Napa County Whole Person Care

Participating Entity Description

1.1 Whole Person Care Pilot Lead Entity and Contact Person

Organization Name	Napa County
Type of Entity	County
Contact Person	Mitch Wippern
Contact Person Title	Chief Deputy Director, Napa County Health and Human Services
Telephone	707 259 8653
Email Address	Mitch.Wippern@countyofnapa.org
Mailing Address	2751 Napa Valley Corporate Parkway Napa, Ca 94559

1.2 Participating Entities

Required Organizations	**Organization Name**	**Contact Name and**	**Entity Description and Role in WPC**
1. Medi-Cal managed care health plan	Partnership Health	Patti McFarland, Chief Financial Officer	Sole Medi-Cal managed care health plan for Napa County. Supply and help analyze data on high system utilizers.
2. Health Services Agency/Department	Napa County Health and Human Services Agency	Mitch Wippern, Chief Deputy Director	Project management and oversight.
3. Specialty Mental Health Agency/Department	Napa County Health and Human Services Agency	Bill Carter, Mental Health Director	Provide mental health case management and outreach to SMI homeless population. Partner with Engagement and Respite components.
4. Public Agency/ Department	City of Napa Housing Authority	Lark Ferrell, Housing Manager	Partner to provide subsidy administration and unit inspection, where applicable.
Additional	**Organization Name**	**Contact Name and**	**Entity Description and Role in**

Organizations		Title	WPC
5. Community Partner 1	Ole Health		Medical and outreach services. Referrals to CES.
6. Community Partner 2	Catholic Charities	Jennielynn Holmes Director of Shelter and Housing	Operates the homeless respite center in Napa, provider of RRH services. Provider for respite services.
7. Community Partner	Napa Police Department	Captain Pat Manzer	Oversees the operation of the Napa PD homeless outreach team to work with Engagement
8. Community Partner	Napa FD	Mike Randolph, Fire Chief	Provide data on EMS response and transportation for target population. Work with project planning team to develop an appropriately sized sobering center operation.
9. Health Services Agency/AOD	Napa County Health and Human Services Agency – Alcohol and Drug Services	Jacqueline Connors, MFT, Administrator of Alcohol and Drug Services	Provide substance abuse treatment services to the target population. Work with Engagement and Sobering Center staff.
10. Community Partner	Napa County Probation	Mary Butler, Chief Probation Officer	Coordinate services to and data on target population individuals who are on probation.
11. Community Partner	Queen of the Valley Medical Center CARE Network	Dana Codron, Executive Director of Community Outreach	The QVCN CARE Network will provide Supplemental Security Income (SSI)/Social Security Disability Income (SSDI) advocacy and application assistance to connect eligible WPC beneficiaries to SSI and SSDI benefits.

1.3 For Letters of Participation, please contact Napa County at 2751 Napa Valley Corporate Parkway Napa, Ca 94559.

2.1 Geographic Area, Community and Target Population Needs

Napa County is struggling to assist hundreds of high-needs, disabled homeless households with very few resources. In a county with a population of only 142,456, fully 9% are living in poverty and more than 1,000 are known to be at risk of losing their homes. For those who do lose their housing, finding a new place to live is daunting. The average rent for a one-bedroom apartment exceeds $2,300 per month, while the HUD standard for fair market rent for a one-bedroom apartment is $1,145.

Data collected in HMIS in 2015 show 1,198 persons who are homeless or at risk of homelessness. Based on the most recent Point in Time counts, homelessness in California dropped 7.5% from 2011 to 2015.[1] For Napa County, the percentage rose 27.4%, from 230 to 293 persons.[2] In particular, there is a growing population of high-need, vulnerable individuals in Napa. Homeless Point-in-time data from 2011 – 2015 show overall increases in percentages of chronically homeless, and those who have severe mental illness and substance abuse disorders. Annual HMIS data indicate high percentages of mental illness (46% in 2014, 44% in 2015), substance abuse (34% in 2014, 32% in 2015), and three or more health conditions (29% in 2014, 27% in 2015).

A large percentage of individuals entering the homeless system come from temporary stays with friends and family, or from institutions like jails, hospitals and detox centers. Further, most individuals that exited shelter went back into homelessness or temporary destinations.

The result is a large population of homeless people who cycle through jail, emergency medical services, detox, and shelters, all high-cost interventions that too frequently leave people back on the street.

Whole Person Care Planning

This WPC Pilot proposal is led by Napa County Health and Human Services Agency (HHSA). HHSA is the County department responsible for enrolling community members in Medi-Cal, and for oversight of the Continuum of Care. The Director of Operations, Director of Mental Health, and Director of AD Services have planned this systems effort with county partners at the Napa County Police Department, Napa County Fire Department, and Partnership Health Plan of California (PHP), (Napa's Health Plan for Medi-Cal), and with outside consulting and technical assistance partners, ,the Corporation for Supportive Housing, the National Alliance to End Homelessness, HomeBase, and numerous local services providers.

Program Description

WPC will allow Napa to assist the county's most vulnerable populations, those who are homeless or at risk of homelessness and high systems users.

Engagement

[1] HUD 2007-2015 Point-In-Time Estimates by State. www.HUDexchange.info

[2] Napa County Health and Human Services Agency, "Homelessness in Napa County: Scope, Resources, Initiatives, Issues," 2015

Napa County will engage people in a housing crisis through the Engagement bundle. This component partners peer outreach with medical assistance through PHP and OLE Health, mental health services through HHSA and Emergency Services through the police and fire departments to meet with and assess homeless Medi-Cal beneficiaries on the street to address their needs in a way that will lead to health and housing stability, rather than cycling people through emergency services.

Referred through the Engagement team, Napa will provide (FFS) sobering services to avoid unnecessary Emergency Department (ED) use, hospitalization, and jail stays. Through follow--up by a Nurse Case Manager, the Engagement referral to (FFS) respite will prevent institutional discharges to homelessness.

Coordinated Entry

Everyone who is within the target population of homeless and at risk of homelessness will be eligible for assistance through Napa's Coordinated Entry system (CE). CE staff in the field or at the CE site will administer a consolidated assessment tool that measures housing, health care, behavioral health, and other services needs. Participants with the highest utilization, who obtain high---cost services from multiple systems with the highest care needs, will be prioritized for Care Coordination and Housing Navigation.

Housing Navigation services will include:

- Problem solving, homelessness prevention assistance, and diversion for those who are no who are at risk; and
- Housing location, application assistance, subsidy matching, and housing placement for those who are homeless.
- Housing resource management to oversee subsidies and connect to rental assistance pool administered outside of WPC.

Tenancy Care

Tenancy Care Coordination services will include:

- Health connections to primary care and other providers;
- Income connections for benefits or workforce services;
- Service connections to substance abuse recovery and mental health providers; and
- Housing stabilization assistance to support life skills, hygiene needs, and resource location.

Through an existing partnership, individuals who have not connected to PHP and do not have a medical home can be linked to healthcare services in a timely manner through partner OLE Health. This partnership includes a primary care clinic on the HHSA campus.

Impact

The impact of these components will be a marked reduction in homelessness, emergency services usage, and unnecessary hospitalization.

Coordination: The coordination of efforts across departments and disciplines has already begun with the forming of a Funders Collaborative group to address homelessness, and the joint planning to craft this initiative. The implementation of WPC will allow Napa to increase coordination at the street level, bringing clinical expertise and peer support to the emergency services teams addressing homelessness and providing ongoing support through engagement, housing placement, and stabilization.

Learning for Future Efforts: Napa has adopted a PDSA approach in HHSA, and will utilize that from the beginning of WPC. In addition, Harvard's Kennedy School Government Performance Lab will provide technical assistance to Napa on performance contracting with WPC implementation.

Sustainability: The system improvements that will result from the WPC implementation will bring savings sufficient to provide ongoing services after the pilots' end. ME will reduce emergency medical services and readmissions, prevent incarceration, and prevent homelessness.

Coordinated Entry will assist hundreds of homeless and at—risk households in finding and stabilizing housing, significantly reducing the homeless population toward a "functional zero" within the pilot period.

Project Partners: Engagement		
Partner Organization	**WPC Role**	**Project Area Role**
Partnership Health (PHP)*di-Cal managed care health plan*	Medi-Cal managed care health plan. Provides ED, inpatient, and primary care. Gather, share, and analyze user data.	Provide data to partners on current homeless/at risk enrollees. Assist in identifying patients at risk of homelessness. Connect to medical services as needed.
HHSA *Napa Health and Human Services Agency*	Project management and oversight. Specialty Mental Health Provider. Substance Abuse Services provider	Provide administrative and delivery infrastructure. Provide Care Coordination. Supervise data sharing and outreach planning.
Housing Authority *City of Napa Housing Authority*	Partner to provide subsidy administration and unit inspection, where applicable.	Provide data to partners on current tenants. Assist in identifying tenants at risk of homelessness.

Project Partners: Engagement		
Emergency Services Police Department, Fire Department	Provide outreach support, emergency medical transport, public complaint response, and data sharing.	Participate in outreach. Respond to public complaints and concerns. Compile and share data on people who are homeless and at-risk.
Probation Napa County Probation	Coordinate services to and data on target population individuals who are on probation.	Connect clients to respite and sobering services when needed. Share data on clients who are homeless and at-risk.
OLE Health	On-site clinic at HHSA campus. Medical and outreach services for homeless beneficiaries.	Provide responsive medical coordination support and assessments to ME clients.
Catholic Charities	Operates homeless respite center, provides Rapid Rehousing and respite services.	Provide respite services to ME homeless and at-risk clients. Share data on participants who may be homeless or at-risk.
McAlister Institute	Detox and sobering center provider.	Provide sobering center for people referred by ME. Refer detox clients who may be homeless or at-risk. Data sharing to prevent new incidences of homelessness.
Project Partners: Coordinated Entry		
Partner Organization	WPC Role	Project Area Role
Partnership Health (PHP) *Medi-Cal managed care health plan*	Medi-Cal managed care health plan. Provides ED, inpatient, and primary care. Gather, share, and analyze user data.	Provide data to partners on current homeless/at risk enrollees. Connect to medical services as needed. Refer patients to CE program. Track ED visits and hospitalizations.
HHSA *Napa Health and Human Services Agency*	Project management and oversight. Specialty Mental Health Provider. Substance Abuse Services provider	Provide administrative and delivery infrastructure. Provide Care Coordination. Supervise data sharing and outreach planning. Oversee resources for CE.

