County of Mendocino

Whole Person Care Pilot Application
Round 2

Original Submitted March 1, 2017

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ACRONYMS, TABLES, and FIGURES

Reference list of acronyms

AOT	Assisted Outpatient Treatment
ASO	Administrative Services Organization
BHRS	Mendocino County HHSA Behavioral Health and Recovery Services Division
CBO	Community Based Organization
DHCS	California Department of Health Care Services
DSS	Mendocino County HHSA Department of Social Services
ER	Emergency Room
FFS	Fee-for-service
HEDIS	Healthcare Effectiveness Data and Information Set
HbA1c	Hemoglobin A1c
HHSA	Mendocino County Health and Human Services Agency
HMIS	Homeless Management Information System
HTN	Hypertension
IGT	Intergovernmental Transfer
IHSS	In-Home Supportive Services
IOCMP	Intensive Outpatient Case Management Program
MAT	Medication Assisted Treatment
MCHC	Mendocino Community Health Clinic
MEPS	Mobile Engagement and Prevention Services
MOU	Memorandum of Understanding
PDSA	Plan-Do-Study-Act
PHC	Partnership HealthPlan of California
PMPM	Per-Member-Per-Month
PY	Program Year
ROI	Release of Information
RQMC	Redwood Quality Management Company
SMI	Serious mental illness
SUD	Substance use disorders
SUDT	Substance use disorder treatment
TCM	Targeted Case Management
UVMC	Ukiah Valley Medical Center
WPC	Whole Person Care

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PRIORITY ELEMENTS

Mendocino County's proposed Whole Person Care (WPC) Pilot program addresses WPC priorities as follows:

- **More than one participating managed care plan:** Mendocino County is served by a single managed care plan, making Mendocino County Health and Human Services Agency (HHSA) ineligible for this priority.
- **More than two community partners:** HHSA has included four community organizations as partnership entities, making the application eligible for 5 priority points.
- **Innovative interventions:** HHSA's proposal includes several innovative interventions, including community integration focused on restoring family relationships and informal "foster family" development with In-Home Supportive Services (IHSS) certification, Peer Extension Workers, and Emergency Room Concierges, making the application eligible for 5 priority points.

SECTION 1. WPC LEAD AND PARTICIPATING ENTITY INFORMATION

1.1 Lead Entity

Mendocino County Health and Human Services Agency (HHSA) is an integrated agency that provides comprehensive services across the core areas of Social Services, Public Health, and Behavioral Health and Recovery Services. HHSA will be the single point of contact for the Whole Person Care (WPC) Pilot.

HHSA's Community Health Improvement Planning process has identified five defined needs in Mendocino County, two of which (mental health and housing) are addressed through the proposed Pilot. The target population for the WPC Pilot includes Medi-Cal beneficiaries who have serious mental illness (SMI), prioritizing those who are high utilizers of mental health and/or medical services and those with the following additional barriers: homelessness or housing instability, co-occurring Substance Use Disorder (SUD), and/or recent interactions with the criminal justice system.

HHSA will provide leadership, coordination, and monitoring through its Behavioral Health and Recovery Services (BHRS) and Social Services Divisions. The county's Mental Health Plan is managed by BHRS, which administers countywide mental health and substance use disorder treatment services. The Department of Social Services (DSS) has a robust Adult Services division that includes core support for Mendocino County's Continuum of Care for the Homeless.

Table 1. Lead entity

Organization Name	Mendocino County Health and Human Services Agency (HHSA)
Type of Entity	County Health Agency
Contact Person	Tammy Moss Chandler
Contact Person Title	Director
Telephone	707-463-7774
Email Address	chandlert@co.mendocino.ca.us
Mailing Address	747 South State Street, Ukiah CA, 95482

1.2 Participating Entities

HHSA's partners in the WPC Pilot include all required participating entities, as listed in Table 2 below.

Table 2. Participating entities

Required Organizations	Organization Name	Contact Name and Title	Entity Description and Role in WPC
1. Medi-Cal managed care health plan	Partnership HealthPlan California (PHC)	Lynn Scuri, Regional Director	• Managed care provider • Referring agency • WPC Team member • Data sharing

Required Organizations	Organization Name	Contact Name and Title	Entity Description and Role in WPC
2. Health Services Agency/ Department	Mendocino County Health and Human Services Agency (HHSA)	Tammy Moss Chandler, Director	• Lead Entity • WPC financial management • WPC Team member • Data coordination and evaluation
3. Specialty Mental Health Agency Department	HHSA Behavioral Health and Recovery Services (BHRS)	Jenine Miller, Branch Director	• County Mental Health and substance use disorder treatment (SUDT) Provider • Coordination of access to mental health services and SUDT • Assisted Outpatient Treatment/AOT • Mobile Engagement and Prevention Services • WPC Team member • Data sharing
4. Public Agency/ Department	HHSA Department of Social Services (DSS)	Bekkie Emery, Deputy Director, Adult Services	• Assist WPC enrollees with accessing public assistance, including Medi-Cal • Coordinate Continuum of Care for the Homeless • Certify clients and care providers through In-Home Supportive Services (IHSS) • Oversee Public Guardianship • Oversee Homeless Management Information System (HMIS) • Data sharing
5. Public Housing Authority (if housing services are provided)	Community Development Commission of Mendocino County	Todd Crabtree, Executive Director	• Housing Authority • Provider of affordable housing • Housing development and management • Data sharing

Required Organizations	Organization Name	Contact Name and Title	Entity Description and Role in WPC
6. Community Partner #1	Ukiah Valley Medical Center (UVMC)	Gwen Matthews, President and Chief Executive Officer	• Hospital emergency room (ER) and inpatient services • Hospital concierge • Coordination of medical respite • WPC Team member • Data sharing
7. Community Partner #2	Mendocino Community Health Clinic (MCHC)	Carole Press, Chief Executive Officer	• Federally Qualified Health Center • House clinic liaison • Co-location of services • WPC Team member • Data sharing
Additional Organizations	**Organization Name**	**Contact Name and Title**	**Entity Description and Role in WPC**
8. Community Partner #3	Redwood Quality Management Company (RQMC)	Tim Schraeder, President	• Administer subcontracts for mental health and related services (e.g. mental health resource centers, mental health transition support, peer extension workers, Assisted Outpatient Treatment/AOT) • WPC Team member • Data sharing
9. Community Partner #4	Mendocino Coast Clinics	Lucresha Renteria, Executive Director	• Federally Qualified Health Center • House clinic liaison • Co-location of services • WPC Team Member • Data sharing

1.3 Letters of Participation and Support

Mendocino County Health and Human Services Agency (HHSA) at 747 South State Street, Ukiah CA, 95482 may be contacted for access to Letters of Participation from partner entities indicating their commitment to participate in the WPC Pilot. Please refer to Section 1.1. Letters of Support are from the following stakeholders:

- City of Fort Bragg
- Ford Street Project
- Manzanita Services, Inc.
- Mendocino Coast District Hospital

- Mendocino Coast Hospitality Center
- Mendocino Community AIDS/viral Hepatitis Network (MCAVHN)
- Mendocino County Probation Department
- National Alliance on Mental Illness (NAMI), Mendocino County Chapter
- NorCal Christian Ministries
- Redwood Community Services, Inc.
- Ukiah Police Department

SECTION 2. GENERAL INFORMATION AND TARGET POPULATION

2.1 Geographic Area, Community, and Target Population Needs

2.1a Geographic area

HHSA will implement the WPC Pilot throughout Mendocino County, focusing on the cities of Ukiah and Fort Bragg, which are the county's two largest population centers.

Predominantly rural, Mendocino County is located on California's northern coast approximately 120 miles north of San Francisco. The county covers 3,506 square miles of mostly mountainous terrain, making it the 15th largest among California's 58 counties. County residents inhabit an area that is almost equal in geographic size to the states of Delaware and Rhode Island combined. The population of Mendocino County is 88,378.[1] Ukiah, the County Seat of Government, is the largest community in the county, with a population of 16,186. Fort Bragg, the primary population center on the coast, has a population of 7,672. Approximately 15% of Mendocino County residents reside in one of the county's four federally-designated Frontier Communities, which are communities with a population density of 6 or fewer people/square mile. Mendocino County's diverse population is 66% White, 24% Hispanic, 6% Native American, and 4% bi-racial or other ethnicities and includes 10 Native American Indian rancherias.

Mendocino County is a federally-designated Medically Underserved Population and includes multiple populations and census tracts designated as Health Professional Shortage Areas. Rural residents must travel to county population centers to access most services, and often need to travel outside the county to obtain higher levels of specialty healthcare. For some rural residents, simply reaching a county population center can entail a round-trip drive of as much as four hours.

The county's scenic beauty contrasts sharply with a chronically depressed economy and high poverty levels. The median household income is $42,980 (just 70% of the statewide median of $61,818), and one in five county residents lives below the federal poverty level. As of December 2016, 6,398 Mendocino County households were enrolled in the state's CalFresh Food Stamp program, representing 19% of county households (compared with 16% statewide).

