or County Departments that are participating in the pilot program – Adult System of Care, Public Health, Human Services, Housing Authority, and Probation – in amounts sufficient to cover 50 percent of the expenditures already paid throughout the year for internal costs, such as staff, and external costs, such as contract payments to outside program participants for their costs attributable to the WPC program.

5.3 Non-Federal Share

HHS, the lead entity, will provide the majority of the non-federal share for payments under the WPC pilot. The sources of the non-federal share include county general funds, realignment revenue, Mental Health Services Act Innovation funds, and other revenue deemed appropriate for federal match. All of the match funds are already with or will be coming from the appropriations specific to Placer County HHS within the county's financial software system.

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

WPC pilot funding will be used to reimburse Placer County for allowable services that are not claimed any other way, nor allowable to be claimed to any other currently available funding streams throughout all of HHS. This funding includes Medi-Cal (including Medicaid Administrative Activities) and Targeted Case Management (TCM), which will be claimed first for any service provisions allowable. In all instances, funding for existing Medi-Cal services (TCM; Specialty Mental Health Services) will be utilized before accessing WPC funding.

Placer County Department of Health and Human Services currently provides TCM services within its Public Health Division. Placer County is currently included in the following TCM approved State Plan Amendments (the number of unique individuals served under each SPA in fiscal year 2015-2016 is included below in parentheses):

- SPA 14 – Children under the age of 21 (23 individuals served)
- SPA 15 – Medically fragile individuals (45 individuals served)
- SPA 16 – Individuals at risk of institutionalization (8 individuals served)
- SPA 17 – Individuals in jeopardy of negative health or psychosocial outcomes (6 individuals served)

It is likely that there will be some overlap between populations eligible for Whole Person Care (WPC) and those eligible for TCM. For instance, a WPC member could very easily be medically fragile, at risk of institutionalization, and/or in jeopardy of negative health or psychosocial outcomes.

However, there is no chance of overlap of staff between the TCM and WPC programs, and very little possibility of overlap between services. At this point, the plan is for each program to have

completely separate staff. Even if there were some staff shared between TCM and WPC at some point, both programs will conduct perpetual time studies where time spent in each programs would be carefully accounted for, leaving no opportunity for claiming a service to both TCM and WPC. TCM already has experience implementing this process to avoid inappropriate overlap with other Placer County programs.

In addition, the services provided by TCM and WPC will be quite different in both their nature and in their timing. Targeted case management services are defined as services furnished to assist individuals, eligible under the State Plan, in gaining access to needed medical, social, educational and other services. Targeted Case Management includes the following assistance:

1. Comprehensive assessment and periodic reassessment of individual needs,
2. Development (and periodic revision) of a specific care plan,
3. Referral and related activities (such as scheduling appointments for the individual), and
4. Monitoring and follow-up activities.

In contrast with the relatively limited scope of services that may be provided under TCM, the services proposed under WPC go well beyond assessment, care planning, referral, and monitoring. Under WPC we propose a much more intensive and longitudinal care coordination and direct service model, similar to Assertive Community Treatment in its level of intensity.

This difference in service intensity is demonstrated by actual TCM encounter data and projected encounter data for WCP. In Fiscal Year 2015-2016, Placer County Public Health Division performed a total of 164 TCM encounters for 82 unique individuals for an average of only 2 encounters per unique individual per year. It is estimated that the WPC Pilot will deliver an average of two (2) encounters per member per **week** or 104 encounters per member per year under WPC. While some assessment, care development, monitoring, and referral-related activities may be services that could be claimed under TCM, there is no risk of these services being inappropriately billed to TCM, as all staff will be required to time-study in the county's payroll system to certify that their costs are only accounted for once and will not be duplicated in the WPC claiming methodology. The budget included in 5.5 below was already discounted for the assumption of drawing down Medi-Cal (including MAA) and TCM revenue for allowable activities. Therefore, the budgeted PMPM rate does not include those costs.

The target populations served by the WPC Team will only include Medi-Cal beneficiaries for any dollar amount claimed back for federal financial participation, which is something that Human Services will participate in for enrollment or verification of benefits, if necessary. The Engagement PMPM bundle also will participate in this critical step during the WPC program enrollment process to ensure all members are Medi-Cal beneficiaries. If a member is not currently enrolled in Medi-Cal, the WPC staff will work with eligibility staff in Human Services to enroll the member. Once enrollment in Medi-Cal is finalized, the member will then become eligible for the WPC program.

