# Whole Person Care

## Marin County Pilot Application

March 1,2017

## Contents

## Section 1: WPC Lead Entity and Participating Entity Information

### Lead Entity Description

The County of Marin's Department of Health and Human Services (Marin HHS) is serving as the lead agency for this application. Marin HHS is the County of Marin's largest department. It has an annual operating budget of $180 million and employs 640 full-time employees. The Department has prioritized addressing social determinants of health. Marin HHS is an integrated department including behavioral health and recovery services, social services, and public health. Marin HHS administers and delivers federal, state, and local programs that address the county's health and welfare needs, including homelessness, aging and adult services, and other safety-net programs. Lisa Santora, MD, MPH, Deputy Public Health Officer, is the single point of contact for the Department of Health Care Services and is responsible for coordinating and monitoring the Whole Person Care Pilot (WPC).

### Participating Entity Description

The following entities will implement Marin County's Whole Person Care pilot:

1. Partnership HealthPlan of California (PHC) is a county organized health system that serves over 500,000 Medi-Cal beneficiaries in 14 northern California counties, including Marin County.
2. Behavioral Health and Recovery Services (BHRS) is a division of Marin HHS. BHRS provides outpatient, residential and hospital care addressing specialty mental health and substance-use service needs of Marin's Medi-Cal beneficiaries and uninsured residents. BHRS also offers prevention and early intervention, suicide prevention, and crisis services to all Marin residents.
3. The Marin County Probation Department (Probation) protects the community through its role in conducting investigations, working with the courts on sentencing rulings, and providing alternatives to incarceration. It offers mandated and optional services for the Court, for adult and youth offenders and crime victims.
4. Marin Housing Authority (Marin Housing) is a public corporation, governed by the Marin Housing Authority Commission and authorized to provide housing for low and moderate-income people. To secure and maintain high-quality, affordable housing, Marin Housing acquires property, develops housing, issues tax-exempt bonds, enters into mortgages and trust indentures, leases property, borrows money, accepts grants, and manages property.
5. Healthy Marin Partnership (HMP), established in 1995, includes all acute-care hospitals in the County as well as Marin HHS, Marin Community Foundation (MCF), Marin County Office of Education (MCOE), and representatives of the business community. HMP completes a triennial community health needs assessment required by not-for-profit hospitals through SB 637. In 2014, HMP began conceptual planning around Whole

Person Care and is poised to align community-wide planning to improve the system of care for populations identified in this proposal.

6. Ritter Center is a Federally Qualified Health Center (FQHC) with the twin missions of preventing homelessness and improving the health and well-being of individuals and families who are homeless or low-income. Ritter Center provides a range of culturally sensitive, easily accessible, high-quality medical care and social services. Ritter Center has had significant experience serving this target population for over 30 years.

### 1.1 Whole Person Care Pilot Lead Entity and Contact Person

| | |
|---|---|
| Organization Name | County of Marin Department Health and Human Services |
| Type of Entity | County Health Department |
| Contact Person | Lisa Santora, MD, MPH |
| Contact Person Title | Deputy Public Health Officer |
| Telephone | 415 473 4163 |
| Email Address | lsantora@marincounty.org |
| Mailing Address | 3240 Kerner Blvd. San Rafael, CA 94901 |

### 1.2 Participating Entities

| Required Organization | Organization Name | Contact Name and Title | Entity Description and Role in WPC |
|---|---|---|---|
| 1.Medi-Cal Managed Care Plan | Partnership HealthPlan of California | Lynn Scuri, MPH, Regional Director | Participates on WPC Steering and Advisory Committees, and shares data |
| 2. Health Services Department | Marin HHS | Lisa Santora, MD, MPH Deputy Public Health Officer | Leads the design, implementation, and evaluation of WPC pilot, facilitates WPC Steering and Committees, oversees HHS WPC Business Unit |
| 3. Specialty Mental Health Department | Marin HHS – Behavioral Health and Recovery Services (BHRS) | Suzanne Tavano, RN, PhD Director, BHRS | Participates on WPC Steering and Advisory Committees, shares data, delivers mental health and substance use treatment programs, coordinates service delivery for WPC enrollees |
| 4. Public Agency | Marin County-Probation Department | Mike Daly Chief, Probation Department | Participates in WPC Steering and Advisory Committees, shares data, coordinates service delivery for WPC enrollees |

| Required Organization | Organization Name | Contact Name and Title | Entity Description and Role in WPC |
|---|---|---|---|
| 5. Public Housing Authority | Marin Housing Authority | Kimberly Carroll, Executive Director | Participates on WPC Steering and Advisory Committees, shares data, identifies and secures housing, coordinates service delivery for WPC enrollees |
| 6. Community Partner #1 | Healthy Marin Partnership | Patricia Kendall, Medical Group Administrator, Kaiser Permanente Medical Center | Participates on WPC Steering and Advisory Committees, leads hospital and community collaborative to align resources, share data, and support system re-design |
| 7. Community Partner #2 | Ritter Center | Cia Byrnes, NP Executive Director | Participates on WPC Steering Advisory Committees, shares data, coordinates service delivery for WPC enrollees |

| Additional Organizations | Organization Name | Contact Name and Title | Entity Description and Role in WPC |
|---|---|---|---|
| 8. Community Partner #3 | Marin City Health and Wellness Center | JayVon Muhammad, Executive Director | Primary care service provider, participates on WPC Advisory Committee, shares data, coordinates service delivery for WPC enrollees |
| 9. Community Partner #4 | Marin Community Clinics | Linda Tavaszi, Chief Executive Officer | Primary care service provider, participates on WPC Advisory Committee, shares data, coordinates service delivery for WPC enrollees |
| 10. Community Partner #5 | Coastal Health Alliance | Steve Siegel, Executive Director | Primary care service provider, participates on WPC Advisory Committee, shares data, coordinates service delivery for WPC enrollees |

| Additional Organizations | Organization Name | Contact Name and Title | Entity Description and Role in WPC |
|---|---|---|---|
| 11. Community Partner #6 | Community Action Marin | Kristen Brock, Executive Director | Provides information and referrals, participates on WPC Advisory Committee, shares data, coordinates service delivery for WPC enrollees |
| 12. Community Partner #7 | St. Vincent de Paul Society | Christine Paquette, Executive Director | Provides information and referrals, participates on WPC Advisory Committee, shares data, coordinates service delivery for WPC enrollees |
| 13. Community Partner #8 | Homeward Bound | Mary Kay Sweeney, Executive Director | Provides information and referrals, participates on WPC Advisory Committee, shares data, coordinates service delivery for WPC enrollees |

| Additional Organizations | Organization Name | Contact Name and Title | Entity Description and Role in WPC |
|---|---|---|---|
| 14. Community Partner #9 | Marin Center for Independent Living | Eli Gelardin, Executive Director | Provides information and referrals, participates on WPC Advisory Committee, shares data, coordinates service delivery for WPC enrollees |
| 15. Community Partner #10 | Downtown Streets Team | Logan McDonnell, Project Director | Provides information and referrals, participates on WPC Advisory Committee, shares data, coordinates service delivery for WPC enrollees |
| 16. Community Partner #11 | Marin Community Foundation | Shirin Vakharia Director, Health and Aging | Participates on WPC Steering and Advisory Committees |

### 1.3 Letters of Support

Lisa Santora, MD, MPH Deputy Public Health Officer for Marin County may be contacted for access to letters of support.

## Section 2 – General Information and Target Population

### Whole Person Care Pilot Model

The vision of the County of Marin's Whole Person Care Pilot is to build a sustainable, evidence-based, outcomes-focused coordinated system of care across health and social sectors to more efficiently and effectively serve the county's most vulnerable Medi-Cal beneficiaries. The WPC pilot will build upon existing programs and services by implementing a unified, coordinated entry and care management system; by standardizing screening, assessments, and care coordination; and, by promoting bi-directional information sharing and care coordination among providers. The goal is for this systems-level change to result in new, coordinated, and sustainable approaches to meeting the needs of high-risk, high-cost Medi-Cal beneficiaries.

The systems change work starts with Marin HHS internally reconfiguring and aligning resources to implement health management for the target populations

based on social determinants for each population. This reconfiguration, the WPC Business Unit, will integrate efforts across Marin HHS divisions and build a sustainable business model (e.g., contract restructuring).

Another essential element to the success of this pilot is effectively building upon and braiding programs, services, and interventions that are working well and ensuring these efforts are integrated and leveraged. For example, the WPC pilot will build on BHRS' Full-Service Partnerships, community-based coalitions of homeless-service providers, and Probation's post-release interventions. The communication plan described below along with effective data sharing and resource coordination through the WPC Business Unit will optimize resources and maximize outcomes.

### WPC Target Population Description

Marin HHS led a collaborative process of gathering and analyzing data with key HHS stakeholders and community partners, including FQHCs and Partnership HealthPlan of California (PHC). Twelve months of Medi-Cal utilization data provided by PHC was disaggregated by mood or psychotic disorders, substance-use disorders (including opioid dependence), emergency department visits, hospitalizations, and cost. We also analyzed data from the criminal justice system and the 2015 Point in Time Count (which measures the number of people who are homelessness). The WPC aims to address the needs of two target Medi-Cal adult populations:

- Individuals who experience homelessness or are precariously housed (approximately **1,068**)
- Individuals who experience complex medical conditions, behavioral health issues, and/or lack social supports that interfere with standards of care which results in high utilization and costs (approximately **2,968**). Specifically, this population includes the top 10 percent of Medi-Cal beneficiaries by spending who have a diagnosis of a mental disorder, substance use disorder, traumatic brain injury, dementia, or opioid use and/or twoor more chronic conditions.

Further information about these two target populations, including how they were identified, is presented in Section 2.3.

## 2.1 Geographic Area, Community, and Target Population Needs

Marin County, located immediately north of San Francisco, is a medium-sized county spanning 520 square miles of land with a total population of 261,221 residents (U.S. Census Bureau, 2016 Population Estimates Program). Marin County is designated as an urban community by the State of California; however, the County consists of suburban, rural, and agricultural regions.

Since the implementation of the Affordable Care Act, the percent of uninsured in the county dropped from 13 percent to 8 percent, and Medi-Cal enrollment nearly doubled from 20,154 to 38,843 beneficiaries. However, reports by health and housing service providers indicate the current system of care in Marin County

fails to engage and support high-risk, high-utilizing Medi-Cal beneficiaries, due to multiple factors, including:

- People are not accessing right level of care at right time,
- Case management is not coordinated across entities and does not meet the needs of the most vulnerable (e.g., high case ratios),
- Evidence-based practices are not implemented consistently across the county.
- Data is not collected, shared, or analyzed to inform programmatic decisions and system improvements,
- High-utilizing Medi-Cal beneficiaries are seen by multiple systems, including community health centers, hospitals, and the criminal justice system, which results in fragmented, inefficient care with uncertainty around effectiveness of care and health outcomes,
- Limited supply of affordable housing across the continuum of care (i.e. medical respite, transitional, supportive housing, rental assistance, sober living, subsidized long-term housing), and,
- Varying philosophical perspectives and interventions used across the health and housing safety-net providers.

Despite increased health care coverage, there are also significant unmet needs for behavioral health services. In Marin County, 59 percent of adults report needing care for emotional or mental health or substance abuse issues who stated that they did not obtain help for those issues in the past year (California Health Interview Survey, 2014). More than 8 percent of low-income households in Marin County, exceeding national and state averages, have serious psychological distress requiring treatment based on the Kessler 6 scale (California Health Interview Survey, 2012). Marin County age-adjusted death rate per 100,000 residents due to suicide (12.4) continues to exceed the state average (10.2). The percentage of adults who report binge drinking on one or more occasions is 44 percent in Marin County compared to 33 percent of California adults (California Health Interview Survey, 2014). Since 2009, annual age-adjusted hospitalization rate due to acute or chronic alcohol abuse has increased from six per 10,000 to eight per 10,000 residents aged 18 years and older in Marin County (Office of Statewide Health Planning and Development, 2014).

Notably, relatively few high-need individuals contribute to the cost of public care in Marin. For instance, from October 2015 through September 2016, PHC spent more than $76 million on 1,650 Marin County Medi-Cal beneficiaries. On the criminal justice side, 34individuals in the County of Marin incurred direct costs of $2,039,463 over a 12-month period for services related to homelessness and chronic addiction to alcohol (Chronic Alcohol Use with Justice-System Involvement Report, 2013 [Marin HHS]). The vast majority of these individuals were male, 91 percent were homeless, and 47 was the average age. These data reflect growing concern across the county regarding uncoordinated spending on certain high-need individuals.

The WPC pilot presents a unique opportunity and incentive to develop and test new approaches to improve health outcomes, especially among populations whose health and well-being is significantly affected by the social determinants of health (e.g., housing, employment, social support, etc.). This application reflects a rigorous analysis of data and input from a range of health and housing service providers and the criminal justice system. For example, Marin HHS convened three internal cross-departmental design team meetings to (1) identify target populations, (2) create a logic model, (3) share information on ongoing WPC-aligned programs and services, and (4) design a framework for a coordinated system of care. The design team's draft framework was further developed and refined through input from community partners via an online survey, a teleconference, and in-person community meeting.