2.1b Participation of partner entities in planning process

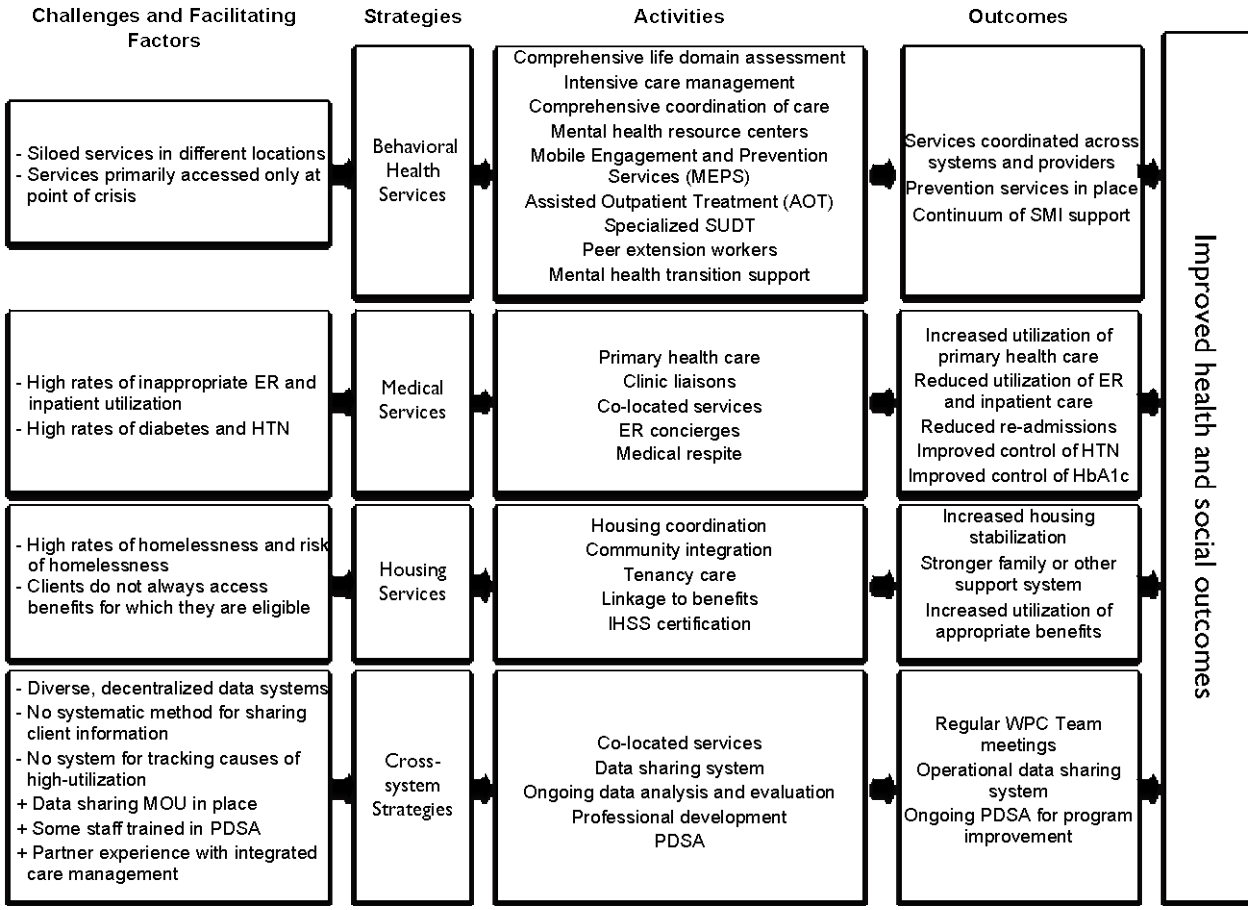
HHSA has been working with its partners to plan for the WPC Pilot since the release of the Round 1 Request for Applications in mid-2016. Numerous preliminary meetings and discussions with the HHSA Advisory Committee culminated in an intensive planning process that began in December 2016 and included more than 15 meetings with representatives of partner entities and other organizations. HHSA also reached out to contact and seek input from other stakeholders. This intensive planning process was key to the development of the proposed WPC Pilot model. The planning team reviewed data, identified gaps and needs not currently addressed through existing services and/or limited by funding restrictions, analyzed information, and developed the strategies presented in this application.

[1] California Department of Finance estimates for January 2016.

2.1c Overarching Pilot vision for system change and needs of target population

People with serious mental illness (SMI) who have access to integrated services, stable housing, and strong social support will increase their participation in prevention and early intervention services, resulting in improved health and social outcomes and reduced utilization of high-cost services. Building on this theory of change, the WPC Pilot will focus on developing, strengthening, and restoring a social support system that ensures a stable environment for each person served. The coordinated nature of this approach will radically change the patient care experience.

Figure 1. WPC Pilot logic model



Over the past year, HHSA and several partners have made steady progress toward establishing coordinated interagency protocols for the assessment and treatment of persons with SMI. HHSA is now in the process of finalizing a Memorandum of Understanding (MOU) that establishes defined roles and responsibilities for each party as well as a structure for timely and reliable communication between the parties on patient needs, conditions, and treatment plans. To build on this effort, the WPC Pilot will focus on serving up to 600

Medi-Cal beneficiaries who have serious mental illness (SMI), prioritizing those that are high utilizers of mental health and/or medical services and those with the following additional barriers: homelessness or housing instability, co-occurring SUD, and/or

recent interactions with the criminal justice system. Particular attention will be given to social and economic barriers to care, including food insecurity and social isolation.

Mendocino County's WPC Pilot proposes to reduce inappropriate and/or avoidable utilization of hospital ERs and inpatient admissions through the immediate, real-time connection of the person to resources, whether the WPC enrollee is already in the ER, seeking services through a community clinic or other community provider, or on the street.

For people with SMIs, navigating systems and programs to meet their mental health, physical health, and basic needs of daily living can be overwhelming. Services are frequently accessed only at the point of crisis and at the highest level of care, whether in the ER and/or a hospital. As a result, the provider delivering services is responding to the immediate crisis, which can contribute to repeat admissions to higher levels of care. Currently, there is no systematic method for communication and sharing of data across the range of providers that serve shared clients. In addition, there is no formal process for identifying high-need individuals, systematically assessing their complex needs, and coordinating services across entities. The need for coordination and data sharing creates opportunities for the WPC Pilot to improve access, quality of care, and client outcomes, and to reduce the overall cost of care.

2.1d General description of WPC Pilot

In order to effectively address the complex individual needs of the target population, the WPC Pilot will offer an integrated array of services that includes the features and supports listed below, none of which are covered by Medi-Cal and all of which are carefully designed to complement existing services. Service access points include: hospital ERs, community clinics, community mental health service providers, BHRS, and homelessness service providers.

HHSA will begin the project by conducting an assessment of the target population to identify those whose high costs are legitimate and those who have incurred excessive costs. Subsequent intake will focus on serving those with excessive costs. See Section 3.1 for detailed descriptions of the following WPC Pilot strategies and services.

- Comprehensive life domain assessment
- Comprehensive coordination of care
- Clinic liaisons to ensure rapid access to healthcare services
- Co-located services to strengthen service integration
- Mobile engagement and prevention services (MEPS)
- Assisted outpatient treatment (AOT)
- ER concierges
- Mental health resource centers
- Mental health transition care
- Medical respite
- Peer extension workers
- Specialized SUDT

- Housing coordination and community integration
- Tenancy care
- Professional development
- Data sharing

2.2 Communication Plan

2.2a Governance structure

The **Lead Entity** is Mendocino County Health and Human Services Agency (HHSA).

The Project Director will chair the **WPC Team**, consisting of representatives from all partner entities and meeting monthly or more frequently as needed as implementation begins. The WPC Team will: review implementation, assess metrics, make refinements, ensure that all entities are fully informed about state requirements, address consumer engagement, including enrollment and retention, and review program sustainability as a standing agenda item. The WPC Team will monitor program communication and be responsible for developing communication standards to ensure program transparency. The WPC Team will be responsible for assessing and addressing needs for professional development, including conducting an annual training needs assessment. Partners and partner staff will receive incentives for their participation in professional development activities. They will also review corrective action plans for participating entities. The Project Coordinator will serve as the primary point of contact.

The **Adult Multidisciplinary Team**, comprising mental health care managers, SUDT counselors, medical care managers, and housing care managers, will implement case conferencing using client and program data to develop, coordinate, and review each client's comprehensive care plan across agencies and services.

The WPC Team will establish ***ad hoc* workgroups** (*e.g.,* data sharing workgroup, evaluation and quality improvement workgroup) to address specific project components or issues as needed. Workgroup members may include any combination of Pilot positions, partners, partner staff, and other 'best fit' stakeholders from participating entities.

2.2b Decision making process

Program decisions will be addressed at the WPC Team level, using a consensus model and an agreed-upon process for conflict resolution.

2.2c Communication strategies

Program-level communication. WPC partners will use the Microsoft Office Suite of communication tools; the Franklin Covey formats for meeting agenda and minutes; Free Conference Call and Skype for off-site meeting participants; and Survey Monkey for voting processes. Meeting agenda and minutes will be disseminated via email at least one week prior to scheduled meetings. WPC Team meetings will provide opportunities for discussion and feedback to ensure that points of duplication and fragmentation are identified and addressed.

Care management-level communication. The data integration system will be accessible for use by all service providers, with appropriate permissions, to see and

update care plans, notes, and contact information for all providers involved in the client's care.

Client-level communication. Participating clients will receive written information about WPC services at the time of enrollment, and will be provided with a written copy of their service plan each time it is updated. Written information will be provided at an appropriate literacy level and be available in both Spanish and English.

Community-level communication. Data from the WPC Pilot will be shared at community meetings, including meetings of the HHSA and BHRS Advisory Boards, the County Board of Supervisors, and the Continuum of Care for the Homeless.

2.3 Target Population(s)

2.3a Target population

The target population for the WPC Pilot includes Medi-Cal beneficiaries who have SMI, prioritizing those that are high utilizers of mental health and/or medical services and those with the following additional barriers: homelessness or housing instability, co-occurring SUD, and/or recent interactions with the criminal justice system.

Individuals with mental health issues are often poorly engaged with physical and behavioral health delivery systems, leading to over utilization of high cost services, such as repeated use of hospital ERs, avoidable in-patient hospital admissions, and frequent mental health crisis services. Many clients in the target population also face extreme social and economic challenges such as lack of housing/housing instability, unemployment, food insecurity, transportation, and lack of social support systems. When co-occurring with SMI, SUD further hinders a person's ability to navigate the health delivery system.

The lack of systematic methods of communication between treatment providers further complicates the ability to navigate the health delivery system and access services at the appropriate level of care.

2.3b Identification of target population

In the process of collecting data to identify the target population, HHSA collaborated with BHRS and the Department of Social Services (DSS), Partnership HealthPlan of California (PHC), the only managed care provider for the county's 38,000 Medi-Cal beneficiaries, and RQMC, the county's administrative services organization for mental health services.

- **Mental health data.** BHRS data listed Medi-Cal reimbursable and non-reimbursable services provided to 1,200 clients for the 12-month period of October 2015 – September 2016. These data show that 79 clients (approximately 7%) had costs in excess of $20,000. Of these clients, 38 were conserved. RQMC provided additional data for the SMI clients, including data on services that were not eligible for Medi-Cal reimbursement. The initial assessment process will determine which of these clients will be appropriate for inclusion in the project, based on appropriateness of costs incurred.

- **Physical health data.** PHC provided member information for Medi-Cal beneficiaries in the top 10% of total cost of care, as well as a listing of members with two or more inpatient admissions and three or more ER visits, for the same 12-month period. Within the listing of the top 10%, there were 139 members with SMIs. Of these, 94 members had been seen in the ER at least 3 times during the year, and 36 had made 10 or more visits to the ER. Of the 139 people with SMI, 82 (59%) were flagged for chemical dependency; 46 (33%) had diabetes diagnoses; and 57 (41%) had hypertension.
- **Homelessness data.** The data received from PCH and BHRS show that 36 (17%) members of the target population were homeless. DSS also provided data on homelessness from the county's 2015 Point-in-Time Homelessness Count, which reported 1,032 homeless individuals. Of these, 212 self-reported serious mental illnesses and 238 individuals self-reported SUD. (Data on persons with co-morbidity were not collected.)

These data sets were compiled and then analyzed to identify the population of Medi-Cal beneficiaries with SMI who incurred high costs. At the beginning and throughout implementation of the Pilot, HHSA and its partners will rely on data from these sources to identify and enroll clients who are eligible for WPC services.