Project Partners: Engagement		
Housing Authority *City of Napa Housing Authority*	Partner to provide subsidy administration and unit inspection, where applicable.	Provide vacancy and eligibility information to CE staff.
Emergency Services Police Department, Fire Department	Provide outreach support, emergency medical transport, public complaint response, and data sharing.	Refer homeless and at-risk clients to CE.
Probation Napa County Probation	Coordinate services to and data on target population individuals who are on probation.	Connect clients to CE. Assist in housing planning.
OLE Health	On-site clinic at HHSA campus. Medical and outreach services for homeless beneficiaries.	Provide responsive medical coordination support and assessments to CE and ME clients. Refer homeless and at-risk clients to CE.
Catholic Charities	Operates homeless respite center, provides Rapid Rehousing and respite services.	Refer clients to CE. Share data on participants who may be homeless or at-risk.
Project Partners: SOAR SSI/SSDI Advocacy		
Partner Organization	WPC Role	Project Area Role
Queen of the Valley Medical Center CARE Network	Connection to income and benefits through SSI/SSDI advocacy and application assistance provided in the SOAR model.	SSI/SSDI Advocacy for clients engaged through ME who are eligible for but not yet approved to receive SSI/SSDI.

2.2 Communication Plan

HHSA has established a Funders Collaborative that meets monthly to plan Napa's response to homelessness and related concerns. The Director of Operations chairs this meeting. The Funders Collaborative, modeled after successful programs in Los Angeles and other California Counties, has representatives from local philanthropic organizations, the Chief Probation Officer, the Chief of Police, the Sheriff, the City Housing Manager, the Assistant City Manager,

representatives from local health care agencies and much of the management team from HHSA. The Collaborative is tasked with adopting metrics to measure the success of the homeless and housing services system. They will provide high-level oversight of these efforts and will guide discussion on system adjustment if goals are not being met. This meeting will be the communications hub for City and County staff collaborating on WPC.

In addition, members of the Funders Collaborative will participate in a newly convened WPC Working Group for the full five years of the pilot. The group will include the primary participants in the initiative, including health care, Engagement, and CES provider agencies. This working group will meet regularly (weekly to monthly) to bring on the ground perspective to PDSA. Topics will include:

Year One and Two:

- Baseline data gathering and analysis
- Program planning and policy development
- Metrics and evaluation framing
- Developing housing relationships
- Comprehensive Systems Mapping
- Implementation Planning

Year Three to Five:

- Review Metrics and Evaluation
- Program Improvement
- Services Monitoring
- Services Coordination
- Health Outcomes
- Housing Outcomes

Other ongoing opportunities for collaboration include partnerships with the Napa Valley Coalition of Nonprofit Agencies (NVCNA), the Healthy Aging Subcommittee, Homeless Shelters and Homeless Resource Centers, supportive housing programs, and other community-based services.

2.3 Target Population

Napa County will serve non-beneficiaries through CoC and other systems, not through WPC. Napa does not intend to set an enrollment cap on beneficiaries within WPC.

Description of Target Population

The eligible population will include beneficiaries who are homeless or at risk of homelessness.

The priority population will be beneficiaries experiencing homelessness or at risk of

homelessness who are identified as high systems users and have a physical disability, serious mental illness or substance use disorder, or co-occurring disorders.

Data Analysis

According to the 2015 Corporation for Supportive Housing/NAEH[3] report on Napa's homeless population needs, and additional 2016 Partnership Health Plan (PHP) statistics drawn from HMIS records, Napa County Census records, and additional HHSA data, the following data trends in Napa were noted:

- Among homeless patients, each person averages 2-3 Emergency Department (ED) visits per year. In 2015 to 2016, there were 2,201 visits per 1,000 people who had homeless or at risk status. In the same time period, the PHP mean for all members was only 609 per 1,000, or less than one third the frequency. Historic numbers show similar results.
- Homeless patients were more likely to have inpatient hospital admissions and readmissions. The number of admissions among homeless people in HMIS was 149 per 1,000, when the average among all members was only 57 per 1,000.

Housed	Number	Admits	Admit/1000
2013	16272	930	78.5
2014	22275	1021	67.5
2015	27551	1290	64.1
Homeles	**Number**	**Admits**	**Admit/1000**
2013	214	16	110.5
2014	459	37	155.5
2015	610	70	144.9

- Overall, PMPM costs were 30% higher for homeless clients than the PHP mean.
- Napa's 2015-2016 HMIS showed that 56% of homeless people (compared with only 6.7% of people under 65 countywide[4]) in the system had a disability.
- CSH research based on the Point in Time count noted that 42% of the 293 counted on the streets or in shelter are severely mentally ill and 43% have chronic substance abuse issues.
- The most common medical conditions among the homeless receiving care through PHP were Chemical Dependency (50%), and Major Depression (35%). Other common

[3]Corporation for Supportive Housing and National Alliance to End Homelessness Recommendations Report for the County and City of Napa, 2016

[4] Estimates for 2015, based on 2010 census: http://www.census.gov/quickfacts/table/PST045215/06055

conditions were Hypertension (27%), and Asthma (22%).

At Risk

People who are at risk of homelessness and have disabilities will be identified for WPC interventions through the following three channels:

Current HMIS Clients: Napa County's high cost of housing and high percentage of households in poverty has resulted in significant numbers of people who seek homelessness prevention assistance and are entered into HMIS.

High Systems Users: Those who receive homeless assistance and emergency services in Napa County are often discharged into homelessness. According to HMIS data, a large percentage of people entering the homeless system come from shelters and transitional housing. People entering emergency shelter often came from detox or substance use centers, and jails or prisons.

Coordinated Entry Assessment: Additional at-risk households will be identified through Coordinated Entry, as people seek homeless and housing assistance. During an initial screening, people with disabilities who are at imminent risk of homelessness will be immediately connected with Care Coordination services under WPC.

Needs Assessment

The County and City of Napa contracted with the Corporation for Supportive Housing (CSH) to perform a homeless and housing services system analysis. Research included stakeholder convening, and data analysis using HMIS and annual performance reports. CSH also reviewed 2014 and 2015 Point in Time (PIT) count data for homeless population demographics and needs.

In addition to recommending bolstering of the supportive and affordable housing portfolio and funding strategies, they recommended the following systems improvements addressed in this application:

- Frequent User System Engagement
- Coordinated Entry system
- Divert people from the homeless assistance

Number in Target Population

Based on HMIS data, there are currently 1,098 who have been identified as homeless or at risk of homelessness. Of these, 293 were living on the streets or in shelters. At least 56% had been diagnosed with at least one disability and 97% are known to be Medi-Cal beneficiaries. As we expect additional identification through CE and, Napa WPC plans to serve 800 people over five years.

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

3.1 Services, Interventions, and Care Coordination

3.2 ENGAGEMENT

Description

Napa's emergency services receive calls for people who are in crisis on the streets on a daily basis. At this time, the Police Department, Fire Department, and Emergency Medical Services are the responders and their options for assisting the people in crisis are very narrow: typically they consist of jail or emergency department, or limited access to mental health crisis support. These are expensive options and are unlikely to result in an immediate plan to address the underlying cause of the crisis: homelessness.

This WPC Engagement team work closely with emergency services to provide on-the-spot assessment and engagement for homeless people who are in crisis or exhibiting nuisance behavior. The Engagement team will consist of: a Clinical Supervisor, to oversee the team and provide clinical analysis and supervision to the direct services staff; a Care Coordinator, to engage clients and work with them to access Coordinated Entry and needed social services; a Nurse Case Manager to assist with health care case management; and Peer Support, to provide outreach and to bring lived experience to the Engagement efforts.

On the scene, the Engagement team will determine whether they are a health plan member, whether they are already active with ME staff, then assess for criminal, medical, psychiatric, substance use, safety, and housing concerns. (People who are ineligible for WPC will be assessed by accompanying staff not funded through WPC.) The ME team will work together to make the most appropriate recommendation for resolution and will create an ongoing services plan. In addition, the team will now have referral access to a Sobering Center, Respite Beds, SSI/SSDI eligibility and application assistance, and Coordinated Entry services.

Responsiveness to Identified Needs

The picture that emerges from the needs analysis work that has been done is of a homeless system of care that does not hold together, and that people with the most severe needs may not be able to access needed housing and services. The most fragile homeless people may be most at risk for cycling through emergency medical services, shelters, and sleeping on the street. The Engagement team will connect with beneficiaries at every juncture to prevent prolonged episodes of homelessness for those most in need of assistance. By replacing unnecessary emergency services with access to sobering beds, and facilitating discharge to respite, instead of to the street, Napa's team will maintain critical connections that improve health and housing outcomes. By connecting every homeless person to the Coordinated Entry system where they receive ongoing Care Coordination and Housing Navigation, housing and healthcare can be stabilized and reoccurrences of homelessness and emergency needs will be prevented. The program will also connect beneficiaries who are eligible for, but not yet connected to, SSI/SSDI a set of advocacy and application assistance services through the SOAR program offered by the CARE Network at QVMC.

Peer Support

Peer support is critical to engaging people on the street who may be struggling with substance use and mental illness, and may feel threatened by law enforcement or medical staff. Peer Support Specialists can model recovery, teach life skills, and offer advice on housing and services through leveraging their own lived experience. Specifically, the Peer Support Specialist will deliver services such as street outreach, connection to case management, daily living skills

modeling and education, and peer--to-peer (non-clinical) counseling. Peer Support will be overseen by a Clinical Supervisor to ensure quality services are delivered and clinical supports are in place.

Connections to Interim Beds

Partnering to maximize the benefit of existing services provided by McAlister Institute for sobering services and with Catholic Charities for Respite, Napa's Engagement team will refer clients in crisis who do not need emergency medical services into a sobering center directly from the street, or respite beds on discharge from hospital or other facility, according to their presenting needs. These interim placements aid in immediate care and stabilization of medically vulnerable clients, while shelter and housing options are identified through Coordinated Entry.

Implementation

Implementation of the Engagement team will require engagement of partners across the medical, behavioral health, substance abuse and criminal justice sectors to share data (lists of frequent ED and hospital users and their costs to the health plan, substance use/detox center data and HMIS data) and determine the overlap of clients in the system.

The next step will be to build out the program, including partner roles, housing intervention opportunities and criteria, determine service interventions, create MOUs and hire any needed staff. Training and technical assistance will be provided in year one and year two, to ensure that all staff is prepared to assist people within the target population to move quickly to safe and affordable housing.

COORDINATED ENTRY

The Napa Continuum of Care (CoC) has been piloting a Coordinated Entry (CE) system using a standard assessment and vulnerability index tool to prioritize those most in need of assistance. With WPC, Napa will be in a position to fully implement CE and provide housing navigation services and care coordination to hundreds of people identified as homeless or at risk of homelessness. Housing options in the CoC currently include scattered site subsidized housing, or houses managed by HHSA. With the addition WPC, Napa will have far greater capacity to match homeless people with disabilities to supportive housing options, and will provide ongoing stabilization assistance to all those placed.