### 2.2 Communication Plan

Clear and consistent oversight and communication across WPC partners is critical to the success of the pilot. The WPC Business Unit, the WPC Steering Committee, and the WPC Advisory Committee will support communication, governance, and decision making.

The WPC Business Unit will prepare a collaboration plan that includes a central communication hub for all WPC partners. The WPC Business Unit will use Enterprise to support centralized events scheduling, real-time work plan status updates, and online review and approval capabilities. The WPC Business Unit will administer the platform, support utilization, and ensure compliance.

The WPC Steering and Advisory Committees are a natural evolution the Healthy Marin Partnership (HMP), a long-standing coalition of executive leaders in health care (including hospitals), business, education, and community-based organizations. HMP successfully convenes multi-sector partners and consumers to engage in community-wide planning efforts. It recently made a collective decision to target resources toward WPCapproaches, recognizing the lack of support and coordination for low-income individuals who are homeless, precariously housed, or have complex physical, behavioral, or socioeconomic conditions. Decision making processes, roles and responsibilities, and meeting logistics will be determined and documented to ensure clear communication across HMP and among committee members.

The WPC Steering Committee, comprised of one representative from each of the WPC required entities, will meet regularly to review pilot program progress, address challenges and identify solutions, review evaluation and program improvement data, as well as ensure timely and effective implementation of the program. The WPC Steering Committee will also routinely assess training needs of the case managers, substance use counselors, and the health care professionals serving the WPC enrollees and plan community-wide training events to build capacity across agencies and health systems. The WPC Advisory Committee, comprised of required and additional WPC entities, will meet quarterly to provide input on progress and challenges associated with WPC pilot

implementation. *Refer to attached Exhibit D for an illustration of the proposed governance structure.*

### 2.3 Target Population(s)

The WPC aims to address the needs of two target Medi-Cal adult populations:

- Individuals who experience homelessness or are precariously housed. (approximately **1,068**)
    - Currently experiencing homelessness. (**462**)
    - At risk of homelessness, including individuals who will experience homelessness upon release from institutions (hospital, subacute care facility, skilled nursing facility, rehabilitation facility, psychiatric health facility, county jail, state prisons, or other). (**606**)
- Individuals who experience complex medical conditions, behavioral health issues, or lack social supports that interfere with standards of care and result in high utilization and costs (approximately **2,986**).
    - Repeated incidents of avoidable emergency use, hospital admissions, or nursing facility placement.(**538**)
    - Two or more chronic conditions. [same population as above]
    - Mental health and/or substance use disorders. (**2,448**)

These two target populations were identified through a collaborative process of gathering and analyzing data with key HHS stakeholders and community partners. With regard to homelessness, the 2015 Point in Time Count (which measures the number of people who are homelessness) showed:

- 1,309 people were homeless (1,115 individuals and 194 people in families),
    - 64 percent of those who were homeless were unsheltered,
- 28 percent reported drug or alcohol abuse; 30 percent reported psychiatric or emotional conditions; 17 percent reported physical disability,
- 21 percent reported spending at least one night in jail during the prior 12 months,
- Of those identified as chronically homeless:
    - 57 percent reported drug or alcohol abuse;
    - 59 percent reported psychiatric or emotional conditions;
    - 44 percent reported physical disability, and,
    - 16 percent reported not using any services.

With respect to the second target population (Complex Medi-Cal beneficiaries), 12 months of Medi-Cal utilization data provided by PHC was disaggregated by mood or psychotic disorders, substance use disorders (including opioid dependence), emergency department visits, hospitalizations, and cost. PHC reported 924 Medi-Cal beneficiaries in the top 10 percent of costs with a diagnosis of a mental disorder, substance use disorder, traumatic brain injury, dementia, or opioid use or two or more chronic conditions. Additionally, in 2016, Marin County Behavioral Health and Recovery Services (BHRS) reported

treating 3,026 Medi-Cal beneficiaries for mental disorders and treating 1,751 Medi-Cal beneficiaries for substance use disorders. Finally, data from the criminal justice system was also taken into consideration. In 2011, approximately 417 Medi-Cal beneficiaries involved with the criminal justice system accessed services through BHRS. The estimated number of Medi-Cal beneficiaries with complex conditions is 6,118 (924 + 3,026 + 1,751 + 417 = 6,118).

The estimated baseline number of beneficiaries served by the WPC pilot may be biased upward due to lack of interoperability across multiple data systems used to track service provision for vulnerable populations (e.g., HMIS, EHR). Therefore the baseline target population estimate is reduced by 50 percent to account for potential overlap of target populations[1]. The WPC pilot baseline number of homeless or precariously housed target population is 1,068 and for the target population with complex conditions is 2,986. It is estimated that 3,516 unduplicated Medi-Cal beneficiaries will be served throughout the entire WPC pilot period.

During the first year of the pilot, Program Year 2 (PY 2), HHS will develop the WPC Steering Committee so that this entity is structured to redesign the system of care for the target populations. At the end of PY 2, it is expected 427 unduplicated Medi-Cal beneficiaries will be identified and enrolled in the WPC pilot. This sub-population will provide an opportunity to design and test a new system of coordinated care. For each subsequent year, the WPC aims to double the population served with the goal of 40 percent of the target population engaged by the conclusion of the pilot.

| Target Populations | PY2 | | | PY3 | | | PY4 | | | PY5 |
|---|---|---|---|---|---|---|---|---|---|---|
| | Total | New | Existing | Total | New | Existing | Total | New | Existing | Total |
| **Homeless or Precariously Housed** | 121 | 139 | 103 | 242 | 279 | 206 | 485 | 557 | 512 | 1069 |
| **Complex** | 306 | 352 | 260 | 612 | 704 | 520 | 1224 | 1407 | 1040 | 2447 |
| **Total** | 427 | 491 | 363 | 854 | 983 | 726 | 1709 | 1964 | 1552 | 3516 |

**Figure 1: Target Populations and Unduplicated Enrollees Program Year Detail**

The WPC Pilot estimates a disenrollment rate of 15 percent per year due to loss of Medi-Cal eligibility, relocation out of the service area, stepped down participation, enrollment in another Medi-Cal case management program, client dissatisfaction, loss to follow-up, or death.

[1] Stewart BA, Fernandes S, Rodriguez-Huertas E, Landzberg M. A preliminary look at duplicate testing associated with lack of electronic health record interoperability for transferred patients. J Am Med Inform Assoc. 2010 MayJun;17(3):341-4

Annual Enrollment Estimates:

- PY 2
  - 427 New Enrollees
- PY 3
  - 64 Dis-enrolled Beneficiaries
  - 491 New Enrollees
- PY 4
  - 128 Dis-enrolled Beneficiaries
  - 983 New Enrollees
- PY 5
  - 256 Dis-enrolled Beneficiaries
  - 1,964 New Enrollees

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

### 3.1 Services, Interventions, and Care Coordination

Four approaches will guide the WPC service delivery model in Marin County: (1) Housing First, (2) Trauma-Informed Approach, (3) Person-Centered, and (4) Social Determinants of Health.

**Housing First**

Countywide efforts to date have been fragmented and have not advanced a "Housing First" approach. Nationwide, communities have seen a significant reduction in homelessness and improved health outcomes through the implementation of "Housing First" policies that provide permanent housing as the initial service, followed by other supports based on an individual's needs and preferences. The Marin County Board of Supervisors recently passed a resolution adopting "Housing First" as the county's primary approach for addressing homelessness.

**Trauma-Informed Approach[2]**

Trauma has affected many persons served by the public welfare system. The WPC Pilot will identify evidence-based and best practice trauma-specific treatment models to address the effects of trauma on an individual's life and facilitate recovery. The WPC Pilots aims to develop a culture of care, safety, and respect through key workforce development activities, including training

[2] Substance Abuse and Mental Health Services Administration. *SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach*. HHS Publication No. (SMA) 14-4884. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2014. Access at SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach

participants on the principles of, and evidence-based and emerging best practices relevant to, trauma-informed care. **Person-Focused Care**[3]

For the WPC pilot, a person-focused care approach aims to decentralize and integrate services across the continuum of care, to cross-train staff from different agencies to implement shared WPC strategies, and to simplify and redesign work while increasing the involvement of enrollees in their care. The priority is designing and aligning systems to reach and serve the client and communities, rather than requiring target populations to overcome systemic structural or cultural barriers.

**Social Determinants of Health**

The WPC Pilot will universally screen enrollees for the non-clinical barriers that may be interfering with their ability to lead healthy, productive lives. The WPC Pilot will implement a validated tool to assess patient complexity using the social determinants of health.

These four approaches to service delivery will be required of all WPC partners. The WPC pilot will support the following services for both target populations with fee-for-service, and bundled per member per month payments:

1. Information and Referral
2. Screening, Assessments, and Referrals
3. Case Management (including care coordination, comprehensive case management, and housing-based case management)

The proposed WPC services and relevant funding mechanisms are described below for both target populations. *Refer to attached Exhibit C for an illustration of the proposed services.*

### 3.1a Information and Referral

Contracted agencies will receive fee-for-service payments for information and referral services. Eligible individuals will be provided information about the WPC pilot and referred to a case manager for screening and assessments. Two approaches will be used:

#### *Homeless or Precariously Housed*

Homeless service providers who provide mobile outreach to the target population will identify potential WPC enrollees. Trusted outreach workers will inform homeless and precariously housed individuals of the WPC pilot, and if eligible individuals express interest in participating in the pilot, a referral will be made for an assessment (if the outreach worker is unable to complete the assessment).

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[3] Vogel, D. P. (1993). Patient-focused care. American Journal of Hospital Pharmacy, 50, 2321-2329. Access at Patient-focused care.

### *Complex Conditions*

Utilization data from Partnership HealthPlan of California (PHC), Behavorial Health and Recovery Services (BHRS), HHS and inmate data from the County Jail will be used to identify potential WPC enrollees. HHS staff will manage the lists across agencies and communicate with the various entities which patients/clients/inmates may be invited to participate in the pilot.

### 3.1b Screenings, Assessments, and Referrals

The purpose of screenings, assessments, and referrals is to match target populations to the right resources at the right time through engagement, standardized screenings and assessments, comprehensive-care plans with person-centered, evidence-based interventions, and effective and appropriate referrals across the full continuum of care.

HHS staff and contracted agencies will use standardized screening and assessment tools for both target populations, including SBIRT (for substance use), PHQ-9 (for depression), AMAS (for anxiety), and a tool to measure social determinants of health. Also, staff will determine if the potential participant is currently engaged in case management services.

An additional assessment for the homeless or precariously housed population will help determine the individuals' chronicity and medical vulnerability. The VI-SPDAT will be the standard assessment tool used across all participating service providers. Participating contracted agencies will be reimbursed on a fee-for-service basis for assessments and reassessments.

### 3.1c Care Coordination and Case Management

Both target populations will access support for care coordination and comprehensive case management, as clinically indicated, through the WPC pilot. Homeless and precariously housed individuals will also access housing-based case management if needed.

### *Care Coordination*

All WPC enrollees will partner with a care coordinator (either someone who the individual is currently working with or a newly assigned case coordinator) to craft a vision for the person's life as part of their local community and determine the actions needed to move it in that direction. This care plan will help an individual and case manager prioritize goals for enrollee's health status and identify resources that might benefit the individual, including a recommendation as to the appropriate level of care. The care plan will take into consideration steps to support continuity of care, including assistance that may be needed when transitioning from one care setting to another. The care plan may also identify collaborative approaches to health, including family participation. Care coordination will be reimbursed on a fee-for-services (FFS) basis.

### *Comprehensive Case Management*

Comprehensive Case Management (CCM) is a collaborative process of assessment, planning, facilitation, care coordination, evaluation, and advocacy

for options and services to meet an individual's and family's comprehensive health needs through communication and available resources to promote quality, cost-effective outcomes. The CCM case manager may be a public health nurse or other licensed professional depending on the individual's needs. The CCM case manager will coordinate provider referrals to alcohol and other drug dependence or behavioral health services and social services.

The CCM case manager will schedule care coordination in-person, telephonic, or video visits with WPC enrollees to complete screenings and assessment as appropriate, monitor progress, and update their care plan. Designated case managers will document ongoing brokerage of needed medical, educational, social, prevocational, vocational, rehabilitative, or other community services. The service activities may include (but are not limited to): communication, coordination, and referral; monitoring service delivery to ensure patient access to service and the service delivery system; measure and evaluate progress toward goals; placement services; and plan development. Contracted agencies providing comprehensive case management will be paid through bundled payments.

### *Housing-based case management*

Housing-based case management will be available to interested WPC enrollees who are homeless or precariously housed. A housing-based case manager is a trained professional who acts as a positive change agent in assisting individuals/ families in achieving and maintaining housing, while also promoting awareness and teaching strategies that reduce the likelihood of a return to homelessness in the future. The WPC Pilot will build upon the successes of two local housing-based case management programs; Homeless Outreach Team (HOT) and the Shelter Plus Care program.