Table 3. Prioritized groups within target population

CRITERIA	NUMBER OF CLIENTS (DUPLICATED)
• Total number of clients with high costs	218
• Mental health services exceeding $20,000	79
• 3 or more ER visits	94
• 2 or more in-patient hospital admissions to an acute care facility	20
• Chemical dependency	82
• Diabetes	46
• Hypertension	57
• Homeless	36

2.3c Estimated number of Medi-Cal beneficiaries to be served

The Pilot will serve an unduplicated total of 600 Medi-Cal beneficiaries over the course of the project. Some WPC enrollees will have complex health and behavioral health conditions and require multi-year services, while others may need only a few months of services to become stable and linked to community services.

Table 4. Target population projections

TARGET POPULATION	PY2	PY3	PY4	PY5	TOTAL
Adult Medi-Cal beneficiaries with SMI	105	360 (255 new)	525 (165 new)	600 (75 new)	600

Note that HHSA will not set an enrollment cap for WPC beneficiaries. Planners estimate from initial analysis that 600 people that meet the enrollment criteria will be served over the life of the Mendocino County WPC Pilot.

SECTION 3. SERVICES, INTERVENTIONS, CARE COORDINATION, AND DATA SHARING

3.1 Services, Interventions, and Care Coordination

3.1a Services

The WPC Team selected services, interventions, and care coordination strategies based on emerging and best practices for the target population, identified needs and gaps, and strengths and resources of collaborative partners. Please see Section 5.1 for discussion of funding structure.

Behavioral Health Services

Mental health resource centers will serve as service hubs, providing a safe, supportive environment and an alternative to the ER for WPC enrollees experiencing less severe mental health crises, with licensed clinicians available to evaluate and assess immediate needs.

Intensive care management will support participants in accessing medical, behavioral, and social non-medical services to address identified needs.

Mobile Engagement and Prevention Services (MEPS) will field two-person teams of a mental health rehabilitation specialist and a sheriff technician to connect WPC participants with mental health support prior to their mental health needs becoming a crisis. MEPS goals include reducing dependence on law enforcement as a primary response to a mental health crisis, reducing use of ERs as a primary source of mental health care, and reducing rates of recidivism for those with mental health needs.

Assisted Outpatient Treatment (AOT) allows WPC enrollees meeting specific criteria to be court ordered to participate in outpatient mental health treatment while living in the community. The goal of AOT is to engage clients in treatment and reduce safety risks to clients and the community.

Specialized SUDT will provide an integrated clinical treatment approach for WPC enrollees with co-occurring disorders. SUDT coordination will focus on overcoming substance abuse and dependence issues for WPC enrollees with co-occurring conditions of SMI and SUD.

Peer extension workers will provide high intensity trauma-informed support to WPC enrollees. RQMC subcontractors will employ Peer Extension Workers and train them using an evidence-based program such as SAMHSA's "Whole Health Action Management." Peer Extension Workers will conduct engagement efforts to encourage people who are not participating fully in prevention and other services, build trusting relationships, encourage early intervention, and facilitate linkage to services.

Mental health transition support beds will be provided to support recuperation and transition to lower levels of care for clients who need additional care following discharge from ERs or inpatient care, multiple inpatient psychiatric placements, and/or an LPS conservatorship.

Medical Services

Clinic liaisons will ensure timely access to healthcare services and health homes for WPC participants referred to the clinic by other partners.

Co-located services, such as county psychiatric care provided on clinic campuses, will foster integration and collaborative care management of shared patients while streamlining participant access and supports.

ER concierges will identify and redirect WPC participants who are using the ER for social or other inappropriate support.

Medical respite will provide post-hospital medical care to WPC participants who are homeless, in an unstable living situation, and/or too ill or frail to recover from physical illness/injury in their usual living environment (but not ill enough to be treated in a hospital or skilled nursing facility).

Housing Services

Housing coordination services will include: tenant screening and assessment of housing needs, housing assessment, individualized housing support plans, assisting with housing applications, matching with appropriate housing service providers, and identifying resources to cover move-in expenses.

Community integration will include intensive work with participants to reconnect them with family members with whom they may have broken or difficult relationships and to re-establish those relationships. Where there is not family restoration, community integration services will help connect participants with new support systems in the form of informal “foster families” who may rent them rooms or small apartments after participating in program training and becoming In-Home Support Services (IHSS) providers where IHSS services are eligible. The WPC Pilot will develop criteria to ensure appropriate matches and landlord protection.

Tenancy care to facilitate long-term housing stability will include: tenant education and coaching, onsite intense care management services for tenants, landlord training and coaching, early intervention, dispute resolution and landlord protection, and ongoing support.

Housing pool. WPC partners will explore the establishment of a housing pool to develop scattered site supportive housing opportunities, including needed renovations for housing the target population. However, this is not included as a Pilot activity and no WPC funds will be used to create or maintain a housing pool**.**

Aligning with and leveraging existing services

To ensure maximum impact and minimum duplication of services, Mendocino County’s WPC Pilot will leverage a range of aligned health improvement efforts, including those described below.

- The Intensive Outpatient Care Management Program (IOCMP) is funded through PHC to Mendocino Community Health Clinic (MCHC) to provide intensive care management services to approximately 50 high-acuity high-cost managed Medi-Cal beneficiaries, with community-based partners linking participants to care,

housing assistance, and harm reduction. Partners maintain executed Release of Information (ROI) consents, to effectively communicate client status, and participate in regularly scheduled case conferencing.

- The Ukiah Valley Medical Center (UVMC) Street Medicine Program, also PHC-funded, brings health assessment and medical treatment into local shelters and homeless encampments and is an integral component of the UVMC family medicine residency program.
- Drug Medi-Cal Expansion, in which HHSA is in Phase IV planning, is expected to begin piloting treatment of co-occurring disorders in early 2018.
- Medication Assisted Treatment (MAT), a pilot project funded by PHC, will be expanding to the use of a second drug for the treatment of opioid addiction, building on the work of the Safe RX Mendocino Opioid Safety Coalition. This effort will prepare the county for Drug Medi-Cal Expansion and build capacity for delivery of specialized SUDT for WPC participants.
- Prop 47 funding (application pending) will provide residential wraparound mental health services and SUDT for non-violent, non-serious offenders with a history of SUD and/or mental illness and a high risk of reoffending.
- The Continuum of Care for the Homeless will benefit from the opportunity provided by the Pilot to enhance data management and coordinated entry, to help people move into and through the system more efficiently.
- The Community Development Commission of Mendocino County, the Mendocino County Housing Authority, will coordinate housing efforts such as Section 8 and other low-income housing development.

3.1b Interventions and strategies

Integration interventions and strategies

Integration efforts will include oversight by the WPC Team and the following strategies.

Co-located services. During PY2, WPC partners will assess and compare the costs and benefits of co-locating services for the target population at participating clinics, BHRS, and/or RQMC. Co-located services will facilitate face-to-face coordination among providers and increase the likelihood that participants will access mental health and medical services as well as preventive health services.

Professional development. At the beginning of PY2 and annually thereafter, the Project Coordinator will conduct a training needs assessment of WPC partners and key staff, including frontline workers. Based on results of the assessment, the Coordinator will implement a professional development schedule that includes a range of training modalities—webinars, workshops, 1:1 technical assistance, conferences, etc.

Plan-Do-Study-Act (PDSA). Using the PDSA process will strengthen relationships among WPC partners and help to identify strategies and implement quality improvement initiatives at all levels of the system, based on ongoing metric assessment and analysis. BHRS has historically used a utilization review and quality improvement process to ensure the quality of individual care. Staff have now been trained and are beginning to implement PDSA at the system level.

Prior experience with integrated care strategies

Mendocino County WPC partners have a long history of planning and developing integrated systems of care for various target populations; two past efforts are described below. Lessons learned from these efforts will inform implementation of the WPC Pilot.

- The Collaborative User System of Care (CUSOC) Project (2008-2011) identified a target population of high-cost, high-utilizing patients who were County Medical Services Program/CMSP beneficiaries. Analysis of pilot results for the 11 enrolled participants showed that aggregate hospital costs decreased by 33% by the end of the project, falling from $344,838 to $230,944. Partners reported that intensive care management, weekly case conferencing, and the universal Release of Information for health care providers, criminal justice, and other community agencies were keys to the success of the program.
- The Access to Treatment and Housing Opportunities in the Mendocino Environment (AT HOME) Project (2008-2014) focused on decreasing homelessness and improving health and wellbeing for homeless people with co-occurring SUD by linking integrated mental health services and SUDT with housing and intensive care management. Project evaluation found that, of 252 participants, 66% had a decrease in the number of days participants experienced mental health issues; 52% had a decrease in days using drugs or alcohol; only 41% of those that had made an ER visit in the 30 days prior to entry had returned to the ER in the 30 days prior to 6-month follow up; and of the clients that were living in a shelter or on the street at their intake 42% were housed at the 6-month follow-up.

3.1c Care coordination

Cross-sector care coordination is designed to counteract the fragmentation that results from categorical funding streams by addressing the underlying behavioral health and socioeconomic needs that influence health outcomes and utilization. Care coordination is intended to divert high utilizers away from ER and inpatient services towards care that addresses their complex needs and promotes long-term health.

The WPC Pilot will bring care managers and other service providers together as the Adult Multi-Disciplinary Team to coordinate care and services. Initially, the team will complete a full assessment of the health, mental health, SUD, criminal justice, support system, housing status, and utilization history of each client and use this data to develop, implement, and monitor individualized, systemwide care management plans. The Adult Multi-Disciplinary Team will then work to coordinate roles and responsibilities and collaboratively develop shared action plans.

The Adult Multidisciplinary Team will meet weekly. Group participants will include: care managers and/or care providers from each program the client is already involved with; housing coordinator; and/or other entities based on unique needs of the client.

3.2 Data Sharing

3.2a Data sharing plans

HHSA is in the process of finalizing data sharing agreements that will facilitate the flow of client information between BHRS, RQMC, MCHC, and UVMC. The WPC Pilot provides an opportunity to expand these agreements to include all WPC partners—clinics, hospitals, and community-based partners. HHSA will leverage these data sharing agreements to inform the development of protocols, tools, and staffing necessary to support the collection and sharing of target population information. Indicators will include in-patient admissions, use of the emergency room, provision of comprehensive care management, and utilization of social services. Data sharing agreements will ensure that all partners are able to access data to support care management services and outcomes. HHSA will prepare and distribute a monthly WPC Dashboard with sufficient data to support performance and PDSA activities, including such indicators as:

- Number of clients with a comprehensive care plan
- Care coordination, care management, and referral data
- Ambulatory care and ER visits
- Hospital inpatient utilization
- Follow-up after hospitalization for SMI
- Initiation and engagement in SUDT
- Recent history of incarceration
- Selected cost data

3.2b Strategies for complying with confidentiality regulations

All WPC partners will be responsible for implementing procedures and client authorizations in compliance with state and federal laws. To facilitate the sharing of client information, each client in the target population will be provided with an overview of the goal of the Pilot and the services available to them as a participant. The client will then be asked to sign a client authorization that will allow the sharing of personal and health information between WPC partners.

