Small County Whole Person Care Collaborative

Application for Participation in the Whole Person Care Pilot Project

Submitted by:
San Benito County Health and Human Services Agency

On behalf of:
Small County Whole Person Care Collaborative Members

Mariposa County Human Services Department
Plumas County Behavioral Health Department
San Benito County Health and Human Services Agency

March 1, 2017

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Part I – Background on the Small County Whole Person Care Collaborative Application for the Whole Person Care Pilot Project

This application for participation in the Whole Person Care Pilot Project is submitted by the San Benito County Health and Human Services Agency on behalf of the Small County Whole Person Care Collaborative (SCWPCC), which is composed of the following three counties:

- Mariposa County. A small, rural county nestled in the Sierra Nevada foothills, Mariposa County has approximately 17,700 residents, spans approximately 1,450 square miles and has an average of 12 residents per square. As of September 2016, DHCS data show that county certified Medi-Cal eligibles totaled 4,786 persons, or roughly 27% of all county residents. Mariposa County has the 5th smallest Medi-Cal enrollment among California counties. The county lead entity is the Mariposa County Human Services Department.

- Plumas County. A small, rural county located in the Northern Sierra Nevada Mountains, Plumas County is home to approximately 18,606 residents. The county spans approximately 2,618 square miles and has an average of 7 residents per square mile. As of September 2016, DHCS data show that county certified Medi-Cal eligibles totaled 6,213 persons, or roughly 34% of all county residents. Plumas County has the 8th smallest Medi-Cal enrollment. The county lead entity is the Plumas County Behavioral Health Services Department.

- San Benito. A small, rural county located in the Coastal Range Mountains, San Benito County is home to approximately 58,792 residents, spans approximately 1,390 square miles, and has an average of 42 residents per square mile. As of September 2016, DHCS data show that county certified Medi-Cal eligibles totaled 19,023 persons, or roughly 32% of all county residents. San Benito County has the 17th smallest Medi-Cal enrollment. The county lead entity is the San Benito County Health and Human Services Agency. San Benito County will also serve as the Collaborative Lead Entity for SCWPCC.

In combination, these three counties represent a total population of 95,098 and a total Medi-Cal population of 30,022 enrollees. The counties are not contiguous; they are geographically dispersed in California, with differing local circumstances, resources, economies and demographics. The combined size of the Medi-Cal enrollee population makes these three counties comparable in size to each of the following counties: Lake, Napa, and Yuba.

Reasons for the Small County Whole Person Care Collaborative (SCWPCC)

The three counties participating in the SCWPCC joined together because the scope, anticipated costs, and local infrastructure needed to fulfill the requirements for participation in the WPC Pilot exceeded their local capacity as individual counties. By joining together, the three counties expanded their capacities in the following areas:

- *Client Data Management and Care Coordination System.* The Collaborative provides a structure for the counties to jointly contract and share the cost of development and implementation of an automated Client Data Management and Care Coordination System. This automated system, described in each county WPC program, will provide a data repository in each county that receives data from various health and human services organizations in each county, including hospitals, managed care plans, mental health providers, county sheriff and probation, and local housing programs; maps and links these data into a centralized database that provides client-specific profiles of health care and behavioral health utilization, assessed health status, and social demographic information, including housing insecurity, interaction with the county justice system, and other matters; and, provides a real-time system for managing the provision of services delivered through Comprehensive Care Coordination that will be provided to each county's WPC target population and for documenting and reporting on these services and their outcomes.

- *Small County Learning Community.* The SCWPCC provides the three small counties with a structure to learn from each other as they develop strategies to address the needs and conditions of high-need, often multi-system utilizers. This shared learning as small counties is important because they face similar local constraints in their delivery of services – sparse populations distributed across a wide geography, some in isolated pockets of each county; limited transportation options for low-income at-risk populations; complications of weather and geographic barriers, which exacerbate transportation barriers; limited housing options; limited service capacity and community capacity in parts of each county; and, little structure for integration across programmatic and service delivery lines.

- *Centralized Financial Claiming and Data Reporting to DHCS.* Each county will work with support from a centralized third party administrator that oversees and guides financing claiming to DHCS by each county and required data reporting to DHCS as required by the WPC Pilot. Instead of each county trying to navigate these claiming and data reporting requirements on their own, they will develop processes jointly and receive technical assistance and support from their third party administrator. The County Medical Services Program (CMSP) Governing Board approved a motion on March 30, 2017 to carry out these third party administration responsibilities under a contract with the SCWPCC. Attached to the application is a document outlining the CMSP's Governing Board role as a third party administrator for the SCWPCC project.

In summary, each county's participation in the WPC Pilot as a part of the SCWPCC provides these counties the needed technical support, economies of scale, and glue required to effectively implement a county level WPC program in these small, rural counties. It also offers an important model for other small counties seeking improvements in their local capacity to serve the Medi-Cal population.

SCWPCC Governance

San Benito County will serve as the Collaborative Lead Entity for the WPC Pilot Project carried out by the SCWPCC and will sign the WPC contract with DHCS on behalf of all SCWPCC counties. Before July 1, 2017, the SCWPCC will make final determinations concerning the governance structure for the SCWPCC and the structure of the SCWPCC's contract with the third party administrator (TPA), the CMSP Governing Board. Either San Benito County will contract with the TPA on behalf of all SCWPCC counties or all three counties will jointly contract with the TPA.

The SCWPCC will have a 3-party Executive Committee composed of the Director of the collaborative lead entity from each county WPC program, and will be supported by key local staff these Directors designate. The Executive Committee will serve as the policy making body for the SCWPCC. The Executive Committee's decision structure and the use of committees or workgroups will be determined during the first two months of program implementation.

To underscore the depth of the commitment to the SCWPCC, the three counties have met weekly since December 2016 to discuss the WPC Pilot opportunity and to build the collaborative foundation for the Pilot Project. The SCWPCC is anticipated to meet monthly in PY 2 and regularly throughout PYs 3-5.

Third party administration services will include the cost of key program and fiscal staff that provide support to the SCWPCC as a whole and provide technical assistance to each county. These staff will report to the Executive Committee and carry out the work designated by that Committee, within a Scope of Services that will be defined in the third party administration contract between SCWPCC and the CMSP Governing Board. The Executive Committee will determine the details of the third party administrator role, scope of services, and contract by July 1, 2017. A cost for these third party administrator services has been included in the budget for each county WPC Pilot.

Common WPC Components for All Counties

As a consortium, the participating counties believe that it is important that certain programmatic and administrative functions be common across all participating counties in order to provide a WPC framework that offers a "unified whole" that allows for review and consideration of the program and its outcomes individually by county and across all three participating counties as a group. To provide this single WPC framework, the participating counties agreed that all of the following components of their WPC Pilots will be common. These common components are described in each of the three WPC Pilot proposals and include:

- Automated Client Data Management & Care Coordination System. As referenced above, the counties are working jointly to contract for development and implementation of the same automated system for client data management and care coordination in each county.

- Participant Engagement. The process for engaging participants in each county will be the same, although the specific staffing composition may vary by county. For example, engagement may be conducted by different types of workers (e.g. Health Worker, Mental Health Worker) depending on the county's WPC target population. Each county's staff composition is presented in their WPC Pilot proposals.
- Comprehensive Care Coordination (CCC). The CCC process will be common to each county, although the composition of CCC Team staffing may vary, depending on the county's target population, local capacity and provision of services and supports. Each county's staff composition is presented in this WPC Pilot proposal.
- Data Collection and Reporting. Each county will report all of the same data in the same manner so that data can be evaluated by county and across all three counties in the SCWPCC.
- Universal and Variant Metrics. These reporting metrics were jointly determined by the three counties and will be the same across all counties so that the findings can be evaluated by county and across all three counties as a whole.
- Financial Claiming and Data Reporting to DHCS. As referenced above, each county will work with support from a centralized third party administrator under contract with the SCWPCC so that financial claiming to DHCS and data reporting to DHCS are provided through this central entity.

District Hospital Participation and PRIME Program Participation in Each County

There are five district/municipal public hospitals (DMPHs) in Mariposa, Plumas, and San Benito Counties, and these are the only source of hospital care in these rural counties. There are no other private hospital providers. All five hospitals – John C. Fremont, Plumas District Hospital, Eastern Plumas Health Care, Seneca Healthcare District, and Hazel Hawkins – are participating in the Public Hospital Redesign and Incentives in Medi-Cal (PRIME) element of Medi-Cal 2020. The WPC Pilots in each of the three counties will complement the district hospital transformation work under the PRIME Program in these counties, and both WPC and PRIME will work jointly to assure complementary and distinct programs that seek improvements in Medi-Cal participant outcomes and increased system efficiencies.

No Current Targeted Case Management (TCM) Participation in Each County

None of the three counties participating in the SCWPCC is approved to participate in any of California's Targeted Case Management State Plan Amendments. Accordingly, none of these counties discounted their service rates in their financing proposals to account for TCM.

Structure of This Whole Person Care Pilot Project Application

To facilitate ease of review, in Part 2 of this application each county's proposed WPC Pilot Project description is included in each of the required sections of the application. Areas that are common to each county Pilot, as referenced above, are identified in their respective sections. Letters of Participation and Support for each county and the Funding Diagrams are provided in separate attachments.

Part II – Small County Whole Person Care Collaborative (SCWPCC) Application

Section 1: WPC County Lead Entity and Participating Entity Information

1a. County Lead Entity Description

San Benito County will be the Collaborative Lead Entity for the Small County Whole Person Care Collaborative (SCWPCC). Additionally, each participating county will have a County Lead Entity.

In Mariposa County, the Mariposa County Human Services Department will serve as a County Lead Entity for the WPC Pilot Project. In Plumas County, the Plumas County Behavioral Health Services Department will serve as County Lead Entity. In San Benito County, the San Benito County Health and Human Services Agency (HHSA) will serve as County Lead Entity for the WPC Pilot Project.

In addition to providing leadership and support for WPC Pilot Project activities, each County Lead Entity will serve as the single point of contact for the California Department of Health Care Services (DHCS) *within* their respective counties and will oversee and provide coordination, monitoring and reporting on WPC Pilot Project activities at the county level.

Small County Whole Person Care Collaborative (SCWPCC) Executive Committee. The SCWPCC Executive Committee will be composed of Director representatives of each county participating in the SCWPCC, including Mariposa, Plumas and San Benito Counties. This Executive Committee will govern joint actions of the SCWPCC.

As a part of the SCWPCC, a set of common WPC Pilot Project components has been structured to enable these three small counties to participate in the WPC Pilot. These common components are designed to create greater scale for the Pilot Project than would otherwise be possible for these counties to achieve on their own. This greater scale allows each participating county to jointly invest in components needed for a WPC program, such as automated data collection and sharing, and will provide each county with the opportunity to be a part of a learning community with other small counties carrying out their WPC Pilots.

By intention, the SCWPCC has determined that all of the following components of the WPC Pilot Project will be common for the three participating counties: 1) Participant Engagement process; 2) CCC process; 3) Data collection and data reporting; 4) Reporting metrics (Universal and Variant); and, 5) Fiscal claiming to DHCS for WPC reimbursement. In furtherance of these common components, the SCWPCC will be jointly contracting for three sets of activities needed for implementation of the WPC Pilot. San Benito County, as the Collaborative Lead Entity for the SCWPCC, will lead these contracting efforts. Contracted activities will include:

- Development of an automated Client Data Management System for identification of target populations, program support for Comprehensive Care Coordination (CCC), and documentation of participant outcomes;
- Centralized administration for Medi-Cal claiming to State DHCS, including IGT submission and documentation; and,
- Centralized data collection and reporting of WPC data to State DHCS.

The SCWPCC Executive Committee will oversee all of the activities described above and jointly make determinations regarding policy, program administration, and financing.

Individual County WPC Collaborative Leadership Committee. Additionally, each county will establish a County WPC Collaborative Leadership Committee. The Mariposa County WPC Collaborative will be composed of the Human Services Department and selected Participating Entities (described further below). The Plumas County WPC Collaborative will be composed of the Behavioral Health Services Department and selected Participating Entities (described further below). The San Benito County WPC Collaborative will be composed of the Human Services Department and selected Participating Entities (described further below).

Through participation on this committee, the Behavioral Health and Human Services Departments and Participating Entities will oversee WPC Pilot operation in the county and assure the following core elements of the WPC Pilot are implemented and made operational: 1) Identification of the target population(s) and timely assessment of their needs; 2) Assurance of local collaboration and programmatic coordination across all Participating Entities; 3) Ongoing facilitation of care coordination among service providers; and, 4) Development of an appropriate and effective strategy for sharing confidential data among Participation Entities that supports identification of common patients, coordination of care, improved access to needed services and support, and data collection and reporting necessary to document individual and system-level health outcomes. A description of each County's Participating Entities and their responsibilities is provided in the following section.

1b. Participating Entity Description

1. Managed Care Health Plans

All of the health plans serving Medi-Cal beneficiaries in the three counties have committed to participate in the WPC program. In particular, these plans will participate in the planning activities, identification and engagement of members, coordination efforts to ensure members are referred to programs that best meet their needs without duplication of services, and providing health outcomes and utilization data for the purpose of evaluation.

In Mariposa and Plumas Counties, there are two Medi-Cal Managed Care Plans (MCP) serving Medi-Cal members: Anthem Blue Cross and California Health & Wellness. In San Benito County, there are two mechanisms for delivery of health care services to Medi-Cal members in San Benito County: Anthem Blue Cross serves as the sole Medi-

Cal Managed Care Plan providing services to certain members in the county. The Fee-For-Service (FFS) Medi-Cal program serves the remainder of Medi-Cal members in the county.

2. Public Agencies

MARIPOSA

County Lead Entity - Mariposa County Human Services Department (MCHSD)

Mariposa County Human Services, the county lead entity for WPC, is the umbrella agency for a number of different divisions participating in WPC. These divisions include Behavioral Health and Recovery Services (Specialty Mental Health), Employment and Community Services, and Social Services. The Human Services Department will do all of the following:

- Provide local WPC program administration and fiscal management
- Monitor contracts with Participating Entities and community based organizations
- Participate in the SCWPCC Meetings
- Lead and coordinate Mariposa County WPC Leadership Committee and planning

Health Services Department - Mariposa County Public Health Department (MCPHD)

This department will do all of the following:

- Provide leadership and oversight of healthcare coordination and services across WPC entities
- Make referrals to WPC
- Participate on Participant Engagement Team
- Participate on WPC Leadership Committee
- Participate on the Comprehensive Care Coordination Team
- Share data for supporting WPC Goals

Specialty Mental Health Department - Behavioral Health and Recovery Services (BHRS) Division

This division will do all of the following:

- Provide leadership in WPC Pilot management and oversight
- Coordinate and participate in Participant Engagement Efforts
- Coordinate and participate on the Comprehensive Care Coordination Team
- Develop Comprehensive Care Plans for WPC participants
- Design local policies and procedures
- Provide data collection and evaluation
- Deliver strength based, wellness and recovery focused services for WPC participants
- Enroll high need WPC members with SMI into Full Service Partnerships with linkages to medical care, primary care and supportive services
- Provide 24/7 crisis response and supportive services

- Link WPC members to CCC Team to resolve immediate crisis and coordinate services to help reduce ED visits and hospitalizations
- Provide outpatient substance abuse services not covered by Medi-Cal and referrals to residential treatment
- Provide assessment and services to WPC members in the criminal justice system
- Coordinate services with Mariposa County Sheriff's Department, Probation Department and Behavioral Health Court

Public Agency - Employment and Community Services (MCECS) Division

This division will do all of the following:
- Assist with access to public assistance benefits including general assistance, Medi-Cal, CalFresh, etc.
- Assist with Social Security advocacy
- Assist with housing/homeless supports
- Provide data collection and sharing to achieve WPC outcomes
- Make referrals to the WPC Pilot
- Participate on the Comprehensive Care Coordination Team, as needed

Public Agency - Social Services (MCSS) Division

This department will do all of the following:
- Coordinate Adult Protective Services for WCP participants involved in that system
- Coordinate Public Conservator/Guardianship Services for WCP participants involved in that system
- Coordinate Child Welfare Services for WCP participants involved in system
- Make referrals to WPC
- Participate on Comprehensive Care Coordination Team, as needed
- Collect and share data to achieve WPC outcomes

Public Agency (Housing) - Stanislaus County Housing Authority (StanCo HA)

This department will do the following:
- Work to create access to Housing Choice Voucher Program for homeless WCP participants
- Assist in the development of housing opportunities for low-income individuals enrolled in WPC

Public Agency - Mariposa County Probation Department (MC Probation)

This department will do all of the following:
- Make referrals to WPC
- Participate on Comprehensive Care Coordination Team, as needed
- Collect and share data to achieve WPC outcomes

PLUMAS

County Lead Entity - Specialty Mental Health Department – Plumas County Behavioral Health Services

As County Lead Entity, the Department will: a) Provide overall leadership for the WPC project; b) Enroll high need WPC participants who have a serious mental illness (SMI) into Full Service Partnership programs and help link these individuals to needed medical care, primary care and supportive services; c) Provide crisis response services and support services after business hours and 24/7 on weekends and holidays; d) Provide a range of recovery-based services, including outpatient substance use and co-occurring treatment services for individuals and families; e) Provide assessment and services to persons in the criminal justice system; f) Provide residential treatment services (90 days); g) Provide respite and sobering supports; h) Provide services to persons with substance use and co-occurring disorders; and, i) Coordinate services with Criminal Justice Court programs and the Probation Department.

Health Department – Plumas County Public Health Agency

This department will: a) Provide HIV specialty care and treatment services including supportive services such as food, housing and transportation to keep multiple diagnosed HIV+ individuals stable and in care; b) Work closely with behavioral health to provide care coordination, resource and referral, and case management to vulnerable senior and veterans populations; and, c) Operate the Opioid Use Prevention program, which works across agencies including behavioral health, criminal justice, first responders, hospitals, local physicians, and community-based organizations to develop processes and systems to reduce the number of opioid related deaths in Plumas County.

Public Agency – Plumas County Community Development Commission and Housing Authority

This department will: a) Make referrals to WPC and share data bi-directionally with the WPC Team; and, b) Coordinate housing services in all four communities for WPC participants and coordinate supportive services.

Public Agency – Plumas County Department of Social Services

This department will: a) Make referrals to WPC and share data bi-directionally with the WPC Team; b) Coordinate supportive services for WPC participants and families and provide access to CalWorks, CalFresh, and enrollment for Medi-Cal; and, c) Provide other assistance as appropriate for adoption, child welfare services, adult protective services, In-Home Supportive Services, and public guardian services.

Public Agency – Plumas County Probation Department

This department will: a) Make referrals to WPC and share data bi-directionally with the WPC Team; b) Coordinate services and training for diversion programs and supervised

participants; c) Make referrals for education and trainings for domestic violence and/or batterers programs; and, d) Work collaboratively with Community Corrections Partners and funded programs.

SAN BENITO

County Lead Entity – San Benito County Health and Human Services Agency

The San Benito County Health and Human Services Agency will have the following responsibilities in its county lead entity management role:

- Provide local WPC pilot administration, oversee and monitor WPC activities and coordinate working relationships with five (5) participating entities and five (5) community partners including reporting and fiscal responsibilities.
- Monitor contracts with participating entities and community based organizations
- Coordinate the WPC Leadership Committee and associated planning
- Coordinate Engagement and Coordinated care systems
- Participate in the SCWPCC meetings

Health Department – San Benito County Public Health Department (SBCPH)

SBCPH is directed by Lynn Mello. SBCPH will provide leadership and oversight of public health community education and care programs with a focus on obesity, diabetes, neighborhood safety and general wellness programs. SBCPH also handles nursing responsibilities and will participate in a cross coordination of care among WPC participating entities and community partners.

Specialty Mental Health Department – San Benito County Human Services Behavioral Health and Recovery Services (SBCBHRS)

SBCBHRS is directed by Alan Yamamoto and is responsible for programs related to mental health and substance abuse. This department will participate by coordinate service functions related to the following areas:

- Coordinate and participate on Comprehensive Care Coordination Team
- Contribute to Comprehensive Care Plans for WPC participants
- Provide and analyze data and coordinate data sharing
- Provide mental health services to WPC members with Serious Mental Illness (SMI)
- Enroll high need WPC members with SMI into Full Service Partnerships with linkages to medical care, primary care and supportive services
- Provide 24/7 crisis response and supportive services
- Provide outpatient substance abuse treatment not covered by Medi-Cal and referrals to residential treatment
- Uses California Outcome Measurement System (CalOMS) to track individuals from intake to treatment and will share applicable data with all other participating entities.

Public Agency – San Benito Probation Department (SBPD)

SBPD is directed by Chief Probation Officer, R. Ted Baraan. The Department will focus on persons associated with the criminal justice system as related to the WPC Pilot. The SBPD will collaborate as regards data sharing, referrals and assessment of released persons with the WPC Pilot entities and community partners. This department will do the following:

- Make referrals of offenders to WPC
- Participate on Comprehensive Care Coordination Team, as needed
- Collect and share data to achieve WPC outcomes

Public Agency (Housing) – Santa Cruz Housing Authority (SCHA)

SCHA is directed by Jenny Panetta, Executive Director. SCHA will coordinate access to Project Based Vouchers as a housing support and will do the following:

- Work to create access to Project Based Voucher Program for homeless WCP members
- Assist in the development of housing support for WPC enrollees.

3. Community Partners

MARIPOSA

The Mariposa County WPC Collaborative has engaged key community partners for participation and support of the WPC Pilot. These partners and their roles are described below.

Community Partner 1: Health Care - John C. Fremont Healthcare District (JCFHCD)

This partner will do the following:

- Provide Hospital Emergency Department and inpatient services
- Share data bi-directionally with WPC entities to achieve outcomes
- Coordinate WPC with Healthcare District's PRIME Grant to increase access to community members and WPC participants
- Identify and refer people in the Emergency Department (ED) or clinics who are appropriate for WPC
- Participate on Comprehensive Care Coordination Team to coordinate medical services for WPC participants
- Provide data for WPC reports

Community Partner 2: Community Based Organization - Alliance for Community Transformations

This partner will do the following:

- Provide Drop-In Center and Recovery Support for homeless WPC members, WPC participants with mental illness, and WPC participants with Substance Use Disorders

- Provide Housing Navigation and Support Services
- Provide Domestic Violence/Rape Crisis Services
- Provide case managers/Substance abuse counselors
- Participate on Comprehensive Care Coordination Team, as needed
- Make referrals to WPC
- Share data to achieve WPC outcomes

PLUMAS

The Plumas County WPC Collaborative has engaged a variety of community partners for participation and support of the WPC Pilot. These partners and their roles are described below.

Community Partner 1: Plumas Rural Services (PRS)

This partner will provide support services for housing, medical respite, and sobering centers, and serve on the WPC Leadership Committee and participate in meetings and WPC planning.

Community Partner 2: Plumas Crisis Intervention and Resource Center (PCIRC)

This partner will provide supportive housing and navigation services and serve on the WPC Leadership Committee and participate in meetings and WPC planning.

Community Partners 3, 4 and 5: Plumas District Hospital (Quincy and Greenville), Seneca Healthcare District (Chester), and Eastern Plumas Health Care (Portola)

The Plumas County WPC Collaborative has partnered with all three Special District Hospitals in Plumas County for participation in the WPC Pilot. All three hospitals operate Rural Health Clinics and will: a) Serve on the WPC Leadership Committee and participate in meetings and WPC planning; b) Provide data to the WPC team; c) Identify people in the Emergency Department (ED) and inpatient services who are appropriate for WPC; d) Make referrals to WPC and share data bi-directionally with the WPC Team; and, e) Create enhanced access to primary care appointments for WPC members and ensure that WPC members receive primary care appointments in a timely manner.

SAN BENITO

Community Partner No. 1: Public Agency – San Benito County Community Services and Workforce Development Division (SBCCSWD)

SBCCSWD is directed by Enrique Arreola. This County division provides a variety of services to low-income persons with a focus on rental assistance and rapid-rehousing services that will be coordinated with all entities in the WPC Pilot. This department will do all of the following:

- Assist with access to public assistance benefits including general assistance, Medi-Cal, CalFresh, etc.
- Assist with social security advocacy
- Assist with housing/homeless supports
- Provide data collection and sharing to achieve WPC outcomes
- Make referrals to WPC
- Participate on Comprehensive Care Coordination Team, as needed

Community Partner No. 2 - Hazel Hawkins Memorial Hospital (HHH)

HHH is directed by Ken Underwood, Chief Executive Officer and is the only hospital to serve San Benito County with inpatient and emergency services. HHH will work in collaboration with the WPC Pilot Leadership committee in the following areas;

- Provide Hospital Emergency Department and inpatient services
- Share data bi-directionally with WPC entities to achieve outcomes
- Coordinate WPC with Healthcare District's PRIME Grant to increase access to community members and WPC participants
- Identify and refer people in the Emergency Department (ED) or clinics who are appropriate for WPC services.
- Participate on Comprehensive Care Coordination Team to coordinate medical services for WPC participants, as appropriate
- Provide data for WPC reports

Community Partner No. 3 – San Benito Health Foundation (SBHF)

SBHF is directed by Rosa V. Fernandez, Chief Executive Officer. SBHF is a Federally Qualified Health Center and a non-profit community health center with a community health mobile unit. SBHF will coordinate planning activities with the WPC Leadership Committee while making referrals and sharing data. Their focus will be to create access to primary care appointments in a timely manner.

Community Partner No. 4 – Coalition of Homeless Service Providers

This Coalition, also known as the Continuum of Care, is directed by Katherine Thoeni, Executive Director. This regional coalition of all homeless service providers in Monterey and San Benito Counties is the approved and recognized regional entity for coordinating homeless services. The Coalition will collaborate as a community partner of the WPC Pilot with a focus on community support to homeless persons.

Community Partner No. 5 – Youth Alliance

Youth Alliance is a local non-profit organization that focuses on the underserved youth populations and works with local schools in providing after school programs, counseling, restorative justice and recreation programs. The Youth Alliance will participate in the WPC as a community partner with a focus on the needs of local youth population and their families.

1.1 Whole Person Care Pilot County Lead Entity and Contact Person

Collaborative Lead Entity and San Benito County Lead Entity:

Organization Name	San Benito County Health and Human Services Agency
Type of Entity	County
Contact Person	Mr. James A. Rydingsword, HHSA Director
Contact Person Title	Mr. James A. Rydingsword, HHSA Director
Telephone	(831) 637-4180
Email	Jrydingsword@cosb.us
Mailing Address	1111 San Felipe Road, #208 , Hollister, CA 95023

Mariposa County Lead Entity:

Organization Name	Mariposa County Human Services
Type of Entity	County
Contact Person	Chevon Kothari, MSW
Contact Person Title	Director of Human Services
Telephone	(209) 742-0892
Email	ckothari@mariposahsc.org
Mailing Address	Mariposa County Human Services 5362 Lemee Lane Mariposa, CA 95338

Plumas County Lead Entity:

Organization Name	Plumas County Behavioral Health Services
Type of Entity	County
Contact Person	Louise Steenkamp, MBA
Contact Person Title	AOD Program Administrator
Telephone	(530) 283-6307, ext. 1052
Email	louisesteenkamp@countyofplumas.com
Mailing Address	270 County Hospital Road, Suite 109 Quincy, CA 95971

Participating Entities

MARIPOSA

Required Organizations	Organization Name	Contact Name and Title	Entity Description and Role in WPC
Medi-Cal managed health care plan #1	Anthem Blue Cross	Janet Paine, Interim Network Relations Manager, North/ Program Manager	Develop strategies for integrating services; coordinating health care services for common patients; share data for supporting WPC goals
Medi-Cal managed health care plan #2	California Health and Wellness	Reina Hudson, Manager of Community Programs	Develop strategies for integrating services; coordinating health care services for common patients; share data for supporting WPC goals
Health Services Department	Mariposa County Health Department (MCPHD)	Dr. Eric Sergienko, Health Department Director /Public Health Officer	Provide leadership and oversight of healthcare coordination and services across WPC Entities
Specialty Mental Health Department	Mariposa County Human Services- Behavioral Health and Recovery Services Division (MCBHRS)	Vacant, Deputy Director of Behavioral Health and Recovery Services	provide leadership in project management, care coordination, referral processes, data collection and evaluation
Public Agency	Mariposa County Human Services - Employment and Community Services Division (MCECS)	Rebecca Maietto, Deputy Director of Employment and Community Services	Social security advocacy, housing/homeless supports and assistance; and, participate in intensive case coordination, housing referrals/assistance and data collection and sharing to achieve WPC outcomes
Public Agency	Mariposa County Human Services - Social Services Division (MCSS)	Baljit Gill, Deputy Director of Social Services	Participate in intensive case coordination, and data collection and sharing to achieve WPC outcomes.

Required Organizations	Organization Name	Contact Name and Title	Entity Description and Role in WPC
Public Agency (Housing)	Stanislaus County Housing Authority (StanCo HA)	Barbara Knauss, Executive Director	Work to create access to the Housing Choice Voucher Program for homeless individuals enrolled in WPC Project
Public Agency	Mariposa County Probation Department (MC Probation)	Pete Judy, Chief of Probation	Participate in intensive care coordination, share data, identify participants, and support Pilot activities
Community Partner 1: Health Care	John C. Fremont Healthcare District (JCFHCD)	Theresa Loya, Clinical Nursing Director	Share data bi-directionally with the other entities in WPC to achieve outcomes; and, coordinate WPC with Healthcare District's PRIME Grant to increase access
Community Partner 2: Community Based Organization	Alliance for Community Transformations (ACT)	Alison Tudor, Executive Director	Provide case managers/ substance abuse counselors for participation in intensive case coordination efforts and Housing Navigation efforts through their various programs including: Housing Navigation and Coordination, Drop-In Center and Recovery Support for homeless individuals and individuals with Mental Illness and Substance Use Disorders, and Domestic Violence/Rape Crisis Services; and, share in data collection and sharing to achieve WPC outcomes.

PLUMAS

Required Organizations	Organization Name	Contact Name and Title	Entity Description and Role in WPC
Medi-Cal managed health care plan #1	Anthem Blue Cross	Janet Paine, Interim Network Relations Manager, North, Program Manager,	Work in partnership with the Behavioral Health Department to share data and refer WPC candidates, develop strategies to manage high utilizers and support WPC goals

Required Organizations	Organization Name	Contact Name and Title	Entity Description and Role in WPC
		Medicaid Business	
Medi-Cal managed health care plan #2	California Health and Wellness	Reina Hudson, LCSW, Manager Community Programs	Work in partnership with the Behavioral Health Department to share data and refer WPC candidates, develop strategies to manage high utilizers and support WPC goals
Health Services Agency	Plumas County Public Health Agency	Mimi Hall, Director	Work with the BH Department to design and implement the pilot project activities, provide HIV education, testing, treatment and support services, take in referrals for Medication Assisted Treatment pilot services, share data, and refer individuals
Specialty Mental Health Department	Plumas County Behavioral Health Services (BH Department)	Bob Brunson, LMFT, Director	As the county lead entity, the BH Department will serve as the contact point for the SCWPCC and DHCS; will provide overall coordination of the Pilot Project and collaboration with participating entities; will provide portals in four community wellness centers to engage and serve WPC members; will provide mental health and substance use outpatient treatment services, will provide case management for all WPC members and serve as liaison for primary care integration, will coordinate and share data with partners and community stakeholders
Public Agency (Housing Authority)	Plumas County Community Development Commission and Housing Authority	Roger Diefendorf, Director	Work with the BH department to design and implement the Pilot Project activities including data sharing, reporting, and housing coordination

Required Organizations	Organization Name	Contact Name and Title	Entity Description and Role in WPC
Community Partner 1 – Community Based Organization	Plumas Rural Services	Michele Piller, Executive Director	Work with the BH department to design and implement the Pilot Project activities including data sharing, reporting, referrals, support services and housing coordination. Provide respite and transitional housing services; provide life skills and other education support services
Community Partner 2 – Community Based Organization	Plumas Crisis Intervention and Resource Center	Johanna A. Downey, Executive Director	Provide support services throughout the county for housing navigation, and assistance to remove health improvement barriers Crisis Line and other safety net supports, refer individuals, and share data
Community Partner 3 – Special District Hospital	Plumas District Hospital	Jeffrey G. Kepple, MD, CEO	Work with the BH Department to design and implement the pilot project activities including data sharing, reporting, care coordination with primary care, referral of individuals, data collection
Community Partner 4 - Special District Hospital	Seneca Healthcare District	Linda Wagner, MHA/MSN, FACHE, CEO	Work with the BH Department to design and implement the pilot project activities including data sharing, reporting, referral of individuals, integration with primary care, data collection
Community Partner 5 - Special District Hospital	Eastern Plumas Health Care	Tom Hayes, Chief Executive Director	Work with the BH Department to design and implement the pilot project activities including data sharing, reporting, referral of individuals, integration with primary care, data collection
Additional Organizations	**Organization Name**	**Contact Name and Title**	**Entity Description and Role in WPC**
Public Agency	Plumas County Department of Social Services	Elliott Smart, Director	Work with the BH Department to implement the pilot project activities including care coordination of WPC members,

Required Organizations	Organization Name	Contact Name and Title	Entity Description and Role in WPC
			data sharing, reporting, and referral of individuals
Public Agency	Plumas County Probation Department	Erin Metcalf, Chief Probation Officer	Work with the BH Department to implement the pilot project activities including care coordination of WPC members, data sharing, reporting, and referral of individuals

SAN BENITO

Required Organizations	Organization Name	Contact Name and Title	Entity Description and Role in WPC
1. Medi-Cal managed health care plan	Anthem-Blue Cross	Janet Paine, Network Relations Manager	Develop strategies for integrating services; coordinating health care services to common patients; share data with WPC; and develop infrastructure to collaborate with other health entities.
2. Health Services Department	HHSA – Public Health	Lynn Mello, PHN, Deputy Director	Provide leadership and oversight of public health care services, including cross coordination of care amongst WPC entities
3. Behavioral Health Department	Behavioral Health Dept.	Alan Yamamoto Director	Provide mental health and substance abuse treatment referrals, coordinate data collection, evaluation, data sharing with other WPC entities
4. Public Agency	County Probation Department	Mr. R. Ted Baran Chief Probation Officer	Collaborate with WPC in data sharing, providing referrals and focusing on homeless and persons released from incarceration
5. Public Agency (Housing)	Santa Cruz Housing Authority	Jenny Panetta, Executive Director	Coordinate access to Project Based Vouchers for homeless and participate in housing pool.
Additional Organizations	**Organization Name**	**Contact Name and Title**	**Entity Description and Role in WPC**
County Division of Health and Human	HHSA – Community Services and	Enrique Arreola, Deputy Director of CSWD	Coordinate delivery of community services to WPC

Required Organizations	Organization Name	Contact Name and Title	Entity Description and Role in WPC
Services Agency – Public Agency Community Partner 1	Workforce Development (CSWD)		enrollees and be a community partner in support of WPC
Community Partner 2	Hazel Hawkins Hospital	Ken Underwood, C.E.O.	Hospital Inpatient and Emergency Services, data sharing, health care integration as related to WPC
Community Partner 3	San Benito Health Foundation	Rosa V. Fernandez	Federal Qualified Health Center to participate in referrals, coordinated care integration, data sharing and act as community partner in support of WPC Pilot
Community Partner 4	Coalition of Homeless Service Providers	Ms. Katherine Thoeni, Executive Director of COC	Participate as community partner in support of WPC services to homeless.
Community Partner 5	Youth Alliance	Diane Ortiz, Executive Director	Participate as a community partner and make referrals and share data with WPC Pilot.

1.3 Letters of Participation and Support

Cynthia Larca, Deputy Director, San Benito County, lead agency for the California Small Counties Collaborative, may be contacted for access to all the letters. Please refer to section 1.1

Mariposa Letters of Participation include all of the following:

- Anthem Blue Cross
- California Health and Wellness
- Mariposa County Public Health Department
- Mariposa County Human Services (on behalf of Behavioral Health and Recovery Services Division – Specialty Mental Health Department, Employment and Community Services Division, and Mariposa County Human Services – Social Services Division)
- Stanislaus County Housing Authority
- Mariposa County Probation Department
- John C. Fremont Healthcare District
- Alliance for Community Transformations

Plumas Letters of Participation and Support include all of the following:

- Anthem Blue Cross
- California Health and Wellness

- Plumas County Public Health Agency
- Plumas County Community Development Commission and Housing Authority
- Plumas Rural Services
- Plumas Crisis Intervention and Resource Center
- Plumas District Hospital
- Seneca Healthcare District
- Eastern Plumas Health Care
- Plumas County Department of Social Services
- Plumas County Probation Department

San Benito Letters of Participation and Support include all of the following:

- Anthem – Blue Cross Managed Care
- San Benito County Public Health;
- San Benito County Behavioral Health
- San Benito County Probation Department
- Housing Authority of Santa Cruz
- County Division – Community Services and Workforce Development. (CSWD)
- Hazel Hawkins Hospital (HHH)
- San Benito Health Foundation
- Coalition of Homeless Service Provider – Monterey/San Benito
- Youth Alliance of Hollister (YA)

Section 2: General Information and Target Population

2.1 Geographic Area, Community, and Target Population Needs

This application for participation in the Whole Person Care Pilot Project is submitted by the San Benito County Health and Human Services Agency on behalf of the Small County Whole Person Care Collaborative (SCWPCC), which is composed of the following three counties:

- Mariposa County. A small, rural county nestled in the Sierra Nevada foothills, Mariposa County has approximately 17,700 residents, spans approximately 1,450 square miles and has an average of 12 residents per square. As of September 2016, DHCS data show that county certified Medi-Cal eligibles totaled 4,786 persons, or roughly 27% of all county residents. Mariposa County has the 5th smallest Medi-Cal enrollment among California counties.

- Plumas County. A small, rural county located in the Northern Sierra Nevada Mountains, Plumas County is home to approximately 18,606 residents. The county spans approximately 2,618 square miles and has an average of 7 residents per square mile. As of September 2016, DHCS data show that county certified Medi-Cal eligibles totaled 6,213 persons, or roughly 34% of all county residents. Plumas County has the 8th smallest Medi-Cal enrollment.

- San Benito. A small, rural county located in the Coastal Range Mountains, San Benito County is home to approximately 58,792 residents, spans approximately 1,390 square miles, and has an average of 42 residents per square mile. As of September 2016, DHCS data show that county certified Medi-Cal eligibles totaled 19,023 persons, or roughly 32% of all county residents. San Benito County has the 17th smallest Medi-Cal enrollment.

