Section 1: WPC Lead Entity and Participating Entity Information

1.1. Whole Person Care Pilot Lead Entity and Contact Person

Organization Name	San Mateo County Health System
Type of Entity (from lead entity description above)	County health agency incorporating San Mateo Medical Center and Clinics, Behavioral Health and Recovery Services, Correctional Health, Environmental Health, Family Health, Health Coverage, Public Health, Policy and Planning, and Aging and Adult Services, which includes APS, IHSS, Public Guardian and Public Authority.
Contact Person	Louise Rogers, Chief, and Peter Shih, Sr. Manager
Telephone	(650) 573-2532 and (650) 573-5094
Email Address	lrogers@smcgov.org and pshih@smcgov.org
Mailing Address	Health System, 225 37th Avenue, 1st Floor, San Mateo, CA 94403

1.2. Participating Entities

Required Organizations	Organization Name	Contact Name and Title	Entity Description and Role in WPC
1. Medi-Cal managed care health plan	Health Plan of San Mateo (HPSM)	Maya Altman, CEO, Edward Ortiz, Provider Network Director and Preston Burnes, Provider Services Special Projects Lead	San Mateo County's single health plan for the County Organized Health System, covers most publicly insured residents. Operates an expanded Community Care Settings program for WPC. **Pilot Participation:** Steering Committee, Operations Committee, Data Sharing

Required Organizations	Organization Name	Contact Name and Title	Entity Description and Role in WPC
2. Health Services Agency/Department	San Mateo County Health System (SMCHS) divisions involved in this proposal: San Mateo Medical Center and Clinics, Public Health Policy and Planning (PHPP), Aging and Adult Services (AAS), Behavioral Health and Recovery Services, and Correctional Health Services	Louise Rogers, Chief CJ Kunnappilly, MD, CEO, San Mateo Medical Center and Clinics (SMMC)	Lead agency for WPC whose divisions have role in multiple aspects of the proposal. SMMC is the division containing the public hospital with emergency department and psychiatric emergency services and federally qualified health center clinics in each region of the County. **Pilot Participation:** Data Sharing, Direct Service Provider
3. Specialty Mental Health Agency/Department	San Mateo County Health System, Behavioral Health and Recovery Services (BHRS)	Steve Kaplan, Director	The Health System Division that brokers or provides all mental health and drug and alcohol services, operates the Medi-Cal mental health plan, and soon the organized delivery system for Drug Medi-Cal. Oversees the IMAT program for WPC. Partners in the Collaborative Care Team (CCT) and other aspects of WPC. Oversees part of Service Connect along with Human Services Agency. **Pilot Participation:** Steering Committee, Operations Committee, Data Sharing, Direct Service Provider

Required Organizations	Organization Name	Contact Name and Title	Entity Description and Role in WPC
4. Public Agency/ Department (if housing services are provided, must include the public housing authority)	San Mateo County Human Services Agency (HSA)	Iliana Rodriguez, Director, and Selina Toy-Lee, Director of Collaborative Community Outcomes	The County agency responsible for all human services in addition to homeless outreach, shelter, and other housing supports. Lead agency for data-sharing project and study of homelessness among County clients. Oversees part of Service Connect along with BHRS. **Pilot Participation:** Data Sharing, Direct Service Provider
5. Community Partner 1	Institute on Aging	Cindy Kauffman, COO	Nonprofit organization that partners with HPSM and others on existing program planned for expansion in this proposal **Pilot Participation:** Data Sharing, Direct Service Provider
6. Community Partner 2	Brilliant Corners	William Pickel, CEO	Nonprofit organization that partners with HPSM and others on existing program planned for expansion in this proposal **Pilot Participation:** Data Sharing, Direct Service Provider

Required Organizations	Organization Name	Contact Name and Title	Entity Description and Role in WPC
7. Public Agency/ Department (if housing services are provided, must include the public housing authority)	San Mateo County Health System, Correctional Health Services (CHS)	Carlos Morales, Acting Director	Health System Division that provides all health and behavioral health services to inmates and partners with others to link clients to services upon re-entry **Pilot Participation:** Steering Committee, Operating Committee, Data Sharing, Direct Service Provider
8. Public Agency/ Department (if housing services are provided, must include the public housing authority)	San Mateo County Housing Department and Housing Authority	Ken Cole, Director	The County agency responsible for permanent housing development and the Housing Authority **Pilot Participation:** Steering Committee, Operating Committee, Data Sharing
9. Public Agency/ Department (if housing services are provided, must include the public housing authority)	San Mateo County Health System, Public Health, Policy and Planning	Cassius Lockett, Director; Anita Booker, Clinical Services Manager, and Frank Trinh, Medical Director	The Health System division responsible for Mobile Health Clinic, street and field-focused Bridges to Wellness Team along with public health functions **Pilot Participation:** Steering Committee, Operating Committee, Data Sharing, Direct Service Provider
10. Community Partner	StarVista	Sara Larios Mitchell, Executive Director	The nonprofit agency that operates First Chance Sobering Center **Pilot Participation:** Data Sharing, Direct Service Provider

Required Organizations	Organization Name	Contact Name and Title	Entity Description and Role in WPC
11. Community Partner	Horizon Services	Keith Lewis, Executive Director	The nonprofit agency that operates Palm Avenue, a social model detox program **Pilot Participation:** Data Sharing, Direct Service Provider
12. Community Partner	HealthRIGHT 360	Vitka Eisen, MSW, Ed.D, Chief Executive Officer	The nonprofit agency that operates substance use disorder (SUD) services including the IMAT clinic **Pilot Participation:** Data Sharing, Direct Service Provider
13. Community Partner	LifeMoves	Marc Sabin, Sr. Director, Programs and Services	The nonprofit agency that operates shelter and housing locater services, and the Homeless Outreach Team (HOT) **Pilot Participation:** Data Sharing, Direct Service Provider
14. Community Partner	Stanford University Medical Center and Clinics	Tim Morrison, Administrative Director, Patient Care Services	Operates Emergency Department (ED) /Trauma Center that serves HPSM members assigned to SMMC. Thought partner in development of WPC. **Pilot Participation:** Data Sharing, Direct Service Provider
15. Community Partner	Voices of Recovery	Ray Mills, Executive Director	Consumer directed self-help and advocacy organization focused on peer support and recovery from mental illness **Pilot Participation:** Data Sharing, Direct Service Provider

Required Organizations	Organization Name	Contact Name and Title	Entity Description and Role in WPC
16. Community Partner	Heart and Soul	Cardum Harmon, Executive Director	Client directed self-help and advocacy organization focused on peer support and recovery from SUD **Pilot Participation:** Data Sharing, Direct Service Provider

1.3 Letters of Participation

Letters attached.

Section 2: General Information and Target Population Description

2.1 Geographic Area, Community and Target Population Needs

2.1.A. Geographic Area Description, Community and Target Population Needs—WPC Structure & Approach

San Mateo County (SMC) is an affluent Bay Area county of 765,135 residents, with a median household income of $91,000 (U.S. Census Bureau, 2015). The county's affluence masks significant poverty, persistent health disparities, and high housing costs, with limited affordable housing options. SMC is an unaffordable place to live, with significant numbers of residents experiencing homelessness, especially those dependent on Social Security Income (SSI) or government assistance. SMC is one of the most diverse counties in the nation, experiencing continued growth of Latino and Asian populations.

WPC Vision, Structure, Entity Participation in Pilot Design. The SMC Whole Person Care (WPC) pilot will be overseen by the San Mateo County Health System (SMCHS). SMC has advanced an incremental healthcare reform process guided by the vision central to the WPC pilot*: To integrate the right services, at the right time, and the right place for the whole person across the continuum of care.* WPC services and supports will also incorporate the principles of trauma-informed outreach and service delivery including an emphasis upon health equity and cultural humility.

To advance this vision, WPC Steering Committee has been formed, comprised of the participating entities listed in Section 1. Each entity has been successful in addressing critical needs of sub-populations of High-Users (HUs) and WPC funding will coordinate, enrich, and expand these services to address the needs of a broader band of HUs who are challenging to engage and retain in treatment. WPC will be used to establish the culturally competent patient engagement, activation, care management, and support strategies necessary for complex HUs facing substantial barriers to connect with their primary care medical home and other services.

WPC will leverage and expand:
Integrated Medication Assisted Treatment (IMAT): A partnership led by BHRS, IMAT targets HU Medi-Cal recipients with chronic SUDs.

Community Care Settings Pilot (CCSP): In 2014, HPSM implemented the CCSP, a partnership designed to prevent institutionalization and to transition members from institutions to community living.

Collaborative Care Team (CCT): Directed jointly by BHRS, AAS, and SMMC, CCT targets adults with serious mental illness (SMI), co-occurring substance use disorders, and medical problems who cycle through EDs, Psychiatric Emergency Services (PES), acute, and locked long term care facilities.

Homeless Outreach Team (HOT): A partnership led by HSA that provides mobile outreach to homeless individuals and facilitates re-entry from jail and EDs for those without housing options.

Bridges to Wellness Team (BWT): A partnership led by PHPP and provides Mobile Health Clinic support to people in shelters, other field sites, and transitioning from jail and EDs, providing field-based medical care and care coordination. It works with HOT to re-establish linkages to each individual's primary care and behavioral health home.

To develop this proposal, leadership from these programs conducted a needs assessment and strategic planning process that included:

- Analysis of prior assessments;
- Review of HPSM's utilization data across settings, including SNFs, Emergency Departments (EDs), and Psychiatric Emergency Services (PES);
- Chart reviews; and
- Interviews with line staff and managers.

Upon reviewing these findings, participants brainstormed how to use WPC funding to reduce barriers and improve patient care. Their vision included: more integrated services; reduced duplication of services and care management; shared health information; and ongoing scrutiny of interventions and their impact. With a shared vision, partners then identified what infrastructure, staffing, training, and information systems were necessary to achieve the vision. White papers were shared among partners and another meeting was held to plan how to use the WPC to implement that vision. Partners found ways to combine forces, reduce duplication, share information, and respond to the needs of HUs.

HU Needs & Need for Pilot. Among findings that demonstrate the need for WPC funding:

A 2015 SMMC study of EDs found:

- 30% face ***housing instability*** with more than 2 address changes in a year;
- 60% have significant behavioral health challenges;
- Most patients have an assigned PCP, however, the ***no-show rate is significant and few utilize their medical home*** appropriately;
- HUs have a mix of ambulatory and non-ambulatory care related to ED visits.
- ***160 HPSM members assigned to SMMC had 10 or more ED visits*** in the past 12 months, ***1,800 had four or more ED visits and the top 4 SMMC HUs had charges of over $4 million***.
- Of the 160 members using the ED 10+ times in a year, they were associated with 217 unique SMMC hospital admissions during that time period. Of the 1,800 members using the ED 4+ times in a year, they were associated with 1,076 unique SMMC hospital admissions during that time period. This data does not capture their other hospital admissions.

Details on each Target Population are reported in Section 2.3.

The Steering Committee defined the Target Population (TP) for the WPC as those HPSM members assigned to SMMC who experienced four or more ED visits in the past year (N=1,800) and specified three subpopulations within this TP:

TP 1: HUs with mental illness and/or medical conditions who present frequently to EDs, PES and/or have avoidable or extended stays in residential treatment, MHRCs, SNFs, due to their illnesses/conditions and the barriers they face to community transitions;

TP 2: HUs whose untreated SUD interferes with their capacity to manage other medical and behavioral conditions and their ability to maintain connections to their primary care medical home;

TP 3: HUs with similar clinical profiles to TP 1 and TP 2, but who are either identified homeless on the streets or recently discharged from jail; are frequently presenting at EDs, and/or PES, are not well-connected to their primary care medical home; and engaging them may require sustained field-based effort.

The Steering Committee identified investments needed to better serve these three TP of HUs:

- Consistent care coordination especially during transitions from PES, EDs, SNFs, MHRCs, correctional facilities or the streets;
- Expanded affordable housing options and support for members to access and maintain housing;
- A broader range of services and supports not funded by Medi-Cal;
- Investment in system infrastructure including administrative, supervisory and direct service personnel; infrastructure equipment and technology; facility expansion, and administrative technology; and
- Expanded data sharing capacity.

The resulting application builds upon needed infrastructure to support an integrated system of services, while communicating and data-sharing across systems. An outcome of the pilot will be a reduction in avoidable costs and in turn create savings for HPSM that can be invested in programs that keep their members well. The goal by 2021 is to have a significantly reduced HUs population and the majority of HPSM members receiving appropriate wrap around services and have stable housing that will lead to a reduction in the overall costs of the Medi-Cal program.

2.2. Communication Plan

SMCHS will serve as the lead entity for the WPC pilot, with Louise Rogers overseeing implementation of the pilot. A WPC Steering Committee has been created, comprised of key leadership from all partners listed in Section 1 and other members with important roles. Staffed by the WPC Director, who will be the central point of contact for DHCS and for partnering entities, the Steering Committee will meet on a monthly basis throughout implementation of the pilot.

Directed by the WPC Director, an Operations Team will serve as an extension of the Steering Committee and be responsible for daily management and oversight of the pilot. During year one, this team will work with the WPC Director to develop an Implementation Dashboard comprised of key metrics for the pilot. The Operations Team will coordinate with the HPSM's Adult Oversight Core Team and an existing County Housing Our Clients Workgroup comprised of HSA, Housing, County Manager, Probation, Sheriff's, SMCHS, and HPSM, who will provide focused coordination of housing services for WPC clients and data integration efforts across systems.