3.2c Data sharing tools, infrastructure development, and sustainability

HHSA will fund a Data Analyst throughout the WPC Pilot. In PY1, the Data Analyst will draft protocols for secure file transfers, formats, and required fields for data submission based on the type of service provided by the participating provider and develop reporting templates to monitor key indicators and outcomes, examine program effectiveness, track costs, and identify barriers to collaboration.

WPC partners will collect data using spreadsheets that will be uploaded to a central, accessible drop box within 24 hours of a key event to ensure near real-time data access for other partners and the ability to provide care management based on current information. The Data Analyst will be responsible for entering the information into a database and compiling reports on a weekly basis to support the ongoing provision of services and comprehensive care management. The Program Coordinator will back up

the Data Analyst to assure these comprehensive reports are available for the weekly Multi-Disciplinary Team care management meetings. The goal is for critical data elements to be available to all providers within 24 hours of a key event (which will be defined by the WPC partners and supporting protocols), and for more comprehensive reports that can be incorporated into existing electronic health records be accessible weekly for the coordination of care management.

Once in place, the proposed system will represent an improved level of collaboration and data sharing among participating entities that will be sustained beyond the Pilot. With data sharing agreements in place, it will be possible for partners to adapt the infrastructure to other vulnerable populations that are high users of multiple systems.

3.2d Data governance structure

HHSA will convene an *ad hoc* Data Sharing Workgroup to support the development and implementation of the data collection and sharing system. WPC partners will build on Pilot success and lessons learned with the long-term goal of creating a comprehensive health information exchange system for all county health and social services providers.

3.2e Anticipated challenges

- **Accessibility.** Currently, database systems are not compatible. The most significant challenge to data sharing will be the development of a data reporting system that is easy to use so that partners are able to sustain the consistent and timely reporting of complete and accurate data necessary to support comprehensive care management and performance measurement.
- **Commitment.** To benefit from available data, all partners must be committed and responsible for implementation within their agencies. The data contributions provided by partner entities in planning this application demonstrate their commitment to the data sharing process. The Pilot budget provides for incentives to mitigate costs associated with data reporting.
- **Limited size of target population.** Although the most comprehensive form of data sharing would be a health information exchange, the relatively small target population precludes that strategy. However, the Pilot provides an opportunity to test data sharing for a limited target population with the long-term goal of expanding to include a broader population of clients who are high-utilizers of high-cost services.

SECTION 4. PERFORMANCE MEASURES, DATA COLLECTION, QUALITY IMPROVEMENT, AND MONITORING

4.1 Performance Measures

The goal underlying all services and measures incorporated in Mendocino County's WPC application is to improve the health and wellbeing of Pilot participants using evidence-based strategies and interventions to the extent possible. WPC partners will develop a data-driven, performance improvement-focused approach to examining the innovative work of the Pilot. The performance measures selected for both universal and variant metrics have wide applicability to the target population and will support WPC partners in assessing strategies and approaches to better understand outcomes and develop modifications. Assessment of the metrics will require data to be shared between many participating entities and community partners, as described in previous sections.

The proposed performance measures will enable the program to: a) track progress in relation to patient care enhancement, improved patient outcomes, and systems change and integration; b) identify areas for program improvement; and c) identify cost savings to support program activities and interventions over the long term.

Upon notification of approval of this application, HHSA will formally execute MOUs with each participating entity, including expectations and commitments to participate in monthly coordination meetings and regular PDSA processes.

During PY1, participating entities will provide initial reports to develop baseline measures as a first step in the increased integration and data sharing between and among all partners. These initial data will also serve to identify data gaps and identify issues pointing to needs for further staff training. Also during PY1, partners will develop data reporting details and timelines and develop related policies and procedures. To monitor this process, the Project Coordinator will develop a master checklist for tracking information received or pending.

Each year, partners will develop detailed action plans that incorporate PDSA cycles to identify and address significant changes and potential areas for improvement. The PDSA process will be informed by data collected by partners and compiled in the program reporting system. Progress of the program as a whole will be assessed by WPC partners based on the identified metrics and baseline data. All performance metrics will be reviewed and action taken to ensure achievement of targeted benchmarks. To the extent possible, HHSA will adapt existing data collection tools and protocols for measuring performance over the Pilot period.

HHSA will assign two primary personnel to provide daily management of the Pilot. The Project Coordinator and Data Analyst will be responsible for day-to-day monitoring and management of contractors, activities, and reporting. HHSA will be responsible for collecting and aggregating Pilot data related to the universal and variant metrics identified below and reporting data to the Department of Health Care Services (DHCS). HHSA staff members will also lead PDSA activities in collaboration with Pilot partner entities to support achievement of Pilot targets.

4.1a Universal metrics

Checked boxes below acknowledge HHSA's responsibility to track and report the universal metrics as required in the application.

☒ **Health Outcomes Measures**

☒ **Administrative Measures**

Table 5 below delineates the universal metrics that will be followed in the WPC Pilot.

Table 5. Universal metrics

Universal Metrics	PY1 2017 (6 months)	PY2 2017 (6 months)	PY3 2018	PY4 2019	PY5 2020
Health Outcomes					
i. Ambulatory Care - Emergency Department Visits (HEDIS) including quarterly utilization of PDSA with measurement and necessary changes	Establish baseline	Maintain baseline	5% decrease from baseline	5% decrease from PY3	5% decrease from PY4
ii. Inpatient Utilization – General Hospital/Acute Care (IPU) (HEDIS) including quarterly utilization of PDSA with measurement and necessary changes	Establish baseline	Maintain baseline	5% decrease from baseline	5% decrease from PY3	5% decrease from PY4
iii. Follow-up After Hospitalization for Mental Illness (FUH) (HEDIS)	Establish baseline	Maintain baseline	5% increase from baseline	5% increase from PY3	5% increase from PY4

Universal Metrics	PY1 2017 (6 months)	PY2 2017 (6 months)	PY3 2018	PY4 2019	PY5 2020
iv. Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET) (HEDIS)	Establish baseline	Maintain baseline	5% increase from baseline	5% increase from PY3	5% increase from PY4
Administrative Outcomes					
v. Proportion of beneficiaries with a comprehensive care plan, accessible by the entire care team, within 30 days of: 1) enrollment 2) anniversary date (conducted annually)	Develop protocols, procedures, and care plan template	1) 50% 2) N/A	1) 60% 2) 80%	1) 70% 2) 85%	1) 80% 2) 90%
vi. Care coordination, care management and referral infrastructure	Submit documentation demonstrating establishment of policies and procedures, monitoring plans, improvement plans, and data compilation and analysis plans	Evaluate using PDSA process	Evaluate using PDSA process	Evaluate using PDSA process	Evaluate using PDSA process

Universal Metrics	PY1 2017 (6 months)	PY2 2017 (6 months)	PY3 2018	PY4 2019	PY5 2020
vii. Data and information sharing infrastructure	Submit documentation demonstrating establishment of data and information sharing policies and procedures, monitoring procedures, and data compilation and analysis plans	Evaluate using PDSA process	Evaluate using PDSA process	Evaluate using PDSA process	Evaluate using PDSA process

4.1b Variant metrics

The Mendocino County WPC Pilot includes the following variant metrics, which are detailed in Table 6 below.

- **Administrative Metric: Partner Coordination.** HHSA will provide the administrative and delivery infrastructure to support the proposed services, including leading the WPC Team.
- **Health Metric: Comprehensive Diabetes Care.** Participating clinics will track and report the percentage of clients whose diabetes is poorly controlled. The numerator for this metric is the number of WPC participants whose diabetes was poorly controlled and the denominator is the total number of clients with diabetes.
- **Health Metric: Controlling Blood Pressure.** Participating clinics will track and report the percentage of clients whose blood pressure is adequately controlled, using the number of participants with a healthy blood pressure (BP<140/90 for age 18-59; BP<140/90 for participants age 60-85 without a diabetes diagnosis; and BP<150/90 for participants age 60-85 with a diabetes diagnosis) as the numerator and using the number of participants with a diagnosis of hypertension (HTN) as the denominator. Mendocino County's WPC Pilot is using this second variant health outcome metric because the WPC Partners do not utilize the PHQ-9.
- **SMI Population Metric: Suicide Risk Assessment.** HHSA will administer and track risk reductions in the NQF 0104 Suicide Risk Assessment tool for participants with major depressive disorder. Data analysis will use patients who had a suicide risk assessment completed at each visit as numerator and all patients with a new diagnosis or recurrent episode of major depressive disorder as denominator.
- **Housing Metric: Housing Permanency.** HHSA will track permanency in housing for formerly homeless clients using the number of previously homeless

participants that are in stable housing for at least 6 months as numerator and the number of homeless participants as denominator.

Table 6 below details the proposed variant metrics that Mendocino County will track.

Table 6. Variant metrics

Metric ID:	***Variant Metric 1***	***Variant Metric 2***	***Variant Metric 3***	***Variant Metric 4***	***Variant Metric 5***
Target Population:	All	All target populations across all program years	All target populations across all program years	SMI population	Homeless/ at-risk for homelessness
Measure Type:	Administrative	Health Outcomes: HbA1c Poor Control <8%	Health Outcomes: Controlling Blood Pressure	Health Outcomes: Required for Pilots w/SMI Target Population	Housing: Permanent Housing
Description:	WPC Team monthly meeting attendance	Comprehensive diabetes care: HbA1 Poor Control <8%	Controlling High Blood Pressure	NQF: 0104 Suicide Risk Assessment	Percent of homeless who are permanently housed for greater than 6 months

Metric ID:	***Variant Metric 1***	***Variant Metric 2***	***Variant Metric 3***	***Variant Metric 4***	***Variant Metric 5***
Benchmark:	*PY 1*: Establish partner participation at 70% average attendance *PY 2*: Maintain partner participation at 70% average attendance *PY 3*: Increase partner participation to 75% average attendance *(continued)* *PY 4*: Increase partner participation to 80% average attendance *PY 5*: Increase partner participation to 85% average attendance	*PY 1*: Establish baseline *PY 2*: Maintain baseline *PY 3*: 5% improvement from PY2 *PY 4*: 5% improvement from PY3 *PY 5*: 5% improvement from PY4	*PY 1*: Establish baseline *PY 2*: Maintain baseline *PY 3*: 5% improvement from PY2 *PY 4*: 5% improvement from PY3 *PY 5*: 5% improvement from PY4	*PY 1*: Establish baseline *PY 2*: Maintain baseline *PY 3*: 5% decrease from PY2 *PY 4*: 5% decrease from PY3 *PY 5*: 5% decrease from PY4	*PY 1*: Establish baseline *PY 2*: Maintain baseline *PY 3*: 5% improvement from PY2 *PY 4*: 5% improvement from PY3 *PY 5*: 5% improvement from PY4

Metric ID:	***Variant Metric 1***	***Variant Metric 2***	***Variant Metric 3***	***Variant Metric 4***	***Variant Metric 5***
Numerator:	WPC Team partners attending monthly meeting	Within the denominator, who had HbA1c control (<8.0%)	Within the denominator, whose BP was adequately controlled during the measurement year based on the following criteria: • Members 18-59 years of age whose BP was <140/90 mm Hg. • Members 60-85 years of age without a diagnosis of diabetes whose BP was <150/90 mm Hg. • Members 60-85 years of age with a diagnosis of diabetes whose BP was <140/90 mm Hg.	Patients who had suicide risk assessment completed at each visit	Number of participants in housing over 6 months
Denominator:	Total number of WPC Team partners	Members 18-75 years of age with diabetes (type 1 and type 2)	Members 18-85 years of age who had a diagnosis of hypertension (HTN)	All patients aged 18 years and older with a new diagnosis or recurrent episode of Major Depressive Disorder	Number of participants in housing for at least 6 months

4.2 Data Analysis, Reporting, and Quality Improvement

4.2a Data management plan

The key tools driving continuous quality and performance improvement will be the collection of accurate, real-time data; adherence to a quality improvement framework for each intervention; analytic support in turning data into usable information; and training, coaching, and supporting the front-line workforce in techniques and approaches that can lead to continuous improvement in program implementation.