MARIPOSA

Although limited in racial/ethnic diversity with a predominantly Caucasian population, the County does have a small Native American population (6%) and an increasing Hispanic population (10%). In addition, nearly 21% of the population aged 5 and older has a disability, as compared to less than 13% in the state overall. The county spans approximately 1,450 square miles, averaging 12 individuals per square mile, and residences tend to be spread out. The majority of services are provided in the township of Mariposa, with some agencies providing limited services to those communities that are geographically removed from the town.

For those that need residential treatment/psychiatric services or supportive/rehabilitative housing, there are extreme limitations in Mariposa. There are no psychiatric units or substance disorder treatment residential programs, no board and care homes, and a very limited number of nursing care beds. There is a 4-bed Emergency Department at our only local rural Healthcare District hospital, John C. Fremont. When inpatient psychiatric admissions are required, individuals may occupy an Emergency Department

bed for many days while awaiting transfer. Additionally, those in need of services face multiple barriers to accessing them, including transportation and poverty. This geographic and social isolation, coupled with limited services, creates an environment ripe for behavioral health disorders and conducive for illegal activities and substance abuse. Moreover, our population struggles with a dearth of affordable housing (as identified by the Mariposa County 2016 Housing Element and Point in Time Count), food insecurity, and multi-generational poverty (as identified in a 2015 Community Needs Assessment). DHCS data show that county certified Medi-Cal eligibles totaled 4,786 persons, or roughly 27% of all county residents.

Nonetheless, Mariposa County is well positioned to implement an integrated care model as collaborative efforts have demonstrated success in recent years. Mental Health Services Act, AB 109 and other grant funded programs have proven successful in bringing community partners such as Human Services, Probation, Law Enforcement and Court partners, the Schools and Community Based Organizations together to build comprehensive programs. Additionally, our local Healthcare District recently received a PRIME grant, for which they have begun to reach out to community partners to explore integrative models of care.

The vision for the Whole Person Care in Mariposa County is to build on existing collaborations and projects in order to more effectively serve the Medi-Cal high utilizer population. For the past several months, Mariposa County partners have been having meetings to discuss WPC opportunities with our small county collaborative partners, as well as key partners within the county including Public Health, JCFHCD, Probation Department, Sheriff's Department, Courts, and our community based organization partners. This team has looked at a variety of data sets and existing needs assessments/stakeholder processes to narrow down and determine areas of focus for the WPC Pilot. This group has met almost weekly over the past few months (either one-on-one between the lead agency and each partner or in small groups) to discuss logistics of the WPC proposal and other collaborative, leveraged projects. Additionally, we have been working with our homeless/housing partners to update our Homeless Strategic Plan, helping to consider the needs of this population. Meetings have occurred with our Housing Authority (HA), which is located in Stanislaus County. Although the HA has not played a large role to date in our County, we envision this partnership expanding in the current year.

In addition to this WPC Pilot Project planning effort, Mariposa agencies have a solid history of collaboration and sharing resources to best address the needs of the community. Last year, MCBHRS launched an Innovation Project through the Mental Health Services Act (MHSA), utilizing an Adult Team Meeting model to work with individuals who are high utilizers of emergency behavioral health services. This model integrates team meetings, comprehensive care coordination and housing for mentally ill individuals. In addition, the Mariposa County Superior Court, in partnership with Probation and MCBHRS, recently launched our Behavioral Health Court and has collaboratively submitted a Proposition 47 proposal to the Board of State and Community Corrections. The WPC Pilot will work closely with these other programs to align services provided to a shared population. No WPC funds will be used to cover

non-WPC services or supplant other funding. We have taken efforts to create a common language and set of principles that can easily align these programs together should we be successful in our applications.

Due to and disparate electronic medical records systems and databases used in each of our partner agencies, Mariposa County, like most small counties, has been challenged to gather reliable utilization data that gives us clear baseline numbers on overlapping populations. Nonetheless, partners are enthusiastic about the opportunity for better care management and data integration that the WPC Pilot will bring through the automated Client Data Management System proposed in this WPC application, and the integrated care delivery that will be made possible through the WPC Pilot.

The overarching vision for the WPC Pilot is to build and strengthen existing collaboration and infuse the existing good intention of the partners with the tools and resources necessary to demonstrate successful outcomes in serving our high utilizer, often “hard to serve” population. Mariposa’s WPC Pilot will serve a platform for improving the way our agencies systemically coordinate care and services for those most in need. Creating common assessment tools, common language, an Automated Client Data Management System, data sharing agreements, and MOU’s to work effectively across agency lines and share resources wherever possible are just a few of the strategies that will be sustainable beyond the life of the Pilot. The Pilot will afford the partners the time and resources to make this successful. Data demonstrating cost savings and strategy effectiveness will serve as the catalyst for reinforcing systemic change beyond the life of the Pilot funding. Moreover, the Pilot will help to reduce and avoid the utilization of other systems components in our County emergency response and supports systems. Cost and resource savings are expected to be demonstrated in various areas, including reduced ED utilization, reduced hospital admissions, reduced behavioral health crisis response services, reduced incarcerations, reduced homelessness and emergency housing supports, and reduced law enforcement emergency response.

PLUMAS

Plumas County is a rural county of 2,618 square miles situated in the far northern end of the Sierra Nevada with National Forest comprising 75% of its area. The Feather River and its tributaries flow throughout the county and provide a scenic, mountainous drive of about 3 hours northeast of Sacramento. The ethnic and racial makeup of the county’s 18,606 residents is 84% Caucasian, 8% Hispanic, 3% Native American, and the balance from other race and ethnicity groups. About 8.8% of the population speaks a language other than English at home, mainly Spanish.

<u>The WPC Pilot Spreads System Changes begun in 2016</u>

Plumas County is well positioned for an integrated care model as small-scale efforts to address whole person care have gained success in recent years. For example, in a joint effort of the Community Justice Court and Behavioral Health, a probationer was successfully referred for dental services and treatment after years of self-medicating for

gum disease and pain. Another success involves Behavioral Health's efforts to reach out to mentally ill and homeless residents. Through a community-based organization, Behavioral Health funded $147,000 for medications, housing, deposits, and utilities over the past year. Another success is Plumas County's Opioid Coalition which was formed to respond to the high rates of opioid-related deaths. With the leadership of an Emergency Department physician, a Medication-Assisted Treatment (MAT) pilot is underway. A criminal justice-involved resident is receiving MAT at the public health clinic and counseling from a community-based LMFT. Agency and community partners are also working together to conduct trainings and disseminate Naloxone Kits, funded by County Alcohol and Drug, to prevent overdose throughout the county.

The vision for the Plumas County Whole Person Care Pilot Project is to spread and sustain the small-scale successes as described above to a broader population. Integrated care needs are well articulated in various plans and assessments. Plumas County's MHSA plan for 2014-2017 identified the need for crisis stabilization that does not over-utilize hospital staff and resources and follow-up/continuity of care for participants who are not hospitalized but still experiencing crisis. The MHSA community collaborative process also identified an increase in homelessness and a shortage of safe, affordable housing for residents living with or at risk for severe mental illness. In an April 2016 Hospital Integration meeting, partners identified the need for respite beds to house medically-cleared participants who meet 5150 criteria and are awaiting transport to an inpatient psychiatric unit, and expressed the desire to share cost and recruit for a psychiatrist that would serve County Behavioral Health and all three hospitals in the county.

Plumas County health care partners have been discussing Whole Person Care in the context of Medicaid 2020 and the State's Waiver for the Organized Delivery System since April 2016. In July 2016, County Behavioral Health services emerged as a unified department providing both mental health and substance use services. All three district hospitals in Plumas County were awarded PRIME grants and Behavioral Health sat at the table to discuss integration of primary care and behavioral health; system improvements for handling 5150 and related crises in the Emergency Departments; and, coordination of supports and housing for mental health or substance use "ED frequent flyers." Behavioral Health, Public Health and hospital partners have met five times to discuss care coordination and integration over the past year beginning on March 23, 2016 and most recently on February 2, 2017.

In July 2016, the new Behavioral Health Director met with the Director of Plumas County Community Development Commission and Housing Authority to explore housing opportunities for mental health and SUD-involved consumers discharged from residential treatment or incarceration. In October 2016, agencies and community-based partners including Behavioral Health, Probation and the District Attorney's Office began meeting around two grant opportunities from the Board of State and Community Corrections (Court Innovations grant and Prop 47). These same partners met on December 1 and 22, 2016; and, January 4 and 19, 2017, and submitted a Prop 47

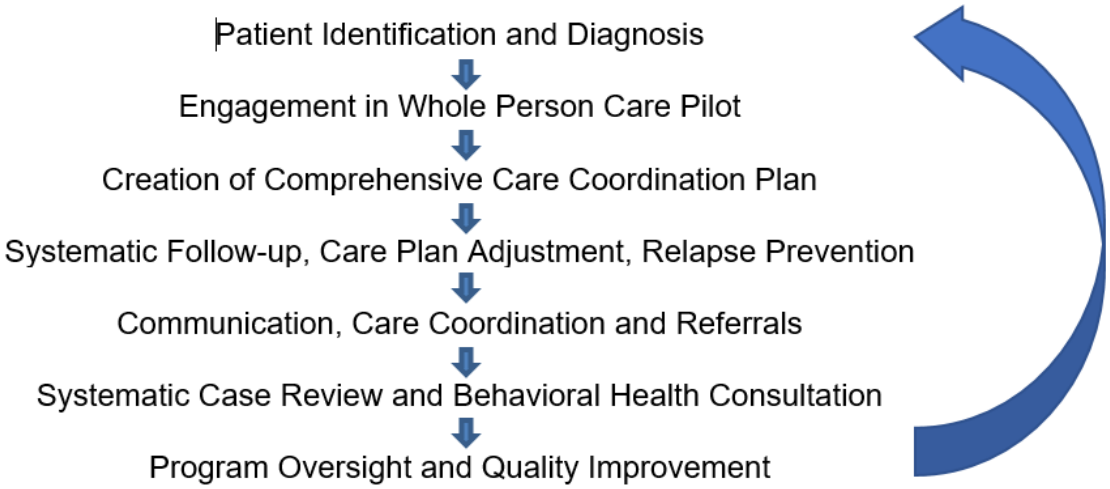
proposal under the District Attorney's Office and agreed to provide services to WPC enrollees if the Prop 47 proposal is not funded.

WPC Establishes a Unified Commitment to Data Sharing and Communications

All partners contributed to defining the vision for Plumas County and the structure for Whole Person Care that includes improved data sharing and communications to address a fragmented system. The disparate electronic medical records used in the three Emergency Departments in Plumas County have posed challenges for data gathering and developing an integrated approach for patients. Plumas County has three special district hospitals - Eastern Plumas Health Care (EPHC) in Portola; Plumas District Hospital (PDH) in Quincy with a clinic in Greenville; and, Seneca Healthcare District (SHD) in Chester – that use distinct electronic medical record systems. The Plumas County Public Health clinic uses another separate electronic medical record system and Plumas County Behavioral Health uses two separate systems for patient data on mental health and substance use disorders. Further, Plumas County has three separate pharmacies in three of its four communities, and there are no psychiatrists in the county. Instead, providers use tele-psychiatry services for medications management, and each of the hospitals and County Behavioral Health has a separate vendor for tele-psychiatry services.

As a result of these dynamics, we have been challenged to gather utilization data for Emergency Departments, hospitals, outpatient services, and pharmaceutical prescriptions. The WPC Pilot will provide Plumas County with the opportunity to build new automated system capacity for working together to track utilization and other data on all WPC participants across all systems, specifically through the proposed automated Client Data Management and Care Coordination System proposed in this SCWPCC Pilot.

The WPC partners anticipate the development and implementation of core tasks and workflow of integrated care as follows:



Overarching Vision

In summary, the Plumas County WPC Pilot builds on the system changes and collaborations that Plumas County partners commenced in recent years. Plumas Partners are committed to the CMS Triple Aim targets for improving the patient experience of care, improving the health of populations, and reducing the per capita cost of health care. Furthermore, the WPC universal and variant metrics for the Pilot will reinforce the outcomes that the hospitals have selected in the PRIME grants. Plumas partners are committed to Continuous Quality Improvement (CQI) and use of the Plan-Do-Study-Act (PDSA) process, and are confident the collaborative learnings from the SCWPCC will inform other small counties and provide them with replicable models for WPC implementation and sustainability.

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Geographic Area

The total County population is 55,269 with a large concentration of Spanish-speaking people and migrant farmworkers, along with a significant number of persons in the criminal justice system. There are 19,023 persons on Medi-Cal as reported by DHCS in September 2016. Anthem Blue Cross, the sole Medi-Cal managed care provider in the county, reports serving 7,673 members. The balance of 11,350 Medi-Cal Members is in Fee for Service Medi-Cal. San Benito County has submitted a request to State DHCS for statistics on the fee for service Medi-Cal population to supplement local data available on this population (see Attachments: San Benito County). In addition, 651 homeless persons were reported in the 2015 HUD Census Point in Time count. The 2017 Homeless Census count has been conducted and a statistical report will be released in May 2017.

Need for the Pilot

San Benito County conducts formal needs assessments to assess community priorities, and there is a community mandate to solve the homeless problem and provide more affordable housing. Existing data supports the needs assessments. There is a critical need for the WPC Pilot Project based on the number of high users of Medi-Cal combined with the continued increase in homeless persons. The 2013 Point in Time Count found 277 persons, while the 2015 count found 651 persons. Additionally, the poverty rate in San Benito County is County is 9.3 %. Impacting those in poverty is the continued rise in housing rents and prices that lead to more homeless persons. The County's annual HMIS data shows a growing percentage of homeless and an increasing number of persons with mental illness, substance abuse, and persons with two or more health conditions. In light of current dynamics, a large population of persons cycle through the jail, emergency medical services, detoxification, and temporary shelters often ending up on streets.

2013 HUD Point in Time Homeless Count	277 persons
2015 HUD Point in Time Homeless Count	651 persons

The count of persons on Medi-Cal is as follows:

Anthem – Blue Cross	7,673
Fee for Service	11,350
Total Medi-Cal - DHCS	19,023

The accumulated data from our needs assessments, homeless census, Anthem and other sources supports our local need to implement a WPC Pilot aimed at reducing high users through participant engagement, coordinated care, housing support services and a planned Medical Respite program.

Process for Defining the Vision and Structure of the WPC Pilot

Since the economic downturn in 2008, the San Benito County Board of Supervisors has been focused on the growing homeless population. At the direction of the Board, the County Health and Human Services Agency (HHSA) formed a Homeless Planning Committee comprised of County Department heads and community partners. This Homeless Planning Committee is a collaborative group that is focused on reducing homelessness in the community. The partnerships in this group are the hub around which the Whole Person Care Pilot will be built. The Board's long-term vision is to eliminate homelessness in San Benito, and the WPC Pilot will allow the county to test strategies to support homeless individuals and individuals at risk of homelessness find permanent housing while supporting reduced Emergency Department visits, reduced inpatient hospital utilization, and overall better health outcomes.

The Homeless Planning Committee worked collaboratively to apply for a grant from the State of California Community Development Block Grant Program. San Benito's HHSA was awarded $1.5 million to develop a permanent Homeless Shelter. The Board of Supervisors voted in April 2016 to acquire and purchase a property for the homeless shelter facility. County staff is currently working through its architectural and engineering process in order to create a rehabilitation plan for the structure that will become the new Homeless Shelter Facility. Completion is scheduled in November of 2017.

Because the homeless shelter facility will only consume about one third or 4,300 square feet of the building occupancy, there remains about 8,800 square feet available for other programs and services to complement the shelter operations. Consequently, the subject property has been divided into two phases: Phase One will be the 4,300 square foot Homeless Shelter Facility for overnight emergency housing. Phase Two is being planned as a space for operation of the Whole Person Care Pilot and other supporting services, including the possibility of job employment training component. This unique Homeless Services Center will therefore combine the Overnight shelter with the WPC supported services component. This outcome is a product of the prior experience of San Benito County in operating a winter seasonal family shelter for homeless persons.

This specific operation uses HMIS data to track homeless occupancy. In addition, the County operates a HUD program titled “Helping Hands” which provides rental assistance and placement in rental housing units and a program of Tenant Based Rental Housing (TBRA) using Federal Home Funds. Together, this prior and current experience has enabled the County to acquire the ability to identify and target homeless and at risk of becoming homeless persons.

Structure and General Description of the WPC Pilot

The San Benito County WPC Pilot will be a unit of special programs and services linked to county lead entity (HHSA), which has a physical location within walking distance to the proposed Pilot location. The WPC Pilot will be staffed with a team that engages and enrolls individuals for assessments and then hands off these individuals for development of a Comprehensive Care Coordination Plan. The county lead entity will convene monthly meetings of the Whole Person Care Leadership Committee, which will be composed of many of the members of the Homeless Planning Collaborative (HPC), to provide oversight, address general service issues and respond to needs for WPC program adjustments based on evaluation reports.

Pilot Strategy for Addressing Needs of Target Population

The county lead entity and the Homeless Planning Collaborative have discussed various strategies for addressing homeless needs. The major strategy has been to develop a permanent homeless shelter to act as a community resource while also maintaining its current winter homeless shelter operations along with providing support services through its existing rapid rehousing and emergency shelter services. Within this context, the WPC will have the following objectives:

- Care Coordination and Alignment with Current System

The coordination of collaborative activities and efforts across our entities, departments and disciplines has already begun with the formation of the Homeless Planning Collaborative. Implementation of the WPC will allow San Benito County to increase coordination at the street level, bring clinical expertise and peer support through Participant Engagement, Comprehensive Care Coordination, and housing placement. The outcome of this added support will be personal stabilization of WPC participants and improved overall health outcomes. Having the full participation from our managed care provider, Anthem, along with the community support from our Hazel Hawkins Hospital will ensure care coordination efforts and system alignment.

- WPC Pilot Will Build Upon and Strengthen Existing Efforts in the Community

Over three years of discussion, the Homeless Planning Collaborative has developed consensus to focus on providing access in four areas to produce the best outcomes for the disadvantaged and vulnerable population groups in the community: health care, education, housing and jobs. As stated in the vision of the American Public Health

Association, “We value all people equally. We optimize the conditions in which people are born, grow, live, work, learn and age. We work with other sectors to address the factors that influence health, including employment, housing, education, health care, public safety and food access.” The WPC Pilot will follow this same approach.

Sustaining Whole Person Care

A result of the Whole Person Care Pilot in San Benito County, it is anticipated that savings will be achieved through coordinated care provided to homeless WPC participants, including:

- Reduced inpatient hospitalizations
- Reduced rates of chronic health problems
- Reduced Emergency Department use for conditions that could have been treated with preventative care
- Reduced interaction with law enforcement and the justice system

These savings will benefit participating entities and community partners and provide evidence of the value of system integration to address the needs of high-need, multi-system utilizers in our community. In addition, the automated Client Data Management System to be established as a part of the WPC Pilot will continue after the Pilot, and this system architecture will provide the county with the continued ability to manage the needs of multi-system utilizers in an integrated manner. It will also demonstrate the effectiveness of this automated system for other small counties in California seeking integrated services delivery for high-need populations.

2.2 Communication Plan

The SCWPCC will have a 3-party Executive Committee composed of the Director of the collaborative lead entity from each county WPC program, and will be supported by key local staff these Directors designate. The Executive Committee will serve as the policy making body for the SCWPCC. The Executive Committee’s decision structure and the use of committees or workgroups will be determined during the first two months of program implementation. The SCWPCC is anticipated to meet monthly in PY 2 and regularly throughout PYs 3-5.

Additionally, each county has developed a detailed process for local communication, which is detailed below:

MARIPOSA

Mariposa County Human Services is the county lead entity for Mariposa County and will provide leadership, coordination, oversight, financial and data management, and overall accountability of the WPC Project. A Whole Person Care Leadership Committee will be formed with administrative and leadership team members from each of the Participating Entities to ensure staff from the participating agencies are collaboratively working to provide the services and meet the objectives of the WPC Pilot outlined throughout this document.

Initially, this team will meet on a monthly basis while protocols and strategies are being developed and implemented. Data from the Pilot will be reported out at each meeting, as available, so that improvements can be made and course corrections can occur to ensure continuous quality improvement. Decision-making will be shared among participating agencies. However, in the event of a disagreement, the Human Services Director, accountable to meet the requirements of the WPC Pilot, will make decisions in alignment with the intent and the scope of the Pilot.

This Leadership Committee will continue to meet throughout the WPC 4-year Pilot and beyond to review data and make Pilot improvements to best serve WPC participants. As community and participant needs change over time, the Pilot will continue to not only look at Pilot specific data, but at community indicators and needs, as well as successful interventions and evidence based practices.

In addition to the Leadership Committee, the CCC Team will meet weekly (or more often as needed) for the purposes of developing comprehensive Care Coordination Plans, discussing participant progress and barriers, sharing resources and information, and reviewing process and outcome data to ensure continuous quality improvement on a participant and systems level. As described in the Services, Intervention, and Care Coordination section of this proposal, the team will be led by the Lead MHA III from Mariposa County Human Services and be attended by representatives from Public Health, JCFHCD, Mariposa County Human Services Behavioral Health and Recovery Services (MCBHRS), and other participating entities, based on individual needs of each participant. During the first year of implementation, the Leadership Committee will meet in conjunction with representatives of the CCC Team in order to develop policies and procedures to guide referral processes, enrollment criteria, documentation, data collection, data sharing, communication, and reporting.

Data will be coordinated and shared between the WPC Pilot and the Managed Care Plans. Additionally, as appropriate data will be discussed with the JCFHCD PRIME Committee, the Mariposa County Homelessness/Emergency Housing Committee, the Mental Health Board, The Alcohol and Drug Advisory Board, and the Mountain Valley Emergency Medical Services Agency and Regional Advisory Boards. Upon WPC Pilot commencement, letters will be sent to all WPC partners and stakeholders to establish a common understanding of Pilot Project goals and services, as well a referral systems into the Project. Additionally, articles will be written by Mariposa County Human Services upon WPC program award and also throughout the Pilot to highlight successes, whenever appropriate. Mariposa County's website will be utilized to share Pilot Project information with the community. Regular Board of Supervisors updates will occur to ensure leadership support.

PLUMAS

Internal Communications

The most frequent contact Plumas County Behavioral Health has with hospitals is for Section 5150 evaluations at hospital Emergency Departments. These patients have complex needs that are not currently being met due to the lack of case management and resource linkage services. The following table will be used to inform partners on clinical integration based on patient needs (Adapted from Mauer 2006):

Low Behavioral Health Risk/Complexity High	*Quadrant II* Patients with high behavioral health and low physical health needs Served in primary care and specialty mental health settings (Example: patients with bipolar disorder and chronic pain)	*Quadrant IV* Patients with high behavioral health and high physical health needs Served in primary care and specialty mental health settings (Example: patients with schizophrenia and metabolic syndrome or hepatitis C
	Quadrant I Patients with low behavioral health and low physical health needs Served in primary care setting (Example: patients with moderate alcohol abuse and fibromyalgia)	*Quadrant III* Patients with low behavioral health and high physical health needs Served in primary care setting (Example: patients with moderate depression and uncontrolled diabetes)
	Low Physical Health Risk /Complexity High	

Improved communications and data sharing are integral outcomes for the WPC partners and will aid in improving patient care. Currently, there is no system for communications and sharing of data collection among hospital partners, county health agencies, health care providers and community-based organizations. In a report of Eastern Plumas Health Care (EPHC), gaps in patient care were identified as follows: communications between providers and consultation notes and prescriptions are manually managed in a cumbersome and inefficient process; ED providers stated it is difficult to determine what psychotropic medications patients seen by tele-psychiatrists are taking and believe patients are often overmedicated; there is a lack of coordination of services between patients who are seeing a tele-psychiatrist and therapists and potentially another psychiatrist provider if they are seeking medications denied by one provider or the other. EPHC estimated that 20% of their total visits to their clinics in 2015 involved a behavioral health diagnosis.

Goals for the WPC pilot are to implement best practice standards including standard screening tools for behavioral health diagnosis (PHQ-9, among others); to establish a

dedicated Lead Case Manager to oversee care coordination and referrals to community-based resources, schools and education resources, and county health and human services programs and other support linkages; and to establish improved methods for data sharing and communications between hospitals and County Behavioral Health.

The WPC Pilot will emphasize five core principles of effective collaborative care (drawn from Improving Mood Across Collaborative Treatment or IMPACT trial and its replications). IMPACT is an intervention for adult patients who have a diagnosis of major or chronic depression, often in conjunction with another major health problem. The IMPACT model is a collaborative, stepped-care approach in which a trained care manager works with the patient, the patient's primary care provider and a psychiatrist to develop and administer a course of treatment. The five core principles include the following:

1. *Care is team-driven and patient centered* – comprised of multi-disciplinary team of WPC agencies and community partners that provide an array of services
2. *Care is population-focused* - and is provided for defined populations of patients and tracked through databases. Information is reviewed regularly by the team to determine if improvement is occurring and make the necessary changes (Plan-Do-Study-Act)
3. *Care is evidence-based* – selections of brief interventions such as motivational interviewing, standard assessment tools, others
4. *Care is measurement-guided* – treatment and care is tracked and monitored. The proposed Client Data Management System will be vital for WPC participant care coordination and monitoring service delivery
5. *Care is accountable for outcomes* – the team takes responsibility for the outcomes and costs of the care provided.

Plumas County Behavioral Health, as County Lead Entity, will convene, at a minimum, monthly meetings with all WPC partners throughout PY 2-5. The County Lead Entity will oversee WPC Pilot operation in the county and assure the following core elements of the WPC Pilot are implemented and made operational: 1) Identification of the target population(s) and timely assessment of their needs; 2) Assurance of local collaboration and programmatic coordination across all Participating Entities; 3) Ongoing facilitation of care coordination among service providers; and, 4) Development of an appropriate and effective strategy for sharing confidential data among Participation Entities that supports identification of common patients, coordination of care, improved access to needed services and support, and data collection and reporting necessary to document individual and system-level health outcomes. Care Teams consisting of case management specialists, hospital liaisons, community-based service providers, and nurses will meet weekly and more frequently as needed to coordinate services for WPC participants. In May and June 2017, Behavioral Health will convene public meetings at its four (4) Community Wellness Centers with all partners and community stakeholders to explain the WPC Pilot and describe the engagement and enrollment process. Throughout the WPC program, Behavioral Health will provide information and updates at the Plumas County Board of Supervisors meetings, the Behavioral Health

Commission monthly meetings, hospital monthly educational meetings, and Community Wellness Center monthly meetings in Chester, Greenville and Portola.

External Communications

Information dissemination will be broad and will include a web page on the Plumas County Behavioral Health web site and a quarterly newsletter that will be distributed electronically to all WPC partners and stakeholders and will also be made available in hard copy. Plumas County's Mental Health Commission recently merged with the Alcohol and Other Drug Advisory Board into the Behavioral Health Commission. Reporting from the WPC Pilot will become a standing agenda item on the monthly meetings of this Commission, which is comprised of consumers and families, and agency representatives.

The WPC Pilot will be represented on the Plumas County Mental Health Services Act stakeholders and community participation group. Representatives from the WPC Pilot will provide, at a minimum, quarterly updates to the Plumas County Board of Supervisors, and the WPC Pilot will have representation in Public Health's 20,000 Lives project, a 2016 Innovation Award recipient by California State Association of Counties (CSAC), in its newsletter, blog and quarterly meetings. Finally, the WPC Pilot will establish a role for a Public Information Liaison to strengthen communications with the public, community partners, and other counties and organizations.

SAN BENITO

The San Benito Health and Human Services Agency (HHSA) is the county lead entity and will provide leadership, coordination, oversight and overall accountability to planning and future implementation of the local Whole Person Care Pilot. The county lead entity will work with the other participating entities such as Behavioral Health, Public Health, and Probation Departments in order to ensure the effectiveness of a communication plan within the participating entities as well as the community partners.

There is existing foundation for inter-department communication when three years ago, the HHSA was tasked by the County Board of Supervisors to address and solve the growing local homeless problem. In response, the HHSA established the Homeless Planning Collaborative that meets regularly to share relevant community information and discuss strategies and activities regarding the local homeless problem and related concerns. The Collaborative is composed of County Department Heads and upper management staff along with representatives from community partners, non-profit organizations and local residents. The County Sheriff and the Mayor of Hollister also attend these meetings. These meetings are, in effect, the communications hub for our County and City staff collaborations with community members. Recently, the Homeless Planning Collaborative added a special committee to address low income housing and further created an advisory committee for our proposed Proposition 47 project. The HHSA Director, Mr. James A. Rydingsword, chairs the Collaborative meetings that have been held for the past three years and will continue on a regular basis.

The Homeless Planning Collaborative, in particular, has been tasked with adopting metrics to measure the performance of the homeless and housing services system. The Collaborative has been instrumental in planning and conducting the federally mandated Homeless Point in Time Count which occurred in years 2013 and 2015 and is presently underway for 2017. HMIS data is used for the purpose of adopting metrics that will provide necessary oversight of activities for measuring need, effectiveness and outcomes. User access to software data by participating entities and partners is being explored.

The Homeless Planning Collaborative membership is in the process of creating a WPC Leadership Committee to initiate formation and implementation of the WPC Pilot. This WPC Leadership Committee will design implementation objectives and specific activities to address barriers, resolve line issues and assure appropriate data collection and systems analysis. The WPC Leadership Committee will meet regularly (weekly to monthly) apart from meetings of the Homeless Planning Collaborative in order to carry out WPC Pilot planning and implementation activities. Objectives of the WPC Leadership Committee are as follows:

WPC Program Objectives in Year One and Two:

- WPC baseline data gathering and analysis
- WPC program planning and policy development
- Review and finalize infrastructure needs
- Metrics and evaluation framing
- Developing housing support relationships
- Comprehensive systems mapping
- Focused implementation planning objectives and activities

WPC Pilot Year Program Objectives in Three to Five:

- Review metrics and evaluation findings
- Use evaluation findings for program improvements
- Services monitoring
- Services coordination
- Health outcomes
- Housing Support outcomes
- Adopt a WPC program sustainability plan

2.3 Target Population

Mariposa, Plumas and San Benito Counties used local data to determine their target populations as follows:

County	Target Populations
Mariposa	• Individuals with a behavioral health condition (mental health, substance abuse, or co-occurring diagnosis) and one or more of the following: o Repeated incidents of Emergency Department use, hospital admissions, or nursing facility placement; o Two or more chronic conditions; o Homeless or at risk for homelessness; and/or, o Recently released from institutions (i.e., hospital, county jail, institutions for mental diseases, skilled nursing facility, etc.) or connection to the criminal justice system.
Plumas	• Individuals with a behavioral health condition (mental health, substance abuse, or co-occurring diagnosis) and one or more of the following: o Repeated incidents of Emergency Department use, hospital admissions, or nursing facility placement; o Two or more chronic conditions; o Homeless or at risk for homelessness; and/or, o Recently released from institutions (i.e., hospital, county jail, institutions for mental diseases, skilled nursing facility, etc.) or connection to the criminal justice system • Individuals who are homeless or at risk for homelessness and one or more of the following: o Have a behavioral health condition (mental health, substance abuse, or co-occurring diagnosis) o Repeated incidents of Emergency Department use, hospital admissions, or nursing facility placement; o Two or more chronic conditions o Recently released from institutions (i.e., hospital, county jail, institutions for mental diseases, skilled nursing facility, etc.) or connection to the criminal justice system

County	Target Populations
San Benito	• Individuals who are homeless or at risk for homelessness and one or more of the following: o Have a behavioral health condition (mental health, substance abuse, or co-occurring diagnosis) o Repeated incidents of Emergency Department use, hospital admissions, or nursing facility placement; o Two or more chronic conditions o Recently released from institutions (i.e., hospital, county jail, institutions for mental diseases, skilled nursing facility, etc.) or connection to the criminal justice system

The following is a description of the local processes and data used to determine the target population.

MARIPOSA

Partner organizations considered possible target populations based on utilization data, community needs and gaps, and other funding opportunities that could be leveraged. While data is difficult to cross-reference in the current proprietary systems that each of the partner agencies utilize, the WPC Pilot will provide the opportunity to build automated system capacity for working together to track data on the WPC participants we will serve across all systems. Based on currently available data, we made the determination that casting a wide net for a broad target population will be most beneficial. In addition, our local Healthcare District (John C. Fremont Healthcare District) recently was awarded a PRIME Grant under the Medicaid Waiver and we will fully collaborate and leverage resources to ensure that we effectively work together to avoid any duplication of efforts.

Medi-Cal and Managed Care Population

Approximately 27% of the county population or a grand total of 4,786 persons are certified Medi-Cal eligible according to DHCS reported data as of September 2016 (http://www.dhcs.ca.gov/dataandstats/statistics/Pages/Medi-Cal-Certified-EligiblesRecentTrends.aspx/Medi-Cal_Cnty_and_4Group_Table_9_2016.xlsx). This includes 1,608 persons in ACA expansion adult age 19 to 64; 1,789 in Parent/Caretaker Relative and Child; and 1,337 in Senior/disabled, and 52 undocumented. DHCS data for Medi-Cal managed care enrollment by county and by health plans as of January 2017 indicate that California Health and Wellness has 912 members and Anthem has 2,888 members (http://www.dhcs.ca.gov/dataandstats/reports/Documents/MMCD_Enrollment_Reports/MMCEnrollRptJan2017.pdf). California Health and Wellness Data for 2016 indicated 541 members received services. Of those members, 143 (28%) have been diagnosed with a mental illness and 120 (22%) with a substance use disorder. In terms of co-morbidity, of their members receiving services: 56 (10%) report a co-occurring mental health/substance use disorder; 75 (14%) report having a mental health/substance use disorder and physical health diagnoses; 75 (14%) have been diagnosed with multiple physical diagnoses; and 417 (77%)

have comorbidities involving both physical health diagnoses and a co-occurring mental health or substance use disorder diagnosis.

In determining our target populating we considered the high levels of those with behavioral health conditions coupled with risk factors such as homelessness/risk of homelessness, those involved in the criminal justice system, and those with comorbid physical health issues in our County. With this in mind, we decided to serve individuals who have a history of repeated incidents of avoidable Emergency Department use or hospital readmissions, who have a behavioral health condition, and who meet one or more than one of the following criteria: homeless or at risk of homelessness; criminal involvement; or chronic physical health issue.

Individuals with Behavioral Health Conditions

Persons ages 12 and older with a behavioral health condition and/or SUD, and enrolled in Medi-Cal are included in the target population for WPC. It is anticipated that many of these individuals will have other confounding risk factors such as homelessness, chronic illnesses, criminal justice involvement, etc. In addition, these individuals will have a history of non-adherence with medications, and have difficulty accessing primary care services to help manage their mental health and health conditions.

Data utilized to help identify this target population includes information from Mariposa County Human Services Behavioral Health and Recovery Services (MCBHRS). This data was examined to identify persons who have Medi-Cal and receive mental health and/or treatment services. Mariposa County uses Anasazi Electronic Health Records by Cerner. This data shows that there were a total of 697 persons that received mental health services in FY 15/16. Of those, 155 were between the ages of 12 and 18; 464 were between the ages of 19 and 59; and 78 were 60 or older. Of these, 18 were enrolled in the Children's System of Care and 20 within the Adult's System of Care. Enrollment in the Systems of Care Full Service Partnerships occur when individuals have intensive SMI needs and functional impairments that necessitate a higher level of service. Approximately 85% are on Medi-Cal or Medi-Cal Eligible.

In Mariposa County, MCBHRS is almost always called out to the Emergency Department when potential mental health concerns arise. In terms of behavioral health ED utilization and hospitalization data, in FY 2015/16 behavioral health staff responded to calls from the ED 272 times, seeing an unduplicated 162 individuals for mental health related calls. Of the calls, 42 individuals were seen 2 times and 16 were seen 3+ times. There were 33 total psychiatric hospitalizations, some of which were repeat hospitalizations. Sixteen individuals used the Emergency Department 3+ times, including individuals under the age of 18. Of those, some were diagnosed with a co-occurring substance use disorders; and other individuals had impairments that resulted in Lanterman-Petris-Short (LPS) Conservatorships.

According to fiscal reports produced by Mariposa County Behavioral Health and Recovery Services, in FY 15/16, there were a total of 495 bed days with an average of 16 days per person. The cost of inpatient psychiatric hospitalization was $449,986. Seventeen individuals utilized a psychiatric respite bed for a total of 23 bed days at a total cost of $22,980. Prices in respite reflect our contract of holding a bed available, as well as actual days utilized. The vast majority of these individuals are on Medi-Cal.

Data was available for individuals with substance use disorders through our California Outcomes Measurement System (CalOMS) reporting system. Ninety-seven individuals received outpatient treatment during FY 15/16; Mariposa County BHRS paid for 15 of these individuals to go to residential treatment for a total cost of $63,471 during FY 15/16. Additionally, Mariposa County Probation paid for additional individuals to go to residential treatment for a total cost of $13,300.

Currently Homeless or At Risk of Homelessness

Mariposa County has engaged in multiple Point in Time (PIT) counts and surveys over the 2 years (2015, 2017) to determine overall need and strategies to address homelessness (https://www.hudexchange.info/resource/reportmanagement/published/CoC_Dash_CoC_CA-526-2015_CA_2015.pdf and http://www.mariposacounty.org/DocumentCenter/View/41898). During 2015, surveys were collected from homeless individuals. Of those surveyed, 48% indicated they struggle with mental health issues; 43% indicated they struggle with substance use issues; 33% indicated they struggle with major health concerns; and, 29% reported a physical disability of some sort. During the 2017 PIT Count, 51 individuals (an increase from the previous count) were counted and survey data demonstrated similar findings. We anticipate that at least 25% of those enrolled in Whole Person Care Pilot will be currently homeless or at risk of homelessness.

Involved in the Criminal Justice System

Although small in population, Mariposa County has individuals involved with the criminal justice system who are also high utilizers of emergency services. In 2014, there were 551 arrests, of which 69% were misdemeanors (CA Dept. of Justice https://openjustice.doj.ca.gov/crime-statistics/arrests). In 2015, approximately 337 individuals were on Probation (156 felony and 153 misdemeanants, with some individuals in Post Release Community Supervision, and Mandatory Supervision). (CA County Probation Data Dashboard https://public.tableau.com/profile/oconnellresearch#!/vizhome/ChiefProbationOfficersofCaliforniaAnnualDataSurvey_0/CPOCProbationSurvey). The average daily population at Mariposa County Jail was 41 individuals in 2015 (California Board of State and Community Corrections https://public.tableau.com/profile/kstevens#!/vizhome/ACJROctober2013/About). A cross referencing of Probation, Jail, Alliance for Community Transformations (local CBO), and MCBHRS data indicate that approximately 50% of incarcerated/criminally involved individuals have experienced or currently experience a mental illness or substance use disorder. We anticipate that at least 25% of those enrolled in Whole Person Care will have had some involvement with the criminal justice system, however, will not be incarcerated at the time WPC-covered services are provided.