Per STC 113, the WPC pilot payments will support infrastructure to integrate services among local entities that serve the target population as evidenced in the budget detail for the Administrative and Delivery Infrastructure budget categories. They also will support services not otherwise covered or directly reimbursed by Medi-Cal to improve care for the target

population such as housing components, as evidenced in the budget detail for the Housing Services PMPM bundle. And lastly, the pilot payments will support other strategies to improve integration, reduce unnecessary utilization of health care services, and improve health outcomes as evidenced in the budget detail for the CCCC and Medical Respite PMPM bundles.

5.5 Funding Request

In addition to this narrative, please refer to the Placer County WPC Pilot Application – Budget Summary document in Excel.

Funding for Placer County's WPC pilot program is separated into six main categories: Administrative Infrastructure, Delivery Infrastructure, Incentive Payments, PMPM Bundles, Pay for Reporting, and Pay for Outcomes. The following activities are attributable to the different categories:

1. Administrative Infrastructure includes county and contracted staff to perform program evaluation and data analysis, as well as program policy development and implementation. The cost breakdown can be found in the Budget Detail document attached to the application.

2. Delivery Infrastructure includes funding for the following - purchasing a care management tracking automated system with enhanced reporting capabilities that would allow the WPC staff the ability to track all client information as well as sync up to existing systems for comprehensive management and state required reporting; county IT staff support for the software system that would include time for set up and maintenance of the WPC software system mentioned above as well as participation in appropriate WPC Team meetings; four vehicles to be purchased and assigned to the staff working on WPC; 14 computers and related equipment such as keyboards for each of the staff members of the WPC Team; 2 printers for the team; 13 wireless tablets to access the software system while out in the field, thus preventing costly double entry or manual record keeping until back in the office; 13 cell phones for the team to be able to communicate with staff and clients at all times including on call and standby time; and minimal staff space costs for their new location to keep the WPC Team located together for further effective and efficient program operations. The cost breakdown can be found in the Budget Detail document attached to the application.

3. Incentive Payments includes two main subcategories – Hospital incentives and Medical Clinic incentives. The Hospital incentive will be paid directly to the hospital when they notify and coordinate with the WPC staff that a WPC member or eligible member has arrived at the hospital. The Medical Clinic incentive will be paid directly to the primary care clinics that reserve one hour per week in their schedule for a primary care visit so that WPC members can be seen within seven days. No single payment of this incentive rate to a medical clinic will exceed 50 percent of their federally-approved encounter rate for an appointment. The cost breakdown can be found in the Budget Detail document attached to the application.

4. PMPM Bundles includes four different bundled service subcategories: Engagement, CCCC, Housing Services, and Medical Respite Care. Each of these subcategories includes a line item for direct allocable costs. These program costs are not associated with only one bundle, but are considered service-related costs that directly benefit all the bundled services, and are therefore allocated to all the bundles based on a percent to total of service cost methodology.

   The costs included in this line are as follows: WPC Program Manager to offer management of the team; Program Supervisor who will provide the direct day-to-day supervision of the team; Senior Administrative Clerk who will assist all the team members with clerical type duties; Accountant Auditor II who will be responsible for all of the time studies, claiming, budgeting, and financial reporting of the program; all attributable county benefits for the salaries tied to the positions above; any professional dues that the corresponding team members require for their positions; travel that will be associated with the team members; office supplies used for the WPC program only; the maintenance of the vehicles that the WPC Team members use; the required staff training for the program; and monthly charges from the county IT Department for the computers and cell phones of the team members.

   <u>Engagement Bundle</u>

   - The Engagement Team focuses on program enrollment, initial applicant screening, obtaining linkages to appointments or transportation needs, initial treatment planning, and initial case management. Specific activities include providing engagement services in the community to the target population such as visiting homeless camps, shelters, and/or Emergency Departments and Hospitals; working to build trust and relationships with program members; offering initial engagement services; and engaging and coordinating services. The goal is to engage and motivate participants so they are willing to enroll in the WPC program.

   - The criteria in this bundle is based on level of engagement. The Engagement Team will work closely with the CCCC team to assure there is a warm hand-off from one team to the next when the participant is ready to enroll in services. Once the participant is accepted for services in the CCCC bundle, the Engagement Team will terminate engagement services.

