Whole Person Care Agreement
Attachment A

Whole Person Care Pilot Application

Submitted by

County of Orange

Health Care Agency

Legacy Application: July 1, 2016

WPC Pilot Expansion Application: March 1, 2017

Section 1: WPC Lead Entity and Participating Entity Information

1.1 Whole Person Care Pilot Lead Entity and Contact Person

Information Requested:	Organizational Information Provided
Organization Name:	County of Orange, Health Care Agency
Type of Entity:	County
Contact Person:	Melissa Tober
Contact Person Title:	Manager, Strategic Projects
Telephone:	(714) 834-5891
Email Address:	mtober@ochca.com
Mailing Address:	Health Care Agency Health Policy, Research & Communications 405 W. 5th Street Santa Ana, CA 92701

1.2 Participating Entities

Required Organization	Organization Name	Contact Name and Title
1. Medi-Cal managed care health plan (MHP)	CalOptima	Michael Schrader, Chief Executive Officer
Entity Description and Role in WPC		
CalOptima is the county organized health system that administers the Medi-Cal health insurance program in Orange County. As the only MHP in Orange County, CalOptima will be responsible for the coordination of all physical health needs of the WPC population as well as the mental health needs for those with mild to moderate mental health symptoms. CalOptima will also be responsible for providing data and reporting metrics to the Lead Agency as required by DHCS, participating on the WPC Collaborative team and on the WPC Steering Committee. **CalOptima will work with its current care management software provider to develop bi-directional sharing capability with the WPC care plan software provider.**		
2. Health Services Agency/Department	County of Orange, Health Care Agency (HCA)	Mark Refowitz, Director
Entity Description and Role in WPC		
HCA is charged with protecting and promoting individual, family and community health through coordination of public and private sector resources. HCA will be responsible for coordinating all efforts required of the County as Lead Entity for the WPC. Also, Behavioral		

Required Organization	Organization Name	Contact Name and Title
Health Services and Public Health Services Programs are part of HCA and will support their activities as specified in this WPC application.		
3. Specialty Mental Health Agency/Department	County of Orange, Health Care Agency, Behavioral Health Services (BHS)	Mary Hale, Deputy Agency Director, Behavioral Health Services
Entity Description and Role in WPC		
Operating under the County's Health Care Agency, BHS is responsible for the coordination of the mental health needs of adults with severe mental illness, children and adolescents who are seriously emotionally disturbed, and substance abuse prevention and treatment for adults, adolescents, and children. BHS is providing a portion of the IGT Match funding primarily through Mental Health Services Act (MHSA) Funding. BHS will be incorporating the WPC concepts and services into its MHSA programs to maximize opportunity and resources for the WPC population and will provide data and reporting metrics related to the seriously mentally ill population. BHS representatives participate in both the WPC Collaborative and on the WPC Steering Committee. BHS and will work closely with the WPC to determine how to best participate in the WPC care plan system given the requirement for the specific consent of the beneficiary		
4. Public Agency/Department (if housing services are proposed, must include the public housing authority)	Orange County Community Resources	Steve Franks, Director
Entity Description and Role in WPC		
Orange County Community Resources (OCCR) includes the Orange County Housing Authority (OCHA), which administers federally funded programs to provide monthly rental assistance to qualified tenants in privately owned rental housing. OCHA is one of four housing authorities in Orange County, covering all of Orange County's cities except three with their own housing authorities: Santa Ana, Garden Grove, and Anaheim. Existing OCHA housing resources such as Housing Choice Vouchers (Homeless Set-Aside), S+C Certificates, VASH and Non-Elderly Disabled Vouchers may be made available to qualified WPC clients. Where required, the referrals will come through Coordinated Entry. OCCR participates on both the WPC Collaborative and on the WPC Steering Committee. They are not direct providers of services, so will not be obtaining or providing information into the WPC Care Plan.		

Required Organization	Organization Name	Contact Name and Title
5. Public Agency/Department	Orange County Community Resources, Homeless Prevention	Julia Bidwell, Interim Director, Housing & Community Development and Homeless Prevention
Entity Description and Role in WPC		
The Homeless Prevention coordinates the preservation and expansion of the County's Continuum of Care (CoC) system for the homeless which focuses on homeless. Homeless Prevention will facilitate connection of resources within the CoC and partner with the Health Care Agency to provide oversight on funds for housing in conjunction with WPC. They are not direct providers of services, so will not be obtaining or providing information into the WPC Care Plan.		
6. Community Partner	2-1-1 Orange County	Karen Williams, President and CEO
Entity Description and Role in WPC		
2-1-1 Orange County (211 OC) is a nonprofit organization that is Orange County's comprehensive information and referral system designed to connect the most vulnerable residents with the health and human services needed. 211 OC maintains the Homeless Management Information System (HMIS) for Orange County and provides the Coordinated Entry system required for all HUD Continuums of Care. Their role in the WPC will be to support the WPC by providing training on what is required for the Coordinated Entry system to the hospitals and clinics and in advising where HUD funded programs may complement those proposed in the WPC Pilot to maximize coordination of services. While they are not direct providers of services, they will be working with the WPC to determine feasibility of linking services the client received shown in the HMIS into WPC Care Plan.		
7. Community Partner	Illumination Foundation	Paul Leon, CEO & President
Entity Description and Role in WPC		
Illumination Foundation is **one** Orange County nonprofit that provides recuperative/respite care to homeless individuals discharged from emergency rooms or inpatient care, yet still needing recovery time. For the WPC, they will be expanding their role to be the resource for hospitals to contact for homeless persons presenting in the emergency room, whether or not there is a medical need, to improve linkage to more appropriate resources and eliminate reliance on emergency rooms for non-medical or non-emergency medical needs. Additionally, Illumination Foundation will be expanding recuperative beds as part of the WPC, including how the beds may be accessed. The County is seeking to expand the number of Recuperative Care providers who will also be responsible for developing the initial WPC care plan.		
8. Community Partners	Safety Net Connect	Keith Matsutsuyu, CEO
Entity Description and Role in WPC		
Safety Net Connect will implement a proposed system called "WPC Connect" which will alert selected participating entities when a patient experiencing homelessness accesses		

Required Organization	Organization Name	Contact Name and Title
emergency room (ER) services and sent notifications to other participating entities in the WPC, primarily Illumination Foundation, for the purpose of linking the beneficiary to services in real time. Safety Net Connect will also be central to the development, sharing and coordination of care plans for participating entities in the WPC.		
9. Community Partners – Community Clinic	Share Our Selves	Karen McGlinn, Chief Executive Officer
Entity Description and Role in WPC		
Share Our Selves (SOS) is a nonprofit Federally Qualified Health Center (FQHC) that also has a Health Care for the Homeless designation. They provide comprehensive safety net services to homeless and low income populations, including food distribution, clothing and emergency financial aid for housing, transportation, and prescriptions. They have implemented a homeless coordinator model connected to the ER of Hoag Hospital. This program will be expanded under the WPC.		
10. Community Partners – Community Clinic	Buena Park Community Clinic	Aiko Tan, Executive Director of Healthcare Services
Entity Description and Role in WPC		
Buena Park Community Clinic is a mobile health care clinic providing primary care services including offering connections to community resources to maximize care coordination for their patients. Under the WPC, they will add a homeless outreach and coordination position specifically to connect beneficiaries to services offered through the WPC, including recuperative care.		
11. Community Partners – Community Clinic	Hurtt Family Health Clinic	Jewel Loff, Chief Executive Officer
Entity Description and Role in WPC		
Hurtt Family Health Clinic provides accessible preventative, primary, and specialized healthcare to homeless and underserved families in Orange County, including mobile primary care at 30 sites. For the WPC, they will be expanding their existing services to add homeless navigators/care coordinators and a driver for a medical transportation van to increase access to care for beneficiaries and link them to additional services such as recuperative care.		
12. Community Partners – Community Clinic	Korean Community Services	Ellen Ahn, Executive Director
Entity Description and Role in WPC		
Korean Community Services is a multi-service agency providing an array of behavioral health, public health and social services to Korean Americans as well as the community at large. Under the WPC, they will provide care navigators specifically targeting homeless beneficiaries and work to link them to additional resources through the WPC participating entities.		
13. Community Partners – Community Clinic	Serve The People	Rocio Nunez-Magdaleno, Executive Director
Entity Description and Role in WPC		
Serve The People is a community clinic meeting the healthcare needs of the low and no-income individuals and families in Orange County. For the WPC, they will expand their staff		

Required Organization	Organization Name	Contact Name and Title
to include care coordinators/navigators to specifically work with homeless beneficiaries to link them to health, behavioral health and other community resources. They are also looking at innovative ways to bring specialty care services to the streets via telemedicine in mobile healthcare vans and will be evaluating technologies and infrastructures to implement this for the WPC beneficiaries.		
14. Community Partners – Community Clinic	Lestonnac Free Clinic	Ed Gerber, Executive Director
Entity Description and Role in WPC		
Lestonnac Free Clinic provides direct patient care to low income persons and has developed the Orange County Community Referral Network to facilitate referrals between community-based clinics, health centers, hospitals, private practitioners, and non-profit providers. For the WPC, they will expand implementation and participation in the Social Services component of this system to increase visibility, access, and utilization of services available to homeless beneficiaries.		
15. Community Partners – Hospital	St. Jude Medical Center	Barry Ross, Vice President, Healthy Communities
Entity Description and Role in WPC		
St. Jude Medical Center is located in Fullerton and has piloted an emergency room care navigator position to specifically work with homeless individuals accessing the hospital's emergency room for medical care and other services to link these individuals to other resources. For the WPC, they will continue these efforts targeting homeless beneficiaries and providing the knowledge learned through their pilot to the WPC Collaborative, including hospitals newly implementing this model under the WPC.		
16. Community Partners – Hospital	St. Joseph Hospital	Glenn Raup, Executive Director, Nursing Services, Emergency Care Center
Entity Description and Role in WPC		
St. Joseph Hospital will follow the model set by its sister St. Jude Medical Center and will hire a homeless coordinator to work in the emergency room to specifically manage the care of WPC beneficiaries to link them to additional resources and care, including recuperative care.		
17. Community Partners – Hospital	Hoag Hospital	Marshall Moncreif, Director of Neurobehavioral Health
Entity Description and Role in WPC		
Hoag will follow the model set by its sister St. Jude Medical Center and will hire a homeless coordinator to work in the emergency room to specifically manage the care of WPC beneficiaries and link with the emergency room homeless care coordinator position that has been established at Share Our Selves for Hoag patient.		

Required Organization	Organization Name	Contact Name and Title
18. Community Partners – Hospital	UC Irvine Medical Center	Jon Gilwee, Executive Director, Government Affairs
Entity Description and Role in WPC		
UC Irvine Medical Center will provide a homeless coordinator to work in the emergency room to identify and specifically manage the care, of WPC beneficiaries by linking them to additional resources and care, including recuperative care and other WPC services. The emergency room at UC Irvine Medical Center also envisions participation in the Safety Net Connect/WPC System describe in this application.		
19. Community Partners – Hospital	Saddleback Memorial and Orange Coast Memorial	Peter Mackler, Executive Director, Government Relations and Policy, MemorialCare Health Systems.
Entity Description and Role in WPC		
Both Saddleback Memorial Hospital and Orange Coast Memorial hospital will, for the WPC, add additional resources to link homeless beneficiaries to other resources and care, including recuperative care.		

Additional Organizations	Organization Name	Contact Name and Title
20. Community Partners – Community Clinic	**Families Together**	**Alexander R. Rossel, Chief Executive Officer**
Entity Description and Role in WPC		
Families Together is a community clinic meeting the healthcare needs of the low and no-income individuals and families in Tustin. For the WPC, they will expand their staff to include care coordinators/navigators to specifically work with homeless beneficiaries to link them to health, behavioral health and other community resources.		
21. Community Partners – Community Clinic	**Livingstone Community Development Corporation**	**Kyung I. Park, MD, Chief Executive Officer**
Entity Description and Role in WPC		
Livingstone Community Development Corporation is a community clinic meeting the healthcare needs of the low and no-income individuals and families in Orange County. For the WPC, they will expand their staff to include care coordinators/navigators to specifically work with homeless beneficiaries to link them to health, behavioral health and other community resources.		

Additional Organizations	Organization Name	Contact Name and Title
22. Community Partners – Community Clinic	**North Orange County Regional Foundation**	**Renee Kaminski, RN, Chief Executive Officer**
Entity Description and Role in WPC		
North Orange County Regional Foundation is a community clinic meeting the healthcare needs of the low and no-income individuals and families in Fullerton located in the northern part of Orange County. For the WPC, they will expand their staff to include care coordinators/navigators to specifically work with homeless beneficiaries to link them to health, behavioral health and other community resources.		
23. Community Partners – Community Clinic	**Southland Integrated Services, aka Vietnamese Community of Orange County**	**Tricia Nguyen, Executive Director**
Entity Description and Role in WPC		
Southland Integrated Services, aka Vietnamese Community of Orange County is a community clinic meeting the healthcare needs of the low and no-income individuals and families in Orange County. For the WPC, they will expand their staff to include care coordinators/navigators to specifically work with homeless beneficiaries to link them to health, behavioral health and other community resources.		
Entity Description and Role in WPC		
24. Community Partners	**Midnight Mission**	**Mike Arnold, Executive Director**
Entity Description and Role in WPC		
Midnight Mission is a non-profit corporation that provides low barrier shelter and service center in the Santa Ana Civic Center. In support of the WPC Program, Midnight Mission coordinates with existing County programs so that health, legal, case management, and outreach services are provided in the service center. They also provide a daytime drop in center to provide service linkages, in addition to showers, meals, restrooms, and storage for belongings.		
25. Community Partners	**Mercy House**	**Larry Haynes, Executive Director**
Entity Description and Role in WPC		
Mercy House is a non-profit corporation that is has been selected as the operator of Orange County's first year-round emergency shelter program to be located in Anaheim. In addition to shelter beds, the facility will also provide a Multi-Service Center coordinating with existing County programs so that health, legal, case management, and outreach services are provided		

Additional Organizations	Organization Name	Contact Name and Title
in the facility. The facility is anticipated to be fully operational in 2018 and it is expected that a portion of the WPC support services provided by the Midnight Mission will be transitioned to Mercy House.		

1.3 Letters of Participation and Support

In accordance with Attachment A.1 for Letters of Participation, please contact Melissa Tober at (714) 834-5891 or at mtober@ochca.com for copies of the letters.

In accordance with Attachment A.2 for Letters of Participation, from each of the Participating Entities identified in Section 1.2 above that are part of the WPC Expansion Application, please contact Melissa Tober at (714) 834-5891 or at mtober@ochca.com for copies of the letters.
In accordance with Attachment B for Letters of Support from other relevant stakeholders as follows, please contact Melissa Tober at (714) 834-5891 or at mtober@ochca.com for copies of the letters:

- County of Orange Health Care Agency, Public Health Comprehensive Health Assessment Team – Homeless (CHAT-H)
- Coalition of Orange County Community Clinics
- Hospital Association of Southern California
- Mission Hospital
- Kingdom Causes dba City Net

Section 2: WPC Lead Entity and Participating Entity Information

2.1 Geographic Area, Community and Target Population Needs

Orange County is 798 square miles, with 42 miles of coastline and is predominantly urban with a population of just over 3.1 million. Orange County will implement the WPC Pilot throughout Orange County and will target full-scope Medi-Cal beneficiaries who are homeless; and will place an emphasis on Medi-Cal beneficiaries who are seriously mentally ill, including those who may also be homeless or at risk of homelessness.

Priority Population

A walk around the County's Civic Center in downtown Santa Ana instantly reveals the increasing needs related to homelessness in our County. There are encampments that have expanded over just the last year, and these persons have created communities based on shared situations

such as mental illness, veteran status, and substance use. Orange County's Board of Supervisors has made addressing the needs of this population a priority and have recently acquired a site for Orange County's first year-round homeless shelter**.** Mercy House has been selected as the operator of this site which is expected to be fully operational in 2018. In addition to shelter beds, this site will also act as a multi-service center. These multi-service center services have been incorporated into the WPC Pilot to effectively address the health, mental health, and social services needs of this population with the goal of moving them to more permanent housing. Additionally, Midnight Mission was selected as the operator of low barrier shelter bed and drop in center in the downtown Civic Center area. This Center has been dubbed the "Courtyard," and which began operating in October, 2016. As with Mercy House, it is the drop-in center services that have been incorporated into the WPC Pilot with the same goal of more effectively addressing the health, mental health, and social services needs of this population to move them to more permanent housing. Additionally, the Board of Supervisors has created a position and hired an individual whose sole priority is to increase communication and collaboration between the County and community providers serving the homeless population to maximize efficiencies and efforts. This position participates in the WPC Collaborative and chairs the WPC Steering Committee.

Since learning about the WPC Grant opportunity, Orange County, as lead entity, has met twice per week with the identified participating entities, forming a "WPC Collaborative," to discuss how to address the growing concerns about homelessness throughout Orange County. The WPC Collaborative reviewed what was being provided presently and by whom, identified gaps and needs not being currently addressed and/or limited due to grant and funding source restrictions, studied the requirements and goals of the WPC Grant, and evaluated the data available regarding this population. Using this information, the WPC Collaborative then defined the vision and structure for its WPC Pilot detailed in this application.

Mercy House and Midnight Mission have joined the WPC Collaborative as participating entities, specifically as their services pertain to the supportive and linkage services that are directly provided, or coordinated by, these organizations. Shelter beds provided by these organizations will not be funded through the WPC Pilot. The supportive and linkage services provided through the drop-in and multi-service centers fit well into Orange County's WPC Pilot as they all focus on addressing all aspects impacting persons who are experiencing homeless, not just shelter.