Significant Chronic Health Condition(s)

Mariposa has one critical access hospital and poor access to primary care services, with 27.5 providers per 100,000 residents, as compared to the US median of 48 providers. Both the age adjusted chronic lower respiratory disease death rate and asthma prevalence are higher than comparable communities. According to data regarding cause of death from the California Department of Public Health, out of 58 Counties in California, Mariposa County

ranks: #1 in suicide related deaths, #2 in opioid related deaths, #5 in drug related deaths, #9 in deaths related to coronary heart disease. Regarding chronic health issues: Mariposa's Coronary Heart Disease rate of incidence is 115.3 per 100,000 residents compared to California's 96.6. For chronic lower respiratory disease, the incidence is 42.9 per 100,000 compared to 33.7 in California http://www.countyhealthrankings.org/app/california/2016/rankings/mariposa/county/outcomes/overall/snapshot); Data from CalBRACE (California Building Resilience Against Climate Effects https://archive.cdph.ca.gov/programs/ohir/Documents/OHIRProfiles2016.pdf) indicates that 38% of the region's adults report one or more chronic health conditions like heart disease, diabetes, asthma, severe mental stress or high blood pressure; 9.7% of adults have diabetes (compared with 8.1% in US); 11% of adults report a diagnosis of asthma.; 19% of adult residents are obese; and, approximately 18% of Mariposa County residents aged 5 years and older have a mental or physical disability (https://archive.cdph.ca.gov/programs/ohir/Documents/OHIRProfiles2016.pdf).

OSHPD data revealed that there were 6,003 ED encounters in Mariposa County in 2016. Of these, 589 resulted in some type of discharge to a hospital, psychiatric unit or jail. Data reveals that 34 of these individuals were discharged to law enforcement and 27 to a psychiatric unit (https://www.oshpd.ca.gov/HID/Find-Hospital-Data.html). JCFHCD data revealed that in 2016, there were a number of individuals who are categorized as "high utilizers" in terms of ED visits. A total of 44 had more than 5 visits at JCFHCD alone. Given that individuals in Mariposa County utilize ED services in surrounding counties including Fresno County, Merced County, and Tuolumne County due to their proximity to those services, we know this number represents just a segment of this population of high utilizers of ED services:

Number of ED Visits	Number of Unduplicated Patients
5+	44
2-4	344
1	1095

Total Target Population

In analyzing the data presented above, WPC partners anticipate serving approximately 20 individuals per year in Comprehensive Care Coordination. Approximately 30 annually will receive Engagement Services prior to enrollment and approximately 12 will receive Housing Navigation and Supports. These individuals will include those with a behavioral health condition (mental health, substance abuse, or co-occurring diagnosis), who are high utilizers of emergency services or hospital admissions and who have one or more of the following:

- Homeless or at risk for homelessness; and/or,
- Involvement with the criminal justice system; and/or
- Chronic physical health issues.

The assumptions used in selecting WPC target populations were developed and confirmed during multiple meetings with WPC partners. Clean, validated data regarding individuals who are high utilizers AND homeless, involved with the criminal justice system and/or have chronic physical health issues have not been available; however, our WPC partners reported

that individuals in these categories are among the most difficult to serve and would benefit the most from a WPC approach.

Although there are many more individuals who could potentially fit in these categories based on the data presented, we felt there were a number of individuals who when outreached to and linked with the appropriate resources, may not need the intensive and comprehensive spectrum of services that WPC provides. In other words, we are assuming that if there are 100 "high utilizers" annually, 70% of them will either not want to engage or will be happy to receive the extra supports that can be afforded to them by enrollment in other services and programs that they may not currently be connected with, which we will facilitate.

The table below illustrates how many individuals we plan to serve throughout the WPC Pilot. The WPC Pilot has four (4) Target Populations:

- Individuals with a Behavioral Health Condition AND who are High Utilizers of ED OR Hospital Admissions but who do not fit into any of the other three categories below by having the additional eligibility criteria of being homeless, involved in the criminal justice system, or with two or more chronic health conditions
- Individuals with a Behavioral Health Condition AND who are High Utilizers of ED OR Hospital Admissions AND who are homeless or at-risk of homelessness
- Individuals with a Behavioral Health Condition AND who are High Utilizers of ED OR Hospital Admissions AND are involved with the criminal justice system
- Individuals with a Behavioral Health Condition AND who are High Utilizers of ED OR Hospital Admissions AND who have two or more chronic health conditions

Total Unduplicated Populations

Target Population	PY2	PY3	PY4	PY5	Total
Behavioral Health Condition and High Utilizer	*2*	*8*	*8*	*8*	*26*
Behavioral Health Condition, High Utilizer and Homeless or At-Risk	*5*	*12*	*12*	*12*	*41*
Behavioral Health Condition, High Utilizer and Criminally Involved	*2*	*6*	*6*	*6*	*20*
Behavioral Health Condition, High Utilizer and Chronic Physical Health Issues	*1*	*4*	*4*	*4*	*13*
	10	*30*	*30*	*30*	*100*

A number of indicators were utilized to determine target population in Mariposa County, including Behavioral Health utilization data, Emergency Department utilization data from John C. Fremont Healthcare District and Managed Care Plans, HUD Point in Time Count Data and Probation Data. JCFHCD Emergency Room data revealed that 44 individuals in 2016 were seen more than 5 times in the ER, categorized as "high utilizers". Because our population includes individuals who are high utilizers and have a behavioral health condition, with ER

input, we estimated that approximately 30 of the 44 per year that were high utilizers would have a behavioral health condition, whether it was primary or secondary to health condition. Determinations were made based on number of individuals in each category as well as number of individuals we felt we could reasonably and effectively serve, understanding that some individuals would participate in the program willingly and some would not be receptive.

PLUMAS

2.3 Target Population(s)

Behavioral Health Population

Adults and children in Plumas County have a wide range of mental health needs. The 2014 MHSA community survey revealed that 73% of respondents feel that sadness or depression is a large issue for adults and 53% feel it is an issue for children and youth; while 71% felt that anxiety was a large issue for adults. Over one third responded that suicide was a large issue in adults and 20% believed suicide was an issue for children. Data from the California Department of Public Health death statistics for 2011-13 indicate Plumas County suicide rate is 113% higher than that of the State. Chronic pain is a significant problem and substantiated by CDPH data indicating Plumas County has nearly 7 times the incidence of opioid overdose than the state. In Lassen, Modoc, Nevada, Plumas and Sierra counties from 2013 to 2014, the rate of mental health-related hospitalizations per 1,000 rose from 3.5 to 4.1 while staying consistent statewide at 5.1. According to data from OSHPD, cited by kidsdata.org, hospitalizations for mental health issue for those age 5-19 years has been on the rise (https://www.oshpd.ca.gov/HID/Find-Hospital-Data.html).

Medi-Cal and Managed Care Population

Data from the US Census Bureau, American Community Survey, indicate the percentage of adults in Plumas County with no health insurance was 19% in 2010 and 18% in 2014. The same source indicates the percentage of disabled individuals rose nearly 20% from 2012 to 2016 and is more than double the rate for the State (18% in 2012 and 21% in 2016). Approximately 34% of the county population or a grand total of 6,213 persons are certified Medi-Cal eligible according to DHCS report data as of September 2016 (http://www.dhcs.ca.gov/dataandstats/statistics/Pages/Medi-Cal-Certified-EligiblesRecentTrends.aspx/Medi-Cal_Cnty_and_4Group_Table_9_2016.xlsx). This includes 1,992 persons in ACA expansion adult age 19 to 64; 2,321 in Parent/Caretaker Relative and Child; and 1,844 in Senior/disabled, and 56 undocumented. DHCS data for Medi-Cal managed care enrollment by county and by health plans as of January 2017, indicate that California Health and Wellness has 2,331 members and Anthem has 2,601 members(http://www.dhcs.ca.gov/dataandstats/reports/Documents/MMCD_Enrollment_Reports/MMCEnrollRptJan2017.pdf). California Health and Wellness Data for 2016 indicated 1,294 members received services with about one-third receiving a mental health diagnosis and 20% receiving a substance abuse diagnosis; 7% or 88 individuals had 4 or more comorbid diagnoses, and 3% or 34 had 5 or more comorbid diagnoses.

Beneficiaries Served by County Behavioral Health

Data from CalEQRO, the external quality review organization for Specialty Mental Health Services for California, for the calendar year 2014 indicated the average number of Medi-Cal eligible beneficiaries per month was 3,941 with a total number of beneficiaries served per year of 379 for mental health services. For the fiscal year 2015-2016, Plumas County's database tracked 405 Medi-Cal approved claims and a total population served of 730 participants for mental health. This indicates an increase of 26 Medi-Cal beneficiaries served (379 to 405) and 325 individuals not covered by Medi-Cal. For alcohol and other drug services (AOD), Plumas County served 194 participants in FY2014-2015. In April 2015, the one-day count indicated 86 persons in outpatient treatment. The table below provides a summary of Plumas County's Medi-Cal beneficiaries served annually by the County Behavioral Health Department and by Managed Care Providers. The data indicates that approximately 32% of Medi-Cal beneficiaries that include the ACA expanded population or 2,000 individuals out of 6,213 beneficiaries are receiving behavioral health services. This data represents 10% of Plumas County's total population of 18,606 residents.

	County Providers	**Managed Care Providers**		**Combined Total**
	Medi-Cal	*Anthem*	*CA H&W*	
Beneficiaries	1,281	2,601	2,331	6,213
MH diagnosis	405	429*	427	1,261
AOD/SUD diagnosis	194	286*	259	739
Total MHSUD diagnosis	599	715	686	2,000

**Extrapolations for Anthem were made using CA H&W percentages provided.*

Disabled, Homeless and At Risk for Homelessness

Significant data include the high percentage of disabled adults, high rates of suicide and opioid-related deaths and a growing proportion of residents 60 years and older (32% in Plumas as compared to 17% in CA). There are 2,134 veterans residing in Plumas County and, through Veteran's Services outreach efforts, a small number of veterans were identified as homeless and a smaller number accessed emergency/ transitional housing in 2016. Collaborative partners are also cognizant of the increase of "couch surfing/homeless students" from 76 in 2014-2015 to 128 in 2015-2016, according to data collected by the School-Based Response Team. The HUD homeless count indicates an increase from 62 in 2015 to 78 in 2016.

Released from Jail and Hospitals

With regard to criminal justice, the Plumas County jail in 2015 had an average of 50 daily jail inmates, consisting of 80% males and 20% females. Thirty-three were un-sentenced and 17 were sentenced. In 2015, there were 843 total arrests with 199 felony offenses and 638 misdemeanors and 6 status offenses. (https://openjustice.doj.ca.gov/data) (jttps://oag.ca.gov/cjsc/pubs). The Community Justice Court (formerly Alternative Sentencing Program) was a consistent referral source for the women's transitional home in 2016. The facility capacity was for 5 women and the home was fully occupied all year. In addition, an apartment funded by the Alternative Sentencing Program houses probationers completing

Drug Court programs or returning from residential treatment. This facility was also occupied all year by several individuals for 2-3 months at a time. Data for March 2017 from the Plumas County Probation Department indicates 300 adults and 30 children on probation and 13 parolees (including sex offenders).

Office of State Health Planning and Development (OSHPD) 2016 Emergency Department data for Plumas County's three hospitals include the following (https://www.oshpd.ca.gov/HID/Find-Hospital-Data.html):

Condition	Eastern Plumas Health Care	Plumas District Hospital	Seneca Healthcare District	Plumas County Total
ED encounters	4,008	4,261	2,420	10,689
Mental disorders	104	158	73	335
Discharged to Psychiatric Hospital	3	16	1	20
Discharged to Court/Law Enforcement	17	46	5	68

Plumas County Behavioral Health's Anasazi data system captures more crisis-related service codes and provides a fuller picture of the county's needs. For example, in contrast to ED data submitted to OSHPD for discharges to psychiatric hospitals, Anasazi indicated 42 service code contacts for psychiatric facilities and 27 referrals in 2016. With regard to Crisis Interventions, the Anasazi report indicates 395 contacts with 234 unduplicated individuals.

Two Defined WPC Target Populations

In analyzing the data presented above, WPC partners anticipate enrolling 40 individuals per year for WPC participation. Veterans and Seniors are a focus population and will be engaged through Public Health's nutrition program funded by the Area Agency on Aging. Veterans and Seniors congregate Monday through Friday for meals offered at the local Veteran's Hall and Senior Center in Portola, Quincy, Greenville and Chester. The target of 40 individuals represents almost 25%of the discharges from Plumas County's three emergency departments (88 individuals) and the 2016 HUD homeless count (78 individuals). WPC partners understand that there is overlap of individuals discharged from hospitals and those who are homeless and that some may be Seriously Mental Ill (SMI). If individuals are SMI and Medi-Cal beneficiaries, they would be referred to the County's Mental Health Plan for services. The WPC pilot will work with the County Mental Health Plan to align services provided to a shared population; no WPC funds will be used to cover non-WPC services nor will WPC funds supplant other funding.

The WPC Pilot will reach out and engage individuals from two target populations as follows:

1. Individuals with a behavioral health condition (mental health, substance abuse, or co-occurring diagnosis) and one or more of the following:
    a. Repeated incidents of Emergency Department use, hospital admissions, or nursing facility placement;
    b. Two or more chronic conditions;
    c. Homeless or at risk for homelessness; and/or,
    d. Recently released from institutions (i.e., hospital, county jail, institutions for mental diseases, skilled nursing facility, etc.).

2. Individuals who are homeless or at risk for homelessness and one or more of the following:
    a. Have a behavioral health condition (mental health, substance abuse, or co-occurring diagnosis)
    b. Repeated incidents of Emergency Department use, hospital admissions, or nursing facility placement;
    c. Two or more chronic conditions
    d. Recently released from institutions (i.e., hospital, county jail, institutions for mental diseases, skilled nursing facility, etc.).

Plumas County WPC Pilot Target Population					
Target Population	PY2	PY3	PY4	PY5	Total
Behavioral Health Condition	10	20	20	20	70
Homeless or At-Risk	10	20	20	20	70
Total	20	40	40	40	140

Plumas County's annual target populations for the WPC pilot are based on hospital discharge data from the California Office of State Health Planning and Development (OSHPD) 2016 Emergency Department data and on the Housing and Urban Development (HUD) homeless count. HUD data indicates an increase from 62 homeless persons in 2015 to 78 homeless persons in 2016. The discharge data provided in the chart above for 2016 indicates that 20 persons with mental health conditions were discharged to a psychiatric hospital and 68 persons were discharged to the court or law enforcement. Plumas County Behavioral Health clinical and case management staff estimates from first-hand experience that the majority of persons that are discharged to a psychiatric hospital and to the court system are homeless and at risk for homelessness. By targeting 40 persons per year for care coordination, Plumas partners anticipate reaching almost 25% of a combined total of the mental health-related hospital discharges (88 individuals) and the 2016 HUD homeless count (78 individuals).

SAN BENITO

Description of the Target Population

Based on local needs assessments, accumulated data from all sources and further based upon discussions with our Homeless Planning Collaborative, we have determined that the WPC Pilot Target Population will be as follows: Persons, ages 18 to 64, who are:

1) Homeless/at risk of homelessness, or
2) High Medi-Cal users, or
3) Persons with a serious mentally illness and/or a substance use disorder, or
4) High hospital emergency department or inpatient utilizers, or
5) Persons involved with the criminal justice system.

Data Analysis and Process Used to Determine Target Population

Below is a summary of the data sources used to select our WPC target population:

- Current HMIS participants: San Benito County's high cost of housing and high percentage of households in poverty have resulted in significant numbers of people seeking homeless prevention services, who are entered into HMIS.
- High System Users: Those who receive homeless assistance and emergency services in San Benito County are often discharged into homelessness. According to HMIS, Anthem and COC data, a large portion comes from shelters and transitional housing, jails, prison or substance abuse centers. Our local hospital, Hazel Hawkins Memorial, also shows data regarding emergency room visits as related to the target group.
- Coordinated Entry: In addition, special efforts will be made to identify additional at-risk households with those on disability receiving immediate attention due to their extra special needs.
- HUD Homeless Census and Related Data: San Benito County had 277 homeless persons counted in 2013 and 651 in 2015 (https://www.hudexchange.info/resource/3031/pit-and-hic-data-since-2007/) . San Benito County also has approximately 600 persons on Adult Probation and more persons in jail that add to the target group numbers. These numbers together with the count of high Medi-Cal Users will provide for our WPC Pilot to serve up to 107 persons over 5 years.
- County and Anthem Medi-Cal Data: In 2016, our local data together with Anthem input reported that there were 8,510 adults and 7,326 children on Medi-Cal for a total of 15,902. (http://www.dhcs.ca.gov/dataandstats/statistics/Pages/Medi-Cal-Certified-EligiblesRecentTrends.aspx/Medi-Cal_Cnty_and_4Group_Table_9_2016.xlsx) Of the 8,510 adults, we estimate up to 7.5% are estimated to be high users. CalOMS data, which tracks individuals with substance abuse disorders, will be made available by the County Behavioral Health Department and shared with all participating entities.

WPC 5-Year Projected Target Population

The projected WPC Pilot target population for PY 2 through PY 5 is set forth below*.

Target Populations	PY 2	PY 3	PY 4	PY 5	Totals
Homeless / At Risk of Homeless	22	45	25	15	107
High Medi-Cal Users	5	5	5	5	20
SMI / SUD	5	5	5	5	20
High Hospital E.R inpatient utilization	5	5	5	5	20
Criminal Justice Population.	5	5	5	5	20
Totals	42	65	45	35	187

*Note: No enrollment cap

To substantiate the San Benito County WPC target number of 187, all available local data indicators were reviewed to determine the WPC target population in San Benito County, including Behavioral Health utilization data, Emergency Department utilization data from Hazel Hawkins Memorial Hospital and Anthem Managed Care John Plans, HUD Point in Time Count Data and Probation Data. In particular, the HUD Point in Time Census revealed an increase from 277 chronic homeless in 2013 which was increased to 651 in 2015.

Emergency Room data (Aggregate data provided by Hazel Hawkins Hospital) revealed that approximately 51 individuals in 2016 were seen more than 5 times in the ER, categorized as “high utilizers”. Because our population includes individuals who are high utilizers and have a behavioral health condition, with ER input, we estimated that approximately 40 of the 51 per year that were high utilizers would have a significant behavioral health condition. Determinations were made based on number of individuals in each category as well as number of individuals we felt we could effectively serve, understanding that some individuals would participate in the program willingly while others would be found unreceptive. The 187 total number is our most reasonably targeted number.

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

3.1 Services, Interventions, and Care Coordination

The SCWPCC has agreed to common processes for Participant Engagement and Comprehensive Care Coordination and similar processes for Housing Navigation and Supports. In addition, each county has identified localized services and interventions that reflect the characteristics of their target populations and local circumstances.

The goal of the WPC Pilot is to engage and connect with participants in order to improve health outcomes, decrease Emergency Department and inpatient utilization and decrease the avoidable utilization of other systems, such as the criminal justice system. To that end, our strategies have been designed to ensure that those who are demonstrating high rates of utilization are quickly and seamlessly engaged and connected to the CCC Team by our various participating partners to develop a Comprehensive Care Coordination Plan and begin providing services and supports in a timely and efficient way.

The following section provides detail concerning the staffing structure that Mariposa, Plumas and San Benito Counties will use to carry out these activities. Some of these activities are Bundled Services and some are Fee for Service.

<u>Participant Engagement and Outreach</u>

Effective participant engagement requires trust between the participant and representatives of the system of care that operate at the "street level." This is especially true for vulnerable populations with complex health and social needs, many of whom have a wide range of experiences with public systems providing health and human services. These participants need to be met where they are, in their own surroundings, whether that is where they live, socialize, or go for support and services. All counties participating in the SCWPCC will carry out participant engagement in the same manner, although the staffing arrangement will vary by county. This is a ***common program component*** among all SCWPCC counties.

The Participant Engagement Team will be composed of professionals who work in common purpose to reach out to the target populations to engage them in the WPC program.

In Mariposa County, the Engagement Team will consist of:

- Lead Mental Health Assistant III (MHA III) (.2 FTE)
- Mental Health Assistant I (.2 FTE)
- Public Health Nurse (.1 FTE)
- Alcohol and Other Drug (AOD) Specialist II, when SUD is suspected (.03 FTE)

In Plumas County, the Participant Engagement Team will include the following team members:

- Behavioral Health Case Management Specialist (.4 FTE)

- Behavioral Health Site Coordinator (.2 FTE)
- Behavioral Health Nurse (.1 FTE)
- Behavioral Health Therapist (.1 FTE)

The San Benito County Participant Engagement Team will be composed of persons with professional capacities in the areas of nursing, clinical experience, community health services, mental health, pharmacy practices, housing support knowledge and street reach out experience and include the following county staff:

- Public Health Nurse 0.20 FTE
- Probation Officer 0.20 FTE
- Peer Advocate 0.50 FTE
- Assessment Coordinator 1.0 FT

Depending on the needs of the participation effort, different team members may be deployed to provide engagement and outreach. Additionally, engagement and outreach efforts may include communication with IHSS providers, family members, health care providers or others who may already have existing connections with the potential participant. Other than the Participant Engagement Team members listed above, no other team members will be paid with WPC funds for this effort.

Two pathways for participant engagement referrals will identify participants from the target population:

- Identification through community outreach conducted by members of the Participant Engagement Team. These outreach efforts will focus on going to participants where they are in their own surroundings, whether that is where they live, socialize, or go for support and services. The Participant Engagement Team will screen individuals for appropriate referrals to WPC or other programs. Because Mariposa, Plumas and San Benito Counties have hospitals that receive a PRIME Grant, individuals will also be screened and referred to the PRIME projects, as appropriate.
- Referrals to the Participant Engagement Team from various referring agencies participating in or supporting the WPC program. These referring agencies shall include local hospitals; community health centers; county behavioral health and associated local nonprofit agencies; county social service and associated local nonprofit agencies; county probation; local housing agencies, and managed care plans.

Engagement and Outreach Services will be provided on a Fee for Service basis with the goal of enrolling individuals in WPC Comprehensive Care Coordination or a referral to another program or agency. The Participant Engagement Team will refer individuals to the CCC Team for further assessment and care planning.

Additional Mariposa Detail. In Mariposa County, engagement will occur at our local homeless shelter (Mariposa Open Arms), Alliance Wellness Center and on the street where homeless individuals who do not frequent these other two locations may spend

time. In addition to reaching out to targeted individuals who are identified through data, the Engagement Team will collaborate with local service providers to make them aware of WPC services and making referrals into the Program. For this reason, Engagement may also occur in individual's homes, in primary care clinics, the senior center or wherever these individuals may feel comfortable meeting. Engagement will occur with all target populations identified in this proposal, including individuals with Mental Illness/SUD, individuals involved with the criminal justice system, individuals who are homeless, and those with chronic illnesses, all who have high Emergency Department utilization rates.

The individuals who fall into the identified categories often distrust and fear governmental systems. However, we have found that meaningful and ongoing outreach helps to build relationships, paving the way for services to be provided. Additionally, our approach includes a Public Health Nurse, as many individuals respond more effectively to health care screenings or support versus a visit by a Mental Health professional, due to the stigma associated with having a mental illness or SUD. Should an individual not be eligible for WPC participation and services, there will be a warm and seamless handoff to partner agencies to provide services that may best fit the individual's needs. In other words, we will ensure the individuals don't fall through the cracks.

Engagement Activities will be participant-centered and include, but not be limited to spending time speaking with, working to eliminate engagement barriers for, and assessing the needs and desires of potential participants in order to build a relationship and better understand their motivations and needs.

It is projected that participant engagement will be conducted with 100 potential WPC participants over the life of the Pilot with an average of 6 engagement contacts per person for a total of approximately 600 contacts throughout the Pilot. Ten individuals will be engaged in PY2 and 30 individuals will be engaged in PY3, PY4, and PY5.

Additional Plumas Detail. Behavioral Health will lead Participant Engagement through its Case Management Specialist (CMS) staff located at the Community Wellness Centers in Quincy, Chester, Greenville and Portola. CMS are currently certified or enrolled in California Association for Alcohol and Drug Education (CAADE) and will also provide support for substance use disorder engagement efforts.

The Engagement Team will conduct outreach and education with local service providers on the benefits of the WPC program and seek referrals. There will be "no wrong door" for referrals. The Engagement Team will reach out far and wide to primary care clinics, Senior Nutrition and Transportation Program, Veterans Meetings, Opioid Coalition, Criminal Justice Court and other communication locations to engage the target population.

Engagement will commence upon contact with the targeted individual and conclude when there is an enrollment in Comprehensive Care Coordination or when a referral is made to another more appropriate program or agency. For example, it is anticipated

that through the assessment process, some individuals may be diagnosed Seriously Mental Ill or SMI and, as a result, would be referred to County Behavioral Health for services billable to Medi-Cal.

Engagement services are factored as a Fee-For-Service (FFS) in the budget for PY2-5. It is projected that participant engagement will be conducted with 40 potential WPC participants annually and that the length of participant engagement services will be an average of 1 month, with a range of 1 to 4 months. The Participant Engagement Team will be responsible for accepting the referral, conducting necessary screening and assessment, and making the hand-off to the CCC Team for further assessment and care planning. It is anticipated that the Engagement Team will have 5 encounters with each WPC participant for engagement services.

Additional San Benito Detail. Community outreach strategies will focus on venturing into business and residential neighborhoods where there are known concentrations of homeless. This will include monitoring locations within our County where we have already experienced and provided homeless shelter and supportive services via our Warming Winter Shelter.

Referrals to the Participant Engagement Team will be actively encouraged from our local hospitals, community health centers, county behavioral and public health departments and various community organizations and groups. The Participant Engagement Team will be responsible for accepting referrals, conducting necessary participant screening and assessment, and assigning a Lead Case Manager that will assume lead responsibility for the following activities:

- Working with the participant to establish the Comprehensive Care Coordination Plan (CCCP);
- Facilitating linkage of the participant to systems care, including assistance in making appointments with health care providers, and follow up assistance to assure participants have travel assistance, attend appointments and actually receive services; and,
- Providing assistance with applications and processing for public benefits.

With the hand-off from the Engagement Team to the Lead Case Manager, the focus will shift to Comprehensive Care Coordination for the participant so that care coordination services may commence and be monitored regularly. This hand-off will seek to maintain a sense of participant trust within a motivated climate that addresses immediate and long term needs in order to promote the likelihood of personal recoveries.

Engagement will commence upon contact with the targeted individual and conclude when there is an enrollment in Comprehensive Care Coordination of WPC or a referral to another program or agency. It is projected that participant engagement will be conducted with an average of 50 potential WPC enrollees annually and that the length of participant engagement services will be an average of 2 months, with a range of 1 to 4 months.

Comprehensive Care Coordination (CCC)

Upon receipt of the referral, further assessment will be conducted and eligibility determined for WPC participation. Depending on the scope of PRIME services, participants that are more appropriate for referral to the local PRIME program will be handed-off to that program. Upon acceptance into the WPC Program, a Lead Case Manager will be assigned to work directly with each participant. This approach will promote stability and continuity in each participant's relationship with the WPC program and allow the Case Manager to build a trusting relationship with the participant that can be sustained over time as the participant's conditions change and improve. Based on the participant's unique needs and barriers, the Case Manager will assemble a Care Coordination Team that works collaboratively with each participant to develop a Comprehensive Care Coordination Plan (CCCP) that addresses the participant's barriers to achieving improved health outcomes. All counties participating in the SCWPCC will carry out CCC in the same manner, although the staffing arrangement will vary by county. This is a ***common program component*** among all SCWPCC counties.

After participants are screened/assessed for WPC eligibility, they will be "enrolled" in CCC and a Comprehensive Care Coordination Plans (CCCP) will be developed. Each CCCP will build on the participant's strengths and reflect the participant's own personal goals to ensure successful implementation, and CCC Team members will be assigned responsibilities based on the needs of the participant. Participants will be involved in regular meetings with their team, when appropriate. If a participant is on Probation, the CCCP will be coordinated with the participant's Probation Case Plan; and if the participant is enrolled in Mental Health or SUD treatment, it will be coordinated with their Behavioral Health Treatment Plan, so as to not duplicate efforts or having conflicting goals. For those participants referred to and linked with Housing Navigation and Supports, Housing Navigators will become part of the CCC Team to ensure continuity of care and case coordination.

It should be noted that services billable to Medi-Cal will not be covered by WPC funds. Only those services that are not billable to Medi-Cal will be provided through WPC funding.

CCC will conclude when individuals "graduate" upon completion of their CCCP goals.

Additional Mariposa Detail. In Mariposa County, the Comprehensive Care Coordination Team (CCCT) will be composed of individuals from various participating agencies and led by a Lead MHA III (Lead Case Manager). The Lead MHA III will be responsible for inviting participating agencies and representatives who may be needed at meetings, based on initial screenings with participants. Attendee composition at weekly meetings will be directed by the needs of the participants to be discussed. Additionally, from time to time, other entities will be invited to CCCT meetings.

Following screenings and assessments, CCC Services will be initiated upon "enrollment" of a participant into this service based on their eligibility for WPC.

The CCC Team will provide care coordination services at a high level of intensity and accountability and will provide "whatever it takes" to support the participant in achieving their recovery goals. This strategy includes 24/7/365 access to services and commitment to engage and collaborate with any potential sources of support to the participant, such as a participant's friends, family, medical providers, pets, treatment providers, probation officer, etc.

Core CCCT members will include:

- Lead Mental Health Assistant III through MCBHRS (.8 FTE): Meeting Coordinator, Screenings, Development of Comprehensive Care Plans
- Mental Health Assistant I through MCBHRS (.8 FTE): Transportation (not for transportation to or from medical services), Case Management, Support and Systems Navigation
- Public Health Nurse through MCPH (.4 FTE): Health Screenings and Case Management

Rotating Members to participate on the CCCT based on participant needs and circumstances include:

- Mental Health Assistant III - Probation (.1 FTE) Probation/Prop 47 match
- Probation Officer (.05 FTE) Probation AB109 match
- Alcohol and Other Drug (AOD) Specialist II (.1 FTE) Realignment match
- MH Clinician through MCBHRS (.65 FTE) BH Realignment and MHSA match
- Eligibility Worker for benefits enrollment (.05 FTE) SS Realignment match
- Social Worker III for SSI Advocacy (.025 FTE) SS Realignment match
- Social Work Supervisor I - Public Conservator/Guardian (.025 FTE) BH Realignment match
- Psychiatric Nurse Practitioner (.025 FTE) BH Realignment match
- MH Assistant III (Crisis/Triage) (.65 FTE) SB 163 Funds match
- Private Therapists (Managed Care Plan Providers) (.025 FTE) no match
- Housing Navigator will participate on the Team when appropriate, however, their time will not be used as a match as it is paid from the Housing Supports Bundle.

Due to the relatively small size of our population and the co-location of many services, Mariposa County has a long and successful history of collaboratively working together to establish programs or build outcomes. Our barriers to collaboration with the existing targeted populations have been primarily connected with information sharing limitations, which will be addressed through data sharing agreements, the proposed automated Client Data Management System, and the strategies developed through this Project.

Based on the CCCP, participants will receive an array of Services and Supports (as described in this document) to ensure successful connections are made and case plan activities are successfully completed.

Eligible WPC participants face myriad of barriers and challenges that prevent them from being successful in managing their illnesses or stabilizing their lives. Some of these include: lack of transportation; lack of income; chronic or situational homelessness; and, difficulty managing symptoms associated with their illnesses. Individuals who are homeless or at risk of homelessness will be referred to the local Housing Navigator for support with these services. Services and Supports not covered by other programs will include, but not be limited to:

- Thorough assessments of needs and goals;
- Warm hand-offs and linkages to a variety of services and supports in the community, including accompaniment to services as necessary to build trust;
- Coordination of health care between various doctors and health care/behavioral health care providers;
- Accompanying to and from appointments
- Development of participant-centered multi-disciplinary comprehensive care plan;
- Weekly team meetings (with a reduction in frequency over time) to coordinate services, discuss barriers, assess progress, and provide encouragement;
- Coordination with partners and providers;
- Evaluation and assessments for mental health treatment, substance abuse treatment, sober living services, housing needs, etc.;
- Social Security Advocacy, as appropriate;
- Provision of support and education to each participant's family members or support network to assist them helping participant to meet their Care Plan goals;
- Helping participants build natural support systems for ongoing sustainable support;
- Assisting in the development of self-sufficiency skills and symptoms management skills to ensure participants are able to manage their illnesses and stabilize their lives.

It is projected that CCC will be conducted with 20 WPC participants annually (PY3-5) and that the length of CCC will last from 3 to 18 months with an average of 12 months per participant. Therefore, there will be 240 members months provided in each of PY3, PY4, and PY5. Fewer overall participants will be served in PY2 due to the 6 month duration – a total of 16 people will be served for an average of 4 months each for a total of 64 member months in PY2. A total of 784 member months will be provided through the life of the Pilot.

Additional Plumas Detail. The CCC Team will be multi-disciplinary and will be comprised of members of the Whole Person Care partners and agencies. A Behavioral Health Case Management Specialist (CMS) will be designated as the lead Case Manager/Navigator for each of the WPC enrollees. As such, the CMS will be the liaison and primary point of contact on behalf of the participant with primary care physicians, public health partners, housing support, hospital navigators, dentists, social services and workforce development, etc. At this level, individual care plans will be developed by

the Behavioral Health Therapists if the participant has a behavioral health or substance use disorder.

Regular Comprehensive Care Coordination Team meetings will be organized to involve a probation officer, criminal justice worker, and other participants of a multi-disciplinary team, as appropriate. The CMS will conduct the initial screening, convene CCC Team Meetings with participating agencies and representatives, develop a Comprehensive Care Plan for each WPC participant with approval from partners, maintain transparent communications with all partners, and collect and enter data and progress notes. The Hospital PRIME grant liaisons are critical partners for high-users of EDs, hospital readmissions, and co-morbid diagnoses. The CMS will have responsibility for maintaining relationships with hospitals and coordinating activities in their PRIME grants to assure appropriate coordination of efforts between WPC and these PRIME programs. Any services billable to PRIME will not be covered by WPC funds.

The CCC Team will include:

- BH Case Management Specialist (2.0 FTE) for screenings, care coordination, liaison with primary care, hospitals, data tracking
- BH Site Coordinator (0.8 FTE) for scheduling, coordination of appointment and ancillary needs
- Behavioral Health Nurse (1.0 FTE) for medications management, tele-psychiatry, tracking vitals and education
- BH Health Therapist I/II, Senior (0.025 FTE) - individual, group counseling, full psycho-social assessment

It should be noted that services billable to Medi-Cal will not be covered by WPC funds. Only those services that are not billable to Medi-Cal will be provided through Whole Person Care funding.

Plumas County partners are submitting a Proposition 47 proposal to the Board of State and Community Corrections. Plumas County has operated a Drug Court Program for the past 10 years and recently commenced a Pre-Trial Program. The WPC Pilot will work with the Probation Department to enroll participants in the WPC Pilot through a deferred entry of judgment or diversion process, when appropriate. During the course of their WPC participation, the courts and criminal justice partners will be involved in supporting their continued participation. WPC participants that have involvement in the criminal justice system will not be incarcerated at the time WPC-covered services are provided.

It is projected that CCC will be conducted with 40 WPC participants annually and that the length of CCC will last from 3 to 18 months with an average of 10 months per participant.

Additional San Benito Detail. San Benito County's CCC Team will be composed of members with capacities in nursing, peer advocacy, probation and social work and

pharmacy assistance for proper medication purposes. The CCC Team will include the following staff:

- Public Health Nurse (.4 FTE)
- Mental Health Clinician (.25 FTE)
- Substance Abuse Recovery Specialist (.2 FTE)
- Lead Care Coordinator (1 FTE)
- Peer Advocate (.5 FTE)

The Peer Advocate position will transition from Participant Engagement to CCC duties

The CCC Team will conduct full assessments of health, mental health, substance abuse and housing needs. Following the assessment, the CCC Team will create a tailored Comprehensive Care Coordination Plan (CCCP) identifying personal goals and needed services in order to works towards a personal recovery and contribute to better health outcomes for the WPC enrollee. The CCC Team will provide care coordination services at a high level of intensity and accountability and will provide "whatever it takes" to support the participant in achieving their recovery goals. This strategy includes 24/7/365 access to services and commitment to engage and collaborate with any potential sources of support to the participant, such as a participant's friends, family, medical providers, pets, treatment providers and a probation officer.

It is projected that CCC will be conducted with 107 potential WPC participants over the life of the Project and that the length of CCC will last from 3 to 12 months with an average of 6.75 months per participant for a total of 722 member months.

Housing Navigation and Supports

All three counties participating in the SCWPCC will be providing housing navigation and supports through their various local infrastructures. All three counties identify high housing costs and lack of affordable housing as issues for Medi-Cal recipients.

Housing Navigation and Supports will include:

- Assessment of eligibility for various housing supports;
- Assisting individuals to search for housing;
- Breaking down barriers associated with obtaining housing;
- Helping with credit repair or criminal record expungement;
- Providing advocacy with landlords; and
- Helping participants to build the skills and supports necessary to maintaining housing over time.

Participants enrolled in CCC who are determined to be homeless or have unstable housing/imminent risk of homelessness, will be linked to the Housing Navigator. Once a WPC participant is linked with the Housing Navigator, they will be assessed for a variety of Housing Services and Supports that may help them with housing costs or placements based on their individual needs.

Housing Navigation and Supports will commence upon referral to the Housing Navigator that is the contracted partner for these services. The Housing Navigator will work with the CCCT to ensure housing goals are included in the CCCP and there is a seamless coordination of services. Once the goals/activities of this service are complete, the Housing Navigator will inform the lead staff (in Mariposa, the Lead Mental Health Assistant III; in Plumas, the Lead Case Manager) which will trigger a "graduation" from Housing Navigation and Supports Bundle.

Additional Mariposa Detail. The Housing Authority of Stanislaus County (StanCo HA), as Mariposa County's Housing Authority, administers the Housing Choice Voucher Program (a Section 8 program). The Human Services Department, in conjunction with our community based organization, Alliance for Community Transformations (ACT), provides the housing navigation and support services for the county. Housing Navigation and Supports for Whole Person Care Pilot participants will be provided through a contract with ACT. This organization has demonstrated a capacity to provide this type of service and is currently doing so for various populations in the community. Funding from WPC will be utilized to expand the Housing Navigation and Supports Services for WPC participants.