LEAP Sitemap

A *WPC Implementation Dashboard* will be available online to all Steering Committee and Operations Team members, as well as program managers of all WPC activities. It will clearly articulate both the Universal and Variant metrics and all other WPC requirements to ensure a clear understanding among partners. On a quarterly basis, the WPC Director, analysts, and Operations Team members will collaborate in developing reports capturing the performance of the overall pilot and each of the three sub-populations in relation to Dashboard measures. This

report will be circulated to Steering Committee members before their next meeting. Using the four-step LEAP process (SMC's PDSA), the Steering Committee will be continuously assessing progress and impact to make timely mid-course corrections in operations. The Steering Committee will also serve as a conduit to participating systems, disseminating what is learned to help increase integration and coordination across the continuum. Finally, the Steering Committee will develop plans to sustain infrastructure and interventions beyond termination of WPC funding. The Health System Chief is accountable to the direction of the County Manager and the Board of Supervisors, and will cultivate and sustain a high degree of collegial collaboration with all partners in the decision-making for WPC implementation.

Quarterly reports will also be posted on the SMCHS web site and reported to the County Manager, Board of Supervisors, HPSM Health Commission and other interested commissions. In order to increase understanding and support of the WPC population and reduce stigma among the broader community, press releases on WPC achievements and challenges will be circulated and stakeholders will seek opportunities to speak in community forums. Public awareness is important to generate support for more systemic strategies to address the social determinants of health that contribute to poor health outcomes: socioeconomic status, education, the physical environment, employment, and social support networks, as well as access to healthcare.

2.3. Target Population

Through the processes described in 2.1, the WPC Steering Committee identified threshold WPC eligibility criteria of at least four ED visits in a 12-month period and then identified three sub-target populations meeting those criteria that collectively represent around 2,000 individuals:

TP 1: HUs with mental illness and/or medical conditions who present frequently to EDs, PES and/or have avoidable or extended stays in residential treatment, MHRCs, SNFs, due to their illnesses/conditions and the barriers they face to community transitions;

TP 2: HUs whose untreated SUD interferes with their capacity to manage other medical and behavioral conditions and their ability to maintain connections to their primary care medical home;

TP 3: HUs with similar clinical profiles to TP 1 and TP 2, but who are either identified homeless on the streets or recently discharged from jail; are frequently presenting at EDs, and/or PES, are not well-connected to their primary care medical home; and engaging them may require sustained field-based effort.

Leadership from SMCHS, HPSM, and each partner agency determined how best to meet the needs of these populations and identified matching funds and the number of HUs to be served by each program. The group then developed a budget comprised of the costs of infrastructure, Medi-Cal ineligible services, care coordination, data sharing capacity, and other costs involved in implementing the WPC. Target Population descriptions follow.

While SMC WPC TP's are clearly defined, potential members are complex and their conditions and needs overlap TP definitions. Part of each WPC team's function is to engage potential HUs wherever they appear and quickly move them to the best program to serve their *whole person care* needs. For this reason, WPC links strategies to multiple points of entry: primary care, institutions, EDs, PES, jail and re-entry points, streets, shelters, courts, etc.

We are estimating a total of 5,000 unique beneficiaries over the entire pilot with about 2,000 enrolled every program year.

2.3.a. TP 1: HUs with mental illness and/or medical conditions who present frequently to EDs, PES and/or have avoidable or extended stays in residential treatment, MHRCs, SNFs, due to their illnesses/conditions and the barriers they face to community transitions.

The Target Population served by HPSM Community Care Settings Pilot (CCSP) partnership with CCT and BTW will be HU members who:

- Experience four or more ED visits in any 12-month period;
- Reside in long-term care settings or Mental Health Rehabilitation Centers (MHRC) and can transition to lower levels of care, but face multiple barriers to community transitions;
- Are currently at-risk of hospitalization or admission to a long-term care facility;
- Are at risk of incarceration
- Are ED and/or PES HUs or likely to become frequent users without stable housing and housing supports.

Potential WPC members are identified via an intake form through various sources, including: SMCHS CCT and BWT, PES/ED/MHRC/SNF staff, HPSM case managers, hospital discharge planners, high utilizer reports, County case managers, supportive housing managers, social service programs, and primary care providers.

SMCHS' Collaborative Care Team (CCT) will partner with the CCSP to infuse the pilot with psychiatric expertise and linkage to BHRS and AAS resources including the Public Guardian. This will enable CCSP to sustain its effective transition work with SNFs and expand its TP to HUs transitioning from MHRCs, PES, and ED.

A report produced by SMMC in early 2015 examined data on SMMC ED HUs and found that annually an average of 160 HPSM members utilize SMMC's ED 10 or more times and around 1,800 HPSM members who utilize SMMC's ED four or more times. The report also found that:

- 30% of ED HU's face housing instability with more than two address changes a year;
- 60% have a behavioral health condition(s);
- While most patients have an assigned PCP, many did not show for appointments and most do not use the PCP in an appropriate manner; and
- Of the 160 members using the ED 10+ times in a year, they were associated with 217 unique SMMC hospital admissions (SNF, Acute Care, Psych in-patient, Intensive Care Units) during that time period. Of the 1,800 members using the ED 4+ times in a year, they were associated with 1,076 unique SMMC hospital admissions during that time period. This data does not capture their other hospital admissions.

A SMCHS study found that 70% of individuals in psychiatric inpatient care experience delays in discharge and 19% experience delays in their discharge from lower levels of residential care. Other findings include:

- 70% of psychiatric inpatients are ready for discharge and cannot move
- 10% of all patients in MHRCs ready for discharge to community housing cannot move

- Daily at each level of care, 20% of the total patients ready for discharge cannot be discharged, thus preventing admission of others who need care.

CCSP's existing partnership with Brilliant Corners (BC), provides a critical housing locator and housing support function that has served the SNF population well and will be a critical component identifying housing options for an expanded group of HPSM members exiting the other settings and levels of care that are impacted by the lack of community housing options.

In addition, WPC funding will enable the expansion to include:

- Psychiatric expertise and linkage to BHRS and AAS resources including the Public Guardian through the CCT;
- Increase in case manager capacity,
- Addition of dedicated program management,
- Peer mentoring program, and
- MD funding will be expanded to improve MD engagement of providers.

Data presented in section 3.1 demonstrate that CCSP has been extraordinarily successful in reducing SNF costs, transitioning SNF residents back to the community, preventing re-hospitalizations, and maintaining individuals at-risk of SNF utilization in the community.

Given the needs described above and CCSP's history of successfully transitioning SNF residents to lower levels of care; its ability to locate affordable housing options and transition institutionalized HUs to the community; and the infusion of CCT's psychiatric expertise, and other resources listed above, CCSP will be able to effectively replicate their approach to SNFs with HU's exiting MHRCs, PES and ED.

TP 2: HUs whose untreated SUD interferes with their capacity to manage other medical and behavioral conditions and their ability to maintain connections to their primary care medical home

Pilot	Enrollment Cap	Total Served Annually	Medi-Cal Enrolled	Non-Medi-Cal Enrolled
Behavioral Health and Recovery Services (BHRS)		1,350		

Integrated Medication Assisted Treatment (IMAT) will serve TP 2 HUs who have or are at-risk of a diagnosed SUD, with an emphasis on alcohol use disorder (AUD) and/or opioid use disorder (OUD), and have one or more of the following:

- Repeated, avoidable visits to the ED and/or PES—at least four ED visits per year;
- Complex mental health and physical health needs, including chronic pain;
- Homeless or at-risk of homelessness, and/or
- Multiple arrests, jail time or other criminal justice involvement.

As described in 3.1.b., IMAT engages potential WPC members via out-stationed care managers in PES, ED, the jail, detox centers, courts, Primary Care Interface based clinicians, and in the Pain Clinic. Individuals will be enrolled in IMAT if their primary problem is SUD.

As part of its needs assessment and WPC research, IMAT leadership participated in an extensive review of data and research coordinated by SMMC. IMAT staff conducted 100 chart audits of clients served in the Pain Clinic, did a random review of lab results and criminal justice reports, and examined HPSM data on ED utilization. In addition***,*** the team reviewed a December 2014 study of frequent ED-using clients who are HPSM members. The following findings point to SUDs contribution to HU ED utilization and its impact upon health outcomes:

- ***160 HPSM members had 10 or more ED visits*** in the past 12 months;
- 4 of the top 7 reasons for ER visits could be impacted by interventions: pain management, ***alcohol-related gastroenterologic conditions***, neurologic conditions, and ***behavioral health conditions;***
- PCP utilization data indicates these patients with SUD are mostly seeking care at the ED, not their PCP;
- Pain and alcohol related reasons accounted for 31% of all ER visits;

This report concludes by stating that "qualitative assessments confirmed that most of these patients have past trauma, are facing a combination of medical and mental health conditions, would benefit from case management and available social services, but due to their complex medical and behavioral health needs, have extreme difficulty connecting to the available services in the current model." As a result, IMAT co-locates care coordinators at SMMC's PES and ED at least 16 hours a day, seven days a week and will increase access to a range of support services and care navigation, as described in 3.1 below***.***

Amplifying the need for expanded IMAT services to the HU SUD population can be found from data derived from a 2013 BHRS pilot. In partnership with the SMMC, IMAT expanded access to medication assisted treatment and enhanced case management, with a focus on the use of Vivitrol for adults who were misusing alcohol, had two or more emergency room (ER) visits over the past two months, and were not currently using opiates. IMAT was able to quickly engage people willing to participate in the pilot and trained nurses on how to give injections. As the chart below depicts, ED, PES and inpatient episodes practically disappeared. In addition to the reduction in emergency services, IMAT also saw a decrease in the participant's drinking days and reduction in cravings.

	6 months prior to injection	in Vivitrol treatment	up to 6 months after the last injection
SMMC ED visits	1.9	0.1	0.5
SMMC PES visits	1.2	0.0	0.2
SMMC ED/PES visits combined	**3.1**	**0.1**	**0.7**
SMMC 3AB Inpatient episodes	0.2	0.0	0.0
Days of SMMC 3AB Inpatient	**2.7**	**0.0**	**0.0**

The data clearly indicates the need for interventions with this population and the capacity of the IMAT to meet those needs.

TP 3: HUs with similar clinical profiles to TP 1 and TP 2 but who are either identified homeless on the streets, discharged from jail, at EDs, and in PES, they are not well-connected to their primary care medical home, and engaging them may require sustained field-based effort.

Pilot	Enrollment Cap	Total Served Annually	Medi-Cal Enrolled	Non-Medi-Cal Enrolled
PHPP's Bridges to Wellness Team		650		

TP 3 will be served by the Bridges to Wellness Team (BWT) collaborating with HOT that will coordinate with the Psychiatric Emergency Response Team (PERT) as necessary. BWT will provide care management and other support for TP 3 to restore linkages back to the primary care medical and behavioral homes. BWT defines its TP as HUs or those who are at high-risk of becoming HUs who are:

- Living on the streets or in shelters and/or
- Transitioning from jail and/or
- Using PES or the ED more than 10 times per year and/or
- Experiencing housing instability and/or
- Having complex medical issues along with a mental health condition and/or
- Not well-connected to their primary care and/or behavioral health homes and require sustained field-based effort to engage.

The common thread to the BWT population is HUs whose ability to appropriately utilize the healthcare system is compromised by either homelessness, behavioral health disorders, or exacerbated by the social determinants of health, primarily poverty and lack of stable housing. As a result, this population experiences high levels of recidivism to jail, crisis, and high utilization of PES and ED.

The criminal justice re-entry population has a high level of SUD and other medical problems and is also at high risk of failure to connect with medical, behavioral health, and other services upon discharge from jail in addition to being at high risk homelessness. A study conducted by SMCHS found that soon after criminal justice realignment commenced, a third of recently discharged inmates became SMMC ED patients. Therefore, SMCHS is expanding the onsite and field-based medical support connected to Service Connect, the jail re-entry program.

The need for expanded outreach and engagement of the homeless population is also clear. In a 2014 study, SMCHS counted 4,911 unduplicated homeless individuals as SMMC patients. The vast majority was served by the Mobile Health Clinic (3,150), which parks near the shelters and other areas where homeless people congregate. In another SMCHS study in FY13-14, 43% (1,168) of all admissions to alcohol and drug treatment providers described themselves as homeless. Almost 44% of these people (512 admissions) had criminal justice involvement. Co-occurring mental illness was present in 32% of the group (418). Only 6.8% (79) of those engaged were working part or full-time, a clear indicator of the impact of social determinants.

To further assess the re-entering inmate needs, Correctional Health Services (CHS):

- Conducted a one-day count of booking information that identified by self-report and police report 145 inmates who had homeless status;
- Reviewed one month service logs and identified 59 inmates who were on ETOH with Librium detox protocol;
- Reviewed pharmacy billing reconciliation for a month to identify 90 inmates with two medications or more for treatment of a chronic medical condition, and
- Reviewed pharmacy billing for reconciliation of psychotropic medication as a marker for treating severe mental illness with approximately 320 inmates identified.

