Whole Person Care Pilot Application

May 30, 2017

Section 1: WPC Lead Entity and Participating Entity Information

1.1 Whole Person Care Pilot Lead Entity and Contact Person

Organization Name	City of Sacramento
Type of Entity	City Government
Contact Person	Emily Halcon
Contact Person Title	Homeless Services Coordinator
Telephone	(916) 808-7896
Email Address	ehalcon@cityofsacramento.org
Mailing Address	Sacramento City Hall, Office of the City Manager 915 I St. 5th Floor Sacramento, CA 95814

1.2 Participating Entities

Required Organizations	Organization Name	Contact Name and Title	Entity Description and Role in WPC
1. Medi-Cal Managed Care Health Plan	Anthem Blue Cross	Beau Hennemann, Director, GBD Special Programs	**Entity Description:** Managed Care Plan for Medi-Cal patients in Sacramento County **Role in WPC:** • Participate in Governance Structure and Communication Process • Provide data necessary for the identification of the target population, project implementation and operations
2. Health Services Agency/Department	Not applicable (City-only application)	Not applicable (City-only application)	Not applicable (City-only application)

Required Organizations	Organization Name	Contact Name and Title	Entity Description and Role in WPC
3. Specialty Mental Health Agency/ Department	Not applicable (City-only application)	Not applicable (City-only application)	Not applicable (City-only application)
4. Public Agency/Department #1	City of Sacramento	Howard Chan, City Manager	**Entity Description:** Municipality **Role in WPC:** Lead entity and authority as point of contact. • Lead and facilitate the development of the WPC pilot, implementation, and evaluation • Procure and monitor contracted services • Provide overall coordination and monitoring of the pilot • Coordinate communication with the community and with partnering entities • Facilitate and staff project governance and oversight
5. Public Housing Authority	Sacramento Housing and Redevelopment Agency (SHRA)	LaShelle Dozier, Executive Director	**Entity Description:** Housing Authority of the City and County of Sacramento **Role in WPC:** • Participate in Governance Structure and Communication Process • Assist in the development of the WPC pilot,

Required Organizations	Organization Name	Contact Name and Title	Entity Description and Role in WPC
			implementation, and evaluation • Support the WPC pilot's efforts to link clients with permanent housing
6. Community Partner #1	Sacramento Steps Forward	Ryan Loofbourrow, CEO	**Entity Description:** Administrator of the Sacramento County Homeless Continuum of Care (CoC) **Role in WPC:** • Participate in Governance Structure and Communication Process • Assist in the development of the WPC pilot, implementation, and evaluation • Administrator of the Homeless CoC coordinated entry system, which the WPC pilot will integrate into • Provide training and support to WPC providers on administration of the VI-SPDAT [1], the community's assessment tool for housing • Contract for and administer the housing services provided in the WPC housing bundle

[1] Vulnerability Index – Service Prioritization Decision Assessment Tool

Required Organizations	Organization Name	Contact Name and Title	Entity Description and Role in WPC
7. Community Partner #2	211 Sacramento	Richard Abrusci, CEO	**Entity Description:** Sacramento County resource and information hub that connects people with community services. **Role in WPC:** • Participate in Governance Structure and Communication Process • Assist in the development of the WPC pilot, implementation, and evaluation • Participate in target population identification and engagement

Additional Organizations (optional)	Organization Name	Contact Name and Title	Entity Description and Role in WPC
8. Community Partner #3	Sacramento Covered	Kelly Bennett, CEO	**Entity Description:** Community-based health navigator program in Sacramento County working to connect people with medical coverage, primary and preventative care and social services. **Role in WPC:** • Participate in Governance Structure and Communication Process • Assist in the development of the WPC pilot, implementation, and evaluation • Participate in target population identification and engagement • Client tracking and outcome reporting • Provide care coordination via dispersed peer outreach navigators
9. Health System #1	Sutter Health	Keri Thomas, Director of Community and Government Relations	**Entity Description:** Health system with one full service hospital in the City of Sacramento. **Role in WPC:** • Participate in Governance Structure and Communication Process • Assist in the development of the WPC pilot, implementation, and evaluation • Participate in target population identification and engagement