Services in Coordinated Entry will begin with diversion, problem solving resources, and screening. Coordinated Entry staff will work with each person coming for services, calling in, or assessed by Engagement to identify any resources that might keep them from entering the homeless system. For example, if someone is sleeping on the couch of a family member and helping to pay for groceries could allow them to stay there, Coordinated Entry staff may set up a grocery purchase plan to divert them from homelessness. They might proceed with additional housing planning and assistance, but the client will not have to exit a relatively safe place in order to receive assistance.

If a person has no viable housing options through diversion, they will progress to assessment. After a person is assessed and prioritized for housing, a Care Coordinator and a Housing Navigator will be assigned. Care Coordinators assist homeless people with establishing benefits,

clearing up credit, connecting to health and social services, and other supports. The Housing Navigators will assist in the creation of a housing plan with every homeless individual. The housing plan will take into account the client's income, physical and mental health needs, and any barriers to housing.

Also within the Coordinated Entry program will be Landlord Liaison services, to identify and secure available apartments or houses for subsidy placements. WPC resources will bolster the identification and securing of additional high-quality affordable and supportive housing to serve the target population. The Housing Resources Coordinator will manage funding from various divisions and programs across systems to allow the money to be used where it is needed most.

TENANCY CARE

After a person is assessed and prioritized for housing, a Care Coordinator will be assigned. Care Coordinators assist homeless people with establishing benefits, clearing up credit, connecting to health and social services, and other supports. They will continue to work with clients through housing placement and stabilization. Care Coordinators will seek to pair the highest needs clients with more intensive specialty case management services when they are available.

SOAR SSI/SSDI ADVOCACY

Any client who is likely eligible for, but not yet connected to, SSI or SSDI income will be referred to SOAR-model SSI/SSDI Advocacy services offered by the CARE Network at Queen of the Valley Hospital. CARE Network's SOAR advocates will provide intensive support on SSI applications, including preparing a detailed Medical Summary Report, gathering extensive medical records to adequately capture the complex circumstances that contribute to the disabling conditions experienced by many homeless people, and supporting clients throughout the application process, which is estimated to take an average of four months per client.

Data Sharing

Initial Data Collection and Sharing

To plan for and prepare the WPC proposal, Napa County convened its key stakeholders who collect relevant data. These include HHSA Mental Health and Alcohol and Drug Services; Partnership Health as the plan provider; CoC representatives regarding Continuum of Care HMIS data on homelessness; and Emergency and Law Enforcement providers regarding street engagement. These are the partners who will be key contributors of data during the baseline data gathering and during the Pilots.

Initial data comparisons for needs analysis were generated by providing HMIS records administered by HHSA (with signed release of information and privacy statements) to Partnership Health. PHP then matched HMIS homeless and at-risk individuals with health plan records for 2015 and 2016, retrieving matches for 1016 records.

Data regarding street-level services were provided by law enforcement and mental health staff, who verified the percentage of calls that concern homeless and chronically homeless people. Further information on the level of disability among people living on the street was gathered through needs analysis work using HMIS and homeless services data collected for annual HUD

CoC funding.

Gathering Baseline Data

The County and PHP have already begun planning for ongoing data sharing, and developing protocols that will allow for the complete baseline dataset for the first WPC pilot year.

Protocols under development include a data sharing/analysis platform and a secure File Transfer Protocol site. Working with CSH to develop agreements, protocols, and to refine data collection and sharing needs, Napa providers will compile baseline data on coordination across entities, beneficiary health outcomes, emergency and inpatient services, utilization of social services, and housing status. These data points will be tied to patient records that indicate target population eligibility for Engagement and for Coordinated Entry.

Data Sharing Infrastructure

Data sharing and privacy agreements are already in place with the primary partners in this application and will be extended to capture any new data needs for WPC. Current agreements include Partnership Health, HHSA, Napa's police and fire departments, probation, and community partners working in HMIS.

To fully implement sharing of new data gathered for WPC across all services for Napa residents who are homeless and disabled, Napa will implement a new eBHS platform to integrate HMIS, behavioral and physical health data. The platform will allow analysis of real-time data related to Engagement encounters, Coordinated Entry, emergency department and hospital entries and exits, and housing placements.

The proposed eBHS, designed by California Institute for Behavioral Solutions, system is a web-based data platform that works as an adjunct to existing data collection systems by allowing upload of client data. Designed to meet State and local tracking, sharing and reporting needs, the platform will offer reporting and querying capability to support individual, population and system improvement, and is HIPAA and CFR42 compliant.

Data sharing and privacy agreements are already in place with the primary partners in this application and will be extended to capture any new data needs for WPC. Current agreements include Partnership Health, HHSA, Napa's police and fire departments, probation, Connect Healthcare, a regional Health Information Exchange and community partners working in HMIS.

To fully implement sharing of new data gathered for WPC across all services for Napa residents who are homeless and disabled, Napa will implement new data strategies to integrate HMIS, social services, and behavioral and physical health data. The strategies will create a platform that will allow analysis of real-time data related to Engagement encounters, Coordinated Entry, emergency department and hospital entries and exits, and housing placements.

One portion of the proposed strategies is eBHS. This system, designed by California Institute for Behavioral Solutions, is a web-based data platform that works as an adjunct to existing data collection systems by allowing upload of client data. Designed to meet State and local tracking, sharing and reporting needs, the platform will offer reporting and querying capability to support individual, population and system improvement, and is HIPAA and CFR42 compliant.

Napa will use this system to aggregate and report on data from internal and external sources. Another portion of the strategy is the creation of a data mart that will allow the aggregation of data from Napa specific data systems such as C-IV, our electronic medical records system and Public Health case management data.

The final portion of the strategy is Connect Healthcare, a regional Health Information Exchange (HIE) that Napa is a founding member of. Other partners in the HIE include most of the healthcare systems providing care for the WOC eligible population. The HIE will allow Napa to exchange Admission, Treatment and Discharge data on a real time basis with those healthcare systems. The combination of these three pieces will create a robust bi-directional data exchange and analysis system that will let us share, analyze and report on WPC data.

Ongoing Data Management

A new staff position at HHSA will oversee data management and evaluation for the lead entity. This position, titled Program Evaluation Specialist, will be the point person for PDSA, and will oversee the procurement and supervision of an outside evaluation contractor. The Evaluation Manager will develop data procedures and protocols to manage data sharing throughout the life of the project. Resulting documentation will include:

- Napa WPC Data Entry & Management – This document will outline data collection procedures including frequency of data collection, which assessments are collected at what time points, roles and responsibilities (who collects the data, who enters the data), where data is to be entered (HMIS, local data entry), simple instructions for data entry, and to whom to turn for support.
- Napa WPC Data Codebook – The codebook will list variable names and labels, descriptions of the variables (e.g., dichotomous, continuous), explanation of data codes (e.g., 1=male, 2=female), codes or missing values, and explanations and command codes for data created after data collection (composite variables created from multiple items). The Codebook will be created in conjunction with the implementation of the eBHS data platform.
- Napa WPC Data Security – This form will clarify how the data is to be stored, maintained and protected, and who has access to what data and for what purpose. Only program staff will have access to the data for the purpose of data entry and providing effective service delivery. The external evaluator will only receive de-identified data. All staff are familiar with or trained in HIPPA Privacy Procedures and will sign an acknowledgement of the Napa WPC Data Security. This effort will be guided by the County's Privacy Officer -- a position embedded in HHSA.

The Data Integration Manager will ensure program, HMIS, and VI-SPDAT data will be entered within seven days of collection. The Data Integration Manager will provide oversight of accurate data entry, data entry training, and addressing barriers with the Program Evaluation Specialist. This position will also work to develop and integrate other data sources such as law enforcement data.

4.1 Performance Measures

The goal underlying all services and measures in Napa's application is to improve the health and wellbeing of vulnerable homeless and at risk residents through evidence-based interventions.

In PY 1, County of Napa will immediately begin work on data needs, gathering information through existing sources, identifying gaps in available data, and aligning systems across the entities to compile baseline data and proceed with the services proposed.

- Lead Entity PY 1 Measure 1: Establish all necessary information sharing and data collection protocols.
- Lead Entity PY 1 Measure 2: Engage consulting and training entities to prepare for 2017 launch.
- Lead Entity PY 1 Measure 3: Prepare RFP/Q to identify needed services contractors.
- Community Partner PY 1 Measure 1: Complete data sharing agreements and assist in production of baseline data.

In PY 2, Napa will begin providing WPC direct services. The Coordinated Entry program will add critical outreach and housing navigation services. With consulting support, policies and procedures will be implemented by pilots. PY 2 will focus on training to ensure the multiple parties participating in the pilots deliver services in a consistent, low-barrier manner. The ME will assist people on the street or at risk of discharge into homelessness through CE referrals, diversion, respite, sobering, and placement into interim housing.

- Lead Entity PY 2 Measure 1: Create and execute bundled contracts and training for PMPM services. Incorporate Pay for Outcomes structure.
- Lead Entity PY 2 Measure 2: Begin operation in ME, CE, TC services.
- Health Plan Partner PY 2 Measure 1: Measure inpatient and readmission among all participating beneficiaries.
- Community Partner PY 2 Measure 1: Assist 75 beneficiaries per month through ME services by the end of PY 2.
- Community Partner PY 2 Measure 2: Assist 60 beneficiaries per month through CE services by the end of PY 2.
- Community Partner PY 2 Measure 3: Initiate SSI/SSDI applications for 15 WPC clients by the end of PY 2.

- Community Partner PY 2 Measure 3: At least 15 beneficiaries obtain and maintain permanent housing by the end of PY 2.

PY 3 will provide an opportunity to initiate the study portion of the PDSA cycle, looking closely at any barriers the teams have faced, analyzing the early results, and refining the approach as needed.

- Lead Entity PY 3 Measure 1: Evaluate PY 2 activities.

- Lead Entity PY 3 Measure 2: Supervise and monitor bundled services.
- Health Plan Partner PY 3 Measure 1: Measure inpatient and readmission among all participating beneficiaries.
- Community Partner PY 3 Measure 1: Assist 75 beneficiaries per month through ME services throughout PY 3.
- Community Partner PY 3 Measure 2: Assist 60 beneficiaries per month through CE services throughout PY 3.
- Community Partner PY 3 Measure 3: Assist up to 85 people per month in ongoing Tenancy Care.
- Community Partner PY 3 Measure 4: Decrease readmission by 5% below baseline among target population served by ME.
- Community Partner PY 3 Measure 5: At least 30 beneficiaries obtain or stabilize permanent housing during PY 3.
- Community Partner PY 3 Measure 6: At least 75% of beneficiaries who obtain or stabilize permanent housing during PY 2 will maintain housing for at least 6 months.
- Community Partner PY 3 Measure 7: Initiate SSI/SSDI applications for 30 WPC clients by the end of PY 3.

The approach in PY 4 and PY 5 will be geared toward refinement and sustainability. After two full years of operations, the number of beneficiaries who are homeless and disabled should be markedly lower.