Overall Approach

Orange County's WPC Pilot is a multiple access approach to addressing the needs of the homeless population, particularly for those who also have mental illness, through increased connectivity and data sharing with the aim to create a seamless continuum of care and services that minimizes the effort and time required by the individual to more effectively have their

needs met for basic necessities such as, but not limited to, food, shelter, medical care, mental health treatment, substance abuse treatment, and/or assistance in accessing and/or applying for benefits . The access points are:

- Hospital emergency rooms (ERs)
- Community Clinics and other community providers
- On the street
- County's Behavioral Health Services programs.
- Civic Center Courtyard
- Year-round homeless multi-service and drop-in centers.

The WPC Pilot proposes to reduce inappropriate and/or avoidable utilization of hospital ERs and admissions though the immediate and real time connection of the person to resources whether the individual is already in the ER, seeking services through a community clinic or other community provider, at one of the recently opened multi-service and drop-in center programs, or on the street. This population is already challenged daily as to how to meet their basic needs of food, shelter and safety. When additional challenges of mental illness, substance abuse, and/or chronic medical conditions are present, navigating the systems and programs to meet their basic needs is overwhelming.

The WPC Pilot:

1) In the formation of the WPC Collaborative to work on this grant application, there has been improved and increased collaboration among the participating entities. In designing the WPC Pilot, each participant has been open to evaluating current processes and how issues and hurdles can be addressed, whether through the implementation of processes and programs proposed for the WPC or within existing abilities. This is expected to continue as the WPC Collaborative continues to meet to fine-tune the proposed processes and programs in anticipation of WPC Grant funding, and through on-going meetings through the term of the WPC funding period to evaluate how effectively the processes and programs have been implemented and if they are having the desired and/or anticipated results. Additionally, many of the proposed processes and programs in our WPC Pilot will result in an enhanced level of collaboration between entities that have not previously worked together to coordinate and communicate behind the scenes so the person being served receives, to the extent possible, a seamless coordination of their care and services.
2) We believe that the interventions are designed to meet a person in real-time, and where they are, are just part of the learnings that will result from the WPC Pilot and will be implemented and used in future efforts beyond the Waiver period. Additionally, a number of strategies and interventions proposed in the WPC Pilot are expansions on ideas and strategies from other smaller efforts that have been proven to provide the results sought by the WPC Pilot such as reduction in ER utilization and inpatient

admissions. By implementing these strategies on a larger scale through the WPC Pilot, such as real-time notification and care navigators, the applicability to other local efforts beyond the term of the waiver will be clearly evident.

3) The electronic notification system that will be developed and implemented through the Orange County's WPC Pilot will have applicability to a broad array of populations and can benefit a number of initiatives, including, but not limited to: Health Homes, Substance Abuse (Drug Medi-Cal), Care Management of Medi-Cal beneficiaries with chronic conditions, and other frequent utilizers of the ER of persons who are not homeless.
4) With the addition of the providers of the recently opened multi-service and drop-in centers to the WPC Collaborative, the WPC Pilot provides an opportunity to encourage beneficiaries' to link to services at a point when many are focused on basic human needs of shelter and food. The WPC Pilot will support the coordination of health, mental health, and social services being provided at the multi-service and drop-in locations and will provide resources, such as recuperative care beds that are specifically for those that arrive at the shelter in a medically compromised or fragile condition, usually following a recent discharge from a hospital inpatient stay or emergency department visit.

Many of the infrastructure and interventions proposed in the WPC Pilot are expected to result in savings to various areas along the continuum of care. The funds provided for the match through this WPC Pilot, in addition to the savings, are anticipated to allow for the continued funding these interventions for not just the WPC Pilot population, but also for other populations where similar results are desired.

2.2 Communication Plan

During the development of this application, the WPC Collaborative has met a minimum of twice per week, with additional smaller focused meetings convening as necessary. Each participating entity has assigned at least one key participant to the WPC Collaborative, and also has identified adjunct and resource staff, and key approvers as required. Agendas and key information is shared electronically with all WCP Collaborative members. Each key participant is responsible for sharing the information with its decision makers. For actions involving Board of Supervisor or Board of Director approval, the key participant has been responsible for advising the WPC Collaborative of its timeframes and the minimum information required to obtain the approvals.

If funded, an MOU will formalize the role of the WPC Collaborative, outline the roles and expectations of each participating entity, include a resolution process for any possible conflicts,

detail WPC Pilot timelines, and contain the processes required for approval of key activities. The WPC Collaborative will meet on a bi-weekly basis as the innovations for the WPC Pilot are implemented and will review data and outcomes until such time that this can be feasibly done on a monthly basis, as mutually agreed to by the participating entities. Electronic communication of progress and updates to all WPC Collaborative members will continue to occur.

The Health Care Agency is leading the WPC Pilot. Melissa Tober, Strategic Projects Manager from the Health Care Agency is the main point of contact for the WPC Application and will continue in that role for the WPC Pilot. CalOptima has hosted all the meetings for the WPC, including conference call in numbers and webinars as necessary, and has provided additional administrative support to the WPC. They have agreed to continue to provide these functions in support of the WPC Collaborative throughout the WPC Pilot.

To promote integration and minimize silos, all innovations must involve communication or coordination of services between at least two participating entities. The Health Care Agency will take the lead on most contracting activities; however, the proposed contracts and/or solicitations will be reviewed by the WPC Collaborative to ensure the innovations and outcomes are appropriately stated. Each participating entity will concur with what is proposed, as well as conclude if it can collaborate and participate and to what extent. Ultimately, as the lead agency, and the provider of the non-federal match dollars, decision-making authority falls to the Health Care Agency.

Providers and stakeholders will receive written information regarding WPC Collaborative activities through key participants such as the Health Care Agency, CalOptima, Behavioral Health Services, 2-1-1 Orange County, the newly established shelter bed providers, and the County Housing Authority. Additionally, information will be shared with the Hospital Association of Southern California, the Coalition of Orange County Community Clinics, and various community advisory boards to aid in reaching providers, stakeholders and beneficiaries. With homeless beneficiaries, particularly those that are seriously mentally ill, information is most likely to be shared as these beneficiaries are reached through the various innovations put into place.

2.3 Target Population(s)

The Orange County WPC will target two populations:

Homeless Beneficiaries:

Since not all beneficiaries readily self-identify as homeless, the WPC Collaborative provided addresses of community homeless providers who are known to receive mail on behalf of persons who are homeless. Many of these addresses came from the Homeless Management Information System (HMIS) maintained by 211-Orange County; and these were augmented with additional information provided by the Health Care Agency and Illumination Foundation. CalOptima integrated this and included individuals who were using Social Service Agency's office locations and shelter addresses, provided by 2-1-1 Orange County, which aid persons to sign up for Medi-Cal benefits as a mailing address. CalOptima was then able to run a report against its enrollment database to determine the number of Medi-Cal beneficiaries in Orange County who could be considered homeless and the result was 11,488 beneficiaries.

CalOptima then compared a subset of data claims data for services provided in 2015 and determined that of the 11,488 persons identified as homeless (Attachment C):

- 5,918 visited the emergency room
- 1,049 had two or more emergency room visits within a rolling three-month period
- 844 had a substance abuse diagnosis
- 587 had mental health conditions (a diagnosis rate that met CalOptima's "condition" threshold)
- 1,457 had chronic medical conditions (also according to CalOptima's method).

When compared against the average CalOptima Medi-Cal members, beneficiaries who are experiencing homelessness have roughly twice the rate of ER visits and inpatient admissions and a significantly lower dollar rate on pharmacy utilization.

The WPC Pilot will look at data relating to all persons identified as being homeless; however, the innovations and services proposed will focus on those persons who are high utilizers of services, such as emergency rooms and inpatient care. The target population of the WPC Pilot are all individuals who are experiencing homelessness and who access hospital ERs for care (5,918). This target automatically captures the subset of persons who access the ER for care two or more times in a rolling three-month period (1,049). For those persons who are not Medi-Cal beneficiaries, including eligibility for emergency Medi-Cal, the County's Medical Safety Net (MSN) Program will provide coverage for medical care and work to link these persons to services using the infrastructure developed by the WPC, including access to assistance to enroll in Medi-Cal. Other than identification of these persons through infrastructures funded through

the WPC Pilot, no other WPC Pilot services will be provided to non-Medi-Cal beneficiaries. We estimate that fewer than 200 people will require assistance of the MSN Program.

Estimates of Unduplicated Enrollees to be Served:

- Through the participating hospital and community clinic providers, the WPC Pilot estimates it will serve approximately 1,100 unduplicated members in Program Year 2 and approximately 2,220 unduplicated members in Program Years 3 through 5, for a total estimated unduplicated member count of 7,760 members during the term of the WPC Pilot Program. These figures are based on the current experience of St. Jude Hospital and Share Our Selves Community Health Center who currently provide the models on which the WPC Pilot is based. Additionally, these figures also recognize that the volume of persons who are homeless does vary depending on the hospital and clinic location. Therefore, the six hospitals and nine community clinics participating in the WPC Pilot Program will provide services for a total of 2,220 unduplicated clients per Program Year. Program Year 2 is a start-up year, is estimated to provide services to a total of 1,100 unduplicated clients.

- Multi-Service Center and Drop-In Facilities: The day time supportive and linkage to community services, including WPC participating entities, provided at the recently opened Drop-In Center in the Civic Center and the year-round Multi-Service Center scheduled to be opened in 2018 will be included in the WPC Pilot. WPC funded services will only be provided to persons who are confirmed to be Medi-Cal beneficiaries. The Courtyard reports 311 to 481 unduplicated clients that use the shelter services at night. Daytime counts are duplicated since participants must sign in every time they re-enter the site. For the purposes of the WPC, it is estimated that working with the various organizations providing services and linkages, that at least 150 unduplicated Medi-Cal beneficiaries can be identified. Participating entities in the WPC Collaborative will reach out to the Drop-In Center providers and organizations providing services to develop plans to further support their efforts. Through the services already being provided, participants are graduating to housing options. It is anticipated that the addition of WPC Pilot resources can increase this level for WPC enrollees, so 75 new beneficiaries per year are projected. (See Attachment G on how to receive a copy of this data). When the year-round Multi-Service Center opens, operated by Mercy House, it is unclear if the level of services in the Courtyard will remain at the current level so the data will be reported collectively from both sites.

Seriously Mentally Ill (SMI) and SMI Homeless Beneficiaries:

Mental health services for the seriously mentally ill (SMI) are currently carved out from CalOptima's scope of services and are provided by the County's Behavioral Health Services Program. Due to Orange County's interpretation of State and Federal regulations regarding the sharing of protected health information for persons assessed as being SMI, sharing data from Behavioral Health Services with the other participating entities has presented a challenge for the WPC Pilot. As a result, the WPC Collaborative was not able to evaluate which of the beneficiaries identified by CalOptima as homeless are also assessed as SMI and receiving services through the County. CalOptima is only able to identify members who received mental health services through one of their network providers. The data sharing issue is being addressed with WPC Pilot and is discussed below.

However, Behavioral Health Services conducted a survey of 369 homeless persons presently living in the Santa Ana Civic Center Area (Attachment D). Of these participants, 64% were identified as having Medi-Cal benefits and approximately 25% were identified as also being SMI. Homeless Medi-Cal beneficiaries that were also assessed as being SMI is another subset of the target population.

Estimates of Unduplicated Enrollees to be Served:

There are three SMI specific programs proposed through the WPC which are discussed in detail is Section 3.1.

- The WPC Pilot is proposing to augment the current and/or new Full Service Partnership (FSP) programs with resources to network in the community and specifically locate sustainable housing opportunities for the SMI homeless beneficiaries enrolled the FSP, thereby increasing opportunities to further reduce homeless days for this population. This is a new resource to Orange County, so we do not have any figures to base an estimated impact on the number of WPC Pilot members who would benefit from these efforts. However, in consideration that 1) Orange County is a challenging housing market; 2) the number of unduplicated enrollees in each FSP is currently averaging 230 members per year; and 3) these services would be in start-up phase during Program Year 2, it is estimated that up to 76 new housing opportunities can be identified per Program Year, starting in Program Year 3, for a total of 228 unduplicated members benefiting from this program during the WPC Pilot term.
- The WPC Pilot has augmented an existing agreement for peer mentoring services provided by College Community Services include staff and services specifically to help SMI homeless Medi-Cal beneficiaries transition to, adjust to, and sustain their permanent housing placement. As specified above, one of the planned FSPs will specifically target homeless adults and the average FSP serves 230 members per year. Therefore, it is estimated that these positions will be able to provide services for up to 115 unduplicated WPC enrollees in Year 2 and up to 230 unduplicated members per

year starting in Program Year 3, for a total of 805 unduplicated members benefiting from this program during the WPC Pilot term.

- Drop-In Center/Multi-Service Center – Civic Center and surrounding areas: As discussed above, these are new programs funded through the WPC Pilot that will provide day time social support services and linkages to community supportive services for targeted adults and older adults living with a serious mental illness who are within the Santa Ana Civic Center area. Based on the survey conducted by Behavioral Health Services in 2015, it is estimated that approximately 60 members (369 x 25% SMI x 64% Medi-Cal) would be eligible for WPC Pilot services based on that data. However, the population of the Civic Center homeless population has been steadily increasing since that time, until the opening of the Courtyard in October 2016. Given this growth, and accounting for efforts of other groups working in the Civic Center area to aid this population in qualifying for Medi-Cal and other benefits, it is estimated that services targeted to this population will serve 30 unduplicated members in Program Year 2 and 60 unduplicated members per year beginning in Program Year 3 for a total of 210 unduplicated members during the WPC Pilot Term.

Target Population(s)	PY 2	PY 3	PY 4	PY 5	Total
Homeless	1,100	2,370	2,295	2,295	8,060
Hospitals/Clinics	*1,100*	*2,220*	*2,220*	*2,220*	*7,760*
Drop-In/Multi Service	*0*	*150*	*75*	*75*	*300*
SMI Homeless	145	366	366	366	1,243
FSP – Housing Navigator	*0*	*76*	*76*	*76*	*228*
Housing Sustainability	*115*	*230*	*230*	*230*	*805*
Drop-In/Multi-Service	*30*	*60*	*60*	*60*	*210*
Total	1,245	2,736	2,661	2,661	9,303

The total number of members to be served during the term of the WPC Pilot, between both populations, is 9,303.

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

3.1 Services, Interventions, and Care Coordination

Homeless Beneficiary Population:

Orange County's WPC Pilot is a multiple access point approach, with each access level addressing the needs of the homeless population.

First Access Point:

Safety Net Connect:

The first access point in the WPC is via Orange County hospital ERs and this access point will target all homeless beneficiaries. As part of Orange County's Low Income Health Program (LIHP), all hospitals and clinics were connected to a system called "ER Connect." Any time a LIHP enrollee accessed an ER for care, their medical home was notified and reached out to the enrollee to discuss the visit and provide patient education for those visits that could have been avoided with appropriate primary care. Even with increasing enrollment, the LIHP was able to demonstrate a reduction in both ER and inpatient admissions per thousand enrollees each year, over its four-year term.

The WPC Pilot proposes to have the same vendor, Safety Net Connect, contract with the County to re-establish this system in all Orange County emergency rooms, which will be a phased-in process starting with those hospitals that see the highest volume of homeless beneficiaries who access care via the ER at least twice in a three-month rolling period. The system will be enhances for WPC and branded as "WPC Connect." WPC Connect will be used by hospital ERs to notify additional resources to work with these beneficiaries in real-time, rather than the beneficiary simply receiving a referral from the hospital and discharged. The WPC Pilot expects WPC Connect to have a similar experience to the LIHP Program. By meeting the beneficiary where they are and providing immediate real-time help and linkage to more appropriate services, the beneficiary will be more likely to accept the assistance and remain connected with the resources, resulting in less reliance on ERs for non-emergency care and services. WPC Connect is funded through the WPC under Delivery Infrastructure for all Program Years.

Illumination Foundation, and other providers yet to be determined, through a contract with the County to provide recuperative and respite care services, will be responding to the majority of notifications to assess if the person's medical condition meets the requirement for recuperative care or other services and will assist the beneficiary in accessing the appropriate services. Recuperative Care is short-term residential care (90 days or less as medically indicated) for homeless individuals who are recovering from an acute illness or injury and whose condition would be exacerbated by living on the streets, a shelter, or other unsuitable places. General oversight of medical conditions will be provided, e.g., monitoring of vital signs, wound care, medication monitoring, etc. just like they can occur at a patient's home for patients with housing. Other services will include development and monitoring of a comprehensive homeless care support services plan; linkage to health, mental health, and substance use disorder services; benefits establishment, transportation; and coordination of the required paperwork for the Coordinated Entry process to link the beneficiary to permanent housing. A real-time notification will also go to CalOptima which will work with Illumination Foundation and these other providers to connect the beneficiary to their primary care provider. Recuperative and

respite care is funded through the WPC under the Fee-For-Service category for Program Years 2 through 5.

After hours response to ERs may be provided by Illumination Foundation or through a recently awarded HUD grant to 211-Orange County which provides for additional homeless outreach workers. This determination will be made as part of the implementation discussions once the WPC is awarded; additionally, at that time more information should be available regarding the staffing and services being funded through the HUD grant.