   - The program budget is based on 210 member months at $2,112 PMPM in Year 2; 300 member months at $2,102 PMPM in Year 3; 300 member months at $2,176 PMPM in Year 4 as staff costs are projected to increase; and then 300 member months at $2,253 PMPM in Year 5 to end the pilot period. Staff to participant ratio is 1:7. The Year 2 budget detail is calculated using a pro-rated formula of 70 percent of full year costs, assuming time for program start up, and is as follows:

Costs	Units	Total
Nurse	0.50	$32,953
Clinician	0.50	$29,133
Peer Advocate	2.00	$77,493
Staff Benefits	1.00	$98,893
Standby/Callback Pay	1.00	$18,235
Probation Officer	0.25	$19,791
Probation Clinician	0.50	$39,655
Marketing Materials	1.00	$3,500
Engagement Activities	150	$10,500
Allocable Direct Costs	1.00	$92,246
Indirect Costs	1.00	$21,121
TOTAL		$443,520
Member Months	210	$2,112

CCCC Bundle

- The majority of enrolled individuals will be eligible for the CCCC if they meet the target population of the WPC program. Eligibility criteria for the CCCC Team includes one or more of the target populations: 1) high-risk, high-utilizing Medi-Cal beneficiaries who have repeated incidents of avoidable ED or hospital readmissions; 2) two or more chronic health conditions; 3) a Serious Mental Illness (SMI) and/or Substance Use Disorder (SUD); 4) homeless or at risk of homelessness; and/or 5) scheduled for release from jail and meets target population criteria. If a person has a good support system and can quickly change their behavior to improve their health they would have an abbreviated length of time in this service. However, we are expecting that most persons enrolled will need assistance in multiple areas in order to be successful in this program and will be enrolled in this service level until they exit the program.

- The CCCC Team will utilize a comprehensive Health Assessment tool to measure several aspects of the individual's life, including health, mental health, substance use, housing, service utilization, medications, and social support network. This tool will help assess and identify the most critical needs and expedite access to services. A Tailored Plan of Care will be developed with each WPC member within the first 30 days to provide a blueprint for needed services; identification of involved entities; a timeline for accessing services; and identified outcomes to meet each individual's needs.

- The CCCC Team will provide care coordination services at a very high level of intensity and accountability. The CCCC team will be modelled after Assertive Community Treatment (ACT) or Full Service Partnership (FSP) teams that Placer County HHS and many other service providers have used for years to promote recovery for residents with serious mental illness who experience multiple psychiatric hospitalizations in a relatively short period of time. This level of care is the most intensive outpatient service in the adult mental health delivery system. The mindset

of ACT/FSP is to provide "whatever it takes" to support the client in achieving their recovery goals. This strategy includes 24/7/365 access to services and commitment to engage and collaborate with any potential sources of support to the client, such as a client's friends, family, medical providers, pets, treatment providers, probation officer, etc.

- Sometimes this model is called "a hospital without walls" because it utilizes a multidisciplinary team of professionals with diverse skills and backgrounds who work closely together as a cohesive team to maximize each of their strengths in service of the client's needs and goals. This team goes wherever it is necessary in order to meet the clients' needs, including in the home, on the street, the Emergency Department, or wherever the client experiences a crisis. The majority of services being provided will occur outside of a standard medical office.

- Similar to our proposed WPC model, ACT and FSP typically utilize "Peer Advocates," or individuals with lived experience in recovery from similar challenges as the clients the team is serving. Placer WPC Peer Advocates will be valuable members of the CCCC team, and will utilize intensive training in motivational interviewing and their own personal experiences in living with challenges such as chronic health conditions, mental illness, substance use disorders, homelessness, and legal troubles in order to effectively engage WPC members in overcoming these challenges in their lives.

- The program budget is based on 504 member months at $1,521 PMPM in Year 2; 720 member months at $1,481 PMPM in Year 3; 720 member months at $1,361 PMPM in Year 4 as billing other outside revenue sources becomes more sophisticated; and then 720 member months at $1,242 PMPM in Year 5 to end the pilot period. The Year 2 budget detail is calculated using a pro-rated formula of 70 percent of full year costs, assuming time for program start up, and is as follows:

Costs	Units	Total
Nurse	1.50	$82,383
Clinician	1.50	$43,700
Case Manager	1.00	$23,419
Peer Advocate	2.00	$77,493
Staff Benefits	1.00	$142,494
Standby/Callback Pay	1.00	$36,469
Probation Officer	1.75	$138,538
Probation Clinician	1.00	$79,311
Contract Physician	1.00	$21,000
Contract Pharmacist	1.00	$10,500
Medication Support	1.00	$17,500
Medication Packets	1.00	$3,500
Allocable Direct Costs	1.00	$236,225
Indirect Costs	1.00	$54,052
SUBTOTAL		$966,584
Offset Medical Revenue		(200,000)
TOTAL		$766,584
Member Months	504	$1,521

The participation to case manager ratio will range from 10 to 15. We designed this recognizing that small ratios work better with the target population, who needs more intensive case management in order to produce beneficial outcomes.