Lack of housing impacts both the homeless and HUD housing report for SMC covering October 1, 2014 - September 30, 2015 underscores the challenge faced by this population with a clear bottleneck in finding permanent supported housing.

Individuals in emergency shelters	1,881
Individuals in transitional shelters	1,983
Individuals in permanent supported housing	517

Finally, for many homeless individuals, lack of housing, mental health and alcohol conditions contribute to their frequently encountering crisis situations with law enforcement officers inadequately trained to diffuse a crisis and having to rely too often upon 5150s and PES. The PERT pairs an experienced mental health clinician with a Sheriff's deputy who provide

consultation, planning support, coordination, and response to officers struggling to respond to homeless individuals in acute crisis.

The clear compounding of clinical, social, and economic challenges creates a HU population that requires intensive outreach, engagement, and support from a multidisciplinary team with expertise in medical, behavioral, housing, and criminal justice systems. As described in 3.1 below, the BWT has created an approach suited to this challenge.

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

3.1 Services, Interventions, and Care Coordination

The vision for the pilot is *to integrate the right services, at the right time and the right place for the whole person across the continuum of care.* To achieve this vision, the Steering Committee and leadership from the partnering programs that comprise the WPC pilot, conducted an assessment of the needs of the HU population across subpopulations. Part of this assessment was a review of eight journal articles. In general, the literature reports that: case management; patient financial incentivization; patient education on chronic disease management; pre-hospital diversion for low-acuity patients; and capacity increase for non-hospital settings have shown some benefit in reducing high utilization. The Steering Committee asked partners to incorporate these findings as they planned how to augment their current program.

The Steering Committee outlined the key elements and strategies that would enhance coordination, collaboration, and data sharing among partners to better serve the target populations. While WPC target populations are described separately, if SMC has learned anything from years of research and development to serve HUs, it is that HUs do not fit neatly into boxes, hence their not being served well by siloes. This pilot has been designed to link to multiple points of entry across the county and respond flexibly with three programs--each of which could also be the point of entry for a HU—communicating across systems and programs to assess needs and assign eligible members to the program that best meets the member's *whole person needs.*

To frame the description of services and supports, infrastructure investments, interventions and care coordination activities, a brief summary of the Virtual Linkage Hub is provided here.

The Hub was developed to facilitate collaboration, communication, and data sharing among programs. A WPC Program Director and analysts will be hired to direct the pilot and manage the Hub. This team will:

- Utilize the Heath Information Exchange (HIE), EHR 2.0, and a SMC WPC Dashboard to capture relevant data on the overall pilot implementation, the ramp-up of each program and WPC-wide and program-specific charts projecting interim, annual, and YTD performance measures, including measures related to health disparities;
- Utilizing predictive analytic software and the HIE, the HUB analyst will work with HPSM staff to develop a risk calculation algorithm to identify individuals at-risk of becoming a HU and assign these individuals to the most appropriate program for assessment and enrollment;
- Conduct interviews and surveys with pilot line staff, managers and members to identify gaps in service delivery, levels of satisfaction, training needs, and infrastructure needs;
- Manage a WPC chatroom where WPC staff and managers can informally exchange ideas and seek information and consultation across programs and systems;

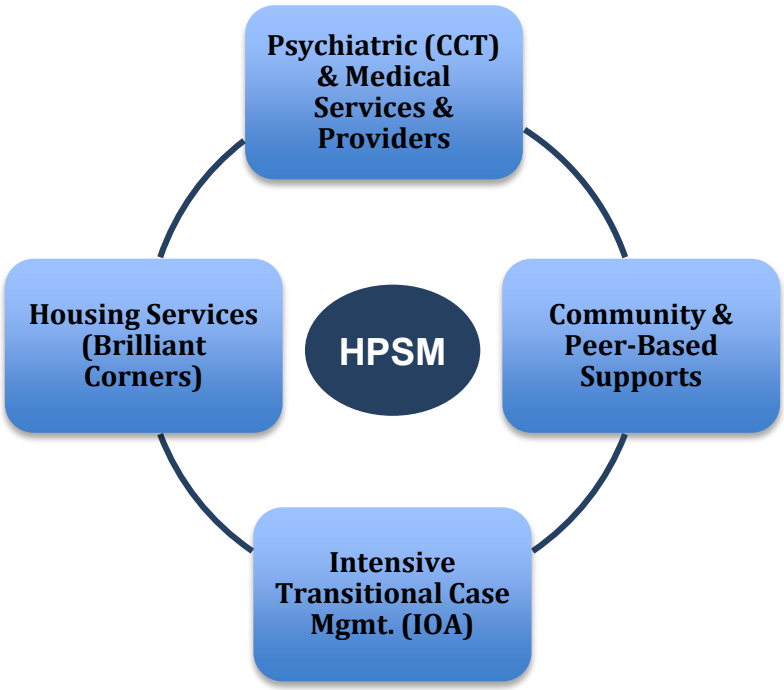
- Track enrollment of new members identified through outreach and monitor intake assessment results and care coordinator assignment to verify member eligibility and to ensure the program placement is the most appropriate available;
- Coordinate reporting of WPC enrollment information to HPSM for integration in their analytics and to the SMCHS Office of Managed Care for assistance with onboarding members;
- Identify the need, schedule, and evaluate an ongoing series of training in the principles and practices of WPC, motivational interviewing, trauma-centered care management and treatment, Cognitive Behavioral Therapy, and staff training for care coordinators, peer mentors, and other staff focused on roles and responsibilities, evidence-based practices relevant to their position and TP served, interpreting and using data relevant to their TP;
- Training will also be offered for Steering Committee members, pilot program managers and staff in conducting LEAP inquiry while also orienting trainees to the WPC metrics, productivity goals, and health outcome measures, so that Steering Committee and program staff can utilize LEAP effectively in ongoing QI and program planning efforts;
- A virtual shelter, transitional shelter and scattered site housing inventory will be maintained and this inventory will be accessible by care coordinators across the WPC, significantly facilitating access to housing for all WPC members; and
- Meetings of the Steering Committee, Operations Team, and action groups formed by leadership will study and discuss specific implementation challenges and opportunities.

Beyond these activities, and other functions identified in the course of WPC operations, the HUB will serve to virtually integrate care management across systems. Program team members identified as care coordinators will join the HUB with existing caseloads who will be enrolled in the WPC pilot. With WPC funding, each program will expand significantly, so as slots open in any program and as new members are enrolled in the WPC, the HUB will serve to monitor the assessment and placement of new members to ensure the most appropriate placement occurs. The plan is for care coordinators to manage their members across the system. Over time, this will eliminate members being managed by multiple care managers in multiple programs and systems. With the HIE, HUB staff will be able to identify where a WPC member has multiple care managers, assess the need for multiple managers and move the system toward the goal of having each member coordinated by a single individual with whom a trusting relationship can be formed via consistent care management being focused on the holistic, *whole-person* goals and needs.

Pre-dating the development of this proposal, SMC had launched a number of programs serving different populations of HUs. Leadership from these programs are members of the WPC Steering Committee and participated in an extensive planning process to develop this application. Each of these programs is charged with improving health outcomes, reducing utilization of high-end levels of care and to utilize the LEAP approach to monitor their program and report to SMCHC on progress. As a result, SMCHS will develop an intimate understanding of what works, what is needed to make services/systems work better, and how to best serve

the three target populations. The pre-existence of these programs and the culture of collaboration and inquiry that surrounds all SMC heath reform efforts is the best assurance of success with the WPC pilot.

The following descriptions highlight the need for interventions for each TP and the rationale and data to support why these programs can significantly improve TP outcomes.



3.1.A* TP 1: *HUs with mental illness and/or medical conditions who present frequently to EDs, PES and/or have avoidable or extended stays in residential treatment, MHRCs, SNFs, due to their illnesses/conditions and the barriers they face to community transitions; the three-tier WPC target population.

Services Not Funded by Medi-Cal

Since January 2015, the CCSP has provided intensive care management program directed by HPSM and implemented by the Institute on Aging (IOA), and Brilliant Corners (BC). For WPC, the Collaborative Care Team (CCT) has joined the partnership to provide psychiatric consultations and services.

CCSP members rely upon an array of services not reimbursed by Medi-Cal:

Housing Supports: Individuals exiting from MHRCs, EDs, and PES will have will have more significant housing needs than those SNF residents CCSP has been serving, so BC will double housing location services and supports. Individuals already residing in the community may also need services and supports to maintain or extend independence. Challenges for members may

include landlord disputes, expiration of Section 8 voucher while hospitalized, or a home that is no longer safe given the member's functional status. BC typically remedies these problems.

Transportation Supports: For members with mobility issues, WPC funding will purchase a lift-equipped vehicle.

Member Incentives: Incentivizes will reward members for participating in care plan activities that encourage self-management of care and participation in prevention, wellness and other services.

Peer Supports: Mentors in Discharge, piloted in Alameda County, reduced hospitalizations by 72% in its first year. Mentors in Discharge matches trained peers with PES/ED experience with patients before they are discharged with the mentor providing ongoing support and encouragement to sustain client commitment to recovery.

Administrative infrastructure in the form of a program manager, assistant, QI director, and analyst, and Medi-Cal billing specialist staffing.

Outreach and care coordination as described below under interventions and coordination.

Staffing to conduct outreach and coordination with Full Service Partnerships (FSP) and other treatment options

Staff travel/communication needs: Cell phones, laptops, office phones, airline tickets.

CCT vehicles: Six staff members currently share two cars. Two additional cars would enable teams to visit client placements more frequently.

Email accounts for contractors will facilitate communication among staff and providers.

Interventions

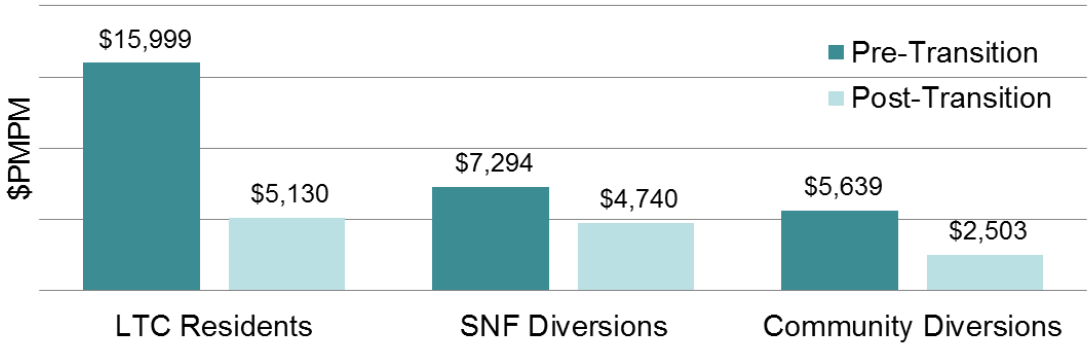
Eligible individuals are identified via an intake form through: PES/ED/MHRC staff, HPSM case managers, hospital discharge planners, high utilizer reports, county agency case managers, supportive housing managers, social service programs, and primary care providers. Once eligibility is determined, an IOA case manager assesses the client, prepares a case summary and presents it to the CCSP Care Group, which includes representatives from SMC BHRS, BC, IOA and HPSM, along with the individual and his/her family, as appropriate. If the individual does not have a safe, stable housing option, BC will work with the individual to identify one.

In addition to providing psychiatric consultation on SNF, LTC, and community diversion cases, CCT clinicians will work with members exiting MHRCs, PES, and ED to plan reentry, ensure continuity of medications, and coordinate with BC to identify an appropriate housing option. CCT clinicians will collaborate daily with psychiatric and medical inpatient units, and at least

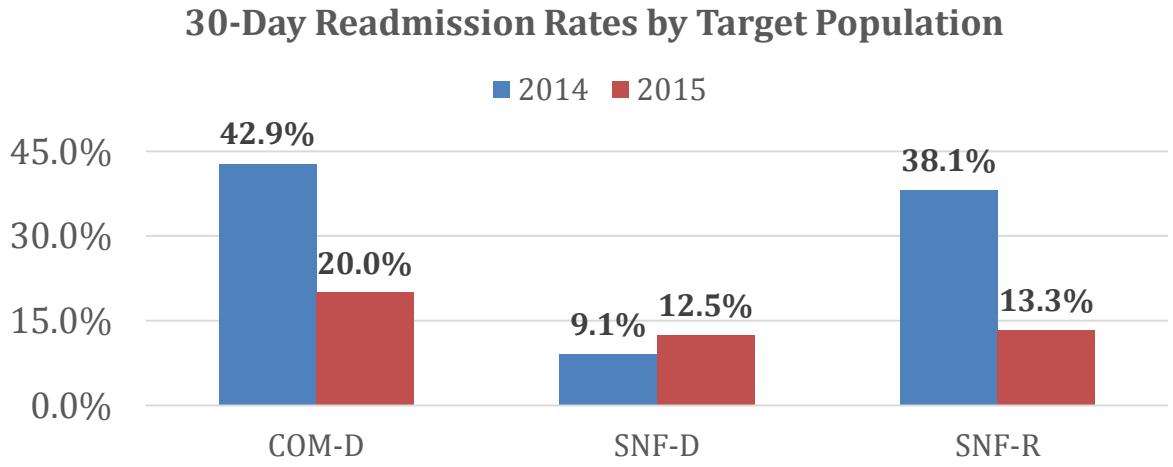
weekly with MHRCs to sustain re-entry planning for patients. CCT clinicians will also build relationships with contract facilities, to improve quality of care, preserve placements for challenging clients and identify slots for MHRC patients ready for discharge. Once a transition occurs, CCT will provide mobile case management to address patient flow throughout the system.