Hospital Homeless Outreach and Navigation Services:

To supplement this effort, six hospitals (St. Jude Hospital, St. Joseph Hospital, Hoag Hospital, Saddleback Memorial Hospital, Orange Coast Memorial Hospital, and UCI Medical Center) with a high volume of homeless persons accessing care through their emergency rooms, will contract with the County to hire new or additional homeless navigators to assist in providing more coordinated care to these beneficiaries. St. Jude Hospital piloted a program with one full-time homeless navigator to work with just the homeless beneficiaries that accessed care through their emergency room. Hospital outreach and navigation services are funded under Incentive Payments to hire and train the necessary staff in Program Year 2 and under a PMPM bundle payment for Program Years 3 through 5. Results from the navigator pilot, include:

- 178 persons served over 7-months
- Coordination of clinic visits and assistance in accessing other homeless services and in finding housing
- 86% had linkages to Medi-Cal, Medi-Cal/Medicare, Medicare or VA benefits
- 14% qualified for Emergency Medi-Cal services
- Reduced ER utilization by 22%

- ### Recuperative Care:

Once connected with recuperative care, in addition to on-site health care oversight, support and linkage services, the beneficiary will receive assistance to complete all necessary paperwork for benefits and access to housing through Coordinated Entry system managed by 211-Orange County as well as linkages to other homeless services coordinated by Illumination Foundation and the other recuperative care providers. In addition to referrals from a hospital, the WPC Pilot is proposing that referrals to recuperative care can come from skilled nursing facilities if that level of care is required before the step down to recuperative care. It is preferable that beneficiaries be ambulatory upon admission to recuperative care, where they will continue to receive any on-going medical interventions such as wound care and medication management that, if not provided, could result in exacerbation of the medical condition and cause the beneficiary to return to the emergency room. Orange County is also proposing that referrals may come from community clinics and shelters if, after evaluation by a medical professional, the beneficiary is determined to be in a medically fragile condition that would

result in a further deterioration of health so as to require an emergency room visit if the beneficiary does not receive medical intervention in a stable environment. Oftentimes these beneficiaries arrive at the shelters and community clinics following an emergency room or hospital discharge, but were not offered or refused to go to recuperative care at that time. All admissions to recuperative care will be reviewed by a nursing case manager for medical appropriateness, as well as on-going medical appropriateness 30 and 60 days following admission if the beneficiary remains in recuperative care at those points.

Additionally, we are proposing that the beneficiary can remain in recuperative care and continue to receive less intensive respite care for a total stay of up to 90 days while working with Illumination Foundation for linkage to short-term or permanent supportive housing. Illumination Foundation will also work with 211-Orange County for information about if/where the person has accessed homeless services as noted in the HMIS and reach out to those organizations for continued support as appropriate to the beneficiary. With the current model of only short-term (14-day maximum) access to these persons at any given time, Illumination Foundation has found that it takes an average of three cycles through recuperative care, which translates to at least three avoidable ER visits, for a beneficiary to complete the necessary paperwork for access to other benefits, including access to short term or permanent supportive housing. Allowing the beneficiary respite services will reduce the ER cycles and more quickly qualify them and connect them to other benefits. 211-Orange County will be training all WPC Participating entities on how to prepare a beneficiary for the Coordinated Entry System and is funded under Incentive Payments to complete these trainings in Program Years 2 through 5.

Second Access Point:

The next access level will be the ability of community clinics and other community providers, including existing outreach staff meeting beneficiaries on the street where they live, to refer patients directly to recuperative care and/or respite services rather than direct the person to an ER for the referral. Nine community clinics (Share Our Selves, Korean Community Service, Serve The People, Buena Park Community Clinic, Hurtt Family Clinic, Families Together, Livingstone, Southland Integrated Services aka Vietnamese Community Clinic, and North Orange County Regional Foundation) will contract with the County to receive WPC funds to expand homeless outreach and navigator services and aid in linking these beneficiaries to Illumination Foundation and other homeless community providers as may be indicated through the HMIS. If the beneficiary has a medical need and is having difficulties getting to see their PCP, any outreach worker will be able to call the designated CalOptima representative(s), funded through the WPC, to discuss the medical needs of the person. CalOptima will then coordinate the necessary authorizations and referrals and the outreach worker will ensure the person receives the necessary care that may keep them from having to visit an ER. By providing immediate real-time assistance to beneficiaries that may otherwise become frustrated in trying to access their care and give up, it will help to build trust with this population and will aid in connecting them

to resources for a longer term. Clinic outreach and navigation services are funded under Incentive Payments to hire and train the necessary staff in Program Year 2 and is funded under a PMPM bundle payment for Program Years 3 through 5.

In addition to linkage to medical care, Lestonnac Free Clinic has developed a Community Referral Network to facilitate access by hospitals, community clinics and Illumination Foundation to help meet the population's social service needs such as clothing assistance, computer training, food assistance, and legal assistance. The WPC Pilot will fund the roll out of this system to interested community clinics first and then to interested hospitals. Lestonnac is funded under Administrative Infrastructure for Program Year 2 and under Delivery Infrastructure for Program Years 3 through 5.

Other than assistance in completing the documentation necessary to provide these beneficiaries access to Coordinated Entry system, there are no WPC funded housing services targeted to the homeless beneficiaries as a whole and no WPC funds that will be used towards any flexible housing pool. Funds to support a housing pool have been identified by a community provider and will likely be separately managed and administered with the County's Community Resources Department, which also includes the County Housing Authority.

Third Access Point

With the addition of the providers of the recently formed Drop-In Center and Multi-Service Center facilities to the WPC Collaborative, the WPC Pilot provides an opportunity encourage beneficiaries to link to services at a point when many are focused on basic human needs of shelter and food. The WPC Pilot will support the coordination of health, mental health, and social services being provided at these locations and will provide resources, such as recuperative care beds that are specifically targeted for those that arrive at the shelter in a medically compromised or fragile condition as a result of being recently discharged from an emergency room. These are likely to be the population that is most engaged by the Outreach and navigation teams and linked to community clinics for needed medical care, and will most benefit from real-time coordinated services to gain trust and willingness to access and use additional supportive services, such as preparing them administratively (paperwork) and emotionally (peer support) to enter into more permanent supportive housing. These providers are funded through the PMPM bundle for their direct services and funded by meeting pay for Reporting related to health metrics and Pay for Outcomes related to the reduction in emergency room utilization. Orange County will fund these services regardless of whether the outcomes are met.

Plan-Do-Study-Act: By creating the above infrastructure and providing the planned interventions, the WPC Pilot is testing if one-on-one, real-time, coordinated care, as well as

addressing social and non-medical needs, can meaningfully reduce the amount of inappropriate or avoidable ER utilization and inpatient admissions, improve care coordination, and increase readiness for short-term and/or permanent supportive housing. Data collection, monitoring and evaluation will occur, as discussed below under Section 4, throughout the WPC Pilot term at not less than quarterly intervals to effectively evaluate what appears to be successful and what interventions or collaborations need to be re-evaluated.

Seriously Mentally Ill (SMI) and SMI Homeless Beneficiaries:

The final access level is through the County's Behavioral Health Services. All of the above mentioned services are anticipated to also touch or include SMI Homeless beneficiaries; however, they will likely take a different path to other interventions once they are identified as being connected with, or become newly connected with, the County's Behavioral Health Services. This is primarily due to other grant funded resources targeted specifically to this population, including Mental Health Services Act (MHSA) funding that is also identified as the non-federal match funding for this WPC Pilot.

Shared Services with General Homeless Population:

For access via the ERs and using WPC Connect, if the person is also known to have accessed mental health services through the County, then Behavioral Health staff will also be notified in real-time, and will connect with either the hospital or the recuperative care provider to determine if County or County-contracted Behavioral Health staff also need to be sent to see the beneficiary in the ER, or if they can wait and connect with the patient in the recuperative care setting. Behavioral Health Outreach and Engagement staff will follow up with the beneficiary in recuperative care and work with the recuperative care providers on discharge plans for the beneficiary that best meet their behavioral health needs.

Additionally, County and County-contracted Behavioral Health staff providing outreach or engagement services to the SMI Homeless population will have the same access and ability to refer patients directly to recuperative care and/or respite services rather than direct the person to an ER for the referral if there are concurrent medical issues that need to be addressed and/or managed. County Behavioral Health staff will address any mental health needs required by the beneficiary, leaving the recuperative care providers to focus on the medical needs. Training on how to best manage the SMI populations in a recuperative care setting will also be provided by County Behavioral Health staff. All services provided directly by County Behavioral Health in the recuperative care setting or as support to the Hospitals and Community Clinics, are addressed under the SMI Outreach and Engagement Services discussed below.

Similarly, if an SMI Homeless beneficiary has a medical need and is having difficulties getting to see their PCP, an outreach and engagement worker will be able to call the designated CalOptima representative(s), funded through the WPC, to discuss the medical needs of the person. The outreach worker will not be required to identify the person as a beneficiary that is also receiving services through the County Behavioral Health Program. The tracking of this information will be done in aggregate, behind the scenes, as discussed in Section 4 below. CalOptima is funded under Administrative Infrastructure for these specific services in Program Years 2 through 5.

Services Unique to the SMI Population

In addition to the above services, the following services are specifically targeted to the SMI Homeless population with the MHSA and matching dollars through the WPC Pilot. They are provided through Behavioral Health Services either directly or through contracts with community-based providers:

Sustainable Housing Opportunities

Behavioral Health Services already funds three Full Service Partnerships (FSPs), two of which serve adults who live with serious mental illness and who are homeless or at risk of homelessness. FSPs provide intensive community-based outpatient services which include peer support, supportive education/employment services, transportation services, housing, benefit acquisition, counseling and therapy, integration and linkage with primary care, and intensive case management. These are individuals who have not been able to access or benefit from traditional models of treatment. In addition to other success measurements, the persons receiving services in this program demonstrated a 78% reduction in total days homeless compared to the year prior to enrolling in the FSP. Behavioral Health Services plans to release a solicitation for at least one FSP program targeting homeless mentally ill adults. Orange County represents a high cost and competitive housing market which is a challenge for this target population to access. The WPC Pilot is proposing to augment the current and/or new programs with resources to network in the community and specifically locate sustainable housing opportunities for the SMI homeless beneficiaries enrolled the FSP, thereby increasing opportunities to further reduce homeless days for this population. These services are funded by meeting Pay for Outcomes related to decreased psychiatric hospital admissions and mental health emergencies. Orange County will fund these services regardless of whether the outcomes are not met.

Sustaining Housing Placement

A solicitation is planned for a "Housing for Homeless" program to assist the homeless adult population to move into permanent housing. County outreach teams, County and County-contracted programs (clinics, PACT, and FSPs), and the Coordinated Entry System through 211-Orange County will identify qualifying SMI homeless adults, who may also have a co-occurring substance abuse disorder, and link them to a home for up to six months. Services are then designed to move them to permanent housing. The WPC Pilot has augmented these services through a peer-mentoring agreement with College Community Services to include staff and services specifically to help SMI homeless beneficiaries transition to, adjust to, and sustain their permanent housing placement. Identified staff will provide supportive services to the beneficiary and/or to the landlord as needed to aid the beneficiary in remaining in their permanent housing. The WPC is proposing that some of these staff positions may be filled by peers who have had successful transitions to permanent housing. These services are funded by meeting Pay for Reporting related to health metrics and Pay for Outcomes based on the increase in the number of days a beneficiary can remain in independent living or permanent supportive housing. Orange County will fund these services regardless of whether the outcomes are not met.

SMI Outreach and Engagement

Drop-In Center and Multi-Service Center – Civic Center and surrounding areas: This is a new program funded through the WPC Pilot that will provide day time services and linkages to community supportive services for targeted adults and older adults who are within the Santa Ana Civic Center and Anaheim areas and who have behavioral health needs. These are likely to be the population that is most engaged by the Outreach and Navigation teams and linked to recuperative care, community clinics for needed medical care, and will most benefit from real-time coordinated services to gain trust and willingness to access and use additional supportive services. For the person living with SMI, County Behavioral Health Outreach and Engagement staff will augment the services provided by Drop-In and Multi-Service Center providers, focusing on the mental health needs and interventions for the Medi-Cal beneficiary and ensuring that they are linked to other resources that have more experience and documented success in working with those living with SMI. These providers are funded through the PMPM bundle for their direct services and funded by meeting pay for Reporting related to health metrics and Pay for Outcomes related to the reduction in emergency room utilization. Orange County will fund these services regardless of whether the outcomes are met.

Plan-Do-Study-Act: By creating the above infrastructure and providing the planned interventions, the WPC Pilot is testing if one-on-one, real-time, coordinated care, as well as addressing social and non-medical needs, can meaningfully reduce the amount of inappropriate or avoidable ER utilization and inpatient admissions, increase appropriate use of primary care providers and other resources, and increase readiness for permanent supportive housing. Additionally, for the SMI Homeless population, the WPC Pilot is testing if concentrated interventions targeted to finding and sustaining housing increases success in maintaining housing and/or accessing care on a consistent basis. Data collection, monitoring and evaluation will occur, as discussed below under Section 4, throughout the WPC Pilot term at not less than quarterly intervals to effectively evaluate what appears to be successful and what interventions or collaborations need to be re-evaluated.

3.2 Data Sharing

Homeless Beneficiary Population:

WPC Connect

The WPC Pilot will rely on technology to provide remote access to a customized alert and notification system, which also provides for a care plan management and specialty care access solution. This will also serve at the data repository for the continuing development of "best practices" reflective of the community resources and target populations needs. Bi-directional data sharing between participating entities will be based on HL7 ADT messaging. Additionally, Illumination Foundation and other recuperative/respite care providers will be able to access and enter the care management plans through a web-based, HIPAA compliant solution utilizing a multi-tier permission schema. All data provided to Safety Net Connect will be housed at a Tier 1 AT&T data facility in Irvine with remote backup in Chicago, Illinois at a similar level AT&T facility. This data will then be shared back with CalOptima and County Behavioral Health as appropriate.

In order to implement WPC Connect to notify the appropriate participating entities when a homeless beneficiary has accessed care through an ER, "enrollment" data will be provided to Safety Net Connect (SNC) from CalOptima, County Behavioral Health Services, and 211-Orange County (from the HMIS). The data shared will be the minimum necessary to identify matches between systems and accurately identify beneficiaries. This will allow the hospital to know when a Medi-Cal beneficiary is also believed or known to be homeless and, in turn, will appropriately notify CalOptima and Illumination Foundation to coordinate care in real time for these persons, and also to notify Behavioral Health Services if the beneficiary is also SMI and has accessed County services (see more detailed information under the SMI Beneficiary Population below). SNC will enter into agreements that contain the appropriate Business Associate language and will agree on the minimum data set necessary to allow SNC to make WPC Connect function as desired by the WPC Collaborative.

After notification of approval for the WPC Pilot, CalOptima, as the Managed Care Plan, will provide its most current enrollment data for all beneficiaries to Safety Net Connect. Persons who can be identified as homeless as determined in accordance with Section 2.3 above, will have a field in the data information that flags them as being a "WPC eligible member." Pending data use agreements, 211-Orange County may provide data for individuals receiving any homeless services from community providers participating in HMIS for the prior 12-month period, and this data will also include those persons who have been identified has being Medi-Cal beneficiaries. SNC can compare these data sets and advise CalOptima of any person that is identified as homeless via the HMIS, but was not identified as a WPC eligible member based on the criteria used against CalOptima's data. Periodic updates of eligibility data from CalOptima and 211-Orange County would occur on a schedule to be agreed upon by these participating entities. Once the eligibility data is complete, the WPC Connect system programmed, Safety Net Connect with work to implement the system, including data feeds from participating hospitals.

After development of WPC Connect and implementation at the hospital, this infrastructure will be sustainable and expandable to other target populations beyond the life of the pilot. It is anticipated that the cost saving benefits of the system created by more effectively managing care and reducing inappropriate and/or avoidable ER and inpatient care - that will be evident to both providers and payors - will be incentive for these parties, and other interested community partners, to identify funding to continue its use beyond the life of the pilot. WPC Connect is funded under Delivery Infrastructure in all Program Years.

Bi-Directional Functionality

SNC will work with CalOptima and the other participating entities to have access to available CalOptima care plans that may exist for the beneficiary. If a care plan is not on file, then the beneficiary can be connected with their primary care provider and/or CalOptima case managers so one can be developed. This will allow for improved coordination of the beneficiary's health care needs, with their other needs, while they are with a recuperative care provider and/or under the care of BHS or a community clinic.

A current challenge is, with the systems that are current in place, how to allow for care plan information to be updated and/or input by participating entities, or how to best share the non-health care plan back to CalOptima so that their primary care providers can also be aware of the patient's situation and how those needs are being addressed. Over the term of the grant, the WPC Collaborative will continue to evaluate these systems as the other innovations are put into place to ensure appropriate bi-directional sharing of information is available to all participating entities including CalOptima. CalOptima will also engage its software provider for its care plan system to work with SNC on the bi-directional functionality. Funding for the additional programming and resources will be paid to CalOptima and is included under Delivery

Infrastructure in Program Year 2 and ongoing management funding for CalOptima for this aspect is included under Administrative Infrastructure for Program Years 3 through 5.

The estimated timeline for development and implementation of WPC Connect and the ability for participating entities to see the medical care coordination plans is as follows:

Action	Target Completion Date
Execute Data Use Agreements	1/31/2017
Complete security assessments/audits	1/31/2017
Load the Eligibility files	2/28/2017
Test HL7 ADT Interfaces	3/31/2017
Program/Develop the WPC Connect platform	5/31/2017
Connect with outside data sources	6/30/2017
Go Live with Phase 1 Hospital(s)	7/1/2017
Number of phases dependent on hospitals implementing individually vs. across systems	
Go Live with Phase 2 Hospital(s)	10/31/2017
Go Live with Phase 3 Hospital(s)	2/28/2018
Go Live with Phase 4 Hospitals(s)	6/30/2018

Seriously Mentally Ill (SMI) and SMI Homeless Beneficiaries:

Due to Orange County's interpretation of State and Federal regulations regarding the sharing of protected health information for persons receiving mental health services from the County, a collaborative data approach to identify common patients who frequently access urgent and emergency services required a creative approach. Because the goal of WPC Connect is to 1) coordinate services for beneficiaries accessing emergency room services, 2) call in recuperative care services as appropriate and, 3) if required, County Behavioral Health staff is being proposed as a level of specialty services being made available to ER physicians to facilitate the best care for the beneficiary, the County has determined that patient-specific Behavioral Health data may be shared with SNC. This data may only be used for the purposes of allowing notification to Behavioral Health staff that a beneficiary known to them as presented in an ER for services and will also alert CalOptima so that the medical and mental health needs of the beneficiaries can be coordinated and managed appropriately.