In 2016, in an effort to more effectively address chronic homelessness, Marin HHS launched the Homeless Outreach Team (HOT) Pilot. Using national best practices, HOT develops a prioritized list of chronically homeless persons, and collectively “works the list” to determine all possible options to house each individual. HOT partners (including clinicians and case managers from HHS, the Housing Authority, community-based organizations, and criminal justice) meet on a bi-weekly basis to craft and implement a tailored action plan to assist each HOT client. An action plan may include access to behavioral-health treatment, reengagement with family, wraparound care management or other assistance, all with the goal of placing that person as quickly as possible in permanent housing appropriate for their needs. Marin County Shelter Plus Care Program is a housing subsidy program for individuals who are chronically homeless and have a qualifying disability. Participants pay approximately 30 percent of their income toward rent and receive ongoing supportive services by the case managers from Marin Housing Authority.

Neither of two above programs is currently reimbursed through Medi-Cal, and both have shown promise for successfully housing people who are homeless or precariously housed. WPC enrollees supported by a housing-based case manager will secure and sustain housing, establish a primary care provider

relationship, access appropriate social service benefits, and receive health care services as needed (e.g. alcohol and other drug treatment initiation and engagement).

Contracted agencies providing housing-based case management will be paid through bundled payments.

### 3.2 Data Sharing

Data sharing is a vital element to the success of Marin County's WPC pilot. Currently, there are nine separate electronic health records (EHR) systems community-based organizations and public entities use across the county. Unfortunately, the nine systems do not communicate with one another. Often individuals have multiple points of contact across the health care system, and providers are unaware of the various services their patients receive. This lack of data sharing results in duplicative, ineffective services and system inefficiencies. The WPC pilot will leverage the current data system used among homeless and housing services providers, the Homeless Management Information System (HMIS), in addition to the new health information exchange, the Marin Health Gateway (Gateway).

Participating entities will share client care plans when each enrollee agrees to release information. Multi-agency, multi-disciplinary case conferences will facilitate inter-agency communication regarding client status for medical and related social support issues to ensure that there is no duplication of service and to ensure that the member receives the optimal level of case management services. Participating entities will comply with Health Insurance Portability and Accountability Act (HIPAA) requirements when sharing protected health information (PHI). The WPC Pilot will establish protocols to ensure care coordination meets enrollees' needs and to maintain continuity of care.
Marin HHS has established relationships data sharing relationships with participating entities:

- Behavioral Health and Recovery Services (BHRS) manages behavioral health for Medi-Cal beneficiaries with serious mental illness as well as the Drug Medi-Cal Organized Delivery System Waiver (DMC-ODS). In accordance with NCQA guidelines, BHRS administers utilization and quality management programs. BHRS' Clinician's Gateway and Share Care practice management supports administrative and clinical reporting, including required universal metrics.
- The Marin HHS Community Epidemiology Unit currently analyzes clinical data extracted from MCC's NextGen EHR system. It also has an established data sharing relationship with Partnership HealthPlan of California (PHC) that supports analysis of county-level claims data. Gateway will provide enhanced access to clinical and claims data from Marin Community Clinics (MCC) and Marin General Hospital (MGH).
- Marin HHS administers the Homeless Management Information System (HMIS). Marin HHS, in partnership with its housing partners, has selected a housing variant metric. The WPC Business Unit will work with the

Homeless Policy Steering Committee (HPSC), which oversees implementation of the county's Continuum of Care (CoC), to align HUD-required data collection and reporting processes with WPC reporting for the housing variant metric.

HMIS is used by federally and locally funded homeless housing and service agencies to collect data on clients and service utilization. Projects are required by HUD to collect self-reported personal identifying information, veteran status, domestic violence status, financial and benefits information, and health information. Current HMIS users include several of the WPC required entities and additional partners, including Buckelew Programs, Downtown Streets Team, Homeward Bound, the Marin Housing Authority, Ritter Center, and St. Vincent de Paul.

Gateway, a health information exchange (HIE), will link County departments with each other and with other community-based provider organizations. The Gateway will provide consolidated health information from numerous sources to health care providers, public health officials and other stakeholders in Marin County to improve the coordination, quality, and cost-effectiveness of care delivered to local residents.

Redwood Mednet, the HIE vendor, is currently engaged in implementing interfaces with the County's initial set of Gateway participants, which include key participants of the WPC pilot (i.e. Marin County Behavioral Health and Recovery Services, Marin General Hospital, Marin Community Clinics, and Ritter Health Center). The Gateway participants are actively engaged in providing input on the priorities of the system, drafting language for contractual agreements, policies, and procedures. Additional safety-net focused partners, including PHC and social service providers, will eventually be included in the HIE potentially during the term of the WPC pilot.

Gateway participants will sign participation agreements within the next month, and clinical data sharing will begin by December 31, 2017. Gateway data can be extended beyond point-of-care treatment to population health analytics and care management applications. An assessment is planned for next year to determine the best approach for implementing a care management module (either within Gateway or integration of Gateway with a third-party application that is already in use by WPC pilot). The assessment will take into consideration the functionality of HMIS currently used by HUD-funded contractors. It is expected the health analytics, and care management module will be implemented in 2019.

The County is committed to financing the costs associated with building the interfaces between users and the clinical data repository. The HIE will be sustained beyond the funding period of the WPC pilot through membership user fees. Once data is flowing through the repository, the cost will be based on the number of lives covered in the HIE. There is a basic charge for the number of

lives covered and an additional cost for the number of lives covered by add-on modules such as analytics and care management.

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

### 4.1 Performance Measures Description

Marin HHS will be responsible for collecting, aggregating and reporting pilot data related to the universal and variant metrics identified below. The WPC Business Unit will use a population health management approach for monitoring program enrollment, service utilization, and completion of assessments, screenings, and referrals. Participating entities contracted to deliver services for the WPC Pilot are responsible for reporting process and outcome measures. Short-term process measures and ongoing outcome measures will be tracked separately for the two different target populations within the WPC pilot. Process measures may include documentation and tracking of contacts with potential enrollees (including in-person meetings, phone calls, and mailings), response and enrollment rates (includes tracking refusals, reasons for refusals, and non-contacts). Participating entities will be required to submit information and referral reports.

The number of individuals who complete the VI-SPDAT assessment (to assess medical vulnerability) is one key process measure that will be used to monitor the performance of the WPC pilot for homeless or precariously housed populations.

The anticipated annual benchmarks for VI-SPDAT assessments are:

- PY 2: 121 Enrollees
- PY 3: 242 Enrollees
- PY 4: 484 Enrollees
- PY 5: 969 Enrollees

The number of individuals who complete the social determinants of health (SDOH) assessments is one key process measure that will be used to monitor the performance of the WPC pilot for both target populations.

The anticipated annual benchmarks for SDOH assessments are:

- PY 2: 306 Enrollees
- PY 3: 612 Enrollees
- PY 4: 1224 Enrollees
- PY 5: 2447 Enrollees

### 4.1a Universal Metrics

✔ Health Outcomes Measures
✔Administrative Measures

The goal in PY 2 is to maintain baseline measures.

### *Health Outcomes Measures*

1. Ambulatory Care – Emergency Department Visits [Adults] (HEDIS).
    1.1. Pilot Goal: Reduce emergency department visits for the WPC target population by 10 percent per year.
2. Inpatient Utilization – General Hospital/Acute Care [Adults] (HEDIS).
    2.1. Pilot Goal: Reduce inpatient utilization for the WPC target population by 10 percent per year.
3. Follow-up after Hospitalization for Mental Illness [Adult] (HEDIS).
    3.1. Pilot Goal: Increase follow-up within seven days post-discharge for Mental Illness [Adults] for the WPC target population by 5 percent per year.
4. Initiation and engagement of alcohol and other drug dependence treatment [Adults] (HEDIS).
    4.1. Pilot Goal: Increase initiation and engagement of AOD dependence treatment for WPC target population by 10 percent per year.

### *Administrative Measures*

1. Proportion of participating enrollees with a comprehensive care plan, accessible by the entire care team within 30 days of enrollment in WPC pilot
    a. Achieve 75 percent of participating enrollees with a comprehensive care plan within 30 days of enrollment in the pilot
    b. Achieve 50 percent of participating enrollees with a new comprehensive care at the anniversary of participation
2. Care coordination, case management, and referral infrastructure
    a. Develop and submit documentation of WPC Steering Committee By-Laws by December 30, 2017
    b. Develop and submit documentation of care coordination, case management and referral policies and procedures across the WPC Pilot by December 30, 2017.
    c. Develop and execute Memoranda of Understanding and new or revised contracts (as appropriate) with WPC participating entities by September 30, 2017
    d. Create WPC Pilot website to publish policies, procedures, agendas, minutes, and work plans by September 30, 2017
    e. Create Google Enterprise accounts for one representative from each participating entity to optimize information and data sharing (e.g., review and approval of MOUs, contract execution, and reporting)
    f. Implement Google Enterprise and LiveStories platforms to collect, analyze and share performance data by December 30, 2017
3. Data and information sharing infrastructure
    a. Execute Participation Agreements between the Marin Health Gateway and local clinics, hospitals, behavioral health providers by September 30, 2017
    b. Execute Participation Agreements between Marin Health Gateway and participating entities by December 30, 2017

c. Develop privacy and security protocols that comply with state and federal confidentiality of protected health information laws by September 30, 2017
d. Submit mid-year report to DHCS that demonstrates implementation of data and information sharing policies and procedures among WPC participating entities by December 30, 2017
e. Submit copies of quarterly WPC pilot performance reports and corrective action plans by June 30, 2018

### 4.1b Variant Metrics

Marin HHS has selected the following variant metrics currently reported under PHC Quality Improvement Program (QIP) or HEDIS. These variant metrics have been extensively reviewed across the region and are presented in further detail in Table 1.

1. Administrative: In each PY, Marin HHS will track the maintenance of a health home among WPC participants by measuring the proportion of WPC enrollees with an in-person primary care provider (PCP) visit 30 days before or after enrollment. This variant metric recognizes that the enrolling entity may be the PCP. The 30-day metric is based upon research showing reduced hospital readmissions with team-based transition of care management services that includes a case manager, medication reconciliation, and follow-up with a physician.[4]
2. Health Outcome: Marin HHS will administer and track overall enrollee health through measuring the self-reported health status among WPC participants. Enrollees will be asked to assess their health status on a Likert scale from Excellent to Poor ("Would you say that in general, your health is excellent, very good, good, fair, or poor?"[5]). The baseline proportion of WPC enrollees with a self-reported health status of Excellent, Very Good, or Good will be determined in the first year of the pilot, then tracked each year after that for improvements.
3. Health Outcome: Marin HHS will track Depression Remission at 12 Months (+/- 30 days) as defined by the NQF 0710. Depression remission will be defined as a PHQ-9 score of <5 within 12 months, given an initial PHQ-9 score of >9 among WPC enrollees diagnosed with Major Depressive Disorder (MDD) or dysthymia.
4. Health Outcome: Marin HHS will track the administration of the NQF 0104 Suicide Risk Assessment tool to all WPC enrollees with a diagnosis of

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[4] Hitch, B., Parlier, A. B., Reed, L., Galvin, S. L., Fagan, E. B., & Wilson, C. G. (2016). Evaluation of a Team-Based, Transition-of-Care Management Service on 30-Day Readmission Rates. North Carolina Medical Journal, 77(2), 87-92.

[5] UCLA Center for Health Policy Research and Evaluation. California Health Interview Survey (CHIS). 2015 Survey Topics. Access at California Health Interview Survey (CHIS). 2015 Survey Topics.

MDD. Results from this assessment will inform the WPC Case Management team's coordination of care.

5. Housing Specific Metric (Homeless Population): Marin HHS will measure and track the proportion of WPC enrollees that receive housing services among those who are referred for housing services. This metric will measure the success of meeting WPC enrollees' housing needs.