- Lead Entity PY 4 & 5 Measure 1: Evaluate WPC activities. Implement refinements following each cycle.
- Lead Entity PY 4 & 5 Measure 2: Supervise and monitor bundled services.
- Health Plan Partner PY 4 & 5 Measure 1: Measure inpatient and readmission among all participating beneficiaries.
- Community Partner PY 4 & 5 Measure 1: Assist 75 beneficiaries per month through ME services throughout PY 3.
- Community Partner PY 4 & 5 Measure 2: Assist 60 beneficiaries per month through CE services throughout PY 3.
- Community Partner PY 4 & 5 Measure 3: Assist up to 85 people per month in ongoing Tenancy Care.
- Community Partner PY 4 & 5 Measure 4: Decrease ED use by 15% below baseline among target population served by ME.
- Community Partner PY 4 & 5 Measure 5: Reduce readmission in PY 4 by 10% for people

assessed in PY 2. Reduce readmission in PY 5 by 15% for clients enrolled in PY 2 and PY 3.

- Community Partner PY 4 & 5 Measure 6: At least 30 beneficiaries per year obtain or stabilize permanent housing.
- Community Partner PY 4 & 5 Measure 7: At least 85% of beneficiaries who obtain or stabilize permanent housing during PY 2 and 3 will maintain housing for at least 12 months.
- Community Partner PY 4 & 5 Measure 8: Initiate SSI/SSDI applications for 30 WPC clients by the end of PY 4 and PY 5, respectively.

4.1.a Universal Metrics

Please check the boxes below to acknowledge that all WPC pilots must track and report the following universal metrics.

- **Health Outcomes Measures Goals:** Reduce Emergency Department use by 10% in PY 2, 15% in PY3, and 20% in PY 4 and PY 5. Reduce Inpatient utilization by 20% for people assessed in Coordinated Entry.
- ☒ **Administrative Measures Goals:** Establish data gathering and care coordination services within the Engagement and the Coordinated Entry system. Establish Housing Support Pool. Beginning in PY 2, assist 75 people per month through Engagement services. Beginning in PY 2, assist 60 people per month in Coordinated Entry.

4.1.b Variant Metrics

Napa has chosen the following Variant Metrics:

1. Administrative: In each PY, Napa will provide the administrative and delivery infrastructure to support the services proposed in Engagement, Coordinated Entry, and Tenancy Care services.

2. Health Metric: In each PY, Napa will track and show reduction in the number of hospital readmissions within 30 days. The services proposed for Napa's WPC package are geared toward shortening the length of time people spend on the street, or preventing time on the street altogether. Research presented in the application shows that effective outreach and care coordination will prevent unnecessary hospitalizations. The metric will be measured using the count of 30-day readmissions as numerator and the count of index hospital stays (HIS) as denominator.

3. Health Metric: Napa will administer and track improvements in self-reported health status and quality of life. This metric will be an appropriate general measure for people who have experienced homelessness and have since received care coordination assistance. Napa will use a total score of the Likert scale response of WPC participants who responded to a health status survey during the reporting period as numerator, and total number of WPC participants who responded to a health status survey during the reporting period as denominator.

4. SMI Population Metric: Napa will administer and track risk reductions in the NQF 0104

Suicide Risk Assessment tool. For clients with SMI, Care Coordinators who have assisted with homelessness prevention or tenancy stabilization will administer this assessment. Results will assist providers in their service plans. Napa will use patients who had suicide risk assessment completed at each visit as numerator and all patients aged 18 years and older with a new diagnosis or recurrent episode of Major Depressive Disorder as denominator.

5. Housing Metric: Napa will track permanency in housing for formerly homeless clients. This metric corresponds with Napa's proposed outcome incentives, and is central to the goals of Engagement, and of Coordinated Entry and Tenancy Care. Napa will use number of participants in housing over 6 months as numerator and number of participants in housing for at least 6 months as denominator.

Variant Metric	**PY 2**	**PY 3**	**PY 4**	**PY 5**
1. Administrative Metric	Provide ME and CE infrastructure	Provide ME and CE infrastructure	Provide ME and CE infrastructure	Provide ME and CE infrastructure
2. Health Outcome Metric	Maintain baseline for readmissions.	Reduce readmissions by 5% from baseline for all clients enrolled in PY2	Reduce readmissions by 10% from baseline for all clients enrolled in PY2	Reduce readmissions by 15% from baseline for all clients enrolled in PY2 and PY3
3. Health Outcome Metric	Maintain baseline for self-reported health status and quality of life.	Improve self-reported health status by 5% for clients enrolled in PY2	Improve self-reported health status by 10% for clients enrolled in PY2	Improve self-reported health status by 15% for clients enrolled in PY2 and PY3
4. SMI Population Metric	Maintain baseline for suicide risk assessment on clients with SMI	Reduce assessed risk by 5% for clients enrolled in PY2	Reduce assessed risk by 10% for clients enrolled in PY2	Reduce assessed risk by 15% for clients enrolled in PY2 and PY3
5. Housing Metric	Maintain baseline for homeless clients who are housed	75% of those placed at least 6 months prior will have maintained housing.	80% of those placed at least 6 months prior will have maintained housing.	85% of those placed at least 6 months prior will have maintained housing.

4.2 Data Analysis, Reporting and Quality Improvement

Data Collection, Reporting, and Analysis

Tools for Homeless Services

The Engagement team will use a specialized tool to assess a member's most immediate needs, and to determine eligibility for available resources. This tool will be developed in the first six months of 2017. Coordinated Entry will use the VI-SPDAT, a tested vulnerability index, for the prioritization process for housing, but will also implement a Housing Planning tool to assist clients in identifying housing barriers, personal resources, and housing goals. This tool will also be developed in the first six months of 2017.

Health Care Data Collection

PHP has already begun tracking multiple measures for homeless clients as a sub-population. These currently include hospital admissions, ED visits, diagnoses noted, cost per member per month, and numbers of office visits. When WPC is implemented, PHP will add hospital readmissions and post-release follow-up visits. They will also create data comparisons that compare homeless patients with housed patients, as opposed to comparing homeless people with the mean, which includes the homeless population. Data sharing agreements will cover these and other sources, across WPC as described in Section 3.2.

Reporting

Semi-annual reports, beginning in Pilot Year Two, will include quantitative data on the progress achieved and barriers encountered. Quantitative data will include demographics of participants, housing status, housing stability, ED visits, and hospitalization rates. Outcomes and all service and retention data will be reported for the whole and by subpopulations to assess for disparities in access, service, and outcomes.

Quality Improvement and Change Management

The Program Evaluation Specialist and the evaluation team will develop a well-articulated theory of change that delineates the strategies and outcomes for each Pilot Year at the systems and individual client levels. This theory of change will guide the development of data collection protocols to supplement those already identified and to fully inform the PDSA process.

Napa intends to procure professional third---party evaluation services to review and test our learning within WPC. The evaluation process will be steered by the Program Evaluation Specialist. The evaluation design, which will be drawn in collaboration with the Corporation for Supportive Housing and potentially in collaboration with the Kennedy School Government Performance Lab, will ensure that all required process and outcomes data for the grant, including all metrics proposed, will be collected and analyzed as indicated in the solicitation.

Napa's proposal to the Kennedy School Government Performance Lab will seek assistance with the development of performance-based contracts with the providers of the Engagement and Coordinated Entry services. Napa's evaluation team also will create a comprehensive quality improvement performance management system through the evaluation design and implementation process using PDSA techniques.

Napa will use PDSA as its approach to quality improvement. One of the most effective models for quality improvement, already in use by Napa and recommended by DHCS, is the Model for Improvement, or "Plan-Do-Study-Act" (PDSA).

Guiding Questions

What are we trying to accomplish?

Napa's PDSA cycle begins with defining what the County, through WPC, is trying to accomplish. The answer is straightforward: Napa County wants to house its residents who are homeless and disabled, and to prevent persons who are at risk from ending up homeless. Many additional benefits to individual health, quality of life, and longevity follow from that intervention, as do systems benefits such as reduced health care costs, reduced diversion of emergency resources, and reduced burden on jails, detox programs, emergency shelters, and other housing programs.

How will we know that a change is an improvement?

Napa County plans to employ a data-driven quality improvement process. The goal of this grant is to bring integrated, effective care to consumers and improve outcomes as measured by housing status and stability, and reduce ED visits and hospitalizations. Those objectives provide the foundation for review of progress. Annually, program data including demographics, service use data, enrollment data, and outcomes data will be analyzed and consolidated into an evaluation report.

What changes can we make that will result in improvement?

The Program Evaluation Specialist, with the Homeless Systems Coordinator and the WPC Project Manager will review reports and identify strengths and problem areas. These will be shared with the Funders Collaborative and other key stakeholders semi-annually and plans to improve and/or maintain quality will be discussed at that time. The quality improvement process will also inform the larger semi-annual reports where barriers, achievements, and adjustments to implementation will be reported.

4.3 Participant Entity Monitoring

For each identified contractor, a Scope of Services will set forth the protocol or plan that HHSA intends to follow for monitoring the contract during the performance period. For WPC bundled services using Performance Metrics, contractor scopes will be developed as performance-based scopes, with regular monitoring.

Site visits will normally be conducted after reasonable prior written notice to the contractor that describes the scope of the review to be conducted, persons requested to attend, and the type of information to be available.

Typical activities during a site visit include review of information submitted by the contractor in preparation for the visit; review of one or more invoices and the contractor's back up documentation, such as timesheets or invoices; review of case files; review of pertinent policies and procedures; review of complaint and incident reports; and review of license, certification, and similar information. A representative from the program division, the Fiscal Division and, if appropriate, the Quality Management Division attend the monitoring visit.

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) all performance standards are met; and (3) the contractor's records accurately reflect whether or not performance metrics and outcome measures have been achieved.

Fiscal Monitoring Requirements

At a minimum, fiscal monitoring will verify that: (1) funding is used for allowable and budgeted activities; (2) proper documentation is provided to substantiate all expenditures for which reimbursement is requested; (3) the contractor does not exceed the contract maximum without appropriate amendments being made; (4) applicable fiscal records are maintained to provide an adequate audit trail; and (5) the contractor has strictly adhered to all applicable federal, state and county contract regulations.

Monitoring Reports

After the visit, the findings of the monitors are combined into a single monitoring report that is sent within 30 days of the monitoring visit to the provider for review. Normally the report should include a summary of information collected or reviewed; the evaluator's assessment, conclusions, and recommendations; and any requirements or sanctions to be imposed on the provider, such as disallowances, recoupments or requests for plans of action. The provider will be given a specified period (normally 30 days) within which to give notice of the provider's disagreement with any of the findings and to present information supporting the provider's position. If appropriate, HHSA may conduct additional monitoring activities to evaluate the provider's position. The report is then submitted to the contract monitor for final review and approval. The final report, normally issued within 30 days of the provider's response, is signed by the program division manager, the Chief Fiscal Officer and, if appropriate, the Quality Management Director, or their designees.