Although there is currently a major shortage of housing in the Mariposa County area, there are multiple efforts underway to develop new housing units and develop financial supports for those most vulnerable in our community. For participants placed in supportive housing through other programs, such as transitional or permanent supportive housing (not funded through WPC Pilot), the Housing team will provide supportive services such as education surrounding budgeting skills, home maintenance and repair and other support services to ensure successful sustainability of housing over time. No WPC funds will be utilized to pay for direct housing costs.

Housing Navigation and Supports are anticipated to last from 2-6 months with an average of 3.6 months per participant. It is estimated that a total of 32 participants will be served during the WPC Pilot (PY2 = 5 participants for a total of 18 member months; PY3 – PY 5 – 9 annually for a total of 36 member months annually). Housing Navigation and Supports may not occur in consecutive months due to extensive time waiting for housing opportunities to open and for participants to secure placements. A total of 126 member months will be provided during the WPC Pilot.

Additional Plumas Detail. The WPC Pilot will work with Plumas County Community Development Commission and Housing Authority, and community partners to provide housing navigation and support services. The Behavioral Health Department currently provides funds from Realignment and local sources to Plumas Crisis Intervention and Resource Center (PCIRC), to manage a 4-bedroom housing unit for individuals in need of short-term (up to 12 months) housing and emergency housing in cabins and hotels for up to 30 days for persons with mental illness or substance use disorders. Of the $147,000 in annual funding to PCIRC, $92,000 was paid out in rent and $55,000 was used for Housing Navigation and Supports serving approximately 25 persons per year for an average duration of 4 months. Based on this model, the WPC Pilot will enter into

a contract with another community partner, Plumas Rural Services, to provide housing navigation and supports for WPC enrollees in the amount of $55,000 per year. No WPC funds will be used to pay for direct housing or rental costs.

Housing Navigation and Support Services will commence upon referral to the Housing Navigator at Plumas Rural Services, the contracted provider for these services. The Housing Navigator will work with the CCC Team to make sure housing goals are included in the CCC participant plan. Once the goals of this service are complete, the Housing Navigator will inform the Lead Case Manager to "graduate" the WPC participate from the Housing and Support Services bundle. The PMPM is based on $55,000 per year or $192,500 for PY2-5 as detailed in the following chart. At a $687 PMPM rate, estimates for member months include 40 member months in PY 2; 60 member months in PY3; 90 member months in PY 4; and 90 member months in PY5. These average months consider WPC participants may overlap in housing supports from one PY to another PY. A total of 280 member months are budgeted for PY2-5).

	PY2	PY3	PY4	PY5
Member months	40	60	90	90
Persons served	10	17	25	24

Additional San Benito Detail. San Benito intends to provide bundled housing support services to our target group in compliance with STC 114 and STC117.b.viii. These bundled housing support services will be provided to WPC enrollees who are homeless or verified to be at risk of homelessness. Our Pilot estimates that up to 25 Homeless persons and 5 at risk persons will receive these services per year. The housing services will include conducting a housing assessment, developing an individualized housing support plan, assisting with housing applications, identifying and securing available resources to assist with available housing subsidies especially the Project based voucher program offered by our participating entity, the Santa Cruz Housing Authority. Our housing services will include support for security deposits, moving costs, utility service issues, furnishings, and disability modifications. We also will monitor placements to be ready to mediate with landlord problems or possible terminations of tenancy. In this area, we shall focus on adverse behaviors in WPC participants that affect tenancy.

It is widely known housing placement options are very limited in San Benito County; however, our Homeless Collaborative is currently working with local governments to Increase the supply of affordable housing as well as develop positive relationships with landlords and property managers to access any and all housing choices. Having the Santa Cruz Housing Authority as a participating entity in the WPC Pilot along with two non-profit housing corporations as partners, will facilitate our housing services for WPC enrollees.

Our WPC Pilot, during implementation, will consider the use of a housing pool that does not use WPC funds nor have administrative costs or positions contained in the WPC budget. Our County CSWD already has Tenant Based Rental Assistance (TBRA) and

other rapid re-housing funds that may be used to serve persons that are homeless or at risk of becoming homeless. Our Housing Authority and local non-profit housing corporations will assist in the formation of a housing pool that is in alignment with our WPC goals and objectives.

Mariposa Population Served By Services Category

The following table demonstrates the anticipated number of individuals to be served by population and by service category.

Outreach and Engagement Table

Target Population	**PY2**	**PY3**	**PY4**	**PY5**	**Total**
Behavioral Health Condition and High Utilizer	*2*	*8*	*8*	*8*	*26*
Behavioral Health Condition, High Utilizer and Homeless or At-Risk	*5*	*12*	*12*	*12*	*41*
Behavioral Health Condition, High Utilizer and Criminally Involved	*2*	*6*	*6*	*6*	*20*
Behavioral Health Condition, High Utilizer and Chronic Physical Health	*1*	*4*	*4*	*4*	*13*
Total Engagement Population Served	**10**	**30**	**30**	**30**	**100**

Comprehensive Care Coordination

Target Population	**PY2**	**PY3**	**PY4**	**PY5**	**Total**
Behavioral Health Condition and High Utilizer	*6*	3	3	3	15
Behavioral Health Condition, High Utilizer and Homeless or At-Risk	*2*	*7*	*7*	*7*	*23*
Behavioral Health Condition, High Utilizer and Criminally Involved	*5*	*7*	*7*	*7*	*26*
Behavioral Health Condition, High Utilizer and Chronic Physical Health	*3*	*3*	*3*	*3*	*12*
Total Engagement Population Served	**16**	**20**	**20**	**20**	**76**

Housing Navigation and Supports

Target Population	**PY2**	**PY3**	**PY4**	**PY5**	**Total**
Behavioral Health Condition and High Utilizer					
Behavioral Health Condition, High Utilizer and Homeless or At-Risk	*5*	*9*	*9*	*9*	*32*

Behavioral Health Condition, High Utilizer and Criminally Involved					
Behavioral Health Condition, High Utilizer and Chronic Physical Health					
Total Housing Navigation and Supports Population Served	**5**	**9**	**9**	**9**	**32**

Note: Each Target Category has **duplicated** eligibles because individuals may fall into more than one sub-population category. Therefore, the **category totals will not total** to the overall population served in each bundle.

Other Programs and Infrastructure to Support Pilot

There are multiple existing programs and resources in the county that will be utilized to support WPC participants. As part of the CCC Care Plan development, the team will identify which services and supports would be best to wrap around participants to support the most positive outcomes. The following programs are not funded by the WPC Pilot. Some of these programs or providers include:

- PRIME: JCFHCD received a PRIME Grant under the Medicaid Waiver to increase access to care to our rural community and to reduce unplanned emergency room and hospital admissions through coordination of services to individuals with chronic illnesses.
- Mental Health Service Act (MHSA): A variety of programs are funded through the Mental Health Services Act including a Wellness Center, which operates 7 days per week, and other supports for individuals who are enrolled in mental health services.
- Behavioral Health Court and Drug Court: These programs, designed to engage individuals with criminal charges in treatment, may be leveraged to enroll participants in WPC through a deferred entry of judgment or diversion process. During the course of their participation, the courts may be involved in supporting continued participation.

ADDITIONAL PLUMAS SERVICES

Respite and Sobering Services

Respite and Sobering Center services will be Fee For Service items and represent distinct services provided by contractors that will assist WPC clients but are not reimbursable through Medi-Cal. In Plumas County, there were two incidents in the past year, where two young adults, aged 21 and 23 were arrested and held for observation at Plumas District Hospital Emergency Room. After Behavioral Health department clinical staff conducted an assessment, a multi-disciplinary team (physician, behavioral health clinician, district attorney's office and sheriff's department) decided the young adults were not appropriate to be held in jail based on the offense and diagnosed condition. It was agreed the young adults would be released to the County's Board and Care Facility as the young adults were homeless. The WPC Pilot will implement Respite

Services based on this model which will provide services for medication management, follow-up and adherence to after-care plans and working with the Behavioral Health Department's Case Management Specialist and contracted Housing Navigator to find housing. Plumas Rural Services, a community partner in the WPC Pilot, has a facility for provision of Respite Services where nursing services can be coordinated and WPC-allowable transportation and other supports can be provided. Respite will provide 24/7 care and supervision by trained mental health professionals for individuals who may be in crisis but do not need 5150 hospitalization and are not appropriate to be held in custody. Respite Center rate is a per bed day cost. The bed days will be made available through a contract between the County Lead Entity and the non-profit that operates the respite center, Plumas Rural Services. The WPC Pilot will contract with PRS for Respite Services at the rate of $500 per bed day for an estimated 3 days per month, or $18,000 per year, to avoid unnecessary and costlier hospitalizations. This bed rate was arrived at by dividing the total operating budget amount by the number of beds in the facility. The projected number of individuals using this service is 1 person per month for an average stay of 3 days or 12 persons per year.

The WPC Pilot will contract with PRS for Sobering services for short stays of 12 to 24 hours per incident. Services will be made available by referral so that WPC clients can gain sobriety and begin recovery. These supportive services, including educational and life skills courses, will be offered by community partner, Plumas Rural Services. Costs are $1,000 per month for 2 beds per month and will be contracted at $12,000 per year The project number of individuals using this service is 2 persons per month for a short stay of 12-24 hours each or 24 persons per year. This sobering center rate was arrived at by dividing the total contract amount by the number of beds for which the County contracts.

ADDITIONAL SAN BENITO SERVICES

Job Skills and Pre-employment Training

One of our partners is the County Community Services and Workforce Development, which has the proven capacity to provide such services to the WPC participants. Specifically, the CSWD has programs targeted to low-income persons who need job find skills, resume writing, job searches and interviewing techniques. This additional support service will be linked to the overall WPC Pilot.

Medical Respite Plan – Proposed Collaboration

Reducing preventable hospital re-admission, especially among frequent users, is an objective in partnership with Hazel Hawkins hospital. This objective is based on evidence that homeless persons are consistently associated with longer and repeated hospital stays and the homeless are disproportionately represented among high users of hospital Emergency Departments. The evidence also shows post-discharge patients often return to environments that are sub-optimal for healing while facing difficulties with medication, follow-up and adherence to after-care plans that result in re-hospitalization.

Medical respite programs offer a real alternative to street discharge for homeless persons by providing temporary overnight beds along with post-acute medical care through access to nursing and medication support.

The county lead entity, HHSA, is currently engaged in discussions with the Hazel Hawkins Hospital toward a vision of creating a Medical Respite facility for purpose of receiving discharged homeless or mentally ill persons from their Emergency Department. Our Pilot recognizes that WPC funds can only cover operational costs of such a facility. However, a partnership will be pursued to create alternative approaches to address the needed facility.

Additional Resources

Our Probation Department will be trained to identify individuals who are within 90 days of release from jail and meet WPC enrollment criteria, including crisis and/or hospitalizations, chronic health conditions and homeless or at risk upon discharge. The Probation staff will be trained on the referral process to the Engagement Team for assessment services. In addition, our County will continue its working relationship with Sun Street Resources, a community nonprofit resource, which currently operates a sober living facility for men and women. In addition, our County has applied to the State Board of Community Corrections for a 3 year grant from which to operate a new program in association with Sun Street aimed at those involved with criminal justice.

Network and Service Provider System

The WPC Pilot will establish a unit of trained multidisciplinary staff who will coordinate WPC services in partnership with each low income WPC participant identified and/or referred to the unit in order to engage such participants in a coordinated assessment and outcome driven care management process. The plan is to provide a coordinated approach to WPC services through a wraparound system of service that engages a wide spectrum of public and community based organizations, described in this application, with the participant to provide access to healthcare, education, housing, and employment intended to improve social determinant outcomes for each participant.

In San Benito County we have adopted the housing first model as described through the National Alliance to End Homelessness. We subscribe to the demonstrated outcomes in Housing First initiatives in the nation that prioritize assisting people experiencing homelessness or at risk of homelessness with permanent housing coupled with the provision of supportive services consistent with access to healthcare, education, housing, and employment. Wrap-around care coordination coupled with a housing first strategy for participants assumes a “whatever works” strategy and the use of coordinated use of resources, including Whole Person Care to achieve positive outcomes. Services will include:

- Support of an interagency multidisciplinary approach utilizing a person focused participant participation module

- Coordination and transportation services (not for transportation of enrollees to or from medical services) for participants to encourage the use of primary care and other supporting services to help each participant remain engaged with mental health and substance abuse services
- Coordination of other services within the public agencies and community based organizations to support the goal of alleviating poverty by creating greater access to health care, education, housing, and employment.
- Coordination with other housing programs, including the Housing Authority and Community Action Board priorities, to alleviate poverty through a housing first approach

3.2 Data Sharing

During the planning phase of the application, our partner organizations across the three counties gathered data concerning high utilizers in their systems. This data, both quantitative and anecdotal, was discussed in conjunction with how to leverage other funding sources to maximize benefits to the potential WPC participants. Additionally, the Medi-Cal Managed Care Plans provided data on those who were high utilizers in their systems. Currently, although each partner organization has a data system that supports data collection/evaluation efforts, the integration of data is not possible and the need for a cross-agency and cross-county strategy through WPC is essential.

This need will be addressed through development of an automated Client Data Management and Care Coordination System (Client Data Management System) that will be developed as a part of the WPC Pilot Project. This system is a foundational and ***common program component*** for all three counties participating in the SCWPCC to facilitate WPC service delivery. The SCWPCC will contract with a vendor for development, operation and maintenance of this system. At this time, negotiations are underway with a designated vendor and costs for this system have been included in this WPC application. Each County Lead Entity will implement the system in its respective County.

The purpose of the Client Data Management System is to provide an automated system with bi-directional capabilities for use by the Lead Case Manager, the CCC Team, and other selected users determined by the county, including hospitals, other health and behavioral health care providers, and community-based service providers, that aggregates and integrates relevant target population data in the following manner:

- Incorporates and maps data across multiple systems, including Medi-Cal Managed Care Plans, the Medi-Cal Fee For Service program, hospitals, differing local EHR systems, County Behavioral Health, and community-based providers;
- Provides integrated data at the individual WPC participant level by creating a profile of each participant's overall utilization of services across multiple systems;
- Incorporates and captures diagnostic information to assist in identifying WPC participants with multiple conditions, including those with behavioral health conditions;

- Incorporates and captures non-health care data, including data on housing instability, homelessness and interaction with the justice system;
- Provides a mechanism for managing Comprehensive Care Coordination services provided to WPC participants, documenting services, and monitoring participant progress;
- Updates data at periodic intervals to capture all utilization and service data for WPC participants over time, including when possible, periods of prior services utilization; and,
- Provides for WPC participant-level and WPC population-level data reporting so that changes and progress for individuals and populations can be monitored, evaluated, documented and Plan-Do-Study-Act processes can be implemented.

The underlying principle for the automated system is "know-engage-manage." With this Client Data Management System, Lead Case Managers and the CCC Team will have access to individual patient profiles that provide a holistic "whole person" view of the needs of each WPC participant, the care they have received, where the continuing service needs and gaps are, and necessary services and support. This information will help the CCC Team "know" about the participant and assist the CCC Team "engage" the participant in development of their CCC Plan. Finally, the system will assist the Lead Case Manager and CCC Team "manage" the delivery of services and supports to the participant through monitoring of each WPC participant's progress, including any difficulties or barriers to achieving their health improvement goals. With the ability to see a comprehensive view of each WPC participant made possible with the automated Client Data Management System, the Lead Case Manager, the CCC Team, and participating providers will be able to effectively meet the unique needs and conditions of each WPC participant.

During the first three months of the WPC pilot the infrastructure for data sharing and joint use of the Client Data Management System among the Lead Entity, participating entities and contracted service providers will be developed. Prior to development, due to the low number of individuals being served in our small counties, we will be able to track this data through spreadsheets that are shared amongst providers. Spreadsheets will be shared in Dropbox with all providers/partners to ensure bi-directional data sharing. Documents will be encrypted to ensure security and privacy of participants PHI/PI. Shared Release of Information forms will be developed that meets the legal requirements of all entities and development of a Memorandum of Understanding (MOU) between all entities that outlines the roles and responsibilities of each entity. The County Lead Entities will serve as the lead agency for collecting and analyzing the shared data and ensuring compliance with all state and federal regulations concerning patient confidentiality, privacy and security of PHI/PI.

Each Participating Entity has committed to working together to meet the challenges of the WPC Pilot, with the knowledge and understanding that data sharing and coordination by Participating Entities will be critical to the process of participant identification, determination of service needs, and provision of services. Participating entities and contracted service providers will have access to comprehensive data on

each WPC participant through the new Client Data Management System. Data sharing will evolve and improve over the life of the project as the system becomes fully utilized. Until data sharing processes are fully functional, reports will be run by the lead entity staff and provided to all partners to ensure data sharing and communication. Leadership Committee meetings of local participating entities will be conducted monthly in PY 2 and PY 3 and at least quarterly in PY 4 and PY 5. The review of data, data sharing, service access, service utilization, and outcomes will be standing matters of consideration so that opportunities for improvement using a PDSA model of change are identified and improvements are implemented.

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

4.1 Performance Measures

Performance measures will be established for each Participating Entity and contracting service provider and data to assess each organization's performance will be collected throughout the term of the WPC Pilot. These data will include assessment, care plan and service utilization data for each WPC participant. These data will be collected across all Participating Entities and contracting service providers to assure maximum consistency in reporting and performance measurement.

Each person referred for Comprehensive Care Coordination will receive screening and assessment, including the PHQ-9 and the VISPDAT assessments, to assure collection of necessary demographic information and to identify health, mental health, substance use, and homelessness status at the time of referral. Findings from these data will be utilized to establish baseline information for each WPC participant and will be updated as these assessments are repeated at periodic intervals to measure and document improvements over the duration that services and supports are provided to each WPC participant.

Service utilization data will include data on each WPC participant's receipt of services, including but not limited to Comprehensive Care Coordination, support services (such as housing, respite care, etc.), Emergency Department and acute inpatient hospital services, psychiatric hospital services, and the range of primary care, specialty care, mental health outpatient, and substance use treatment services provided to each participant. These data will be collected through the Client Data Management System, as described above, and data will be populated for each WPC Participant as it is entered into the system by the Lead Case Manager and on a monthly basis for all other utilization data. The Lead Case Manager and the Comprehensive Care Coordination Team will use these data to manage and oversee the delivery of services and supports to each WPC Participant and to monitor participant service utilization and progress. These data will also provide documentation of all services and supports provided to each WPC Participant.

Data reporting from the Client Data Management System will provide documentation of the number of persons served by the Pilot each month, specific services provided, assessment findings, and associated outcomes. These data will be incorporated into management reports that are submitted to the WPC Leadership Committee for review and consideration in order to monitor the effectiveness of the interventions, including improvements in housing stability and changes in participant use of Emergency Departments, acute inpatient hospitalization and psychiatric inpatient utilization. The WPC Leadership Committee will closely monitor these and other outcomes to examine the effectiveness of services and costs and continuing barriers to effective service delivery, and use this information to guide its Plan-Do-Study-Act (PDSA) process.

4.1.a Universal Metrics

Check the boxes below to acknowledge that all WPC pilots must track and report the following universal metrics (see STC 115.b.xii, STC 122, Attachment MM).

☑ Health Outcomes Measures

☑ Administrative Measures

The SCWPCC has agreed to a set of common Universal Metrics for the three participating counties, as set forth below. This is a ***common program component*** among all SCWPCC counties.

Required Universal Metrics Table

Item	PY 2	PY 3	PY 4	PY 5
Health Outcomes Measures Goals: Ambulatory Care	Maintain baseline ED use	Reduce ED use by 5%	Reduce ED use by 10%	Reduce ED use by 15%
Health Outcomes: Inpatient Utilization-General Hospital/Acute Care (IPU)	Maintain baseline inpatient utilization for people assessed as part of Comprehensive Care Coordination	Reduce inpatient utilization by 5% for people assessed as part of Comprehensive Care Coordination	Reduce inpatient utilization by 10% for people assessed as part of Comprehensive Care Coordination	Reduce inpatient utilization by 15% for people assessed as part of Comprehensive Care Coordination
Health Outcomes: Follow-up After Hospitalization for Mental Illness (FUH)	Maintain baseline for follow-up after Hospitalization	50% of participants receive follow-up within 30 days after hospitalization	55% of participants receive follow-up within 30 days after hospitalization	60% of participants receive follow-up within 30 days after hospitalization
Health Outcomes: Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET)	Maintain baseline for initiation and engagement of alcohol and other drug dependence treatment	Initiate and engage with 50% of participants with identified treatment need	Initiate and engage with 55% of participants with identified treatment need	Initiate and engage with 60% of participants with identified treatment need

Item	PY 2	PY 3	PY 4	PY 5
Administrative: Comprehensive Care Plan	Proportion of participating beneficiaries with a comprehensive care plan, accessible within 30 days of o Enrollment into the WPC pilot: 65% of WPC enrolled members will have a completed assessment and care plan within 30 days of enrollment to WPC o Annual re-assessment: 75% of WPC enrolled members have a re-assessment and updated Tailored Plan of Care after 12 months of WPC services	Proportion of participating beneficiaries with a comprehensive care plan, accessible within 30 days of o Enrollment into the WPC pilot: 70% of WPC enrolled members will have a completed assessment and care plan within 30 days of enrollment to WPC o Annual re-assessment: 80% of WPC enrolled members have a re-assessment and updated Tailored Plan of Care after 12 months of WPC services	Proportion of participating beneficiaries with a comprehensive care plan, accessible within 30 days of o Enrollment into the WPC pilot: 75% of WPC enrolled members will have a completed assessment and care plan within 30 days of enrollment to WPC o Annual re-assessment: 85% of WPC enrolled members have a re-assessment and updated Tailored Plan of Care after 12 months of WPC services	Proportion of participating beneficiaries with a comprehensive care plan, accessible within 30 days of o Enrollment into the WPC pilot: 80% of WPC enrolled members will have a completed assessment and care plan within 30 days of enrollment to WPC o Annual re-assessment: 90% of WPC enrolled members have a re-assessment and updated Tailored Plan of Care after 12 months of WPC services
Administrative: Care Coordination, Case	Submission of documentation demonstrating the	Provide annual policy updates	Provide annual policy updates	Provide annual policy updates

Item	PY 2	PY 3	PY 4	PY 5
Management and Referral Infrastructure	establishment of care coordination, case management, and referral policies and procedures across the WPC pilot lead and all participating entities which provide for streamlined case management o Will develop shared policies and procedures, review semi-annually and utilize the PDSA model to modify and implement change across entities.			
Administrative: Data and Information Sharing Infrastructure	Submission of documentation demonstrating the establishment of data and information sharing policies and procedures across the	Submission of documentation demonstrating the establishment of data and information sharing policies and procedures across the WPC	Submission of documentation demonstrating the establishment of data and information sharing policies and procedures across the WPC	Submission of documentation demonstrating the establishment of data and information sharing policies and procedures across the WPC

Item	PY 2	PY 3	PY 4	PY 5
	WPC collaborative, county pilot leads and all participating entities o 75% of WPC contract providers implement data collection processes to document access, quality, cost effectiveness and outcomes.	collaborative, county pilot leads and all participating entities 80% of WPC contract providers implement data collection processes to document access, quality, cost effectiveness and outcomes.	collaborative, county pilot leads and all participating entities 85% of WPC contract providers implement data collection processes to document access, quality, cost effectiveness and outcomes.	collaborative, county pilot leads and all participating entities 90% of WPC contract providers implement data collection processes to document access, quality, cost effectiveness and outcomes.

4.1.b Variant Metrics

The SCWPCC has agreed to a set of common Variant Metrics for the three participating counties, as set forth below. This is a ***common program component*** among all SCWPCC counties.

Variant Metrics Table

Metric ID	Target Population	Measure Type	Description	Numerator	Denominator	PY 2- 5 Improvement
Variant Metric 1	All	Utilize a uniform housing assessment tool – Vulnerability Index Service Prioritization Decision Assistance	Implement VISPDAT for WPC participants	Count of WPC individuals receiving VISPDAT	All WPC enrollees in the program year	PY 2: Maintain Baseline PY 3: Improve baseline by 5% PY 4: Improve over prior year by 5%

Metric ID	Target Population	Measure Type	Description	Numerator	Denominator	PY 2- 5 Improvement
		Tool (VISPDAT) – to assess housing insecurity of WPC participants				PY 5: Improve over prior year by 5%
Variant Metric 2	All target populations across all program years	Health outcomes: 30 day all cause readmissions	30 Day All Cause Readmissions	Count of 30-day readmission	Count of index hospital stay	PY 2: Maintain Baseline PY 3: Reduce baseline by 5% PY 4: reduce over prior year by 5% PY 5: reduce over prior year by 5%
Variant Metric 3	PHQ-9/depression	Health Outcomes: Required for Pilots using PHQ-9	NQF 0710: Depression Remission at 12 months	Adults who achieved remission at 12 months as demonstrated by a 12 month (+/- 30 days) PHQ-9 score of less than 5	Adults age 18 and older with a diagnosis of major depression or dysthymia and an initial PHQ-9 score greater than 9 during an outpatient encounter	PY 2: Maintain Baseline PY 3: 15% PY 4: 20% PY 5: 25%
Variant Metric 4	SMI population	Health Outcomes: Required for Pilots	NQF: 0104 Suicide Risk	Patients who had a suicide risk	All patients aged 18 years and older with a	PY 2: Maintain Baseline PY 3: 50%

Metric ID	Target Population	Measure Type	Description	Numerator	Denominator	PY 2- 5 Improvement
		with SMI Target Population	Assessment	assessment completed at each visit	new diagnosis or recurrent episode of Major Depressive Disorder	PY 4: 55% PY 5: 60%
Variant Metric 5	Homeless/ at-risk for homelessness	Housing: Housing Services	Percent of homeless receiving housing services in PY that were refereed for housing services	Number of participants referred for housing services that receive services	Number of participants referred for housing services	PY 2: Maintain baseline PY 3: 55% PY 4: 60% PY 5: 65%

4.2 Data Analysis, Reporting, and Quality Improvement

All counties participating in the SCWPCC are prepared to meet all required data collection, reporting and analysis requirements. In preparing this application, each of the counties collected, analyzed, and utilized data to determine their target populations and to determine the set of services and supports to be provided under their WPC Pilots. Going forward, all SCWPCC counties will carry out Data Analysis and Reporting in the same manner. This is a ***common program component*** among all SCWPCC counties.

Data Analysis and Reporting

Throughout the project, key data will be collected on persons participating in the WPC pilot. These data will include demographic information, source of referral, timeframe for response to the referral, timeframe for development of CCC Plan, and documentation of the services provided to all pilot program participants. Additional data on each participant will be collected and supplement this information using health assessments and surveys, including tools that collect information on existing health conditions (e.g. diabetes, hypertension, cardiovascular disease, etc.), tools for assessing suicide risk; and, tools for screening, diagnosing, monitoring and measuring the severity of depression, i.e. the Patient Health Questionnaire 9 (PHQ-9).

Participants in the WPC program will be asked to sign a Universal Release of Information (ROI) and an Informed Consent, so that the CCC Plan can be structured

effectively and so that data about participants can be shared across all participating entities. These instruments will be developed by July 1st, 2017.

Each County Lead Entity will execute data sharing and privacy agreements with all Participating Entities and contracting service providers by July 1, 2017. Following execution of these agreements, each County Lead Entity will assure data is collected from Participating Entities and service providers associated with each component of the WPC program, including Participant Engagement, CCC Planning, and direct services funded under the program, such as Housing Services. Under these agreements, each Participating Entity and contracted service provider will report utilization data in accordance with specific dataset requirements.

Overall, data that will be collected will include data on acute hospital and psychiatric hospital admissions and Emergency Department utilization, with associated diagnosis codes, procedure codes, and length of stay (LOS) data. Data will also include service utilization data for each contracted service provider and relevant data from associated service providers, such as County Behavioral Health, and County Social Services. When available, data will be collected on WPC participants for the period prior to participation in WPC. The form and content of the datasets to be required will be determined by July 1, 2017.

The County Lead Entities will regularly analyze collected utilization and service data to determine the effectiveness of program services. Findings from these analyses will be presented to each County's WPC Leadership Committee monthly during the PY 2 and PY 3 of the Pilot and then at least a quarterly basis during PY 4 and 5. This will help ensure course corrections can be made in the data collection/sharing efforts early on in the Pilot if needed. Among other key duties, the WPC Leadership Committees will closely monitor key indicators and outcomes to assess the effectiveness of services, cost of services is consistent with expectations, barriers to effectiveness and alternative approaches to improve effectiveness as identified through a Plan Do Study Act (PDSA) process described below.

Quality Improvement

As a part of the SCWPCC, the over-arching aim of the WPC Pilot is to develop an *integrated system of coordinated care* at the county level for individual WPC participants in the midst of an existing structure of separately organized, funded and administered health care, behavioral health and social service programs serving participants across each county. Through development of this integrated system of coordinate care, the chief goal is that WPC participants will receive timely assessment of their health, behavioral health and other support needs and provision of coordinated services that address their barriers to health improvement. Improvements in WPC participant functioning will be demonstrated through such outcome measures such as reductions in Emergency Department visits, reductions in acute inpatient and psychiatric inpatient hospitalizations, housing stability, regular use of primary care services, and improvements in participant reported health and mental health status.

Plan-Do-Study-Act (PDSA)

Each County, and the SCWPCC as a whole, will use the Plan-Do-Study-Act (PDSA) method for facilitating quality improvement by:

- Identifying the aim to be achieved;
- Describing the measurable outcomes to be achieved toward that aim; and,
- Defining the processes currently in place; identifying opportunities for improvement; and, determining necessary changes to the intervention based on analysis.
- The Plan-Do-Study-Act Cycle will be included at multiple points during Project implementation and throughout the life of the Project.

As stated in Section 2.2 Communication Plan, each County Lead Entity will convene monthly meetings with WPC partners in PY 2-5 to address the workflow of integrated care and core tasks. In addition, the monthly meetings will focus on quality improvement and discussion of processes, outcomes and reports generated by the Client Data Management System. Based on analysis of the data, WPC partners will be able to make changes to processes together and quickly implement changes by disseminating desired changes to relevant staff of their individual organizations. These process changes are the "tests" or PDSA cycles that are intended to be short and quick.

The SCWPCC will focus on three questions for improvement: 1) What are we trying to accomplish? 2) How will we know that a change is an improvement? 3) What changes can we make that will result in improvement? Each County Lead Entity will review reports and identify strengths and problem areas. These will be shared with the WPC partners and other key stakeholders quarterly and plans to improve and/or maintain quality will be discussed at that time. The quality improvement process will also inform each County Lead Entity and WPC partners where barriers, achievements, and adjustments to implementation will occur.

On a monthly basis, the PDSA process will be used with the Comprehensive Coordinated Care Teams and the Engagement staff to assist with improving outreach and coordination for WPC participants. The CCC Team – consisting of mental health assistant staff and a public health nurse in Mariposa; case management specialists, hospital liaisons, community-based service providers (Plumas Rural Services, Plumas Crisis Intervention and Resource Center) in Plumas; and a public health nurse, mental health clinician, substance abuse recovery specialist, care coordinator and Perry advocate in San Benito – will meet monthly and as needed to coordinate services for WPC participants.

The CCC Team will also use the PDSA cycles to implement and "test" changes to improve care. For example, the CCC bundle includes the use of the Vulnerability Index and Family Service Prioritization Decision Assistance Tool (VI-F-SPDAT). If it is observed that the client is not engaging or meaningfully responding to the survey questions, the interviewer may modify how the survey is conducted or explore alternative tools. Based on this process change that is "tested" with a few clients, the

team can decide together the effectiveness of the change and whether to implement the change longer term.

The Plan-Do-Study-Act Cycle will be quarterly for each county WPC partners and monthly for the CCC Teams. Additionally, the SCWPCC will discuss the PDSA learnings quarterly so that the information can be shared across all three counties.

This scientific method of trying something small scale, looking at the results, and refining the project or activity based on what is learned has multiple applications in this Project. Additionally, this method can be used on a systems wide level as well as on a case level. Some areas that will benefit from the PDSA Cycle include: development and implementation of engagement strategies, screening tools, Care Plan documents, data collection tools, data entry processes, report development, service and support implementation, and housing navigation strategies. Additionally, on an individual level, every person is different - engaged and motivated by different factors, responsive to different treatment modalities or medications, responsive to different service providers, or in need of a different level of care or intervention.

The Pilot will be open to trying things out, observing and being open to results and have an ongoing willingness to change course when something is not working so that more successful outcomes can be achieved. Examples of individual level or case-level areas that will benefit from PDSA include: During our care management meetings with participants it is likely that the Care Coordination Team as well as the participant themselves will look at how they are progressing towards meeting their goals. There will be discussions and assessments about which factors in their lives are helping them and which are hindering them from making meaningful changes or progress. With this analysis of what is working and what is not, course corrections can be made to ensure goals are achievable and that everyone on the team is working towards the same end.

4.3 Participant Entity Monitoring

All counties participating in the SCWPCC will carry out Participating Entity Monitoring in the same manner. This is a ***common program component*** among all SCWPCC counties.

Toward this end, all Participating Entities and each contractor providing WPC services will enter into a Memorandum of Understanding (MOU) with the County Lead Entity by July 1, 2017, that describes the role and responsibilities of all parties. This MOU will include a Scope of Services as well as the process the County Lead Entity will follow in monitoring performance of these services. For Participating Entities and contractors with WPC bundled services that use Performance Metrics, the terms of this monitoring and will be separately described. Monitoring will incorporate both program monitoring and financial monitoring. As determined appropriate, the County Lead Entity will conduct site visits to Participating Entities or contractors as a part of the monitoring process. Site visit activities may include, but are not limited to, review of invoices and associated documentation; employee timesheets; case files; policies and procedures; and complaint and incident reports.

Each County Lead Entity's program monitoring will be structured to assure that the Participating Entity and Contractors are:

- Held accountable for carrying out the agreed-to scopes of services and performance standards;
- Meet service requirements associated with performance metrics specified in the contract; and,
- Maintain and provide records that accurately reflect whether performance metrics and outcome measures have been achieved or not achieved.

Each county's financial monitoring will, at a minimum, assess and confirm that:

- Funding has been used for allowable and budgeted activities;
- Expenditures are supported with proper documentation, and financial records are maintained that provide an appropriate audit trail
- Payment to Participating Entity or Contract do not exceed the contract maximum without appropriate amendment
- Contractor has appropriately complied with all applicable federal, state and county contract laws and regulations.

Each County Lead Entity shall monitor all Participating Entities and Service Contractors with a frequency of at least quarterly throughout the life of the Pilot. This monitoring will produce a written Monitoring Report that is prepared by the County Lead Entity for review by the county's WPC Leadership Committee. The County Lead Entity will also submit this Monitoring Report to the SCWPCC Executive Committee. Each County Lead Entity will determine the structure of Participating Entity and Service Contractor monitoring by July 1, 2017.

Section 5: Financing

5.1 Financing Structure

The SCWPPC Pilot program is designed to maximize resources by utilizing a multi-disciplinary service delivery model. It includes services offered by a team of county staff for the activities that each county performs well, and services offered by contracted community providers with proven track records for successful service delivery for the activities that are better served within the community.

The SCWPPC Pilot has developed a financing structure that looks to maximize resources by leveraging funds outside of the WPC program for the population to be served and for the aspects of care, such as housing, that are not allowable under WPC funding guidelines. To access WPC funds, the team will utilize a combination of a bundled services payment structure, a fee for service model, and a pay for incentives or reporting model.

The SCWPPC has identified bundles to categorize services offered to the target populations. The bundles are specific to each county, as county circumstances – including staff costs, local economies and local providers – are different. These bundles include: 1) Comprehensive Care Coordination (CCC); and 2) Housing Navigation and Services. Each bundled program has unique costs attributable to the specific services and activities being performed within the bundle. These costs were divided by the anticipated number of members served to arrive at the required per-member-per-month (PMPM) rate (detail included in section 5.5 below). The costs associated with the services will be paid through a monthly invoicing process.

The SCWPPC has also included the use of Fee-for-Service (FFS) payments, as follows:

- Engagement and Outreach (all three counties)
- Respite (Mariposa and Plumas) and
- Sober Living Support Services paid in contract to community partner, Plumas Rural Services (Plumas)

The Pilot is responsible for paying 100% of the costs as they are incurred. Through the IGT process, and according to the 50% Federal Medicaid Assistance Percentage (FMA) identified for pilots, the approved 50% non-federal match sent up to DHCS by the pilot will be used to draw down the 50% federal financial participation. Both amount together equaling 100% of approved costs, are then sent down to the Pilot. The pilot remains responsible for 50% of approved costs.

All program payments will be tracked in the county's existing financial software system. This system allows for the use of multiple coding options that will ensure all WPC Pilot payments are accurately classified for reimbursement and that match is accurately tracked as well. Each County Lead Entity will assign the oversight and governance for

all financial aspects of the WPC pilot program to its respective Administrative & Fiscal Services Division.

Additional Mariposa Detail. A separate WPC budget will be set up and tracked within the County's existing budgeting system (AS400) to not only serve as a vehicle for IGT transfers, but to correctly track all expenditures and revenues. Departmental costs will be allocated to that budget and revenues from WPC and other match sources will be utilized through journal entries to offset those costs. The costs associated with bundles are mostly internal and will be tracked and paid through journal entries. Those bundle costs that are contracted, namely Housing Navigation and Supports, will be invoiced to the WPC Lead Agency (Human Services) on a monthly basis and will be paid based on the county's established pay schedule and no more than 45 days after services are rendered.

Currently, our community is not utilizing a value or performance based model for payment or capitated rate structure. The WPC Pilot will assist us in creating a model for moving forward with this type of financing structure.

The financing structure also includes the use of fee for services payment to partnering entities who will all contribute to make the WPC pilot program a success. Incentive payments will be utilized for JCFHCD to encourage participation in meetings and care coordination activities. Pay for reporting will also be utilized to incentivize our hospital partners to share real time data with our team re: ED utilization. Pay for outcomes is a relatively new contracting model to most of the community providers in the county, so this introduction will serve a critical first step for launching a more long-term transition to contract performance reimbursement strategies.

Additional Plumas Detail. Plumas will be contracting with hospitals (EPHC, PDH, and SHD) to pay for incentives or outcomes. Incentive payments will be utilized for our three hospital partners to share utilization data and refer participants to the WPC pilot. Pay for outcomes will be a new mechanism in our project to facilitate communications and integration of primary care with behavioral health outcomes.