Description of Variant Metrics by WPC Pilot Year

| Variant Metric | Numer-ator | Denomin-ator | PY2 | PY3 | PY4 | PY5 |
|---|---|---|---|---|---|---|
| Enrollment Goals | | | 427 | 854 | 1,709 | 3,516 |
| 1. Admin-istrative - Maintain Health Home | WPC Enrollees Primary Care Provider (PCP) visit within 30 days of enroll-ment | Total Number of WPC Enrollees | 50% of enroll-ees have PCP visit within 30 days of enroll-ment | 55% of enroll-ees have PCP visit within 30 days of enroll-ment | 60% of enroll-ees have PCP visit within 30 days of enroll-ment | 65% of enroll-ees have PCP visit within 30 days of enroll-ment |
| 2. Health Outcome - Overall Beneficiary Health | WPC enrollees with self-reported health status of Good, Very Good, or Excellent | Total Number of WPC Enrollees | Maintain baseline | Improve self-reported health status by 5% from baseline | Improve self-reported health status by 5% (from the previous year) | Improve self-reported health status by 5% (from the previous year) |

Description of Variant Metrics by WPC Pilot Year

| Variant Metric | Numer-ator | Denomin-ator | PY2 | PY3 | PY4 | PY5 |
|---|---|---|---|---|---|---|
| 3. NQF 0710: Depression Remission at 12 Months | Enrollees who achieved remission at twelve months as demonstrated by a 12 month (+/- 30 days) PHQ- 9 score <5 | Enrollees with a diagnosis of MDD or dysthymia and an initial PHQ-9 score greater than nine | Maintain baseline % of enrollees with PHQ score of 9 or more. | Increase annually by 5% (from the previous year) the % which have a score of less than 5 and previously had a score of 9 | Increase annually by 5% (from the previous year) the % which have a score of less than 5 and previously had a score of 9 | Increase annually by 5% (from the previous year) the % which have a score of less than 5 and previously had a score of 9 |
| 4. Suicide Risk Assess-ment SMI Population (NQF: 0104) | Patients who had suicide risk assess-ment complet-ed at each visit | Enrollees with a diagnosis of Major Depressive Disorder (MDD) | 50% of clients with MDD diagnosis are screened | 55% of clients with MDD diagnosis are screened | 60% of clients with MDD diagnosis are screened | 65% of clients with MDD diagnosis are screened |
| 5. Housing - WPC enrollees who received housing services | Number of WPC enrollees referred for housing services who receive services | Number of WPC enrollees referred for housing services | Maintain baseline | Increase complet-ed referrals by 5% over baseline | Increase complet-ed referrals by 5% over prior year | Increase complet-ed referrals by 5% over prior year |

### 4.2 Data Analysis, Reporting and Quality Improvement

The WPC Business Unit's Analytical Team, with assistance from Marin HHS' Community Epidemiology Unit, will coordinate data collection with participating entities as part of a comprehensive performance monitoring plan. Data analysis from the sources described in the table below will be used to determine if the following primary objectives of the WPC pilot have been met, including:

- secure housing for prioritized enrollees,
- enroll members of the target populations in a shared case management system,
- identify and designate a lead case manager for each enrollee,
- complete a comprehensive needs assessment,
- assign a care level, develop and coordinate a care plan,
- maintain continuous health care coverage,
- maintain a health home,
- screening for, refer to and initiate evidence-based AOD treatment and behavioral health programs and services,
- optimize utilization of public welfare benefits and entitlement programs,
- analyze the appropriateness, effectiveness, and efficiency of care plans,
- monitor outcomes and,
- adjust results due to loss to follow-up and potential biases.

Current and Planned Data Sources and Data Sets for WPC Pilot Quality Improvement

| Data Sources | Data Sets |
|---|---|
| Partnership HealthPlan of California | QIP Reporting and Claims Data |
| Participating Health Care Entities (includes FQHCs - Coastal Health Alliance, Marin City Health and Wellness Center, Marin Community Clinics, and Ritter Center - and Marin General Hospital (MGH) | Marin Health Gateway<br>- Care Management Module |
| Behavioral Health and Recovery Services | Clinician's Gateway and Share Care |
| Emergency Medical Services (EMS) | Marin Health Gateway |
| Social Services Agency | C-IV System is a fully integrated case management system that is designed to manage data for the following public assistance programs:<br>• California Work Opportunity and Responsibility to Kids (CalWORKs)<br>• CalFresh (formerly known as Food Stamps) |

| Data Sources | Data Sets |
|---|---|
| | • County Medical Services Program (CMSP)<br>• Medi-Cal<br>• Foster Care<br>• Adoption Assistance Program (AAP)<br>• Cash Assistance Program for Immigrants (CAPI)<br>• Child Care Programs<br>• Emergency Assistance (EA)<br>• Employment Services (WtW, FSET)<br>• Kinship Guardianship Assistance Program (KinGAP)<br>• Refugee Assistance Program<br>• Approved Relative Caregiver Program (ARC) |
| Homeless Management Information System (HMIS) | Bitfocus Clarity |

### Homeless Care Data Collection and Assessment

Homeless service providers and the Probation Department will utilize the VI-SPDAT, a validated assessment tool, to determine the chronicity and medical vulnerability of homeless WPC enrollees. Case managers will create shared care plans on the cloud-based Clarity Human Services software, case management software configured to be a Homeless Management Information System (HMIS). All referrals to housing and clinical services (primary care and behavioral health) will be documented and tracked. Data from the HMIS will be extracted and analyzed quarterly to track program performance.

### Health Care Data Collection and Assessment

Health care providers will conduct standardized, validated social determinants of health (SDOH), Screening, Brief Intervention, and Referral to Treatment (SBIRT), and PHQ-9 screenings for all WPC enrollees. All associated referrals and services provided will be documented.

Partnership HealthPlan of California (PHC) routinely collects data on all Medi-Cal recipients, including those in Marin's target population. These data include emergency department visits, hospitalizations, the number of office visits, diagnoses, and cost of services provided. Marin HHS plans to expand the Marin Health Gateway (Gateway) to include PHC. Data will be extracted from the Gateway quarterly for WPC enrollees and analyzed to track health outcomes, services indicated and provided during a clinical encounter, and healthcare associated costs utilizing statistical software.

## Reporting

Marin HHS will complete mid-year and annual reports in alignment with DHCS requirements, including required data to measure progress toward the objectives specified in the WPC Special Terms and Conditions. Reports will include information and data related to enrolled participants (e.g., beneficiary demographics; clinical profiles and service utilization; housing stability; access to social services); type and volume of medical, non-medical, emergency department and inpatient services utilized; and the total amount of funds spent. Reports will also include a narrative description of implementation and evaluation activities, including process and outcome measures. Report appendices will contain agendas and minutes from steering and advisory committee meetings. We will also report the results of all CQI and PDSA efforts. We will participate in theDHCS-conducted mid-point and final statewide evaluations and accommodate data requests.

Quarterly reports summarizing healthcare utilization, services provided, and associated costs will also be generated by the WPC Business Unit. The reports will be used by the WPC Steering Committee to track the pilot's progress and assess whether or not further action is warranted (via the Quality Improvement and Change Management process described in detail below). Universal and variant metric measures will be compared between WPC enrollees, WPC dis-enrollees, and non-enrollees in the two target populations to assess the impact of the WPC pilot. The WPC Business Unit will also be responsible for preparing and submitting mid-year and annual reports to DHCS.

## Quality Improvement and Change Management

Marin HHS plans to use the Plan-Do-Study-Act (PDSA) framework to facilitate quality improvement. The WPC Business Unit will be responsible for developing quarterly quality improvement reports and program recommendations based on existing research, implementation experience, and data from new and existing system components. A real-time data visualization system, utilizing Google Cloud Storage and LiveStories, will be developed so that timely program improvements can be made. Google Cloud Storage allows worldwide storage and retrieval of any amount of data at any time. Google Cloud Storage will support website content, storing data, or distributing large data objects to users via direct download. A Dropbox will be set up to allow uploading and sharing of data, reports, and documents. LiveStories is a web-based software that transforms data into a user-friendly format. Universal and variant metrics will be reported through a data dashboard. This function supports public visualization of real-time, aggregate statistics about WPC performance. The platform will be HIPAA compliant and will allow case managers to enter service information provided to WPC enrollees.

When reviewing routine outcome metrics for WPC enrollees, the following key evaluation questions will be considered and addressed:

- Is the WPC Pilot program meeting its outreach, access, utilization, and outcome goals? To what extent? Which goals are not being met?

- If performance metrics are not being met, what systematic issues in program coordination, case management, service delivery, or service integration are potentially responsible?
- What changes might improve program performance?
- What processes will be implemented to ensure that program changes are effective?

### 4.3 Participant Entity Monitoring

The WPC Business Unit will be responsible for ensuring that the WPC pilot is in compliance with the requirements outlined by DHCS. The WPC Business Unit will be responsible for monitoring each participating entities':

- accountability to the annual WPC work plan
- achievement of performance standards and coordination of care
- use of WPC funds for budgeted, approved activities
- documentation of performance standards, services provided, participant outcomes, and coordination of care (all as applicable)

During the development of the WPC Pilot, an annual work plan that outlines the expectations of all WPC participating entities will be created with input from key stakeholders. The entity-specific WPC work plans will be reviewed annually to make any necessary changes or adjustments.

All participating entities will serve on the WPC Steering Committee and will collectively monitor progress and recommend service delivery adjustments. Entities that are non-compliant or failing to provide the contracted services will receive a corrective action and/or technical assistance within 30 days of the report. Technical assistance will be provided by any of the participating entities depending on the subject matter. Participating entities, by signing letters of participation or support, committed to offering in-kind resources to support WPC Pilot implementation. Corrective action plans and results will be reviewed by the WPC Steering Committee to determine if further action is required and if termination should be considered.

Participating entities will be required to submit bi-annual reports, documenting the services provided, use of WPC funds, and performance metrics as outlined by entity-specific work plans. The WPC Business Unit may conduct site visits, as applicable, to ensure that all WPC standards are being met. At first identification of a violation of the WPC work plan or poor program performance, participating entities will be issued a formal report from the WPC Business Unit. The WPC Business Unit and the WPC Steering Committee will work closely with the participating entity to identify and recommend the corrective action needed. Any continuous violations of the WPC work plan or indications of continued poor performance will warrant further action by Marin HHS, who will decide whether or not the WPC pilot should be terminated.

## Section 5: Financing

### 5.1 Financing Infrastructure

The WPC Pilot is designed to maximize the impact of WPC funding as well as other non-duplicated funding streams. Marin HHS' Financial Services in the Division of General Administration, under the direction of the Chief Fiscal Officer, will provide overall direction and oversight of all fiscal and related administrative services. Marin HHS' Financial Services unit manages and administers robust fiscal services, including fiscal planning and budget development, general accounting, accounts payable and accounts receivable, contracts administration, third party billing services, cost reporting, audits for federal, local and state funds, and payroll processing services.

Marin County's financial management system is used by all departments. All accounting transactions are preliminarily processed and approved at first level within the Marin HHS Financial Services. They are then approved at level two and finally processed through the County Department of Finance. Supporting documents must accompany all accounting transactions.
HHS Financial Services work with program managers and supervisors in developing budgets. HHS annual baseline budgets and new budget proposals are approved by the Marin County Board of Supervisors before they are implemented. The same approval process is in effect for contract provider contracts.

A new WPC Fiscal business unit will be created to distinguish and separately define WPC funding and fiscal operations. This process includes adding a new fund and budgeting structure within the existing financial management system. The long-term success of the WPC Pilot depends on fiscal viability and operational sustainability. Various funding strategies will be developed, in partnership with community partners and stakeholders, to provide sustained funding for WPC beyond the pilot period.

The WPC Business Unit will be responsible for managing and coordinating countywide investments in WPC-aligned programs and services. This responsibility includes budget planning and development, adoption of flexible fiscal planning, and contract management. The WPC Business Unit will develop recommendations for sustainable funding models based on results of the pilot. The WPC Business Unit will also identify opportunities to braid and blend funding for continued and/or expanded delivery of WPC programs and services. The WPC Business Unit will prepare annual budget recommendations. Upon review and approval by the Chief Fiscal Officer (CFO), the proposed budget will be submitted to the WPC Steering Committee for input.

The WPC Business Unit will manage WPC revenue and spending. The WPC Steering Committee, under Healthy Marin Partnership (HMP) will provide fiscal oversight for the WPC pilot. The WPC Steering Committee will meet regularly to review the WPC pilot performance. This review will include monitoring Key Performance Indicators (KPIs) from the pilot's Evaluation Plan. Standardized

KPIs will improve consistency across the WPC pilot and ensure that Pilot goals and objectives are being met.

Copies of the County's financial policies and procedures are available upon request. The Director of Finance maintains the accounts of County government in conformance with the principles and standards for financial reporting set forth by the Governmental Accounting Standards Board (GASB) and Generally Accepted Accounting Principles (GAAP). Recommended guidelines by the Government Finance Officers Association (GFOA) of the United States and Canada are also followed.

### 5.2 Funding Diagram

Marin HHS will establish a separate operating fund, where WPC-related expenditures, revenues, and service provider payments will be accounted for. Marin HHS will submit deliverables and payment requests to DHCS. DHCS will determine the payment amount earned by Marin HHS, and provide notification of the IGT amount that Marin HHS is required to transfer to DHCS. The IGT funds will be matched with federal funds, and the combined gross amount will be paid to Marin HHS. Marin HHS will disburse payments to service providers within a reasonable time when deliverables are met and within 30 calendar days of receiving funds. Services provider payment requirements, process and procedures will be described in the service provider contracts.

Figure 2: WPC Funding Diagram


### 5.3 Non-Federal Share

Marin HHS, as the lead entity, intends to provide the non-federal share to be used for payments under the WPC Pilot using existing county general funds and other funds. It will be collaborating with community partners for their participation in providing non-Federal share during the pilot period.