Section 5: Financing

5.1 Financing Structure Administrative Cost Payment

The majority of administrative costs will be paid through HHSA. Costs for HHSA will be managed internally per County protocols. The Administrative Infrastructure costs will be paid by HHSA and through WPC.

Administrative Contract Procurement and Payment

Contracts for Systems work and technical assistance, such as tools and policies and procedures, will be awarded based on previous or new RFP. These contracts are administered by HHSA. Intended contractors include the Corporation for Supportive Housing for homeless system redesign; National Alliance to End Homelessness for Shelter and Interim Housing/Front Door Services Systems, HomeBase for WPC Policies and Procedures, and contractors to be identified for evaluation, training, and other technical assistance for WPC program implementation.

Payments to these contracts may be based on invoice by deliverable or on cost reimbursement. Contract payments will be made within 45-60 days of receipt of a verifiable invoice.

Bundled Services Procurement and Payment

Contracts for PMPM Engagement will be procured by competitive bid. Upon notification of the WPC award, Napa staff will create a Request for Proposals (RFP) or similar solicitation for performance-based services for Engagement, and for Coordinated Entry. The RFP(s) will outline the PMPM expectations and the Pay for Outcomes structure of the grant.

Contract payments will be made based on actual PMPM services provided and documented for bundled programs, and based on outcome achievement for Outcome Metric programs. HHSA will base contracts on the WPC grant application deliverables and tie payments to grant PMPM and deliverables to ensure contractors do not overspend.

Systems Development

Napa County will implement performance-based contracting for its PMPM Services bundles and its Pay for Outcomes Metrics. To do this within the PDSA framework, HHSA will work with the Harvard Kennedy School Government Performance Lab (Performance Lab) to develop contracts that will help prepare HHSA and its contractors and other participant entities to transition to value based payment. The PDSA cycle of the WPC project will allow HHSA and contractors to work with Performance Lab and hired evaluators to fine-tune those processes over the course of the pilot.

Performance Lab provides technical assistance to cities that seek to adopt results-driven contracting strategies for their grants and procurements. These strategies include clearly defining performance goals, measuring outcomes achieved, tying payments to successful outcomes, and using performance data to inform future procurement decisions. All of these areas will be critical in shaping Napa's Performance-based contracting system for WPC.

Tracking

HHSA Fiscal will dedicate a Fiscal Analyst to tracking all transfers, payments, revenues, and expenses for WPC.

Invoices will have layered approval. The Program Manager will first review the PMPM demonstrated number of beneficiaries served for the billing period. The Program Manager will then forward the invoice to the Fiscal Manager who will review the costs for eligibility before approving for payment.

Fiscal monitoring will be conducted per agreed schedule. A summary of protocols already in place is provided in Section *4.3 Participant Entity Monitoring.*

Funds Availability

HHSA is its own fund and carries a 10% reserve that may be used to front costs while awaiting reimbursement. This is a working system already in place and in use for existing federal and state reimbursement programs.

5.2 Funding Diagram

(Attachment)

5.3 Non--Federal Share

County of Napa, General Funds and Tobacco Master Settlement Agreement Funds Proposition 63 Mental Health Services Act (non-capital)

City of Napa, Police, and Homeless Services

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

Napa County's proposal is largely centered on its development of Coordinated Entry services, supported and supplemented by Engagement and Tenancy Care. These services all begin with an initial eligibility assessment, which will refer beneficiaries into WPC services and will assist non--beneficiaries using other means. The primary interventions in the WPC pilot – Outreach, Care Coordination, and Housing Navigation – are services not otherwise covered or directly reimbursed by Medi-Cal, and the administrative infrastructure and delivery systems are being newly created to serve the beneficiary target population and support the pilots. Housing stabilization will be a core component of care coordination, but will be specific to non-medical care like assistance in working with landlord, connection to money management of other income supports, and organization of resources.

Contracts with providers will specify that to be eligible for payment, services will need to be limited to Medi-Cal eligible individuals. As described in the Monitoring portion of the application, all payments to providers will be evaluated for beneficiary eligibility before being processed. Sobering Center and Respite payments will be for non-medical care coordination and the Community Partner's cost of providing the safe place to the beneficiary. The Engagement team will be coordinated with law enforcement and emergency services, but the WPC services consist of street outreach, assessment for homeless assistance, peer support, care coordination, and nurse case management to ensure access to appropriate medical care, rather than direct provision of medical care.

Based on initial comparisons, almost all participants in homeless services in Napa are already known to be beneficiaries. However, those who are apparently within the target population who are not beneficiaries will be assisted by other community partners to establish eligibility or other assistance.

Targeted Case Management

The County of Napa Health and Human Services Agency (HHSA) is authorized under its State plan with DHCS to bill Targeted Case Management (TCM) for the following categories:

- Medically fragile individuals
- Individuals in jeopardy of negative health or psycho-social outcomes
- Individuals with a communicable disease.
- Specialty mental health services

The HHSA Public Health Division provides the first three services. The HHSA Mental Health Division provides Specialty Mental Health. The case management services that will be part of our Whole Person Care program will not duplicate services provided under and billed to TCM. The case management services that are part of the Whole Person Care program are

primarily focused on service connection and housing stability.

The vast majority of the activities and interactions of the care coordination teams will not duplicate Medi-Cal's targeted case management ("TCM") benefit. Specifically, the PMPM services in Engagement and Coordinated Entry depart significantly from the encounter-based structure of TCM, and in the vast majority of cases the encounters between the MT staff and CE staff and patients/clients/members would not be eligible for reimbursement under TCM, as the activities are related to coordination and housing navigation, rather than case management activities, and many of the staff positions, like the Landlord Liaison and the Housing Resources positions, do not have regular client contact. Moreover, the scope of care support and coordination activities available through WPC is intended to be more robust than available through Medi-Cal TCM. WPC teams will engage in activities such as peer support and community center services, which are distinct from and outside the TCM benefit. Staff will meet with WPC participants and ask if they are receiving case management services elsewhere in HHSA. If it appears that they may be receiving case management services elsewhere, staff will meet to review the services provided and ensure sure that there is no duplication. If TCM services are pre-existing then TCM billing will take priority over WPC billing.

In order to prevent duplication with TCM services, Napa has reduced its total projected bundle costs by 5% in the PMPM budget calculations for each bundle, during each PY.

NAPA COUNTY BUDGET NARRATIVE

Administrative Infrastructure

Description: Napa County's WPC Administrative Infrastructure creates the backbone of a new, fully coordinated approach to ending homelessness among vulnerable residents. By braiding together all homeless assistance for Medi-Cal recipients, these interventions result in a robust WPC program.

Rationale: Napa will bolster its homeless services through program oversight and administration, new prioritization strategies for those who are homeless and disabled, data collection and coordination, resource administration, and intensive staff training in order to create a cohesive system that moves people quickly into housing and reduces reliance on emergency services. Studies have shown that effective program integration across health, housing, and social services will result in successful reduction of ED visits and hospitalization.[1]

Item

Program Manager

Data Integration Manager

Program Evaluation Specialist

HHSA Fiscal Support

HHSA HMIS Administrator

HHSA Fiscal Analyst

HHSA Chief Deputy Director

HHSA Homeless Services Coordinator

These positions are HHSA staff positions necessary to administer the programs being developed for WPC. Each of these will be dedicated to WPC for the amount of time noted. All positions include fringe benefits in the total shown.

WPC Program Manager: This position will oversee all aspects of WPC implementation and pilots.

Data Integration Manager: This position will oversee the coordination and data sharing with Partnership Health, CES, Law Enforcement, ME, and HMIS.

Program Evaluation Specialist: This position will work on establishing the baseline, then they will develop and track all performance measures. S/he will work closely with the contracted evaluation team.

HHSA Fiscal Support: Various percentages of 15 fiscal staff that combine to constitute 1 FTE for

[1] Effect of a Housing and Case Management Program on Emergency Department Visits and Hospitalizations Among Chronically Ill Homeless Adults A Randomized Trial Laura S. Sadowski, MD, MPH Romina A. Kee, MD, MPH Tyler J. VanderWeele, PhD David Buchanan, MD, MS, 2009

WPC activity. Duties include reviewing documentation to substantiate expenditures, assisting with the preparation of budgets and estimated actuals, preparing selective hiring requests, paying contract claims ensuring they have not exceeded the contract maximum, preparing and reviewing agenda items for board actions, reconciling the general ledger to paid claims, providing monthly budget to actual reports to the program divisions, preparing accounts receivable entries for revenue earned and preparing reports on WPC expenditures.

HHSA HMIS Administrator: HHSA will need the assistance of data entry specialists trained in HMIS to enter and report on all data for the target population. HMIS Administration is budgeted at .40 FTE.

HHSA Fiscal Analyst: HHSA Fiscal will dedicate 50 % of a Fiscal Analyst to work on WPC. This position will be a centralized point of contact for coordinating and communicating. They will gather the information from the various fiscal tracking mechanisms to properly claim and assemble audit trail back-up documentation for everything claimed to Whole Person Care including match sources.

HHSA Chief Deputy Director: This position will supervise the Program Manager, the Homeless Services Coordinator and all contracted consultants. This position is the primary liaison with the health plan. HHSA has budgeted .40 FTE of this position for WPC oversight.

Homeless Services Coordinator: This position will oversee the services programs and subcontractors working on Engagement, CES, Tenancy Care, and all services for homeless Medi-Cal recipients within WPC. HHSA has budgeted .40 FTE of this position to work on WPC integration within homeless services during the Pilot Years.

Data Integration Specialist: This position will oversee the data sharing protocols and put in place the necessary policies to integrate data sharing for WPC. This position is budgeted at .40 FTE.

WPC Infrastructure Capacity Needs		
Information Technology Services	65,207.28	1.00
Facilities Maintenance/Copiers	43,240.64	1.00
Travel/Mileage/Fleet charges	36,710.02	1.00
Liability Insurance/Workers Comp	10,191.73	1.00
Telephone/Utilities	5,837.98	1.00

The Infrastructure Capacity items will support the Administrative components of the WPC program.

Information Technology Services: These costs are associated with general computer maintenance, operations, network accessibility, and computer upkeep for Napa County Health and Human Services employees working on the Whole Person Care project.

Facilities Maintenance/Copiers: These costs are for the maintenance of buildings and space

occupied by Napa County Health and Human Services employees working on the Whole Person Care project. These costs also include the cost of leasing copiers used by these staff.

Travel/Mileage/Fleet Charges: These costs for reimbursement of mileage and other travel costs for Napa County Health and Human Services employees associated with the Whole Person Care project. These costs also cover the fuel and maintenance of county owned vehicles for the time they are used by these staff.

Liability Insurance/Workers Comp: These costs are for employer paid premiums for employee workers compensation and risk management for Napa County Health and Human Services employees allocated based on the amount of time charged to the Whole Person Care project.