Additional Organizations (optional)	Organization Name	Contact Name and Title	Entity Description and Role in WPC
10. Health System #2	Dignity Health	Laurie Harting, Senior Vice President Operations	**Entity Description:** Health system with two full service hospitals in the City of Sacramento. **Role in WPC:** • Participate in Governance Structure and Communication Process • Assist in the development of the WPC pilot, implementation, and evaluation • Participate in target population identification and engagement
11. Health System #3	UC Davis Health System	Ann Madden Rice, Chief Executive Officer	**Entity Description:** Health system with one full service hospital in the City of Sacramento. **Role in WPC:** • Participate in Governance Structure and Communication Process • Assist in the development of the WPC pilot, implementation, and evaluation • Participate in target population identification and engagement
12. Health System (#4) and Medi-Cal managed care plan (#2)	Kaiser Permanente	Sandy Sharon, Senior Vice President & Area Manager and Patricia Rodriguez, Senior Vice	**Entity Description:** Health system and health plan with one full service hospital in the City of Sacramento. **Role in WPC:** • Participate in Governance Structure

Additional Organizations (optional)	Organization Name	Contact Name and Title	Entity Description and Role in WPC
		President and Area Manager	and Communication Process • Assist in the development of the WPC pilot, implementation, and evaluation • Participate in target population identification and engagement • Provide data necessary for the identification of the target population, project implementation and operation
13. Medi-Cal managed care health plan #3	Molina Healthcare	Robert O'Reilly, Director of Policy	**Entity Description:** Managed Care Plan for Medi-Cal patients in Sacramento County **Role in WPC:** • Participate in Governance Structure and Communication Process • Provide data necessary for the identification of the target population, project implementation and operations
14. Medi-Cal managed care health plan #4	Health Net	Abbie Totten, Vice President, Government Programs, Policy, & Strategic Initiatives	**Entity Description:** Managed Care Plan for Medi-Cal patients in Sacramento County **Role in WPC:** • Participate in Governance Structure and Communication Process • Provide data necessary for the identification of the target population,

Additional Organizations (optional)	Organization Name	Contact Name and Title	Entity Description and Role in WPC
			project implementation and operations
15. Medi-Cal managed care health plan #5	United Healthcare	Kevin Kandalaft, CEO	**Entity Description:** Managed Care Plan for Medi-Cal patients in Sacramento County **Role in WPC:** • Participate in Governance Structure and Communication Process • Provide data necessary for the identification of the target population, project implementation and operations
16. Medi-Cal managed dental health plan #1	Access Dental	Alisha Hightower, Director, Government Programs	**Entity Description:** Managed Care Dental Plan for Medi-Cal patients in Sacramento County **Role in WPC:** • Participate in Governance Structure and Communication Process • Provide data necessary for the identification of the target population, project implementation and operations
17. Medi-Cal managed dental health plan #2	Liberty Dental	John Carvelli, Executive Vice President and Compliance Officer	**Entity Description:** Managed Care Dental Plan for Medi-Cal patients in Sacramento County **Role in WPC:** • Participate in Governance Structure and Communication Process • Provide data necessary for the identification of

Additional Organizations (optional)	Organization Name	Contact Name and Title	Entity Description and Role in WPC
			the target population, project implementation and operations
18. Public Agency/Department #2	City of Sacramento Police Department Impact Team	Brian Louie, Interim Chief of Police	**Entity Description:** Unit of the Sacramento Police Department providing outreach and engagement with the homeless population, with a goal of linking to services and avoiding incarceration **Role in WPC:** • Participate in Governance Structure and Communication Process • Assist in the development of the WPC pilot, implementation, and evaluation • Provide data necessary for the identification of the target population, project implementation and operation • Oversee the Impact Team partnership with outreach navigators and Street Nurses
19. Public Agency/Department #3	City of Sacramento Fire Department	Walt White, Fire Chief	**Entity Description:** Fire department and EMS for the City of Sacramento **Role in WPC:** • Participate in Governance Structure and Communication Process • Assist in the development of the WPC pilot, implementation, and evaluation