Because of the high level of protection surrounding mental health services data, the WPC Pilot will face other challenges in terms of reporting use and outcomes of other services as defined in this WPC Pilot when they are provided to an SMI beneficiary, and in collaborating on care plans for mutual beneficiaries, without the specific consent of the beneficiary to share their mental health information. The WPC Collaborative, with Behavioral Health Services, will work with each participating agency for the services described and determine how best to ensure the any

patient specific data that becomes known to any participating entity through the collaboration of caring for the person, is only reported in aggregate to the WPC Collaborative and is not shared with any other participating entity. Prior to and during the term of the WPC Pilot, County Counsel and the Health Care Agency's Compliance staff will continue to evaluate consent forms and service provision to allow for the appropriate bi-directional sharing of information, particularly as it pertains to coordination of care.

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

4.1 Performance Measures

Overview

The WPC Pilot will provide an improved model of collaboration and data sharing across the various participating entities increased hands-on, real-time provision of care and services to the target populations; improvement of their health outcomes; and demonstration of more effectively utilizing the resources both within and outside CalOptima. Ultimately, the participating entities can readily apply the infrastructure, data sharing, and other interventions to other vulnerable populations that are high users of multiple systems.

The WPC Collaborative will identify, for each type of participating entity, from which system(s) the data for both baseline and future years' will be derived; including if the data is dependent on information from other sources. Timelines for regular submission of data will be developed so information is consistently gathered throughout the WPC Pilot and submitted consistently to the WPC Collaborative. A master checklist will be derived for each quarter noting which information was received or pending. Progress of the WPC Pilot as a whole will be reviewed by the WPC Collaborative based on the data measurements agreed to in comparison to the baseline data. The WPC Collaborative may also identify possible balance measures (the unintended consequences, good or bad, of implementing new innovations).

By Program Year

Year 1 – 2016

<u>*Short Term Process Measures:*</u>

WPC Pilot: Beginning on November 4, 2016, the goal of the WPC Pilot as a whole will be to submit the baseline data required by DHCS and also to consider any other data measurements that will assist in evaluation of the WPC Pilot innovations through the Plan-Do-Study-Act process. Homeless data will primarily be provided by CalOptima, with County Behavioral Health responsible for additional SMI information.

All participating entities: Upon notification of approval of the WPC Pilot Application, formally approve and execute the MOUs regarding the WPC Collaborative, expectations of each participating entity, and commit to a regular meeting schedule.

Ongoing Outcome Measures:
WPC Pilot: Quarterly reporting of the data measurements identified, with CalOptima providing the majority of the beneficiary data.

All participating entities: Provide initial reports, as applicable, related to the WPC Pilot population before implementation of the innovations. This will begin the increased integration and data sharing between and among County's Behavioral Health Services, CalOptima, hospitals, community clinics, and community providers providing services along the continuum of care for the target population such as Illumination Foundation and 2-1-1-Orange County providers.

Annual Target Benchmark:
Baseline data collected for the target populations for both reporting to DHCS and to use as part of the Plan-Do-Study-Act process as part of determining the success of the WPC Pilot innovations.

Year 2 – 2017

Short Term Process Measures:
WPC Pilot: Develop Policies & Procedures to establish the care coordination, communication structure and data sharing requirements for the WPC Pilot.

All participating entities: Execute the start-up phases for each planned innovation including, but not limited to: hiring necessary staff, completing computer programming or re-programming of systems to identify WPC beneficiaries and report information accordingly, exchanging data to test the WPC Connect system and other systems as necessary, conducting solicitations and negotiating the resulting agreements, commencing services and go live with infrastructure developments.

Ongoing Outcome Measures:
Increase and improve integration between and among County's Behavioral Health Services, CalOptima, hospitals, community clinics, and community providers providing services along the continuum of care for the target population.

Drop-In Center, Multi-Service Center, and corresponding community providers: Orange County is proposing to hire or contract for up to two data coordinators to aid in collecting and validating the services provided and beneficiaries receiving those services at the Drop-In Center, Multi-Service Center and various outreach locations. Other than encounter data, there is no patient-specific tracking of services and linkages. It is expected this data can be incorporated into the beneficiaries' care plans and WPC Participating entities can further coordinate with other resources to more effectively meet the needs of these beneficiaries. Funding for these positions is included in the PMPM bundle rate for services provided by the Hospital and Community Clinics as well as the Drop-In and Multi-Service Center providers.

Annual Target Benchmark:
Full implementation of the programs identified in the WPC Pilot with policies and procedures operationalized across participating entities.

Year 3 and 4 – 2018 through 2019

Short Term Process Measures:
WPC Pilot: Collect quarterly data resulting from the implemented innovations and begin analysis against metric and desired outcomes.

All participating entities: Initiate the "Do" phase of the Plan-Do-Study-Act Process by providing the WPC Pilot innovations, give feedback to the WPC Collaborative on any changes/challenges/barriers to implementing the innovations as planned, and provide the initial data resulting from the implemented innovations.

Ongoing Outcome Measures:
Initiate the Study and Act phases of the Plan-Do-Study-Act Process by analyzing the data, summarizing what was learned, review what did not to work, and determine what modifications, if any, are needed.

Annual Target Benchmark:
Meeting the metric targets identified in 4.1.a and 4.1.b below.

Year 5 – 2020

Short Term Process Measures:
WPC Pilot: Work with each participating entity on sustainability plans past the term of the WPC Pilot.

All participating entities: Begin identifying other areas of applicability for the innovations proposed that would allow sustainability of services to the WPC populations.

Ongoing Outcome Measures:
Identify and estimate cost savings, both tangible and intangible, resulting from the innovations put in place for the WPC Pilot.

Annual Target Benchmark:
Innovations implemented for the WPC will continue into 2021, and have been expanded or evaluated for expansion to other programs/populations served by CalOptima.

4.1a Universal Metrics

☒ **Health Outcome Measures**

☒ **Administrative Measures**

Universal Health Metric	PY 1	PY 2	PY 3	PY 4	PY 5
Ambulatory Care-ER Visits (HEDIS)	Reduce ER Visits Baseline Year: (TBD – 2016)	Reduce ER Visits Decrease 10% over Baseline year	Reduce ER Visits Decrease 15% over Baseline year	Reduce ER Visits Decrease 20% over Baseline year	Reduce ER Visits Decrease 25% over Baseline year
Inpatient Utilization – General Hospital/Acute Care (HEDIS)	Reduce IP Utilization Baseline Year: (TBD – 2016)	Reduce IP Utilization Decrease 10% over Baseline year	Reduce IP Utilization Decrease 15% over Baseline year	Reduce IP Utilization Decrease 20% over Baseline year	Reduce IP Utilization Decrease 25% over Baseline year
Follow Up After Hospitalization for Mental Illness (HEDIS)	Baseline Year: (TBD – 2016)	This is not a focus of our WPC Pilot. 0% change over baseline year	This is not a focus of our WPC Pilot. 0% change over baseline year	This is not a focus of our WPC Pilot. 0% change over baseline year	This is not a focus of our WPC Pilot. 0% change over baseline year
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (HEDIS)	Baseline Year: (TBD – 2016)	This is not a focus of our WPC Pilot. 0% change over baseline year	This is not a focus of our WPC Pilot. 0% change over baseline year	This is not a focus of our WPC Pilot. 0% change over baseline year	This is not a focus of our WPC Pilot. 0% change over baseline year
Proportion of participating beneficiaries with a comprehensive care plan, accessible by the entire care team	Baseline Year 0	25% of Persons newly admitted into Recuperative Care will have a comprehensive care plan that will be accessible by the entire care team	25% of Persons newly admitted into Recuperative Care will have a comprehensive care plan that will be accessible by the entire care team	25% of Persons newly admitted into Recuperative Care will have a comprehensive care plan that will be accessible by the entire care team	25% of Persons newly admitted into Recuperative Care will have a comprehensive care plan that will be accessible by the entire care team

Universal Health Metric	PY 1	PY 2	PY 3	PY 4	PY 5
Care Coordination, case management, and referral infrastructure	Agree to timelines with DHCS for submission of documentation establishing policies and procedure for the WPC Pilot	Draft documentation establishing policies and procedure for the WPC Pilot; including method to monitor these procedures	Using PDSA, continue to evaluate and determine if any modifications are needed.	Using PDSA, continue to evaluate and determine if any modifications are needed.	Using PDSA, continue to evaluate and determine if any modifications are needed.
Data and information sharing infrastructure	Agree to timelines with DHCS for submission of documentation establishing policies and procedure for the WPC Pilot	Draft documentation establishing policies and procedure for the WPC Pilot; including method to monitor these procedures	Using PDSA, continue to evaluate and determine if any modifications are needed.	Using PDSA, continue to evaluate and determine if any modifications are needed.	Using PDSA, continue to evaluate and determine if any modifications are needed.

4.1.b. Variant Metrics

Orange County's Variant Metrics are specified in the table below. Please note that while we included the required Variant Metric #4 in consideration that our target population includes the SMI population, neither CalOptima or the Behavioral Health Services team collect this data. We have included and alternative for consideration, and can measure the SMI clients separately for this category.

Metric ID	Variant Metric 1	Variant Metric 2	Variant Metric 3	Variant Metric 4	Variant Metric 5
Target Population:	All	All target populations across all program years	All target populations across all program years:	All target populations across all program years, including the SMI Population	SMI Homeless/at-risk for homelessness

Metric ID	Variant Metric 1	Variant Metric 2	Variant Metric 3	Variant Metric 4	Variant Metric 5
Measure Type	Administrative	Health Outcomes: 30 Day All Cause Readmissions	Health Outcomes: HbA1c Poor Control <8%	Health Outcomes: Required for Pilots w/SMI Target	Housing: Housing Supportive Services
Description	Members in recuperative care linked to CalOptima Case Management.	30 Day All Cause Readmissions	Comprehensive diabetes care: HbA1c Poor Control <8%	NQF: 0104 Suicide Risk Assessment	Percent of homeless referred for supportive housing who receive supportive housing
Numerator	Count of members in recuperative care linked to CalOptima Case Management.	Count of 30-day readmission	Within the denominator, who had HbA1c control (<8.0%)	Patients who had suicide risk assessment completed at each visit	Number of participants referred for supportive housing who receive supportive housing
Denominator	Count of all members in recuperative care.	Count of index hospital stay (HIS)	Members 18–75 years of age with diabetes (type 1 and type 2)	All patients aged 18 years and older with a new diagnosis or recurrent episode of Major Depressive Disorder	Number of participants referred for supportive housing
Benchmark**:**	Year 2: Maintain baseline Year measurement: # 30-Day All Cause	Year 2: Maintain baseline Year measurement: # 30-Day All Cause	Year 2: Maintain baseline Year data: Homeless members with	Years 2 – 5: 0% change – this data is not captured by CalOptima or	Year 2: Maintain percent of homeless referred for supportive

Metric ID	Variant Metric 1	Variant Metric 2	Variant Metric 3	Variant Metric 4	Variant Metric 5
	Readmissions for Homeless members Year 3: Decrease of 5% to 10% Year 4: Decrease of 8% to 12% Year 5: Decrease of 10% to 15%	Readmissions for Homeless members Year 3: Decrease of 5% to 8% Year 4: Decrease of 7% to 10% Year 5: Decrease of 8% to 12%	diabetes with HbA1c <8% / Homeless members with diabetes Year 3: Decrease of 5% to 8% Year 4: Decrease of 7% to 10% Year 5: Decrease of 8% to 12%	Behavioral Health Services Year 3: Decrease of 5% to 8% Year 4: Decrease of 7% to 10% Year 5: Decrease of 8% to 12%	housing who receive supportive housing Year 3: Increase of 5% to 8% Year 4: Increase of 7% to 10% Year 5: Increase of 8% to 12%
Reason(s) for choosing the selected metric, including how the findings from the metric will help with understanding the performance of the pilot and its effect on participating individuals:	Real time referral from the ER to Recuperative Care is a key component of the WPC Pilot and this metric and successfully linking a member to CalOptima Case Management demonstrates success in moving these individuals from sporadic care management to constant case management	Providing real-time health and social interventions to beneficiaries accessing the ER for potentially avoidable medical needs, and upon discharge, should improve the beneficiaries' abilities to access or implement preventive care measures and reduce reliance on emergency	Providing real-time health and social interventions to beneficiaries accessing the ER should improve the beneficiaries' abilities to access or implement preventive care measures and become more compliant with medication use, thereby improving the HbA1c control in diabetic	Required metric, however, the data is not currently or planned to be captured	For the SMI Population in particular, our WPC Pilot Program includes providing additional supportive services to the SMI Homeless population to aid them in maintaining their housing placements. Through the WPC Pilot, we anticipate this resulting in this population maintaining their housing placements for

Metric ID	Variant Metric 1	Variant Metric 2	Variant Metric 3	Variant Metric 4	Variant Metric 5
		rooms for initial care and potentially avoidable inpatient admissions.	homeless members.		a longer period of time.
Reasons(s) why this metric was selected instead of other available menu metrics:	WPC Pilot Choice	Our focus area is to provide interventions that will reduce inappropriate ER utilization and increase access to primary care; these interventions should also help reduce avoidable inpatient readmissions.	Our focus area is to provide interventions that will reduce inappropriate ER utilization and increase access to primary care; these interventions should also help increase understanding of diabetes care and access to appropriate medications. Other available metrics were either already selected by this pilot or are not appropriate for our interventions.	Required by WPP Pilot	This metric more closely aligned with the services being proposed in the WPC Pilot than the other options can be more readily measured.

4.1.c. Outcome Metrics

In addition to the Variant Metrics required for the WPC Pilot, Orange County is also proposing the following Outcome Metrics, by target population:

Outcome Metric	PY 1	PY 2	PY 3	PY 4	PY 5
Population: Homeless Beneficiaries					
Administrative Metric:	Number of members in recuperative care linked to CalOptima case management. Baseline Year: 12%	Number of members in recuperative care in Program Year 2 who are linked to CalOptima case management: 15%	Number of members in recuperative care in Program Year 3 who are linked to CalOptima case management: 18%	Number of members in recuperative care in Program Year 4 who are linked to CalOptima case management: 21%	Number of members in recuperative care in Program Year 5 who are linked to CalOptima case management: 24%
Health Outcome Metric	Increase in Primary Care Physician (PCP) Office Visits Baseline Year: (TBD – 2016)	Increase in PCP Office Visits Increase 10% over Baseline year	Increase in PCP Office Visits Increase 15% over Baseline year	Increase in PCP Office Visits Increase 20% over Baseline year	Increase in PCP Office Visits Increase 25% over Baseline year
Depression Remission at Twelve Months or Alternative Metric (NQF 0210)	Alternative health outcome: Increase Appropriate Medication Utilization (compliance with medications to control conditions such as blood pressure or diabetes – resulting in the	Increase Appropriate Medication Utilization Increase 10% over Baseline year	Increase Appropriate Medication Utilization Increase 15% over Baseline year	Increase Appropriate Medication Utilization Increase 20% over Baseline year	Increase Appropriate Medication Utilization Increase 25% over Baseline year

Outcome Metric	PY 1	PY 2	PY 3	PY 4	PY 5
	patient taking meds on a consistent basis, and therefore, an increase in medication utilization) Baseline Year: (TBD – 2016)				
Adult Major Depression Disorder (MDD): Suicide Risk Assessment (NQF 0104) or Alternative Metric	Alternative metric: Number of members in recuperative care completing assessments for coordinated entry process. Baseline Year: (TBD – 2016)	Increase in number of persons in recuperative care completing assessments for coordinated entry process. Increase 10% over Baseline year	Increase in number of persons in recuperative care completing assessments for coordinated entry process. Increase 15% over Baseline year	Increase in number of persons in recuperative care completing assessments for coordinated entry process. Increase 20% over Baseline year	Increase in number of persons in recuperative care completing assessments for coordinated entry process. Increase 25% over Baseline year
Housing-Specific Metric (if applicable)	N/A	N/A	N/A	N/A	N/A
Population: SMI Beneficiaries. Including SMI Homeless Beneficiaries					
Administrative Metric	Percent of referrals from WPC participating entities during the program year that result in a linkage to service from County Behavioral	Percent of referrals from WPC participating entities during the program year that result in a linkage to service from County Behavioral	Percent of referrals from WPC participating entities during the program year that result in a linkage to service from County Behavioral	Percent of referrals from WPC participating entities during the program year that result in a linkage to service from County Behavioral	Percent of referrals from WPC participating entities during the program year that result in a linkage to service from County Behavioral

Outcome Metric	PY 1	PY 2	PY 3	PY 4	PY 5
	Health Programs: Baseline Year: 0%	Health Programs: Baseline Year: 30%	Health Programs: Baseline Year: 30%	Health Programs: Baseline Year: 30%	Health Programs: Baseline Year: 30%
Health Outcome Metric	Number of days psychiatrically hospitalized. Baseline Year: (TBD – 2016)	Number of days psychiatrically hospitalized decrease 25% over baseline year Baseline for 2018 TBD in 2017	Number of days psychiatrically hospitalized decrease 25% over baseline year Baseline for 2019 TBD in 2018	Number of days psychiatrically hospitalized decrease 25% over baseline year Baseline for 2020 TBD in 2019	Number of days psychiatrically hospitalized decrease 25% over baseline year
Depression Remission at Twelve Months or Alternative Metric (NQF 0210)	Alternative health outcome metric: Reduction in depressive symptoms as measured by the Symptom Distress subscale for participants scoring in the clinical range. Baseline Year 0%	Alternative health outcome metric: Reduction in depressive symptoms as measured by the Symptom Distress subscale for participants scoring in the clinical range. Baseline Year 10%	Alternative health outcome metric: Reduction in depressive symptoms as measured by the Symptom Distress subscale for participants scoring in the clinical range. Baseline Year 10%	Alternative health outcome metric: Reduction in depressive symptoms as measured by the Symptom Distress subscale for participants scoring in the clinical range. Baseline Year 10%	Alternative health outcome metric: Reduction in depressive symptoms as measured by the Symptom Distress subscale for participants scoring in the clinical range. Baseline Year 10%
Adult Major Depression Disorder (MDD): Suicide Risk Assessment (NQF 0104) or Alternative Metric	Alternative health outcome metric is the number of times an adult receiving services experienced a	The number of times an adult receiving services experienced a mental health emergency decreased x times or 25%	The number of times an adult receiving services experienced a mental health emergency decreased x times or 25%	The number of times an adult receiving services experienced a mental health emergency decreased x times or 25%	The number of times an adult receiving services experienced a mental health emergency decreased x times or 25%

Outcome Metric	PY 1	PY 2	PY 3	PY 4	PY 5
	mental health emergency Baseline Year TBD 2016	over the baseline year. Baseline for 2018 TBD in 2017	over the baseline year. Baseline for 2019 TBD in 2018	over the baseline year. Baseline for 2020 TBD in 2019	over the baseline year.
Housing-Specific Metric (if applicable)	Number of days homeless: TBD 2016	Number of days homeless decreases 25% over the baseline year Baseline for 2018 TBD in 2017	Number of days homeless decreases 25% over the baseline year Baseline for 2019 TBD in 2018	Number of days homeless decreases 25% over the baseline year Baseline for 2020 TBD in 2019	Number of days homeless decreases 25% over the baseline year
Other Metric (Optional)	Number of days in independent living or permanent supportive housing. Baseline year TBD 2016.	The number of days in independent living or permanent supportive housing increase 25% over the baseline year. Baseline for 2018 TBD in 2017	The number of days in independent living or permanent supportive housing increase 25% over the baseline year. Baseline for 2019 TBD in 2018	The number of days in independent living or permanent supportive housing increase 25% over the baseline year. Baseline for 2020 TBD in 2019.	The number of days in independent living or permanent supportive housing increase 25% over the baseline year.