Telephone/Utilities: These costs are for usage and general repairs of telephone, messaging, or other communication services; consumption of gas, electricity and water; and fire suppression services allocated based on the amount of time charged by Napa County Health and Human Services employees to the Whole Person Care project.

Contract Positions: These contract positions will assist Napa with the systems change and capacity building necessary to implement WPC as a system of care transformation.

System Mapping will look at the connections and create linkages between clients, Partnership Health, and the services being brought on line. This contract will also cover recommendations for data sharing and integration.

Policies and Procedures Development: This contract will be for WPC policies and procedures development and distribution.

Tools Development: This contract will be for the analysis, planning, and development of tools for WPC tracking and prioritization.

Training Services: Training will include work to facilitate the adoption of national best and evidenced based practices to ensure high quality outcomes. The WPC-specific curriculum will begin in PY2 and will continue through PY 5, though later years will have reduced training needs.

Baseline and Implementation: Upon award of WPC, Napa will engage a consultant to guide the grant-specific implementation process to ensure consistency with the proposal and with STC guidelines. This contract is only in PY2.

Homeless Systems Change: Napa maintains contracts with homeless systems consultants that will be configured to focus on the integration of WPC with all countywide homeless services for Medi-Cal beneficiaries. The amount of this line item reduces significantly in later PY.

Multidisciplinary Care Unit (MCU): The MCU will be funded through Infrastructure through PY 2 so that a full unit can be operational when client services begin. In PY3, the MCU will transition to a FFS item. The MCU will assess all new WPC clients for Mental Health needs and connect them to needed services.

Delivery Infrastructure

Delivery Infrastructure costs represent the cost of tangible items and specific deliverables, primarily software and hardware costs. These systems will allow the key program components to share data across disciplines, to record key prioritization factors and needs, and to track individual and aggregate outcomes. This infrastructure will require complex accountancy, and crossover data with HMIS and eBHS.

Item
Data integration Platform User Licenses
Data integration Platform Report Writing
Data integration Platform EHR Integration
HMIS Enhancements
Data Integration Tools
Evaluation
Transportation (Van)
Innovations Community Center
Health Information Exchange

Innovations Community Center: Napa intends to provide employment related services to all WPC eligible clients through the Innovations Community Center. Clients will be provided with easy access to on-site Voc Rehab services including positions for people with mental illness. WPC will pay for the delivery infrastructure to make this program an integral component of WPC. This is a new service-type for Napa, without a baseline number, but could be moved to a PMPM rate in PY3 or after.

Health Information Exchange: Connect Healthcare is a regional Health Information Exchange (HIE). The concept of an HIE is to create a central repository in which participating entities can store health information. That shared repository allows, with patient permission, the electronic sharing of healthcare information. Such sharing increases opportunities for provider collaboration and decreases the need for duplicating tests as results will be readily available. Connect Healthcare will be of use to our WPC efforts in that it is the place where hospitals and healthcare partners will store Admission, Treatment and Discharge information.

Services Established through Delivery Infrastructure

In PY 2, services in Engagement, Coordinated Entry, Tenancy Care and SSI Advocacy will be part of Delivery Infrastructure, to allow for hiring and training of staff, and initial outreach and intake for clients. Tenancy Care services will continue to be partly funded in Delivery Infrastructure in PY3, as caseloads will continue to fill in that period. In PY4 and PY5, these services positions will be reflected in PMPM services.

Engagement
Driver - PMPM /Engagement
Clinical Supervisor
Care Coordinator
Nurse Case Manager
Peer Support
Engagement Assessment
Co-Located Behavioral Health Specialists M
Co-Occurring Disorder Support Services - M

Homeless Coordinated Entry System Staffing
Coordinated Entry Manager
Shelter CM Care Coordination - M
Housing Landlord Liaison - PMPM/Housing Support
Housing Navigator
Housing Navigation Resource Administrator

Tenancy Care
Tenancy Care Manager
Care Coordinator/Housing Stabilization

SOAR Model SSI Advocacy
Social Worker

Incentive Payments
PY2

Item	*Max Amount Per Unit*
Submission of Admission, Treatment and Discharge records to HIE by one health care partner	25,000
Implementation of eHBS	25,000
Addition of Behavioral Health Data to the data mart	25,000

These incentives reflect major milestones involved in preparing the system for WPC implementation. They will be paid to the responsible divisions within HHSA.

PY3

Item	*Max Amount Per Unit*
Submission of Admission, Treatment and Discharge records to HIE by one new health care partner	8,000
Addition of Emergency Medical Services data to the data mart	8,500

These incentives reflect major milestones involved in preparing the system for WPC implementation. They will be paid to the responsible divisions within HHSA.

PY4

Item	*Max Amount Per Unit*	*Max Units*
Increase TAY count in PIT	500	22

Napa will pay incentives to downstream providers able to connect with newly identified homeless youth and conduct intakes for Coordinated Entry and/or Engagement.

PY5

Item	*Max Amount Per Unit*	*Max Units*
Clients housed by Coordinated entry report having a primary care physician	500	50
Clients housed by Coordinated entry are connected to employment training services	160	75

Napa will pay downstream providers incentives to connect clients to primary care and employment in PY5.

Fee for Service

Item

Sobering

Respite

Mental Health Support Services

Alcohol and Drug Services

Multidisciplinary Care Access Unit (Hub)

OLE Health Coordinated Clinic Services

Housing Related Legal Assistance

The FFS items represent distinct services provided by contractors that will assist WPC clients, but are non-reimbursable through Medi-Cal.

Sobering and Respite: These services will be connected by referral from the ME. The sobering center FFS is a per bed per day cost. The bed nights will be made available through an expansion of a contract that the County has for the operation of a detox and residential treatment center. This rate was arrived at by dividing the total contract amount by the number of beds for which the County contracts.

The **Respite Center** rate is a per bed per day cost. The bed nights will be made available by entering in to a contract with the non-profit that operates the respite center. This rate was arrived at by dividing the total operating budget by the number of beds in the facility.

Mental Health Support: Supplemental services which assist clients with supportive programs and activities that facilitate the provision of direct treatment services and treatment services that are non-claimable to Short-Doyle Medi-Cal.

Alcohol and Drug Services (ADS): ADS is the Alcohol and Drug Services Division of the County of Napa Health and Human Services Agency. They offer an array of prevention, treatment and recovery services in both English and Spanish. Services are provided through County-operated programs and contracts with community-based organizations. This division also manages the County funded detox, sobering and residential treatment facility located in Napa. Budgeted in WPC are services that are not part of the current Drug Medi-Cal delivery system or do not meet title 22 regulations, but are delivered to the Medi-Cal eligible population. These include services such as educational groups, individual therapy, ancillary groups, staff administered urinalysis tests, treatment community activity, and groups with greater than 10 participants. The FFS cost represents projected cost per visit.

Multidisciplinary Care Unit (MCU): The MCU will be funded through Infrastructure through PY 2 so that a full unit can be operational when client services begin. In PY3, the MCU will transition to a FFS item. The MCU will assess all new WPC clients for Mental Health needs and connect them to needed services.

OLE Health: OLE Health is the Federally Qualified Health Care Center operating in Napa County. The OLE Health team and Napa have worked collaboratively to establish a clinic on the Napa HHSA site. This well-known clinic site will be used as a referral point for WPC clients. OLE Health will assist with clinical care coordination, and direct referrals to ME and CES. The FFS proposed represents the projected cost per WPC client visit.

Housing Related Legal Assistance: The County of Napa provides funding to Fair Housing Napa Valley. Services provided by Fair Housing Napa Valley to WPC participants will include mediation for repair, occupancy and eviction issues for people entering ME or CE who are at risk of homelessness. Fair Housing Napa Valley will also provide training on fair housing rights including rights of people with disabilities, families with children and all classes protected under the Fair Housing Act to WPC participants and their service providers.

Bundled PMPM Services

Napa has proposed four sets of bundled services, the Engagement team, the Coordinated Entry system, Tenancy Care, and SOAR-Model SSI Advocacy. While their client population and referral systems will overlap and will be coordinated, their primary areas of focus are distinct.

Engagement Team

Engagement will provide specialized assessment and ongoing assistance for homeless services and coordinated care on the street, in collaboration with emergency services and law enforcement staff, and will follow up with homeless clients being discharged from hospitals and other settings, to ensure they are not discharged back into homelessness.

Eligibility

Eligibility for Engagement is based on Medi-Cal eligibility and homeless status. The majority of

intakes to WPC will be through the outreach process, targeting people living on the street. Additional referrals will be from institutions discharging beneficiaries without housing, and people in crisis at imminent risk of homelessness.

Staff will continue to work with homeless members until they have identified a source of ongoing services and support. This may be through Coordinated Entry, in which case the person's primary care coordination assistance will be transferred. If a client does not have another service provider, services will continue until their stabilization plan is implemented.

Rationale: Bringing specialized staff positions to focus on the needs of homeless people will increase the effectiveness of current street engagement efforts, and will create seamless referral systems into Coordinated Entry, sobering or detox, and respite beds to avoid discharge into homelessness. A study on sustained outreach effectiveness concluded that staff effectiveness was most improved by dispatching a team that is skilled in building a trusting relationship, and that has knowledge of where homeless people congregate.[2]

This team will consist of the following positions:

Engagement Staffing

Driver - PMPM / Engagement

Clinical Supervisor

Care Coordinator

Nurse Case Manager

Peer Support

Engagement and Assessment

Co-Located Behavioral Health Specialists

Co-Occurring Disorder Support Services

- Clinical Supervisor: This position will oversee the provider team and will connect with the mental health system when needed.
- Care Coordinator: This position will connect clients to homeless assistance, social services, income supports, employment or credit assistance, and homelessness prevention services as needed. The Care Coordinator will continue to assist clients until they can be transferred to the Tenancy Care Coordinator. Care Coordination services during are expected to be provided at a Coordinator to Client ratio of approximately 1/35. This ratio should be sufficient because we will also employ a Nurse Case Manger to

[2] Mobile Health Care for Homeless People: Using Vehicles to Extend Care by Patricia Post, MPA

focus specifically on medical care coordination.

Rationale: Care coordination has been shown to deliver health benefits to those with multiple needs, while improving their experience of the care system and driving down overall health care (and societal) costs.[3]

- Nurse Case Manager: This position will ensure that each homeless client seen has a connection to health care options and entitlements, and that medical follow-up has been arranged. They will coordinate with hospitals and other institutions to avoid discharging vulnerable clients into homelessness.
- Mental Health Support: Mental Health Services include supplemental services to assist clients with supportive programs and activities that facilitate the provision of direct treatment services and treatment services that are non-claimable to Short-Doyle Medi-Cal.
- Rationale: The Nurse Case Manager, with Mental Health Support staff, will employ a Critical Time Intervention strategy in case management, which has been shown to improve housing outcomes, decrease the length and frequency of hospital stays, and reduce psychiatric symptoms.[4]
- Peer Support: The will hire Outreach staff with lived experience of homelessness.
- Engagement and Assessment: The Engagement and Assessment position will provide intake and access to Coordinated Entry on the street, in shelter, or in other locations.