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

The WPC Pilot will follow DHCS Targeted Case Management and Managed Care Plan Memorandum of Understanding Protocols to ensure that care management activities do not duplicate Medi-Cal's targeted case management (TCM) benefit. Marin HHS staff (e.g., public health nurses or social workers) who submit time studies for TCM will not record time for WPC enrollees. Marin HHS clinical staff will shift from case management to population health management, which does not require direct contact with enrollees (i.e., WPC Case Management Team). The WPC Pilot will also utilize exclusion criteria to ensure that duplicate claims are not submitted for PRIME case management or PHC's intensive outpatient case management (IOCM).

Marin HHS will enter into Memoranda of Understanding (MOU) with participating entities that define protocols to avoid duplication of services and activities. Currently, Marin HHS does not coordinate TCM reimbursement with participating entities. Additionally, most of the services, interventions, and care coordination offered by the WPC Pilot will be delivered by staff who would not be eligible for TCM reimbursement because they lack the education, experience, and training required for TCM case workers. Furthermore, WPC case management teams will engage in activities that are not included in the TCM benefit.

Marin HHS, Partnership HealthPlan of California (PHC), and Marin General Hospital (MGH) will collaborate so that enrollees receive the appropriate level of case management services. The WPC's Steering Committee by-laws will delineate the case management roles and responsibilities for the Medi-Cal Managed Care Health Plan (PHC), Marin HHS' TCM programs, and MGH's PRIME program. Each of the above entities will designate a contact party to facilitate the required coordination and to address any and all issues as they arise. Each enrollee will be assigned a lead case manager to serve as the contact person for care management provided by the participating entity. Only participating entities assigned lead care coordination or care management responsibilities will be reimbursed for care coordination services (including case management).

The WPC Pilot will also use a client identification system to facilitate proper coordination of case management services. The WPC Business Unit will review electronic information identifying beneficiaries receiving Targeted Case Management (TCM) services quarterly. The WPC Business will review any duplicated cases with the member's PCP, the TCM case manager, and any additional case managers engaged in care management (i.e., IOCM and PRIME). This case review will determine the most appropriate care management program and confirm the lead case manager.

### 5.5 Funding Request

The WPC Pilot is the nidus for broader organizational change at Marin HHS. In 2015, Marin HHS launched a strategic planning process that has prioritized increasing access to coordinated and integrated whole person care, and addressing the social determinants of health (SDOH), including income inequality, housing affordability, and educational attainment. The WPC Pilot will build a framework for coordinated, system-wide strategic planning and investment. WPC Pilot funding represents only a portion of Marin HHS' investment in the organizational-level change needed to support "Whole Person Care" as a collective impact strategy.

Marin County's Whole Person Care pilot program is requesting a total of $20,000,000 for the term of the demonstration project. Specifically, Program Year 2 includes a request for $5,000,000 – including $2,500,000 for the required local match - for submission of the application, baseline data collection and analysis, and infrastructure building. Program Years 3-5 each include an annual request of

$5,000,000 – for a total of $15,000,000. A budget template is attached to the application.

| | Federal Funds | IGT | Total Funds |
|---|---|---|---|
| PY 1 | $1,250,000 | $1,250,000 | $2,500,000 |
| PY 2 | $1,250,000 | $1,250,000 | $2,500,000 |
| PY 3 | $2,500,000 | $2,500,000 | $5,000,000 |
| PY 4 | $2,500,000 | $2,500,000 | $5,000,000 |
| PY 5 | $2,500,000 | $2,500,000 | $5,000,000 |
| **Total** | **$10,000,000** | **$10,000,000** | **$20,000,000** |

*Refer to attached Exhibit A for the summary of funding request by budget category.*

### Administrative Infrastructure Funding

Description: The WPC Administrative Infrastructure creates the backbone of a new coordinated and integrated approach to addressing the needs of Marin County's most vulnerable Medi-Cal beneficiaries. The systems change work starts with Marin HHS internally reconfiguring and aligning resources through the creation of a WPC Business Unit. The unit will integrate efforts across Marin HHS divisions and build a sustainable business model (e.g., contract restructuring).

The WPC Business Unit will fiscally and programmatically integrate Marin HHS' homelessness, health information exchange (HIE), and clinical integration outreach units. It will optimize alignment through consolidation of housing programs (i.e. CalWORKs HSP, Behavioral Health and Recovery Services' (BHRS) Marin County Shelter Plus Care, and Rapid Re-housing). It will also create continuous cross-divisional connections (i.e., BHRS, Social Services, and Public Health) to inform program planning and implementation to create a seamless and frictionless person-centered experience for enrollees.

### *Proposed Administrative Infrastructure Budget*

The WPC Business Unit will include the following positions:

| WPC Admin - Business Unit Salaries and Benefits | FTE | Salary | Benefits (60%) | Total Cost |
|---|---|---|---|---|
| Division Director | 1.00 | 129,355 | 77,613 | $206,968 |
| Sr. Department Analyst | 0.50 | 106,912 | 64,147 | $85,529 |
| Sr. Department Analyst | 0.25 | 106,912 | 64,147 | $42,764 |
| Sr. Department Analyst - Homeless | 0.75 | 106,912 | 64,147 | $128,294 |
| Department Analyst II - Evaluation | 1.00 | 97,261 | 58,357 | $155,618 |
| Sr. Program Coordinator - Homeless | 0.75 | 80,906 | 48,544 | $97,087 |
| Sr. Program Coordinator - BHRS | 1.00 | 80,906 | 48,544 | $129,450 |
| Sr. Program Coordinator - Aging and Adult | 1.00 | 80,906 | 48,544 | $129,450 |
| Sr. Program Coordinator - HMP | 0.25 | 80,906 | 48,544 | $32,362 |
| Accountant II | 1.00 | 80,906 | 48,544 | $129,450 |
| Technology System Specialist II | 0.50 | 91,007 | 54,604 | $72,805 |
| **Subtotal - WPC Admin Business Unit** | **8.00** | **1,042,889** | **625,733** | **$1,209,777** |

| WPC Admin Planning - Salaries and Benefits | FTE | Salary | Benefits (60%) | Total Cost |
|---|---|---|---|---|
| Deputy Health Officer | 0.60 | 177,341 | 106,405 | $170,247 |
| Chief Fiscal Officer | 0.15 | 151,445 | 90,867 | $36,346 |

The Administrative Infrastructure includes 8.75 projected full-time employee equivalents (FTEs) who are assigned to administer the pilot.

- The Deputy Public Health Officer (DPHO) will provide clinical oversight for the WPC Pilot (0.60 FTE) during PY1 and PY2. This position will oversee the creation of the coordinated network of care, homeless policy and program development, case management infrastructure, and the health information exchange. The DPHO will provide WPC the leadership for planning and start-up of the WPC Business unit until the Division Director is hired.
- The Chief Fiscal Officer (0.15 FTE) will manage and lead the start-up financial planning and operations of WPC during PY 1 and PY 2.

The hiring of new staff will begin in PY2 and early PY3. Marin HHS budgets for hiring all staff at step 5. All new positions will require a hiring review process, which includes approval by the County Administrator's Office. This process may

delay the hiring of new staff. Upon award notification, Marin HHS will submit a budget change request to the Marin County Board of Supervisors to expedite this approval process. Marin HHS staff can be hired at step 1 through step 5. Staff hired at Step 3 or higher requires approval by Marin HHS' Deputy Director. Staff hired at Step 4 or higher requires approval from the County Administrator's Office. Marin County's employee benefits cost is approximately 60 percent of the employees' base salaries. Base salaries for PY 2 reflect a budgeted 3 percent Cost of Living Allowance (COLA) increase effective July 1, 2017. The County of Marin also has a budgeted 3 percent COLA increase scheduled for January 1, 2020. These salary changes are reflected in the budget summary submitted. In the last fiscal year, salaries and benefits at Marin County have increased to reflect bargaining agreements and updated pension and retirement costs. Compared to the rest of the country, Marin County's cost of living is 150 percent higher than the U.S. average.

### Other WPC Planning Staff

Countywide health care system redesign requires the engagement of Marin HHS Leadership staff. Other WPC Planning Staff includes Marin HHS' directors, division directors, and key managers. They are actively participating in planning efforts across the agency and with community stakeholders to shift the service delivery model in Marin County to a value-based system. The following positions play instrumental roles in the design and implementation of the WPC pilot.

The Epidemiology Manager is responsible for the daily operations and outcomes of epidemiology programs and services under policies and guidelines established by the County Public Health Officer, local, state and federal statutes. The Manager participates in the development of program evaluation metrics for HHS, and is responsible for developing and fostering data systems to inform local health policy initiatives.

The BHRS Division Director is responsible for management of Access, Quality Management and Information Technology for the Division of Behavioral Health and Recovery Services. The Access Team serves as the entry point to Specialty Mental Health Services. The Quality Management Team is responsible for a range of duties focused on compliance with the Division's contractual and regulatory requirements, preparation for DHCS program audits and quality reviews, and producing data to guide system improvements in the areas of access, timeliness and outcomes, as well as data-driven decision making. The Information Technology Team supports the clinical and fiscal end users of the Division's Electronic Medical Record and Practice Management Systems, as well as the required reporting functions of the Division.

The Consulting Chief of Addiction Services works with HHS and BHRS to develop a Substance Use Disorder (SUD) services delivery system by developing both intramural capacity and enhancing/building resources in the community system of care. The Consulting Chief assists in developing programs related to expanding access to and linkage with medication-assisted treatment

(MAT) (e.g. Behavioral Health and Substance Use Services, Jail, FQHCs, and Drug/Medi-Cal Outpatient Delivery Services).

The County Public Health Officer is responsible for providing public health leadership and developing public health policy for the County and for planning, organizing and directing public health programs including enforcement of applicable public health laws and regulations. The position serves as the County liaison and medical expert to the State, the local medical society, and other agencies and community groups. It also serves as County spokesperson on public health issues, including those involving health equities and public health principles as well as on clinical and disease control issues. The Public Health Officer advocates for effective disease prevention and health promotion programs and activities and provides leadership in the development of public health policy and implementation of effective public health programs.

The BHRS Director provides leadership, strategic direction and overall management of operations and all programs in the division. Responsibilities include recommending, developing, implementing and evaluating strategic plans, goals, objectives, policies and procedures. The position also plans, organizes, directs, oversees, reviews and coordinates all facets of mental health and substance use programs and services provided by County staff and contracting agencies. Services include residential, children's and adult outpatient treatment, emergency, court treatment and other programs of direct treatment.

The Director of Social Services is responsible for the overall direction and program outcomes of Social Services division. The Director provides day-to-day administrative oversight, integration, and coordination of all social services programs, mandates, and initiatives designed to protect the community and ensure self-sufficiency. They provide leadership and coordination between multiple major agency programs, working collaboratively with departmental administrative staff, County Boards and Commissions, community groups, school districts, local municipalities and State and regional organizations to maximize funding and local services. Directs, coordinates and participates in developing and implementing agency program goals, objectives, policies, procedures, and priorities; ensures compliance with all applicable mandated regulations, codes, legal requirements, contractual terms and consistency with the County's Strategic Plan.

The Division Director for BHRS Substance Use Services is the program administrator responsible for the overall management, direction and programmatic outcomes of all services and activities of publicly funded substance use services in Marin County. The position and duties of the position are statutorily required by the Health and Safety Code. The position requires interaction with Federal and State representatives, County leadership and management, community-based organizations and various other community partners to ensure appropriate planning and delivery of services to the community.

The Program Manager for Aging and Adult Services in the Social Services division oversees the Area Agency on Aging, Aging and Disability Resource Connection, Long-Term Care Ombudsman, and Transition Care Program. The position is responsible for planning, contracting, coordinating, monitoring, and evaluating of programs and services for older adults, persons with disabilities, and family caregivers.

The Division Director of the Area Agency on Aging and Adult Social Services is the program administrator responsible for the overall management and direction of programs and activities to support older adults, family caregivers, and persons with disabilities. The division consists of a staff of 50+ social workers, public health nurses, administrators/planners, and office support personnel. The Area Agency on Aging is charged with planning for older adults, administering Older Americans Act funding, and collaborating with the community on policies and services. Adult Social Services provides Adult Protective Services and In-Home Supportive Services programs.

### WPC Business Unit

The Division Director will lead the WPC Business Unit (1.0 FTE). The position will act as liaison with DHCS, oversee management of program deliverables, provide program guidance and be responsible for reporting requirements. The WPC Business Unit will consist of three teams: Policy, Analytical, and Case Management. Staff will not be delivering direct services to enrollees, therefore, are not funded through fee-for-service or bundled payments.

### WPC Business Unit's Policy Team

The Policy Team will be composed of existing Sr. Department Analysts (1.50 FTE). To date, staff has been working disparately to serve the target populations. An integrated WPC Business Unit will support information sharing that aims to align their efforts, identify redundancies and achieve operational efficiencies in support of the WPC Pilot goals and objectives. The Sr. Department Analysts will:

- manage relationships with participating entities across the health and social service sectors;
- coordinate implementation of HMIS, Coordinated Entry, and the HIE;
- revise existing and execute new contracts (as required by County Policy) with participating entities; and,
- manage contracts and reporting with participating entities.