Additional Organizations (optional)	Organization Name	Contact Name and Title	Entity Description and Role in WPC
			• Provide EMS data on response and transportation necessary for the identification of the target population, project implementation and operation
20. Community Partner #8	Capitol Health Network	Steve Heath, Executive Director	**Entity Description:** Consortium of FQHCs and community-based clinical healthcare providers **Role in WPC:** • Participate in Governance Structure and Communication Process • Participate in target population identification and engagement • Client tracking and outcome reporting
21. Community Partner #9	Sacramento Native American Health Center (SNAHC)	Britta Guerrero, Executive Director	**Entity Description:** Non-profit, urban Indian FQHC **Role in WPC:** • Participate in Governance Structure and Communication Process • Participate in target population identification and engagement • Client tracking and outcome reporting
22. Community Partner #10	Health and Life Organization (HALO)	Jerry Bliatout, Chief Executive Officer and J. Miguel Suarez, MD,	**Entity Description:** Non-profit FQHC **Role in WPC:** • Participate in Governance Structure and Communication Process

Additional Organizations (optional)	Organization Name	Contact Name and Title	Entity Description and Role in WPC
		Clinic Director	• Participate in target population identification and engagement • Client tracking and outcome reporting
23. Community Partner #11	Elica Health Centers	Karen Freeman, COO	**Entity Description:** Non-profit, FQHC **Role in WPC:** • Participate in Governance Structure and Communication Process • Participate in target population identification and engagement • Client tracking and outcome reporting
24. Community Partner #12	WellSpace Health	Dr. A. Jonathan Porteus, CEO	**Entity Description:** Non-profit, FQHC **Role in WPC:** • Participate in Governance Structure and Communication Process • Participate in target population identification and engagement • Client tracking and outcome reporting • Operate the ICP+ Respite program
25. Community Partner #13	Cares Community Health	Christy Ward, CEO	**Entity Description:** Non-profit, FQHC **Role in WPC:** • Participate in Governance Structure and Communication Process • Participate in target population

Additional Organizations (optional)	Organization Name	Contact Name and Title	Entity Description and Role in WPC
			identification and engagement • Client tracking and outcome reporting

1.3 Letters of Participation and Support

The partners listed above have all explicitly expressed commitment to the Pilot and have provided letters of participation. [Emily Halcon, Homeless Services Coordinator may be contacted for access to the letters at (916) 808-7896 or ehalcon@cityofsacramento.org.]

Section 2: General Information and Target Population

2.1 Geographic Area, Community and Target Population Needs

Community Description and Need

The City of Sacramento is the largest and most populous City in Sacramento County, with a population of approximately 490,000 people living within the 100 square miles of the City, which is predominantly urban. According to county eligibility data from September 2016, of the roughly 470,000 Medi-Cal beneficiaries in Sacramento County, 300,000 reside in the City of Sacramento (64%).[1] While Whole Person Care (WPC) more typically is a County led initiative, the City of Sacramento is the home to a majority of the County's Medi-Cal population, including emergency departments (EDs) from all four local hospital systems and every clinic/federally qualified health center (FQHC) serving the County's Medi-Cal population. It is also home to a majority of the homeless population in the County.

A local 2016 community health needs assessment found that challenges in accessing housing created many challenges for community members in maintaining their health and transitioning to more stability.[2] One health care service provider stated:

"We are confronted daily with huge housing crisis in our region and it feels, we feel powerless to be able to help people with all the things that we may be able to help them with. We may be able to get them enrolled in Medi-Cal and we may be able to try to help them navigate those systems or see if we can help with medications but you can't make it over to the pharmacy or get to an appointment with a psychiatrist if you slept in the bushes last night or if you're looking at a housing situation that's dangerous to your health so housing is a huge problem in our region that has to be looked at through a health lens and we need to have sustainable solutions that are innovative and creative and also consider the intersections of where folks come from."

While little data exists on the numbers of high utilizers who are also homeless, a local coverage and navigation program provided preliminary data for the last six months indicating that, of the Medi-Cal population referred to the program and served from one of the local EDs, 8% were homeless.