4.2 Data Analysis, Reporting and Quality Improvement

Approach

Upon approval of the WPC Pilot, the WPC Collaborative will develop Policies & Procedures (P&Ps) to establish the data sharing requirements for the WPC Pilot, and for each specific participating entity, emphasizing the need for bi-directional data exchange with CalOptima wherever possible. These P&Ps will be incorporated by reference into formal agreements and MOUs as appropriate. Data will be collected by all participating entities in the pilot and submitted to the WPC Collaborative through the County Health Care Agency for summary and analysis. This will include aggregated data on shared clients through WPC Connect. The data will be submitted at quarterly intervals in preparation for required reporting on Universal and

Variant Metrics, as well as other data measurements, as determined by the WPC Collaborative, to use as balance measures (the unintended consequences, good or bad, of implementing new innovations) that will also be indicators of success and/or a need to implement a shift in strategy.

Methods for identification of target populations have been defined with the submission of this WPC Pilot Application; however, additional indicators may be identified for further analysis of the data specifically for use during the Plan-Do-Study-Act process. Data sources may include encounter data, authorization/claims data, or pharmacy data from CalOptima's systems, and encounter data from the County's Behavioral Health System and 2-1-1-Orange County. Since the WPC is Medi-Cal beneficiary focused, in order to prevent exclusion of specific member populations, data from CalOptima's Clinical Data Warehouse will be utilized. The Clinical Data Warehouse aggregates data from CalOptima's core business systems and processes, such as member eligibility, provider, encounters, claims, and pharmacy. This data will be matched to the encounter data provided by Behavioral Health Services and 211-Orange County to capture any additional clients not initially identified as a homeless person in CalOptima's systems.

Each participating entity will be required to regularly report performance and outcome measures to the WPC Collaborative. This data will be analyzed by the WPC Collaborative as part of the Plan-Do-Study-Act process for comparison to the change in the HEDIS data for the period being evaluated as well as quantitative measurements identified for the matrices. Other balance measurements may also be reviewed. The WPC Collaborative recognizes the Plan-Do-Study-Act approach for quality improvement as a continual process. In the "Study-Act" part of the process, the results of analyzing the data, summarizing what was learned, and reviewing what did not to work may lead to modifications to the WPC Pilot that put the intervention back in the "Plan-Do" phase. Even if the results were as desired, a review of the unintended consequences and variables not known during the initial "Plan-Do" phase may also prompt enhancements that start the cycle again to see if there can be additional improvements. The WPC Collaborative will include the participating entities in all discussions regarding the outcomes and proposed modifications to get input and buy-in on the review of the data and any changes that need to happen in the P&Ps and implementation to achieve the desired results in improvement in health outcomes.

Regular reporting on the progress and challenges of the WPC Pilot in meeting the outcomes and metrics will be shared quarterly with all WPC Collaborative members. This will include financial analysis from CalOptima and the County regarding cost variances year to year for more intensive (ER visits, inpatient admissions, psychiatric hospital admissions) as compared to the programs funded through the WPC Pilot to further evaluate the Return on Investment (ROI) of the WPC Pilot innovations. All changes in WPC Pilot approaches will be formally documented between all participating entities, as well as solicitations for suggestions for improvements and final decisions on changes to be implemented.

The capabilities to capture the information from the separate participating entities exists and can be merged and summarized by the WPC Collaborative. However, one of the goals of the WPC Pilot is to improve data collection and sharing among the participating entities. With the development and implementation of WPC Connect, which will also incorporate the ability of the participating entities to view CalOptima's health care plans for the beneficiary, a significant piece of the data sharing element will be in place to capture and report on the impact of the WPC Pilot innovations. Additionally, through WPC Connect, there will be a development of a platform for Illumination Foundation to formally capture its data to share with CalOptima and the WPC Collaborative.

Challenges:

The ongoing challenge will be for the WPC Collaborative to expand past the ability for other participating entities to see the CalOptima Care Plan to allow the sharing of other care plans in the system and eventually a "merger" of the data. We believe this is achievable during the term of the WPC, but the initial focus will be to allow the other participating providers to see CalOptima's care plans and incorporate this information as part of the collaborative effort to provide better coordinated care to the beneficiary.

Another challenge will be to effectively, appropriately, and legally, share Behavioral Health Services data with the other participating entities. As mentioned previously in this application, prior to and during the term of the WPC Pilot, County Counsel and the Health Care Agency's Compliance staff will continue to evaluate consent forms and service provision to allow for the appropriate sharing of information, particularly as it pertains to the coordination of care. We will also look at data sharing practices in neighboring counties and anticipate that the learnings provided by other WPC funded applicants may also provide approaches to review and evaluate for implementation in Orange County.

WPC Connect will be operational and implemented with the first phase of Orange County hospitals by July 1, 2017. The platform for sharing CalOptima's care plans and for implementation of a data platform to be used by Illumination Foundation is targeted to be in place by July 1, 2017.

4.3 Participant Entity Monitoring

There will be formal contracting or MOU arrangements between all participating entities, as well as formal acknowledgement and acceptance of all P&Ps related to data collection, reporting, and review, and the implementation of any resulting corrections, modification, or enhancements. These agreements provide the formal mechanism to commit a participating entity to the goals and vision of the WPC Collaborative. For participating entities that enter into contractual relationships with the County in exchange for compensation, they will have, in addition to the quarterly reporting requirements for the WPC Collaborative, monthly progress reporting requirement as to how well they are meeting the terms of their agreement.   The

WPC Lead will be receiving regular reports from contract administration staff that will be shared with the WPC Collaborative.

If a participating entity is not meeting the terms of its arrangement with the County and/or the WPC Collaborative, the WPC Collaborative will make recommendations regarding the need for technical assistance, corrective action or termination of the pilot. Upon the first identification of any issues, the WPC Lead, the assigned Health Care Agency contract administrator, and any interested WPC Collaborative members will meet with the participating entity to identity the particular areas of concern that may be able to be addressed through technical assistance or through re-evaluation in accordance with Plan-Do-Study-Act if the reality of the implementation was not properly aligned with what was planned. However, if the issue persists, a corrective action plan will be formally issued and the participating entity notified that failure to correct the issue may result in termination from the WPC Pilot.

Section 5: Financing

5.1 Financing Structure

Receipt and disbursement of WPC funds will be overseen by the Orange County Auditor-Controller utilizing the County's Chart of Accounts. WPC payments to the Orange County Health Care Agency will be tracked through subsidiary accounts for both intake and disbursement of the funds. Subsidiary accounts will be reviewed and monitored monthly.

All payments from the Health Care Agency to participating entities will be tracked using job coding set up specifically for the WPC grant through the County's general ledger system via transactions in the County Auditor-Controller's CAPS+ ERP system. The current County Auditor-Controller's CAPS+ ERP system is adequate to support WPC fiscal tracking and monitoring. Orange County Health Care Agency will closely monitor and control disbursement of funds based on project budget and contractual agreements based on meeting milestones for those services, as outlined in this application.

The County of Orange will receive the WPC Pilot payments and will distribute payments to participating entities as shown in Attachment E. All participating entities are vested in, and see the value of, their contribution to the performance of the WPC Pilot as a whole. Contracts, MOUs and other formal notices with these participating entities will emphasize that all payment is tied to the ability to meet the performance objectives identified in the WPC Pilot. With the performance of the WPC Pilot related to outcome measures that are indicators of improved beneficiary health, it is ultimately the patient that achieves the best outcome.

5.2 Funding Diagram

Please see Attachment E-1 for WPC Legacy Application

Please see Attachment E-2 for the Second Round WPC Application

5.3 Non-Federal Share

The Orange County Health Care Agency will provide all the non-federal-share using Tobacco Settlement Revenues, Mental Health Services Act Funding and County Funds. No other participating entities are contributing to the non-federal-share.

5. 4 Non-Duplication of Payments and Allowable Use of Federal Financial Participation

All WPC Pilot service funding will only reimburse activities or services that are not otherwise billable to Medi-Cal through CalOptima as the Managed Care Plan, Short-Doyle Medi-Cal via the County's Behavioral Health Program, or Targeted Case Management. CalOptima, Behavioral Health Services, and Public Health Services, as members of the WPC Collaborative, have provided consultation on services that would be considered billable to Medi-Cal as services/activities have been discussed for inclusion in the WPC Pilot. The proposed WPC pilot will fund infrastructure and data sharing through the development of WPC Connect; recuperative care and respite services to persons that are experiencing homelessness; hospital and community clinic based outreach and coordination services; assistance in seeking/developing housing resources; support/resources to beneficiaries and/or landlords to maintain housing placement; and providing information for accessing social needs such as food, clothing, and legal assistance.

The level of care coordination that will be provided by the hospitals, community clinics, and recuperative/respite care programs do meet the requirements specified in Title 42 of the Code of Federal Regulations, Section 440.169(d) for Targeted Case Management which are:

- Comprehensive Assessment and Periodic Reassessment
- Development of a Specific Care Plan
- Referral and Related Activities
- Monitoring and Follow Up Activities

We recognize the purpose of the WPC Pilot is to develop a care plan that can be accessed by all the participating entities; however, Orange County's approach is more focused on care coordination and meeting the immediate needs of the client, and heavily emphasize trust-building, motivational support, disease specific education, and general reinforcement of health concepts. The care plans developed by the WPC Pilot participating entities will be focused on the short-term immediate needs of the client. There is no long term care plan that will be developed until these immediate needs are met. Once a beneficiary gets to the point that a

more traditional, long term care plan can be developed, and the client can commit to following the care plan, including participation in the periodic reassessments, then CalOptima, the County's Public Health Nurses, and County's Behavioral Health Services staff, as appropriate for the beneficiary, will take over the more formal case management. At this point, these services would no longer be covered by the WPC Pilot and would be otherwise billable/covered by Medi-Cal under Targeted Case Management, Short-Doyle Medi-Cal, or CalOptima as the Managed Care Plan.

CalOptima, by definition as the Medi-Cal Managed Care Plan, can only provide plan-covered services to Medi-Cal beneficiaries enrolled in their plan. Persons receiving emergency Medi-Cal (and therefore not in CalOptima's enrollment files) or having other coverage, may be linked to care via the infrastructure put in place by the WPC Pilot through WPC connect. WPC Connect will be used so hospitals and community clinic outreach workers hired specifically to support the WPC will only work with Medi-Cal beneficiaries. Other clients will be provided services through other resources provided by these entities (if the WPC is expanding staff), or will receive information about other resources, but will not receive the care coordination/navigation of services under the WPC Pilot. As exists now, referrals for services may be provided by community providers within their capacity to do so. For medical care required outside of the hospital, and not covered by emergency Medi-Cal, the County's Medical Safety Net Program will provide care coordination of non-Medi-Cal patients and uncovered services of those receiving Emergency Medi-Cal until such time that they can be enrolled in Medi-Cal.

5.5.a Funding Request

Please see Attachment F for the Budget Summary by Program Year.

Orange County is requesting annual budgets of $4,700,000 for a 5-Year total budget of $23,500,000. Orange County is requesting additional funding for additional services proposed to be provided beginning mid-Program Year 2. For Program Year 2, and additional $1,080,980 is being requested, and for Program Years 3 through 5, and additional $2,161,960 per year is being requested, bringing the total additional funding requested to $7,566,860.

Program Year 1:

Submission of the Application	$3,525,000
Submission of Baseline Data	$1,175,000
TOTAL:	$4,700,000

There are no members that will served during this Program Year.

Program Year 2:

Administrative Infrastructure	$ 351,480
Delivery Infrastructure	$3,728,100
Incentive Payments $	$ 100,000
FFS Services	$ 602,509
PMPM Bundle	$ 698,892
Pay for Outcomes	$ 300,000
TOTAL:	$5,780,980

It is anticipated that up to 1,100 unduplicated members will be served by the WPC Pilot Programs during this start-up year. These members were calculated based on the number anticipated to be served by the hospitals and community clinics, as well the newly opened drop-in and multi-service centers. The hospitals and clinics are referral sources, via Safety Net Connect, for recuperative care services. Further, 145 unduplicated members through the WPC Pilot SMI specific programs will receive services in Program Year 2. Please see Section 2.3 for further details.

Program Year 3:

Administrative Infrastructure	$ 202,665
Delivery Infrastructure	$ 969,600
Incentive Payments	$ 180,000
FFS Services	$1,193,105
PMPM Bundle	$3,761,640
Pay for Reporting	$ 206,050
Pay for Outcomes	$ 348,900
TOTAL:	$6,861,960

It is anticipated that up to an additional 2,370 unduplicated members will be served by the WPC Pilot Programs during this start-up year through the drop-in/multi-service centers, hospitals, and community clinics, and up to 366 unduplicated members through the WPC Pilot SMI specific programs. Please see Section 2.3 for further details.

Program Year 4:

Administrative Infrastructure	$ 202,547
Delivery Infrastructure	$ 765,000
Incentive Payments	$ 10,000
FFS Services	$1,567,823
PMPM Bundle	$3,761,640
Pay for Reporting	$ 206,050
Pay for Outcomes	$ 348,900
TOTAL:	$6,861,960

It is anticipated that up to an additional 2,295 unduplicated members will be served by the WPC Pilot Programs during this start-up year through the drop-in/multi-service centers, hospitals and community clinics, and up to 366 unduplicated members through the WPC Pilot SMI specific programs. Please see Section 2.3 for further details.

Program Year 5:

Administrative Infrastructure	$ 202,547
Delivery Infrastructure	$ 765,000
Incentive Payments	$ 10,000
FFS Services	$1,567,823
PMPM Bundle	$3,761,640
Pay for Reporting	$ 206,050
Pay for Outcomes	$ 348,900
TOTAL:	$6,861,960

It is anticipated that up to an additional 2,295 unduplicated members will be served by the WPC Pilot Programs during this start-up year through the drop-in/multi-service centers, hospitals and community clinics, and up to 366 unduplicated members through the WPC Pilot SMI specific programs. Please see Section 2.3 for further details.

5.5.b Funding Request - Detail

Administrative Infrastructure:

Community Referral System (Lestonnac)

Administrative Infrastructure payments are only budgeted for Program Year 2 for Lestonnac to encourage the recruiting and hiring of the key positions to implement the Community Referral System as quickly as possible.

FTE	Salaries and Benefits	Services and Supplies	Mileage, Transportation and Travel	Outreach/ Training	Overhead
	Total				
2	$125,763	$45,467	$3,360	$5,410	$20,000
	Average Cost per FTE				
	$62,881.5	$22,734	$1,680	$2,705	$10,000

There are 4 positions comprising the 2 FTEs to implement the Community Referral System. The staffing to be funded reflects only the work directly attributable to WPC activities and processes:

- Social Services Case Manager, .4 FTE, responsible for validating and processing the in-bound and out-bound referrals entered into the system, contacting and coordinating services with the beneficiary.
- Social Services Project Manager, .7 FTE, This person will be the main point of contact for the Community Referral Network and interacting with WPC Participating Entities, marketing to providers of homeless services regarding participating in or accessing the network, providing system demonstrations, and leading user meetings.
- Social Services Project Coordinator, .4 FTE, assist/support the Social Services Project Manager
- Programmer/System Oversight, .5 FTE, enhance the system, improve/expand reporting functionality, participate in marking and outreach activities, and ensure reporting of activities relating to WPC beneficiaries is completed and submitted to the WPC Collaborative.

CalOptima – Orange County's Managed Care Plan

Additionally, there is administrative funding proposed for Program Years 2 through 5 for CalOptima to reflect the key role and activities of the Managed Care Plan in the WPC Pilot; including, IT coordination and data, participation in the Plan-Do-Study-Act process, and designating/training staff to work with Behavioral Health and Public Health staff and beneficiaries to more easily navigate care as needed.