Additional San Benito Detail. The financing structure also includes the use of incentive payments to partnering entities within San Benito County who will all contribute to make the WPC pilot program a success. The pilot program proposes to pay health care providers $75 for each completed referral packet submitted to the WPC. Pay for performance is a relatively new contracting model to most of the community providers in the county, so this introduction will serve a critical first step for launching a more long-term transition to contract performance reimbursement strategies and capitated rate concepts.

5.2 Funding Diagram

The attached funding diagram demonstrates how the WPC program funds will flow to and from State DHCS. To summarize, IGT funds will flow from each County to the

contracted Third Party Administrator (TPA), and the total amount of IGT funding from all three counties in the SCWPCC will be submitted for claiming to DHCS by the TPA. DHCS will send the non-federal funds received from the TPA and federal funds from CMS back to the TPA. In turn, the TPA will return the non-federal funds to each county along with the corresponding federal funds.

As referenced previously, the County Medical Services Program (CMSP) Governing Board, a public entity, has approved a motion to carry out TPA responsibilities under a contract with SCWPCC to be executed by July 1, 2017.

Once received from the TPA, each County Lead Entity will distribute the revenue to the county department participating in WPC. Contractors and other service vendors, incentive payments and bundled services will be paid through the County's existing accounts payable process. Service providers will be paid monthly for fee-for-service and for bundled services.

5.3 Non-Federal Share

Each County lead entity will provide the non-federal share for payments under the WPC. All of the match funds are already with or will be coming from the appropriations specific to each County Lead Entity within the county's financial software system.

In Mariposa County, all non-federal share of funds will be provided for the Project from a variety of sources, including: Behavioral Health and Social Services Realignment revenue, Mental Health Services Act funds, AB 109 funds, Proposition 47 funds, SB 163 funds, and other identified revenue deemed appropriate for federal match. Some of these funding sources are administered by the Probation Department, who will in turn provide the non-federal share to the MCHSD. All non-federal share of funds will be provided, regardless of source.

The sources of the non-federal share in Plumas County include Behavioral Health Realignment revenue and Mental Health Services Act funds and other identified revenue deemed appropriate for federal match.

In San Benito, HHSA, the county lead entity, and the County Probation Department will provide the non-federal share for payments under the WPC pilot. The sources of the non-federal share include Realignment revenue, Mental Health Services Act funds, AB 109 funds and other revenue deemed appropriate for federal match. All of the match funds are already with or will be coming from the appropriations specific to San Benito County within the county's financial software system.

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

WPC Pilot funding will be used to cover services that are not claimable or covered by Medi-Cal. In all instances, funding for existing Medi-Cal services (including Specialty Mental Health Services) will be utilized before accessing WPC funding.

The target populations served by the WPC Team will only include Medi-Cal beneficiaries for any dollar amount claimed to DHCS for WPC federal financial participation. County Human/Social Services agencies will provide the WPC program with information on Medi-Cal status, as necessary. During Participant Engagement staff will ensure that WPC participants are either currently enrolled in Medi-Cal or they will work with the eligibility staff to enroll the participant prior to commencement of WPC services.

Per STC 113, the WPC pilot payments will support infrastructure to integrate services among local entities that serve the target population as evidenced in the budget detail for the Administrative and Delivery Infrastructure budget categories. They also will support services not otherwise covered or directly reimbursed by Medi-Cal to improve care for the target population such as housing navigation and supports, as evidenced in the budget detail for the Housing Services PMPM bundle. And lastly, the Pilot payments will support other strategies to improve integration, reduce unnecessary utilization of health care services, and improve health outcomes as evidenced in the budget detail for the CCC PMPM bundles and FFS.

Mariposa, Plumas and San Benito Counties are not approved to participate in any of California's Targeted Case Management State Plan Amendments. Accordingly, none of the counties have discounted any service rates in our WPC financing proposal that accounts for TCM.

5.5 Funding Request

In addition to this narrative, please refer to the SCWPCC Pilot Application – Budget Summary document in Excel (see Budget Attachments: SCWPCC) Following Section 5.5 is a Budget Narrative for further details.

The budget contains significant detail on each individual county's costs. Due to local circumstances, economies, resources, and staffing and provider contexts, the component parts of the budget differ from county to county.

Funding for SCWPCC pilot program is separated into six main categories: Administrative Infrastructure, Delivery Infrastructure, Incentives, PMPM Bundles, Fee-for-Service Services, and Pay for Outcomes. The following activities are attributable to the different categories:

Administrative Infrastructure: Includes county and contracted staff to perform program oversight and administration, development, and fiscal management. Funding for facilities and maintenance, and IT, Communications and Copiers are all included in the Administrative Infrastructure budget. SCWPCC will contract with a Third Party Administrator to be lead fiscal and administrative agent for program management purposes. The cost breakdown can be found in the Budget Narrative attached to the application.

1. Mariposa Administrative Infrastructure: Funding for facilities and maintenance, and IT, Communications and Copiers are all included in the Administrative Infrastructure budget. Travel and Training costs will be factored in to ensure WPC leadership team and staff are able to attend both the required trainings/meetings hosted by DHCS in Sacramento, as well as additional trainings and meetings for SCWPCC governance and learning.
2. Plumas Administrative Infrastructure: Funding for facilities and maintenance, and IT, Communications and Copiers are included in the Administrative Infrastructure budget.
3. San Benito Administrative Infrastructure: Includes the following county staff: Fiscal Support at .25 FTE; Deputy Director at .20 FTE (PY2 FTE are less, based on startup estimates). The Contractor costs include a proportional share of the collaborative contracts for: policy and procedure development, assessment tool development and TPA. Travel costs are for out of county collaborative meetings for up to 3 staff. Office space costs are for additional space to be occupied within our currently building. Training costs are calculated for up to 6 staff in the PY3 and less in PY 4 & 5. PY2 includes one-time office startup costs for items such as furniture and equipment.

Position	Salary	Benefits	Total	FTE	Total Category
Deputy Director	117,720	67,100	184,820	.20	36,964
HHSA Fiscal Support	43,462	24,773	68,235	.25	17,059

Delivery Infrastructure: Includes funding for contracting for a care management tracking automated system with reporting capabilities that would allow the WPC staff the ability to track all participant information and state required reporting. The cost breakdown can be found in the Budget Narrative attached to the application.

1. Mariposa Delivery Infrastructure: includes one new vehicle assigned to the staff working on WPC; 2 computers and related equipment such as keyboards for each of the staff members of the WPC Team; and 2 cell phones for the team to be able to communicate with staff and participants.
2. Plumas Delivery Infrastructure: Includes funding for the following – one new vehicle assigned to the staff working on WPC; 2 computers and related equipment such as keyboards for each of the staff members of the WPC Team; 2 cell phones for the team to be able to communicate with staff and participants. Additionally, during PY2

only, Delivery Infrastructure includes staff costs of individuals who will work on the program in their various units to go through training, begin meeting to develop processes and procedures, develop MOU's, learn the assessment tools and database, etc.

3. San Benito Delivery Infrastructure: Includes funding for the following – Communication costs for 3 cell phones for the team to be able to communicate with staff and clients at all times; 3 computers and related equipment such as keyboards for each of the staff members of the WPC Team; 1 copier/printer/scanner for the team; Transportation is for the lease of van assigned to the staff working on WPC.

Incentives: Includes payments to providers for participating in Whole Person Care activities.

1. Mariposa Incentives: John C. Fremont Healthcare District (JCFHCD) is a partner in this Project in a variety of ways including participation in care coordination meetings and development of care plans, outreach with the team when necessary for engagement purposes when a relationship has already been built between JCFHCD and potential participants, linkages and referrals to various medical providers, follow up with CCC Team, and sharing of data. Because various JCFHCD staff will be attending team meetings, it was more feasible to build in a weekly participation incentive at $300 per week for participation instead of funding one or more staff at various levels. If there is no need for JCFHCD staff participation during the week, they will not be paid this weekly incentive. In addition, JCFHCD will be paid an incentive payment of $150 when they notify WPC staff that a WPC member or eligible member has arrived at the Emergency Department. Payments will occur each time a notification is made. Multiple reports may occur on one individual.
2. Plumas Incentives: Eastern Plumas Health Care, Plumas District Hospital and Seneca Health Care District will be paid an incentive payment for participation in WPC activities, which include attending Comprehensive Care Planning meetings and coordinating services during the Engagement Bundle. Each hospital will be paid $300 for attending WPC meetings. The County anticipates 52 in-person meetings with all three district hospitals starting in PY 3.Additionally, hospitals will be paid directly when they notify and coordinate with the WPC staff that a WPC member or eligible member has arrived at the Emergency Department. They will be paid $150 for each encounter.
3. San Benito Incentive Payments: These payments will be paid directly to the health care provider when they complete the referral form, notify and coordinate with the WPC staff regarding a client that may be eligible for WPC has arrived at their site. The referral forms will be tallied monthly and health care providers will be paid $75.00 for each referral meeting eligibility criteria. Additionally, Hazel Hawkins Hospital (HHH) will receive $600 each month for 12 months in PY3-5 ($500 for 3 months in PY2) as an incentive for reporting on WPC participants in the Emergency Department and notify the WPC Team to provide services in accordance with the Comprehensive Coordinated Care Plan. Potential eligibles

will also be referred; however, payment will only occur on those individuals currently enrolled in WPC CCC Services.

PMPM Bundles: The SCWPCC pilot is proposing two different bundled services, one for Comprehensive Care Coordination and one for Housing Supports.

Mariposa Bundle: Comprehensive Care Coordination (CCC) Bundle

A. A number of individuals that are provided engagement services will meet the eligibility criteria for CCC. Eligibility criteria for CCC includes placement in one or more of the target populations: 1) high-risk, high-utilizing Medi-Cal beneficiaries who have repeated incidents of avoidable ED or hospital readmissions; 2) two or more chronic health conditions; 3) a Serious Mental Illness (SMI) and/or Substance Use Disorder (SUD); 4) homeless or at risk of homelessness; and/or 5) scheduled for release from jail and meets target population criteria. We are expecting that most persons enrolled will need assistance in multiple life domains in order to decrease their overall utilization of ED and inpatient services.

B. The Bundle will commence upon "enrollment" into the CCC Service. The CCC Team will develop a Care Plan with each WPC member within the first 30 days of "enrollment" into CCC to provide a blueprint for needed services; development of comprehensive and multi-disciplinary Care Plan; identification of involved entities; a timeline for accessing services; and identified outcomes to meet each individual's needs. Care Plans will be reviewed and amended at least monthly during a participant's enrollment in CCC Services to ensure goals are being met and revised as conditions change.

C. The CCC Team will provide a comprehensive and multidisciplinary approach to care coordination to assist participants with services and supports necessary to break down the barriers and challenges that prevent them from being successful in managing their illnesses or stabilizing their lives.

D. CCC will conclude when individuals "graduate" upon completion of their Care Plan goals or when CCC is no longer helping to support the goals of the participant. It is estimated that CCC will last from 3 to 18 months with an average of 12 months per participant.

E. It is estimated that a total of 68 individuals will receive CCC services during the course of the Project (PY2 = 16; PY3 = 20; PY4 = 20; and PY5 = 20) at a rate of $1,721 PMPM.

Plumas CCC Bundle

1. A number of persons that are provided engagement services will meet CCC eligibility criteria, which will include a behavioral health diagnosis or homeless/at risk for homelessness, and one or more of the following: 1) high-risk, high-utilizing Medi-

Cal beneficiaries who have repeated incidents of avoidable ED or hospital readmissions; 2) two or more chronic health conditions; 3) a behavioral health condition (mental health, substance abuse or co-occurring disorder); 4) homeless or at risk of homelessness; and/or 5) scheduled for release from jail, institution for mental disease, nursing facility. We expect that most persons enrolled will need assistance in multiple life domains.

2. The CCC Team will develop a Care Plan with each WPC member within the first 30 days of "enrollment" into CCC to provide a blueprint for needed services; identification of involved entities; a timeline for accessing services; and identified outcomes to meet each individual's needs.

3. The CCC Team will provide a comprehensive and multidisciplinary approach to care coordination to assist participants with services and supports necessary to break down the barriers and challenges that prevent them from being successful in managing their illnesses or stabilizing their lives.

4. CCC will conclude when individuals "graduate" upon completion of their Care Plan goals. It is estimated that CCC will last from 3 to 18 months with an average of 10 months per participant.

5. The program budget is based on 872.8 member months at $1,467 PMPM over the duration of the program. PY 2 is budgeted for 20 member months (10 individuals); PY 3 is budgeted for 300 member months; PY4 is budgeted for 302.86 member months (25 individuals on average); and PY5 is budgeted for 250 member months. The PMPM of $1,467 was calculated based on the "cost" of the CCC Team as articulated in the chart below. The cost of $320,122.5 was multiplied by 4 since the CCC Team would be providing services during each of PY2, PY3, PY4 and PY5. This total of $1,280,490 was then divided by the number of member months of 872.8 to derive a PMPM of $1,467. The PMPM of $1,467 stays constant throughout PY 2 through PY 5.

Position	**Base Salary**	**Benefits**	**Total**	**FTE**	**Amount**
Case Management Specialists – located at Community Wellness Centers in Quincy, Portola, Chester and Greenville; each at .5 FTE for a total of 2 FTE. Will conduct intake, substance use assessment, care coordination and liaison with contracted partners for housing supports, medical	$56,053	$15,134	$71,187	2.0 FTE	$ 142,374

Position	Base Salary	Benefits	Total	FTE	Amount
appointments, manage WPC client data record.					
Behavioral Health Site Coordinators – located at 4 Community Wellness Centers, each at .2 FTE for a total of .8 FTE. Will assist in scheduling of appointments and coordination with partners.	$50,440	$13,620	$64,060	.8 FTE	$ 51,248
Behavioral Health Nurse: will be located at the Quincy Community Wellness Center and travel to Portola, Chester, and Greenville as needed for tele-psychiatry, care coordination with primary care providers, hospitals.	$83,157	$22,452	$105,610	1.0 FTE	$105,610
Behavioral Health Therapist I/II, or Senior: Provides care coordination for individuals involved with the criminal justice system, may attend court meetings, provide individual or group counseling.	$64,188	$17,322	$81,520	.25 FTE	$20,890.5
TOTAL					**$320,122.5**

San Benito CCC Bundle

1. The hand off of the participant from Engagement to CCC takes place when the participant agrees to enroll in the program. The majority of enrolled individuals will be eligible for the CCC if they meet the target population of the WPC program. Eligibility criteria for the CCC Team includes one or more of the target populations: 1) high-risk, high-utilizing Medi-Cal beneficiaries who have repeated incidents of avoidable ED or hospital readmissions; 2) two or more chronic health conditions; 3) a Serious Mental Illness (SMI) and/or Substance Use Disorder (SUD); 4) homeless or at risk of homelessness; and/or 5) scheduled for release from jail and meets target population criteria. We are expecting that most persons enrolled will need assistance in multiple areas in order to be successful in this program and will be enrolled in this service level until they exit the program – a full 12 months per participant per year.

2. The CCC Team will develop a Tailored Plan of Care with each WPC participant within the first 30 days to provide a blueprint for needed services; identification of involved entities; a timeline for accessing services; and identified outcomes to meet each individual's needs.

3. The CCC Team will provide care coordination services at a very high level of intensity and accountability. The CCC Team will provide "whatever it takes" to support the participant in achieving their recovery goals. This strategy includes 24/7/365 access to services and commitment to engage and collaborate with any potential sources of support to the client, such as a participant's friends, family, medical providers, pets, treatment providers, probation officer, etc.

4. Sometimes this model is called "a hospital without walls" because it utilizes a multidisciplinary team of professionals with diverse skills and backgrounds who work closely together as a cohesive team to maximize each of their strengths in service of the participant's needs and goals. This team goes wherever it is necessary in order to meet the participants' needs, including in the home, on the street, the Emergency Department, or wherever the participant experiences a crisis. The majority of services being provided will occur outside of a standard medical office.

5. Our proposed WPC model will utilize a "Peer Advocate," or an individual with lived experience in recovery from similar challenges as the participant the team is serving. San Benito WPC Peer Advocate will be a valuable member of the CCC Team, and will utilize intensive training in motivational interviewing and their own personal experiences in living with challenges such as chronic health conditions, mental illness, substance use disorders, homelessness, and legal troubles in order to effectively engage WPC participants in overcoming these challenges in their lives.

6. The program budget is based on a PMPM cost of $1,657 as detailed in the chart below based on Year 3. We anticipate 30 member months in Year 2; 195 member months Year 3; 259 member months in Year 4 and 257 in Year 5. The Year 2 budget detail is calculated using a pro-rated formula of full year costs:

Position	**Salary**	**Benefits**	**Total**	**FTE**	**Total Category**
Program Manager	78,461	44,725	123,186	.3	36,956
Staff Service Analyst	54,665	31,159	85,824	.3	25,747
Care Coordinator	66,465	37,885	104,350	1	104,350
Peer Advocate	39,394	22,455	61,849	.5	30,925
Public Health Nurse	69,454	39,590.	109,044	.4	43,617
Mental Health Clinician	80,404	45,830	126,234	.25	31,559
Substance Abuse Splst	63,292	36,076	99,368	.2	19,874

Mariposa Bundle: Housing Navigation and Supports Bundle

A. Housing Navigation and Supports include: assessment of eligibility for various housing supports, assisting individuals to search for housing, breaking down barriers associated with obtaining housing, helping with credit repair or criminal record expungement, providing advocacy with landlords, and helping participants to build the skills and supports necessary to maintaining housing over time. Additionally, for participants placed in supportive housing through other programs, such as transitional or permanent supportive housing (not funded through WPC Pilot), the Housing team will provide supportive services such as teaching budgeting skills, home maintenance and repair and providing other supports to ensure successful maintenance of housing over time.

B. Housing Navigation and Supports will commence upon referral to the Housing Navigator at Alliance for Community Transformations, the contracted partner for these services. The Housing Navigator will work with the CCCT to ensure housing goals are included in the Care Plan. Once the goals/activities of this service are complete, the Housing Navigator will inform the Lead Mental Health Assistant which will trigger a “graduation” from Housing Navigation and Supports Bundle.

C. It is estimated that a total of 32 individuals will receive Housing Navigation and Support services during the course of the Project (PY2= 5; PY3 = 9; PY4 = 9; and PY5 = 9). It is estimated that on average members will participate in this bundle for 4 months, with a range of 2-6 months.

D. The program budget is based on 126 member months at $1,389, including: 18 member months in PY2, for an average of 3.6 member months each; 36 member months in PY3 for an average of 4 member months each; 36 member months in PY4 for an average of 4 member months each; and 36 member months in PY5 for an average of 4 member months each. PY 2 budget detail is calculated using a pro-rated formula of 50 percent of full year costs.

Plumas Housing Supports Bundle

1. Housing Supports include: assessment of eligibility for various housing supports, assisting individuals to search for housing, breaking down barriers associated with obtaining housing, helping with credit repair or criminal record expungement, providing advocacy with landlords, and helping participants to build the skills and supports necessary to maintaining housing over time.

2. Housing Supports will commence upon referral to the funded Community-Based Organization. The Case Management Specialist will ensure housing goals are included in the Care Plan. Once the goals/activities of this service are complete, the participant will complete and “graduate” from the Housing Supports Bundle.

3. The program budget is based on working with 10 WPC participants in PY2 for 40 member months; 17 WPC participants in PY 3 for 60 member months; 25 WPC

participants in PY 4 for 90 member months; and 24 participants in PY-5 for 90 member months. This represents a total of 280 member months.

4. The PMPM for Housing Supports was calculated based on a model that the Behavioral Health department funded from July 2015 through June 2016. The Behavioral Health department funded another community based organization in the amount of $147,000 for that year and it was estimated that $55,000 of the funded amount was expended for Housing Navigation and Supports (the remaining amount was expended on rental payments). Since the WPC Pilot funds cannot be used on rental payments, Plumas County anticipates expending $55,000 per year on Housing Navigation and Supports. The PMPM was factored by multiplying $55,000 times 3 ½ years for a total of $192,500 for PY2-5. That total amount was divided by 280 total member months and a PMPM of $687 was derived. A PMPM of $687 for Housing Supports remains a constant amount for PY2-5. The chart below indicates differing numbers of individuals served per year due to the variability in the number of months each individual may require Housing Navigation and Supports. For example, one individual may require 4 months of housing supports and another may require 8 months of housing supports due to individual circumstances including Section 8 application assistance, clearing up financial-related matters, etc.

	PY2	**PY3**	**PY4**	**PY5**	**Total**
Member months	40	60	90	90	280
Cost	$27,500	$41,250	$61,875	$61,875	$192,500
Persons served	10	17	25	24	76

<u>San Benito Housing Support Services Bundle</u>

1. Housing Support Services program focuses on review of WPC assessment and update for housing goals. Should the review reveal that the participant is homeless or at risk of homelessness then staff will initiate this bundle of services. The Housing Support Services staff will assist with locating housing, securing funding/benefits/vouchers, developing skills in living independently, work with landlords to support stability in living arrangement, resolve landlords and/or tenant relationship challenges, and provide transportation for the participant to and from non-medical appointments. Specific activities include assessing and modifying the Tailored Plan of Care with the WPC participant to reflect housing goals; securing safe housing options; assisting in the application process for housing; training in daily living skills; and linking the participant to specialty services as needed.

2. This program is designed to have a dedicated service bundle to better address the achievement of housing by developing expertise and focus on this particular issue. The coordination between the CCC and Housing Support Services will be outlined for each participant so that there is no duplication of effort or resources.

It is anticipated that members will be using this service for an average of 4 months. Housing Support Services will terminate once stable housing is obtained.

3. The program budget is based on a PMPM cost of $1,936 as detailed in the chart below based on Year 3. We anticipate 8 member months in Year 2; 70 member months Year 3; 67 member months in Year 4 and 60 in Year 5. The Year 2 budget detail is calculated using a pro-rated formula of full year costs.

Position	Salary	Benefits	Total	FTE	Total Category
Program Manager	78,461	44,725	123,186	.05	6,159
Staff Service Analyst	54,665	31,159	85,824	.05	4,291
Housing Navigator	84,838	48,357	133,195	.5	66,598
Tenancy Care Support	49,820	28,397	78,217	.5	39,109

Fee-for-Service Payments. The SCWPCC includes FFS payments for Outreach and Engagement Services. Additionally, Mariposa and Plumas are providing respite FFS payments.

Mariposa FFS: Outreach and Engagement: Mariposa County Behavioral Health and Recovery Services and Mariposa County Public Health will have team members (Mental Health Assistants, Alcohol and Drug Specialists and a Public Health Nurse) who provide outreach and engagement services. A Fee for Service Model will be utilized. It is estimated that 100 individuals over the life of the Pilot (PY2 = 10; PY3 = 30; PY4 = 30; PY5 = 30) will be outreached to or engaged. It is estimated that each individual will have an average of 6 encounters for a total of 600 encounters over the life of the Pilot. Each encounter with one of these individuals will be comprised of: 1) identification of the individuals and their whereabouts through referrals or data provided on high utilizers; 2) face-to face outreach and engagement; 3) documentation; 4) follow-up with other partners and providers concerning the target individuals; it is estimated that each of these encounters from start to finish will take between 30 minutes and 5 hours based on their location in the county and willingness to engage. Based on salary, overhead and travel costs, an encounter cost of $250 will be paid to the lead entity, Mariposa County Human Services, for each encounter. Based on the staff who provided the encounter, payments will be made to the various participating entities (MCBHRS and MCPH) to offset their costs. Individuals who both meet criteria and are willing to participate in CCC services will be enrolled in CCC and graduate from Participant Engagement and Outreach Services.

Plumas FFS: Outreach and Engagement Services: These services focus on identifying high utilizers, screening and assessing for program eligibility. Engagement will occur at the Community Wellness Centers in Quincy, Portola, Greenville and Chester; at the hospital Emergency Departments and clinics, and in designated venues as appropriate to meet Veterans and Senior citizens. Engagement will commence upon contact with the targeted individual and conclude when there is an enrollment in Comprehensive Care Coordination of WPC or a referral to another program or agency. It is expected

that the length of Participant Engagement Services will be an average of 1 month, with a range of 1 to 2 months. The program budget is based on serving 140 participants in PY 2-5 for an average of 5 encounters per participant or a total of 660 encounters as indicated in the chart below.

	PY2	**PY3**	**PY4**	**PY5**	**Total**
Persons engaged	20	40	40	40	140
Encounters	86	196	189	189	660

Engagement costs include the salary and benefit costs of the Engagement Team as described below. The FFS rate for engagement was arrived at by computing the total costs for the engagement team for PY 2-5 and dividing that by the total number of encounters. Total costs for the engagement team were calculated by taking the Total Amount for the Team and multiplying the Total Amount by 3.5 years. This calculation was $56,560 X 3.5 years = $197,960. The FFS rate was calculated at $300 per encounter by taking $197,960 and dividing by the total number of anticipated encounters 660.

For Plumas County, benefits include Retirement and FICA/Medicare which are calculated at 27% of the base salary. These amounts are calculated for the positions in the Engagement Team in the chart below.

Position	**Base Salary**	**Benefits**	**Total**	**FTE**	**Amount**
Case Management Specialist I/II	$56,053	$15,134	$71,187	.4 FTE	$28,475
BH Site Coordinator	$50,440	$13,618	$64,058	.152 FTE	$9,718
Behavioral Health Nurse	$83,157	$20,732	$103,889	.1 FTE	$10,388
BH Therapist I/II	$64,188	$15,602	$79,790	.10 FTE	$7,979
Total					$56,560

San Benito Fee-For-Service: Engagement & Outreach

The Engagement Team focuses on program enrollment, initial applicant screening, obtaining linkages to appointments or non-medical transportation needs, initial treatment planning, and initial case management. Specific activities include providing engagement services in the community to the target population such as visiting homeless camps, Hospital Emergency Departments and Medical Clinics; working to build trust and relationships with program members; offering initial engagement services; and engaging and coordinating services. The goal is to engage and motivate participants so they are willing to enroll in the WPC program.

The criteria for this service is based on level of engagement. The Engagement process will begin with receipt of the referral. Once the participant is deemed eligible, the Engagement Team will work closely with the CCC Team to assure there is a warm hand-off from one team to the next when the participant is ready to enroll in services. Once the participant is accepted for services in the CCC bundle, the Engagement Team will terminate engagement services. Engagement is expected to take one to two months.

The budget is based on a fee for services cost of $365.67 per encounter. Each encounter consists of approximately 3-6 hours of service to an individual or an encounter cost of $365.67. Each person served will receive between 8-9 encounters. We anticipate providing engagement services to 31 people in PY2; 65 people will be served in PY 3; 46 people served in PY4; and 45 served in PY5. The Year 3 budget detail for the Engagement Team is shown in the table below. The total amount for this service is $204,042 in PY3. We plan to serve a total of 187 enrollees over the course of the pilot. Please see the budget narrative below for details.

Position	Salary	Benefits	Total	FTE	Total
Program Manager	78,461	44,725	123,186	.2	24,638
Staff Service Analyst	54,665	31,159	85,824	.2	17,165
Assessment Coordinator	49,820	28,398	78,218	1	78,218
Probation	59,834	34,105	93,939	.2	18,788
Public Health Nurse	69,454	39,590	109,044	.2	21,809
Peer Advocates	54,668	19,680	74,348	.584064	43,424

Mariposa FFS: Psychiatric Respite Care: Mental Health Respite Costs will be paid for WPC participants at a rate of $500 per bed night to avoid unnecessary and more costly hospitalizations. Respite stays include care by a trained mental health professional and are not billable to Medi-Cal. Mental Health Respite provides 24/7 care and supervision by trained mental health professionals for individuals who may be in crisis, but do not need 5150 hospitalization. Those needing respite often have either suicidal ideation but are willing to contract for safety or have other mental health symptoms that can be stabilized through medication or through intensive outpatient supports. Because some medications administered in an ER setting often take some time to take effect and need to be monitored, respite provides an easy way for staff to monitor these medication side effects and mental health symptoms outside of a hospital setting. Respite services are located close to major medical services which can be accessed readily as necessary. Respite providers also provide accompaniment to appointments. It is estimated that a total of 11 bed nights will be utilized in PY 2 and 57 bed nights in each of PY 3-5 for an average of 2-3 nights per participant or a total of 30 participants served over the life of the Pilot. Individuals will enter respite when they are unable to go home and be on their own. They will leave respite when they are stable enough to move to a lower level of care or to their own home.

Plumas Respite Care: Mental Health Respite Costs will be paid for WPC Participants at a rate of $500 per bed night to avoid unnecessary and costlier hospitalizations. Respite

provides 24/7 trained supervision and supports for individuals who may be in crisis, but can stabilize through intensive outpatient supports. Respite services will be budgeted at $1,500 per month for an average of 3 days and contracted with Plumas Rural Services. The total annual contract will be $18,000 (as detailed in the table below). The number of persons served per year will be 12.

Eligibility Criteria are that all adult individuals who meet the Homeless High-risk population criteria and also meet the following criteria: do not have clinical needs requiring a hospital or skilled nursing facility but for which shelter or homelessness would not reasonably afford the patient an opportunity for sufficient recovery to avoid re-hospitalization.

Cost	**Justification**	**Total**
Staffing	$25 per hour (salary and benefits) x average of 12 hours x 3 days per person x 12 people served.	$10,800
Operations and Overhead	$200 per day for administrative costs, rent, utilities, food, insurance, etc. x 3 days per person x 12 people served.	$7,200
Total		**$18,000**

Plumas Sobering Supportive Services. These supportive services will be offered as needed with community partner, Plumas Rural Services. Costs are $1,000 per month and will be contracted at $12,000 per year for 2 WPC members per month or 24 persons per year **(as detailed in the table below)**. This rate was arrived at by dividing the total contract amount by the number of beds for which the county contracts. A total of 72 persons will be served in PY3-5.

Cost	**Justification**	**Total**
Staffing Costs	$15 per hour (for salary and benefits) x 40 hours per week x 52 weeks for Support Services Staff = $31,200 annually/ 12 months = $2,600 monthly / 6 clients = $433.33 per month per clients in care; $433.33 per month per client in care x 2 clients in care = $866.66 per month x 12 months = $10,400	$10,400

Cost	Justification	Total
Operations	$66.67 per month for operations (rent, utilities, insurances, food, etc.) per client x 2 clients per month x 12 months = $1,600	$1600
Total		**$12,000**

Pay for Outcomes: These payments will be made to the local hospital for their assistance in achieving the desired reduction rates of WPC participants' visits to the emergency department.

1. Mariposa Pay for Outcomes: In PY 2-5 we anticipate a 5% reduction annually in ED utilization and hospital admissions. A Pay for Outcomes amount has been included in each of those program years as demonstrated in the Budget Narrative. During PY2, equal annual payments of $500 each will be made to five WPC partners: Mariposa County Human Services, Mariposa County Health Department, JCFHCD, Alliance for Community Transformations, and the Probation Department, totaling $2,500. During PY3 and PY4, equal payments of $1000 each will be made to above listed WPC partners, totaling $5,000. In PY5, equal payments of $5,000 each will be made to the above listed partners, totaling $25,000.
2. Plumas Pay for Outcomes: In PY 2-5 we anticipate a 5% reduction annually in ED utilization and hospital admissions. A pay for outcomes amount has been included in each of those program years as demonstrated in the Budget Narrative.
3. San Benito Pay For Outcomes: In PY 2-5 we anticipate a 5% reduction annually in ED utilization and hospital admissions. A pay for outcomes amount has been included in each of those program years as demonstrated in the Budget Narrative

SCWPPC Funding Request – Budget Narrative

PROGRAM YEAR 1 – The requested budget amount of $1,295,272 is for the submission of the application and the required baseline data.

- Mariposa: $401,265
- Plumas: $394,007
- San Benito: $500,000

PROGRAM YEAR 2 – The requested budget amount of $1,295,272 is for the initial year of implementation of the Whole Person Care Pilot Program.

The details of Program Year 2 by county are as follows:

MARIPOSA PROGRAM YEAR 2: The requested budget amount of $401,265 is for the initial year of implementation of the Whole Person Care Pilot Program

Administrative Costs

Operations Costs (6-month estimates)	Justification	Total
Facility and Maintenance: Includes the rental costs of facilities, maintenance staff, and utilities.	$1489.67per month X 6 months	$8,938
Information Technology, Communications, Copiers: Costs of phones, computers, internet, IT maintenance, copier usage and supplies.	$403.50 per month x 6 months	$2,421

Administrative Staff (6 month estimates)

Staff	Salary	Benefits	FTE	Total
Human Services Director: The Director of HS is responsible for overall oversight of the Project, including participation on the Small County Collaborative Governing board and WPC Leadership Team. Total Annual Costs include salary and benefits (Social Security, Medicare, medical, dental, vision, retirement, life insurance, and SDI State Disability)	$71,978	$34,897	0.05	$5,344
Assistant Director: The AD is responsible for oversight of operations, personnel, fiscal management, IT, and contracts. Total Annual Costs include salary and benefits (Social Security, Medicare, medical, dental, vision, retirement, life insurance, and SDI State Disability)	$49,560	$24,029	0.05	$3,679

Staff	Salary	Benefits	FTE	Total
Senior Administrative Analyst: Responsible for fiscal management, budgets, invoicing, contracting and contract monitoring, fiscal project management and reporting. Total Annual Costs include salary and benefits (Social Security, Medicare, medical, dental, vision, retirement, life insurance, and SDI State Disability)	$40,237	$19,508	0.1	$5,975
Network Administrator: Responsible for assisting with integration of new Automated Data Systems with existing Electronic Health Records and other IT systems within the Human Services Department. Total Annual Costs include salary and benefits (Social Security, Medicare, medical, dental, vision, retirement, life insurance, and SDI State Disability)	$46,799	$22,689	0.05	$3,474
Other Costs (6-month estimates)				
Training: Cost of training WPC Team members in the delivery of WPC services and best practices. Funds will be combined with funds from other SCWPCC County partners to provide consistent training between counties. Trainers will include experts in strategies to be delivered through WPC. Costs include trainers and attendance fees at conferences.				$5,000
Travel: Costs associated with required travel to Sacramento for WPC meetings, Leadership Team Meetings, Small County Collaborative Meetings, and collaboration meetings that occur outside of the bundled services.				$7,500
Third Party Administrator: Cost of Third Party Administrator to oversee WPC Small County Collaborative, Evaluation/Reporting functions, IGT Transfers, , Reporting to DHCS, Interfacing with Software Vendor, etc.				$37,500
Administrative Cost Total				**$79,831**

Delivery Infrastructure Costs

Cost	Justification	Total
Vehicle: Purchase of vehicle for WPC Team Members to provide services to participants.	$35,000 for one vehicle	**$35,000**
Laptop computers, printers, cell phones, jet packs for WPC Team members to perform essential functions of their roles.	3 computers/ printers/ jetpacks X $2,077; 3 cell phones X $150; 2 cell phone plans x 6 months x $40 per month	**7,161**
WPC Software Vendor: Vendor to be selected to provide care management software and data integration software. Upfront and Annual costs to be split between Small County Collaborative partners.	Mariposa County's share of Start Up Costs	**$111,760**
Delivery Infrastructure Total		**$153,920**

Fee For Service Services: $15,000 Total

1. **Outreach and Engagement**: Costs cover staffing, travel costs and overhead of staff responsible in Human Services and Public Health Departments for providing outreach and engagement services. $250 per encounter x 10 participants x average of 6 encounters per participant = **$15,000**

Cost	Justification	Total
Staffing Costs	Average of $70 per hour (including salary and benefits for case managers/public health nurse with more than one team member responding at times) x 3 hours per encounter average x 60 encounters	$12,600
Operations and Overhead	Average of $25 per encounter x 60 encounters	$1,500
Travel	Average of $15 per encounter for gas/mileage x 60 encounters	$900
Total		**$15,000**

2. Psychiatric Respite Care: Costs cover respite bed to provide stabilization of symptoms. **$500 per bed day** x 11 bed days = **$5500**

Cost	Justification	Total
Staffing	$25 per hour (salary and benefits) x average of 12 hours x 11 days	$3300

Operations and Overhead	$200 per day for administrative costs, rent, utilities, food, insurance, etc. x 11 days	$2200
Total	**=**	**$5,500**

Incentives: $4,000 Total

Weekly Participation by JCFHCD ($300 per week): John C. Fremont Health Care District will be paid $300 per week for each week they participate in the WPC activities through Care Planning and Coordination Meetings, through case coordination and coordination of communication with healthcare providers, etc. Because a number of their health care providers/coordinators/nurses will participate, the incentive payment will ensure a variety of providers is involved based on the needs of the participants. Prorated for number of weeks of participation anticipated during PY2. If there is no need for JCFHCD staff participation during the week, this incentive will not be paid. **$300 per week x 26 weeks = $7,800**

JCFHCD for Reporting ED Utilization: JCFHCD will receive $150 each time they identify a WPC participant in the Emergency Department and notify the WPC Team or After Hours Crisis/Triage Contractor to provide services in accordance with the Comprehensive Coordinated Care Plan. Potential Eligibles will also be referred, however, payment will only occur on those individuals currently enrolled in WPC CCC Services. **$150 per report x 5 reports = $750**

PMPM Bundles: $144,245 Total

Bundle 1: Comprehensive Care Coordination: $1721 PMPM Cost x 64 Member Months = $110,965

CCC costs include the salary and benefit costs of the Engagement Team as well as transportation (not for transportation of enrollees to or from medical services) costs associated with the bundle. Over time, the CCC Team will grow to include more time and more team members at the needs of the participants are identified.