During transition planning, particularly for members with ambulatory issues, IOA care managers identify and schedule appropriate in-home supports, especially important during the initial transition periods where individuals adjust to independent living.

While CCSP's target population is being expanded to serve individuals exiting from PES, ED, and MHRCs, CCSP's success in managing SNF clients, many of whom also had mental health and SUD disorders, makes SMCHS confident that it will continue to succeed with the SNF population and with this new population, especially with the infusion of CCT psychiatric support. As the graphic below depicts, CCSP achieved dramatic reductions in utilization and PMPM costs for LTC residents, SNF diversions and Community Diversions.



The next table provides further evidence of CCSP's effectiveness. In 2014, before CCSP services were initiated, the overall hospital readmission rate for SNFs was historically high and in 2015 after CCSP's launch, these rates were reduced significantly, indicating that CCSP interventions and supports were effective in reducing readmission rates.



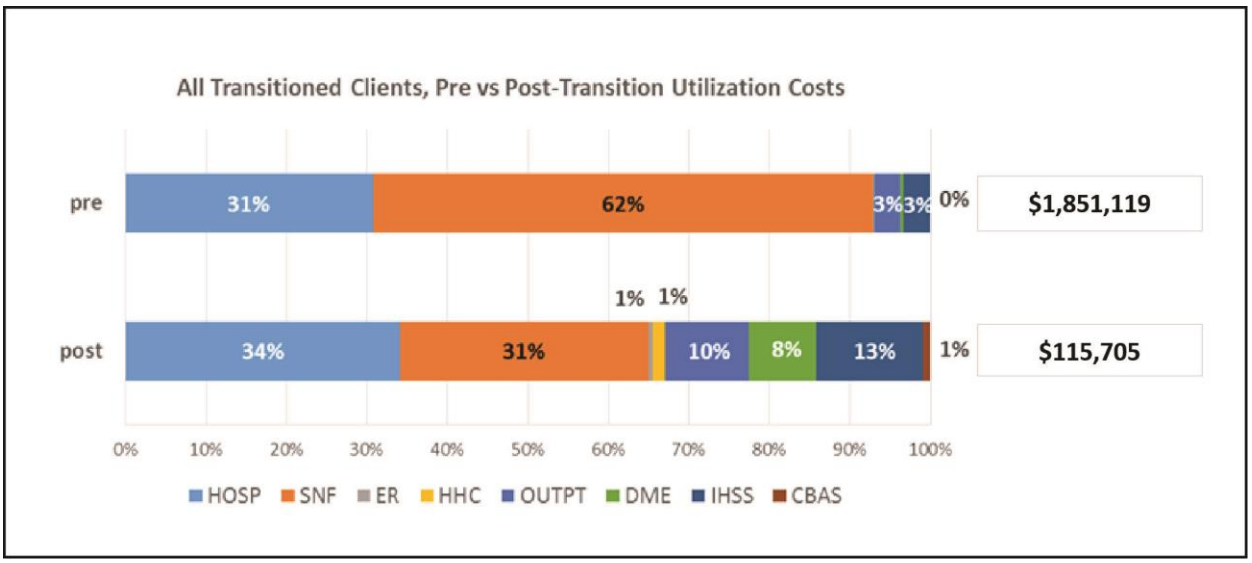
Care Coordination

Once a member is engaged, the transitioning process begins. While transition planning from a SNF or MHRC may take several weeks or months, transition from PES and the ED will move much more quickly. The IOA case manager will meet with the member and involve the family, physicians, other providers, or social workers and the CCT psychiatrist for PES, ED, and MHRC transitions. For all individuals requiring residential services, the CCSP Core Group (operations) determines the least restrictive community housing option that is likely to succeed. Then the IOA case manager either works with a contracted assisted living facility operator, residential treatment facility, or coordinates with BC to identify affordable housing and rental subsidy information. A Mentors in Discharge team (peers) will be recruited, trained, and assigned to caseloads of 20 members being discharged from MHRCs, PES, or ED. Mentors will provide socialization and support and will serve as an extension of the care team, providing reminders about appointments, medications, and self-management strategies.

Once an individual is transitioned to the community and connected to services, there is an evaluation period to ensure that the placement and/or implemented services are effective and likely to allow the member to continue to reside in the community long-term. For those exiting SNFs, IOA care managers operating with a caseload of 15-20 members, will conduct home visits, maintain phone contact, and coordinate the work of the Mentors in Discharge. BC will remain connected to members requiring housing services throughout the pilot and support them as a landlord liaison, emergency contact, and habitability and wellness checks, along with other roles.

Expanding the population to serve members with SMI required partnering with CCT whose care managers will deliver clinical services to members exiting PES, ED, and MHRCs with a goal of reconnecting members to their behavioral health home and maintaining them in the least restrictive level of care possible. To achieve these goals, care managers will maintain a caseload of 10-15 members so they can conduct home or treatment program visits at least weekly during the initial transition and monthly once the transition is more firmly established.

As the graphic below depicts, CCSP has been extraordinarily effective in both transitioning members from SNF to the community at immense savings to the system.



The integration of the CCSP and CCT and the incorporation of the Mentors in Discharge program will significantly strengthen an already high-performing program and expand the breadth of its coverage to HUs of the MHRCs, PES, and EDs.

3.1.B. TP 2: HUs whose untreated SUD interferes with their capacity to manage other medical and behavioral conditions and their ability to maintain connections to their primary care medical home

Services Not Funded by Medi-Cal

HUs with chronic substance abuse disorders (SUD) will be served and managed by the Integrated Medication Assisted Treatment Team. In operation since 2015, IMAT is a partnership led by BHRS. HUs with chronic SUD will require many services and supports not funded by Medi-Cal, including:

Housing Supports: For members with challenges accessing housing, IMAT will collaborate with BC to identify the most appropriate affordable housing available and provide ongoing support to the tenant and landlord to ensure housing continuity.

Transportation: Supports are needed to facilitate members participating in the range of IMAT services and supports and to more easily access BHRS treatment services and their primary care home.

Sobering Station Partnership: WPC funds will also strengthen a partnership with the Sobering Station. The Sobering Station operates 24 hours a day, 7 days a week. The Station will admit clients at any time and can safely hold individuals for up to 18 hours. Adding two FTE contracted IMAT case managers to the Sobering Station will add a needed resource to engage clients. This function is not Medi-Cal reimbursable.

To expand the availability of residential detoxification (ASAM 3.2 WM) services, WPC funding will also be used to fund tenant improvements to the Sobering Station for the addition of showers, allowing for the addition of detoxification beds. These detox beds will eventually be billable under Medi-Cal, but services are not currently billable.

Medication Assisted Treatment Not Currently under Medi-Cal: The IMAT Clinic, which currently only serves those with AUD, will begin offering Suboxone and other medications for those struggling with chronic opioid use issues. HealthRIGHT 360 operates the IMAT clinic and offers transitional primary care in addition to MAT services. WPC funds will support HR 360 OUD service expansion until such time that Drug Medi-Cal coverage is in place.

Wellness Programming: To reduce pain and lower opioid dosage and prescribing, wellness programming for pain management and rehabilitation will be offered at the pain clinic such as Mindfulness, Yoga, Acupuncture, Health Education groups, and Tai Chi.

Peer Supports: Peer Recovery Coaches increase client participation in wellness and recovery activities to improve self-management, reduce relapse, and increase social supports by providing coaching and linking clients to organizations/activities such as Wellness Recovery Action Planning – an evidenced-based practice to identify key recovery issues and plan for self-improvement. A peer run local nonprofit agency that encourages and supports personal, family and community recovery by offering non-clinical, peer-driven assistance to foster resilience, and prevent relapse. Voices of Recovery will provide these services.

Administrative infrastructure will be made up of a fiscal services manager, program manager, senior accountant, patient assistant services staff, and management fellow.

Outreach and care coordination as described below under interventions and coordination.

As funding policies change related to some of the above treatments, the pilot will carve out these components and shift those funds to expand other unfunded services and supports.

Interventions

HU members with SUD require a finely tuned combination of medical, behavioral, and peer services to enter and maintain their commitment to recovery. Key intervention strategies include:

- Intensive case management;
- Improved care coordination through staff co-location;
- Stabilization of acute intoxication and non-medical withdrawal management;
- Expand access to medication-assisted treatment (MAT) and other appropriate SUD treatments;
- Integrate treatment of SUD and chronic pain using evidence-based approaches; and
- Connect to peer-based community recovery supports

Integrated Treatment of Addiction, Pain, and Trauma: IMAT builds an integrated team of experts to improve treatment outcomes in partnership with the SMMC Pain Clinic. With WPC funding, a dedicated IMAT case manager will be embedded in the pain clinic. SMMC's pain clinic will hire 1.5 FTE addictionologists and 2 FTE trauma-informed licensed clinicians to provide coordinated pain management and SUD services.

Vivitrol Injections: In 2013, in partnership with the SMMC, BHRS launched a small pilot testing the impact of expanded access to medication assisted treatment and enhanced case management. The extraordinary reductions in use of ED, PES and inpatient settings are described in a chart and narrative in Section 2.2.

Care Coordination

Intensive case management is provided by the IMAT team to engage high-risk individuals with SUDs in services. This population is often ambivalent about SUD treatment and struggles to access the complicated service system. IMAT case managers retain low caseloads of 1:10-1:15 to provide the intensity of service needed to support individuals and link them to care. The IMAT case manager coordinates all appropriate care and prevents duplication of services. To facilitate outreach, engagement and care coordination, IMAT outstations care managers throughout the SMMC and partner systems. The co-location at the ED, PES, the jail, detox, and primary care clinics enables IMAT to more quickly and easily engage clients before discharge and begin planning for re-entry into the community.

When a client is referred to IMAT, the case manager (CM) who has the first contact with the client becomes the client's primary care coordinator. The CM works collaboratively with the member and other involved care providers to design an integrated, individualized, culturally appropriate, and strength-based plan to address the client's own needs and goals. The IMAT CM checks up to five EHR systems for client health information to ensure care is coordinated and to prevent duplication with other case managers such as those served by BWT. As part of the WPC, the Hub and HIT Department will construct an HIE and EHR 2.0 that will significantly simplify this coordination function.

Case Manager Responsibilities:

- Work with ED, PES, and SMMC clinic staff, criminal justice, other SUD providers and systems to identify, outreach, and engage individuals for the IMAT program;
- Facilitate referrals for individuals in immediate need of stabilization of acute intoxication and non-medical withdrawal management;
- Assess member housing needs and work through the Hub to access BC housing;
- Assess members' needs and identify key clinical interventions;
- Build trust with members by using Motivational Interviewing, and Harm Reduction practices;
- Use contingency management and other reinforcement procedures to modify behaviors of substance abusers;

- Connect members to a continuum of SUD services, including medication assisted treatments and medical, mental health, and social service programs;
- Assessment of medication symptoms, side effects with particular attention to the 30-day induction phase in IMAT clinic;
- Provide client transportation and attend appointments as appropriate;
- Connect members to housing resources, conduct home visits as needed;
- Ensure clients enroll for benefits, including health coverage, aid, and food assistance; and
- Provide crisis support

Taken together, the IMAT treatment partnership successfully engages and treats perhaps the most treatment-resistant population in SMC.

3.1.C. TP 3: HUs with similar clinical profiles to TP 1 and TP 2 but they are either identified homeless on the streets, discharged from jail, at EDs, and in PES, are not well-connected to their primary care medical home, and engaging them may require sustained field-based effort.

Services Not Funded by Medi-Cal

The services, supports, interventions and care coordination provided to TP 3s will be delivered by the BWT in collaboration with Homeless Outreach Team (HOT), and the Psychiatric Emergency Response Team (PERT) operated by the Sheriff's Department and BHRS. TP 3 HUs will need many of the same supports as TP 1 and 2 including:

Housing Supports: To address the need for housing and supports, LifeMoves offers the Housing Readiness Program through HOT, which provides accessible and housing support services as well as coaching to develop skills, tools, and resources that facilitate long-term housing. As needed, HOT care managers will collaborate with BC to access its housing inventory and housing supports.

Transportation: WPC funds will support replacing the 12-year old mobile health clinic coach used to drop off community health outreach workers and peers at parks, under bridges, and other locations frequented by homeless individuals, before parking at shelters and programs serving homeless individuals. Most coach-delivered medical services are Medi-Cal billable but purchasing a new coach is not.

Self-Management Education & Empowerment Classes: Classes focusing on self-management of a range of conditions from depression to diabetes and hypertension will be offered by BWT Resiliency Specialists, with peer mentors supporting sustained commitment to wellness and recovery. BWT will pilot use of 60 SMART phones (not Medi-Cal reimbursable) with members

and will use these phones to provide automated reminders about appointments, self-care, and medication regimen.

Mobility and Communication Tools: To improve data sharing and communication, WPC funding will purchase wireless laptops, SMART phones for staff, and set up Patient Interpretation Services Equipment (HCIN).