Lead Entity WPC Administrative Costs

Orange County has dedicated the following additional resources to the direct implementation, monitoring and administrative oversight of the WPC expansion as proposed in this application:

Position	FTE	Salaries	Benefits	Indirect (5%)	Total Cost
Strategic Project Administrator	.50	$42,143	21,214	$3,168	$ 66,525
Strategic Project Administrator	.25	$21,627	$10,887	$1,626	$34,140
TOTAL	.75	$63,768	$32,101	$4,793	$100,665
Estimated Annual Travel					$2,000
Total Annual Admin Budget					$102,665

The Strategic Project Manager is Melissa Tober who has also been identified as the primary contact for the WPC Program. This position is responsible for all administrative aspects of the WPC, including creating the WPC applications and edits for the resulting contracts, all communications with DHCS, implementing administrative metrics, documenting PDSA activities, development of scopes of work for contracts and MOUs resulting from WPC funding, overall monitoring of the WPC budget and reconciliation to funding sources, all communications with WPC Collaborative, County Executive Management, County Board of Supervisors, and other community groups regarding WPC activities. This position liaisons with staff included in the indirect costs including budget analysts, contract administrators, and accounting regarding WPC administrative activities and monitoring.

The activities from the WPC Pilot activities approved in Round 1 are already more than one FTE worth of effort and Ms. Tober has other responsibilities in addition to the WPC Pilot. With the efforts associated with the WPC expansion, additional staff were required to aid in coordination with the additional WPC participating entities and to provide the additional administrative support that they require (contract implementation and monitoring, report gathering and coordination, expenditure monitoring/tracking, etc.).

Two Strategic Project Administrators have been hired/reassigned into a part-time positions dedicated to supporting the Strategic Project Administrator in WPC Pilot expansion administrative activities described above. These positions will only work on the WPC Pilot Program and is what allows the Strategic Project Manager to focus on the WPC Pilot activities from Round 1 and also divert her time to other projects as may be needed.

For Orange County, benefits include retirement contributions, workers' compensation, Medicare, and the following insurance contributions: unemployment, health, salary continuance, dental, life, and accidental death and dismemberment. For new County employees, Orange County has one of the lowest retirement pension plans (1.62% at 67). Additionally, all employees regardless of their retirement plan, must contribute the employee portion of their own retirement, and also contribute a portion to those that are or will be participating at the prior retirement formula of 2.7% at 55 (known as the reverse pick-up). This make recruiting qualified and capable staff to Orange County challenging, so higher benefit packages are needed.

Delivery Infrastructure:

There are three components that are included the category of Delivery Infrastructure that are designed to improve coordination among the participating entities and other community providers currently serving homeless persons.

- Hospital/Community Clinic Outreach and Coordination is only included in Program Year 2

- Costs associated with WPC Connect and the Community Referral Systems are included in Program Year 2 through Program Year 5; however, the specific deliverables are additional/new and not the same as the prior Program Year
- One-time costs for the bi-directional functionality associated with the Managed Care Plan's care management system which is expected to start in Program Year 2 and be completed in Program Year 3.

Hospital and Community Clinic Homeless Outreach and Navigation:

For Program Year 2:

FTE	Salaries and Benefits	Services and Supplies	Mileage Transport and Travel	Training	Overhead	Linkage IT support for Safety Net Connect and Lestonnac referral system	Total
	Total						
20.5	$1,731,275	$253,225	$26,250	$32,500	$252,750	$562,500	$2,858,500
	Average Cost per FTE					Facility Cost	
	$84,452	$12,352	$1,280	$1,585	$12,329	N/A	$139,439

There are a total of 21 positions comprising the 20.5 Care Coordinator/Navigator/Driver FTEs to be hired to provide intensive outreach and coordination to homeless persons presenting in six emergency rooms and in five community clinics. The positions will be hired directly by each participating entity and have the following roles/responsibilities:
Drivers:

- Drive mobile clinic vans and assist in set-up and engagement

Care Coordinators/Navigators:

- Engagement – developing trusting relationships, providing emotional support, assessing needs, defining service goal for immediate needs
- Resource Management - developing and/or expanding resources for beneficiary referrals
- Information – providing information to beneficiaries about other services.

Community Referral System:

Lestonnac Free Clinic has developed an electronic Community Referral Network to facilitate access by hospitals, community clinics, Illumination Foundation, and any other interested community providers to help match the target population's social service needs (i.e., clothing assistance, computer training, as well as mail, food, and legal assistance) with providers of these services who can respond in real time with what is immediately available to fill the needs. The system is already in place with a small number of community clinics, hospitals, and nonprofit service providers. The WPC Pilot will fund the roll out of this system to Illumination Foundation, additional interested community clinics and hospitals, the network of community homeless services providers, as well as adding additional referral sources to the network.

Total cost to the WPC for the Community Care Referral System is $1,000,000, of which $800,000 is for staffing as identified under Administrative Infrastructure above and $50,000 per year for additional marketing and outreach costs are included in Program Years 2 through 5 (total $200,000).

For Program Year 2, Lestonnac, with 2-1-1 Orange County and the WPC Collaborative, will develop the policies relating to participation and use as well as develop an outreach plan to add additional nonprofit providers to the referral network (focusing on those providing services to homeless persons as a first priority). Lestonnac will also develop a plan to add clinics, hospitals and other providers to use the system for referral of beneficiaries, which activities should also begin in Year 2. It is expected that the system will also benefit non-WPC individuals, so costs included in the WPC application and the lead entity WPC Pilot payments to Lestonnac reflect that only a fraction of the system will benefit Medi-Cal beneficiaries (please see proposed staffing under *Administrative Infrastructure*).

For Program Years 3 through 5, Lestonnac will be expected to add at least one new participant per quarter to continue to enhance active linkage of beneficiaries to social support services and WPC Pilot resources.

WPC Connect:

For the WPC Pilot, a proposed system called "WPC Connect" will alert selected participating entities when a beneficiary experiencing homelessness accesses emergency room (ER) services. Safety Net Connect developed a notification system that will be re-tooled and re-programmed for the WPC Pilot. Notifications would primarily go to Illumination Foundation who would go to the ER to connect with the beneficiary and take them into to recuperative care and/or to other homeless services as needed and appropriate. Behavioral Health Services, participating community clinics and various homeless providers through 2-1-1-Orange County, may also be alerted to the presence of the beneficiary in the ER depending on the beneficiary's needs as assessed by the ER and/or Illumination Foundation. The goal is to address the beneficiary's needs in real-time rather than simply providing them with a referral or information and discharging them from the ER. The Safety Net Connect System also sets up the framework that allows the

system to be rolled out to all community clinics, skilled nursing facilities, and other providers interacting with homeless persons that may need assistance in linking them to recuperative care or other services.

The estimated cost to the WPC Pilot for WPC Connect system development is $456,250. Ongoing costs for system maintenance and one-time connection fees to add new participating entities is anticipated to be $1,965,000 for a total of $2,421,250.

For Program Year 2, the primary focus of Safety Net Connect will be to program and test the system, load WPC eligibility data, and connect implement the system in at least two hospitals with notifications to Illumination Foundation. Working with the WPC Collaborative, policies and procedures relating to its use will be develop for Illumination Foundation and the WPC participating entities.

For Program Years 3 through 5, Safety Net Connect will be expected to add at least one participating entity per quarter to the Safety Net Connect System for the WPC Pilot.

CalOptima – Bi-Directional Care Plan:

CalOptima will work with its Care Plan software vendor, Altruista, to develop the ability to share health and social information between the WPC Care Coordination platform and CalOptima's Care Management System as the County's Managed Care Plan. This will allow CalOptima Case Managers and Care Coordinators to have the ability to view WPC member information seamlessly without the need to log into multiple systems to manage their WPC population. These are one-time costs for a projected 6-month project that will start in Program Year 2 and be completed by Program Year 3. CalOptima will amend its current contract with Altruista, its software vendor, to incorporate the work for the WPC. The work effort estimated by Altruista for this project is as follows, based on an hourly rate bid. These costs are separate from those that would be incurred directly by CalOptima. This is a cost in PY2 and PY3 and it is a contracted activity so additional benefits and the indirect costs are not applicable.

Labor	Rate	Duration (Hours)	Cost
Developers (2)	110	1,740	$191,400
Technical Analyst 1	95	870	$82,650
Technical Tester 1	95	870	$82,650
Project Manager	105	500	$52,500
Total		3,980	$409,200

Incentive Payments:

Current experience by Illumination Foundation, as mentioned in Section 3.1, is that it takes an average of three cycles through recuperative care, which translates to at least three avoidable ER visits, for a beneficiary to complete the necessary paperwork for access to other benefits, including access to short term or permanent supportive housing through the Coordinated Entry system. So the component under this pricing structure is the training of the hospital and community clinic care coordination/navigation staff on what is required for a beneficiary to be entered into the Coordinated Entry process.

Coordinated Entry Training: This is one element of the services to be provided by 2-1-1 Orange County in support of the WPC Pilot Program, so only a fraction of the anticipated $566,908 to be paid to this participating entity is included in this payment structure. There are a total of 14 hospital and community clinic providers, plus an anticipated two additional recuperative care providers and it is expected that all of their Care Coordinators will receive training by the end of Program Year 3, with new staff and refresher training being offered in Program Years 4 and 5. The proposed value of each initial training is $20,000 and the proposed value of new staff and/or refresher training is $2,000.

Program Year 2: Five of the providers will be trained in Program Year 2, for a total of $100,000

Program Year 3: Nine of the providers will be trained in Program Year 3, for a total of $180,000.

Program Year 4: Due to staff turnover or any updates in procedures, we anticipate at least five new staff and/or refresher trainings in Program Year 4, for a total of $10,000

Program Year 5: Due to staff turnover or any updates in procedures, we anticipate at least five new staff and/or refresher trainings in Program Year 5, for a total of $10,000

FFS Services:

Recuperative and Respite Care, is a critical component to the WPC to reduce the amount of inappropriate ER and Inpatient utilization, particularly for those that have medical conditions that have not been properly managed.

Recuperative and Respite Care is included in this category for Program Years 2 through 5.

Recuperative & Respite Care: The estimated costs of Recuperative and Respite Care is for Program Years 2 through 5 is $4,931,260 for 27,320 bed days at an average cost of $180.50 per bed day broken down as follows:

$150.00 Average Reimbursement directly to recuperative care providers

$ 7.50 Indirect costs associated with recuperative care (5%/bed day)

$ 23.00 Cost of RN to review medical necessity

$180.50 Average Recuperative Care bed/day

Position	FTE	Salaries & Benefits	Indirect (5%)	Total Cost
Senior Public Health Nurse	.75	$110,112	$5,506	$115,618

Program Years 2 through 5: Recuperative and Respite Care is a critical component of Orange County's WPC Pilot. It is expected that beneficiaries will be in recuperative/respite care for up to 90 days. If the beneficiary is being admitted into recuperative care directly from a hospital contracted with CalOptima, CalOptima will pay for up to 15 days of recuperative care, depending on the medical need. The WPC will pick up payment for recuperative/respite care after CalOptima stops payment up to day 90 of the beneficiary's stay. If the beneficiary is admitted from a non-hospital setting, then the WPC Pilot will be responsible for reimbursement for the entire 90-day stay. The WPC Pilot proposes to provide the following bed days each Program Year:

Program Year 2: 3,338
Program Year 3: 6,610
Program Year 4: 8,686
Program Year 5: 8,686

PMPM Bundle:

WPC Provider Data Coordinator/Quality Assurance

Orange County is proposing to hire or contract for up to two data coordinators to aid in collecting and validating the services provided, and beneficiaries receiving those services, at the various shelter and outreach locations, as well as hospitals and community clinics. Other than encounter data, there is currently no patient-specific tracking of services and linkages. It is expected this data can be incorporated into the beneficiaries' care plans and WPC Participating entities can further coordinate with other resources such as Behavioral Health, the Managed Care Plan, and those staff that may be assisting with housing navigation and housing stability. Orange County estimates salaries for these positions to be approximately $50,000 without benefits or organizational overhead, and has determined $157,500 annually is sufficient to cover these costs for Program Years 3 through 5, with Program Year 2 prorated for 6 months.

These positions will work directly with the WPC participating entities and other community providers being coordinated by the shelter bed providers to deliver supportive and linkage services collecting and validating beneficiary data, entering the information into the beneficiaries' care plans if appropriate, and acting as a liaison with these providers and the WPC Collaborative to determine a more efficient mechanism, including direct access to the WPC Care Plan as appropriate. These positions will not be interacting with beneficiaries directly and are to support the WPC Participating entities engaging in outreach and navigation to accurately submit reports, access the bi-directional care plan, and interface with WPC Connect and the Community Referral Network.

The cost of these positions are included in the PMPM bundles discussed below, with one FTE allocated to the hospital and clinic PMPM calculation and one FTE allocated to the Drop-In and Multi-Service Center PMPM calculation.

Hospital and Community Clinic Outreach and Navigation:

This financing structure encompasses all of the services to be provided by the Care Coordinator/Navigators to be hired by the 15 hospitals and community clinics identified in this WPC Pilot Application.

For Program Year 2, Orange County is expanding the number of providers by four, with a proposed additional 3.5 FTE as follows, plus 50% of the Data Coordinator position discussed above:

TABLE A

Position	FTE	Salaries	Benefits	Indirect (5%)	Total Cost
Care Navigators	3.5	$198,732	$66,244	$13,248	$278,224
Data Coordinator	1.0	$ 50,000	$25,000	3,576	$78,576
Total Staff:	4.5	$248,732	$91,244	$16,824	$356,800
			Supplies/Etc.	Indirect 5%	Total Cost
Supplies/Training/Mileage			$74,862	3,940	$78,802
TOTAL:	4.5	$248,732	$166,106	$20,764	$435,602

Benefits vary by hospital and clinic, but may include, but not be limited to: workers' compensation, Medicare, Social Security taxes, and the following insurance contributions: unemployment, health, salary continuance, dental, life, and accidental death and dismemberment, 401k match.

Each of the hospitals has a different experience in the level of homeless beneficiaries that they currently encounter, and over the course of the WPC Pilot, it is anticipated that volume should drop as homeless persons are more appropriate routed to other resources for non-medical needs in lieu of relying on emergency rooms. Similarly, the community clinics that have agreed to participate in the WPC Pilot range in size and capacity. In surveying each of the providers, and using St. Jude and SOS as extreme examples of what is currently experienced, an average of 200 beneficiaries per provider/per month has been determined to be reasonable, with some providers doing more and some providers potentially seeing fewer. Overall, each care navigator is anticipated to provide service a little under 100 beneficiaries per month. Beneficiaries will receive all or a portion of the following services:

- Engagement – developing trusting relationships, providing emotional support, assessing needs, defining service goal for immediate needs
- Resource Management - developing and/or expanding resources for beneficiary referrals
- Information – providing information to beneficiaries about other services

Beneficiaries are considered WPC "enrollees" if they are enrolled in CalOptima, homeless, do not have a detailed care plan completed through their primary care physician on file with CalOptima, and are not otherwise being seen by a Targeted Care Management provider. Typically, these persons need more interactions to establish trust and rapport to with the navigators before they are willing to consider the assistance being offered. They will continue to be considered WPC "enrollees" for hospitals and clinics until they are admitted or transitioned to another program funded through the WPC, such as the drop-in and multi-service centers, recuperative care, or funded through the County or other resources, such as a County Behavioral Health Program. At the point when the beneficiary is being managed by another organization, they will no longer be counted in the PMPM reporting by the hospital or clinic.

There is no set timeframe or time limit for a beneficiary to receive these services. Some beneficiaries may be able to move on to other programs faster depending on how quickly the care navigators can build rapport and gain their trust.

The total previously budgeted for these services to be provided by hospitals and community clinics is $2,858,500 annually. Per Table below.

TABLE B

Salaries and Benefits	Services and Supplies	Mileage, Transportation and Travel	Training	Overhead	Linkage IT support for Safety Net Connect and Lestonnac referral system	TOTAL
Total						
$1,731,275	$434,100	$126,250	$132,500	$293,750	$140,625	$2,858,500

The positions comprising the Salaries and Benefits are as follows, with all positions being care managers, except for one position at Hurtt, which is a driver. The positions proposed for the expansion are added as follows:

TABLE C

Provider	FTE	Positions	S& EB
Hurtt	3.75	4	$323,750
KCS	1.25	1	$ 98,312.50
Serve The People	1.25	1	$131,250
Buena Park	0.625	1	$ 62,500
SOS	5	5	$297,962.50
St. Jude	1.25	1	$130,000
St. Joe's	1.25	1	$125,000
Hoag	2.5	3	$250,000
UCI	1.25	1	$125,000
Memorial (Orange Coast + Saddleback)	2.25	3	$187,500
SUBTOTAL	20.5	21	$1,731,275
Expansion Proposal:			
Families Together	1.0	1	$ 75,707
Livingstone	1.0	1	$ 75,707
North OC Regional	1.0	1	$ 75,707
Southland Int. Svcs	.5	1	$ 37,854
SUBTOTAL	3.5	4	$ 264,975
TOTAL	24	25	$1,996,250

The total member months is calculated as follows:

TABLE D

		X	Y	= X * Y
Program Year	**WPC Pilot Members/ Month**	**Round 2-expansion Revised Members/Month**	**Months**	**Total Member Months**
Program Year 2	0	592	6	3,552
Program Year 3	2,000	2,220	12	26,640
Program Year 4	2,000	2,220	12	26,640
Program Year 5	2,000	2,220	12	26,640
TOTAL:	6,000	7,252	42	83,472

For Program Year 2, it is anticipated that an additional 592 members per month will receive services as a result of adding four additional community clinic providers. For services beginning July 1, 2017, this would be equal to 3,552 member months (592 * 6 = 3,552).

For Program Years 3 through 5, *all* providers are included in the PMPM calculation and this is 15 * 148 * 12 = 26,640.

The grand total is $10,100,112 for Program Years 2 through 5.

TABLE E:

	From Table B	From Table A	
Program Year	**Initial WPC Pilot**	**Round 2-expansion New Clinics**	**Total**
Program Year 2	$0	$217,800	$ 217,800
Program Year 3	$2,858,500	$435,604	$3,294,104
Program Year 4	$2,858,500	$435,604	$3,294,104
Program Year 5	$2,858,500	$435,604	$3,294,104
TOTAL:	$8,575,500	$1,524,612	$10,100,112

For Program Year 2, the PMPM bundle will capture only the costs associated with the additional four clinics for the expansion request from Table A, prorated for the 6-month period to $217,800.