Finally, an existing Sr. Program Coordinator position (0.25 FTE) will provide the staff support for HMP, the WPC Steering and Advisory Committees.

### WPC Business Unit's Analytical Team

The Analytics Team will consist of a new Department Analyst II (1.0 FTE) to coordinate evaluation and reporting, an existing Technology System Specialist II (0.5 FTE), and a new Accountant II (1.0 FTE). The team will conduct analytical studies to develop, implement, evaluate and improve the WPC pilot. The team will provide professional level management decision making support for the WPC business unit. The Department Analyst II will facilitate the PDSA improvement process within the WPC Business Unit and the WPC Steering Committee. The Accountant II will be responsible for the Accounts Payable/Receivable functions related to WPC Pilot billing. The position will also be responsible for business analytics of value-based reimbursements and shared savings. The Analytics Team will be supported by Marin HHS' Community Epidemiology unit. The Technology System Specialist II will coordinate Marin Health Gateway's (Gateway) data sharing and reporting capabilities.

### WPC Business Unit's Case Management Team

The WPC Business Unit's Case Management Team will include three new Sr. Program Coordinators (2.75 FTE). The Case Management Team will work with the Analytical Team to implement a population health management system to monitor enrollee-level care plans. These positions will serve as divisional liaisons at the programmatic level. There will be a Senior Program Coordinators representing Marin HHS' Aging and Adult Services, Marin HHS' Homelessness Program, and BHRS. These teams are developing a population health management system. Their roles and responsibilities include identifying and creating subpopulation groups based on diagnoses, risk factors, care team, and other factors; help providers identify patterns; examine detailed characteristics of patient subpopulations; facilitating communication and coordination between providers and participants; monitoring clinical performance measures, aggregating and sharing data. The Case Management Team will be supported by nurses who will guide the development of standardized care management policies, protocol, and procedures. The Case Management Team will assist case managers from participating entities navigate the system of care. The team will also coordinate weekly case conferences.

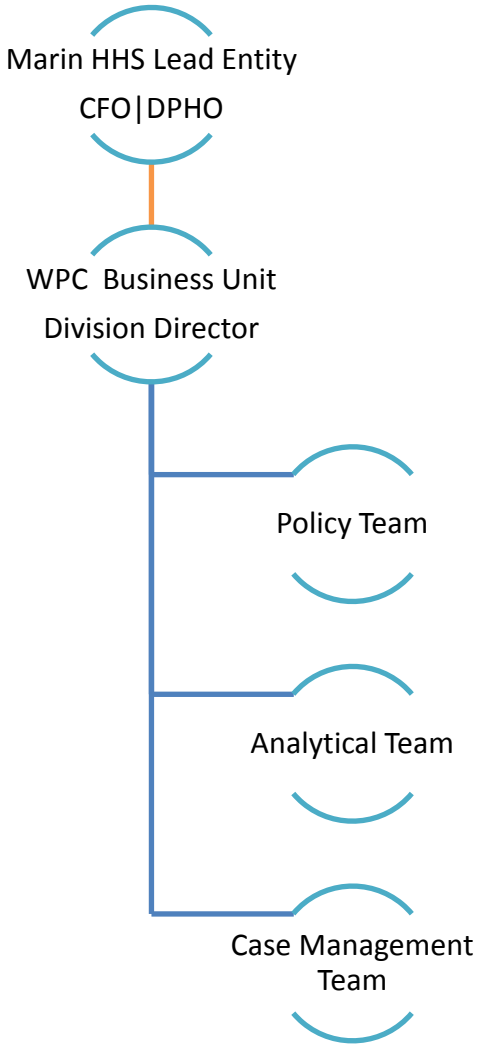


**Figure 3: WPC Business Unit Organizational Structure**

Rent – For cost of office space @ approximately $4,500 per month for the WPC Staff
Building Maintenance and Utilities – For janitorial services and cost of building utilities at approximately ($12,000 per year)
Supplies – For cost of office supplies such as copier paper, pens, postage, printing supplies ($4,500 per year)
Training – For program related and staff development training ($750/employee)
Travel/Mileage – Cost of local mileage to program related meetings ($563/employee)
WPC Planning Consultant – Consultation services for WPC program planning, development and implementation ($30,000 per year)
Marketing and Communications – The WPC business unit will develop a strategic marketing and communications plan to advance and strengthen the WPC pilot brand (name to be determined), encourage community engagement, and reinforce the relevance of participating entities in the lives of key target audiences, including potential and current enrollees and community stakeholders. The WPC business unit will employ news promotions,

publications, and web and other electronic communications to enhance the visibility of the WPC pilot. It will utilize social media, networks and new technologies to engage enrollees and the community. This budget item includes purchasing all advertising and promotion media, including internet, newspaper, radio, TV, and direct mail (postage). It also includes producing (design, artwork) and printing all communications. This includes newsletters, brochures, websites, press kits, etc. It will also fund the production of special events (e.g., "Housing First" trainings) ($50,000 - $113,000 per year).

Office Expenses

For the cost of computer lease @ $600 per computer per year for 8 FTE. The county leases computers via a countywide computer lease program. The county opted to lease instead of purchase computers as it was determined to be more cost-effective. ($4,800)

For the cost of subscriptions to Google Cloud Software and LiveStories for WPC staff and staff from participating entities. We estimate that at least 50 staff will use the Google Cloud Software, costs $5 per user per month ($60 per person per year). The LiveStories software costs $129 per month ($1548). Funding will cover approximate 25 percent of the costs of this collaborative technology. ($1,200)
(Total = $6,000 per year)
*Refer to attached Exhibit B for the Administrative Infrastructure Budget for PY 2 – PY 5.*

### Delivery Infrastructure Funding

The WPC pilot will build an integrated, social-determinants driven population health management system that transforms data into actionable intelligence that can help inform, prioritize, and sequence strategies (including investment), policies, and programs countywide. Marin HHS will integrate the countywide Health Information Exchange (HIE) Marin Health Gateway (Gateway) planning, implementation, expansion, and maintenance into the delivery infrastructure of the WPC pilot. Gateway will execute Participation Agreements with Participating Entities. It will develop privacy and security policies that comply with state and federal confidentiality of protected health information laws. By the end of PY 2, the Gateway Management Team will test and complete interfaces between and Participating Entities. It will also provide training and technical assistance for end users and new users. During PY 2, Marin HHS' WPC Business Unit will use delivery infrastructure funding to implement the Homeless Management Information System (HMIS) and the County's Coordinated Entry Systems. Marin HHS will contract with Bitfocus to implement its Clarity Human Services software. This is case management software that will be used by homeless service providers participating in the WPC pilot. Gateway will integrate Clarity into its network. Notably, Gateway will create Social Determinants of Health (SDOH) Assessment and Case Management modules to support shared care planning and to avoid the addition of another legacy software. Additionally, delivery infrastructure funding will be used to fund the biennial Point-in-Time Homeless

Count. In the past, Marin HHS has used county general funds to fund the Point-in-Time Count. As part of the WPC pilot, future Point-in-Time Counts will be used as part of the information and referral process. WPC staff will participate in the Point-in-Time Count along with staff from participating entities. This will provide an outreach opportunity to identify homeless persons and assess their medical and social needs. Data will be used to prioritize the most vulnerable, Medi-Cal eligible chronically homeless individuals and to enroll them in housing-based case management. This count will also inform future WPC policy and program-level decisions.

Marin HHS also recognizes that increased engagement of community partners in person-centered advocacy will increase demand for public welfare benefits. While the Marin HHS' Public Assistance eligibility workers have the capacity to serve enrollees, the Department's Employment and Training Branch will need to increase case management staff. The WPC Pilot will use delivery infrastructure funds for one (1.0) FTE Employment Counselor, who will be assigned to assist homeless and precariously housed individuals in accessing other benefits that are available through the County.

During PY2 and PY3, Marin HHS will utilize delivery infrastructure funding for Homeless Program Strategic Planning and Consultation Services. Marin HHS will contract with HomeBase to coordinate and facilitate grant applications for HUD's McKinney grant process; to ensure that WPC strategies meet HUD requirements; and support community-wide engagement through the Homeless Policy Steering Committee and subcommittees. Marin HHS will build internal capacity for these roles and responsibilities during PY 4-5.

Delivery Infrastructure funding will also be used to support the large-scale social change, and cross-sector coordination the WPC Pilot aims to achieve. Annually, the WPC Business Unit, in partnership with HMP, will present countywide learning opportunities to advance WPC principles (e.g. Housing First; Trauma-Informed Approaches; Person-Centered Care; and Social Determinants of Health). The intention is to build a shared vision and a collective "Whole Community" approach to "Whole Person Care."

During PY 2, the WPC Business Unit will utilize delivery infrastructure funding to finance information and referral; screening, assessment, and referral; care coordination; and case management (i.e., Downtown Streets Teams; Homeless Outreach Team; and, Rapid Rehousing/ Transition and Supported Housing related services). Participating entities (St. Vincent de Paul's and Ritter Center) are currently under contract with Marin HHS to deliver these services. During PY 2, the WPC Business Unit will work with Marin HHS Financial Services to integrate these programs into the WPC Pilot and to transition current contracts with homeless service providers into Pay-for-Performance contracts (i.e., FFS, bundled payments). As part of their current contracts, the Downtown Streets Team and St. Vincent de Paul's Homeless Outreach Team (HOT) will identify potential enrollees for the WPC pilot commencing July 1, 2017. Outreach

workers will engage potential enrollees to build trust and secure permission to complete coordinated entry, provide information and referral services, and to enroll clients in housing-based case management. As part of their current contracts, participating entities (St. Vincent de Paul's and Ritter Center) are providing housing-based case management. From PY3 onward, this funding will shift from Delivery Infrastructure to Fee-for-Service and Bundled Payments.

In PY 2, services in Information and Referral, Screening, Assessments and Referral, and Case Management will be part of Delivery Infrastructure, to allow for the restructure and transition of existing non-Federal/non-State funded services, and to allow for hiring and training of staff. Beginning PY 3, these services will be part of PMPM and/or FFS. Delivery costs are prorated based on a percentage of Medi-Cal population.

***Proposed Delivery Infrastructure Budget***

| | **PY 2** | **PY 3** | **PY 4** | **PY 5** |
|---|---|---|---|---|
| HIE Implementation, Expansion, Maintenance | $480,721 | $272,479 | $149,495 | $166,307 |
| Homeless Management Information System | $25,000 | $50,000 | $50,000 | $50,000 |
| Point-in-time Homeless Count | | $25,000 | | $25,000 |
| Employment Development Counselor (1.0 FTE) | $49,029 | $98,058 | $98,058 | $98,058 |
| Homeless Program Strategic Planning and Consultation Services | $33,415 | $66,830 | n/a | n/a |
| Training – Housing First | $10,000 | $20,000 | $20,000 | $20,000 |
| Training – Case Mgmt | $10,000 | $20,000 | $20,000 | $20,000 |
| Information and Referral | $56,875 | FFS | FFS | FFS |
| Housing-based Case Management | $770,199 | PMPM | PMPM | PMPM |
| Screening, Assessments and Referrals | $37,995 | FFS | FFS | FFS |
| **Total** | **$1,473,234** | **$552,367** | **$337,553** | **$379,365** |

## Pay For Performance

Nationwide, states have been implementing care coordination, case management, and patient navigation to reduce health care spending. In designing the WPC Pilot, Marin HHS reviewed resource papers and evaluation reports from the Centers for Medicare & Medicaid Services (CMS) on value-based payments.[6,7,8] We also analyzed current levels of Marin HHS spending (estimating per member per month costs) to support housing-based case management services offered by homeless service providers. These analyses have provided a significant amount of data and information to inform the case rates selected for the WPC Pilot. The WPC Pilot will use a combination of Fee-For-Service (FFS) rates and Bundled Payments to finance information and referral services; screening, assessments, and referrals; care coordination; and, case management.

### *Fee for Service (FFS) – Budget*

The FFS budget was developed based on latest known cost rate from existing contract providers that provide comparable services in other health-related programs. The FFS rates have been calculated by projected costs and estimated face-to-face contacts with potential and actual WPC enrollees. The number of units is based on the projected number of clients to be served in the target population.