Peer Mentors in Transition and Recovery: BWT will partner with Mentors in Discharge and match peers with similar life experiences to new WPC members. In addition to outreach, peer mentors will provide ongoing support to members.

Administrative infrastructure will be in the form of patient services, a management analyst, and program support staffing.

Outreach and care coordination conducted by the field-based outreach worker and Health Resiliency Specialists are described below under interventions and coordination.

Psychiatric Emergency Response Team (PERT): The PERT will pair a Sheriff's Deputy with an experienced BHRS mental health clinician. The PERT will conduct a field assessment of individuals experiencing a crisis and the mental health clinician will determine if the individual is known to BHRS already utilizing smart phones to access the individual's EHR. The PERT will stabilize the individual by adopting a non-threatening approach using motivational interviewing.

Interventions

The Mobile Health Clinic (MHC) has been in existence for almost 20 years and consists of a fully staffed clinic, based out of a mobile coach vehicle parking at multiple sites throughout the county on a weekly schedule with patients seen on a walk-in basis to improve access. In January 2015, the MHC expanded to include in its route the Service Connect site in San Carlos to target inmates released from the jail. The MHC also serves the SMC Drug Court where nonviolent, diversion-eligible defendants who have been accused of a drug-related offense can enter treatment and upon successful completion of treatment, have charges dismissed or reduced.

In January 2016, the BWT team formed a partnership with MHC. The MHC team continues to deliver medical care in the field directly to homeless individuals by bringing medical equipment and medications to the tents, encampments, and streets. The MHC team works alongside the HOT, which locates street homeless individuals needing medical care. The goal of the MHC program and BWT is to provide bridging primary care services while linking homeless individuals to the SMMC's primary care clinics and BHRS.

The HOT engages homeless individuals so that medical services can be brought to them. Once patients are seen in the field by the MHC, the HOT follows-up with them to facilitate their

making it to scheduled appointments and lab/radiology visits. This model of field medicine with field-based supportive services has resulted in a >70% show rate to appointments made in the Health System.

The majority of homeless individuals have mental health and/or drug dependence issues that often contribute to their homelessness. As a result, achieving successful health outcomes will require adequate management of these needs. To expand the range of services available in the field and to foster member reintegration into the BHRS clinic system, WPC will fund integration of psychiatric personnel into BWT. With increased psychiatric capacity, BWT will be better able to deliver field-based, psychiatric outreach and services to facilitate engagement and reconnecting members with their behavioral health home.

Care Coordination

After engagement, the HUs will need to continue accessing the Health System at multiple points, requiring care coordination so homeless patients continue utilizing services consistently. With WPC funding, the BWT will expand the field-based outreach worker and Health Resiliency Specialist who will be responsible for:

- ED High Utilizer Patient outreach, building trust with the patients and engaging patients to enroll in program;
- Connecting ED High Utilizers to Primary Care or back to their Primary Care Medical Home (PCMH);
- Connecting ED High Utilizers to BHRS; to HSA resources; to shelters, transportation, and housing;
- Connecting ED High Utilizers facing alcohol addiction to IMAT services;
- Connecting ED High Utilizers facing drug addiction to the County's addiction services;
- Reminding patients of appointments and attending appointments with patients if necessary;
- Visiting the jail and Service Connect to work with Correctional Health Services to initiate re-entry planning and to outreach to the Drug Court;
- Conducting home and/or field visits;
- Supervise the peer Mentors-in-Transition team; and
- Helping patients with prescription refills.

To ensure BWT engages patients in real time, SMMC staff will place alerts on the HU patient charts in the systems of care. This will enable a care manager working with a patient to identify that the patient is eligible for WPC and encourage that patient to engage the BWT and enroll in WPC while being face to face with the patient.

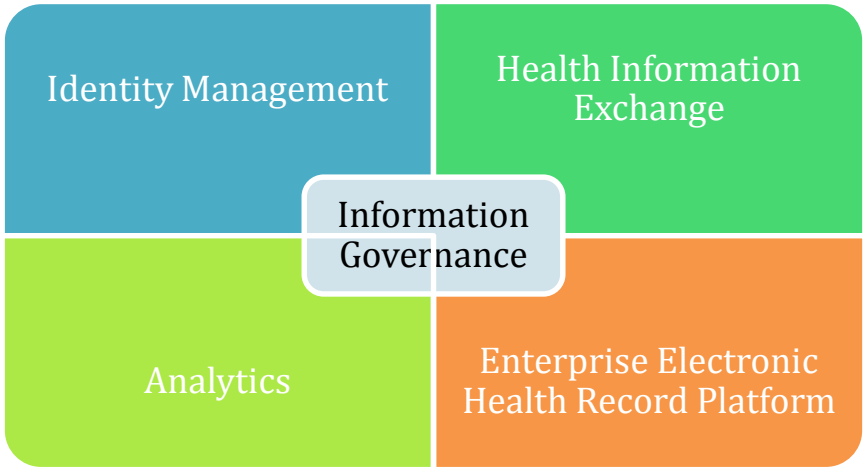
BWT fills a critical role in engaging a population that resists engagement in the typical pre-established care settings due to a combination of social determinants of health and struggles with chronic behavioral and/or medical conditions and is either a HU or is at high risk of becoming one. These are people who seek help in the most expensive settings without

requisite support services and require an aggressive, but sensitive outreach effort to restore them to housing, treatment within well-established behavioral or primary care homes.

3.2. Data Sharing

The pilot calls for development of a completely integrated Health Information Exchange that will serve all Target Populations. To avoid duplication and to provide the reader with a clear understanding of the scope and scale of this HIE, it is described in one section with a 1436 word count. Hence, 1475/3=492 words taken from each TP discussion: 750-492=258 per TP.

The delivery of services described by the WPC pilot demands a highly interoperable Healthcare Information Technology (HIT) infrastructure. Many healthcare organizations struggle with the presence of essential information in multiple data sources where a lack of information governance clouds the vision of a future state where the data describing the social determinants of health are joined with the data describing the direct healthcare services that our clients consume.



Vision

The vision for HIT interoperability in the San Mateo County Health System (SMCHS) is clear: Information on demand, putting our clients first. SMCHS has articulated a multi-pronged approach for HIT interoperability, all supported by a robust information governance capability. Information governance is at the core of our vision because it represents the intersection of requirements, governing statutes, policy and most importantly, organizational trust.

The vision of putting our clients first goes beyond the Health System. The Health System has several data-sharing agreements with HPSM to support care coordination for HPSM members who have SUD and mental illness. The County partners involved in the Housing Our Clients oversight group also have a data-sharing agreement and have initiated work and signed agreements to examine the overlap of HPSM, Health System, and other clients in the housing services systems and have expressed interest in using Health System technology to integrate this data routinely. This would support an integrated view at the point of care as well as better data for program planning.

Identity Management (IM)

SMCHS has implemented a master person index (MPI) technology that currently matches identities across clients assigned to SMCHS by the HPSM and all SMCHS electronic health record systems.

The technology is scalable and can serve as a baseline for matching identities from virtually any source of demographic data. This opens the door for strong identity management across traditional health as well as social services information systems, such as those managed in the Department of Housing and the Human Services Agency. The MPI also houses a provider directory, an essential phonebook of public agency and community-based service providers that serves as the directory for a secure communications environment in a health information exchange.

Health Information Exchange (HIE)

The HIE will support several layers of interoperability both within and beyond the boundaries of SMCHS. Initial capability will include direct secure messaging and an email system that enables encrypted communications between providers. The first practical use of direct messaging will be to enable communications between WPC partner agencies within and across Target Populations.

A longitudinal patient record (LPR) will be established and multiple roles will be defined to deliver information to service providers with a need to know in a format that best serves their requirements. This includes traditional physical and behavioral health providers, but also social services providers in programs like AAS and HSA. A team of four specialists will begin working this summer to validate clinical and administrative workflows and develop the views for the LPR to support care coordination needs.

In close partnership with our primary payer, the HPSM, SMCHS will also incorporate data on services rendered in non-SMCHS facilities to patients assigned to us. As a by-product of the HIE subscription, any records from other contributing delivery systems (e.g., Institute on Aging) and insurers in the HIE that match our MPI data will automatically be joined to our LPR.

As SMCHS continues to build ties with partner organizations within San Mateo County, information from complementary information systems (e.g., housing) can be extracted and transformed into continuity of care documents that can also contribute to the LPR. The richness of the LPR, now including information on the social determinants of health, will enable not just a more complete set of information for use at the point of service, but a whole new database from which to mine, analyze, and ultimately predict outcomes.

Analytics

We call this new data store the Enterprise Data Warehouse (EDW). In an example of how information governance will support our analytical requirements, decisions made in the coming months will ensure that clinical terminology is completely standardized, resulting in a very clean

source of data flowing from the HIE to the EDW. The EDW is being established to welcome traditional electronic health record data, claims data, pharmacy benefits data, and virtually any other data source that we can transform into formats that can contribute to our goal of making more informed decisions based on as much data as possible. As the EDW is built in Year 2 of the WPC, SMCHS will invest in a set of analytical tools that will not just provide reports and trends to SMCHS leaders and partners, but will also provide visualizations to providers at the point of service so that process improvements can be monitored and adjusted over the course of the WPC pilot.

Enterprise Electronic Health Record Platform (EHR 2.0)

With the successful deployment of the HIE serving as a major stepping stone to more complete visibility into the physical, behavioral, and social aspects of the health of our clients, we will be well poised to achieve the next major milestone in our quest for an interoperable enterprise EHR. That step is the planning and creation of an enterprise EHR, what we call EHR 2.0.

By the end of Year 2 of the WPC, we will have completed an organizational assessment and develop a set of plans for EHR 2.0, a new patient management system that will provide more equality between social and patient-generated health data and the more traditional healthcare information gathered in an office or examination room.

When the planning is complete, we will take our pioneering requirements to industry where we have a high degree of confidence that our current EHR and complementary systems can be collapsed into just a few and perhaps just one system. Our goal will be to simplify and reduce complexity while at the same time enhancing the amount of actionable information that will be available to the provider, regardless of setting. This journey will likely take two years from the day SMCHS signs a contract for the EHR 2.0 solution.

When implemented, SMCHS will be operating with a technological solution that enables the utilization of many pieces of information that are not incorporated in the EHR space today, and with that we aspire to see client outcomes improve because of our more holistic view of the client's health.

Predictive Analytics and Prevention of ED Utilization: The ability to use patient data to predict patients who are likely to become high users of the emergency systems will allow provider systems to intervene earlier and ultimately prevent excess utilization when other care is more appropriate. Prior predictive software has been developed with populations quite different from WPC populations and focused on conditions covered by health plans. In Years 2 and 3 of the pilot, we will be working in partnership with Stanford Health Care in consultation with HPSM to build the capability for predictive analytics to help our systems learn about risk stratification and potential areas for intervention before patients become high utilizers of the ED. By the end of Year 3 of the WPC pilot, we envision beginning a small sub-pilot to work with patients at risk of becoming high utilizers of the ED. In Years 4 and 5 of the pilot, part of our patient panel will begin to include those patients at risk of becoming high ED utilizers.

SMCHS has been using Lean/LEAP principles for several years. If granted funding, we will continue to ensure Lean principles are an essential part of our program implementation and evaluation in order to support the LEAP cycle. We have allocated budget funds for a statistician and one of their responsibilities will be producing the reports necessary to report out on pilot metrics and track our progress. They will be asked to develop a program dashboard to allow staff to regularly track their performance on grant metrics and measures related to health equity. In addition, we have built in casework review for quality and safety and timeliness into the Licensed Supervisor's role to allow for continuous LEAP cycles. In addition, the WPC staff will also participate in weekly case conferences on patients to identify opportunities for improvement.

A summary for how each of the TP will utilize this HIE and other unique ways in which data sharing will be conducted with each TP is described below with a limit of 248 words per TP.

TP 1:
The CCSP will benefit from the development of SMCHS' HIE in critical ways. The seamless communication system in the HIE and the shared EHRs resulting from development of EHR 2.0 will facilitate coordination of transitions from acute care to community settings. In facilitating discharge from MHRCs, PES, and/or EDs, CCSP care coordinators will have quick access to member medical and behavioral care records, be better able to monitor utilization of clinic supports, and facilitate re-establishing connections with the members' medical and behavioral homes. In instances where the member has an established provider in SMMC or with a community provider, communication with that provider can happen instantly to restore that connection. For members moving from the hospital to a SNF or from a SNF to a residential care facility, or supported housing, and for individuals moving from a MHRC, slot availability and conditions will be immediately available. If the member is moving back home, immediate access to real-time IHSS resources will be available instantly.

The Virtual Hub will have access to a real time inventory of housing, supported housing, residential care facilities, and scattered site affordable housing which will be available to BC, LifeMoves, and IMAT care coordinators.

As members re-establish their placement and their condition(s) stabilize, CCSP care coordinators will be able to easily track compliance with appointment schedules and help manage changes in IHSS supports. Lastly, using smart phone technology and innovative new self-care apps, care coordinators and Mentors in Discharge will be far better able to support members' self-care efforts.