Ongoing data collection, reporting, and analysis of WPC interventions, strategies, participant health outcomes, and return on investment will be accomplished using existing and new data sources. Although data systems currently used by WPC partners are diverse and decentralized, and vary in sophistication as well as amount and type of data collected, partners contributed data to document the need for the Pilot—PHC and BHRS both provided data on high utilizers, while RQMC provided data on utilization and capacity. However, because of the diverse data systems in play, initial data aggregation, reporting, and analysis will rely heavily on manual methods of sharing data while an automated approach is developed.

Throughout the project, data will be collected on all persons participating in the Pilot, including basic demographic information, referral source, and timeliness of response to the referral. Evidence-based assessment tools will be utilized to identify WPC enrollee needs.

Upon approval of this application, the WPC Team will finalize policies and procedures for data collection and reporting. Data will be collected by all participating entities in the Pilot and submitted to HHSA quarterly for summary, aggregation, and analysis. WPC partners are discussing a data subsystem that will minimize duplication of effort while ensuring access to client data. This system will require each partner entity to submit data in spreadsheet format into a centralized system where it will be uploaded to a database for compilation and ease of access. Data entries will be made daily, as appropriate, enabling near real-time data access for other partners. Analysis of return on investment will utilize BHRS and Partnership HealthPlan claims data and other data as identified under the Pilot. Other details of the system will be developed during PY1, including standardized report templates, reporting fields, and timelines.

Reports generated from the database will be analyzed to assess effectiveness of interventions and strategies as well as patient outcomes. Resulting analyses will be used by WPC Teams for quality improvement and change management. As discussed previously, HHSA has already been working to establish data-sharing protocols with partners, and is near the point of signing data sharing agreements.

The analysis of system-level and person-level performance data will be conducted on an ongoing basis. A WPC Dashboard will be developed to identify the number of persons served by each program each month and cumulatively; services delivered; and key outcomes (e.g., time to first appointment, improved health, mental health, substance use treatment outcomes, and housing). Using data reports, the dashboard, and monitoring of participant health indicators, the WPC Team will be able to quickly identify a number of key indicators. For example, for participants who are homeless, the

dashboard will provide information on the number of people housed, length of time in the living situation, and reasons for movement to another home. Similarly, data for the Medical Respite program will report the number of persons in the program, length of stay, improvement in health condition(s), and the number of persons who are re-admitted to the hospital or emergency department following medical respite services.

Table 7. Data timeline

PROGRAM YEAR	DATA ACTIVITIES
PY1	• Finalize data sharing agreements • Develop integrated data systems • Establish baseline data • Develop scoring criteria to determine program eligibility • Develop policies and procedures • Develop data file instructions, including secure file transfer protocols • Develop comprehensive Release of Information • Develop standardized Excel reporting templates • Develop database for importing Excel reports • Form Evaluation/Quality Improvement Workgroup • Develop an external evaluator contract • Contract evaluator • Develop evaluation plan • Purchase software or license, as determined
PY2	• Enter baseline data into data hub • Collect ROIs from participants • Train appropriate staff in data collection, reporting, and retrieval • Collect and enter data using standardized Excel spreadsheets • Compile data from spreadsheets in database accessible to all entities • Develop WPC dashboards • Use PDSA to refine evaluation plan
PY3-5	• Begin use of integrated data system • Generate aggregate data reports for review by WPC Team • Follow PDSA process to utilize data reports for program improvement

4.2b Quality improvement and change management

Pilot data will enable the WPC Team to continuously improve the quality and quantity of services to ensure that the needs of clients, partners, and the community as a whole are met. The Evaluation/Quality Improvement Workgroup will review, analyze, and utilize data on an ongoing basis and provide timely information to the WPC Team. This workgroup will obtain data from HHSA's fiscal department to analyze cost-effectiveness of services and ensure that programs remain within budgeted allocations. Program data will be used to monitor key indicators and outcomes, examine the effectiveness of the program overall and the effectiveness of specific strategies, monitor costs, identify barriers to services, develop solutions, and celebrate successful outcomes. HHSA will

develop a reporting dashboard, accessible to all partners, showing the status of universal and variant metrics.

Each participating entity will be required to report performance and outcome measures. These data will be analyzed by the WPC Team as part of the PDSA process. The WPC Team recognizes the PDSA approach for quality improvement as a continual process. In the "Study-Act" part of the process, the results of analyzing the data, summarizing what was learned, and reviewing what did not to work may lead to modifications to the WPC Pilot that put the intervention back in the "Plan-Do" phase. Even with desired results, a review of unintended consequences and variables not known during the initial "Plan-Do" phase may also prompt enhancements that start the cycle again to see if there can be additional improvements.

To support sustainability planning, data will include cost efficiencies and track the success of WPC cost-avoidance strategies overall, and enable partner entities to access and analyze subsets of services and strategies. Services and interventions that result in appropriate resource allocation and/or reduced costs will be presented to the WPC Team with strategic recommendations for adjustments to current functions and/or allocations.

4.3 Participant Entity Monitoring

HHSA is the lead entity for the WPC Pilot and will be responsible for monitoring contracted partner entities. At the beginning of the Pilot, HHSA will draft policies and procedures on timely data collection, reporting, quality indicators, and outcome measures. These will be reviewed with the WPC Team to ensure a collaborative process.

There will be formal contracting and/or MOU arrangements between all participating entities. A clear scope of work with deliverables, timelines, and specification of services and applicable incentive payments will be developed for each contractor, including protocols and plans for monitoring the contract during the performance period.

At a minimum, program monitoring will verify that: (1) the contractor is held accountable to the service plan and metrics specified in the contract; (2) performance standards are met; and (3) the contractor records accurately reflect whether or not performance metrics and outcome measures have been achieved. Fiscal monitoring will verify that: (1) funding is used for allowable and budgeted activities; (2) proper documentation is provided to substantiate all expenditures; (3) the contractor does not exceed the contract maximum; (4) applicable fiscal records are maintained; and (5) the contractor has adhered to all applicable federal, state and county contract regulations.

Monitoring strategies will include both data review and site visits. Client, service, and outcome data will be reviewed on an ongoing basis to monitor timeliness of access to services; referrals to services; and client-and system-level outcomes. If an entity has difficulty submitting data, has ongoing barriers to services, and/or does not achieve planned outcomes, HHSA will provide additional technical assistance to remedy the issues.

Any noncompliance that may place performance of the agreement or success of the WPC Pilot in jeopardy if not corrected will be communicated to the participating entity in

writing with a request for an improvement/corrective action plan. The improvement plan will be presented to the WPC Team to identity particular areas of concern that could be addressed through technical assistance or through re-evaluation in accordance with PDSA. However, if the issue persists, a corrective action plan will be formally issued and the participating entity notified that failure to correct the issue may result in termination of the agreement.

SECTION 5. FINANCING

5.1 Financing Structure

Mendocino County's WPC Team reviewed current services, utilization, and costs of the target population and reviewed available data to identify gaps and reasonable budget requests for the identified service strategies. The WPC Team also reviewed the cost methodology of Round 1 proposals to identify similar strategies and determine the reasonableness of the amount of funding requested in relation to Mendocino County's proposed WPC Pilot activities. Through this process, the WPC Team has developed a financing structure that looks to maximize resources by leveraging funds outside of the WPC grant while connecting with and/or expanding existing programs wherever possible. For activities identified as current service gaps, the WPC Team will access WPC grant funds as appropriate. HHSA will develop contracts with participant entities and monitor payment processes with subcontractors/downstream providers. The Lead Entity will issue payments to contracted entities on a quarterly basis for incentive, fee for service claims and bundled services. Outcome payments are anticipated to be paid on an annual basis beginning with the completion of PY3.

WPC payments will go to downstream providers in the following key categories:

1. **Comprehensive Coordination of Care.** Coordination of care across primary care, hospital care, behavioral health services, and other specialty care will serve a range of needs and will be paid through per-member-per-month (PMPM) bundle payments, pay for reporting payments, and incentive payments.
2. **Housing Solutions**. This specialized service will focus on community integration, including helping participants to restore relationships with family members, and facilitate patient-centered long term housing solutions. Housing Solutions are incorporated into the Short Term Care Coordination PMPM, with additional supports through modest fee-for-service (FFS) payments, incentive payments, and pay for reporting payments.
3. **Peer Extension Workers.** These services will be delivered through the High Intensity Care Coordination for specific high priority WPC enrollees within the target population, and will be paid through delivery infrastructure funds and PMPM bundle payments.
4. **Mental Health Resource Center.** This expansion and enhancement of available services will develop a healthy-living day program and will be paid through delivery infrastructure funds and pay for reporting payments in coordination with the Comprehensive Coordination of Care.
5. **Mental Health Transitional Support.** This service will include non-Medi-Cal billable services to support intensive wrap-around supports for participants who are in temporary or transitional housing situations. Functioning as a mental health respite center, these services will be paid through FFS payments at a daily rate with planned average stay of 4 days, with up to 90 days based on need. Other services will be connected with incentive and reporting payments.
6. **Medical Respite.** This service expansion will utilize a 4-bed facility that will be paid through FFS payments at a daily rate with planned average stay of 4 days,

with up to 90 days based on need. Other services will be connected with incentive and reporting payments.