Medical Respite Care Bundle

- Medical Respite Care program is a 5-bed facility that allows members to stay up to 28 days with renewals available based upon need. The service is contracted with a community provider whose specific activities will include health condition management (in individual or group settings) for conditions such as diabetes, COPD, Obesity, Hypertension, Hyperlipidemia, and Stress Management. They will train and support activities of daily living, including how to care for current wounds and/or active health conditions, as well as provide symptom management and medication management. They will work closely with the WPC Team on the development and implementation of a Tailored Plan of Care to ensure a smooth transition for the WPC member after the 28 days are complete.

- However, members with ongoing medical respite needs beyond the anticipated 28-day length of stay will have the opportunity to apply to extend their stay every 28 days for a maximum total stay of 90 days. In order to be eligible for the Medical Respite Program, the acuity of medical need must be sufficiently great to necessitate this level of care, as the condition could not be managed at other levels of care. For instance, a member might be eligible for the Medical Respite Program because, while not so acute as to meet medical necessity for an ongoing inpatient hospitalization, the

acuity of the member's condition prevents the member from being admitted to a homeless shelter or drug rehabilitation program. It is anticipated that most individuals will receive services from the Medical Respite Team for an average of three (3) weeks, with an average of two (2) weeks to three (3) months, depending upon improvement in their chronic health conditions.

- The program budget is based on 34 member months at $8,826 PMPM (Per Bed Per Month) in Year 2; 48 member months at $8,845 PMPM (Per Bed Per Month) in Year 3; 48 member months at $9,713 PMPM (Per Bed Per Month) in Year 4 as contracted staff costs are projected to increase; and then 48 member months at $10,666 PMPM (Per Bed Per Month) in Year 5 to end the pilot period. The Year 2 budget detail is calculated using a pro-rated formula of 70 percent of full-year costs, assuming time for program start up, and is as follows:

Costs	Units	Total
Contract Provider	1.00	$204,315
Transportation	1.00	$19,954
Allocable Direct Costs	1.00	$61,693
Indirect Costs	1.00	$14,122
TOTAL		$300,084
Member Months	34	8,826

Housing Services Bundle

- Housing Services program focuses on review of WPC assessment and update for housing goals, support member to find housing, secure funding/benefits/vouchers, develop skills in living independently, work with landlords to support stability in living arrangement, resolve landlords and/or tenant relationship challenges, and provide transportation to appointments and housing. Specific activities include assessing and modifying the Tailored Plan of Care with the WPC member to reflect housing goals; securing safe housing options; assisting in the application process for housing; training in daily living skills; and linking member to specialty services as needed.

- This program is designed to have a dedicated service bundle to better address the achievement of housing by developing expertise and focus on this particular issue. The coordination between the CCCC and Housing Services will be outlined for each participant so that there is no duplication of effort or resources.

- It is anticipated that individuals will receive Housing Services for approximately nine (9) months, with a range of six (6) months to two (2) years. Once the individual is placed in a safe living situation and is stable for a few months, he/she may be linked back to the CCCC Team, and/or continue receiving CCCC Team services, as needed, to meet the goals of their Tailored Plan of Care.

- The program budget is based on 252 member months at $1,603 PMPM in Year 2 as the program is ramping up, 360 member months at $1,681 PMPM in Year 3, 360 member months at $1,757 PMPM in Year 4 as staff costs are projected to increase, and then 360 member months at $1,838 PMPM in Year 5 to end the pilot period. Staff to participant ratio is 1:17. The Year 2 budget detail is calculated using a pro-rated formula of 70 percent of full year costs, assuming time for program start up, and is as follows:

Costs	Units	Total
Housing Coordinator	1.00	$40,461
Staff Benefits	1.00	$30,609
Contract Provider – Housing Services	1.00	$229,695
Allocable Direct Costs	1.00	$83,950
Indirect Costs	1.00	$19,241
TOTAL		$403,956
Member Months	252	$1,603