TP 2:
Given the complexity of engaging and treating individuals with chronic SUD, the ability to access an EHR to clarify the status of member engagement in treatment is essential. For example, IMAT Case Managers (CM) receive referrals directly from ED nursing and medical staff. Most patient referrals are individuals in distress and/or intoxicated and have difficulty reporting their health status. Currently, during the screening and engagement process, IMAT CM access EHR

systems to collect information about current/past service providers and health needs of the whole person: physical and mental health, substance use conditions, and medical / psychiatric hospitalizations. To complete this process, the care coordinator must access five separate EHR systems – which is at best a cumbersome task posing barriers to coordinated patient care and, at worst, a dangerous process of preventing access to potentially life-saving information. Many IMAT patients receive Vivitrol, an opiate blocker prescribed by a contracted provider in an off-site MAT clinic. This information is stored in an EHR not accessible to ED staff. As this medication is not in the ED's EHR, staff would not know that administering opiate medication would send a patient into immediate withdrawal and have no effect on addressing pain. ***This is but one example of how the introduction of a HIE is this kind of information that would be readily available across systems and providers while allowing for compliance with all HIPAA requirements.***

TP3:
The solution to management of the complexities of active care and transitions is highly information dependent and requires aggregation and integration of large amounts of data. BWT would benefit from the HIE and EHR 2.0 in all the ways described above, however, given that BWT operates almost entirely in the field and that the pilot spans the HSA, Criminal Justice, and the Health System, access to EHRs and capacity to communicate across these systems through the HIE is essential.

The development of the HIE will be especially important to CHS as it is currently paper-driven. The development of the HIE and EHR 2.0 will enable CHS to make re-entry planning decisions with real-time information from an integrated EHR, the housing inventory, and treatment programs.

Access to real time client information from the criminal justice and health systems will facilitate tracking of members' appropriate treatment and service use and with the use of smart phone technology will expedite communication with unsheltered individuals.

In summary, the development of the HIE and all its functions will enable care managers and clinicians to have immediate, seamless information that has historically been siloed and unavailable. This access to information and the ability to communicate with partners and other providers will streamline operations and facilitate coordinated care that long has been the dream of most medical, behavioral, and social service professionals. More important than the streamlining of providers' responsibilities, the HIE will save lives that are too often lost due to lack of access to critical health and medication information in real time.

Attached is a PDF of a flow diagram to graphically represent how San Mateo's WPC pilot would work along with use cases to delineate what is covered by the pilot and what is covered by Medi-Cal.

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

4.1. Performance Measures

SMCHS applies the principles of LEAP to its planning, development, and evaluation with a vision of using data to determine need, impact, and performance using Evidence-Based-Practices (EBP) to identify how best to improve performance. Sections 4.2 and 4.3 describe how that vision and approach will be applied to QI and potential corrective actions and tracking performance measures will apply the same principles. Sections 4.1.a. and 4.1.b. provide the universal and variant measures selected by the WPC Steering Committee to measure the performance of the WPC pilot and to report to the State. They are not hoops to jump through, but rather as described below, represent authentic measures of our pilot's effectiveness. We will analyze and use these measures not to ensure continuing funding, but to ensure continuing development of a health system that achieves our goals of improving health outcomes and reducing costs.

With each TP, we will develop a performance dashboard that summarizes baseline performance for WPC members in each TP and then track performance over time to identify needs for adjustments in service delivery. Specific examples of how this might apply are provided below.

For TP 1 Example: Six months after the pilot begins, the dashboard for TP 1 shows that performance is 0% on the measure: Longevity of placement remaining in community setting post-transition (% of WPC participants maintaining community living three months post placement). Deeper discussion with the staff and peer mentors most involved in supporting participant community transitions reveals a series of barriers and interventions that can be tried to improve performance.

For TP 2 & 3 Example: Six months after the pilot begins, the dashboard for TP 2 and 3 shows that 95% of participants have HbA1c < 8 (% of WPC participants with diabetes who have HbA1c< 8). Deeper discussion with participants themselves as well as clinical outreach staff suggests that strategies that aimed to link those participants with a range of exercise, meditation, yoga, and other prevention activities have not been accessible to the larger than expected homeless population. Problem-solving how to engage homeless TP 2 and 3 in those activities using peer mentors ensues.

4.1.a. Universal Metrics

SMCHS proposes to set the goals for the health outcome measures as the following with the stipulation that the goals may change based on feedback from DHCS/CMS.

☑ **Health Outcomes Measures**

- Ambulatory Care - Emergency Department Visits (HEDIS) including utilization of PDSA with measurement and necessary changes a minimum of quarterly
  - By the end of the pilot period, there will be a 25% reduction from baseline
- Inpatient Utilization-General Hospital/Acute Care (IPU) (HEDIS) including utilization of PDSA with measurement and necessary changes a minimum of quarterly
  - By the end of the pilot period, there will be a 25% reduction from baseline
- Follow-up After Hospitalization for Mental Illness (FUH) (HEDIS)
  - By the end of the pilot period, 40% of WPC enrollees that had a hospitalization for mental illness will have had a follow-up within 30 days
- Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET) (HEDIS)
  - By the end of the pilot period, 35% of WPC enrollees with SUD diagnosis will have had initiation for treatment and 50% will have been engaged for treatment

☑ **Administrative Measures**

20% of the participating WPC beneficiaries with a comprehensive care plan, accessible by the entire care team, within 30 days by the end of the pilot period (baseline 10% of total population with 2% each program year):

1. Enrollment into the WPC Pilot
2. The beneficiary's anniversary of participation in the Pilot (to be conducted annually)

Care coordination, case management, and referral infrastructure measured by:

1. 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 beneficiary case management. Upon completion, and within a timeline approved by the State, the policies and procedures will be submitted to the State for review and approval.
   a. All participating entities will have access to and be provided with timely access and updates to beneficiary information for care coordination and case management purposes.
   b. The policies and procedures shall establish a communication structure for participating beneficiaries. The number of participating entities for purposes of the Pilot as points of contact for beneficiaries shall be minimalized.

2. Monitoring procedures for oversight of policies and procedures and regular review to determine any needed modifications.

Data and information sharing infrastructure measured by:

1. Submission of documentation demonstrating the establishment of data and information sharing policies and procedures across the WPC Pilot lead and all participating entities that provide for streamlined beneficiary care coordination, case management, monitoring, and strategic improvements, to the extent permitted by

applicable state and federal law. Upon completion, and within a timeline approved by the State, the policies and procedures will be submitted to the State for review and approval.

a. All participating entities will have access to and be provided with timely access and updates to necessary beneficiary data and information to the extent permitted by applicable state and federal law for streamlined beneficiary care coordination, case management, monitoring, and strategic improvements.

2. Monitoring procedures for oversight of policies and procedures and regular review to determine any needed modifications.

4.1.b. Variant Metrics (All Target Populations)

Variant Metric	PY 1	PY 2	PY 3	PY 4	PY 5
Administrative Metric	Assignment of care coordinator (50% of WPC participants who have a care coordinator assigned)	Assignment of care coordinator (50% of WPC participants who have a care coordinator assigned)	Assignment of care coordinator (52.5% of WPC participants who have a care coordinator assigned)	Assignment of care coordinator (55.13% of WPC participants who have a care coordinator assigned)	Assignment of care coordinator (57.88% of WPC participants who have a care coordinator assigned)
30 Day All Cause Readmissions	30 Day All Cause Readmissions (30% of WPC participants)	30 Day All Cause Readmissions (30% of WPC participants)	30 Day All Cause Readmissions (28.50% of WPC participants)	30 Day All Cause Readmissions (27.08% of WPC participants)	30 Day All Cause Readmissions (25.72% of WPC participants)
NQF: 0104 Suicide Risk Assessment	Completion Of Suicide Risk Assessment (20% of WPC participants)	Completion Of Suicide Risk Assessment (20% of WPC participants)	Completion Of Suicide Risk Assessment (21% of WPC participants)	Completion Of Suicide Risk Assessment (22.05% of WPC participants)	Completion Of Suicide Risk Assessment (23.15% of WPC participants)
Housing: Housing Services	30 Percent of homeless participants receiving housing	30 Percent of homeless participants receiving housing	31.5 Percent of homeless participants receiving housing	33.08 Percent of homeless participants receiving housing	34.73 Percent of homeless participants receiving housing

	services in PY that were referred for housing services	services in PY that were referred for housing services	services in PY that were referred for housing services	services in PY that were referred for housing services	services in PY that were referred for housing services
Health Outcome Metric	HbA1c < 8 (20% of WPC participants with diabetes who have HbA1c< 8)	HbA1c < 8 (20% of WPC participants with diabetes who have HbA1c< 8)	HbA1c < 8 (21% of WPC participants with diabetes who have HbA1c< 8)	HbA1c < 8 (22.05% of WPC participants with diabetes who have HbA1c< 8)	HbA1c < 8 (23.15% of WPC participants with diabetes who have HbA1c< 8)

4.2 Data Analysis, Reporting & QI

As part of the HIE development, a consistent definition of services delivered within the pilot will be developed and used across programs. Charting of all service delivery and member contact will be available on the cloud allowing for instantaneous updating and sharing of services delivered across the pilot and throughout the HPSM, SMMC, HSA, Housing, BHRS, AAS, and criminal justice systems. Permissions will be developed and only those with appropriate 'need-to-know' permissions will have access to sensitive health information (e.g. HIV status, mental health diagnosis and treatment, etc.).

Working with the HPSM, Business Intelligence Program, Office of Managed Care, WPC Director, and analysts, a series of dashboards will be developed to capture baseline, YTD, and current quarter data that will show the status of WPC implementation and impact. Dashboards and databases will capture:

- Caseloads of all pilots and member drop out numbers;
- Time frame from initial engagement to: first appointments in primary care and/or behavioral health, and establishment of stable housing;
- Implementation dashboards capturing projected time for completion of specific infrastructure acquisitions, personnel hiring, and system improvements and the current status in relation to each;
- WPC universal and variant metrics will also be tracked and summarized in a dashboard that will provide both WPC wide performance and performance of each target population (described more fully in 4.1, above);
- Using HPSM claims files, a database will be constructed capturing WPC historic (2014 and 2015) and baseline (2016) utilization and service costs related to PES, ED, MHRCs, and SNFs along with all other SMMC utilization and costs. Each quarter, the database will be updated to capture the quarterly utilization and cost total for all WPC members. This will be used to analyze ROI and project HPSM savings resulting from WPC interventions. Analysts will construct tables depicting changes in cost and utilization by

TP, gender, ethnicity, language, primary and secondary diagnoses, housing status, and other factors to assess utilization and costs of different subpopulations of WPC members, enabling the Steering Committee to monitor how much these subpopulations are benefiting from interventions. A dashboard will be created that is flexible and shifts its focus to different emerging trends in service utilization.

- A fourth dashboard capturing historic health outcomes also disaggregated by gender and ethnicity to monitor continued efforts to address health equity;
- A graphic depicting the YTD WPC investments and match.

Working with HPSM, SMCHS will capture member-level data on all health outcomes and universal and variant measures and will be able to produce reports disaggregated by pilot, as well as by ethnicity, gender, language, medical condition(s), housing status, service utilization levels, and other relevant factors. Quarterly reports will be generated analyzing correlations between appropriate and timely utilization of primary care, prevention, care navigation, and peer supports and use of ED, PES, and other high-cost acute care interventions. These reports will be disaggregated by target population, ethnicity, gender, language and other factors and will be available on the Hub to both the Steering Committee members and to program managers of each pilot before the next Quarterly Steering Committee Study Session. These quarterly study sessions represent the 'review' phase of the LEAP cycle.

During that month, Steering Committee members will review the data and submit questions, make observations and suggest deeper dives into specific areas where data is puzzling, disappointing, or astonishingly good. The WPC Director will synthesize these inquiries and depending upon the nature of the focus of concerns, assign analysts to go into the field with a specific set of questions to be answered. The analysts will interview clients, staff, and managers and observe program operations and then return to the office to conduct clarifying data inquiries. After discussion with the WPC Director and other stakeholders to clarify initial findings, the analysts will disseminate a report to all Steering Committee members prior to the Study Session. The report will include findings, recommendations, and questions for future inquiry.

Based upon the report and discussions conducted at the Study Session, the Steering Committee could initiate an immediate action such as a mid-course correction in services, interventions, and infrastructure acquisition plans or initiation of a training series targeting an area identified as needing strengthening through the use of an EBP approach.

At the end of Year 2, WPC analysts will answer the question: "What does it look like to have found your medical and behavioral home?" The analysis will begin with mining the data sources above for patterns of appropriate use of clinics, no-show rates, consistency in making follow-up appointments, etc. A pool of WPC members will be developed from this analysis and a qualitative study will be conducted by interviewing line staff and members to ascertain the key high leverage interventions or factors that led to full engagement and effective use of the health system. This information will be used by the Steering Committee to identify ways to use what is learned to modify outreach, engagement and care management approaches.

This iterative inquiry process will be the backbone to the SMC WPC QI process. Through this dynamic, data and research-informed process, in an almost real-time environment, the Steering Committee will identify:

- system and program shortcomings in need of correction;
- effective practices that can be replicated elsewhere (SMCHS will work with local universities like Stanford);
- needs for new policies for which the Steering Committee can advocate locally and at State and National levels;

On an annual basis, the Hub team will create an annual report on the state of the WPC Pilot and will post this on the SMCHS website, disseminating information about its content and location to the Board of Supervisors, city-level councils, neighborhood associations, professional associations, and in the media. This communication will include information about an annual community meeting at which staff, managers, and department leaders will share their views on the state of WPC in San Mateo County. At the end of the day, WPC is not about just the care of individual members but about that care as an expression of the values of our community and our commitment to supporting our most vulnerable neighbors.