For Program Years 3 through 5, the PMPM includes the costs of all hospital and clinic providers ($2,858,500 + $435,604 = $3,294,104) as shown in the table above.

The PMPM rate calculation is as follows:

	$10,100,112 Total Costs (from Table E)
Divided by	83,472 total member months (from Table D)
Equals	$121 PMPM

Since the number of member months for Program Year 2 is not proportional to those in Program Years 3 through 5, this calculation translates to the budget document as shown in Table F below. The total in Table G below is the same as that shown in Table F above.

Table F:

	From Table E	Calculated Above	
Program Year	**Member Months**	**PMPM**	**PMPM Budget**
Program Year 2	3,552	$121	$ 429,792
Program Year 3	26,640	$121	$3,223,440
Program Year 4	26,640	$121	$3,223,440
Program Year 5	26,640	$121	$3,223,440
TOTAL:	83,472	$121	$10,100,112

Supportive and Linkage Services – Drop-In and Multi-Service Centers:

The Orange County Board of Supervisors has allocated $1,400,000 in County General Funds to Midnight Mission for providing a 24/7 low barrier shelter and drop-in service center in the Santa Ana Civic Center, known as the Courtyard. Orange County's WPC Pilot does not support the funding of the actual shelter beds.

Services at Mercy House, budgeted at $2,775,000 annually, will be phased in starting April 2017 and are anticipated to be fully operational by the last quarter of 2017. Orange County is not sure of the impact of this facility on those services currently being provided in the Courtyard, so the proposed funding may be shared with the funding calculated for just the Midnight Mission services for all Program Years; however, Mercy House will be incorporated into the WPC Collaborative prior to becoming a participating entity and data will be tracked across both providers.

Of the total $4,175,000 allocated to both Midnight Mission and Mercy House, Orange County is estimating that 50% of the services would be WPC eligible services (not shelter bed, shower and meal services). Of the WPC eligible services, Orange County estimates that approximately 35% will be able to be confirmed as Medi-Cal beneficiaries. As a result, $699,025 of the $4,175,000 worth of services will be incorporated into the WPC Pilot.

The above funding includes coordination of service providers as well as provision of direct services. As a result, approximately 50% of the funding for these services will be from meeting reporting and outcome measures as described below and 50% will be through a PMPM bundle that will be comprised of the following to beneficiaries:

- Program Orientation – developing trusting relationships, providing emotional support, assessing needs, defining service goal for immediate needs
- Resource Management - developing and/or expanding resources for beneficiary referrals
- Information – providing information to beneficiaries about other services.

Beneficiaries are considered WPC "enrollees" if they are enrolled in CalOptima, homeless, are not otherwise being seen by a Targeted Care Management provider, and are relying on the non-WPC services of the Drop-In or Multi-Service Center for their activities of daily living. Services will continue to be provided until the beneficiary is able to transition to a more stable housing placement, at which time they will be connected to other community resources to assist them with any on-going needs. Clients securing services through the Drop-in and Multi-Service Centers are the most challenging to move to more stable housing, so it is difficult to estimate how long they will receive these bundled services; however, they are also likely to be engages in some level of service more frequently than if they were inappropriately trying to obtain assistance through an emergency room. With a ratio of service navigators to clients approximately 35:1, we anticipate that half will be successfully transitioned each year, with an average length of stay of six months. It is Orange County's expectation that by providing one-stop areas and better coordinated services will allow these beneficiaries to be more successful in securing and sustaining housing.

Factoring in that these beneficiaries are more likely to receive multiple services over the course of a month than if they were receiving outreach and linkage services at a hospital or community clinic, Orange County estimates approximately 150 beneficiaries per month will be actively engaged in services for a total of 6,300 member months that will be provided from Program Year 2 through Program Year 5.

The total budgeted for these services to be provided through the PMPM bundle is $1,260,000 for Program Years 2 through 5, which includes the cost of one data coordinator discussed above. The PMPM rate calculation is as follows:

Program Year	Round 2- expansion Drop-In/ Multi-Service Center	Round 2 - expansion Data Coordinator	Total	50% to PMPM bundle payment in budget
Program Year 2	$ 349,513	$ 39,288	$ 388,801	$ 194,400
Program Year 3	$ 699,025	$ 78,576	$ 777,601	$ 388,800
Program Year 4	$ 699,025	$ 78,576	$ 777,601	$ 388,800
Program Year 5	$ 699,025	$ 78,576	$ 777,601	$ 388,800
TOTAL:	$2,446,588	$275,016	$2,721,604	$1,360,800

$1,360,800/42 months = $32,400 per month
$32,400/150 beneficiaries per month = $216 PMPM

SMI Specific Care Coordination:

For the person living with SMI, County Behavioral Health Care Coordination staff will augment the services provided by Hospitals, community clinics, recuperative care, and the Drop-In and Multi-Service Center providers. These staff will focus on the mental health needs and interventions for the Medi-Cal beneficiary, act as a resource for the other WPC Participating Entities in managing the needs of this population, and ensuring that these beneficiaries are linked to appropriate County resources as well as other resources that have more experience and documented success in working with those living with SMI. They will also actively seek out and engage beneficiaries that are living in encampments along the County's various riverbeds.

Funding includes coordination of services and a significant portion to travel to the beneficiary, as well as provision of direct services. As a result, approximately 70% of the funding for these services will be from meeting reporting and outcome measures as described below and 30% will be through a PMPM bundle that will be comprised of the following to beneficiaries:

- Program Orientation - assessing mental health and/or substance abuse status and defining service goals for immediate mental health and/or substance abuse needs
- Resource Management - developing and/or expanding resources for beneficiary referrals specifically geared towards those living with SMI
- Information – providing information to beneficiaries about other services.
- As requested, directly going to emergency rooms, community clinics, recuperative care locations, and drop-in/multi-service centers to directly engage those clients that identified as living with SMI.
- Frequenting other areas where beneficiaries who are homeless and living with SMI are known to be living for outreach and engagement into appropriate programs, including those funded through the WPC Pilot.

Beneficiaries are considered WPC “enrollees” if they are enrolled in CalOptima, homeless, are living with a mental illness, and are not otherwise being seen by a Targeted Care Management provider. The services provided by these staff are mobile and an adjunct to other services that beneficiaries may be receiving from a hospital, community clinic, drop-in/multi-service center, or recuperative care. These staff focus primarily on the mental health needs of the clients, providing expertise that these other providers do not have. The County’s Behavioral Services area has various programs targeted to those that are experiencing homelessness and living with Mental Illness. Services will continue to be provided until the beneficiary is able be successfully linked to one of the County’s Mental Health programs, which can take anywhere from a month to a year. While the beneficiary may still be homeless, the County Behavioral Health Program will actively care managed the client once they are successfully linked and the client will be “dis-enrolled” from this aspect of the WPC Program.

The following staffing and costs have been included in the Whole Person Care Pilot:

Position	**FTE**	**Salaries**	**Benefits**	**Indirect (5%)**	**Total Cost**
Mental Health Specialist	*1*	*$56,077*	*$28,599.25*	*$4,157.75*	*$88,834*
Subtotal MHS:	x4	$224,308	$114,397	$16,631	$355,336
Service Chief	1	$89,980	$45,890	$6,794	$142,664
TOTAL All FTE	5	$314,288	$160,287	$23,425	$498,000

And are translated to the budget documents as follows:

Program Year	**WPC Pilot**	**Round 2-expansion Drop-In/Multi-Service Center**	**Total**	**30% to PMPM bundle payment in budget**
Program Year 2	$ 249,000	$0	$ 249,000	$74,700
Program Year 3	$ 498,000	$0	$ 498,000	$149,400
Program Year 4	$ 498,000	$0	$ 498,000	$149,400
Program Year 5	$ 498,000	$0	$ 498,000	$149,400
TOTAL:	$1,743,000	$0	$1,743,000	$522,900

The County estimates funding through County estimates approximately 60 beneficiaries per month will be actively engaged in services for a total of 2,520 member months that will be provided from Program Year 2 (beginning July 1, 2017) through Program Year 5.

The total budgeted for these services to be provided through the PMPM bundle is $498,000 for Program Years 3 through 5, which includes the cost of one data coordinator discussed above.

The PMPM rate calculation is as follows:

> $522,900/42 months = $12,450 per month
> $12,450/60 = $207.50 PMPM

Reporting and Quality:

Based on the emphasis of the PDSA model throughout the WPC Pilot application, Orange County focused on two reporting elements that are critical to this process and highlighted in Attachment MM of the STCs. With the requested budget modifications in the expansion proposal, the Pay for Reporting and Quality budget is consistently 3% of the total budget for Program Years 3 through 5 and decreases the cumulative percentage from 2.76% to 2.27% of the total requested budget for all Program Years.

Program Year 2: There are no Pay for Reporting measurements in this year as staff are being hired and the administrative infrastructure is being put in place.

Program Year 3: Per Attachment MM, WPC Pilots are to report on all the Universal and Variant metrics (both administrative and health), and at this point, should be able to describe early trends based on the strategies and interventions employed by the WPC Pilot for health metrics. Orange County also proposes to include the Outcome Metrics it has identified above. By Program Year 3, the early impacts of the infrastructure and hired staff should be evident in both the formal an informal review of the program. The budget amount was determined by taking the amount remaining in the total proposed budget after the amount for the other categories were taken into consideration and dividing it between Reporting and Outcomes, weighting dollars more on the Outcomes. This amount of funding highlights the importance of the study aspect of the PDSA and the value of the first indications of the proposed WPC Pilot having the impact anticipated. Therefore, for Program Year 3, the budget is $103,025 for reporting on Administrative metrics and $103,025 for reporting on Health metrics.

Program Year 4: Per Attachment MM, WPC Pilots should be able to describe the direction of the changes in the data, noting: 1) improvement, anticipated or not, 2) interventions that are not having the results as predicted, and 3) unintended consequences of the WPC Pilot, both positive and negative. Based on this information, the WPC Collaborative will need to determine what aspects of the WPC Pilot need to be adapted, if any, to move towards the predicted and/or desired results, or improve on trends noted. This is a critical part of the Plan-Do-Study-Act process; therefore, the budget amount for Program Year 4 is increased to $206,050, which is split equally between the reporting for Administrative and Health metrics.

Program Year 5: Per Attachment MM, WPC Pilots should be able to describe the direction of the changes in the data, noting: 1) improvement, anticipated or not, 2) interventions that are

not having the results as predicted, and 3) unintended consequences of the WPC Pilot, both positive and negative. Based on this information, particularly following any adaptations made following the Program Year 4 PDSA review, the WPC Collaborative will need to determine what other aspects of the WPC Pilot need to be adapted, if any, to move towards the predicted and/or desired results, or improve on trends noted. Also, the WPC Collaborative will need to determine what components of the WPC Collaborative will be sustained or expanded past the WPC Pilot funding. The budget amount is the same as that set for Program Year 4. Therefore, the budget amount for Program Year 5 is $206,050, which is split equally between the reporting for Administrative and Health metrics.

Pay for Outcomes

Consistent with the expanded services, Orange County is proposing corresponding increases in the Pay for Outcomes Budget as described below. However, even with the requested budget modifications in the expansion proposal, the Pay for Outcome budget is consistently slightly over 5% of the total budget for Program Years 2 through 5 and actually decreases the cumulative percentage allocated to Pay for Outcomes from 6.38% to 5.11% of the total requested budget for all Program Years.

Program Year 2: Of the annual budget of $5,780,980, $300,000 is not otherwise captured in the prior budget allocation categories explained above for this Program Year. Program Year 2 is the first year implementing the WPC Pilot, collecting the necessary data from the participating entities, and going out for solicitation for SMI Target programs. Consistent with this focus, two administrative Universal Metrics were identified as critical in the implementation of the WPC Pilot: 1) Drafting policies and procedures relating to care coordination, case management and referral and 2) Drafting policies and procedures relating to data and information sharing infrastructure.

Program Years 3 through 5:

- Program Year 3: $348,900
- Program Year 4: $348,900
- Program Year 5: $348,900

As the WPC Pilot moves out of implementation, and the impacts of the services and interventions start to be realized, key outcome measures were identified and budget amounts allocated based on the total remaining and not otherwise captured in the prior budget allocation categories explained above. The steady value to Outcome Reporting from Program Year 3 to Program Year 5 reflects the commitment to the projected outcomes and reflects a predicted level of experience gained over the term of the WPC Pilot such that these outcome

measures should be met. Payment would be triggered by meeting the objectives specified in the budget.

For example, in Program Year 4, upon demonstrating a reduction in emergency room utilization by 20% as compared to the baseline year, Orange County as the Lead Entity would be reimbursed $87,225.

ATTACHMENT A.**1**

LETTERS OF PARTICIPATION

Legacy Application

For copies of the letters, please contact Melissa Tober at (714) 834-5891 or at mtober@ochca.com

ATTACHMENT A.2

LETTERS OF PARTICIPATION

Expansion Application

For copies of the letters, please contact Melissa Tober at (714) 834-5891 or at mtober@ochca.com

ATTACHMENT B

LETTERS OF SUPPORT

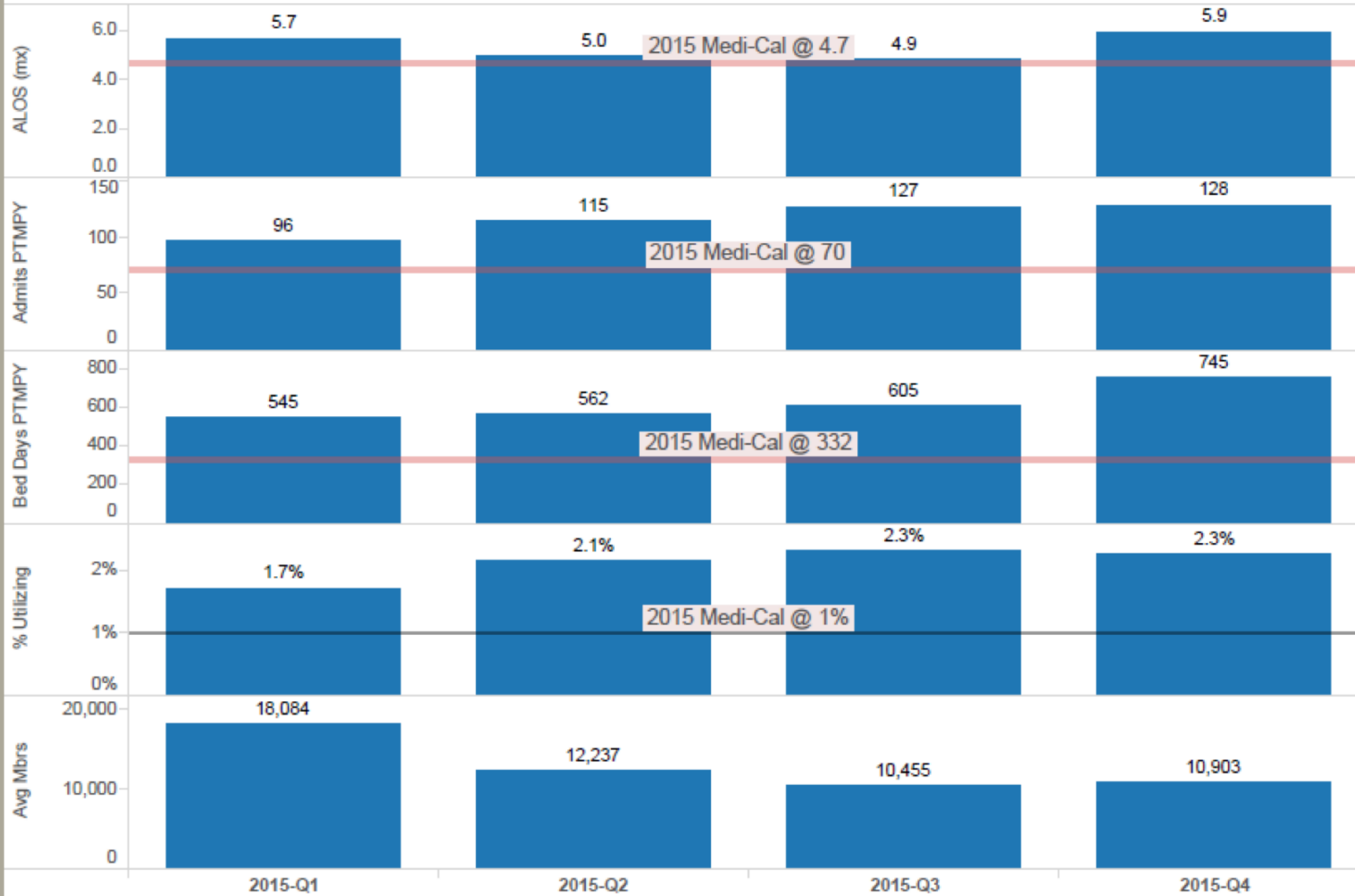
For copies of the letters, please contact Melissa Tober at (714) 834-5891 or at mtober@ochca.com

ATTACHMENT C

CALOPTIMA DATA
2015 HOMELESS POPULATION

Yr-Mo (Begin)
2015-01

Yr-Mo (End)
2015-12



Yr-Mo (Begin)
2015-01

Yr-Mo (End)
2015-12

Cat of Svc L1

- [ ] Hospice
- [x] Inpatient
- [ ] IP Rehab
- [ ] Outpatient
- [ ] Pharmacy
- [ ] Professional
- [ ] Psych (fac)
- [ ] SNF

ATTACHMENT D

2015 ORANGE COUNTY CIVIC CENTER HOMELESS SURVEY

2015 Orange County Civic Center Homeless Survey

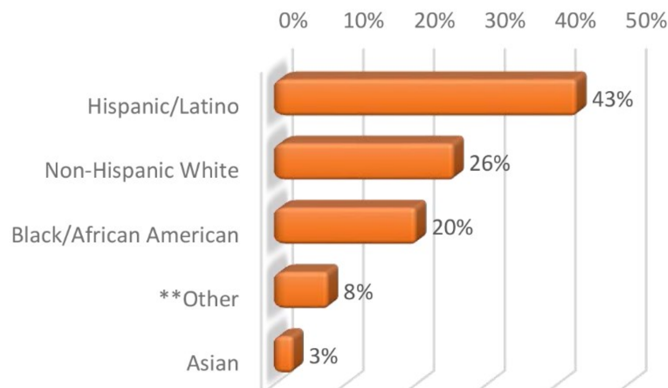
Introduction

The Homeless Survey of the Civic Center area was administered on Monday, August 31, 2015. The Civic Center is comprised of the geographic area featured on the map below. A team of 27 staff and volunteers from Health Care Agency and Illumination Foundation surveyed this area from 8:30am to 8:00pm to get a snapshot of the number of homeless people in the Civic Center area, their demographic breakdown, and the needs of this population. The results of this survey depict a diverse group of individuals who are struggling with a variety of physical and behavioral health issues that have limited their ability to connect to supportive services and housing. A total of 406 Civic Center participants were counted and a total of 369 participants completed a survey.