### Information and Referral

Participating entities will be reimbursed for providing information and completed referrals for potential enrollees. It is projected that each potential enrollee will require up to 2 hours of staff time for information and referral prior to enrollment. Engagement is a key component of information and referral. Staff will locate, identify, and build relationships with targeted beneficiaries (e.g., sheltered and unsheltered homeless; patients with complex conditions) for the purpose of enrolling in the WPC pilot. Staff will complete an initial assessment of needs and eligibility and will actively connect the potential enrollee to a participating entity for screening and assessment. Staff will provide oral and written information about the WPC pilot to potential enrollees and describe the benefits of enrollment. Staff will confirm their interest in participation, verify potential enrollees' eligibility status, identify if the person is enrolled in another program,

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[6]Center for Health Care Strategies, Inc., Enhanced Primary Care Case Management Programs in Medicaid: Issues and Options for States (2009). Access at Enhanced Primary Care Case Management Programs in Medicaid: Issues and Options for States (2009)

[7]Bailit, M. Payment Brief (2011). Access at Payment Brief (2011)

[8]Center for Health Care Strategies, Inc., Case Rate Scan for Care Management (2012) Entities. Access at Case Rate Scan for Care Management (2012) Entities

and enter the potential enrollees' demographic information into the Google Cloud Software. This encounter will be billable upon completed referral to the WPC pilot. Based upon the number of patients/clients currently served, we are projecting that participating entities will deliver 491 information and referral units (PY3), 983 information and referral units (PY4), and 1,277 information and referral units (PY5). This totals to 2,751 projected billable information and referral units.

### Information and Referral (FFS) Cost Calculation

| Item | Units | Annual Cost per Unit | Total |
|---|---|---|---|
| **Staff** | | | |
| Case Manager | 0.4 | $53,365 | $21,346 |
| Peer Support | 0.6 | $31,135 | $18,681 |
| **Infrastructure** | | | |
| Administrative Costs (10%) | 1 | $4,163 | $4,163 |
| **Total** | | | $44,190 |
| **SAR Costs** | **491 Units** | | **$90 FFS** |

### Information and Referral Rates and Units

| | PY 3 | PY 4 | PY 5 |
|---|---|---|---|
| Rate | $90 | $90 | $90 |
| # of Units | 491 | 983 | 1,277 |
| Total | $44,190 | $88,470 | $114,894 |

Unit = Up to 2 hours of service

### Screening, Assessments, and Referrals

Participating entities will be reimbursed for completing standardized screening and assessment for potential WPC enrollees. It is projected that each potential enrollee will require one 90-minute, face-to-face screening and assessment prior to enrollment. Intake staff (i.e., support service workers) will complete a health and psychosocial assessment, taking into account the cultural and linguistic needs of each client. Staff will identify problems or opportunities that would benefit from either care coordination or case management. After screening and assessment, a case manager or nurse will review the assessment and assign enrollees to a level of care (i.e., care coordination; comprehensive case management; or, housing based case management). After assignment, intake staff will then enroll participants and coordinate referrals (as appropriate). We are

projecting that participating entities will deliver 602 screening and assessment units (PY3), 1,563 screening and assessment units (PY4), and 1,563 screening and assessment units (PY5). This totals to 3,368 projected billable screening and assessment units.

### Screening, Assessment and Referrals (FFS) Cost Calculation

| Item | Units | Annual Cost per Unit | Total |
|---|---|---|---|
| **Staff** | | | |
| Senior Registered Nurse | 0.2 | $150,000 | $30,000 |
| Support Service Worker | 0.5 | $59,000 | $29,500 |
| Social Service Worker | 0.25 | $65,000 | $16,250 |
| **Infrastructure** | | | |
| Employee Development | 4 | $500 | $2,000 |
| Office Supplies | 4 | $300 | $1,200 |
| Program Supplies | 4 | $358 | $1,430 |
| Administrative Costs (10%) | 4 | $2,000 | $8,000 |
| **Total** | | | $88,380 |
| **SAR Costs** | **602 Units** | | **$147 FFS** |

### Screening, Assessments, and Referrals Rates and Units

| | PY 3 | PY 4 | PY 5 |
|---|---|---|---|
| Rate | $147 | $147 | $147 |
| # of Units | 602 | 1204 | 1563 |
| Total | $88,380 | $176,940 | $229,788 |

One unit includes 60 minutes for screening and assessment; 30 minutes for case management review and assigment; and 30 minute for referral coordination

### Care Coordination

Participating entities will be reimbursed for completing and updating care plans for WPC enrollees assigned to care coordination. It is projected that each enrollee in care coordination will require at least one 90-minute, face-to-face encounter upon enrollment. Staff will document relevant, comprehensive information and data using interviews, research, and other methods needed to develop a plan of care. Care coordinators will manage referrals and coordinate communications, as appropriate, with specialists, enrollees, and families. A case manager or nurse will review and approve each completed care plan. This encounter will be billable upon completion of an initial care plan or submission of an updated care plan. We are projecting that participating entities will deliver up

to 1,307 care coordination encounters (PY3), 2,616 care coordination encounters (PY4), and 3,399 care coordination encounters (PY5). This totals to 7,322 projected, duplicated encounters for care coordination.

### Care Coordination (FFS) Cost Calculation

| Item | Units | Annual Cost per Unit | Total |
|---|---|---|---|
| **Staff** | | | |
| Senior Registered Nurse | 0.25 | $150,000 | $37,500 |
| Support Service Worker | 1 | $59,000 | $59,000 |
| Social Service Worker | 1 | $65,000 | $65,000 |
| **Infrastructure** | | | |
| Employee Development | 4 | $2,500 | $10,000 |
| Office Supplies | 4 | $585 | $2,340 |
| Program Supplies | 4 | $578 | $2,310 |
| Administrative Costs (10%) | 4 | $4,000 | $16,000 |
| **Total** | | | $192,150 |
| **Care Coordination Costs** | **1307** | | **$147 FFS** |

### Care Coordination Planning Rates and Units (i.e., Unduplicated Enrollees)

| | PY 3 | PY 4 | PY 5 |
|---|---|---|---|
| Rate | $147 | $147 | $147 |
| # of Units (Unit = unduplicated enrollee) | 1,307 | 2,616 | 3,399 |
| Total | $192,150 | $384,525 | $499,590 |

Unit = 75 minutes of service

### *Per Member Per Month (PMPM) Bundled Payments – Budget*

The PMPM budget was developed based on latest known cost rate from existing contract providers that provide comparable services in other health-related programs. The PMPM bundled payment rates have been calculated by projected costs and estimated face-to-face contacts with actual WPC enrollees. The bimonthly rate is multiplied by the number of members per month.

### Comprehensive Case Management

Participating entities will be reimbursed through bundled payments for WPC enrollees assigned to comprehensive case management. It is projected that each enrollee in comprehensive case management will require, on average, 90-minutes, face-to-face comprehensive case management per month for 12 months. Trained case management staff will identify immediate, short-term, long-term, and ongoing needs, as well as develop appropriate and necessary case management strategies and goals to address those needs. Case managers will document relevant, comprehensive information and data using interviews, research, and other methods needed to develop a plan of care. They will employ

ongoing assessment and documentation to measure the client's response to the plan of care. Case managers will maximize the client's health, wellness, safety, adaptation, and self-care through quality case management, client satisfaction, and cost-efficiency. We are projecting that participating entities will enroll 306 unduplicated participants in comprehensive case management (PY3), 330 unduplicated participants in comprehensive case management (PY4), and 245 unduplicated participants in comprehensive case management (PY5). This totals to 881 projected enrollees in comprehensive case management with a case ratio of 1:30.

### *Comprehensive Case Management PMPM Cost Calculation*

Countywide, the following staff mix (or equivalents) and infrastructure costs will support the comprehensive case management component of the WPC pilot:

| Item | Units | Annual Cost per Unit | Total |
|---|---|---|---|
| **Staff** | | | |
| Senior Registered Nurse | 1.9 | $150,000 | $285,000 |
| Support Service Worker | 4 | $59,000 | $236,000 |
| Social Service Worker | 4 | $65,000 | $260,000 |
| **Infrastructure** | | | |
| Travel | 4 | $4,610 | $18,440 |
| Employee Development | 4 | $4,000 | $16,000 |
| Rent | 4 | $10,000 | $40,000 |
| Utilities | 4 | $1,000 | $4,000 |
| Office Supplies | 4 | $5,000 | $20,000 |
| Expendable Equipment <$5000 | 4 | $1,000 | $4,000 |
| Program Supplies | 4 | $2,000 | $8,000 |
| Insurance | 4 | $1,000 | $4,000 |
| Telephone | 4 | $1,000 | $4,000 |
| Administrative Costs (10%) | 4 | $23,000 | $92,000 |
| **Total** | | | $991,440 |
| **Comprehensive CM Costs** | **306 enrollees** | **3672 member months** | **$270 PMPM** |

*Comprehensive Case Management Bundled Payment Rates*

| | PY 3 | PY 4 | PY 5 |
|---|---|---|---|
| PMPM Rate | $270 | $270 | $270 |
| # of Members Per Month x 12 Months | 3,672 | 3,966 | 2,936 |
| Total | $991,440 | $1,070,755 | $792,828 |

## Housing-Based Case Management

Participating entities will be reimbursed through bundled payments for WPC enrollees assigned to housing-based case management. It is projected that each enrollee in housing-based case management will require, on average, 180-minutes, face-to-face housing-based case management per month for 12 months. Case management staff, trained in homelessness prevention and rapid rehousing, will identify immediate, short-term, long-term, and ongoing needs, as well as develop appropriate and necessary case management strategies and goals to address those needs. Case managers will document relevant, comprehensive information and data using interviews, research, and other methods needed to develop a plan of care. They will employ ongoing assessment and documentation to measure the client's response to the plan of care. Case management will focus on determining the need for specific levels of housing assistance and helping the household identify and obtain housing. We are projecting that participating entities will enroll 242 unduplicated participants in housing-based case management (PY3), 200 unduplicated participants in housing-based case management (PY4), and 200 unduplicated participants in housing-based case management (PY5). This totals to 642 projected enrollees in housing based case management with a case ratio of 1:17.

### *Housing-Based Case Management PMPM Cost Calculation*

Countywide, the following staff mix (or equivalents) and infrastructure costs will support the housing-based case management component of the WPC pilot:

| Item | Units | Annual Cost per Unit | Total |
|---|---|---|---|
| **Staff** | | | |
| Senior Registered Nurse | 2 | $150,000 | $300,000 |
| Support Service Worker | 4 | $59,000 | $236,000 |
| Social Service Worker | 4 | $65,000 | $260,000 |
| Case Manager | 3 | $53,365 | $160,095 |
| Peer Support | 4 | $31,135 | $124,540 |
| Counselor | 3 | $55,576 | $166,728 |
| **Infrastructure** | | | |
| Client Expenses | 4 | $2,000 | $8,000 |
| Travel | 4 | $6,699 | $26,797 |
| Employee Development | 4 | $4,000 | $16,000 |
| Rent | 4 | $17,500 | $70,000 |
| Utilities | 4 | $1,000 | $4,000 |
| Office Supplies | 4 | $5,000 | $20,000 |
| Expendable Equipment <$5000 | 4 | $2,000 | $8,000 |
| Program Supplies | 4 | $4,000 | $16,000 |
| Insurance | 4 | $1,000 | $4,000 |
| Telephone | 4 | $2,000 | $8,000 |
| Administrative Costs (10%) | 4 | $35,000 | $140,000 |
| **Total** | | | $1,568,160 |
| **Housing-based CM Costs** | **242 enrollees** | **2904 member months** | **$540 PMPM** |

### Housing-Based Case Management Bundled Payment Rates

| | PY 3 | PY 4 | PY 5 |
|---|---|---|---|
| PMPM Rate | $540 | $540 | $540 |
| # of Members Per Month x 12 Months | 2,904 | 2,400 | 2,400 |
| Total | $1,568,160 | $1,296,000 | $1,296,000 |

### Pay for Performance Payments

Marin HHS estimates that it will contract with four (4) community health centers to deliver WPC services, interventions, and care coordination. It has budgeted an annual payment for each participating community health center for submitting reports as required and achieving the expected outcomes.

### Pay for Reporting

On time reporting of Universal and Variant Metrics is a Pay for Reporting deliverable, with potential payments outlined below for each PY. Community health centers will request payments for on-time submissions of the Universal and Variant Metrics on a biannual basis. This deliverable involves 100 percent payment triggered at on-time submission of the annual report.

During program years 3, 4, 5, community health centers will receive payment for reporting upon completed submission. Reimbursement is based upon a rate per report for the following reported measures:

- Completion of screenings and assessments (i.e., Social Determinants of Health [SDOH]; self-reported health status; PHQ-9 (for depression); SBIRT (for substance use); and suicide risk assessment (if indicated);
- Completion of comprehensive care plan for enrollees;
- Maintain a health home for enrollees;
- Follow-up after hospitalization for mental Illness (as indicated); and,
- Initiation and engagement of alcohol and other drug dependence treatment for enrollees (as indicated).

### Pay for Reporting Payment Rates

| | PY 3 | PY 4 | PY 5 |
|---|---|---|---|
| P4R Rate | | | |
| # of community health centers | 4 | 4 | 4 |
| Rate per report per CHC | $500 | $2500 | $2500 |
| Reporting screenings and assessment | $2000 | $10,000 | $10,000 |
| Reporting care plans ($500 per CHC) | $2000 | $10,000 | $10,000 |
| Reporting health homes ($500 per CHC) | $2000 | $10,000 | $10,000 |
| Reporting follow up after hospitalization for AMI ($500 per CHC) | $2000 | $10,000 | $10,000 |
| Reporting initiation and engagement in AOD treatment ($500 per CHC) | $2000 | $10,000 | $10,000 |
| Total | $10,000 | $50,000 | $50,000 |

### Pay for Outcomes

On time reporting of Universal and Variant Metrics is a Pay for Outcomes deliverable, with potential payments outlined below for each PY. Community health centers will request payments for demonstrating achievement of selected Universal and Variant Metrics on an annual basis. Payment will be triggered at on-time submission of the annual report, reflecting achievement of selected outcomes.