4.3 Participant Entity Monitoring

The above LEAP process will be the mechanism that triggers identification of needs for technical assistance, corrective actions, and the termination of services to any of the three TPs being served with WPC funding, or the termination services to all three TPs.

Should the QI process identify an under-performing strategy or program, the Steering Committee would first go through the LEAP process described above and seek mid-course corrections in operations, with the goal of strengthening the underperforming entity. As part of any corrective action, a set of performance measures and/or client outcomes would be established with threshold levels of performance clearly delineated. A written agreement would be developed describing the specific actions to be taken, investments to be made, technical assistance to be provided, timeframe for implementation of actions, and outcomes anticipated as a result of the changes made. The outcomes or change that should be evident would be specific and time sensitive. Interim measures will also be developed that would indicate progress toward needed improvements. The agreement would also include specific dates when representatives from the entity involved and the WPC Director would meet to discuss progress. The agreement would be signed and shared with the Steering Committee. In preparation for scheduled meetings to discuss progress, the entity involved would prepare a brief report describing progress made, barriers encountered, and other actions being considered.

It is expected that through this kind of collegial, supportive process, under-performance would be addressed without the necessity of termination, but in the event that changes either were

not made, as planned or the desired results were not achieved, one of two paths could be followed. In the instance where the project or partner had made a good faith effort to implement changes and where there were credible factors that continued to impede progress, further study would inform making additional design, resource deployment, training, or even personnel changes. As with the first step described above, the parties would again form an agreement specifying steps to be taken and projected performance measures and the process would be repeated. In the event that the Steering Committee felt that either a good-faith effort was not made or the lack of progress jeopardized client safety or health or the success of the pilot, the Steering Committee would first develop a specific plan for addressing the gap in service delivery or infrastructure development left by the termination of the strategy and then vote on whether to terminate the activity under study.

This same process would be used for conducting QI and corrective action in relation to services provided to the three WPC TPs, except in this instance the SMCHS would also seek technical assistance from the State and other research expertise to help consider all other alternatives. This same path would be utilized if it was viewed that the SMC WPC, as a whole, was not meeting expectations and that even with the best-faith effort could not be improved to the Steering Committee or State's satisfaction.

Section 5: Financing

5.1 Financing Structure

As the lead entity for the WPC pilot, San Mateo County Health System (SMCHS) will use local funds that comply with STC 126a. The cash from SMCHS will be sent to DHCS through the IGT process and then received from DHCS with the federal match plus the county match. Once the funds are received, they will be distributed to each participating non-County entity via contracts for services performed or budget allocation if County entity.

Funds will be tracked through SMCHS' accounting system with clear designation of the funding source being the WPC pilot. There will be monthly reports produced to track how funds are expended compared to the budget submitted in the WPC application. SMCHS has a long history of effectively managing funds and paying our partners for services rendered to our mutual clients. We will be incorporating the pilot in our current accounting system without incident.

The pilot will enhance all of the innovative strategies that SMCHS is already doing around pay for performance for outcomes and administrative metrics that we already have in place with the HPSM and our partners. We are looking forward to the pilot funding new technology that will allow better sharing of data so partners can coordinate information and resources required to care for our clients that lead to better outcomes and reduced costs.

5.2 Funding Diagram [Funding flow chart is attached]

5.3 Non-Funding [list of entities that will provide non-federal share to lead entity to be used for payments under WPC pilot]

San Mateo County Health System, San Mateo Medical Center
San Mateo County Health System, Behavioral Health and Recovery Services (BHRS)
San Mateo County Human Services Agency (HSA)
San Mateo County Health System, Public Health, Policy and Planning
San Mateo County Health System, Correctional Health Services (CHS)
Health Plan of San Mateo (HPSM)
County of San Mateo

5.4. Non-Duplication of Payments & Allowable Use of Federal Financial Participation

SMCHS is the safety net for San Mateo County's most vulnerable populations. SMCHS' primary patient population are those who are on Medi-Cal and other government funded programs. As a County Organized Health System (COHS), there's only one managed care Medi-Cal plan paying for services rendered to all Medi-Cal beneficiaries. We all have a clear understanding of what is

Medi-Cal reimbursable and what is not. SMCHS will ensure that all pilot funds will comply with STC 113 to the benefit of Medi-Cal beneficiaries. Being a COHS county, SMCHS will also work closely with HPSM to ensure that there is no duplication of services or funding for participants who receive multiple service bundles at the same time and we will also attest to this.

Potential Targeted Case Management (TCM) Overlap

The vast majority of the activities and interactions of the care coordination teams will not duplicate Medi-Cal's targeted case management ("TCM") benefit. Specifically, enhanced care coordination departs significantly from the encounter-based structure of TCM, and in the vast majority of cases the encounters between intervention and patients/clients/members would not be eligible for reimbursement under TCM, as the workers either would not meet the education/experience requirements for TCM case workers or the team members would be in a supervisory role and would have few, if any, direct contact with clients. Moreover, the scope of care support and coordination activities available through WPC is intended to be more robust than available through Medi-Cal TCM. WPC teams will engage in activities such as peer support which are distinct from and outside the TCM benefit.

WPC will also provide direct social and other services that would not be recognized as TCM, such as tenancy supports. For these reasons, we have concluded that the vast majority of WPC Pilot activities will not duplicate services available through Medi-Cal TCM. Using data from the last five years, we've identified two cases where there may be an overlap with our WPC target populations. However, in response to concerns of payment duplication, we have applied a TCM budget adjustment to the potentially affected service bundles. The TCM budget adjustment can be found in our Bridges to Wellness (BWT) and Behavioral Health and Recovery Services (BHRS) PMPM bundles. The specific adjustment for BWT is in the Care Coordinator work that is out in the field. The specific adjustment for BHRS is in the Case Manager work with co-occurring disease. These staff would be providing the services that could potentially overlap with TCM services.

The methodology used to calculate PMPM adjustments is based on San Mateo's TCM reimbursement trending over the last five fiscal years and the potential of overlapping target populations. Over the last five fiscal years, San Mateo has averaged $2.8 M in TCM reimbursement at a TCM encounter rate of $534.68. We conservatively estimate that 20 clients could be WPC eligible and that they would be seen every month by TCM staff accounting for $128,323 in TCM reimbursement. We are estimating that 80% of TCM clients could be serviced by the BHRS bundle (case management) with the remaining 20% by the BWT bundle (health coaching).

5.5. Funding Request [Budget is attached]

Budget Narrative

San Mateo's budget is the culmination of the strategies described in sections 2 through 4 with the majority of the budget allocated in the PMPM bundle for our key programs (49% of total) to

move the organization to a value-based delivery structure. Putting 29.7% of the budget in the pay for reporting and outcomes sections further incentivizes our programs to focus on activities that create the greatest impact to the target populations. The remaining 21.3% of the budget is funding the administrative and delivery infrastructure to make sure our staff have the resources and tools they need to get better serve our WPC enrollees.

Administrative Infrastructure

Each program requires an administrative support structure that provides analyses, oversight, and reporting that ensures the program is meeting its goals with efficiency and effectiveness. The programs also require facilities, tools, and training that allow staff to carry out their duties.

The Bridges to Wellness Team (BWT) will be utilizing a mobile coach to take staff to the field so staff can reach the target population where they reside, whether it's under a bridge, highway underpass, or shelters. Also included in the budget are communication tools that allow field staff to relay information to the mobile coach and maximize the effectiveness of care coordination. Since BWT will be adding over 30 new staff members, they will need to be housed while not out in the field (Table 1A).

TABLE 1A - Administrative Infrastructure Annual Budget - Bridges to Wellness Team Program				
Item	**FTEs**	**Wages**	**Benefits**	**Annual Budget for Program Years**
Personnel				
Analyses and Reports				
-Epidemiologist/Statistician	1.00	$123,225	$63,945	$187,170
-Financial & Data Analyst	0.50	$61,115	$31,935	$93,050
Financial Management				
-Financial Services Manager	0.10	$15,494	$7,460	$22,954
-Senior Accountant	1.00	$115,265	$60,879	$176,144
Program Management				
-Management Fellow	2.00	$190,865	$114,519	$305,384
-Grant/Program Manager	1.00	$142,430	$70,554	$212,983
Personnel Subtotal				**$997,686**
Item	**Units**	**Cost per Unit**	**-**	**Annual Budget for Program Years**
Non Personnel				
Staff Training	30	$1,000		$30,000
Health Coach Mobile Technology	24	$1,000		$24,000
Health Coach & Nursing Staff Mileage	24	$2,000		$48,000
Mobile Coach	1	$110,000		$110,000
Office Space	1	$300,000		$300,000
Contractor Services (Communications)	1	$60,000		$60,000
Print Materials	1	$1,000		$1,000
Passenger Van	1	$7,000		$7,000
Van Maintenance	1	$8,000		$8,000
Centrifuge	1	$590		$590
Medical Fridge	1	$452		$452
Socket Installation	1	$400		$400
Computers	1	$18,400		$18,400
Furniture	1	$27,600		$27,600
Non Personnel Subtotal				**$635,442**
TOTAL BRIDGES TO WELLNESS TEAM PROGRAM				**$1,633,128**

Behavioral Health and Recovery Services (BHRS) will also require analysis and program support to ensure staff and management have the information they need to effectively provide coordination of services to clients. The non-personnel costs are supporting 72 BHRS staff members and the indirect total is calculated a total BHRS budget of $15.6 M equaling 4% for total indirects (Table 1B).

TABLE 1B - Administrative Infrastructure Annual Budget - Behavioral Health & Recovery Services Program				
Item	**FTEs**	**Wages**	**Benefits**	**Annual Budget for Program Years**
Personnel				
Administration Support				
-Management and Financial & Data Ana	3.00	$318,319	$198,732	$517,051
Personnel Subtotal				**$517,051**
Item	**Units**	**Cost per Unit**	**-**	**Annual Budget for Program Years**
Non Personnel				
Telecom	1	$82,474		$82,474
Computer	1	$28,000		$28,000
Travel	1	$151,703		$151,703
Other Operating	1	$408,386		$408,386
Indirect	1	$619,375		$619,375
Office Space	1	$546,333		$546,333
Vehicles	1	$15,900		$15,900
Vehicle Maintenance	1	$9,000		$9,000
Non Personnel Subtotal				**$1,861,171**
TOTAL BEHAVIORAL HEALTH & RECOVERY SERVICES PROGRAM				**$2,378,222**

Correctional Health Services (CHS) will also require program management to ensure this focus on the WPC client in the criminal justice system is effectively carried out over the course of the pilot (Table 1C).

TABLE 1C: Administrative Infrastructure Annual Budget - Correctional Health Services Program				
Item	**FTEs**	**Wages**	**Benefits**	**Annual Budget for Program Years 2-5**
Personnel				
Program Management				
-Correctional Health Director	0.05	$8,526	$5,116	$13,642
Personnel Subtotal				**$13,642**
TOTAL CORRECTIONAL HEALTH SERVICES PROGRAM				**$13,642**

Especially critical to the effectiveness of the WPC pilot will be a functioning county-wide Health Information Exchange (HIE) that can be utilized by different healthcare and social services organizations that will be caring for our shared clients. We are also endeavoring to connect organizations that are serving our clients in other counties to connect our HIEs. The HIE will allow staff to have near real time access to enrollee information so that they can better coordinate and manage the services that are needed by the client and better meet their needs. The pilot funding will allow the community of providers in health, housing, and social services to better communicate and work together to share information on clients that they are currently caring for independent of each other (Table 1D).

Another critical tool is an enterprise wide Electronic Health Record (EHR) that will connect all the electronic medical record systems (EMR) throughout the San Mateo County Health System (SMCHS). Built into the EHR and HIE is a two-way referral system that will allow providers in the provider directory to communicate with each other about shared clients that have pertinent information attached to each message. The percentage allocation of these essential data tools are calculated based on the number of targeted population within the total Medi-Cal beneficiaries served by SMCHS. The 15% is calculated by dividing the pilot's targeted number of clients by the total Medi-Cal managed care lives served by SMC.

TABLE 1D: Administrative Infrastructure Annual Budget - Health Information Technology

Item	Units	Cost per Unit	-	Annual Budget for Program Years 2-5
Non Personnel				
Master Patient Index-Health Information E	1	$135,046		$135,046
Electronic Health Record (EHR)	1	$2,103,387		$2,103,387
Non Personnel Subtotal				**$2,238,433**
TOTAL HEALTH INFORMATION TECHNOLOGY				**$2,238,433**

Delivery Infrastructure

Correctional Health Services (CHS) is an essential part of the SMCHS that serves our target populations. Essential to the success of connecting CHS to the rest of the delivery system in the County is access to technology and staff to provide care coordination not reimbursed by Medi-Cal. A large percentage of the CHS clients that are pre-trial/pre-incarceration and post-release are in need of medication management that require technology not currently available along with an EMR system that allows CHS to share information across the County and with external partners. Transportation and housing support services are what is needed to ensure the target population are put in the best situation to receive needed services and recovery from care received (Table 2).