Rationale: Peer-delivered services (also referred to as consumer-operated services) have been researched and evaluated repeatedly over the past 20 years and are designated by the Center for Mental Health Services (CMHS) as an evidence-based practice.[5] The reasoning is intuitive: it can be reassuring to work with someone who has already been through the system of care the homeless individual is considering entering. This may be even more effective when the Peer has successfully secured employment and housing. The same article points to evidence that including former consumers can also benefit the person with lived experience and the other team members.

Also included are co-located behavioral health and recovery support staff to assist the ME team with assessment and referral for these specific needs.

Coordinated Entry

Coordinated Entry will assess and prioritize all homeless and at-risk beneficiaries for housing

[3] Craig C, Eby D, Whittington J. Care Coordination Model: Better Care at Lower Cost for People with Multiple Health and Social Needs. IHI Innovation Series white paper. Cambridge, Massachusetts: Institute for Healthcare Improvement; 2011. (Available on www.IHI.org)

[4] Effectiveness of Case Management for Homeless Persons: A Systematic Review
Renée de Vet, MSc, Maurice J. A. van Luijtelaar, MSc, Sonja N. Brilleslijper-Kater, PhD, Wouter Vanderplasschen, PhD,Mariëlle D. Beijersbergen, PhD, and Judith R. L. M. Wolf, PhD, 2013

[5] Substance Abuse and Mental Health Services Administration. Consumer-Operated Services: The Evidence. HHS Pub. No. SMA-11-4633, Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services, 2011.

and care coordination. Napa has already secured HUD Continuum of Care funding for part-time positions providing assessment and outreach. However, to make the service available to all homeless and at risk persons, a much more significant investment is required.

Eligibility

Eligibility for Coordinated Entry is based on Medi-Cal eligibility and homeless status. The majority of CE referrals will be from social services and medical care providers, targeting people living on the streets or in shelters, and people at risk of homelessness.

People will continue to work with CE until their housing has been stabilized. This means services will continue while a person is homeless or at risk of homelessness, during housing navigation and placement, and through initial stabilization

Staffing

The WPC proposal includes the following positions:

Homeless Coordinated Entry System Staffing

Coordinated Entry Manager

Shelter CM Care Coordination

Housing Landlord Liaison - PMPM/Housing Support

Housing Navigator

Housing Navigation Resource Administrator

- Coordinated Entry Manager: The CE Manager will provide program management for the CE bundled services.
- Shelter CM Care Coordination: Case Managers in shelter will provide care coordination through on-site services, connecting residents to CE staff and assisting with intake and assessment appointment management and follow-up. They will also help clients establish eligibility and retrieve needed documentation for CE. Care Coordination ratios for shelter participants vary based on program occupancy. An average Coordinator to client ratio will be 1/25.
- Housing Landlord Liaison: This position is responsible for seeking out property owners and operators to secure units for housing placement. The Liaison will maintain a database of available units and eligibility, and will negotiate rent and lease terms for potential tenants.
- Housing Navigator: Two Housing Navigators will assist 30 clients each per month in planning for and obtaining permanent housing. Their primary role will be to work with homeless or marginally housed clients to create and follow through with a Housing Stabilization Plan.

- Housing Navigation Resource Coordination: This position will seek out and track available rental assistance sources and programs, keeping a database of rapid rehousing resources and eligibility, along with other subsidy opportunities.

Rationale: Creating a Coordinated Entry system allows the County to prioritize those most in need of housing. Placing homeless and disabled clients into housing will greatly reduce health costs for this population. A study on integrating housing and health documented strong results, decreasing ED events even in the first year.[6]

Tenancy Care

Tenancy Care will be provided by Care Coordinators assigned to Coordinated Entry Clients who are placed in housing. These services will connect people to healthcare, behavioral healthcare, and other resources needed to stabilize in housing.

In many cases, Care Coordination will continue if other services have not been identified through supportive housing or other providers. If a permanent service provider has been established, care coordination through CE will end. During initial placement and stabilization, we expect acuity to be higher, and staffing will be available at a 1/25 ratio. As more clients are housed, many will have stabilized and will need a lower level of ongoing care. At peak numbers in PY 3-5, we will still maintain a 42/1 client to Care Coordinator ratio, which should be adequate when complemented with outside services for those with the highest needs.

Eligibility

Initial eligibility for Tenancy is based on Medi-Cal eligibility and participation in Coordinated Entry. TC referrals will be from CE intake staff. If a client has been participating in Care Coordination through Engagement, the case will be transferred to TC.

People will continue to work with TC until their housing has been stabilized. This means services will continue as long as needed. We project an average length of services at 12 months, with some clients transitioning to other services, and others no longer needing assistance. For those who do not have other available services and who need ongoing assistance, services will continue.

Staffing

Tenancy Care Manager
2 FTE Care Coordinators

Tenancy Care Manager: The Tenancy Care Manager will provide program management, overseeing TC services.

Care Coordinator/Housing Stabilization: The Care Coordinator position, already described, will work with consumers throughout their involvement with Coordinated Entry, accessing all connected services. They will follow clients into housing, assisting with stabilization, identifying

[6] Integrating Housing & Health Prepared For Home Forward By: CORE The Center for Outcomes Research & Education Providence Health & Services, 2014

sources for needed resources, and working with landlords to create a smooth transition into housing.

Rationale: Communities where health care and housing providers have partnered together have seen dramatic improvements in health, costs, and patient experience, including increased engagement in preventive care, increased management with self-care, higher self-reported health status, and dramatic decreases in individuals' health care costs.[7]

SOAR-model SSI/SSDI Advocacy:

SOAR-trained benefits advocates at the CARE Network of the Queen of the Valley Medical Center will provide advocacy and application assistance for any individual identified through other Whole Person Care services who is eligible for, but not yet connected to, SSI/SSDI income supports. The services will be provided by the CARE Network of Queen of the Valley Hospital, staffed by a part-time Social Worker, with additional support and oversight offered by a Lead Social Worker.

Eligibility: The beneficiaries that will be enrolled in the SOAR Model SSI/SSDI Advocacy will be disabled individuals who are enrolled in Medi-Cal and eligible for, but not enrolled in SSI or SSDI.

Rationale: SSI advocacy is an essential service for homeless people living with disabilities and directly aligned with the larger goals of Whole Person Care. The SOAR Model of SSI Advocacy is a nationally-recognized best practice of SSI advocacy that is designed specifically for homeless people who, because of documentation challenges, fragmented medical histories, and other impairments, are unlikely to submit a successful application without intensive support. This is a relatively short-term (approximately 4 months), but very intensive service that is truly distinct from standard care management, but tremendously beneficial for ongoing housing stability. An individual will receive SSI/SSDI Advocacy Services for a maximum of seven months. The months do not have to be continuous.

Members in PMPM Bundles

This WPC application was built on the assumption that the pilot would serve approximately 18 unique individuals per month for a total of approximately 200 unique individuals per year or 800 unique individuals over the life of the project.

In PY2, Napa will begin staffing in the first quarter, and begin client services in Month 7, resulting in a much higher PMPM cost for year 2. Member months during ramp-up are projected as follows:

[7] Craig C, Eby D, Whittington J. Care Coordination Model: Better Care at Lower Cost for People with Multiple Health and Social Needs. IHI Innovation Series white paper. Cambridge, Massachusetts: Institute for Healthcare Improvement; 2011. (Available on www.IHI.org)

PMPM Member Months

Members PY 2	M 7	M8	M9	M10	M11	M12	Total PY2	Count Type
New ME	18	18	18	18	18	18	**108**	Unique
Continuing ME	0	18	36	54	54	54		
Total Monthly ME	18	36	54	72	72	72	**324**	Member Months
New CE	20	20	20	15	15	15	**105**	Unique
Continuing CE	0	20	40	45	45	45		
Total Monthly CE	20	40	60	60	60	60	**300**	Member Months
New Tenancy Care	0	5	5	5	5	5	**25**	Unique
Continuing TC	0	0	5	10	15	20		
Total Monthly TC	0	5	10	15	20	25	**75**	Member Months
New SSI Adv.	3	3	3	3	2	2	**16**	Unique
Continuing SSI Adv	0	3	6	9	14	13		
Exits				(-1)	(-3)	(-2)		
Total Monthly SSI Adv	3	6	9	11	11	11	**51**	Member Months

Beginning in PY 3 and continuing through PY 5, the average client counts per month are projected as stable for MT, CE, and SSI Advocacy, with 70 per month in Engagement, 60 per month in Coordinated Entry, and 10-12 per month in SSI Advocacy.

Member Months in PY 3-5	Members	Months	Member months
ME Total per month	70	12	**840**
CE Total per month	60	12	**720**

In Tenancy Care, numbers may continue to shift throughout the Pilot Years. We project an average length of services at 12 months, with some clients transitioning to other services, and others no longer needing assistance. Tenants will not, however be limited to 12 months if they are still in need of services. Based on this assumption, the number of continuing clients levels off at 60 in PY 3, month 8. During initial placement and stabilization, we expect acuity to be higher, and staffing will be available at a 1/25 ratio. As more clients are housed, many will have stabilized and will need a lower level of ongoing care. At peak numbers in PY 3-5, we will still maintain a 42/1 client to Care Coordinator ratio, which should be adequate when complemented with outside services for those with the highest needs.

Members PY 3 Months	1	2	3	4	5	6	7	8	9	10	11	12	Total	Count Type
New Tenancy Care	5	5	5	5	5	5	5	5	5	5	5	5	60	Unique
Continuing TC	25	30	35	40	45	50	55	60	65	70	75	80		
Total Monthly TC	30	35	40	45	50	55	60	65	70	75	80	85	690	Member Months

Members PY 4 & 5 Months	1	2	3	4	5	6	7	8	9	10	11	12	Total	Count Type
New Tenancy Care	5	5	5	5	5	5	5	5	5	5	5	5	60	Unique
Continuing TC	80	80	80	80	80	80	80	80	80	80	80	80		
Total Monthly TC	85	85	85	85	85	85	85	85	85	85	85	85	1020	Member Months

Enrollment in the SSI Advocacy Bundle will be limited to a subset of Whole Person Care clients – those who are eligible for but not receiving SSI/SSDI benefits. Participation for each participant will initiate upon meeting with CARE Network staff to receive services, and will terminate after the application submission/review is completed. The enrollment time period is estimated to be 4 months per client. After ramping up in PY -2 Ltd, enrollment is expected to stabilize at 10-12 participants at any point in time, with 2-3 new enrollments per month, and 2-3 disenrollments per month.