During program years 3, 4, 5, community health centers will receive payment for outcomes. Pay for Outcomes will be divided into two components:

1. Completion rates for screening and assessments and timely comprehensive care plans
2. Health outcome improvements

During PY 3, community health centers will receive a payment upon demonstrating achievement of the following completion rates:

- Completion rates for screenings and assessments

    - Social Determinants of Health [SDOH] screening completed with 60 percent of enrollees and increase by 5 percent each year (PY 4 and 5)
    - Self-reported health status assessment completed with 60 percent of enrollees and increase by 5 percent each year (PY 4 and 5)
    - PHQ-9 (for depression) screening completed with 60 percent of enrollees and increase by 5 percent each year (PY 4 and 5)
    - SBIRT (for substance use) screening completed with 60 percent of enrollees and increase by 5 percent each year (PY 4 and 5)
    - Suicide risk assessment completed for 60 percent of enrollees with positive screening for depression (PHQ-9) and increase by 5 percent each year (PY 4 and 5)

During PY 4 and 5, community health centers will be reimbursed for maintaining completion rates. Additionally, community health centers will receive payment based on established rate per achievement of selected health outcomes.

- Health Outcome Improvements
    - Reduce inpatient utilization for the WPC target population by 5 percent per year
    - Reduce inpatient utilization for the WPC target population by 5 percent per year
    - Increase follow-up within seven days post-discharge for Mental Illness [Adults] for the WPC target population by 5 percent per year.
    - Increase initiation and engagement of AOD dependence treatment for WPC target population by 5 percent per year

## Pay for Outcomes Payment Rates

| | PY 3 | PY 4 | PY 5 |
|---|---|---|---|
| P4O Rate | | | |
| # of community health centers | 4 | 4 | 4 |
| Rate per completion rates per CHC | $500 | $2500 | $2500 |
| Completion rates for SDOH Assessment | $2000 | $10,000 | $10,000 |
| Completion rates for self-reported health status | $2000 | $10,000 | $10,000 |
| Completion rates for PHQ-9 | $2000 | $10,000 | $10,000 |
| Completion rates for SBIRT | $2000 | $10,000 | $10,000 |
| Rate per achievement of outcomes per CHC | $2500 | $2500 | $2500 |
| Reduce Emergency Department visits by 10% from prior year | $10,000 | $10,000 | $10,000 |
| Increase Follow Up after Hospitalization for Mental Illness by 5% from prior year | $10,000 | $10,000 | $10,000 |
| Increase Initiation and Engagement in AOD dependence treatment by 10% from prior year | $10,000 | $10,000 | $10,000 |
| Reduce Inpatient Utilization by 10% from prior year | $10,000 | $10,000 | $10,000 |
| Total | $10,000 | $50,000 | $50,000 |

**EXHIBIT A**

**COUNTY OF MARIN**
**HEALTH AND HUMAN SERVICES**
**WHOLE PERSON CARE PROGRAM**
**BUDGET SUMMARY**

| | PY 1 | PY 2 | PY 3 | PY 4 | PY 5 | Total |
|---|---|---|---|---|---|---|
| | | Jul - Dec 2017 | Jan - Dec 2018 | Jan - Dec 2019 | Jan - Dec 2020 | |
| Administrative Infrastructure | | $1,026,766 | $1,543,313 | $1,545,757 | $1,587,535 | |
| Delivery Infrastructure | | $1,473,234 | $552,367 | $337,553 | $379,365 | |
| Incentive Payments | | $0 | $0 | $0 | $0 | |
| Services - FFS | | $0 | $324,720 | $649,935 | $844,272 | |
| Services - PMPM Bundle | | $0 | $2,559,600 | $2,366,755 | $2,088,828 | |
| Pay For Reporting | | $0 | $10,000 | $50,000 | $50,000 | |
| Pay for Outcomes | | $0 | $10,000 | $50,000 | $50,000 | |
| **TOTAL** | **$2,500,000** | **$2,500,000** | **$5,000,000** | **$5,000,000** | **$5,000,000** | **$20,000,000** |

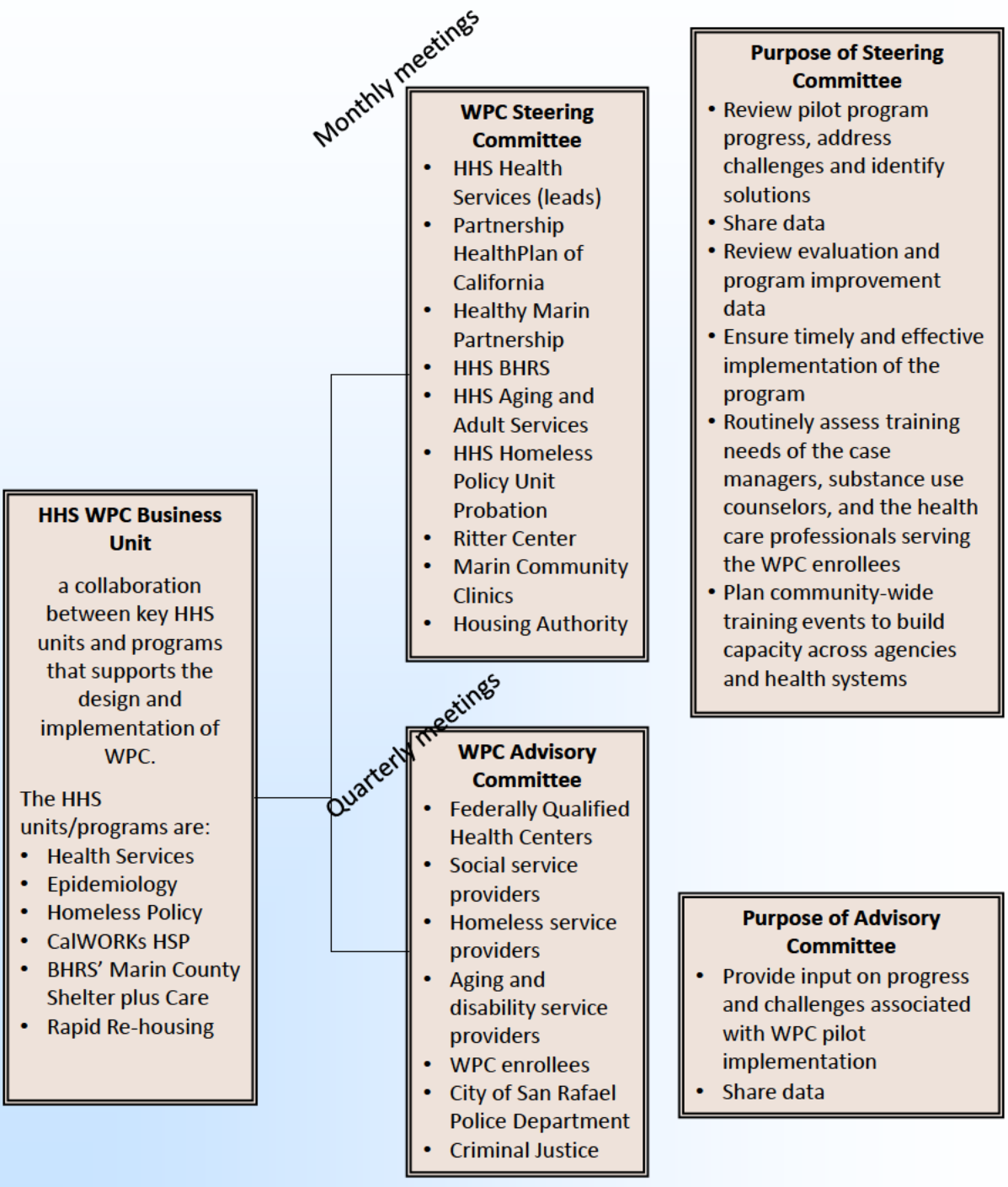
# Marin County WPC Services, Partners, Financing, and Outcomes

*The Vision: A sustainable, evidence-based, outcomes-focused coordinated system of care across health and social sectors that efficiently and effectively serves Marin County's most vulnerable Medi-Cal beneficiaries*

| | Information and Referral | Screening, Assessment and Intake | Case Management | Outcomes | Outcomes |
|---|---|---|---|---|---|
| **Medi-Cal beneficiaries ages 18+ who are homeless or precariously housed** | Mobile Outreach Teams invite eligible/potential enrollees to participate in WPC | VI-SPDAT, SBIRT, PHQ-9, Social Determinants of Health (SDOH), Inventory of current case managers, if any | • Person-Centered Care Planning<br>• Comprehensive Case Management<br>• Housing-based Case Management | • Completion of screenings and assessments<br>• Completion of comprehensive care plan<br>• Maintain a health home for enrollees<br>• Follow-up after hospitalization for mental Illness Initiation and engagement of AOD treatment | • Completion rates for screenings and assessments<br>• Health Outcome Improvements |
| **Medi-Cal beneficiaries ages 18+ with complex conditions** | Eligible/potential enrollees identified through data analytics from PHC, BHRS, Jail, and Adult and Aging Services Division are invited to participate in WPC | SBIRT, PHQ-9, SDOH, Inventory of current case managers, if any | • Person-Centered Care Planning<br>• Comprehensive Case Management | | |
| **Participating Entities** | **Community based organizations** | **Community health centers** | **Community health centers** | **Community health centers** | **Community health centers** |
| **Financing** | Fee-for-Service (FFS) | Fee-for-Service (FFS) | Bundled Payments | Pay for Performance | Pay for Performance |

Signed consent to share information

# Marin County WPC Communication and Governance



**Second Round WPC Budget Template, New Applicant: Summary and Top Sheet**

| | |
|---|---|
| **New WPC Applicant Name:** | *County of Marin Health and Human Services* |

| | Federal Funds *(Not to exceed 90M)* | IGT | Total Funds |
|---|---|---|---|
| **PY 1 Annual Budget Amount Requested** | 1,250,000 | 1,250,000 | 2,500,000 |
| **PY 2 Annual Budget Amount Requested** | 1,250,000 | 1,250,000 | 2,500,000 |
| **PYs 3-5 Annual Budget Amount Requested** | 2,500,000 | 2,500,000 | 5,000,000 |

| **Second Round PY 1 Budget Allocation (Note PY 1 Allocation is predetermined)** | |
|---|---|
| **PY 1 Total Budget** | 2,500,000 |
| *Approved Application (75%)* | 1,875,000 |
| *Submission of Baseline Data (25%)* | 625,000 |
| **PY 1 Total Check** | OK |
| **Does PY 1 Total = 50% of PY 3 Total?** | Yes |

| **Second Round PY 2 Budget Allocation** | |
|---|---|
| **PY 2 Total Budget** | 2,500,000 |
| *Administrative Infrastructure* | 1,026,766 |
| *Delivery Infrastructure* | 1,473,234 |
| *Incentive Payments* | 0 |
| *FFS Services* | 0 |
| *PMPM Bundle* | 0 |
| *Pay For Reporting* | 0 |
| *Pay for Outcomes* | 0 |
| **PY 2 Total Check** | OK |
| **Does PY 2 Total = 50% of PY 3 Total?** | Yes |

| **Second Round PY 3 Budget Allocation** | |
|---|---|
| **PY 3 Total Budget** | 5,000,000 |
| *Administrative Infrastructure* | 1,543,313 |
| *Delivery Infrastructure* | 552,367 |
| *Incentive Payments* | 0 |
| *FFS Services* | 324,720 |
| *PMPM Bundle* | 2,559,600 |
| *Pay For Reporting* | 10,000 |
| *Pay for Outcomes* | 10,000 |
| **PY 3 Total Check** | OK |

| **Second Round PY 4 Budget Allocation** | |
|---|---|
| **PY 4 Total Budget** | 5,000,000 |
| *Administrative Infrastructure* | 1,545,757 |
| *Delivery Infrastructure* | 337,553 |
| *Incentive Payments* | 0 |
| *FFS Services* | 649,935 |
| *PMPM Bundle* | 2,366,755 |
| *Pay For Reporting* | 50,000 |
| *Pay for Outcomes* | 50,000 |
| **PY 4 Total Check** | OK |

| **Second Round PY 5 Budget Allocation** | |
|---|---|
| **PY 5 Total Budget** | 5,000,000 |
| *Administrative Infrastructure* | 1,587,535 |
| *Delivery Infrastructure* | 379,365 |
| *Incentive Payments* | 0 |
| *FFS Services* | 844,272 |
| *PMPM Bundle* | 2,088,828 |
| *Pay For Reporting* | 50,000 |
| *Pay for Outcomes* | 50,000 |
| **PY 5 Total Check** | OK |