TABLE 2A - Delivery Infrastructure Annual Budget - Correctional Health Services Program				
Item	**FTEs**	**Wages**	**Benefits**	**Annual Budget for Program Years 2-5**
Personnel				
Clinical Management				
-Clinical Services Manager (Mental Heal	0.07	$9,204	$5,069	$14,272
-Clinical Services Manager (Nursing)	0.07	$9,492	$5,227	$14,718
Clinical Supervision				
-Supervising Mental Health Clinician	0.10	$13,264	$7,305	$20,569
Nurse				
-Clinical Nurse (Medical Management &	1.17	$160,445	$88,357	$248,802
Personnel Subtotal				**$298,362**
Item	**Units**	**Cost per Unit**	**-**	**Annual Budget for Program Years 2-5**
Non Personnel				
EHR CHS Bridging Licenses	1	$50,000		$50,000
Pyxys satellite pharmacy system	2	$20,000		$40,000
Talyst medication packaging system	2	$25,580		$51,160
Medication administration scanning systen	8	$5,460		$43,680
Mobile workstation computers w/ wireless	8	$700		$5,600
Transportation	500	$30		$15,000
Transitional Housing Support	200	$100		$20,000
Peer Case Management Support	200	$75		$15,000
Non Personnel Subtotal				**$240,440**
TOTAL BRIDGES TO WELLNESS TEAM PROGRAM				**$538,801**

PMPM Bundle

The **Bridges to Wellness Team** budget is made up primarily of staff to better connect with the WPC enrollees. Utilizing the PMPM bundle method of reimbursement allows us to provide an enhanced care coordination approach to better serve the clients we engage. Our staff will focus on tracking the number of clients served and ensuring that they get connected to the services they need and providing the services in the field when necessary (Table 3A). The PMPM calculation is based on enrolling 650 clients every program year for a PMPM of $636 which incorporates the TCM adjustment of $3. The area of potential TCM overlap is in the work of BWT Care Coordinators. No other staff on the BWT will provide the potentially overlapping services. See Figure 2 (p. 2) in Overview PDF attached for BWT client timeline.

TABLE 3A - PMPM Bundle -- Bridges to Wellness Team				
Item	**FTEs**	**Wages**	**Benefits**	**Annual Budget for Program Years**
Personnel				
Care Coordination				
-Health Coach/Care Coordinators	14.00	$1,229,909	$727,521	$1,957,431
-TCM Adjustment				-$25,665
Clinical Management				
-Medical Director	0.25	$57,678	$25,533	$83,211
Clinical Supervision				
-Nurse Practitioner	1.00	$188,284	$86,779	$275,063
Driver and Outreach Worker				
-Community Worker II/ Driver-Outreach	1.00	$67,471	$44,925	$112,396
Nurse				
-RN Case Manager	1.00	$159,158	$76,636	$235,794
Patient/Medical Assistants				
-Medical Services Assistants and Comm	10.00	$640,099	$436,654	$1,076,753
-Patient Services Assistant	1.00	$68,174	$45,099	$113,274
Pharmacist				
-Pharmacist	0.50	$80,179	$38,708	$118,887
Social Work				
-Licensed Social Worker Supervisors	2.00	$214,214	$116,189	$330,402
-Psych Social Worker	1.00	$107,107	$58,094	$165,201
-Social Worker III (Clinics)	3.00	$310,678	$172,866	$483,545
Personnel Subtotal				**$4,926,292**
Item	**Units**	**Cost per Unit**	**-**	**Annual Budget for Program Years**
Enhanced Care Coordination				**$31,215**
TOTAL BRIDGES TO WELLNESS TEAM PROGRAM				**$4,983,172**
Calculated PMPM				**$639**
TOTAL BRIDGES TO WELLNESS TEAM PROGRAM WITH TCM ADJUSTMENT				**$4,957,507**
Calculated PMPM WITH TCM ADJUSTMENT				**$636**

The **Behavioral Health & Recovery Services** budget is made up primarily of staff and contracts with partners in the community. The PMPM bundle method of reimbursement will allow staff to focus on client engagement and ensuring they get the services they need through trust building and coordinating their care (Table 3B). The PMPM calculation is based on enrolling 1,350 clients from two of the three target populations every program year for a PMPM of $829 which incorporates the TCM adjustment of $6. The area of potential TCM overlap is in the work

of BHRS Case Managers. No other staff in BHRS will provide the potentially overlapping services. WPC partners will receive payments through contracts tied to PMPM bundle payments as a result of achieving goals. See Figure 3 (p. 5) in Overview PDF attached for BHRS client timeline.

TABLE 3B - PMPM Bundle -- Behavioral Health and Recovery Services				
Item	FTEs	Wages	Benefits	Annual Budget for Program Years 2-5
Personnel				
Case Manager				
-Case Manager/Assessment Specialist	18.00	$1,461,946	$867,906	$2,329,852
-TCM Adjustment				-$102,658
-Community Worker	2.00	$131,502	$74,231	$205,733
-Mental Health Counselor	5.00	$271,144	$142,223	$413,367
-Peer Support Worker	1.00	$55,062	$34,838	$89,900
-Senior Community Worker	1.00	$68,152	$44,631	$112,783
Clinical Management				
-Clinical Services Manager (Mental Heal	1.45	$210,957	$115,638	$326,596
-Health Services Manager	1.00	$133,835	$84,610	$218,446
Clinical Supervision				
-BHRS Supervisor	3.00	$352,519	$217,949	$570,469
-Supervising Mental Health Clinician	3.00	$390,647	$239,165	$629,812
Data Support				
-Systems Engineer	1.00	$129,574	$72,081	$201,655
Financial Management				
-Financial Services Manager	1.00	$138,596	$68,747	$207,343
Medical Supervision				
-Supervising Adult Psychiatrist	1.00	$282,804	$111,609	$394,413
Nurse				
-Community Mental Health Nurse	1.00	$146,258	$68,031	$214,289
Patient Services Assistant				
-Medical Office Specialist	1.00	$74,854	$49,777	$124,631
-Office Assistant	1.00	$53,542	$39,207	$92,749
-Patient Services Assistant	3.00	$196,019	$147,354	$343,372
Physician				
-Adult Psychiatrist	1.85	$485,156	$213,628	$698,785
Psych Social Work				
-Mental Health Program Specialist	4.00	$455,169	$261,785	$716,955
-Psychiatric Social Worker	17.00	$1,051,732	$503,266	$1,554,997
Public Guardian Support				
-Department Public Guardian	1.50	$133,124	$87,959	$221,084
Personnel Subtotal				**$9,564,571**

Item	Units	Cost per Unit	-	Annual Budget for Program Years
Non Personnel				
HealthRight360	1	$1,285,078		$1,285,078
StarVista Sobering	1	$118,309		$118,309
Horizon Services	1	$176,503		$176,503
Peer Recovery Collaborative	1	$726,702		$726,702
StarVista 1st Chance	1	$1,006,375		$1,006,375
Heart & Soul	1	$366,554		$366,554
Voices of Recovery	1	$179,635		$179,635
Non Personnel Subtotal				**$3,859,156**
TOTAL BEHAVORIAL HEALTH & RECOVERY SERVICES				**$13,526,385**
Calculated PMPM				**$835**
TOTAL BEHAVORIAL HEALTH & RECOVERY SERVICES WITH TCM ADJUSTMENT				**$13,423,727**
Calculated PMPM WITH TCM ADJUSTMENT				**$829**

Pay for Reporting

SMCHS will work closely with our partners, SMC departments, and especially HPSM to report regularly the following metrics as required in universal and variant metrics by the pilot. Each metric achieved and reported will be paid $350,000 for each program year. These incentives will allow our clients to be served in a coordinated fashion and allow them to access programs with housing supports (CCSP and HOT) they need to stay well and reduce utilization of the avoidable healthcare services they are currently over-utilizing. The total pay for reporting each year is $3,150,000, five universal and four variant totaling nine metrics.

The first metric is Ambulatory Care - Emergency Department Visits (HEDIS) including utilization of PDSA with measurement and necessary changes made quarterly. SMCHS will work with partners to achieve a 5% reduction each program year for a total reduction of 25% by the end of the pilot period for the baseline enrolled WPC population.

The second metric is Inpatient Utilization - General Hospital/Acute Care (IPU) (HEDIS) including utilization of PDSA with measurement and necessary changes made quarterly. SMCHS will work with partners to achieve a 5% reduction each program year for a total reduction of 25% by the end of the pilot period for the baseline enrolled WPC population.

The third metric is Follow-up After Hospitalization for Mental Illness (FUH) (HEDIS). SMCHS will work with partners to achieve an 8% increase each program year for a total increase of 40% by the end of the pilot period for WPC enrollees that had a hospitalization for mental illness will have had a follow-up within 30 days from the baseline enrolled WPC population.

The fourth metric is Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET) (HEDIS). For WPC enrollees with a SUD diagnosis, SMCHS will work with partners to achieve a 7% increase each program year for a total of 35% by pilot end, treatment will have been initiated. In addition, SMCHS will work with partners to increase by 10% each program year, WPC enrollees will be engaged for treatment totaling 50% by pilot end for the baseline enrolled WPC population with a SUD diagnosis.

The last metric is 20% of the participating WPC enrollees will have a comprehensive care plan, accessible by the entire care team, within 30 days of by the end of the pilot period (baseline is 10% with a 2% increase each program year for total enrolled population):

1. Enrollment into the WPC Pilot
2. The beneficiary's anniversary of participation in the Pilot (to be conducted annually)

Below are the variant metrics that will be reported each program year with their goals by year.

Variant Metric	PY 1	PY 2	PY 3	PY 4	PY 5
Administrative Metric	Assignment of care coordinator (50% of WPC participants who have a care coordinator assigned)	Assignment of care coordinator (50% of WPC participants who have a care coordinator assigned)	Assignment of care coordinator (52.5% of WPC participants who have a care coordinator assigned)	Assignment of care coordinator (55.13% of WPC participants who have a care coordinator assigned)	Assignment of care coordinator (57.88% of WPC participants who have a care coordinator assigned)
30 Day All Cause Readmissions	30 Day All Cause Readmissions (30% of WPC participants)	30 Day All Cause Readmissions (30% of WPC participants)	30 Day All Cause Readmissions (28.50% of WPC participants)	30 Day All Cause Readmissions (27.08% of WPC participants)	30 Day All Cause Readmissions (25.72% of WPC participants)
NQF: 0104 Suicide Risk Assessment	Completion Of Suicide Risk Assessment (20% of WPC participants)	Completion Of Suicide Risk Assessment (20% of WPC participants)	Completion Of Suicide Risk Assessment (21% of WPC participants)	Completion Of Suicide Risk Assessment (22.05% of WPC participants)	Completion Of Suicide Risk Assessment (23.15% of WPC participants)
Housing: Housing Services	30 Percent of homeless participants receiving	30 Percent of homeless participants receiving	31.5 Percent of homeless participants receiving	33.08 Percent of homeless participants receiving	34.73 Percent of homeless participants receiving

	housing services in PY that were referred for housing services	housing services in PY that were referred for housing services	housing services in PY that were referred for housing services	housing services in PY that were referred for housing services	housing services in PY that were referred for housing services

Pay for Outcomes

One pay for outcome metric is required by the WPC pilot, so working with its partners, SMCHS will reduce the HbA1c to be less than 8 for the enrolled WPC clients over the course of each program year. Diabetes is a chronic disease that is prevalent in our target population and is preventable and can be better managed in order to prevent utilization of other costly services. The achieved metric and report will be paid $1,00,000 for each program year. These funds will be utilized to provide housing supports so that these clients can better manage their disease.

In addition, since SMCHS has set specific program year outcomes for each universal and variant metric, we are including the metrics below in the pay for outcomes section. Each achieved outcome per metric will be paid $467,510 per program year totaling $4,740,080 for four Universal and four Variant metrics.

- Ambulatory Care - Emergency Department Visits (HEDIS) including utilization of PDSA with measurement and necessary changes a minimum of quarterly
- Inpatient Utilization-General Hospital/Acute Care (IPU) (HEDIS) including utilization of PDSA with measurement and necessary changes a minimum of quarterly
- Follow-up After Hospitalization for Mental Illness (FUH) (HEDIS)
- Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET) (HEDIS)
- Assignment of Care Coordinator
- 30 day all cause readmissions
- Completion Of Suicide Risk Assessment
- Percent of homeless participants receiving housing services that were referred for housing services

Variant Metric	**PY 1**	**PY 2**	**PY 3**	**PY 4**	**PY 5**
Health Outcome Metric	HbA1c < 8 (20% of WPC participants with diabetes who have HbA1c< 8)	HbA1c < 8 (20% of WPC participants with diabetes who have HbA1c< 8)	HbA1c < 8 (21% of WPC participants with diabetes who have HbA1c< 8)	HbA1c < 8 (22.05% of WPC participants with diabetes who have HbA1c< 8)	HbA1c < 8 (23.15% of WPC participants with diabetes who have HbA1c< 8)

Section 6: Attestations & Certifications

Signed certification by SMCHS' Chief is attached.

County of San Mateo: WPC Funds Flow Diagram