---

[2] Sutter Medical Center, Sacramento and Sutter Center for Psychiatry. 2016 Community Health Needs Assessment. Available online at: http://www.suttermedicalcenter.org/CHNA/smcs-2016-chna.pdf

According to the 2015 Homeless Point in Time Count, there are approximately 5,600 people experiencing homelessness in Sacramento County during the year, with over 2,600 on any given night, 35% of whom lack shelter. [3] This is further confirmed by Sacramento Steps Forward (SSF), the City's non-profit partner in preventing and ending homelessness, who assessed over 5,000 individuals and almost 1,700 families experiencing homelessness from 2015 to 2016. Of the households active on the SSF waitlist for homeless housing placements (the "community queue"), approximately 77% were single adults and 44% were families. While limited data exists specific to Sacramento's homeless population, we know this population is:

- Mentally ill – 27%
- Suffering from addiction to alcohol or drugs or both – 48%
- Chronically homeless – 16.7%

This population faces significant challenges meeting basic requirements of everyday life, further limiting the ability of these individuals to manage and maintain their health needs. Many seek care in EDs and urgent care centers, often waiting until health conditions are acute instead of seeking preventative and primary care. Those who are discharged from these acute care settings are discharged back to the streets when the existing 16 crises respite beds in the county are unavailable. According to the 2016 Sacramento Homeless Deaths Report: [4]

- Frequency of homeless deaths doubled from 32 deaths per year (2002) to 78 deaths per year (2015). *This means that one homeless person died every week over the last 14 years in Sacramento County.*
- Of these deaths, 61% were between the ages of 40-59.

---

[1] Sacramento County Department of Health & Human Services. Medi-Cal beneficiaries by Zip Code. September 2016. Available online at: http://www.dhhs.saccounty.net/PRI/Documents/Sacramento-Medi-Cal-Managed-Care-Stakeholder-Advisory-Committee/Monthly%20Meeting%20Documents/2016/20160926/Medi-Cal-Beneficiaries-by-Zip-Code-Sept.pdf

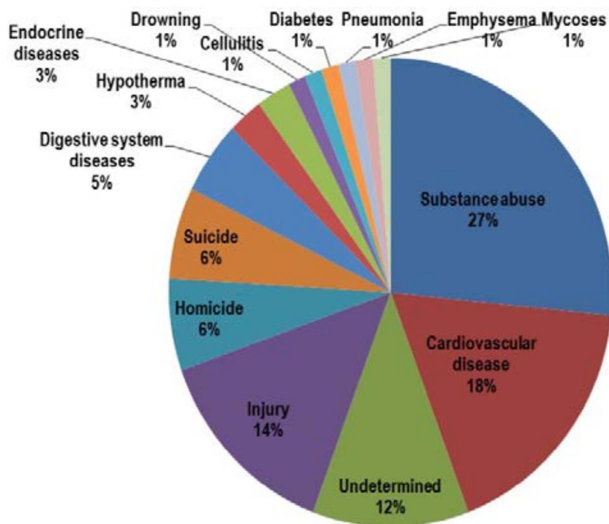
[3] Sacramento Steps Forward. Homelessness in Sacramento, Available online at: http://sacramentostepsforward.org/understanding-homelessness/point-in-time-pit-scope-size-populations

[4] Sacramento Regional Coalition to End Homelessness. Sacramento County 2016 Homeless Deaths Report. December 2016. Available at: https://media.wix.com/ugd/ee52bb_8cc49b7195a24254a1c7e96dd2378784.pdf

- Using 75 years of age as the national average for life expectancy, the lives of Sacramento's homeless was cut short, on average, by 34% or about 30 years.

The underlying causes of death of Sacramento County's homeless population in 2015 are identified in the chart below. Substance abuse (27%), cardiovascular disease (18%), and violent deaths (26% - including injury, homicide and suicide) accounted for 71% of the deaths in Sacramento County's homeless population.

The underlying causes of death of Sacramento County's homeless population in 2015 are identified in the chart below. Substance abuse (27%), cardiovascular disease (18%), and violent deaths (26% - including injury, homicide and suicide) accounted for 71% of the deaths in Sacramento County's homeless population.



Underlying Causes of Death 2015

There is also growing racial and gender disparities within this population. While 59% of homeless deaths were Caucasian, this represents a significant decline in Caucasian homeless deaths from 69% in 2002-2014. It also corresponds with an increase in African American homeless deaths, from 17% in 2002 to 26% in 2015 (1.5x increase). The percentage of homeless female persons of color is 1.6 times great than homeless male persons of color in the county. Men account for 8 times the deaths by accident compared to women (42% vs. 6%).