5. Pay for Reporting includes payments to WPC pilot program participating entities that are required to submit monthly, semi-annual, and annual reports to the lead entity, HHS, for the life of the grant. These reports will be utilized to track all required metrics listed in the application, as well as track outcomes associated with care of the WPC members. There are five subcategories of participants including hospitals, medical clinics, Managed Care Plans, Probation Department, and Housing Authority. All payment amounts were calculated the same way, assuming that 8 hours per month would be required for the monthly reports, and 8 hours for both the semi-annual and annual reporting requirements. An average cost of $75 an hour was used for all subcategories. Also, there is a pay for reporting incentive for the WPC Team for the timely submission of all necessary program reporting required by the State. This would include reporting on all the metrics and outcomes included in this application. The cost breakdown can be found in the Budget Detail document attached to the application.

6. Pay for Outcomes Metrics includes incentive payments for achievements, as follows:

   - Universal Metric – 70% of WPC members with a primary diagnosis of mental illness who are seen in the emergency department will have a CCCC visit within 7 days.
   - Universal Metric – Incentive payments will be provided to psychiatric hospitals for their assistance in meeting the WPC pilot program outcome of 80% of WPC members with a Serious Mental Illness (SMI) will receive a CCCC service following a discharge from a psychiatric hospital within 30 days. The incentives are $200 for notification to CCCC upon admission; and $400 for notification to CCCC at least 24 hours prior to release; or $200 for notification to CCCC upon discharge. The cost breakdown can be found in the Budget Detail document included with the application.

- Universal Metric – 70% of WPC members will have a completed assessment and Tailored Plan of Care within 30 days of enrollment. (Tailored Plan of Care is accessible to all WPC entities).
- Variant Metric – Percent of WPC members discharged from Index Hospital Stay who are not re-hospitalized within the next 30 days. Goal: 55% (Year 2), 60% (Year 3); 65% (Year 4); 70% (Year 5).

The funding requests for each of the categories for all of the 5 program years are detailed below:

- Program Year 1 – the requested budget amount of $4,025,258 is for the submission of the application and the required baseline data.

- Program Year 2 – the requested budget amount of $4,025,258 is for the initial year of implementation of the Whole Person Care Pilot Program. It is anticipated that if awarded the grant, it will take Placer County a few months to be fully implemented, so a pro-rated calculation of 70 percent was applied to total costs in Year 2. To offset the program cost decreases, the Year 2 budget includes more money in the Infrastructure category, as appropriate one-time startup costs. Please see the chart below for the annual requested funding amount for each individual line item for which funding is proposed:

Budget Line Item Description	Program Year 2 Amount
Administrative Infrastructure	$255,831
Delivery Infrastructure	$1,237,629
Incentive Payments	$45,192
PMPM Bundles	$1,914,144
Pay for Reporting	$171,133
Pay for Outcomes	$401,329
Grand Total WPC Year 2 Costs	$4,025,258

- Program Year 3 – the requested budget amount of $4,025,258 is for the second year of implementation of the Whole Person Care Pilot Program. It is anticipated that the program will be fully operational at this time, and Infrastructure costs will be fully expended and only included at an ongoing maintenance level. Please see the chart below for the annual requested funding amount for each individual line item for which funding is proposed:

Budget Line Item Description	Program Year 3 Amount
Administrative Infrastructure	$227,561
Delivery Infrastructure	$244,197
Incentive Payments	$64,560
PMPM Bundles	$2,726,640
Pay for Reporting	$211,931
Pay for Outcomes	$550,369
Grand Total WPC Year 2 Costs	$4,025,258

- Program Year 4 – the requested budget amount of $4,025,258 is for the third year of implementation of the Whole Person Care Pilot Program. It is anticipated that at this point in the grant, the WPC Team will have gained a higher level of sophistication with leveraging non-WPC program revenues, as well as gained the ability to begin to tap into existing community or hospital supported resources, and therefore, typical cost of living increases will not all have to be funded with WPC grant funds. Please see the chart below for the annual requested funding amount for each individual line item for which funding is proposed:

Budget Line Item Description	Program Year 4 Amount
Administrative Infrastructure	$232,924
Delivery Infrastructure	$252,585
Incentive Payments	$64,560
PMPM Bundles	$2,731,464
Pay for Reporting	$212,198
Pay for Outcomes	$531,527
Grand Total WPC Year 2 Costs	$4,025,258

- Program Year 5 – the requested budget amount of $4,025,258 is for the fourth and final year of implementation of the Whole Person Care pilot program. Again, it is anticipated that a majority of the cost of living increases will be absorbed by non-WPC program revenues and/or community resources. Please see the chart below for the annual requested funding amount for each individual line item for which funding is proposed:

Budget Line Item Description	Program Year 5 Amount
Administrative Infrastructure	$238,537
Delivery Infrastructure	$252,160
Incentive Payments	$64,560
PMPM Bundles	$2,743,788
Pay for Reporting	$212,786
Pay for Outcomes	$513,427
Grand Total WPC Year 2 Costs	$4,025,258

- WPC pilot program budgeted costs for the entire 5-year grant period are as follows:

Budget Line Item Description	Total Grant Budget Amount
Administrative Infrastructure	$954,853
Delivery Infrastructure	$1,986,571
Incentive Payments	$238,872
PMPM Bundles	$10,116,036
Pay for Reporting	$808,048
Pay for Outcomes	$1,996,652
Year 1 WPC Grant Budget	$4,025,258
Grand Total WPC Grant Budget	$20,126,290

Section 6: Attestations and Certification

Please note that the Attestation contained in the final application document is superseded by the revised Attestation which is included in the Agreement.

Attachments 1 and 2

Please note that Attachment 1 (Letters of Participation) and Attachment 2 (Letters of Support) that are contained in the final application document have been removed from this document for accessibility purposes. These documents are available upon request. Please contact the Placer County Health and Human Services department at the following location for information on accessing these letters:

Placer County Health and Human Services Department
3091 County Center Dr., Ste. 290
Auburn, CA 95603

Phone: 530-886-1870 or 1-855-729-0340

Attachment 3 – Funding Diagram

County of Placer
WPC Funds Flow

Note: This summary is a written description of the visual WPC Funds Flow Diagram (flow chart) that was included in the original application. The diagram has been converted to text to ensure accessibility.

Whole Person Care (WPC) grant funds flow from the federal Centers for Medicare and Medicaid Services (CMS), through the California Department of Health Care Services (DHCS), and then to the grantee, Placer County Health and Human Services. County match dollars are transferred from the County to DHCS, and then, in the form of intergovernmental transfers, flow from DHCS to CMS.

Placer County Health and Human Services transfers WPC funding to the various County departments that are participating in the WPC pilot, including Probation; Adult System of Care; Public Health; Housing Authority; and Human Services.

The Public Health department then distributes WPC funds to community providers via contracts. The community providers that are participating in the WPC pilot project include Anthem Blue Cross; California Health and Wellness; WellSpace; Sutter Hospital; Western Sierra; and Chapa De.

Attachment 4 (optional)

This attachment is not applicable to the Placer County WPC Pilot application.

WPC Budget Template: Summary and Top Sheet

WPC Applicant Name:	**Placer County Health and Human Services**

	Federal Funds *(Not to exceed 90M)*	IGT	Total Funds
Annual Budget Amount Requested	2,012,629	2,012,629	4,025,258

PY 1 Budget Allocation (Note PY 1 Allocation is predetermined)	
PY 1 Total Budget	4,025,258
Approved Application (75%)	3,018,944
Submission of Baseline Data (25%)	1,006,315
PY 1 Total Check	OK

PY 2 Budget Allocation	
PY 2 Total Budget	4,025,258
Administrative Infrastructure	255,831
Delivery Infrastructure	1,237,629
Incentive Payments	45,192
FFS Services	0
PMPM Bundle	1,914,144
Pay For Reporting	171,133
Pay for Outomes	401,329
PY 2 Total Check	OK

PY 3 Budget Allocation	
PY 3 Total Budget	4,025,258
Administrative Infrastructure	227,561
Delivery Infrastructure	244,197
Incentive Payments	64,560
FFS Services	0
PMPM Bundle	2,726,640
Pay For Reporting	211,931
Pay for Outomes	550,369
PY 3 Total Check	OK

PY 4 Budget Allocation	
PY 4 Total Budget	4,025,258
Administrative Infrastructure	232,924
Delivery Infrastructure	252,585
Incentive Payments	64,560
FFS Services	0
PMPM Bundle	2,731,464
Pay For Reporting	212,198
Pay for Outomes	531,527
PY 4 Total Check	OK

PY 5 Budget Allocation	
PY 5 Total Budget	4,025,258
Administrative Infrastructure	238,537
Delivery Infrastructure	252,160
Incentive Payments	64,560
FFS Services	0
PMPM Bundle	2,743,788
Pay For Reporting	212,786
Pay for Outomes	513,427
PY 5 Total Check	OK