7. **Specialized SUDT Coordination** will help WPC enrollees with co-occurring conditions overcome substance abuse and dependence issues through better integration of their substance use disorder treatment services. This coordination will be paid through PMPM bundle payments. Other services will be connected with incentive and reporting payments.

The knowledge sharing that will occur across primary care, hospital services, substance use treatment services, and specialty mental health care will be invaluable in driving improvements to the delivery of care and achieving the Triple Aim of improving the experience of care, improving the health of the target population, and reducing costs. The WPC Pilot will help providers think about different ways of measuring success and receiving payment for services by focusing on health outcomes, shared incentives, and the value of the care they deliver, rather than only considering the amount and type of services they provide under a traditional grant or fee-for-service model. This will ideally result in providing better care at a lower cost in a patient-centered paradigm, resulting in improved health outcomes. Specialty behavioral health services, in particular, have not functioned in this way due to California's bifurcated Medi-Cal funding structures for specialty mental health services and the limited availability of SUDT for the Medi-Cal population, particularly in rural California.

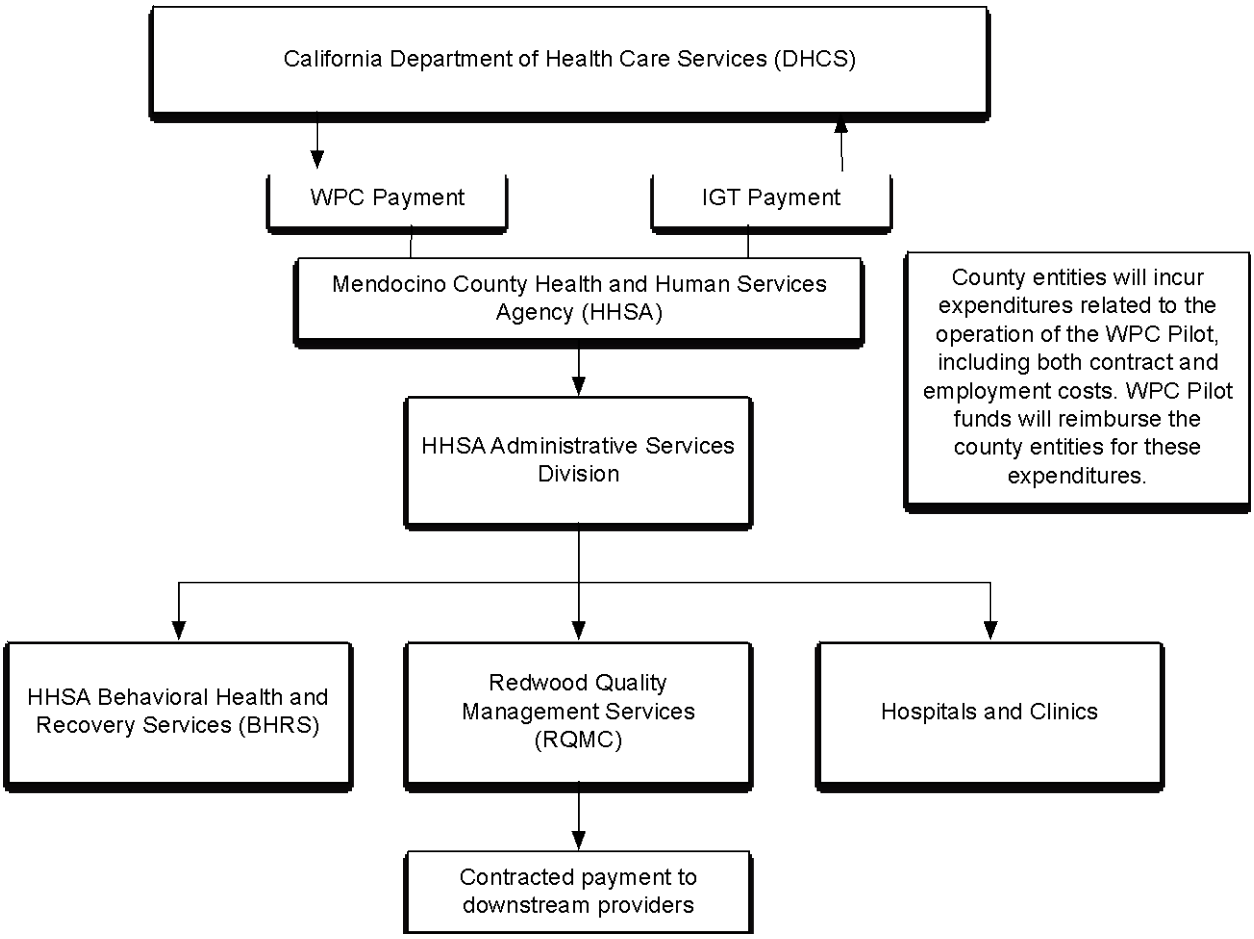
The WPC Pilot will use PMPM bundled payments, incentives, reporting, and outcome payments to build value-based approaches to services and payments. Pay for performance is a relatively new contracting model to most community providers, so this introduction will serve as a critical first step for launching a more long-term transition to contract performance reimbursement strategies for Mendocino County.

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

5.2 Funding Diagram

HHSA is the WPC Pilot Lead Entity. Local funds for the WPC Pilot will originate with the County of Mendocino, and HHSA will transfer funds through the Intergovernmental Transfer (IGT) process to receive WPC Pilot payments from DHCS. Funds will flow from DHCS to Mendocino County's HHSA Administrative Services Branch. Once received, HHSA Administrative Services will journal the revenue to the other HHSA Branches that are participating in the Pilot to cover internal staffing and infrastructure costs, as well as contracts with participating entities and downstream service providers for the WPC Pilot.

Figure 2. Funding diagram



5.3 Non-Federal Share

Mendocino County HHSA will provide the non-federal share for payments under the WPC Pilot. The sources of the non-federal share include Mental Health Services Act funds, realignment revenue, and other local revenue deemed appropriate. All of the non-federal share of funds are already within or will be coming from the appropriations specific to Mendocino County HHSA using the county's budgeting and financial software system.

5.4 Non-Duplication of Payments and Federal Financial Participation

Mendocino County is not currently part of the State Plan for Medi-Cal's Targeted Case Management (TCM) benefit. Mendocino County does bill for other Medi-Cal eligible services (specifically through Specialty Mental Health Services). The County will leverage the WPC Pilot opportunity to explore implementation and sustainability possibilities of certain service strategies through TCM.

5.5 Funding Request

In addition to this summary budget and narrative, please refer to the Mendocino County WPC Pilot Application – Excel Budget Workbook.

Mendocino County's budget uses all seven of the budget categories allowable within the WPC Pilot's budget template: Administrative Infrastructure, Delivery Infrastructure, Incentive Payments, FFS Services, PMPM Bundles, Pay for Reporting, and Pay for Outcomes. The activities detailed below are attributable to the different categories.

ADMINISTRATIVE INFRASTRUCTURE

Administrative Infrastructure includes county staff positions to perform program oversight, policy and procedure development, and program implementation as well as operating costs for these activities. This budget includes staffing to oversee data analysis for evaluation, and contract and fiscal monitoring for the WPC pilot. Personnel and fringe benefits are prorated as to the percent of time dedicated to the WPC pilot.

Personnel

Position	FTE	Annual Salary	PY2 (6 months)	PY3	PY4	PY5
Project Director	0.50	94,975	23,744	47,488	47,488	47,488
Program Coordinator	1.00	75,130	37,565	75,130	75,130	75,130
Data Analyst	1.00	64,179	32,090	64,179	64,179	64,179
Fiscal Analyst	Y2: 1.00 Y3: 0.50 Y4-5: 0.25	64,179	32,090	32,090	16,045	16,045
TOTALS			**125,489**	**218,887**	**202,842**	**202,842**

Fringe benefits

Position	Percent of Total Compensation	PY2 (6 months)	PY3	PY4	PY5
Project Director	41.7%	16,977	33,954	33,954	33,954
Program Coordinator	39.7%	24,726	49,452	49,452	49,452
Data Analyst	40.3%	21,676	43,351	43,351	43,351
Fiscal Analyst	40.3%	21,676	21,676	10,838	10,838
TOTALS		**85,055**	**148,433**	**137,595**	**137,595**

Other costs

Item	Calculation	PY2 (6 months)	PY3	PY4	PY5
Communication	*See below*	2,905	2,490	2,283	2,283
Office supplies	*See below*	545	931	524	177
Data processing	*See below*	350	600	550	550
Legal fees	*See below*	4,000	3,600	1,600	1,600
Education and training	*See below*	2,625	4,500	4,125	4,125
Design and printing	*See below*	3,000	3,125	1,000	2,500
Equipment	*See below*	2,625	4,500	0	0
Travel: In county	*See below*	2,418	7,254	7,254	6,045
Travel: Out of county	*See below*	900	3,250	2,600	2,600
TOTALS		**19,368**	**30,250**	**19,936**	**19,880**

Other costs include the County fiscal system's categories for operations, services and supplies. In summary these costs include:

- Communication. The expense unit of $830 for this category is based on the costs to provide communications for one FTE included within the Administrative Infrastructure for the Pilot Year. The amount is prorated for individuals whose duties are not 100% dedicated to the WPC Pilot. The communication package unit for 1.0 FTE is comprised of the subscription costs of one landline and one cell phone for the PY. One time purchase costs for communications equipment are included in the details listed in the Equipment category of the Administrative Infrastructure budget.
- Office supplies. The unit of measurement for office supplies is based on one year's estimated costs for the Administrative Infrastructure personnel. These costs include printer service, toner, folders, printing brochures and training supplies, paper, pens, etc., and are budgeted with a decrease in reliance on this funding over the project years.
- Data processing. The expense unit of $200 for this category is based on the costs to provide data processing for one FTE included within the Administrative Infrastructure for one Pilot Year. The amount is prorated for individuals whose duties are not 100% dedicated to the WPC Pilot. Costs include County information technology standard budgeted costs for software and hardware upgrades.
- Legal fees. The expense unit of $200 for this category is based on an hourly rate of $200 per hour. These costs are direct charges for County Counsel/legal support of program and data sharing agreements, as well as contract review and approval. Most of these costs will occur during PY2 and PY3 of the project as legal agreements are developed and finalized.
- Education and training. The expense unit is based on a training rate of $1,500 per County employee as part of their negotiated benefits. The amount is prorated for individuals whose duties are not 100% dedicated to the WPC Pilot. Costs include professional development for the employee, including professional education, workshop and conference registration fees and materials.
- Design and printing. The expense unit of $125 for this category is based on an hourly rate of $125 per hour. Costs include graphic design, marketing and technical writing for brochures, reports, data summaries, etc. These costs will be highest at the beginning and end of the project (PY2 and PY5).
- Equipment. This expense unit is based on the average County costs per FTE to receive the necessary equipment within the Administrative Infrastructure. The amount is prorated for individuals whose duties are not 100% dedicated to the WPC Pilot. Costs include assets that are one-time costs, such as furniture, computer, printer, and tablet and phone equipment for project staff. These items will be purchased by the end of PY 3.
- Travel: In County. Costs include travel to partner locations and project sites for meetings and monitoring, as well as garage services. Mileage costs are budgeted to be reimbursed at Mendocino County's current approved rate of $0.50 per mile.