Compared to the general population in the county in 2015, the homeless population had:

- Mortality rate that was 4x higher
- Suicide rate that was 16x higher
- Alcohol and drug related deaths were 52x higher

Sacramento County's Geographic Managed Care (GMC) Medi-Cal Health Plans reviewed data on top 50 adults who are the highest utilizers of non-primary care services in calendar year 2015, including homelessness.[5] Of these top 50 utilizers:

- 14% of Anthem Blue Cross's top utilizers were homeless
- 16% of Health Net's top utilizers were homeless, and
- 20% of Molina's top utilizers homeless.

Plan data indicated that these enrollees have multiple co-morbid health conditions, frequently have a physical health and behavioral health condition and many have two or more ED visits in a calendar year. Averaging across the four systems, 30% of beneficiaries required complex care management, and 70% had three or more comorbid conditions. Top five chronic conditions for this population include hypertension (65%), substance abuse disorder (50%), major depressive disorder (48%), diabetes (48%), and congestive heart failure (46%). Moreover, according to county coroner's reports, while 38% of homeless deaths occurred outside, 35% occurred at a hospital (ED or inpatient), calling for both interventions in the community and within hospitals settings.

Sacramento is also experiencing an increase in market rents and a decrease in vacancy rates, creating a situation where those precariously housed are at higher risk of becoming homeless. Named one of the top 10 "hottest" housing markets in the nation in 2017, average rents are rising from $1,351 in January of 2015 to $1,534 in January of 2017, a 13.5% increase in just two years.[6] This increase is coupled with a vacancy rate of fewer than 3%, making it more difficult both to secure housing for people experiencing homelessness and for people living in poverty to maintain their housing and not fall into homelessness.

Clearly, this is a population with significantly more challenges accessing and maintaining health, with higher acuity levels, and greater than normal navigation needs to overcome barriers caused by housing instability or lack thereof.

---

[5] Sacramento County Care Coordination Workgroup. Health Plan Data Comparisons of Top 50 Utilizers in 2015*.* March 2017. Available online at: http://www.dhhs.saccounty.net/PRI/Documents/Sacramento-Medi-Cal-Managed-Care-Stakeholder-Advisory-Committee/Care%20Coordination%20Work%20Group/Meeting%20Materials/2017/20170327/Data%20Summary%20Reports%202015-2016-Plan%20Comparisons.pdf

[6] Zillow. Sacramento Home Prices & Values*.* Available online at: *https://www.zillow.com/sacramento-ca/home-values*

Project Background and Scope

The WPC pilot is an opportunity for the City to develop a comprehensive approach to addressing the health, social and housing needs of its most vulnerable populations. Given the large numbers of Medi-Cal beneficiaries in the City, the large numbers of homeless, and the number of city programs that engage this population, we believe that the City can have the greatest impact on high utilizers who have significant unmet healthcare needs and who are homeless or at-risk of homelessness. WPC is an important new mechanism that provides a nexus allowing the City to engage health care partners in redesigning the way care is delivered to this population.

The pilot is led by the City of Sacramento, in partnership with a broad range of community and health care stakeholders, including all current Medi-Cal managed care plans, all four local hospital systems, all but one of our FQHCs, homeless organizations, police, fire and other community-based organizations.