Position	Salary	Benefits	FTE	Total
Mental Health Assistant III: Lead worker responsible for all CCC coordination of meetings, development of care plans in coordination with team members, communication between team members and providers, leads CCC work of other team members, responsible for data entry and reporting with administrative team. (Social Security, Medicare, medical, dental, vision, retirement, life insurance, and SDI State Disability)	$34,304	$16,631	0.6	$30,561

Position	Salary	Benefits	FTE	Total
Mental Health Assistant I: responsible for implementing CCC activities to assist participants in meeting care plan goals. (Social Security, Medicare, medical, dental, vision, retirement, life insurance, and SDI State Disability)	$22,818	$11,063	0.6	$20,329
Public Health Nurse: Coordination of health education, public health appointments and linkages, navigation of health care delivery systems and services, medical consultation to other team members and participant support network. (Social Security, Medicare, medical, dental, vision, retirement, life insurance, and SDI State Disability)	$39,331	$19,069	0.2	$11,680
MH Asst. III (Probation): Provides case management and care coordination for individuals involved with the criminal justice system. (Social Security, Medicare, medical, dental, vision, retirement, life insurance, and SDI State Disability)	$29,534	$14,319	0.05	$ 2,193
AOD Specialist II: Provides assessments, case consultation, care coordination and planning and treatment/support not covered by Medi-Cal. (Social Security, Medicare, medical, dental, vision, retirement, life insurance, and SDI State Disability)	$28,655	$13,893	0.05	$ 2,127
Staff Services Analyst II: Responsible for establishing policies and protocols, day to day program management, data system management, data reporting, data tool development, training coordination, outreach and to partners/providers. Costs include salary and benefits (Social Security, Medicare, medical, dental, vision, retirement, life insurance, and SDI State Disability)	$33,439	$16,212	0.25	$12,413
Social Work Supervisor II: Responsible for day to day management of WPC activities, hiring and training of WPC staff and team, supervision of staff, oversight of data management and care planning, linkages with partners and providers, attends and coordinates leadership team meetings. Costs include salary and benefits (Social Security, Medicare, medical, dental, vision, retirement, life insurance, and SDI State Disability)	$52,124	$25,271	0.2	$15,479
Public Health Nurse Manager: Responsible for supervision of Public Health Nurse. Responsible for participating on leadership team and ensuring Public	$75,336	$36,525	0.05	$5,593

Position	Salary	Benefits	FTE	Total
Health participation in WPC Activities. Costs include salary and benefits (Social Security, Medicare, medical, dental, vision, retirement, life insurance, and SDI State Disability)				
JCFHCD Care Coordinator: Responsible for oversight of JCFHCD participation in WPC activities, oversight of participating staff, case coordination and reporting. Costs include salary and benefits (Social Security, Medicare, medical, dental, vision, retirement, life insurance, and SDI State Disability)	$50,575	$24,520	0.05	$3,755
After Hours Contracted Providers: Mariposa County Behavioral Health and Recovery Services contracts with after-hours mental health professionals to provide crisis intervention and supportive services to individuals referred by the ER or various agencies. This team will serve as an integral part of the CCC Team.				$ 5,000
Program Costs for Accompaniment Services associated with this bundle (Gas and Mileage)				$1,835
Total				**$110,965**

Bundle 2: Housing Navigation and Supports: $1,389 PMPM x 18 Member Months = $25,000

Cost	Justification	Total
Housing Navigator/Program Specialist: Provides screening and assessment for various housing programs, linkages, assistance with breaking down barriers to obtaining housing, and supportive services once housed.	$40,000 annual salary and benefits (includes: SDI, Workers Comp, Medical, Dental, Vision, Life, 401K) x .5 year x .75 FTE	$15,000
Administrative /Infrastructure costs of Alliance for Community Transformations: Includes Program Director and Executive Director Costs, Accounting/Audit, Insurance, IT Support and use of agency vehicle.	20% of cost of contract	$5,000
Program Supplies/Costs: Includes outreach tools and materials, includes assistance costs in obtaining Identification Cards, Driver's Licenses,	$500 per month x 6 months	$3,000

Cost	Justification	Total
Costs of Housing Applications, Credit Repair, and Accompaniment to Appointments.		
Rent/Utilities/Communication Costs: Includes rent, utilities, phone, internet, for program staff, including office to provide services to participants.	$333.33 per month x 6 months	$2,000
Total		**$25,000**

Pay for Outcomes: $500 outcome payment x 5 partners = $2,500

Reduce ED utilization and hospital admissions of WPC enrolled participants (those enrolled in CCC Services) by 5%: Should the target outcome be achieved, equal payments of $500 each will be made to five WPC partners: Mariposa County Human Services, Mariposa County Health Department, JCFHCD, Alliance for Community Transformations, and the Probation Department, totaling $2,500.

Plumas PROGRAM YEAR 2: The requested budget amount of $394,007 is for the initial year of implementation of the Whole Person Care Pilot Program

Administrative Costs

Operations Costs (6-month estimates)	Justification	Total
Facility and Maintenance: Includes the rental costs of facilities, maintenance staff, and utilities.	$3,717.83 per month X 6 months	$22,307
Information Technology, Communications, Copiers: Costs of phones, computers, internet, IT maintenance, copier usage and supplies.	$395.33 per month x 6 months	$2,372

Administrative Staff (6 month estimates)				
Staff	**Salary**	**Benefits**	**FTE**	**Total**
Behavioral Health Director: The Director is a member of the WPC Leadership Team, participates in monthly meetings, and supervises the WPC Program Administrator (BH AOD	$137,970	$51,030	0.025	$4,725

Administrative Staff (6 month estimates)				
Staff	**Salary**	**Benefits**	**FTE**	**Total**
Program Administrator listed below). Total annual costs factor in salary and benefits.				
Deputy Director: Responsible for clinical operations, direct supervision of behavioral health therapists, case management specialists, and liaison with Probation and justice partners	$106,288	$39,312	0.025	$3,640
BH AOD Program Administrator: Acts as the WPC Program Administrator; primary contact with hospitals, community-based partners; compliance with WPC pilot requirements, policies and protocols	$90,000	$27,081	0.11	$12,879
Administrative Services Officer: Budget oversight, fiscal management and reporting, hiring and staff training	$68,034	$25,150	.035	$3,261
Quality Assurance Director: Intake/on-call crisis team, referral to psychiatric hospitals, data management and care planning, quality control and grievance process, HIPAA and confidentiality officer	$74,410	$27,510	.025	$2,548
Behavioral Health Nurse Supervisor: Medications management, liaison with primary care providers, tele-psychiatry services, record vitals and provide clinic oversight	$101,920	$27,510	.078745	$10,192
Case Management Specialists: Located at Community Wellness Centers in Quincy, Portola, Chester and Greenville; will conduct intake, substance use screening and assessment, care coordination ad liaison with contracted partner for housing supports, medical appointments, data entry into WPC client data management system, referrals	$109,640	$40,551	.15	$22,528

Administrative Staff (6 month estimates)				
Staff	**Salary**	**Benefits**	**FTE**	**Total**
Anasazi Administrator: Responsible for data integrity and reporting in client data system, including integration of new tracking system for WPC pilot participants, provide training for new users	$53,649	$19,842	0.15	$11,023
Site Coordinator Supervisor: Responsible for operations of Community Wellness Centers in Quincy, Chester, Portola and Greenville; supervision of site coordinators and implementation of WPC procedures for engagement, care coordination, WPC client scheduling and tracking	$53,290	$19,710	.20	$14,600
Other Costs				
Third Party Administrator: Cost of Third Party Administrator to oversee WPC Small County Collaborative, Evaluation/Reporting functions, IGT Transfers, , Reporting to DHCS, Interfacing with Software Vendor, etc.				$37,482
Administrative Cost Total				**$147,557**

Delivery Infrastructure Costs

Cost	**Justification**	**Total**
Vehicle: Purchase of vehicle for WPC Team Members to provide services to participants.	$20,000 for one vehicle	**$20,000**
Laptop computers and printers for WPC Team members to perform essential functions of their roles.	3 computers and printers at $1,193	**$3,580**
Training: Cost of training WPC Team members in the delivery of WPC services and best practices. Funds will be combined with funds from other SCWPCC County partners to provide consistent training between counties. Trainers will include experts in strategies to be delivered through WPC. Costs include trainers and attendance fees at conferences.		**$5,000**

Cost	Justification	Total
Travel: Costs associated with required travel to Sacramento for WPC meetings, Leadership Team Meetings, Small County Collaborative Meetings, and collaboration meetings that occur outside of the bundled services.		**$7,500**
WPC Software Vendor: Vendor to be selected to provide care management software and data integration software. Upfront and Annual costs to be split between Small County Collaborative partners.	Plumas County's share of Start Up Costs	**$123,000**
Delivery Infrastructure Total		**$159,080**

Incentives: $2,250 Total
Weekly Participation: Eastern Plumas Hospital (Portola), Plumas District Hospital (Quincy) and Seneca Health Care District (Chester) will be paid for participation in WPC activities. For PY 2, we anticipate 6 in-person meetings with all three district hospitals for which each hospital will be compensated $300 per meeting. Behavioral Health's Case Management Specialists will be located at the Community Wellness Centers in each of the communities where the hospitals and their clinics are located and will be meeting on a one-on-one basis with individual hospitals at least weekly during WPC implementation in PY 2 to discuss WPC participants, enrollment, integration of primary care needs, and care coordination.
300 per week x 6 meetings = $1,800

Notification of ER Visits: Hospitals will be paid directly when they notify and coordinate with the WPC staff that a WPC member or eligible member has arrived at the Emergency Department. They will be paid $150 for each encounter.
$150 per report x 3 reports = $450

Fee For Service Services: $25,800 Total
Outreach and Engagement FFS: Costs cover salary and benefits costs of the Engagement Team as described below. We anticipate serving 20 WPC clients for an average of 4-5 encounters per client for a duration of 1 month per client in PY 2. The FFS rate is $300 per encounter for 86 encounters or $25,800.

The FFS rate for engagement was arrived at by computing the total costs for the engagement team for PY 2-5 and dividing that by the total number of encounters. Total costs for the engagement team were calculated by taking the Total Amount for the Team and multiplying the Total Amount by 3.5 years. This calculation was $56,560 X 3.5 years = $197,960. The FFS rate was calculated at $300 per encounter by taking $197,960 and dividing by the total number of anticipated encounters 660 for PY2-5.

For Plumas County, benefits include Retirement and FICA/Medicare which are calculated at 27% of the base salary. These amounts are calculated for the positions in the Engagement Team in the chart below.

Position	Base Salary	Benefits	Total	FTE	Amount
Case Management Specialist I/II	$56,053	$15,134	$71,187	.4 FTE	$28,475
BH Site Coordinator	$50,440	$13,618	$64,058	.1517 FTE	$9,718
Behavioral Health Nurse	$83,157	$20,732	$103,889	.1 FTE	$10,388
BH Therapist I/II	$64,188	$15,602	$79,790	.10 FTE	$7,979
Total					$56,560

PMPM Bundles: $56,820 Total

Bundle 1: Comprehensive Care Coordination: $1,467 PMPM Cost x 20 Member Months = $29,340

The program budget is based on 872.8 member months at $1,467 PMPM over the duration of the program. PY 2 is budgeted for 20 member months (10 individuals); PY 3 is budgeted for 300 member months; PY4 is budgeted for 302.86 member months (25 individuals on average); and PY5 is budgeted for 250 member months. The PMPM of $1,467 was calculated based on the "cost" of the CCC Team as articulated in the chart below. The cost of $320,122.5 was multiplied by 4 since the CCC Team would be providing services during each of PY2, PY3, PY4 and PY5. This total of $1,280,490 was then divided by the number of member months of 872.8 to derive a PMPM of $1,467. The PMPM of $1,467 stays constant throughout PY 2 through PY 5.

Position	Base Salary	Benefits	Total	FTE	Amount
Case Management Specialists – located at Community Wellness Centers in Quincy, Portola, Chester and Greenville; each at .5 FTE for a total of 2 FTE. Will conduct intake, substance use assessment, care coordination and liaison with contracted partners for housing supports, medical appointments, manage WPC client data record.	$56,053	$15,134	$71,187	2.0 FTE	$ 142,374
Behavioral Health Site Coordinators – located at 4	$50,440	$13,620	$64,060	.8 FTE	$ 51,248

Position	Base Salary	Benefits	Total	FTE	Amount
Community Wellness Centers, each at .2 FTE for a total of .8 FTE. Will assist in scheduling of appointments and coordination with partners.					
Behavioral Health Nurse: will be located at the Quincy Community Wellness Center and travel to Portola, Chester, and Greenville as needed for tele-psychiatry, care coordination with primary care providers, hospitals.	$83,157	$22,452	$105,610	1.0 FTE	$105,610
Behavioral Health Therapist I/II, or Senior: Provides care coordination for individuals involved with the criminal justice system, may attend court meetings, provide individual or group counseling.	$64,188	$17,322	$81,520	.25626 FTE	$20,890.5
TOTAL					**$320,122.5**

Calculation: $320,122.50 x 4 years = $1,280,490/872.8 Member Months = $1467 PMPM x 20 Member Months for PY 2 = $29,340

Bundle 2: Housing Navigation and Supports: $687 PMPM x 40 Member Months = $27,480

The bundle costs include the contract cost with Plumas Rural Services to provide housing navigation and supports. We anticipate serving 10 WPC clients for 40 member months in PY 2. The PMPM was calculated based on a model that the Behavioral Health department funded from July 2015 through June 2016. The Behavioral Health department funded another community based organization in the amount of $147,000 for that year and it was estimated that $55,000 of the funded amount was expended for Housing Navigation and Supports (the remaining amount was expended on rental payments). Since the WPC Pilot funds cannot be used on rental payments, Plumas County anticipates expending $55,000 per year on Housing Navigation and Supports. The PMPM was factored by multiplying $55,000 times 3 ½ years for a total of $192,500 for PY2-5. That total amount was divided by 280 total member months for PY2-5 and a PMPM of $687 was derived. A PMPM of $687 for Housing Supports remains a constant amount for PY2-5. Differing numbers of individuals are served per year due to the variability in the number of months each participant may require Housing Navigation and Supports. For example, one individual may require 4 months of housing supports and another may require 8 months of housing supports due to individual circumstances including Section 8 application assistance, clearing up financial-related matters, etc.

	PY2	PY3	PY4	PY5	Total
Member months	40	60	90	90	280
Cost	$27,480	$41,220	$61,830	$61,830	$192,500
Persons served	10	17	25	24	76

Pay for Outcomes: $500 outcome payment x 5 partners = $2,500

Reduce ED utilization and hospital admissions of WPC enrolled participants (those enrolled in CCC Services) by 5%: Should the target outcome be achieved, equal payments of $500 each will be made to five WPC partners: Eastern Plumas Healthcare. Plumas District Hospital, Seneca Healthcare District, Plumas County Probation Department, and Plumas Rural Services, totaling $2,500.

SAN BENITO PROGRAM YEAR 2: The requested budget amount of $500,000 is for the initial program year of implementation of the Whole Person Care Pilot Program

Administrative Costs

Administrative Staff (6 month estimates)		
Human Services Deputy Director: The Deputy Director of HS is responsible for overall oversight of the Project, including participation on the Small County Collaborative Governing board and WPC Leadership Team. Total Annual Costs include salary and benefits (Social Security, Medicare, medical, dental, vision, retirement, life insurance, and SDI State Disability)	$184,820 annually x .5 year x .20 FTE	$18,482
HHSA Fiscal Support - Account Clerk III: Responsible for budgets, invoicing, contracting and contract monitoring, fiscal project management and reporting. Total Annual Costs include salary and benefits (Social Security, Medicare, medical, dental, vision, retirement, life insurance, and SDI State Disability)	$68,235 annually x .5 year x .4 FTE	$13,647
Operations Costs	**Justification**	**Total**
Office Space: Costs of office for staff	$2400 x 6 months	$12,000
Utilities: Monthly cost of utilities for office space	$500 x 5 months	$2,500
Furniture: For office start up		$7,500

Office Supplies: paper, pens, file folders and other start up supplies		$2,500
Telephones: Cost of communication on landline and cell phones	$500 per month x 5 months	$2,500
Training: Costs of training sessions and trainer fees	$5,000 x 3 WPC Staff	$15,000
Travel: Costs of lodging, meals for travel outside of the county.		$15,000
Policy & Procedure development: Contract costs for development of policies and protocols necessary for interagency collaborations and client participation		$6,000
Assessment Tool Development: Contract costs for development of tools necessary for data collection and evaluation		$4,000
Third Party Administrator: Cost of Third Party Administrator to oversee WPC Small County Collaborative, Evaluation/Reporting functions, IGT Transfers, Training of WPC staff, Reporting to DHCS, Interfacing with Software Vendor.		$50,000
Administrative Cost Total		**$149,129**

Delivery Infrastructure Costs

Cost	Justification	Total
Cell Phones: Initial purchase of cell phones for staff assigned to lead roles in the daily management of the program.	$100 per phone x 3 staff	$300
Computers, printers and tablets to be used for case management, data collection, reporting and claiming.	$3,000 per staff x 3	$9,000
Data Integration - WPC Software Vendor: Vendor to be selected to provide care management software and data integration software. Upfront and Annual costs to be split between Small County Collaborative partners.	40% of PY2 startup costs.	$164,400
Miscellaneous Supplies:		$1,243

Cost	Justification	Total
Vehicle: Initial lease costs of vehicle to be used by county staff in delivery of services.		$5,000
Delivery Infrastructure Total		**$179,943**

Incentives: $4,500 Total
Submission of referral packets by local healthcare providers to the engagement team. Referral criteria will be documented in WPC policy and procedures. Participating providers will be paid $75 per referral meeting the criteria. It is estimated in PY2 that 40 referrals will be eligible for this incentive**. $75 x 40 = $3000**

Hazel Hawkins Hospital (HHH) for Reporting ED Utilization: HHH will receive $500 each month for notifying the WPC Team when WPC participants utilize the Emergency Department and notify the WPC Team to provide services in accordance with the Comprehensive Coordinated Care Plan. Potential eligibles will also be referred, however, payment will only occur on those individuals currently enrolled in WPC CCC Services. It is anticipated that 3 months of reporting will occur in PY2. **$500 x 3 months = $1500.**

Fee For Service
Engagement: $365.67 per encounter x 8.71 encounters per person x 31 people = $98,730

Engagement costs include the salary and benefit costs (Social Security, Medicare, medical, dental, vision, retirement, life insurance, and SDI State Disability) of the team as well as transportation costs (not for transportation of enrollees to or from medical services), outreach materials and communication costs associated with the services. Each unit of service is defined as an encounter with potential participants.

Position/Item	FTE	Total
Outreach materials		$4,000
Vehicle Lease		$1,440
Cell Phone Service		$450
Program Manager: Responsible for day to day management of WPC activities, hiring and training of WPC staff and team, supervision of staff, oversight of data management and care planning, linkages with partners and providers, attends and coordinates leadership team meetings.	.2	$24,638
Staff Analyst: Responsible for implementing policies and protocols, data system management, data reporting, data tool development, training coordination, outreach to partners/providers.	.2	$17,165
Assessment Coordinator: Lead worker responsible for all coordination of meetings, development of assessment plans in coordination with team members, communication between team	1	$78,218

Position/Item	FTE	Total
members and providers, leads engagement work of other team members, responsible for data entry and reporting with administrative team.		
Probation Officer: Provides case management and care coordination for individuals involved with the criminal justice system.	.2	$18,788
Public Health Nurse: Coordination of health education, public health appointments and linkages, navigation of health care delivery systems and services, medical consultation to other team members and participant support network.	.2	$21,809
Peer Advocate: responsible for implementing engagement activities to assist participants in meeting enrollment criteria and understanding the WPC program.	.5	$30,925
Total Service Cost		$197,433
Average Number of service units per year		90
Service cost per unit = Total Services Costs / Avg Units per year		$2,194

PMPM Bundles: **$65,198 Total**

Bundle1: Comprehensive Care Coordination: $1,657 PMPM Cost x 30 Member Months = $49,710

CCC costs include the salary and benefit (Social Security, Medicare, medical, dental, vision, retirement, life insurance, and SDI State Disability) costs of the CCC Team as well as transportation (not for transportation of enrollees to or from medical services) and communication costs associated with the bundle.

Position	FTE	Total
Vehicle Lease		$4,200
Cell Phone Service		$900
Program Manager: Responsible for day to day management of WPC activities, hiring and training of WPC staff and team, supervision of staff, oversight of data management and care planning, linkages with partners and providers, attends and coordinates leadership team meetings.	.3	$36,956
Staff Analyst: Responsible for implementing policies and protocols, data system management, data reporting, data tool development, training coordination, outreach to partners/providers.	.3	$25,747
CCC Coordinator: Lead worker responsible for all coordination of meetings, development of care plans in coordination with team members, communication between team members and providers, leads CCC work of other team members, responsible for data entry and reporting with administrative team.	1	$104,350
Mental Health Clinician: Provides assessments, case consultation, care coordination and planning and treatment/support not covered by Medi-Cal.	.25	$31,559

Position	FTE	Total
Substance Abuse Counselor: Provides assessments, case consultation, care coordination and planning and treatment/support not covered by Medi-Cal.	.2	$19,874
Public Health Nurse: Coordination of health education, public health appointments and linkages, navigation of health care delivery systems and services, medical consultation to other team members and participant support network.	.4	$43,617
Peer Advocate: responsible for implementing engagement activities to assist participants in meeting enrollment criteria and understanding the WPC program.	.5	$30,925
Total Bundle Cost	=	$298,248
Average number of Member Months per year	=	180
Per Member Per Month = Total Bundle Costs / Avg Member Months	=	$1,657

Bundle 2: Housing Navigation and Supports: $1,936 PMPM x 8 Member Months = $15,488

Housing Support Service costs include the salary and benefit (Social Security, Medicare, medical, dental, vision, retirement, life insurance, and SDI State Disability) costs of the Housing Team.

Position	FTE	Total
Program Manager: Responsible for day to day management of WPC activities, hiring and training of WPC staff and team, supervision of staff, oversight of data management and care planning, linkages with partners and providers, attends and coordinates leadership team meetings.	.05	$6,159
Staff Analyst: Responsible for implementing policies and protocols, data system management, data reporting, data tool development, training coordination, outreach to partners/providers.	.05	$4,291
Housing Navigator/Program Specialist: Provides screening and assessment for various housing programs, linkages, assistance with breaking down barriers to obtaining housing, and liaison with land lords.	.5	$66,598
Tenancy Care Support: Provide supportive services to participant once housed.	.5	$39,109
Total Bundle Costs		$116,157
Average number of Member Months per year		60
Per Member Per Month =Total Bundle Costs / Avg Member Months		$1,936

<u>Pay for Outcomes</u>: $500 outcome payment x 5 partners = $2,500

Reduce ED utilization and hospital admissions of WPC enrolled participants (those enrolled in CCC Services) by 5%: Should the target outcome be achieved, equal payments of $500 each will be made to WPC partners: San Benito County Health &

Human Services, Behavioral Health Department, Probation Department, San Benito Health Foundation, and HHH, totaling $2,500.

PROGRAM YEAR 3: The requested budget amount of $2,590,544 is for Program Year 3 of the Whole Person Care Pilot Program.

Mariposa PROGRAM YEAR 3: Total - $802,530

Administrative Costs

Operations Costs	Justification	Total
Facility and Maintenance: Includes the rental costs of facilities, maintenance staff, and utilities.	$3,450.58 X 12 months	$41,407
Information Technology, Communications, Copiers: Costs of phones, computers, internet, IT maintenance, copier usage and supplies.	$403.42 x 12 months	$4,841

Administrative Staff				
	Salary	**Benefits**	**FTE**	**Total**
Human Services Director: The Director of HS is responsible for overall oversight of the Project, including participation on the Small County Collaborative Governing board and WPC Leadership Team. Total Annual Costs include salary and benefits (Social Security, Medicare, medical, dental, vision, retirement, life insurance, and SDI State Disability)	$143,956	$69,794	0.05	$10,688
Assistant Director: The AD is responsible for oversight of operations, personnel, fiscal management, IT, and contracts. Total Annual Costs include salary and benefits (Social Security, Medicare, medical, dental, vision, retirement, life insurance, and SDI State Disability)	$99,121	$48,057	0.05	$7,359
Senior Administrative Analyst: Responsible for fiscal management, budgets, invoicing, contracting and contract monitoring, fiscal project management and reporting. Total Annual Costs include salary and benefits (Social Security, Medicare,	$80,474	$39,016	0.1	$11,949

Administrative Staff				
	Salary	**Benefits**	**FTE**	**Total**
medical, dental, vision, retirement, life insurance, and SDI State Disability)				
Network Administrator: Responsible for assisting with integration of new Automated Data Systems with existing Electronic Health Records and other IT systems within the Human Services Department. Total Annual Costs include salary and benefits (Social Security, Medicare, medical, dental, vision, retirement, life insurance, and SDI State Disability)	$93,597	$45,379	0.05	$6,949
Other Costs				
Training: Cost of training WPC Team members in the delivery of WPC services and best practices. Funds will be combined with funds from other SCWPCC County partners to provide consistent training between counties. Trainers will include experts in strategies to be delivered through WPC. Costs include trainers and attendance fees at conferences.			$10,000	
Travel: Costs associated with required travel to Sacramento for WPC meetings, Leadership Team Meetings, Small County Collaborative Meetings, and collaboration meetings that occur outside of the bundled services.			$15,000	
Third Party Administrator: Cost of Third Party Administrator to oversee WPC Small County Collaborative, Evaluation/Reporting functions, IGT Transfers, Training of WPC staff, Reporting to DHCS, Interfacing with Software Vendor, etc.			$75,000	
Administrative Cost Total			**$183,193**	

Delivery Infrastructure Costs

Cost	Justification	Total
Cell Phone Plans	2 cell phone plans x 12 months x $38.33 per month	**$920**
WPC Software Vendor: Vendor to be selected to provide care management software and data integration software. Upfront and Annual costs to be split between Small County Collaborative partners.	Mariposa County's share of ongoing maintenance/tech support	$59,713
Delivery Infrastructure Total		**$60,633**

Fee For Service Services: $45,000 Total

Outreach and Engagement: Costs cover staffing, transportation (not for transportation of enrollees to or from medical services)costs and overhead of staff responsible in Human Services and Public Health Departments for providing outreach and engagement services. $250 per encounter x 30 participants x average of 6 encounters per participant = **$45,000**

Cost	Justification	Total
Staffing Costs	Average of $70 per hour (including salary and benefits for case managers/public health nurse with more than one team member responding at times) x 3 hours per encounter average x 180 encounters	$37,800
Operations and Overhead	Average of $25 per encounter x 180 encounters	$4,500
Travel	Average of $15 per encounter for gas/mileage x 180 encounters	$2,700
Total		**$45,000**

Psychiatric Respite Services: Costs cover respite bed to provide stabilization of symptoms. **$500 per bed day** x 57 bed days = **$28,500**

Cost	Justification	Total
Staffing	$25 per hour (salary and benefits) x average of 12 hours x 57 days	$17,100
Operations and Overhead	$200 per day for administrative costs, rent, utilities, food, insurance, etc. x 57days	$11,400
Total		**$28,500**

Incentives: $17,100 Total

Weekly Participation by JCFHCD ($300 per week): John C. Fremont Health Care District will be paid $300 per week for each week they participate in the WPC activities through Care Planning and Coordination Meetings, through case coordination and coordination of communication with healthcare providers, etc. Because a number of their health care providers/coordinators/nurses will participate, the incentive payment will ensure a variety of providers is involved based on the needs of the participants. Payments will not be made for weeks in which their participation is not required. **$300 per week x 52 weeks = $15,600.**

JCFHCD for Reporting ED Utilization: JCFHCD will receive $150 each time they identify a WPC participant in the Emergency Department and notify the WPC Team or After Hours Crisis/Triage Contractor to provide services in accordance with the Comprehensive Coordinated Care Plan. Potential Eligibles will also be referred, however, payment will only occur on those individuals currently enrolled in WPC CCC Services. **$150 per report x 10 reports = $1,500**

PMPM Bundles: $481,664 Total

Bundle 1: Comprehensive Care Coordination: $1,721 PMPM Cost x 240 Member Months = $413,104

CCC costs include the salary and benefit costs of the Engagement Team as well as transportation (not for transportation of enrollees to or from medical services) costs associated with the bundle. Over time, the CCC Team will grow to include more time and more team members at the needs of the participants are identified.

Position	Salary	Benefits	FTE	Total
Mental Health Assistant III: Lead worker responsible for all CCC coordination of meetings, development of care plans in coordination with team members, communication between team members and providers, leads CCC work of other team members, responsible for data entry and reporting with administrative team. (Social Security, Medicare, medical, dental, vision, retirement, life insurance, and SDI State Disability)	$68,607	$33,263	0.839	$85,497
Mental Health Assistant I: responsible for implementing CCC activities to assist participants in meeting care plan goals. (Social Security, Medicare, medical, dental, vision, retirement, life insurance, and SDI State Disability)	$45,636	$22,126	0.830	$56,210
Public Health Nurse: Coordination of health education, public health appointments and	$78,662	$38,138	0.314	$36,720

Position	Salary	Benefits	FTE	Total
linkages, navigation of health care delivery systems and services, medical consultation to other team members and participant support network. (Social Security, Medicare, medical, dental, vision, retirement, life insurance, and SDI State Disability)				
MH Asst. III (Probation): Provides case management and care coordination for individuals involved with the criminal justice system. (Social Security, Medicare, medical, dental, vision, retirement, life insurance, and SDI State Disability)	$59,068	$28,638	0.123	$10,771
AOD Specialist II: Provides assessments, case consultation, care coordination and planning and treatment/support not covered by Medi-Cal. (Social Security, Medicare, medical, dental, vision, retirement, life insurance, and SDI State Disability)	$57,310	$27,786	0.100	$ 8,510
Eligibility Worker: Provides enrollment and case management services to individuals to access a variety of entitlement and benefits programs. Participates in care planning and case coordination. Costs include salary and benefits (Social Security, Medicare, medical, dental, vision, retirement, life insurance, and SDI State Disability)	$57,079	$27,674	0.062	$5,238
Mental Health Clinician: Participates in care planning and case coordination efforts. Costs include salary and benefits (Social Security, Medicare, medical, dental, vision, retirement, life insurance, and SDI State Disability)	$75,665	$36,685	0.695	$78,028
Psychiatric Nurse Practitioner: Participates in care planning and case coordination efforts. Costs include salary and benefits (Social Security, Medicare, medical, dental, vision, retirement, life insurance, and SDI State Disability)	$179,895	$87,219	0.032	$8,678
MH Asst. III (Crisis/Triage): Participates in care planning and case coordination efforts. Provides supportive services and triage services to individuals enrolled in WPC activities. Costs include salary and benefits (Social Security,	$59,879	$29,031	0.122	$10,890

Position	Salary	Benefits	FTE	Total
Medicare, medical, dental, vision, retirement, life insurance, and SDI State Disability)				
Social Security Advocate: Provides SSI/SSDI Assistance with applications and advocacy. Costs include salary and benefits (Social Security, Medicare, medical, dental, vision, retirement, life insurance, and SDI State Disability)	$57,793	$28,020	0.025	$2,145
Public Guardian/Public Conservatorship Supervisor: Assessment and consultation regarding needs for LPS or Probation conservatorships; Participation on team as necessary for case coordination and care planning purposes. Costs include salary and benefits (Social Security, Medicare, medical, dental, vision, retirement, life insurance, and SDI State Disability)	$80,083	$38,827	0.058	$6,945
Probation Officer: Participation in team meetings for case coordination and care planning for individuals involved with the criminal justice system to ensure that Probation Case Plan aligns with CCCP. Costs include salary and benefits (Social Security, Medicare, medical, dental, vision, retirement, life insurance, and SDI State Disability)	$59,014	$28,612	0.096	$8,381
Staff Services Analyst II: Responsible for establishing policies and protocols, day to day program management, data system management, data reporting, data tool development, training coordination, outreach and to partners/providers. Costs include salary and benefits (Social Security, Medicare, medical, dental, vision, retirement, life insurance, and SDI State Disability)	$66,877	$32,424	0.250	$24,825
Social Work Supervisor II: Responsible for day to day management of WPC activities, hiring and training of WPC staff and team, supervision of staff, oversight of data management and care planning, linkages with partners and providers, attends and coordinates leadership team meetings. Costs include salary and benefits (Social Security, Medicare, medical, dental,	$104,248	$50,543	0.200	$30,958

Position	Salary	Benefits	FTE	Total
vision, retirement, life insurance, and SDI State Disability)				
Public Health Nurse Manager: Responsible for supervision of Public Health Nurse. Responsible for participating on leadership team and ensuring Public Health participation in WPC Activities. Costs include salary and benefits (Social Security, Medicare, medical, dental, vision, retirement, life insurance, and SDI State Disability)	$150,671	$73,050	0.050	$11,186
JCFHCD Care Coordinator: Responsible for oversight of JCFHCD participation in WPC activities, oversight of participating staff, case coordination and reporting. Costs include salary and benefits (Social Security, Medicare, medical, dental, vision, retirement, life insurance, and SDI State Disability)	$101,150	$49,041	0.050	$7,510
After Hours Contracted Providers: Mariposa County Behavioral Health and Recovery Services contracts with after-hours mental health professionals to provide crisis intervention and supportive services to individuals referred by the ER or various agencies. This team will serve as an integral part of the CCC Team.				$10,000
Program Costs for Accompaniment Services associated with this bundle (Gas and Mileage)				$10,612
Total	**=**			**$413,104**

Bundle 2: Housing Navigation and Supports: $1,389 PMPM x 36 Member Months = $50,000

Cost	Justification	Total
Housing Navigator/Program Specialist: Provides screening and assessment for various housing programs, linkages, assistance with breaking down barriers to obtaining housing, and supportive services once housed.	$40,000 annual salary and benefits (includes: SDI, Workers Comp, Medical, Dental, Vision, Life, 401K) x .75 FTE	$30,000
Administrative /Infrastructure costs of Alliance for Community Transformations: Includes Program Director and Executive Director Costs,	20% of cost of contract for Alliance for Community Transformations	$10,000

Cost	Justification	Total
Accounting/Audit, Insurance, IT Support and use of agency vehicle.		
Program Supplies/Costs: Includes outreach tools and materials, includes assistance costs in obtaining Identification Cards, Driver's Licenses, Costs of Housing Applications, Credit Repair, and Accompaniment to Appointments.	$500 per month x 12 months	$6,000
Rent/Utilities/Communication Costs: Includes rent, utilities, phone, internet, for program staff, including office to provide services to participants.	$333.33 per month x 12 months	$4,000
Total	**=**	**$50,000**

Pay for Outcomes: $1,000 outcome payment x 5 partners = $5,000

Reduce ED utilization and hospital admissions of WPC enrolled participants (those enrolled in CCC Services) by 5%: Should the target outcome be achieved, equal payments of $1,000 each will be made to WPC partners: Mariposa County Human Services, Mariposa County Health Department, JCFHCD, Alliance for Community Transformations, and the Probation Department, totaling $5,000.

Plumas PROGRAM YEAR 3: The requested budget amount of $788,014 is for PY3 of implementation of the Whole Person Care Pilot Program

Administrative Costs

Operations Costs (12-month estimates)	Justification	Total
Facility and Maintenance: Includes the rental costs of facilities, maintenance staff, and utilities.	$3,056.50 per month X 12 months	$36,678
Information Technology, Communications, Copiers: Costs of phones, computers, internet, IT maintenance, copier usage and supplies.	Will be paid in part by other Co-located programs	$2,372

Administrative Staff (12 month estimates)				
Staff	**Salary**	**Benefits**	**FTE**	**Total**
Administrative Services Officer: Budget oversight, fiscal	$68,034	$25,150	.1533337	$14,284

Administrative Staff (12 month estimates)				
Staff	**Salary**	**Benefits**	**FTE**	**Total**
management and reporting, hiring and staff training				
Other Costs				
Third Party Administrator: Cost of Third Party Administrator to oversee WPC Small County Collaborative, Evaluation/Reporting functions, IGT Transfers, , Reporting to DHCS, Interfacing with Software Vendor, etc.				$67,500
Administrative Cost Total				**$120,834**

Delivery Infrastructure Costs

Cost	**Justification**	**Total**
Cell phones: Monthly fees associated with cell phones for four Case Management Specialists in 4 Community Wellness Centers. Pro-rated based on .5FTE at each center.	$40 per month X12 months X 4 phones at 50% for .5FTE	**$960**
Training: Cost of training WPC Team members in the delivery of WPC services and best practices. Funds will be combined with funds from other SCWPCC County partners to provide consistent training between counties. Trainers will include experts in strategies to be delivered through WPC. Costs include trainers and attendance fees at conferences.		**$10,000**
Travel: Costs associated with required travel to Sacramento for WPC meetings, Leadership Team Meetings, Small County Collaborative Meetings, and collaboration meetings that occur outside of the bundled services.		**$15,000**
WPC Software Vendor: Vendor to be selected to provide care management software and data integration software. Upfront and Annual costs to be split between Small County Collaborative partners.	Plumas County's share of Start Up Costs	**$49,000**
Delivery Infrastructure Total		**$74,960**

Incentives: $17,100 Total
Weekly Participation: Eastern Plumas Hospital (Portola), Plumas District Hospital (Quincy) and Seneca Health Care District (Chester) will be paid for participation in WPC activities. For PY 2, we anticipate 6 in-person meetings with all three district hospitals for which each hospital will be compensated $300 per meeting. Behavioral Health's Case Management Specialists will be located at the Community Wellness Centers in each of the communities where the hospitals and their clinics are located and will be meeting on a one-on-one basis with individual hospitals at least weekly during WPC implementation in PY 2 to discuss WPC participants, enrollment, integration of primary care needs, and care coordination.
300 per week x 52 meetings = $15,600

Notification of ER Visits: Hospitals will be paid directly when they notify and coordinate with the WPC staff that a WPC member or eligible member has arrived at the Emergency Department. They will be paid $150 for each encounter.
$150 per report x 10 reports = $1,500

Fee For Service Services: $88,800 Total

1. Outreach and Engagement FFS: Costs cover salary and benefits costs of the Engagement Team as described below. We anticipate serving 40 WPC clients for an average of 4-5 encounters per client for a duration of 1 month per client in PY 3. The FFS rate is $300 per encounter for 196 encounters or $58,800.

The FFS rate for engagement was arrived at by computing the total costs for the engagement team for PY 2-5 and dividing that by the total number of encounters. Total costs for the engagement team were calculated by taking the Total Amount for the Team and multiplying the Total Amount by 3.5 years. This calculation was $56,560 X 3.5 years = $197,960. The FFS rate was calculated at $300 per encounter by taking $197,960 and dividing by the total number of anticipated encounters 660 for PY2-5.

For Plumas County, benefits include Retirement and FICA/Medicare which are calculated at 27% of the base salary. These amounts are calculated for the positions in the Engagement Team in the chart below.