Members PY 3 - 5 Months	1	2	3	4	5	6	7	8	9	10	11	12	Total	Count Type
New SSI Adv.	2	3	3	2	3	3	2	3	3	2	2	2	30	Unique
Continuing SSI Adv.	11	10	10	11	11	11	11	11	11	12	12	11		
Exits	-3	-3	-2	-2	-3	-2	-2	-3	-2	-2	-3	-2	-30	
Total SSI Adv.	10	10	11	11	11	11	11	11	12	12	11	11	132	Member Months

Since these are new programs we will be testing our service assumptions in PY2 and will adjust our processes and expectations accordingly. In particular, the overlap between the PMPM bundles is not yet known, though it is expected to be significant in some cases, as all homeless clients assisted by the Engagement staff will be referred into Coordinated Entry for housing navigation assistance. However, these cross-referrals will not result in duplication of services

because the services are distinct and the integrated data systems will base all counts on unduplicated client information.

PMPM Cost Calculation

Item	***Max per unit***	***FTE/Unit***
Engagement Staffing		
Driver - PMPM /Engagement	33,750.00	1
Clinical Supervisor	86,067.00	1
Care Coordinator	60,750.00	1
Nurse Case Manager	71,550.00	1
Peer Support	28,000.00	1
Engagement and Assessment	45,220.00	1
Co-Located Behavioral Health Specialists	95,940.00	0.85
Co-Occurring Disorder Support Services	98,568.00	0.85
Homeless Coordinated Entry System Staffing		
Coordinated Entry Manager	100,000.00	.75
Shelter CM Care Coordination	147,199.00	1.5
Housing Landlord Liaison - PMPM/Housing Support	81,000.00	1
Housing Navigator	162,000.00	2
Housing Navigation Resource Administrator	67,000.00	1
Tenancy Care Coordination Bundle		
TC Manager	100,000.00	.25
Care Coordinator/Housing Stabilization	162,000.00	2
SOAR Model SSI Advocacy Bundle		
Social Worker	69,326.00	0.5
Lead Social Worker	106,600.00	0.12

Targeted Case Management: In order to prevent duplication with TCM services, Napa has reduced its total projected bundle costs by 5% in the PMPM budget calculations for each bundle, during each PY. That calculation is shown at the end of each PMPM bundle calculation and is titled "Reduction for TCM overlap -5%"

Pay for Metric Outcomes Achievement

The proposed Pay for Metric Outcomes consist of two health and two housing metrics. The health outcomes measure decreased use of ED services and decreased hospitalizations, based on services through Engagement, Coordinated Entry, and Tenancy Care. The proposed housing outcomes are for obtaining and maintaining housing after participation in Coordinated Entry. These metrics increase in numbers housed and in time housed in later Pilot Years.

Drawing from the "Health in Housing" study published in 2016, Enterprise Community Partners' research validated community efforts to provide housing with integrated health services as means of reducing ED visits and hospitalization. Adding to a growing evidence base, the study demonstrated higher cost savings than Napa has proposed, however, the PMPM cost for patients was much higher in the year before housing in the Portland study. Their findings:

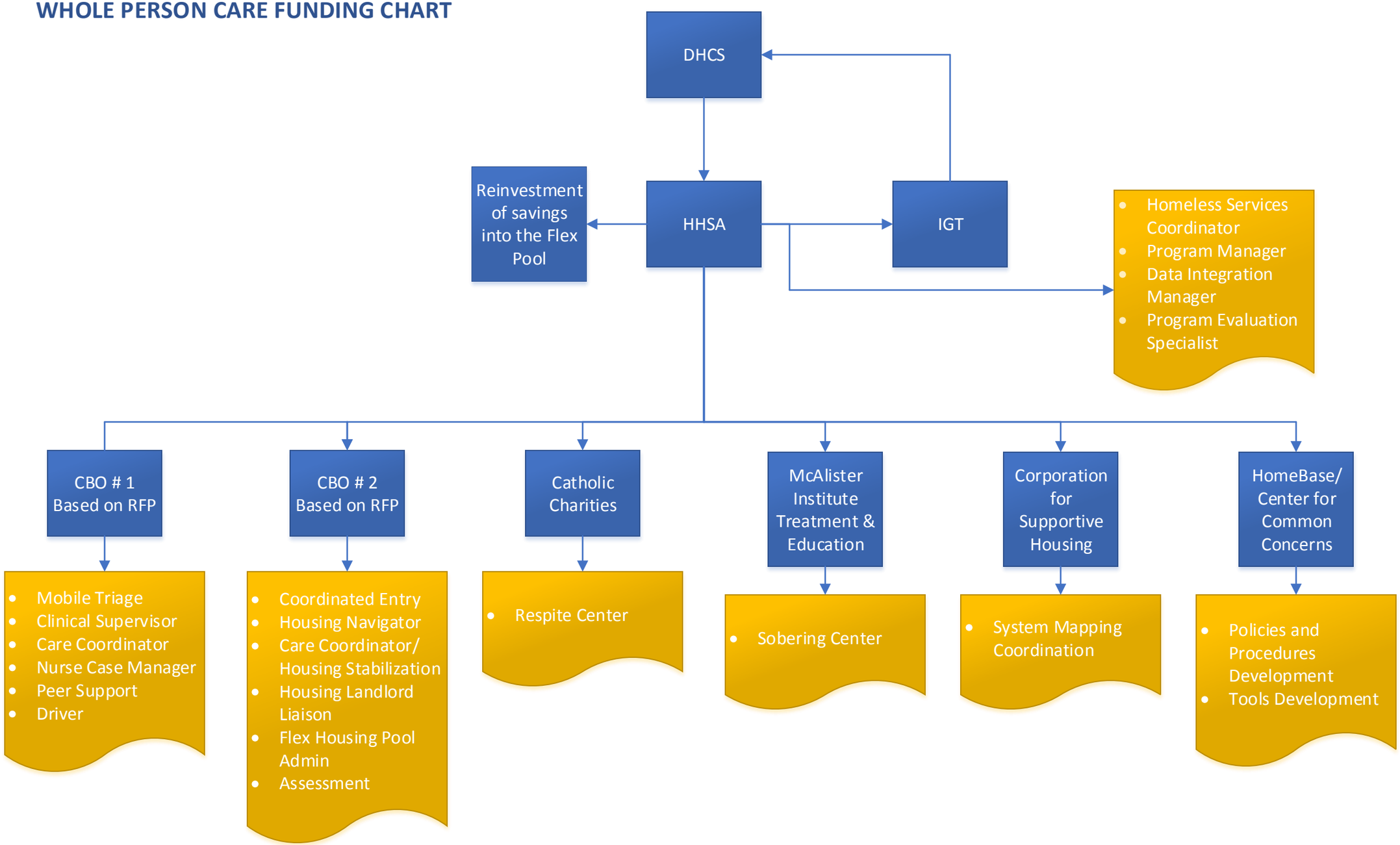
- Expenditures: Total health care expenditures were 12 percent less the year after moving in when compared to the year before, averaging a reduction of nearly $50 per member per month (PMPM).
- Emergency Department Visits: Residents had significantly fewer ED visits (-18 percent) in the year after moving in than in the year before move-in. This difference was evident across all housing types, with the largest change among PSH residents (-37 percent). [8]

Pay for Outcomes
1. Reduce hospital readmissions within 30 days for people assisted in WPC PMPM services.
PY2: Maintain baseline for all clients enrolled in PY2
PY3: Reduce readmissions by 5% from baseline for all clients enrolled in PY2
PY4: Reduce readmissions by 10% from baseline for all clients enrolled in PY2
PY5: Reduce readmissions by 15% from baseline for all clients enrolled in PY2 and PY3

[8] Health In Housing: Exploring The Intersection Between Housing & Health Care A study completed by Center for Outcomes Research and Education (CORE) in partnership with Enterprise Community Partners, Inc., and with generous support from the Meyer Memorial Trust, 2016

Pay for Outcomes
2. Improve self-reported health status among people assisted in PMPM services PY2. Maintain baseline for self-reported health status and quality of life. PY3: Improve self-reported health status by 5% for clients enrolled in PY2 PY4: Improve self-reported health status by 10% for clients enrolled in PY2 PY5: Improve self-reported health status by 15% for clients enrolled in PY2 and PY3
3. Clients with SMI are assessed with reduced suicide risk PY2: Maintain baseline for suicide risk assessment on clients with SMI PY3: Reduce assessed risk by 5% for clients enrolled in PY2 PY4: Reduce assessed risk by 10% for clients enrolled in PY2 PY5: Reduce assessed risk by 15% for clients enrolled in PY2 and PY3
4. People placed in housing through Coordinated Entry maintain housing. PY2: Maintain baseline for homeless clients who are housed PY3: 75% of those placed at least 6 months prior will have maintained housing PY4: 80% of those placed at least 6 months prior will have maintained housing PY5: 85% of those placed at least 6 months prior will have maintained housing

WHOLE PERSON CARE FUNDING CHART



WPC Budget Template: Summary and Top Sheet

WPC Applicant Name:	County of Napa Health and Human Services Agency

	Federal Funds *(Not to exceed 90M)*	**IGT**	**Total Funds**
Annual Budget Amount Requested	**2,302,232**	**2,302,232**	**4,604,464**

PY 1 Budget Allocation (Note PY 1 Allocation is predetermined)	
PY 1 Total Budget	4,537,206
Approved Application (75%)	3,453,348
Submission of Baseline Data (25%)	1,134,302
PY 1 Total Check	

PY 2 Budget Allocation	
PY 2 Total Budget	4,570,835
Administrative Infrastructure	1,480,328
Delivery Infrastructure	1,280,137
Incentive Payments	75,000
FFS Services	1,178,829
PMPM Bundle	461,541
Pay For Reporting	0
Pay for Outomes	95,000
PY 2 Total Check	

PY 3 Budget Allocation	
PY 3 Total Budget	4,604,464
Administrative Infrastructure	1,418,467
Delivery Infrastructure	579,489
Incentive Payments	16,500
FFS Services	1,256,382
PMPM Bundle	1,248,626
Pay For Reporting	0
Pay for Outomes	85,000
PY 3 Total Check	OK

PY 4 Budget Allocation	
PY 4 Total Budget	4,604,464
Administrative Infrastructure	1,420,445
Delivery Infrastructure	510,075
Incentive Payments	11,000
FFS Services	1,256,382
PMPM Bundle	1,311,562
Pay For Reporting	0
Pay for Outomes	95,000
PY 4 Total Check	OK

PY 5 Budget Allocation	
PY 5 Total Budget	4,604,464

Administrative Infrastructure	1,420,365
Delivery Infrastructure	524,316
Incentive Payments	37,000
FFS Services	1,225,962
PMPM Bundle	1,301,821
Pay For Reporting	0
Pay for Outomes	95,000
PY 5 Total Check	OK