- Travel: Out of County. The expense unit is based on an average of regional and state/Sacramento travel costs for Mendocino County personnel. The maximum units are based on the maximum number of trips anticipated per year. Costs include travel (e.g. mileage, airfare, per diem) for professional development and conferences specific to the WPC Pilot. This includes regional collaboration with other counties that are part of Partnership HealthPlan of California (PHC), which is Mendocino County's Medi-Cal Managed Care Plan.

DELIVERY INFRASTRUCTURE

Delivery Infrastructure includes funding for development of the data sharing hub and methodologies to evaluate the quality, quantity and timeliness of the data. Delivery infrastructure also includes specific program development and infrastructure costs that are not attributable to direct services to WPC enrollees. These costs include infrastructure development for the Mental Health Resource Center, data integration and process improvements based on continuous assessment using PDSA.

The infrastructure for the Mental Health Resource Centers includes one-time costs for facility improvements and equipment and furniture purchase and set up in PY2 and PY3. The 5 participating entities, as well as the 5 downstream behavioral health providers, estimate that they need approximately $7,500 each to set up their data systems to interface with the WPC data infrastructure. Another $2,500 per entity/provider has been set aside in PY3-PY5 to build on the initial project design and assure that the program and identified process improvements can be fully integrated and supported by each participating entity and downstream provider. Funding can also support on-going PDSA based data evaluations and the implementation of identified improvements to assure whole person care is being implemented across primary care, hospital and specialty health care, specialty mental health care and substance use disorder treatment services.

The infrastructure for Homeless Services includes one-time costs for 7 homeless service providers for data compatibility needs and supports. The estimated combined one-time needs total $50,000 in PY2.

Delivery infrastructure summary

Item	Calculation	PY2 (6 months)	PY3	PY4	PY5
Mental Health Resource Centers – equipment, facility improvements, other one-time costs	*Based on one-time cost estimates from WPC CBO partners*	35,000	8,731	0	0
Data compatibility and PDSA evaluation support for each provider	*$7,500 x 10 in PY2; $2,500 x 10 in PY3-PY5*	75,000	25,000	25,000	25,000
Homeless Services – Data hub compatibility and infrastructure support for 7 homeless service providers	*Based on one-time cost estimates from WPC CBO partners*	50,000	0	0	0

INCENTIVE PAYMENTS

Incentive Payments for downstream providers include the four subcategories of hospitals, clinics, behavioral health providers, and homeless service providers. This program of incentive payments was developed in consultation with participating entities based on the best strategies to support comprehensive participation. The Lead Entity is responsible for capturing all data and information required to validate that requirements for each element have been met and to issue quarterly payments to successful participating entities. Incentive payments will recognize participating entities for:

- Attendance and participation in Governance meetings;
- Participation in complex care coordination meetings;
- Attendance at education and training programs;
- Participation in PDSA and quality improvement activities that support the WPC Pilot services and project goals.

Incentive payments

Incentives	Calculation	PY2 (6 months)	PY3	PY4	PY5
Hospitals	2 hospitals* x up to $50,000/year	25,000	100,000	100,000	100,000
Clinics	2 clinic systems x up to $62,500/year	100,000	125,000	125,000	125,000
Behavioral health providers	7 providers x up to $20,000/year	70,000	140,000	140,000	140,000
Homeless service providers	7 providers x up to $10,000/year	35,000	70,000	70,000	70,000
TOTALS		**230,000**	**435,000**	**435,000**	**435,000**

Hospital providers can receive up to $50,000 annually in incentive payments. *One hospital will begin participating in PY2, with the second hospital joining the project in PY3. Participating Primary Care Clinic systems can receive up to $62,500 annually, and behavioral health providers can receive up to $20,000 annually. Homeless service providers can receive up to $10,000 annually in incentive payments for participating in coordinated care plans and training programs to adapt their protocols, procedures, and Homeless Management Information System (HMIS) to better serve WPC enrollees. Incentive payments by program year can be found in the Budget Detail in Mendocino County's Excel Budget Workbook.

FEE FOR SERVICE (FFS) PAYMENTS

Fee for Service (FFS) payments have been established for four service modalities. Fees are based on available FFS information and the detail for each program year for these specific services can be found in the Budget Detail in Mendocino County's Excel Budget Workbook. These services include:

1. **Medical respite** services for the target population ($154 per bed day) will be provided in a 4-bed facility that will allow WPC enrollees to stay for a planned average of 4 days duration dependent upon their needs, up to 90 days. Bed day rate includes clinical staffing to provide physical and mental health care needs,

medication management, additional supports to decrease barrier behaviors that result in the need for higher level care; and non-clinical staffing to provide ancillary services such as, access to occupational and life skill classes, and supervision and connection with all other available services. Each WPC enrollee will have a tailored plan of care developed by the WPC Team.

2. **Mental health transitional support** services ($150 per day) will provide intensive supportive services needed post discharge from a hospital or skilled nursing facility. The rate includes clinical staffing to address physical health care needs, additional supports to decrease barrier behaviors that result in the need for higher level care, medication management, and non-clinical staff to provide occupational needs and daily living skills. Supervision and connection with all other available services including a tailored plan of care in coordination with the WPC Team. Services to WPC enrollees in this six-bed facility will be authorized for an average stay of 4 days duration dependent upon their needs, up to 90 days. Each WPC enrollee will have a tailored plan of care developed by the WPC Team.

3**. Family finding** services will support WPC enrollees, when possible, to restore family and social relationships. Services provided to adults are modeled after services used in the youth fostering and child welfare system to find disengaged family members and facilitate relationship restoration. This service will facilitate reintegration of the WPC enrollee into the community through the psychosocial supports that are developed through establishing or re-establishing supports. The rate of $50 covers the technology and staffing costs to facilitate one report that can be used by the care coordination team to develop family plans.

FFS payments

FFS	Calculation	PY2 (6 months)	PY3	PY4	PY5
Medical Respite	$154/person/bed-day x 160 bed-days in PY2 540 bed-days in PY3 550 bed-days in PY4 450 bed-days in PY5	24,640	83,160	84,700	69,300
Mental Health Transitional Support	$150/person/bed-day x 750 bed-days in PY2 1550 bed-days in PY3 1500 bed-days in PY4 1400 bed-days in PY5	112,500	232,500	225,000	210,000
Family Finding for relationship restoration	$50/person/family finding search x 20 searches in PY2 70 searches in PY3 70 searches in PY4 70 searches in PY5	1,000	3,500	3,500	3,500
TOTALS		**138,140**	**319,160**	**313,200**	**282,800**

BUNDLED PER-MEMBER-PER-MONTH (PMPM) PAYMENTS

Bundled PMPM payments include the services associated with Comprehensive Care Coordination and Peer Extension Services. These services will be tracked and communicated through the assessment and referral process, and will be affirmed and continued through the concurrence of the care managers who work together through the Adult Multidisciplinary Team.

PMPM bundle summary

Item	Calculation	PY2 (6 months)	PY3	PY4	PY5
Bundle 1: Care Coordination	PY2: $564 PMPM, 300 MM PY3: $564 PMPM, 1020 MM PY4: $564 PMPM, 1112 MM PY5: $564 PMPM, 1166 MM	169,200	575,280	627,168	657,624
Bundle 2: High Intensity Care Coordination	PY2: $816 PMPM, 240 MM PY3 - PY5: $816 PMPM, 840 MM	195,840	685,440	685,440	685,440
TOTALS		**365,040**	**1,260,720**	**1,312,608**	**1,343,064**

PMPM bundle 1: Care Coordination

The **Care Coordination** bundled payment is intended to provide coordination for medium to high risk individuals needing short term assistance. An assessment process that is comprehensive, multi-disciplinary, and client-centered will help develop a tailored plan for the WPC enrollee to receive this bundle service for no more than 180 continuous days. Short term comprehensive care coordination will be provided to WPC enrollees who have been diagnosed with a current DSM-V diagnosis of a serious mental health disorder and demonstrate a need for care coordination by virtue of their history and current level of functioning. It is anticipated that most WPC enrollees will need this entry level of care coordination across primary care, hospital and specialty care, and specialty mental health services. This bundle includes a clinical manager who will function as the Integrated Care Specialist to assure that comprehensive assessments are completed for every WPC enrollee and that the assessment process includes the involvement of clinic, hospital and specialty mental health providers who participate on the Adult Multidisciplinary Team. The Integration Specialist will be contracted through the County's contracted Administrative Services Organization (ASO) for adult mental health services, which functions as a third party administrator and program coordinator for most of the County's mental health services. The ASO will oversee infrastructure and payments in order to support the assessment process for behavioral health service providers and WPC enrollee participation; coordinate with the Mental Health Resource Centers to assure there are adequate education and support services; and, oversee clinical integrity of assessment processes in coordination with the WPC pilot's data infrastructure.

The care coordination bundle also includes specialized substance use treatment coordinated through the ASO, and two positions that will be County positions due to their specialized nature. These positions include a specialist to coordinate and

support Assisted Outpatient Treatment (AOT) and a specialist to assist with housing and tenancy issues for WPC enrollees who need additional intensive services in these specialized areas of care and coordination.

WPC enrollees will step down to a lower level of mental health services as their level of needs and functioning improves, but will continue to be assessed at six month intervals to assure that their needs continue to be met and their functioning continues to remain stabilized. Therefore, this Care Coordination bundle allows for a bi-annual assessment for every target population participant and the support of the Adult Multidisciplinary Team to determine appropriate next steps and follow up, which could include referral to the High Intensity Care Coordination bundle that provides intensive Peer Extension Services, links to other fee for service programs, or other services available in the community.

The Care Coordination bundle includes the further development of tenancy education and curriculum that is specific to this target population, as well as other housing policy and infrastructure development. Because of the balance of fixed versus variable costs in this bundle, there is a clear economy of scale as the WPC Pilot serves more members of the target population and develops a shared risk and service delivery model over the period of the WPC Pilot. In PY2, some costs will be provided through County supported start-up funding as described below.