Map of Civic Center Area

Ethnicity

43% of participants surveyed were Hispanic/Latino, 26% were Non-Hispanic White, 20% were Black/African American, 3% were Asian, and 8% were other race/ethnicity

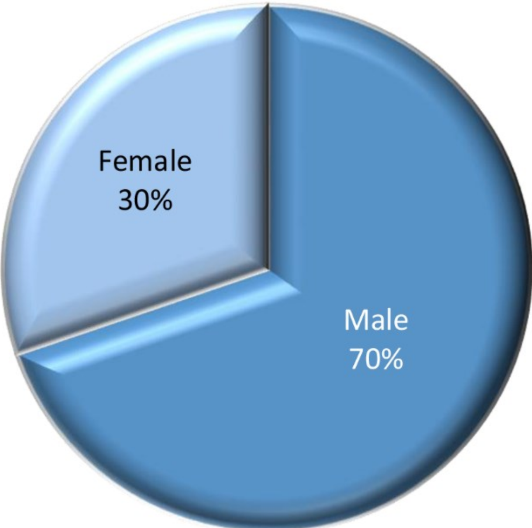


**Other: Native American, Italian, American Indian, Hawaiian, Iran, Pacific Islander, Samoan, multi-ethnicity

Participant Demographics

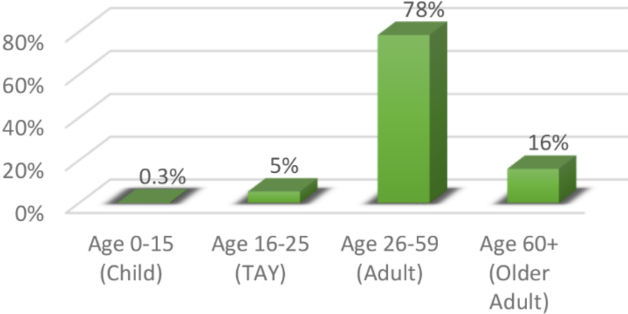
Gender

70% of participants surveyed were male and 30% were female



Age

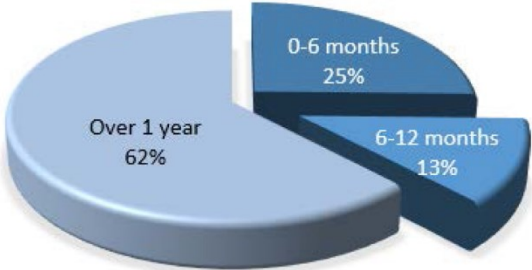
The majority of participants (78%) were adults 26-59 years of age, 16% were older adults 60+ years of age, 5% were transitional age youths 16-25 years of age, and .3% were children 0-15 years of age.



Survey Questions and Responses

How long have you been homeless in the Civic Center?

62% of participants have been homeless in the Civic Center for over one year, 25% from 0 to 6 months, and 13% from 6 to 12 months.



Which of these answers best describes why you are homeless today?

	Total	Percent
Loss of job	191	52%
No affordable housing options	155	42%
Medical or disability challenges	99	27%
Relationship Challenges	99	27%
Mental health challenges	89	24%
Substance abuse related	59	16%
**Other	24	7%

**Other can be summarized within three broader categories:

legal issues, financial issues, and lack of documentation

What prevents you from accessing services you want?

	Total	Percent
Lack transportation to get there	190	54%
Don't know what is available to me	152	43%
Need help with how to access	145	41%
System seems too complicated	120	34%
Tried before and I was not successful	105	30%
Don't have the documentation I need	104	29%
Other services are not a priority right now	44	12%
**Other	39	11%

**Other can be summarized within six broader categories:

legal issues, financial issues, mental illness/substance abuse, housing, lack of employment, and medical issues.

Do you receive any of the following?

	Total	Percent
Medi-Cal	172	64%
Food Stamps/EBT	163	61%
Social Security	75	28%
General Relief	37	14%
CalWORKS	10	4%
Section 8- Rental Assistance	6	2%
**Other	4	1%

**Other: VA Disability and Veteran HUD

Survey Questions

Survey Questions	"No"	"Yes"	Percent of "Yes"
Do you have any physical health issues that interfere with your daily living?	199	166	45%
Do you feel you have a mental health condition?	210	154	42%
Have you ever accessed substance use treatment?	241	107	31%
Have you ever accessed mental health treatment?	235	107	31%
In the past year, has drinking or drug use prevented you from doing things you want to do?	263	104	28%
Do you feel you have a substance use problem?	276	89	24%
Do you have any legal issues that you feel are barriers to accessing services?	289	76	21%
Have you ever served in the Armed Forces?	321	46	13%

What additional resources would you find most helpful?

Most participants surveyed stated that programs that could help them find housing, employment, financial assistance, transportation, health care, legal issues, basic needs (e.g., clothing, laundry), education, and help with child care would be most helpful.

ATTACHMENT E**.1**

FUNDING DIAGRAM

Legacy Application

Attachment E.1 Whole Person Care Funding Flowchart

County of Orange → (Non-Federal Match) → Department of Health Care Services

Department of Health Care Services → (Non-Federal Match + Federal Match) → County of Orange

County of Orange → Health Care Agency

Health Care Agency:

- Safety Net Connect - WPC Connect
- Lestonnac Community Referral System
- Illumination Foundation -Recuperative & Respite Care
- Homeless Outreach & Coordination
  - Hospitals
    - St. Jude Hospital
    - St. Joseph Hospital
    - Hoag Hospital
    - UCI Medical Center
  - Clinics
    - Buena Park Community Clinic
    - Korean Community Services
    - Serve the People
    - Hurtt Family Medical
    - Share Our Selves
- CalOptima Personal Care Coordinator
- 211 OC Coordinated Entry Training
- Behavioral Health SMI Targeted Programs
  - Housing Sustainability
  - Housing Re-sources
  - Drop In Center

Attachment E.1 – Whole Person Care Funding Flow Chart Description

Attachment E.1 graphically depicts the flow of the funds related to the Whole Person Care Pilot for the County of Orange.

The County of Orange will send its Non-Federal Match dollars to the Department of Health Care Services (DHCS). DHCS will then send these funds back to the County, along with the Federal Match dollars.

Within the County of Orange, all WPC dollars will be sent to the Health Care Agency where they will then be distributed to the WPC Participating Entities in accordance with:

- Contracts put into place for each Participating Entity's services in support of the WPC Pilot
- Correctly submitted invoices
- Corresponding data in support of the invoices

The following are the Participating Entities, and their corresponding services, which will be funded through the WPC Pilot:

- Safety Net Connect
    - For development, implementation, and maintenance of the Safety Net Connect notification system for persons who are homeless and accessing services through the Emergency Rooms and also for assistance in development of a shared care plan.
- Lestonnac Free Clinic
    - For development, implementation, and maintenance of the Community Referral System to connect persons who are homeless to providers of identified social service needs.
- Recuperative Care & Respite Services
    - Services designed to aid persons in recovering from medical interventions received in a hospital setting after discharge, such as wound care.
    - Illumination Foundation was one provider identified in Orange County's WPC Pilot Application. Orange County anticipates additional providers will also be part of a master agreement with the Health Care Agency to provide these services.
- Homeless Outreach and Coordination
    - Services designed to aid persons who are homeless to connect with the appropriate level of medical interventions and also to connect with providers of various social services as required by each individual beneficiary.
    - The following hospitals have agreed to hire and/or designate staff to these activities:
        - St. Jude Hospital
        - St. Joseph Hospital
        - Hoag Hospital
        - Orange Coast Memorial
        - Saddleback Memorial

        - UCI Medical Center

    - The following community clinics have agreed to hire and/or designate staff to these activities:
        - Buena Park Community Clinic
        - Korean Community Services
        - Serve the People
        - Hurtt Family Medical Clinic
        - Share Our Selves Community Health Center
- CalOptima
    - As Orange County's only Managed Care Plan, CalOptima will provide the equivalent of a Personal Care Coordinator to aid beneficiaries, the staff provided by the hospitals and clinics, and/or other community outreach staff in navigating the beneficiary's provider network for timely access to services and/or prescriptions.
    - CalOptima will also be provide the majority of the data required by DHCS for the WPC Pilot.
- 211 OC
    - For training all hospitals and community clinics on the Coordinated Entry System and providing any necessary data to aid in the reporting or care plan development process.
- Behavioral Health Seriously Mentally Ill (SMI) Targeted Program
    - These programs are going out to bid, so specific providers cannot be identified at this time.
    - There are three specific programs identified for the SMI Homeless population:
        - Housing Sustainability – services designed to help beneficiaries stay in their permanent housing placement.
        - Housing Resources – services designed to seek out and secure housing opportunities.
        - Drop-In Center – services targeted specifically to beneficiaries in the Santa Ana area to connect them resources for all aspects of living (shelter, food, and social service components).

ATTACHMENT E.2

FUNDING DIAGRAM

Expansion Application

Attachment E-2 Whole Person Care Funding

County of Orange

Non-Federal Match

Department of Health Care Service

Non-Federal Match + Federal Match

County of Orange

Health Care Agency
WPC Implementation & Monitoring Costs

Orange County Community Resources

Midnight Mission

City Net

Mercy House

Safety Net Connect - WPC Connect

Lestonnac Community Referral System

Illumination Foundation - Recuperative & Respite Care

Homeless Outreach & Coordination

CalOptima Personal Care Coordinator **& Integrated Care Plan**

211 OC Coordinated Entry Training

Housing Navigators

Behavioral Health SMI Targeted Programs

Hospitals

St. Jude Hospital
St. Joseph's Hospital
Hoag Hospital
UCI Medical Center

Clinics

Buena Park Community Clinic
Korean Community Services
Serve the People
Hurtt Family Medical
Share Our Selves
Livingstone
Families Together
North OC Regional Foundation
Southland Integrated Services

Housing Sustainability

Housing Resources

Drop-In Center

Attachment E.2 – Whole Person Care Funding Flow Chart Description

Attachment E.2 graphically depicts the flow of the funds related to the Whole Person Care Pilot for the County of Orange.

The County of Orange will send its Non-Federal Match dollars to the Department of Health Care Services (DHCS). DHCS will then send these funds back to the County, along with the Federal Match dollars.

Within the County of Orange, all WPC dollars will be sent to the Health Care Agency where they will then be used to offset a small portion of the Health Care Agency's administrative costs, with the majority distributed to the WPC Participating Entities in accordance with:

- Contracts put into place for each Participating Entity's services in support of the WPC Pilot
- Correctly submitted invoices
- Corresponding data in support of the invoices

The following are the Participating Entities, and their corresponding services, which will be funded through the WPC Pilot:

- Safety Net Connect
    - For development, implementation, and maintenance of the Safety Net Connect notification system for persons who are homeless and accessing services through the Emergency Rooms and also for assistance in development of a shared care plan.
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- Recuperative Care & Respite Services
    - Services designed to aid persons in recovering from medical interventions received in a hospital setting after discharge, such as wound care.
    - Illumination Foundation was one provider identified in Orange County's WPC Pilot Application. Orange County anticipates additional providers will also be part of a master agreement with the Health Care Agency to provide these services.
- Homeless Outreach and Coordination
    - Services designed to aid persons who are homeless to connect with the appropriate level of medical interventions and also to connect with providers of various social services as required by each individual beneficiary.
    - The following hospitals have agreed to hire and/or designate staff to these activities:

        - St. Jude Hospital
        - St. Joseph Hospital
        - Hoag Hospital
        - Orange Coast Memorial
        - Saddleback Memorial
        - UCI Medical Center

    - The following community clinics have agreed to hire and/or designate staff to these activities:
        - Buena Park Community Clinic
        - Korean Community Services
        - Serve the People
        - Hurtt Family Medical Clinic
        - Share Our Selves Community Health Center
        - Livingstone
        - Families Together
        - North Orange County Regional Foundation
        - Southland Integrated Services
- CalOptima
    - As Orange County's only Managed Care Plan, CalOptima will provide the equivalent of a Personal Care Coordinator to aid beneficiaries, the staff provided by the hospitals and clinics, and/or other community outreach staff in navigating the beneficiary's provider network for timely access to services and/or prescriptions.
    - CalOptima will also be provide the majority of the data required by DHCS for the WPC Pilot.
- 211 OC
    - For training all hospitals and community clinics on the Coordinated Entry System and providing any necessary data to aid in the reporting or care plan development process.
- Behavioral Health Seriously Mentally Ill (SMI) Targeted Program
    - These programs are going out to bid, so specific providers cannot be identified at this time.
    - There are three specific programs identified for the SMI Homeless population:
        - Housing Sustainability – services designed to help beneficiaries stay in their permanent housing placement.
        - Housing Resources – services designed to seek out and secure housing opportunities.
        - Drop-In Center – services targeted specifically to beneficiaries living in the Santa Ana area to connect them resources for their behavioral health needs as well as for all aspects of living (shelter, food, and social service components).

- Orange County Community Resources for Multi-Service Center and Drop-In Center Services
    - Orange County Community Resources manages the contracts with:
        - Midnight Mission - Drop-In Center – services targeted specifically to beneficiaries in the Santa Ana area to connect them resources for all aspects of living (shelter, food, and social service components).
        - Mercy House- Multi-Service Center – services targeted to beneficiaries in northern Orange County area to connect them resources for all aspects of living (shelter, food, and social service components).
    - City Net is not receiving funding through the WPC Pilot Program but is a supportive partner by coordinating community volunteer resources for the Drop-In Center.

ATTACHMENT F

ORANGE COUNTY WPC BUDGET FORM

WPC Budget Template: Summary and Top Sheet

WPC Applicant Name:	County of Orange		
	Federal Funds *(Not to exceed 90M)*	**IGT**	**Total Funds**
Annual Budget Amount Requested-Round 1 - PY 1	2,350,000	2,350,000	4,700,000
Annual Budget Amount Requested-Round 2-PY2	540,490	540,490	1,080,980
Annual Budget Amount Requested-Round 1 + 2-PY 2	2,890,490	2,890,490	5,780,980
Annual Budget Amount Requested-Round 2-PY 3-5	1,080,980	1,080,980	2,161,960
Annual Budget Amount Requested-Round 1 + 2-PY 3-5	3,430,980	3,430,980	6,861,960

PY 1 Total Budget	4,700,000	0	4,700,000
Approved Application (75%)	*3,525,000*	*0*	3,525,000
Submission of Baseline Data (25%)	*1,175,000*	*0*	1,175,000

PY 2 Total Budget	4,700,000	1,080,980	5,780,980
Administrative Infrastructure	*300,000*	*51,480*	351,480
Delivery Infrastructure	*3,523,520*	*204,580*	3,728,100
Incentive Payments	*103,530*	*(3,530)*	100,000
FFS Services	*472,950*	*129,559*	602,509
PMPM Bundle	*0*	*698,892*	698,892
Pay For Reporting	*0*	-	0
Pay for Outomes	*300,000*	-	300,000

PY 3 Total Budget	4,700,000	2,161,960	6,861,960
Administrative Infrastructure	*100,000*	*102,665*	202,665
Delivery Infrastructure	*765,000*	*204,600*	969,600
Incentive Payments	*100,000*	*80,000*	180,000
FFS Services	*472,950*	*720,155*	1,193,105
PMPM Bundle	*2,856,000*	*905,640*	3,761,640
Pay For Reporting	*106,050*	*100,000*	206,050
Pay for Outomes	*300,000*	*48,900*	348,900

PY 4 Total Budget	4,700,000	2,161,960	6,861,960
Administrative Infrastructure	*100,000*	*102,547*	202,547
Delivery Infrastructure	*765,000*	-	765,000
Incentive Payments	*0*	*10,000*	10,000
FFS Services	*472,950*	*1,094,873*	1,567,823
PMPM Bundle	*2,856,000*	*905,640*	3,761,640
Pay For Reporting	*206,050*	-	206,050
Pay for Outomes	*300,000*	*48,900*	348,900

PY 5 Total Budget	4,700,000	2,161,960	6,861,960
Administrative Infrastructure	*100,000*	*102,547*	202,547
Delivery Infrastructure	*765,000*	-	765,000
Incentive Payments	*0*	*10,000*	10,000
FFS Services	*472,950*	*1,094,873*	1,567,823
PMPM Bundle	*2,856,000*	*905,640*	3,761,640
Pay For Reporting	*206,050*	-	206,050
Pay for Outomes	*300,000*	*48,900*	348,900

ATTACHMENT G

CIVIC CENTER UPDATE
FEBRUARY, 2017

For a copy of the Civic Center Update, please contact Melissa Tober at (714) 834-5891 or at mtober@ochca.com