Position	Base Salary	Benefits	Total	FTE	Amount
Case Management Specialist I/II	$56,053	$15,134	$71,187	.4 FTE	$28,475
BH Site Coordinator	$50,440	$13,618	$64,058	.1517 FTE	$9,718
Behavioral Health Nurse	$83,157	$20,732	$103,889	.1 FTE	$10,388
BH Therapist I/II	$64,188	$15,602	$79,790	.10 FTE	$7,979
Total					$56,560

2. Sober Living Support: Plumas Rural Services will provide contracted services for sober living and transitional services. The house will be managed by staff with ongoing supervision. WPC clients will participate in activities including cooking, cleaning. Life skills education and supports. It is anticipated that 2 beds per month will be utilized at a budget of $1000 per month or $12,000 per year (**per the chart below**). The monthly rate of **$1000 x 12 months** = **$12,000**

Cost	**Justification**	**Total**
Staffing Costs	$15 per hour (for salary and benefits) x 40 hours per week x 52 weeks for Support Services Staff = $31,200 annually/ 12 months = $2,600 monthly / 6 clients = $433.33 per month per clients in care; $433.33 per month per client in care x 2 clients in care = $866.66 per month x 12 months = $10,400	$10,400
Operations	$66.67 per month for operations (rent, utilities, insurances, food, etc.) per client x 2 clients per month x 12 months = $1,600	$1600
Total		**$12,000**

3. Respite: Plumas Rural Services (PRS) will provide contracted services for respite provisions as determined by the Care Coordination Team. The house will be available for safe and supportive respite care for an average of 1-3 nights. Trained mental health clinicians from PRS or the Behavioral Health Department will provide services as determined in the Care Coordination Plan. Costs cover respite bed to provide stabilization of symptoms. **$500 per bed day x 36 bed days = $18,000**

Cost	**Justification**	**Total**
Staffing	$25 per hour (salary and benefits) x average of 12 hours x 3 days per person x 12 people served.	$10,800
Operations and Overhead	$200 per day for administrative costs, rent, utilities, food, insurance, etc. x 3 days per person x 12 people served.	$7,200
Total		**$18,000**

PMPM Bundles: **$481,320 Total**

Bundle 1: Comprehensive Care Coordination: $1,467 PMPM Cost x 300 Member Months = $440,100

The program budget is based on 872.8 member months at $1,467 PMPM over the duration of the program. PY 3 is budgeted for 300 member months; PY4 is budgeted for 302.80 member months (25 individuals on average); and PY5 is budgeted for 250 member months. The PMPM of $1,467 was calculated based on the "cost" of the CCC Team as articulated in the chart below. The cost of $320,122.5 was multiplied by 4 since the CCC Team would be providing services during each of PY2, PY3, PY4 and PY5. This total of $1,280,490 was then divided by the number of member months of 872.8 to derive a PMPM of $1,467. The PMPM of $1,467 stays constant throughout PY 2 through PY 5.

Position	Base Salary	Benefits	Total	FTE	Amount
Case Management Specialists – located at Community Wellness Centers in Quincy, Portola, Chester and Greenville; each at .5 FTE for a total of 2 FTE. Will conduct intake, substance use assessment, care coordination and liaison with contracted partners for housing supports, medical appointments, manage WPC client data record.	$56,053	$15,134	$71,187	2.0 FTE	$ 142,374
Behavioral Health Site Coordinators – located at 4 Community Wellness Centers, each at .2 FTE for a total of .8 FTE. Will assist in scheduling of appointments and coordination with partners.	$50,440	$13,620	$64,060	.8 FTE	$ 51,248
Behavioral Health Nurse: will be located at the Quincy Community Wellness Center and travel to Portola, Chester, and Greenville as needed for tele-psychiatry, care coordination with primary care providers, hospitals.	$83,157	$22,452	$105,610	1.0 FTE	$105,610

Position	Base Salary	Benefits	Total	FTE	Amount
Behavioral Health Therapist I/II, or Senior: Provides care coordination for individuals involved with the criminal justice system, may attend court meetings, provide individual or group counseling.	$64,188	$17,322	$81,510	.25629 FTE	$20,890.5
TOTAL					**$320,122.5**

Calculation: $320,122.50 x 4 years = $1,280,490/872.8 Member Months = $1467 PMPM x 300 Member Months for PY 2 = $440,100

Bundle 2: Housing Navigation and Supports: $687 PMPM x 60 Member Months = $41,220.

The bundle costs include the contract cost with Plumas Rural Services to provide housing navigation and supports. We anticipate 60 member months in PY 3. The PMPM was calculated based on a model that the Behavioral Health department funded from July 2015 through June 2016. The Behavioral Health department funded another community based organization in the amount of $147,000 for that year and it was estimated that $55,000 of the funded amount was expended for Housing Navigation and Supports (the remaining amount was expended on rental payments). Since the WPC Pilot funds cannot be used on rental payments, Plumas County anticipates expending $55,000 per year on Housing Navigation and Supports. The PMPM was factored by multiplying $55,000 times 3 ½ years for a total of $192,500 for PY2-5. That total amount was divided by 280 total member months for PY2-5 and a PMPM of $687 was derived. A PMPM of $687 for Housing Supports remains a constant amount for PY2-5. Differing numbers of individuals are served per year due to the variability in the number of months each participant may require Housing Navigation and Supports. For example, one individual may require 4 months of housing supports and another may require 8 months of housing supports due to individual circumstances including Section 8 application assistance, clearing up financial-related matters, etc.

	PY2	PY3	PY4	PY5	Total
Member months	40	60	90	90	280
Cost	$27,480	$41,220	$61,830	$61,830	$192,500
Persons served	10	17	25	24	76

<u>Pay for Outcomes</u>: $500 outcome payment x 5 partners = $5,000

Reduce ED utilization and hospital admissions of WPC enrolled participants (those enrolled in CCC Services) by 5%: Should the target outcome be achieved, equal

payments of $500 each will be made to five WPC partners: Eastern Plumas Healthcare. Plumas District Hospital, Seneca Healthcare District, Plumas County Probation Department, and Plumas Rural Services, totaling $5,000.

San Benito County PROGRAM YEAR 3: Total - $1,000,000

Administrative Costs

Administrative Staff		
Human Services Deputy Director: The Deputy Director of HS is responsible for overall oversight of the Project, including participation on the Small County Collaborative Governing board and WPC Leadership Team. Total Annual Costs include salary and benefits (Social Security, Medicare, medical, dental, vision, retirement, life insurance, and SDI State Disability)	$184,820 annually x .20 FTE	$36,964
HHSA Fiscal Support - Account Clerk III: Responsible for budgets, invoicing, contracting and contract monitoring, fiscal project management and reporting. Total Annual Costs include salary and benefits (Social Security, Medicare, medical, dental, vision, retirement, life insurance, and SDI State Disability)	$68,235 annually x .25 FTE	$17,059
WPC Infrastructure Capacity Needs; Operations Costs	**Justification**	**Total**
Facility and Maintenance: Includes the rental costs of facilities, utilities.	$3,000 per month	$36,000
Office costs: Includes supplies.		$1,600
Training: Costs of training sessions and trainer fees	$5,000 x 6 WPC Staff	$30,000
Travel: Costs of lodging, meals for travel outside of the county.		$15,000
Third Party Administrator: Cost of Third Party Administrator to oversee WPC Small County Collaborative, Evaluation/Reporting functions, IGT Transfers, Training of WPC staff, Reporting to DHCS, Interfacing with Software Vendor.	40% x $250,000	$100,000
Administrative Cost Total		**$236,623**

Delivery Infrastructure Costs

Cost	Justification	Total
Data Integration - WPC Software Vendor: Vendor to be selected to provide care management software and data integration software. Upfront and Annual costs to be split between Small County Collaborative partners.	40% of Estimated annual costs	$80,000
Delivery Infrastructure Total		**$80,000**

Incentives: $16,200 Total
Submission of referral packets by local healthcare providers to the engagement team. Referral criteria will be documented in WPC policy and procedures. Participating providers will be paid $75 per referral meeting the criteria. It is estimated in PY3 that 120 referrals will be eligible for this incentive. **$75 x 120 = $9000**

Hazel Hawkins Hospital (HHH) for Reporting ED Utilization: HHH will receive $600 each month for notifying the WPC Team when WPC participants utilize the Emergency Department and notify the WPC Team to provide services in accordance with the Comprehensive Coordinated Care Plan. Potential eligibles will also be referred, however, payment will only occur on those individuals currently enrolled in WPC CCC Services. It is anticipated that 3 months of reporting will occur in PY2. **$600 per month x 12 months = $7,200**

Fee For Services
Engagement: $365.67 per encounter x 8.585 encounters per person x 65 people = $204,042

Engagement costs include the salary and benefit costs (Social Security, Medicare, medical, dental, vision, retirement, life insurance, and SDI State Disability) of the team as well as transportation (not for transportation of enrollees to or from medical services) costs, outreach materials and communication costs associated with the services. Each unit of service is defined as an encounter with potential participants.

Position/Item	FTE	Total
Outreach materials		$2,110
Vehicle Lease		$2,880
Cell Phone Service		$900
Program Manager: Responsible for day to day management of WPC activities, hiring and training of WPC staff and team, supervision of staff, oversight of data management and care planning, linkages with partners and providers, attends and coordinates leadership team meetings.	.2	$24,638
Staff Analyst: Responsible for implementing policies and protocols, data system management, data reporting, data tool development, training coordination, outreach to partners/providers.	.2	$17,165

Position/Item	FTE	Total
Assessment Coordinator: Lead worker responsible for all coordination of meetings, development of assessment plans in coordination with team members, communication between team members and providers, leads engagement work of other team members, responsible for data entry and reporting with administrative team.	1	$78,218
Probation Officer: Provides case management and care coordination for individuals involved with the criminal justice system.	.2	$18,788
Public Health Nurse: Coordination of health education, public health appointments and linkages, navigation of health care delivery systems and services, medical consultation to other team members and participant support network.	.2	$21,809
Peer Advocate: responsible for implementing engagement activities to assist participants in meeting enrollment criteria and understanding the WPC program.	.5	$30,925
Total Service Cost		$197,433
Average Number of service units per year		90
Service cost per unit = Total Services Costs / Avg Units per year		$2,194

PMPM Bundles: **$458,635 Total**

Bundle 1: Comprehensive Care Coordination: $1,657 PMPM Cost x 195 Member Months = $323,115

CCC costs include the salary and benefit (Social Security, Medicare, medical, dental, vision, retirement, life insurance, and SDI State Disability) costs of the CCC Team as well as transportation (not for transportation of enrollees to or from medical services) and communication costs associated with the bundle.

Position	FTE	Total
Vehicle Lease		$4,320
Cell Phone Service		$900
Program Manager: Responsible for day to day management of WPC activities, hiring and training of WPC staff and team, supervision of staff, oversight of data management and care planning, linkages with partners and providers, attends and coordinates leadership team meetings.	.3	$36,956
Staff Analyst: Responsible for implementing policies and protocols, data system management, data reporting, data tool development, training coordination, outreach to partners/providers.	.3	$25,747
CCC Coordinator: Lead worker responsible for all coordination of meetings, development of care plans in coordination with team members, communication between team members and providers, leads	1	$104,350

Position	FTE	Total
CCC work of other team members, responsible for data entry and reporting with administrative team.		
Mental Health Clinician: Provides assessments, case consultation, care coordination and planning and treatment/support not covered by Medi-Cal.	.25	$31,559
Substance Abuse Counselor: Provides assessments, case consultation, care coordination and planning and treatment/support not covered by Medi-Cal.	.2	$19,874
Public Health Nurse: Coordination of health education, public health appointments and linkages, navigation of health care delivery systems and services, medical consultation to other team members and participant support network.	.4	$43,617
Peer Advocate: responsible for implementing engagement activities to assist participants in meeting enrollment criteria and understanding the WPC program.	.5	$30,925
Total Bundle Cost		$298,248
Average number of Member Months per year		180
Per Member Per Month = Total Bundle Costs / Avg Member Months		$1,657

Bundle 2: Housing Navigation and Supports: $1,936 PMPM x 70 Member Months = $135,520

Housing Support Service costs include the salary and benefit (Social Security, Medicare, medical, dental, vision, retirement, life insurance, and SDI State Disability) costs of the Housing Team.

Position	FTE	Total
Program Manager: Responsible for day to day management of WPC activities, hiring and training of WPC staff and team, supervision of staff, oversight of data management and care planning, linkages with partners and providers, attends and coordinates leadership team meetings.	.05	$6,159
Staff Analyst: Responsible for implementing policies and protocols, data system management, data reporting, data tool development, training coordination, outreach to partners/providers.	.05	$4,291
Housing Navigator/Program Specialist: Provides screening and assessment for various housing programs, linkages, assistance with breaking down barriers to obtaining housing, and liaison with land lords.	.5	$66,598
Tenancy Care Support: Provide supportive services to participant once housed.	.5	$39,109
Total Bundle Costs		$116,157

Position	FTE	Total
Average number of Member Months per year		60
Per Member Per Month =Total Bundle Costs / Avg Member Months		$1,936

Pay for Outcomes: $900 outcome payment x 5 partners = $4,500
Reduce ED utilization and hospital admissions of WPC enrolled participants (those enrolled in CCC Services) by 5%: Should the target outcome be achieved, equal payments of $900 each will be made to WPC partners: San Benito County Health & Human Services, Behavioral Health Department, Probation Department, San Benito Health Foundation, and HHH, totaling $4,500.

PROGRAM YEAR 4: The requested budget amount of $2,590,544 is for Program Year 4 of the Whole Person Care Pilot Program.

Mariposa County PROGRAM YEAR 4: Total - $802,530

Administrative Costs

Operations Costs	**Justification**	**Total**
Facility and Maintenance: Includes the rental costs of facilities, maintenance staff, and utilities.	$3,450.58 X 12 months	$41,407
Information Technology, Communications, Copiers: Costs of phones, computers, internet, IT maintenance, copier usage and supplies.	$403.42 x 12 months	$4,841

Administrative Staff				
Staff	**Salary**	**Benefits**	**FTE**	**Total**
Human Services Director: The Director of HS is responsible for overall oversight of the Project, including participation on the Small County Collaborative Governing board and WPC Leadership Team. Total Annual Costs include salary and benefits (Social Security, Medicare, medical, dental, vision, retirement, life insurance, and SDI State Disability)	$143,956	$69,794	0.05	$10,688
Assistant Director: The AD is responsible for oversight of operations, personnel, fiscal management, IT, and contracts. Total Annual Costs include salary and benefits (Social Security, Medicare, medical, dental, vision, retirement, life insurance, and SDI State Disability)	$99,121	$48,057	0.05	$7,359
Senior Administrative Analyst: Responsible for fiscal management, budgets, invoicing, contracting and contract monitoring, fiscal project management and reporting. Total Annual Costs include salary and benefits (Social Security, Medicare, medical, dental, vision, retirement, life insurance, and SDI State Disability)	$80,474	$39,016	0.1	$11,949

Network Administrator: Responsible for assisting with integration of new Automated Data Systems with existing Electronic Health Records and other IT systems within the Human Services Department. Total Annual Costs include salary and benefits (Social Security, Medicare, medical, dental, vision, retirement, life insurance, and SDI State Disability)	$93,597	$45,379	0.05	$6,949
Other Costs				
Training: Cost of training WPC Team members in the delivery of WPC services and best practices. Funds will be combined with funds from other SCWPCC County partners to provide consistent training between counties. Trainers will include experts in strategies to be delivered through WPC. Costs include trainers and attendance fees at conferences.			$10,000	
Travel: Costs associated with required travel to Sacramento for WPC meetings, Leadership Team Meetings, Small County Collaborative Meetings, and collaboration meetings that occur outside of the bundled services.			$15,000	
Third Party Administrator: Cost of Third Party Administrator to oversee WPC Small County Collaborative, Evaluation/Reporting functions, IGT Transfers, Training of WPC staff, Reporting to DHCS, Interfacing with Software Vendor, etc.			$75,000	
Administrative Cost Total			**$183,193**	

Delivery Infrastructure Costs

Cost	Justification	Total
Cell Phone Plans	2 cell phone plans x 12 months x $38.33 per month	**$920**

Cost	Justification	Total
WPC Software Vendor: Vendor to be selected to provide care management software and data integration software. Upfront and Annual costs to be split between Small County Collaborative partners.	Ongoing maintenance and tech support	**$59,713**
Delivery Infrastructure Total		**$60,633**

Fee For Service Services: $45,000 Total

Outreach and Engagement: Costs cover staffing, transportation (not for transportation of enrollees to or from medical services)costs and overhead of staff responsible in Human Services and Public Health Departments for providing outreach and engagement services. **$250 per encounter x 30 participants x average of 6 encounters per participant = $45,000**

Cost	Justification	Total
Staffing Costs	Average of $70 per hour (including salary and benefits for case managers/public health nurse with more than one team member responding at times) x 3 hours per encounter average x 180 encounters	$37,800
Operations and Overhead	Average of $25 per encounter x 180 encounters	$4,500
Travel	Average of $15 per encounter for gas/mileage x 180 encounters	$2,700
Total		**$45,000**

Psychiatric Respite Services: Costs cover respite bed to provide stabilization of symptoms. **$500 per bed day x 57 bed days = $28,500**

Cost	Justification	Total
Staffing	$25 per hour (salary and benefits) x average of 12 hours x 57 days	$17,100
Operations and Overhead	$200 per day for administrative costs, rent, utilities, food, insurance, etc. x 57days	$11,400
Total		**$28,500**

Incentives: $17,100 Total

Weekly Participation by JCFHCD ($300 per week): John C. Fremont Health Care District will be paid $300 per week for each week they participate in the WPC activities through Care Planning and Coordination Meetings, through case coordination and

coordination of communication with healthcare providers, etc. Because a number of their health care providers/coordinators/nurses will participate, the incentive payment will ensure a variety of providers is involved based on the needs of the participants. Payments will not be made for weeks in which their participation is not required. **$300 per week x 52 weeks = $15,600.**

JCFHCD for Reporting ED Utilization: JCFHCD will receive $150 each time they identify a WPC participant in the Emergency Department and notify the WPC Team or After Hours Crisis/Triage Contractor to provide services in accordance with the Comprehensive Coordinated Care Plan. Potential Eligibles will also be referred, however, payment will only occur on those individuals currently enrolled in WPC CCC Services. **$150 per report x 10 reports = $1,500**

PMPM Bundles: $481,664 Total

Bundle 1: Comprehensive Care Coordination: $1,721 PMPM Cost x 240 Member Months = $413,104

CCC costs include the salary and benefit costs of the Engagement Team as well as transportation (not for transportation of enrollees) to or from medical services)costs associated with the bundle. Over time, the CCC Team will grow to include more time and more team members at the needs of the participants are identified.

Position	Salary	Benefits	FTE	Total
Mental Health Assistant III: Lead worker responsible for all CCC coordination of meetings, development of care plans in coordination with team members, communication between team members and providers, leads CCC work of other team members, responsible for data entry and reporting with administrative team. (Social Security, Medicare, medical, dental, vision, retirement, life insurance, and SDI State Disability)	$68,607	$33,263	0.839	$85,497
Mental Health Assistant I: responsible for implementing CCC activities to assist participants in meeting care plan goals. (Social Security, Medicare, medical, dental, vision, retirement, life insurance, and SDI State Disability)	$45,636	$22,126	0.830	$56,210
Public Health Nurse: Coordination of health education, public health appointments and linkages, navigation of health care delivery systems and services, medical consultation to other team members and participant support network. (Social Security, Medicare, medical, dental, vision, retirement, life insurance, and SDI State Disability)	$78,662	$38,138	0.314	$36,720

Position	Salary	Benefits	FTE	Total
MH Asst. III (Probation): Provides case management and care coordination for individuals involved with the criminal justice system. (Social Security, Medicare, medical, dental, vision, retirement, life insurance, and SDI State Disability)	$59,068	$28,638	0.123	$10,771
AOD Specialist II: Provides assessments, case consultation, care coordination and planning and treatment/support not covered by Medi-Cal. (Social Security, Medicare, medical, dental, vision, retirement, life insurance, and SDI State Disability)	$57,310	$27,786	0.100	$ 8,510
Eligibility Worker: Provides enrollment and case management services to individuals to access a variety of entitlement and benefits programs. Participates in care planning and case coordination. Costs include salary and benefits (Social Security, Medicare, medical, dental, vision, retirement, life insurance, and SDI State Disability)	$57,079	$27,674	0.062	$5,238
Mental Health Clinician: Participates in care planning and case coordination efforts. Costs include salary and benefits (Social Security, Medicare, medical, dental, vision, retirement, life insurance, and SDI State Disability)	$75,665	$36,685	0.695	$78,028
Psychiatric Nurse Practitioner: Participates in care planning and case coordination efforts. Costs include salary and benefits (Social Security, Medicare, medical, dental, vision, retirement, life insurance, and SDI State Disability)	$179,895	$87,219	0.032	$8,678
MH Asst. III (Crisis/Triage): Participates in care planning and case coordination efforts. Provides supportive services and triage services to individuals enrolled in WPC activities. Costs include salary and benefits (Social Security, Medicare, medical, dental, vision, retirement, life insurance, and SDI State Disability)	$59,879	$29,031	0.122	$10,890
Social Security Advocate: Provides SSI/SSDI Assistance with applications and advocacy. Costs include salary and benefits (Social Security, Medicare, medical, dental, vision, retirement, life insurance, and SDI State Disability)	$57,793	$28,020	0.025	$2,145
Public Guardian/Public Conservatorship Supervisor: Assessment and consultation regarding needs for LPS or Probation conservatorships; Participation on team as	$80,083	$38,827	0.058	$6,945

Position	Salary	Benefits	FTE	Total
necessary for case coordination and care planning purposes. Costs include salary and benefits (Social Security, Medicare, medical, dental, vision, retirement, life insurance, and SDI State Disability)				
Probation Officer: Participation in team meetings for case coordination and care planning for individuals involved with the criminal justice system to ensure that Probation Case Plan aligns with CCCP. Costs include salary and benefits (Social Security, Medicare, medical, dental, vision, retirement, life insurance, and SDI State Disability)	$59,014	$28,612	0.096	$8,381
Staff Services Analyst II: Responsible for establishing policies and protocols, day to day program management, data system management, data reporting, data tool development, training coordination, outreach and to partners/providers. Costs include salary and benefits (Social Security, Medicare, medical, dental, vision, retirement, life insurance, and SDI State Disability)	$66,877	$32,424	0.250	$24,825
Social Work Supervisor II: Responsible for day to day management of WPC activities, hiring and training of WPC staff and team, supervision of staff, oversight of data management and care planning, linkages with partners and providers, attends and coordinates leadership team meetings. Costs include salary and benefits (Social Security, Medicare, medical, dental, vision, retirement, life insurance, and SDI State Disability)	$104,248	$50,543	0.200	$30,958
Public Health Nurse Manager: Responsible for supervision of Public Health Nurse. Responsible for participating on leadership team and ensuring Public Health participation in WPC Activities. Costs include salary and benefits (Social Security, Medicare, medical, dental, vision, retirement, life insurance, and SDI State Disability)	$150,671	$73,050	0.050	$11,186
JCFHCD Care Coordinator: Responsible for oversight of JCFHCD participation in WPC activities, oversight of participating staff, case coordination and reporting. Costs include salary and benefits (Social Security, Medicare, medical, dental, vision, retirement, life insurance, and SDI State Disability)	$101,150	$49,041	0.050	$7,510

Position	Salary	Benefits	FTE	Total
After Hours Contracted Providers: Mariposa County Behavioral Health and Recovery Services contracts with after-hours mental health professionals to provide crisis intervention and supportive services to individuals referred by the ER or various agencies. This team will serve as an integral part of the CCC Team.				$10,000
Program Costs for Accompaniment Services associated with this bundle (Gas and Mileage)				$10,612
Total				**$413,104**

Bundle 2: Housing Navigation and Supports: $1,389 PMPM x 36 Member Months = $50,000

Cost	Justification	Total
Housing Navigator/Program Specialist: Provides screening and assessment for various housing programs, linkages, assistance with breaking down barriers to obtaining housing, and supportive services once housed.	$40,000 annual salary and benefits (includes: SDI, Workers Comp, Medical, Dental, Vision, Life, 401K) x 12 months x .75 FTE	$30,000
Administrative /Infrastructure: Includes Program Director and Executive Director Costs, Accounting/Audit, Insurance, IT Support, Use of Vehicle for Alliance for Community Transformations.	20% of cost of contract	$10,000
Program Supplies/Costs: Includes outreach tools and materials, includes assistance costs in obtaining Identification Cards, Driver's Licenses, Costs of Housing Applications, Credit Repair, and Accompaniment to Appointments.	$500 per month x 12 months	$6,000
Rent/Utilities/Communication Costs: Includes rent, utilities, phone, internet, for program staff, including office to provide services to participants.	$333.33 per month x 12 months	$4,000
Total		**$50,000**

<u>Pay for Outcomes</u>: $1,000 outcome payment x 5 partners = $5,000

Reduce ED utilization and hospital admissions of WPC enrolled participants (those enrolled in CCC Services) by 5%: Should the target outcome be achieved, equal

payments of $1,000 each will be made to WPC partners: Mariposa County Human Services, Mariposa County Health Department, JCFHCD, Alliance for Community Transformations, and the Probation Department, totaling $5,000.

Plumas PROGRAM YEAR 4: The requested budget amount of $788,014 is for PY4 of implementation of the Whole Person Care Pilot Program

Administrative Costs

Operations Costs (12-month estimates)	**Justification**			**Total**
Facility and Maintenance: Includes the rental costs of facilities, maintenance staff, and utilities.	$2,402.16 per month X 12 months			$28,826
Information Technology, Communications, Copiers: Costs of phones, computers, internet, IT maintenance, copier usage and supplies.	Will be paid in full by other Co-located programs			$0
Administrative Staff (12 month estimates)				
	Salary	**Benefits**	**FTE**	**Total**
Administrative Services Officer: Budget oversight, fiscal management and reporting, hiring and staff training	$68,034	$25,150	.10	$9,318
Other Costs				
Third Party Administrator: Cost of Third Party Administrator to oversee WPC Small County Collaborative, Evaluation/Reporting functions, IGT Transfers, , Reporting to DHCS, Interfacing with Software Vendor, etc.				$60,000
Administrative Cost Total				**$98,144**

Delivery Infrastructure Costs

Cost	Justification	Total
Cell phones: Monthly fees associated with cell phones for four Case Management Specialists in 4 Community Wellness Centers. Pro-rated based on .5FTE at each center.	$40 per month X12 months X 4 phones at 50% for .5FTE	**$960**
Training: Cost of training WPC Team members in the delivery of WPC services and best practices. Funds will be combined with funds from other SCWPCC County partners to provide consistent training between counties. Trainers will include experts in strategies to be delivered through WPC. Costs include trainers and attendance fees at conferences.		**$10,000**
Travel: Costs associated with required travel to Sacramento for WPC meetings, Leadership Team Meetings, Small County Collaborative Meetings, and collaboration meetings that occur outside of the bundled services.		**$15,000**
WPC Software Vendor: Vendor to be selected to provide care management software and data integration software. Upfront and Annual costs to be split between Small County Collaborative partners.	Plumas County's share of Start Up Costs	**$49,000**
Delivery Infrastructure Total		**$74,960**

Incentives: $17,100 Total

Weekly Participation: Eastern Plumas Hospital (Portola), Plumas District Hospital (Quincy) and Seneca Health Care District (Chester) will be paid for participation in WPC activities. For PY 2, we anticipate 6 in-person meetings with all three district hospitals for which each hospital will be compensated $300 per meeting. Behavioral Health's Case Management Specialists will be located at the Community Wellness Centers in each of the communities where the hospitals and their clinics are located and will be meeting on a one-on-one basis with individual hospitals at least weekly during WPC implementation in PY 2 to discuss WPC participants, enrollment, integration of primary care needs, and care coordination.

300 per week x 52 meetings = $15,600

Notification of ER Visits: Hospitals will be paid directly when they notify and coordinate with the WPC staff that a WPC member or eligible member has arrived at the Emergency Department. They will be paid $150 for each encounter.

$150 per report x 10 reports = $1,500

Fee For Service Services: **$86,680 Total**

1. Outreach and Engagement FFS: Costs cover salary and benefits costs of the Engagement Team as described below. We anticipate serving 40 WPC clients for an average of 4-5 encounters per client for a duration of 1 month per client in PY 4. The FFS rate is $300 per encounter for 189 encounters or $56,680.

The FFS rate for engagement was arrived at by computing the total costs for the engagement team for PY 2-5 and dividing that by the total number of encounters. Total costs for the engagement team were calculated by taking the Total Amount for the Team and multiplying the Total Amount by 3.5 years. This calculation was $56,560 X 3.5 years = $197,960. The FFS rate was calculated at $300 per encounter by taking $197,960 and dividing by the total number of anticipated encounters 660 for PY2-5.

For Plumas County, benefits include Retirement and FICA/Medicare which are calculated at 27% of the base salary. These amounts are calculated for the positions in the Engagement Team in the chart below.

Position	Base Salary	Benefits	Total	FTE	Amount
Case Management Specialist I/II	$56,053	$15,134	$71,187	.4 FTE	$28,475
BH Site Coordinator	$50,440	$13,618	$64,058	.1517 FTE	$9,718
Behavioral Health Nurse	$83,157	$20,732	$103,889	.1 FTE	$10,388
BH Therapist I/II	$64,188	$15,602	$79,790	.10 FTE	$7,979
Total					$56,560

2. Sober Living Support: Plumas Rural Services will provide contracted services for sober living and transitional services. The house will be managed by staff with ongoing supervision. WPC clients will participate in activities including cooking, cleaning. Life skills education and supports. It is anticipated that 2 beds per month will be utilized at a budget of $1000 per month or $12,000 per year. Costs cover bed to provide stabilization of symptoms. **$1000** x **12 months per year** = **$12,000**

Cost	Justification	Total
Staffing Costs	$15 per hour (for salary and benefits) x 40 hours per week x 52 weeks for Support Services Staff = $31,200 annually/ 12 months = $2,600 monthly / 6 clients = $433.33 per month per clients in care;	$10,400

Cost	Justification	Total
	$433.33 per month per client in care x 2 clients in care = $866.66 per month x 12 months = $10,400	
Operations	$66.67 per month for operations (rent, utilities, insurances, food, etc.) per client x 2 clients per month x 12 months = $1,600	$1600
Total		**$12,000**

3. Respite: Plumas Rural Services (PRS) will provide contracted services for respite provisions as determined by the Care Coordination Team. The house will be available for safe and supportive respite care for an average of 1-3 nights. Trained mental health clinicians from PRS or the Behavioral Health Department will provide services as determined in the Care Coordination Plan. Costs cover respite bed to provide stabilization of symptoms. **$500 per bed day x 36 bed days = $18,000**

Cost	Justification	Total
Staffing	$25 per hour (salary and benefits) x average of 12 hours x 3 days per person x 12 people served.	$10,800
Operations and Overhead	$200 per day for administrative costs, rent, utilities, food, insurance, etc. x 3 days per person x 12 people served.	$7,200
Total		**$18,000**

PMPM Bundles: $506,130 Total

Bundle 1: Comprehensive Care Coordination: $1,467 PMPM Cost x 302.862986 Member Months = $444,300

The program budget is based on 872.8 member months at $1,467 PMPM over the duration of the program. PY4 is budgeted for 302.862986 member months (25 individuals on average); and PY5 is budgeted for 250 member months. The PMPM of $1,467 was calculated based on the "cost" of the CCC Team as articulated in the chart below. The cost of $320,122.5 was multiplied by 4 since the CCC Team would be providing services during each of PY2, PY3, PY4 and PY5. This total of $1,280,490 was then divided by the number of member months of 872.8 to derive a PMPM of $1,467. The PMPM of $1,467 stays constant throughout PY 2 through PY 5.

Position	Base Salary	Benefits	Total	FTE	Amount
Case Management Specialists – located at Community Wellness Centers in Quincy, Portola, Chester and Greenville; each at .5 FTE for a total of 2 FTE. Will conduct intake, substance use assessment, care coordination and liaison with contracted partners for housing supports, medical appointments, manage WPC client data record.	$56,053	$15,134	$71,187	2.0 FTE	$ 142,374
Behavioral Health Site Coordinators – located at 4 Community Wellness Centers, each at .2 FTE for a total of .8 FTE. Will assist in scheduling of appointments and coordination with partners.	$50,440	$13,620	$64,060	.8 FTE	$ 51,248
Behavioral Health Nurse: will be located at the Quincy Community Wellness Center and travel to Portola, Chester, and Greenville as needed for tele-psychiatry, care coordination with primary care providers, hospitals.	$83,157	$22,452	$105,610	1.0 FTE	$105,610
Behavioral Health Therapist I/II, or Senior: Provides care coordination for individuals involved with the criminal justice system, may attend court meetings, provide individual or group counseling.	$64,188	$17,322	$81,510	.25629 FTE	$20,890.5
TOTAL					**$320,122.5**

Calculation: $320,122.50 x 4 years = $1,280,490/872.8 Member Months = $1467 PMPM x 302.862986 Member Months for PY 4 = $444,300

Bundle 2: Housing Navigation and Supports: $687 PMPM x 90 Member Months = $61,830.

The bundle costs include the contract cost with Plumas Rural Services to provide housing navigation and supports. We anticipate 90 member months in PY 4. The PMPM was calculated based on a model that the Behavioral Health department funded from July 2015 through June 2016. The Behavioral Health department funded another community based organization in the amount of $147,000 for that year and it was estimated that $55,000 of the funded amount was expended for Housing Navigation and Supports (the remaining amount was expended on rental payments). Since the WPC Pilot funds cannot be used on rental payments, Plumas County anticipates expending $55,000 per year on Housing Navigation and Supports. The PMPM was factored by multiplying $55,000 times 3 ½ years for a total of $192,500 for PY2-5. That total amount was divided by 280 total member months for PY2-5 and a PMPM of $687 was derived. A PMPM of $687 for Housing Supports remains a constant amount for PY2-5. Differing numbers of individuals are served per year due to the variability in the number of months each participant may require Housing Navigation and Supports. For example, one individual may require 4 months of housing supports and another may require 8 months of housing supports due to individual circumstances including Section 8 application assistance, clearing up financial-related matters, etc.

	PY2	PY3	PY4	PY5	Total
Member months	40	60	90	90	280
Cost	$27,480	$41,220	$61,830	$61,830	$192,500
Persons served	10	17	25	24	76

<u>Pay for Outcomes</u>: $500 outcome payment x 5 partners = $5,000

Reduce ED utilization and hospital admissions of WPC enrolled participants (those enrolled in CCC Services) by 5%: Should the target outcome be achieved, equal payments of $500 each will be made to five WPC partners: Eastern Plumas Healthcare. Plumas District Hospital, Seneca Healthcare District, Plumas County Probation Department, and Plumas Rural Services, totaling $5,000.

San Benito County PROGRAM YEAR 4: Total - $1,000,000

<u>Administrative Costs</u>

Administrative Staff		
Human Services Deputy Director: The Deputy Director of HS is responsible for overall oversight of the Project, including participation on the Small County Collaborative Governing board and WPC Leadership Team. Total	$184,820 annually x .20 FTE	$36,964

Annual Costs include salary and benefits (Social Security, Medicare, medical, dental, vision, retirement, life insurance, and SDI State Disability)		
HHSA Fiscal Support; Account Clerk III: Responsible for budgets, invoicing, contracting and contract monitoring, fiscal project management and reporting. Total Annual Costs include salary and benefits (Social Security, Medicare, medical, dental, vision, retirement, life insurance, and SDI State Disability)	$68,235 annually x .25 FTE	$17,059
WPC Infrastructure Capacity Needs; Operations Costs	**Justification**	**Total**
Facility and Maintenance: Includes the rental costs of facilities, utilities.	$3,000 per month	$36,000
Office costs: Includes supplies.		$2,098
Training: Costs of training sessions and trainer fees	$5,000 x 1 WPC Staff	$5,000
Travel: Costs of lodging, meals for travel outside of the county.		$2,500
Third Party Administrator: Cost of Third Party Administrator to oversee WPC Small County Collaborative, Evaluation/Reporting functions, IGT Transfers, Training of WPC staff, Reporting to DHCS, Interfacing with Software Vendor.	40% x $250,000	$100,000
Administrative Cost Total		**$199,621**

Delivery Infrastructure Costs

Cost	**Justification**	**Total**
Data Integration - WPC Software Vendor: Vendor to be selected to provide care management software and data integration software. Upfront and Annual costs to be split between Small County Collaborative partners.	40% of Estimated annual costs	$80,000
Delivery Infrastructure Total		**$80,000**

Incentives: $11,700 Total

Submission of referral packets by local healthcare providers to the engagement team. Referral criteria will be documented in WPC policy and procedures. Participating

providers will be paid $75 per referral meeting the criteria. It is estimated in PY4 that 60 referrals will be eligible for this incentive. **$75 per referral x 60 referrals = $4500**

Hazel Hawkins Hospital (HHH) for Reporting ED Utilization: HHH will receive $600 each month for notifying the WPC Team when WPC participants utilize the Emergency Department and notify the WPC Team to provide services in accordance with the Comprehensive Coordinated Care Plan. Potential eligibles will also be referred, however, payment will only occur on those individuals currently enrolled in WPC CCC Services. It is anticipated that 3 months of reporting will occur in PY2. **$600 per month x 12 months = $7,200**

Fee For Services $144,804

Engagement: $365.67 per encounter cost x 8.6086 encounters per person x 46 people = $144,804

Engagement costs include the salary and benefit costs (Social Security, Medicare, medical, dental, vision, retirement, life insurance, and SDI State Disability) of the team as well as transportation (not for transportation of enrollees to or from medical services) costs, outreach materials and communication costs associated with the services. Each unit of service is defined as an encounter with potential participants.

Position/Item	FTE	Total
Outreach materials		$2,110
Vehicle Lease		$2,880
Cell Phone Service		$900
Program Manager: Responsible for day to day management of WPC activities, hiring and training of WPC staff and team, supervision of staff, oversight of data management and care planning, linkages with partners and providers, attends and coordinates leadership team meetings.	.2	$24,638
Staff Analyst: Responsible for implementing policies and protocols, data system management, data reporting, data tool development, training coordination, outreach to partners/providers.	.2	$17,165
Assessment Coordinator: Lead worker responsible for all coordination of meetings, development of assessment plans in coordination with team members, communication between team members and providers, leads engagement work of other team members, responsible for data entry and reporting with administrative team.	1	$78,218
Probation Officer: Provides case management and care coordination for individuals involved with the criminal justice system.	.2	$18,788
Public Health Nurse: Coordination of health education, public health appointments and linkages, navigation of health care delivery systems and services, medical consultation to other team members and participant support network.	.2	$21,809

Position/Item	FTE	Total
Peer Advocate: responsible for implementing engagement activities to assist participants in meeting enrollment criteria and understanding the WPC program.	.5	$30,925
Total Service Cost		$197,433
Average Number of service units per year		90
Service cost per unit = Total Services Costs / Avg Units per year		$2,194

PMPM Bundles: $558,875 Total

Bundle 1: Comprehensive Care Coordination: $1,657 PMPM Cost x 259 Member Months = $429,163

CCC costs include the salary and benefit (Social Security, Medicare, medical, dental, vision, retirement, life insurance, and SDI State Disability) costs of the CCC Team as well as transportation (not for transportation of enrollees to or from medical services) and communication costs associated with the bundle.