PMPM bundle 1: Care Coordination

Item	Calculation	PY2 (6 months)	PY3	PY4	PY5
Integration Specialist	1 FTE	48,000	96,100	96,100	96,100
ASO Admin Support	1 FTE by PY4	0	31,745	42,330	42,320
ASO Data Support	1 FTE by PY4	0	41,775	55,700	55,700
Assessment incentives and participation costs	PY2: 50 WPC enrollees PY3: 170 enrollees PY4: 280 enrollees PY5: 330 enrollees x $200 per year	10,000	34,000	56,000	66,000
Dual Diagnosis Consulting	$100 per hour	14,000	38,000		
Substance Use Treatment	1 FTE	52,300	104,600	104,600	104,600
Tenancy Consulting	$100 per hour	7,400	20,000	10,400	
Housing Coordinator	.5 FTE - 1 FTE	0	37,645	56,390	75,130
Benefits for Housing Coordinator	.5 FTE - 1 FTE	0	24,725	37,118	49,684
AOT Coordinator	.5 FTE - 1 FTE	County start	37,565	37,565	37,565
Benefits for AOT Coordinator	.5 FTE - 1 FTE	if needed	24,725	24,725	24,725
Mental Health Resource Centers Staffing liaison	$25,000 per site	37,500	75,000	75,000	75,000
Training/classes at Resource Centers	$100 per hour, 6 hours/week by PY4	County start up if needed	9,400	31,200	30,800

Item	Calculation	PY2 (6 months)	PY3	PY4	PY5
TOTALS		**169,200**	**575,280**	**627,128**	**657,624**

PMPM bundle 2: High Intensity Care Coordination

The **High Intensity Care Coordination** bundle incorporates evidence-based peer supportive services and will be overseen by a clinical manager that will be hired through the Administrative Services Organization (ASO). This set of care coordination services is designed as a longer term care coordination bundle for individuals with high needs that are likely to persist over time. Intensive coordination will focus on maintaining engagement and focus on the health/recovery needs and establishing/maintaining a level of independence. WPC enrollees will be re-evaluated every 180 days for continuation in this High Intensity Care service.

The clinical manager that will oversee the High Intensity Care Coordination bundle will help facilitate the placement of Peer Extension Workers with individual WPC Pilot enrollees. These will be paid Peer Extension Worker positions that serve a small number of WPC enrollees and provide intensive supports to WPC enrollees that are not available through current Medi-Cal billable case management services, including transporting WPC enrollees to appointments, attending peer recovery meetings, aiding in the establishment of healthy social supports, and sharing personal experiences related to system navigation and/or health and wellness activities.

The High Intensity Care Coordination and Peer Extension Services will be provided to WPC enrollees who have been diagnosed with a current DSM-V diagnosis of a serious mental health disorder and demonstrate a need for higher levels of intensive care coordination based on their level of functioning and high acuity needs. Peer Extension Services provide an alternative to inpatient psychiatric treatment when a WPC enrollee is not a danger to self/others but requires more intensive supportive services. It is estimated that 70 WPC enrollees will be served annually through this intervention based on current data analysis. WPC enrollees will be moved to lower level of care services as their acuity stabilizes and level of functioning improves across the priority areas of housing stability, substance abuse recovery, and utilization of medical and behavioral health services.

The program anticipates 10 FTE Peer Extension Workers at no more than 7 WPC enrollees per 1 FTE, but anticipates that most Peer Extension Workers will work part time so the total number of Peer Extension Workers being supported by the clinical manager will be more than 10. The clinical manager will work with the existing case management supervisors to provide ongoing professional and personal development supports to the Peer Extension Workers. The clinical manager will help assure that Peers Extension Workers are receiving the training and support needed to provide effective services.

Bundled services include participation on care coordination teams and development of a patient-centered care plan, coordination with housing support

services, coordination with the mental health resource center, mental health, substance use and primary care/medical providers, home visits, transportation, medication and health literacy connections, and access to other daily living needs and eligible programs. This will include the coordination and support of Mobile Engagement and Prevention Services (MEPS) to help engage physically and/or socially isolated WPC enrollees who are difficult to reach, including liaison with law enforcement when needed. MEPS are specifically designed to focus on the more rural areas of the County where services are more difficult to access and there is more social isolation. Because of the close coordination with law enforcement, MEPS will particularly be considered for those WPC enrollees who have a recent incarceration and have a mental illness and/or at risk for incarceration due to a mental health issue. As WPC enrollees become engaged in services and their level of outreach support needs decrease they are transitioned out of MEPS support services.

This PMPM bundle related to the intensive wrap around services of peer extension workers and enhanced case management is designed to serve the highest priority target population members each month and is valued at $816 PMPM with an estimated 840 member months annually.

PMPM bundle 2: High Intensity Care Coordination

Item	Calculation	PY2 (6 months)	PY3	PY4	PY5
Clinical Manager	1 FTE – ASO provider	48,000	96,100	96,100	96,100
Admin Support	1 FTE – ASO provider	20,920	42,330	42,330	42,330
CBO provider vehicle charges	Vehicle maintenance for 5 CBO providers	8,000	20,000	20,000	20,000
Peer Extension Workers	10 FTE by PY2 through CBO providers	111,000	370,000	370,000	370,000
Training for case managers	$110 per hour/4 hours per month	2,640	5,280	5,280	5,280
Training for peer extenders	$110 per hour/8 hours per month	5,280	10,560	10,560	10,560
MEPS specialist	1 FTE	County start	50,230	50,230	50,230
MEPS benefits	1 FTE	County start	32,650	32,650	32,650
Sheriff's tech	1 FTE	County start	35,755	35,755	35,755
Sheriff's tech benefits	1 FTE	County start	22,535	22,535	22,535
TOTALS		**195,840**	**685,440**	**685,440**	**685,440**

PAY FOR METRIC REPORTING

Pay for Metric Reporting proposes to pay for specific universal metrics and variant metrics that represent provider-specific data elements that must be called out and tracked in a new way to meet the quality improvement goals of the WPC Pilot. The Pay for Metric Reporting payment recognizes the value of specific metrics to address WPC enrollee health status, link traditional HEDIS information with behavioral health HEDIS elements, develop shared understanding of data related to value-based payments, and the potential for further health system improvements. These metrics include: follow up

after hospitalization for mental illness, initiation and engagement with alcohol and other drug dependence treatment, suicide risk assessment data, comprehensive diabetes care, and controlling blood pressure. Although higher payments were budgeted in some of the Round 1 proposals, Mendocino's modest reporting payments are acceptable for the two clinic systems and the community based ASO for adult mental health services who will be reporting these five metrics. Up to $10,000 per metric per year will be available for most data sets. The Lead Entity will receive these complete data sets from the clinics and will issue payments to these two participating entities bi-annually for successfully reporting this data.

Up to $15,000 is available for reporting WPC enrollee engagement with alcohol and other drug dependence treatment because it will be a new process for the ASO and its subcontracting entities to develop and report. The Lead Entity is responsible for receiving data on *mental illness follow up after hospitalization* and *alcohol and drug treatment* from the ASO and will issue payments bi-annually for successfully reporting this data.

Pay for metric reporting

Item	PY2 (6 months)	PY3	PY4	PY5
Suicide risk assessment	5,000	10,000	10,000	10,000
Comprehensive diabetes care	5,000	10,000	10,000	10,000
Controlling blood pressure	5,000	10,000	10,000	10,000
Follow-up after hospitalization for mental illness	5,000	10,000	10,000	10,000
Initiation and engagement for alcohol and other drug dependence treatment	7,500	15,000	15,000	15,000
TOTALS	**27,500**	**55,000**	**55,000**	**55,000**

PAY FOR METRIC OUTCOME ACHIEVEMENT

Pay for Metric Outcome Achievement includes payments for achieving the WPC Pilot goals of improving follow up after hospitalization for mental illness and initiation and engagement with alcohol and other drug dependence treatment by at least 5% annually. These two outcome measures were selected by the WPC Team because of their potential to improve the experience of care, improve the health of the target population, and reduce overall costs. Across behavioral health, primary care, and hospital providers there is a shared vision that access to substance use treatment services and supports for WPC enrollees in high-risk mental health transitions will result in better health outcomes, improved patient experiences, and reduced costs across traditional health care and behavioral health care delivery systems. In a rural area that covers a vast geography, there are concerns about meeting these outcome and quality goals. Mendocino County selected an outcome payment incentive structure that includes the ability to provide value-based outcome payments to downstream behavioral health providers who are less familiar with value-based incentives than their clinical partners in the field. All downstream providers in the WPC Pilot will be eligible to receive outcome payments following successful maintenance of each of the baseline data categories in PY 2. The seven behavioral health providers in the Pilot will be able to receive additional outcome incentives in PY3 – PY5 as the downstream providers responsible

for assuring the bi-annual assessment of the target population. They will be eligible to receive outcome payments in PY3 – PY5 for annual achievement of the two outcome goals of improving follow up after hospitalization for mental illness and initiation and engagement with alcohol and other drug dependence treatment.

Pay for metric outcome achievements

Item	PY2 (6 months)	PY3	PY4	PY5
Maintain baseline metrics	200,000	0	0	0
5% increase in follow-up after hospitalization for mental illness	0	100,000	100,000	100,000
5% increase in initiation and engagement for alcohol and other drug dependence treatment	0	100,000	100,000	100,000
TOTALS	**200,000**	**200,000**	**200,000**	**200,000**

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

New WPC Applicant Name: **Mendocino County Health & Human Services Agency (HHSA)**

	Federal Funds (Not to exceed 90M)	IGT	Total Funds
PY 1 Annual Budget Amount Requested	675,295	675,295	1,350,590
PY 2 Annual Budget Amount Requested	675,295	675,295	1,350,590
PYs 3-5 Annual Budget Amount Requested	1,350,590	1,350,590	2,701,180

Second Round PY 1 Budget Allocation (Note PY 1 Allocation is predetermined)	
PY 1 Total Budget	1,350,590
Approved Application (75%)	1,012,943
Submission of Baseline Data (25%)	337,648
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	1,350,590
Administrative Infrastructure	229,910
Delivery Infrastructure	160,000
Incentive Payments	230,000
FFS Services	138,140
PMPM Bundle	365,040
Pay For Reporting	27,500
Pay for Outcomes	200,000
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	2,701,180
Administrative Infrastructure	397,569
Delivery Infrastructure	33,731
Incentive Payments	435,000
FFS Services	319,160
PMPM Bundle	1,260,720
Pay For Reporting	55,000
Pay for Outcomes	200,000
PY 3 Total Check	OK

Second Round PY 4 Budget Allocation	
PY 4 Total Budget	2,701,180
Administrative Infrastructure	360,372
Delivery Infrastructure	25,000
Incentive Payments	435,000
FFS Services	313,200
PMPM Bundle	1,312,608
Pay For Reporting	55,000
Pay for Outcomes	200,000
PY 4 Total Check	OK

Second Round PY 5 Budget Allocation	
PY 5 Total Budget	2,701,180
Administrative Infrastructure	360,316
Delivery Infrastructure	25,000
Incentive Payments	435,000
FFS Services	282,800
PMPM Bundle	1,343,064
Pay For Reporting	55,000
Pay for Outcomes	200,000
PY 5 Total Check	OK