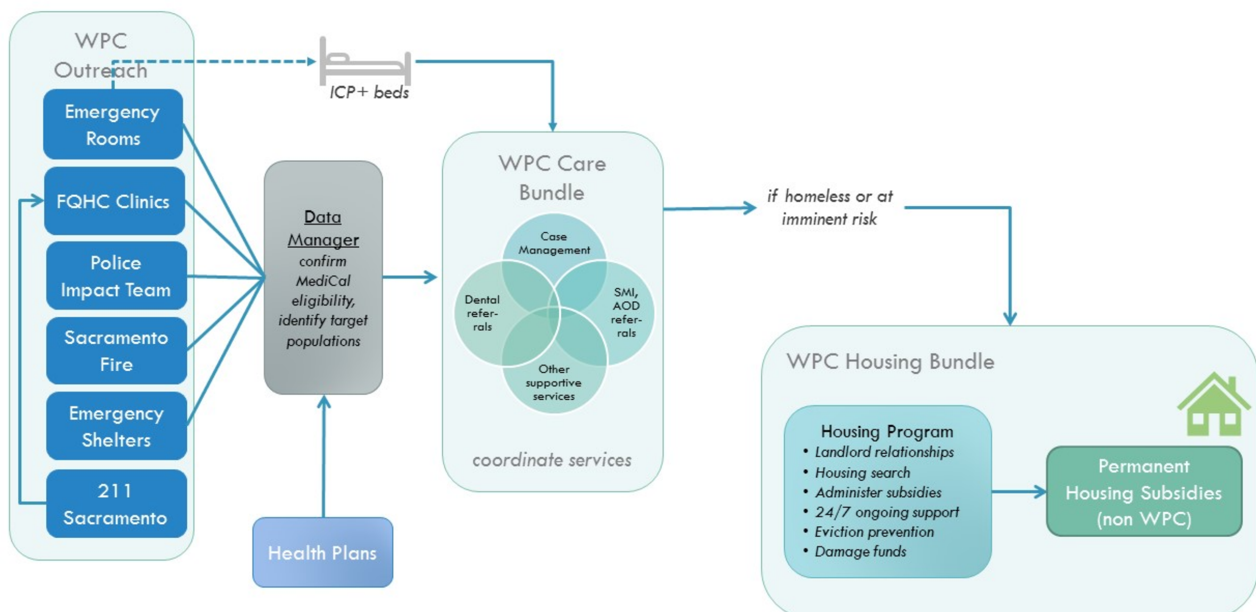
The Sacramento WPC program is the outcome of an organic community desire to bring WPC services to Sacramento and was designed in consultation with numerous community partners. At the on-set of the City's efforts to create a WPC program, we sought out the advice of health care partners with experience in the Sacramento system of care and with the community clinics currently providing direct health care for Medi-Cal patients. The design of the Sacramento WPC program was iterative, building on the expertise and experience of our community partners. The development included one-off meetings with each partner, as well as group meetings with health systems, FQHCs and homeless providers.

As a top priority, the City of Sacramento has committed significant resources over the past three years to create broader strategies to address the needs of its most vulnerable populations, including the homeless. However, the City recognizes that shelter and housing alone is not sufficient. A comprehensive approach to meeting the needs of high utilizers who are also homeless or at-risk of homelessness must encompass a suite of intensive services that includes health care, behavioral health, and housing support tailored to the individual, that meets people "where they are," and that is flexible to the changing needs of the individual. Both the City and its partners have a shared goal to support the unique and unmet needs of our target population through new outreach, case management and care coordination services through the pilot, including developing 16 new crises respite beds, provided by the pilot.

Our approach leverages and complements existing housing supports and other local social service programs. Before WPC, the City of Sacramento took a leadership role in finding solutions to prevent and end homelessness in the region, including:

- Launched the community's homeless coordinated entry system, creating an infrastructure of outreach navigators using a common assessment tool placing the most vulnerable people in interim shelter beds while linking them with permanent housing.
- Partnered with Sacramento County to allocate up to 1,700 housing opportunities through the City and County Public Housing Authority over three years.
- Expanded and enhanced the community's response to the crisis of unsheltered homelessness by: 1) creating an outreach team within the Sacramento Police Department to engage the City's homeless population, and 2) expanding availability of emergency shelter locally.

Building on the success of programs already operational in Sacramento, the WPC pilot will create an integrated system of care that can support people with a variety of outreach; case management; and physical health, behavioral health, substance abuse, and housing services; as depicted in the graphic below. By building shared infrastructure and approaches, we will increase collaboration across siloed providers and provide learning for further systems integration, informing and enhancing other health initiatives. Furthermore, by addressing the complex needs of our homeless population and building common data sharing infrastructure, we intend to improve health outcomes and create savings in the delivery system from reduced ED and inpatient utilization that will support future efforts after the pilot ends.