Position	FTE	Total
Vehicle Lease		$4,320
Cell Phone Service		$900
Program Manager: Responsible for day to day management of WPC activities, hiring and training of WPC staff and team, supervision of staff, oversight of data management and care planning, linkages with partners and providers, attends and coordinates leadership team meetings.	.3	$36,956
Staff Analyst: Responsible for implementing policies and protocols, data system management, data reporting, data tool development, training coordination, outreach to partners/providers.	.3	$25,747
CCC Coordinator: Lead worker responsible for all coordination of meetings, development of care plans in coordination with team members, communication between team members and providers, leads CCC work of other team members, responsible for data entry and reporting with administrative team.	1	$104,350
Mental Health Clinician: Provides assessments, case consultation, care coordination and planning and treatment/support not covered by Medi-Cal.	.25	$31,559
Substance Abuse Counselor: Provides assessments, case consultation, care coordination and planning and treatment/support not covered by Medi-Cal.	.2	$19,874
Public Health Nurse: Coordination of health education, public health appointments and linkages, navigation of health care delivery systems and services, medical consultation to other team members and participant support network.	.4	$43,617

Position	FTE	Total
Peer Advocate: responsible for implementing engagement activities to assist participants in meeting enrollment criteria and understanding the WPC program.	.5	$30,925
Total Bundle Cost		$298,248
Average number of Member Months per year		180
Per Member Per Month = Total Bundle Costs / Avg Member Months		$1,657

Bundle 2: Housing Navigation and Supports: $1,936 PMPM x 67 Member Months = $129,712

Housing Support Service costs include the salary and benefit (Social Security, Medicare, medical, dental, vision, retirement, life insurance, and SDI State Disability) costs of the Housing Team.

Position	FTE	Total
Program Manager: Responsible for day to day management of WPC activities, hiring and training of WPC staff and team, supervision of staff, oversight of data management and care planning, linkages with partners and providers, attends and coordinates leadership team meetings.	.05	$6,159
Staff Analyst: Responsible for implementing policies and protocols, data system management, data reporting, data tool development, training coordination, outreach to partners/providers.	.05	$4,291
Housing Navigator/Program Specialist: Provides screening and assessment for various housing programs, linkages, assistance with breaking down barriers to obtaining housing, and liaison with land lords.	.5	$66,598
Tenancy Care Support: Provide supportive services to participant once housed.	.5	$39,109
Total Bundle Costs		$116,157
Average number of Member Months per year		60
Per Member Per Month =Total Bundle Costs / Avg Member Months		$1,936

<u>Pay for Outcomes</u>: $1,000 outcome payment x 5 partners = $5,000

Reduce ED utilization and hospital admissions of WPC enrolled participants (those enrolled in CCC Services) by 5%: Should the target outcome be achieved, equal payments of $1,000 each will be made to WPC partners: San Benito County Health & Human Services, Behavioral Health Department, Probation Department, San Benito Health Foundation, and HHH, totaling $5,000.

PROGRAM YEAR 5: The requested budget amount of $2,590,544 is for Program Year 5 of the Whole Person Care Pilot Program.

Mariposa County PROGRAM YEAR 5: Total - $802,530

Operations Costs	**Justification**	**Total**
Facility and Maintenance: Includes the rental costs of facilities, maintenance staff, and utilities.	$2,660X 12 months	$31,920
Information Technology, Communications, Copiers: Costs of phones, computers, internet, IT maintenance, copier usage and supplies. Based on 6 month estimates.	$403.42 x 12 months	$4,841

Administrative Staff				
	Salary	**Benefits**	**FTE**	**Total**
Human Services Director: The Director of HS is responsible for overall oversight of the Project, including participation on the Small County Collaborative Governing board and WPC Leadership Team. Total Annual Costs include salary and benefits (Social Security, Medicare, medical, dental, vision, retirement, life insurance, and SDI State Disability)	$143,956	$69,794	0.05	$10,688
Assistant Director: The AD is responsible for oversight of operations, personnel, fiscal management, IT, and contracts. Total Annual Costs include salary and benefits (Social Security, Medicare, medical, dental, vision, retirement, life insurance, and SDI State Disability)	$99,121	$48,057	0.05	$7,359
Senior Administrative Analyst: Responsible for fiscal management, budgets, invoicing, contracting and contract monitoring, fiscal project management and reporting. Total Annual Costs include salary and benefits (Social Security, Medicare, medical, dental,	$80,474	$39,016	0.1	$11,949

Administrative Staff				
	Salary	**Benefits**	**FTE**	**Total**
vision, retirement, life insurance, and SDI State Disability)				
Network Administrator: Responsible for assisting with integration of new Automated Data Systems with existing Electronic Health Records and other IT systems within the Human Services Department. Total Annual Costs include salary and benefits (Social Security, Medicare, medical, dental, vision, retirement, life insurance, and SDI State Disability)	$93,597	$45,379	0.05	$6,949
Other Costs				
Training: Cost of training WPC Team members in the delivery of WPC services and best practices. Funds will be combined with funds from other SCWPCC County partners to provide consistent training between counties. Trainers will include experts in strategies to be delivered through WPC. Costs include trainers and attendance fees at conferences.				$10,000
Travel: Costs associated with required travel to Sacramento for WPC meetings, Leadership Team Meetings, Small County Collaborative Meetings, and collaboration meetings that occur outside of the bundled services.				$15,000
Third Party Administrator: Cost of Third Party Administrator to oversee WPC Small County Collaborative, Evaluation/Reporting functions, IGT Transfers, Training of WPC staff, Reporting to DHCS, Interfacing with Software Vendor, etc.				$75,000
Administrative Cost Total				**$173,645**

Delivery Infrastructure Costs

Cost	Justification	Total
Cell Phone Plans	2 cell phone plans x 12 months x $38.33 per month	**$920**
WPC Software Vendor: Vendor to be selected to provide care management software and data integration software. Upfront and Annual costs to be split between Small County Collaborative partners.	Ongoing maintenance and tech support	**$49,200**
Delivery Infrastructure Total		**$50,120**

Fee For Service Services: $45,000 Total

Outreach and Engagement: Costs cover staffing, transportation (not for transportation of enrollees to or from medical services)costs and overhead of staff responsible in Human Services and Public Health Departments for providing outreach and engagement services. $250 per encounter x 30 participants x average of 6 encounters per participant = **$45,000**

Cost	Justification	Total
Staffing Costs	Average of $70 per hour (including salary and benefits for case managers/public health nurse with more than one team member responding at times) x 3 hours per encounter average x 180 encounters	$37,800
Operations and Overhead	Average of $25 per encounter x 180 encounters	$4,500
Travel	Average of $15 per encounter for gas/mileage x 180 encounters	$2,700
Total		**$45,000**

Psychiatric Respite Services: Costs cover respite bed to provide stabilization of symptoms. **$500 per bed day x 57 bed days = $28,500**

Cost	Justification	Total
Staffing	$25 per hour (salary and benefits) x average of 12 hours x 57 days	$17,100
Operations and Overhead	$200 per day for administrative costs, rent, utilities, food, insurance, etc. x 57days	$11,400
Total		**$28,500**

Incentives: $17,100 Total

Weekly Participation by JCFHCD ($300 per week): John C. Fremont Health Care District will be paid $300 per week for each week they participate in the WPC activities through Care Planning and Coordination Meetings, through case coordination and coordination of communication with healthcare providers, etc. Because a number of their health care providers/coordinators/nurses will participate, the incentive payment will ensure a variety of providers is involved based on the needs of the participants. Payments will not be made for weeks in which their participation is not required. **$300 per week x 52 weeks= $15,600.**

JCFHCD for Reporting ED Utilization: JCFHCD will receive $150 each time they identify a WPC participant in the Emergency Department and notify the WPC Team or After Hours Crisis/Triage Contractor to provide services in accordance with the Comprehensive Coordinated Care Plan. Potential Eligibles will also be referred, however, payment will only occur on those individuals currently enrolled in WPC CCC Services. **$150 per report x 10 reports = $1,500**

PMPM Bundles: $481,664 Total

Bundle 1: Comprehensive Care Coordination: $1,721 PMPM Cost x 240 Member Months = $413,104

CCC costs include the salary and benefit costs of the Engagement Team as well as transportation (of enrollees) costs associated with the bundle. Over time, the CCC Team will grow to include more time and more team members at the needs of the participants are identified.

Position	Salary	Benefits	FTE	Total
Mental Health Assistant III: Lead worker responsible for all CCC coordination of meetings, development of care plans in coordination with	$68,607	$33,263	0.839	$85,497

Position	Salary	Benefits	FTE	Total
team members, communication between team members and providers, leads CCC work of other team members, responsible for data entry and reporting with administrative team. (Social Security, Medicare, medical, dental, vision, retirement, life insurance, and SDI State Disability)				
Mental Health Assistant I: responsible for implementing CCC activities to assist participants in meeting care plan goals. (Social Security, Medicare, medical, dental, vision, retirement, life insurance, and SDI State Disability)	$45,636	$22,126	0.830	$56,210
Public Health Nurse: Coordination of health education, public health appointments and linkages, navigation of health care delivery systems and services, medical consultation to other team members and participant support network. (Social Security, Medicare, medical, dental, vision, retirement, life insurance, and SDI State Disability)	$78,662	$38,138	0.314	$36,720
MH Asst. III (Probation): Provides case management and care coordination for individuals involved with the criminal justice system. (Social Security, Medicare, medical, dental, vision, retirement, life insurance, and SDI State Disability)	$59,068	$28,638	0.123	$10,771
AOD Specialist II: Provides assessments, case consultation, care coordination and planning and treatment/support not covered by Medi-Cal. (Social Security, Medicare, medical, dental, vision, retirement, life insurance, and SDI State Disability)	$57,310	$27,786	0.100	$ 8,510
Eligibility Worker: Provides enrollment and case management services to individuals to access a variety of entitlement and benefits programs. Participates in care planning and case coordination. Costs include salary and benefits (Social Security, Medicare, medical, dental, vision, retirement, life insurance, and SDI State Disability)	$57,079	$27,674	0.062	$5,238
Mental Health Clinician: Participates in care planning and case coordination efforts. Costs include salary and benefits (Social Security, Medicare, medical, dental, vision, retirement, life insurance, and SDI State Disability)	$75,665	$36,685	0.695	$78,028
Psychiatric Nurse Practitioner: Participates in care planning and case coordination efforts. Costs	$179,895	$87,219	0.032	$8,678

Position	Salary	Benefits	FTE	Total
include salary and benefits (Social Security, Medicare, medical, dental, vision, retirement, life insurance, and SDI State Disability)				
MH Asst. III (Crisis/Triage): Participates in care planning and case coordination efforts. Provides supportive services and triage services to individuals enrolled in WPC activities. Costs include salary and benefits (Social Security, Medicare, medical, dental, vision, retirement, life insurance, and SDI State Disability)	$59,879	$29,031	0.122	$10,890
Social Security Advocate: Provides SSI/SSDI Assistance with applications and advocacy. Costs include salary and benefits (Social Security, Medicare, medical, dental, vision, retirement, life insurance, and SDI State Disability)	$57,793	$28,020	0.025	$2,145
Public Guardian/Public Conservatorship Supervisor: Assessment and consultation regarding needs for LPS or Probation conservatorships; Participation on team as necessary for case coordination and care planning purposes. Costs include salary and benefits (Social Security, Medicare, medical, dental, vision, retirement, life insurance, and SDI State Disability)	$80,083	$38,827	0.058	$6,945
Probation Officer: Participation in team meetings for case coordination and care planning for individuals involved with the criminal justice system to ensure that Probation Case Plan aligns with CCCP. Costs include salary and benefits (Social Security, Medicare, medical, dental, vision, retirement, life insurance, and SDI State Disability)	$59,014	$28,612	0.096	$8,381
Staff Services Analyst II: Responsible for establishing policies and protocols, day to day program management, data system management, data reporting, data tool development, training coordination, outreach and to partners/providers. Costs include salary and benefits (Social Security, Medicare, medical, dental, vision, retirement, life insurance, and SDI State Disability)	$66,877	$32,424	0.250	$24,825
Social Work Supervisor II: Responsible for day to day management of WPC activities, hiring and training of WPC staff and team, supervision of staff, oversight of data management and care	$104,248	$50,543	0.200	$30,958

Position	Salary	Benefits	FTE	Total
planning, linkages with partners and providers, attends and coordinates leadership team meetings. Costs include salary and benefits (Social Security, Medicare, medical, dental, vision, retirement, life insurance, and SDI State Disability)				
Public Health Nurse Manager: Responsible for supervision of Public Health Nurse. Responsible for participating on leadership team and ensuring Public Health participation in WPC Activities. Costs include salary and benefits (Social Security, Medicare, medical, dental, vision, retirement, life insurance, and SDI State Disability)	$150,671	$73,050	0.050	$11,186
JCFHCD Care Coordinator: Responsible for oversight of JCFHCD participation in WPC activities, oversight of participating staff, case coordination and reporting. Costs include salary and benefits (Social Security, Medicare, medical, dental, vision, retirement, life insurance, and SDI State Disability)	$101,150	$49,041	0.050	$7,510
After Hours Contracted Providers: Mariposa County Behavioral Health and Recovery Services contracts with after-hours mental health professionals to provide crisis intervention and supportive services to individuals referred by the ER or various agencies. This team will serve as an integral part of the CCC Team.				$10,000
Program Costs for Accompaniment Services associated with this bundle (Gas and Mileage)				$10,612
Total				**$413,104**

Bundle 2: Housing Navigation and Supports: $1,389 PMPM x 36 Member Months = $50,000

Cost	Justification	Total
Housing Navigator/Program Specialist: Provides screening and assessment for various housing programs, linkages, assistance with breaking down barriers to obtaining housing, and supportive services once housed.	$40,000 annual salary and benefits (includes: SDI, Workers Comp, Medical, Dental, Vision, Life, 401K) x 12 months x .75 FTE	$30,000

Cost	Justification	Total
Administrative /Infrastructure: Includes Program Director and Executive Director Costs, Accounting/Audit, Insurance, IT Support, Use of Vehicle for the Alliance for Community Transformations.	20% of cost of contract	$10,000
Program Supplies/Costs: Includes outreach tools and materials, includes assistance costs in obtaining Identification Cards, Driver's Licenses, Costs of Housing Applications, Credit Repair, and Accompaniment to Appointments.	$500 per month x 12 months	$6,000
Rent/Utilities/Communication Costs: Includes rent, utilities, phone, internet, for program staff, including office to provide services to participants.	$333.33 per month x 12 months	$4,000
Total		**$50,000**

Pay for Outcomes: $5,000 outcome payment x 5 partners = $25,000

Reduce ED utilization and hospital admissions of WPC enrolled participants (those enrolled in CCC Services) by 5%: Should the target outcome be achieved, equal payments of $5,000 each will be made to WPC partners: Mariposa County Human Services, Mariposa County Health Department, JCFHCD, Alliance for Community Transformations, and the Probation Department, totaling $25,000

PLUMAS PROGRAM YEAR 5: The requested budget amount of $788,014 is for PY5 of implementation of the Whole Person Care Pilot Program

Administrative Costs

Operations Costs (12-month estimates)	Justification	Total
Facility and Maintenance: Includes the rental costs of facilities, maintenance staff, and utilities.	$3,793.91 per month X 12 months	$45,527
Information Technology, Communications, Copiers: Costs of phones, computers, internet, IT maintenance, copier usage and supplies.	$403.41 per month X 12 months	$4,841

Administrative Staff (12 month estimates)				
	Salary	**Benefits**	**FTE**	**Total**
BH AOD Program Administrator: Acts as the WPC Program Administrator; primary contact with hospitals, community-based partners; compliance with WPC pilot requirements, policies and protocols	**$90,000**	**$27,081**	**0.124**	**$14,518**
Administrative Services Officer: Budget oversight, fiscal management and reporting, hiring and staff training	**$68,034**	**$25,150**	**.124**	**$11,569**
Quality Assurance Director: Intake/on-call crisis team, referral to psychiatric hospitals, data management and care planning, quality control and grievance process, HIPAA and confidentiality officer	**$74,410**	**$27,510**	**.011**	**$11,211**
Case Management Specialists: Located at Community Wellness Centers in Quincy, Portola, Chester and Greenville; will conduct intake, substance use screening and assessment, care coordination and liaison with contracted partner for housing supports, medical appointments, data entry into WPC client data management system, referrals	**$109,640**	**$40,551**	**.0360075**	**$5,408**
Site Coordinator Supervisor: Responsible for operations of Community Wellness Centers in Quincy, Chester, Portola and Greenville; supervision of site coordinators and implementation of WPC procedures for engagement, care coordination, WPC client scheduling and tracking	**$53,290**	**$19,710**	**.139**	**$10,119**

Administrative Staff (12 month estimates)				
	Salary	**Benefits**	**FTE**	**Total**
Other Costs				
Third Party Administrator: Cost of Third Party Administrator to oversee WPC Small County Collaborative, Evaluation/Reporting functions, IGT Transfers, , Reporting to DHCS, Interfacing with Software Vendor, etc.				**$67,500**
Administrative Cost Total				**$170,694**

Delivery Infrastructure Costs

Cost	**Justification**	**Total**
Cell phones: Monthly fees associated with cell phones for four Case Management Specialists in 4 Community Wellness Centers. Pro-rated based on .5 FTE at each center.	$40 per month X12 months X 4 phones at 50% for .5 FTE	**$960**
Training: Cost of training WPC Team members in the delivery of WPC services and best practices. Funds will be combined with funds from other SCWPCC County partners to provide consistent training between counties. Trainers will include experts in strategies to be delivered through WPC. Costs include trainers and attendance fees at conferences.		**$10,000**
WPC Software Vendor: Vendor to be selected to provide care management software and data integration software. Upfront and Annual costs to be split between Small County Collaborative partners.	Plumas County's share of Start Up Costs	**$49,000**
Delivery Infrastructure Total		**$59,960**

Incentives: $17,100 Total

Weekly Participation: Eastern Plumas Hospital (Portola), Plumas District Hospital (Quincy) and Seneca Health Care District (Chester) will be paid for participation in WPC activities at $300 per meeting. Behavioral Health's Case Management Specialists will be located at the Community Wellness Centers in each of the communities where the

hospitals and their clinics are located and will be meeting on a one-on-one basis with individual hospitals at least weekly during WPC implementation to discuss WPC participants, enrollment, integration of primary care needs, and care coordination.
300 per week x 52 meetings = $15,600

Notification of ER Visits: Hospitals will be paid directly when they notify and coordinate with the WPC staff that a WPC member or eligible member has arrived at the Emergency Department. They will be paid $150 for each encounter.
$150 per report x 10 reports = $1,500

Fee For Service Services: $86,680 Total

1. Outreach and Engagement FFS: Costs cover salary and benefits costs of the Engagement Team as described below. We anticipate serving 40 WPC clients for an average of 4-5 encounters per client for a duration of 1 month per client in PY 5. The FFS rate is $300 per encounter for 189 encounters or $56,680.

The FFS rate for engagement was arrived at by computing the total costs for the engagement team for PY 2-5 and dividing that by the total number of encounters. Total costs for the engagement team were calculated by taking the Total Amount for the Team and multiplying the Total Amount by 3.5 years. This calculation was $56,560 X 3.5 years = $197,960. The FFS rate was calculated at $300 per encounter by taking $197,960 and dividing by the total number of anticipated encounters 660 for PY2-5.

For Plumas County, benefits include Retirement and FICA/Medicare which are calculated at 27% of the base salary. These amounts are calculated for the positions in the Engagement Team in the chart below.

Position	Base Salary	Benefits	Total	FTE	Amount
Case Management Specialist I/II	$56,053	$15,134	$71,187	.4 FTE	$28,475
BH Site Coordinator	$50,440	$13,618	$64,058	.1517 FTE	$9,718
Behavioral Health Nurse	$83,157	$20,732	$103,889	.1 FTE	$10,388
BH Therapist I/II	$64,188	$15,602	$79,790	.10 FTE	$7,979
Total					$56,560

2. Sober Living Support: Plumas Rural Services will provide contracted services for sober living and transitional services. The house will be managed by staff with ongoing supervision. WPC clients will participate in activities including cooking, cleaning. Life skills education and supports. It is anticipated that 2 beds per month will be utilized at a budget of $1000 per month or $12,000 per year. Costs cover bed to provide stabilization of symptoms. **$1000 x 12 months per year = $12,000**

Cost	Justification	Total
Staffing Costs	$15 per hour (for salary and benefits) x 40 hours per week x 52 weeks for Support Services Staff = $31,200 annually/ 12 months = $2,600 monthly / 6 clients = $433.33 per month per clients in care; $433.33 per month per client in care x 2 clients in care = $866.66 per month x 12 months = $10,400	$10,400
Operations	$66.67 per month for operations (rent, utilities, insurances, food, etc.) per client x 2 clients per month x 12 months = $1,600	$1600
Total		**$12,000**

3. Respite: Plumas Rural Services (PRS) will provide contracted services for respite provisions as determined by the Care Coordination Team. The house will be available for safe and supportive respite care for an average of 1-3 nights. Trained mental health clinicians from PRS or the Behavioral Health Department will provide services as determined in the Care Coordination Plan. Costs cover respite bed to provide stabilization of symptoms. **$500 per bed day x 36 bed days = $18,000**

Cost	Justification	Total
Staffing	$25 per hour (salary and benefits) x average of 12 hours x 3 days per person x 12 people served.	$10,800
Operations and Overhead	$200 per day for administrative costs, rent, utilities, food, insurance, etc. x 3 days per person x 12 people served.	$7,200
Total		**$18,000**

PMPM Bundles: $ 428,580 Total

Bundle 1: Comprehensive Care Coordination: $1,467 PMPM Cost x 250 Member Months = $366,750

The program budget is based on 872.8 member months at $1,467 PMPM over the duration of the program. PY5 is budgeted for 250 member months. The PMPM of $1,467 was calculated based on the "cost" of the CCC Team as articulated in the chart below. The cost of $320,122.5 was multiplied by 4 since the CCC Team would be providing services during each of PY2, PY3, PY4 and PY5. This total of $1,280,490 was then divided by the number of member months of 872.8 to derive a PMPM of $1,467. The PMPM of $1,467 stays constant throughout PY 2 through PY 5.

Position	Base Salary	Benefits	Total	FTE	Amount
Case Management Specialists – located at Community Wellness Centers in Quincy, Portola, Chester and Greenville; each at .5 FTE for a total of 2 FTE. Will conduct intake, substance use assessment, care coordination and liaison with contracted partners for housing supports, medical appointments, manage WPC client data record.	$56,053	$15,134	$71,187	2.0 FTE	$ 142,374
Behavioral Health Site Coordinators – located at 4 Community Wellness Centers, each at .2 FTE for a total of .8 FTE. Will assist in scheduling of appointments and coordination with partners.	$50,440	$13,620	$64,060	.8 FTE	$ 51,248
Behavioral Health Nurse: will be located at the Quincy Community Wellness Center and travel to Portola, Chester, and Greenville as needed for tele-psychiatry, care coordination with primary care providers, hospitals.	$83,157	$22,452	$105,610	1.0 FTE	$105,610
Behavioral Health Therapist I/II, or Senior: Provides care coordination for individuals involved with the criminal justice system, may attend court meetings, provide individual or group counseling.	$64,188	$17,322	$81,510	.25629	$20,890.50
TOTAL		**=**			**$320,122.5**

Calculation: $320,122.50 x 4 years = $1,280,490/872.8 Member Months = $1467 PMPM x 250 Member Months for PY 5 = $366,750

Bundle 2: Housing Navigation and Supports: $687 PMPM x 90 Member Months = $61,830.

The bundle costs include the contract cost with Plumas Rural Services to provide housing navigation and supports. We anticipate 90 member months in PY 5. The PMPM was calculated based on a model that the Behavioral Health department funded from July 2015 through June 2016. The Behavioral Health department funded another community based organization in the amount of $147,000 for that year and it was estimated that $55,000 of the funded amount was expended for Housing Navigation and Supports (the remaining amount was expended on rental payments). Since the WPC Pilot funds cannot be used on rental payments, Plumas County anticipates expending $55,000 per year on Housing Navigation and Supports. The PMPM was factored by multiplying $55,000 times 3 ½ years for a total of $192,500 for PY2-5. That total amount was divided by 280 total member months for PY2-5 and a PMPM of $687 was derived. A PMPM of $687 for Housing Supports remains a constant amount for PY2-5. Differing numbers of individuals are served per year due to the variability in the number of months each participant may require Housing Navigation and Supports. For example, one individual may require 4 months of housing supports and another may require 8 months of housing supports due to individual circumstances including Section 8 application assistance, clearing up financial-related matters, etc.

	PY2	PY3	PY4	PY5	Total
Member months	40	60	90	90	280
Cost	$27,480	$41,220	$61,830	$61,830	$192,500
Persons served	10	17	25	24	76

<u>Pay for Outcomes</u>: $5,000 outcome payment x 5 partners = $25,000

Reduce ED utilization and hospital admissions of WPC enrolled participants (those enrolled in CCC Services) by 5%: Should the target outcome be achieved, equal payments of $5,000 each will be made to five WPC partners: Eastern Plumas Healthcare. Plumas District Hospital, Seneca Healthcare District, Plumas County Probation Department, and Plumas Rural Services, totaling $25,000.

San Benito County PROGRAM YEAR 5: Total - $1,000,000

<u>Administrative Costs</u>

Administrative Staff		
Human Services Deputy Director: The Deputy Director of HS is responsible for overall oversight of the Project, including participation on the Small County Collaborative Governing board and WPC Leadership Team. Total	$184,820 annually x .20 FTE	$36,964

Administrative Staff		
Annual Costs include salary and benefits (Social Security, Medicare, medical, dental, vision, retirement, life insurance, and SDI State Disability)		
HHSA Fiscal Support; Account Clerk III: Responsible for budgets, invoicing, contracting and contract monitoring, fiscal project management and reporting. Total Annual Costs include salary and benefits (Social Security, Medicare, medical, dental, vision, retirement, life insurance, and SDI State Disability)	$68,235 annually x .25 FTE	$17,059
WPC Infrastructure Capacity Needs; Operations Costs	**Justification**	**Total**
Facility and Maintenance: Includes the rental costs of facilities, utilities.	$3,000 per month	$36,000
Office costs: Includes supplies.		$288
Training: Costs of training sessions and trainer fees	$5,000 x 1 WPC Staff	$5,000
Travel: Costs of lodging, meals for travel outside of the county.		$2,500
Third Party Administrator: Cost of Third Party Administrator to oversee WPC Small County Collaborative, Evaluation/Reporting functions, IGT Transfers, Training of WPC staff, Reporting to DHCS, Interfacing with Software Vendor.	40% x $250,000	$100,000
Administrative Cost Total		**$197,811**

Delivery Infrastructure Costs

Cost	**Justification**	**Total**
Data Integration - WPC Software Vendor: Vendor to be selected to provide care management software and data integration software. Upfront and Annual costs to be split between Small County Collaborative partners.	40% of Estimated annual costs	$80,000
Delivery Infrastructure Total		**$80,000**

Incentives: $18,450 Total
Submission of referral packets by local healthcare providers to the engagement team. Referral criteria will be documented in WPC policy and procedures. Participating providers will be paid $75 per referral meeting the criteria. It is estimated in PY5 that 150 referrals will be eligible for this incentive. **$75 per referral x 150 referrals = $11,250**

Hazel Hawkins Hospital (HHH) for Reporting ED Utilization: HHH will receive $600 each month for notifying the WPC Team when WPC participants utilize the Emergency Department and notify the WPC Team to provide services in accordance with the Comprehensive Coordinated Care Plan. Potential eligibles will also be referred, however, payment will only occur on those individuals currently enrolled in WPC CCC Services. It is anticipated that 3 months of reporting will occur in PY2. **$600 per month x 12 months = $7,200**

Fee For Service $142,610 Total
Engagement: $365.67 per encounter x 8.6666 encounters per person x 45 people = $142,610
Engagement costs include the salary and benefit costs (Social Security, Medicare, medical, dental, vision, retirement, life insurance, and SDI State Disability) of the team as well as transportation (not for transportation of enrollees to or from medical services) costs, outreach materials and communication costs associated with the services. Each unit of service is defined as an encounter with potential participants.

Position/Item	FTE	Total
Vehicle Lease		$2,880
Cell Phone Service		$900
Program Manager: Responsible for day to day management of WPC activities, hiring and training of WPC staff and team, supervision of staff, oversight of data management and care planning, linkages with partners and providers, attends and coordinates leadership team meetings.	.2	$24,638
Staff Analyst: Responsible for implementing policies and protocols, data system management, data reporting, data tool development, training coordination, outreach to partners/providers.	.2	$17,165
Assessment Coordinator: Lead worker responsible for all coordination of meetings, development of assessment plans in coordination with team members, communication between team members and providers, leads engagement work of other team members, responsible for data entry and reporting with administrative team.	1	$78,218
Probation Officer: Provides case management and care coordination for individuals involved with the criminal justice system.	.2	$18,788
Public Health Nurse: Coordination of health education, public health appointments and linkages, navigation of health care delivery	.2	$21,919

Position/Item	FTE	Total
systems and services, medical consultation to other team members and participant support network.		
Peer Advocate: responsible for implementing engagement activities to assist participants in meeting enrollment criteria and understanding the WPC program.	.5	$30,925
Total Service Cost		$197,433
Average Number of service units per year		89.988
Service cost per unit = Total Services Costs / Avg Units per year		$2,194

PMPM Bundles: **$542,009 Total**

Bundle 1: Comprehensive Care Coordination: $1,657 PMPM Cost x 257 Member Months = $425,849

CCC costs include the salary and benefit (Social Security, Medicare, medical, dental, vision, retirement, life insurance, and SDI State Disability) costs of the CCC Team as well as transportation (not for transportation of enrollees to or from medical services) and communication costs associated with the bundle.

Position	FTE	Total
Vehicle Lease		$4,320
Cell Phone Service		$900
Program Manager: Responsible for day to day management of WPC activities, hiring and training of WPC staff and team, supervision of staff, oversight of data management and care planning, linkages with partners and providers, attends and coordinates leadership team meetings.	.3	$36,956
Staff Analyst: Responsible for implementing policies and protocols, data system management, data reporting, data tool development, training coordination, outreach to partners/providers.	.3	$25,747
CCC Coordinator: Lead worker responsible for all coordination of meetings, development of care plans in coordination with team members, communication between team members and providers, leads CCC work of other team members, responsible for data entry and reporting with administrative team.	1	$104,350
Mental Health Clinician: Provides assessments, case consultation, care coordination and planning and treatment/support not covered by Medi-Cal.	.25	$31,559
Substance Abuse Counselor: Provides assessments, case consultation, care coordination and planning and treatment/support not covered by Medi-Cal.	.2	$19,874
Public Health Nurse: Coordination of health education, public health appointments and linkages, navigation of health care delivery systems and services, medical consultation to other team members and participant support network.	.4	$43,617

Position	FTE	Total
Peer Advocate: responsible for implementing engagement activities to assist participants in meeting enrollment criteria and understanding the WPC program.	.5	$30,925
Total Bundle Cost		$298,248
Average number of Member Months per year		180
Per Member Per Month = Total Bundle Costs / Avg Member Months		$1,657

Bundle 2: Housing Navigation and Supports: $1,936 PMPM x 60 Member Months = $116,160

Housing Support Service costs include the salary and benefit (Social Security, Medicare, medical, dental, vision, retirement, life insurance, and SDI State Disability) costs of the Housing Team.

Position	FTE	Total
Program Manager: Responsible for day to day management of WPC activities, hiring and training of WPC staff and team, supervision of staff, oversight of data management and care planning, linkages with partners and providers, attends and coordinates leadership team meetings.	.05	$6,159
Staff Analyst: Responsible for implementing policies and protocols, data system management, data reporting, data tool development, training coordination, outreach to partners/providers.	.05	$4,291
Housing Navigator/Program Specialist: Provides screening and assessment for various housing programs, linkages, assistance with breaking down barriers to obtaining housing, and liaison with land lords.	.5	$66,598
Tenancy Care Support: Provide supportive services to participant once housed.	.5	$39,109
Total Bundle Costs		$116,157
Average number of Member Months per year		60
Per Member Per Month =Total Bundle Costs / Avg Member Months		$1,936

<u>Pay for Outcomes</u>: $3,824 outcome payment x 5 partners = $19,120

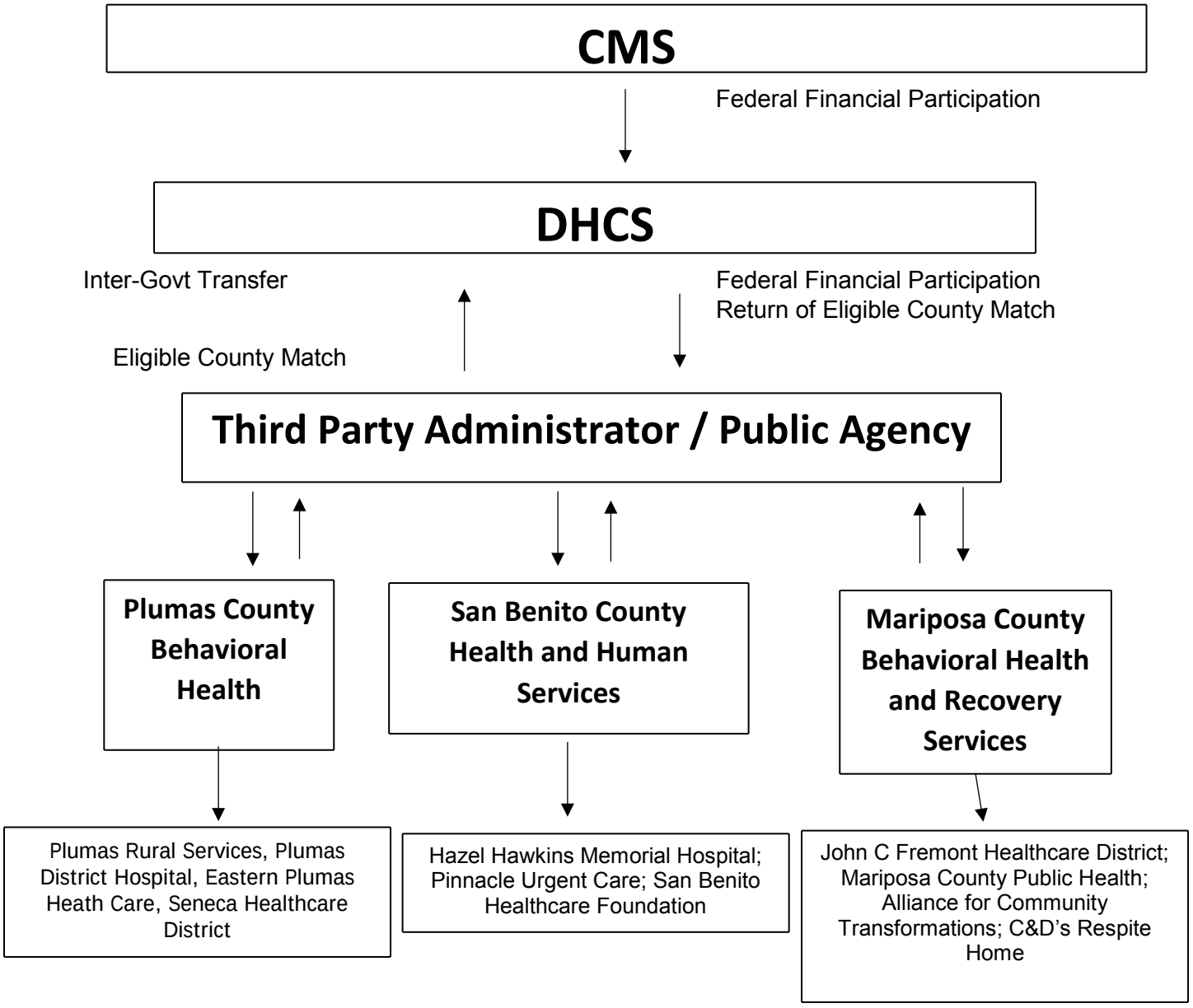
Reduce ED utilization and hospital admissions of WPC enrolled participants (those enrolled in CCC Services) by 5%: Should the target outcome be achieved, equal payments of $3,824 each will be made to WPC partners: San Benito County Health & Human Services, Behavioral Health Department, Probation Department, San Benito Health Foundation, and HHH, totaling $19,120.

Attachment

Small County Collaborative Whole Person Care Pilot

5.2 Program Funding Diagram

The diagram below reflects the flow of requested funds from the Small County Collaborative to DHCS and return from DHCS to the three County partners and other community partners.



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

New WPC Applicant Name:	*Small County Consortium (San Benito, Mariposa, Plumas)*

	Federal Funds *(Not to exceed 90M)*	IGT	Total Funds
PY 1 Annual Budget Amount Requested	647,636	647,636	1,295,272
PY 2 Annual Budget Amount Requested	647,636	647,636	1,295,272
PYs 3-5 Annual Budget Amount Requested	1,295,272	1,295,272	2,590,544

Second Round PY 1 Budget Allocation (Note PY 1 Allocation is	
PY 1 Total Budget	1,295,272
Approved Application (75%)	971,454
Submission of Baseline Data (25%)	323,818

Second Round PY 2 Budget Allocation	
PY 2 Total Budget	1,295,272
Administrative Infrastructure	376,516
Delivery Infrastructure	492,943
Incentive Payments	15,300
FFS Services	145,030
PMPM Bundle	257,983
Pay For Reporting	0
Pay for Outcomes	7,500

Second Round PY 3 Budget Allocation	
PY 3 Total Budget	2,590,544
Administrative Infrastructure	540,650
Delivery Infrastructure	215,593
Incentive Payments	50,400
FFS Services	366,342
PMPM Bundle	1,403,059
Pay For Reporting	0
Pay for Outcomes	14,500

Second Round PY 4 Budget Allocation	
PY 4 Total Budget	2,590,544
Administrative Infrastructure	480,958
Delivery Infrastructure	215,593
Incentive Payments	45,900
FFS Services	304,984
PMPM Bundle	1,528,109
Pay For Reporting	0
Pay for Outcomes	15,000

Second Round PY 5 Budget Allocation	
PY 5 Total Budget	2,590,544
Administrative Infrastructure	542,211
Delivery Infrastructure	190,080
Incentive Payments	52,650
FFS Services	302,790
PMPM Bundle	1,433,693
Pay For Reporting	0
Pay for Outcomes	69,120