Key to the WPC pilot will be the outreach fee for service (FFS) component, embedded in physical locations and with community partners regularly serving the WPC pilot target population. Sacramento Covered, a local outreach and navigation community-based organization, will expand their already successful health navigator program both in quantity, services and locations to ensure that vulnerable Medi-Cal eligible patients are linked with WPC services. Sacramento Covered's team of health navigators already provide outreach and navigation into health and social services, partnering with all five EDs in Sacramento and in other community locations. Their navigation work includes helping beneficiaries and families identify a primary care provider and a primary care home, get same day or same week appointments for non-emergent health care needs, addressing social determinants of health by identifying and addressing barriers to accessing care by arranging services and conducting follow-up to ensure that the beneficiary and family has received care in a clinically appropriate setting and has their health care needs addressed. Expanding their scope to include linkages into the homeless continuum of care managed by SSF, makes them the ideal partner to bridge people in need with a full spectrum of WPC supports.

Sacramento Covered will also be responsible for referring potential clients to primary and specialty care offered at partner FQHCs, receiving referrals directly from the FQHCs' internal teams at their clinics, on the street, and from the Interim Care Program (ICP+). They will also work with clinical care coordinators in participating FQHCs who will provide clinical case management. As partner health plans provide referrals to the pilot, these referrals will be aggregated by the data manager and analyst to create updated target lists for outreach. The target lists will be provided to outreach staff and partners to find and connect plan beneficiaries eligible for the pilot. WPC coordinators will work with the data team and appropriate plan for data and information sharing. The Sacramento Covered navigators will be responsible for overall care coordination, including:

- Receiving referrals from EDs, community clinics, and other community partners
- Enrolling eligible participants into the WPC Pilot
- Conducting screenings and follow-ups
- Proactively identifying potential high users of services and reaching out directly to connect clients with a WPC care coordinator
- Helping uninsured clients enroll in Medi-Cal
- Helping clients establish a medical home
- Helping clients gain access to primary and preventative care
- Arrange for transportation to non-Medi-Cal covered appointments and other social services (as needed) to ensure clients receive and attend their appointments

- Following up with clients to ensure their needs are met
- Providing referrals to the WPC housing partner for homeless clients

The WPC housing services provider and the care coordinator will work collaboratively, as one is coordinating on-going health care and supportive services, and one is working to identify and secure appropriate housing. The care coordinator will remain with the client after they are housed and working with the housing provider to ensure that the client's social, medical and behavioral health care needs are managed so they can remain healthy in the community and stably housed.

Past and Current Efforts with Similar Populations

The concept for the WPC pilot was developed with community partners who have experience in administering health navigation programs, respite care beds for homeless individuals discharged from acute care facilities, and supportive wrap-around services in permanent housing. These projects have, individually, been extremely successful in improving the health and well-being of the clients served; by expanding on these concepts and coordinating them through one central program, the impacts should multiply. Examples of current health projects informing the WPC program in Sacramento are:

- Interim Care Program (ICP): This program provides respite beds and medical care for persons who are homeless and discharging from an acute care facility. The ICP allows a homeless person to recuperate in a shelter setting, outside a hospital facility, and to be linked to social services and housing upon healing.
- Triage-Transport-Treat (T3): This program engages the highest non-urgent utilizers of ED services, providing wrap-around case management and supportive housing.
- Street Nurse: This program brings direct street level care to persons who are currently homeless, including referrals to community clinics for on-going preventative and primary care.

In addition to these innovative programs currently offered on a small scale by health partners, the City of Sacramento has made efforts to work with the County to offer a range of services, both health and social services, to homeless populations on the street. The health programs above are separate and discrete from the City's new housing programs described earlier in the prior section. Our proposed WPC pilot will revamp existing siloed system to create one comprehensive system meeting all the health and social service needs of our most vulnerable population, keeping them healthy in the community and engaged in their care.

2.2 Communication Plan

The WPC Pilot will be coordinated by the City of Sacramento Office of Homeless Services in the Office of the City Manager, who will have responsibility and authority to act as point of contact for all participating entities. To ensure program fidelity and oversight, as well as establish a transparent and collaborative process to ensure buy-in and engagement from partners and stakeholders, we propose a governance structure comprising of an executive committee, steering committee, information technology (IT) committee, and Clinical/Process Redesign Committee (please see organizational chart and corresponding table for details on committee structure, roles, participants and meeting frequency).

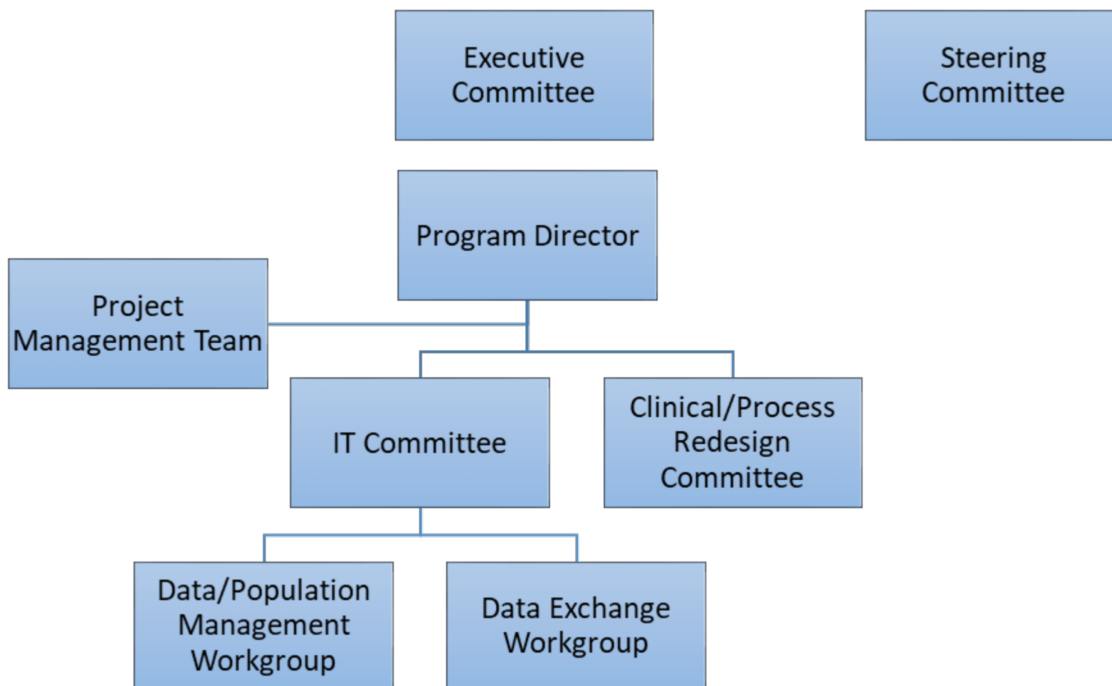
The work will be led by a Program Director, and the day-to-day operations conducted by a project management team reporting to the Program Director.

Committee/ Workgroup	Responsibilities	Participants	Meeting Frequency
Executive Committee	Provide oversight and direction to the pilot; decision making body; responsible for ensuring that program maintain fidelity to the program design and City's policy priorities; provide guidance to the Steering Committee and will review program outcomes (operational and fiscal) in the context of larger City initiatives.	o Assistant City Manager o Representative from the Office of the Mayor o Deputy Chief of Police o Deputy Fire Chief o Pilot Director o CEO of Sacramento Covered o CEO of Sacramento Steps Forward o CEO of WellSpace Health	As needed, at a minimum quarterly

Committee/ Workgroup	Responsibilities	Participants	Meeting Frequency
Steering Committee	Advisory Committee providing feedback and thought leadership to Executive Committee, Operational committee responsible for coordinating on day to day operations of the WPC pilot and developing reports for review of the Executive Committee	Dedicated "C-suite" leadership from partner organizations: o Representative from each of the four health systems o Representative from each of the six health plans o CEO/COO of Sacramento Covered o COO of 211 Sacramento o CEO/COO of each participating FQHC o Executive Director of the Sacramento Housing and Redevelopment Agency o CEO/COO of Sacramento Steps Forward o Leadership from the Housing Services Program administrating agency	Monthly
IT Committee	Technical committee supporting data and information sharing requirements of the pilot	IT Leadership (preferably CIO) from appropriate partner organizations	As needed (quarterly at a minimum)
Data/Population Management Workgroup	Cross functional working group under the IT and Clinical supporting data analysis	Subset of IT Committee	As needed

Committee/ Workgroup	Responsibilities	Participants	Meeting Frequency
Data Exchange Workgroup	Working group under IT to address issues of sharing data	Subset of IT Committee	As needed
Clinical/Process Redesign Committee	Technical Committee on issues related to establishing procedures and protocols for care coordination, case management, and other wrap-around supportive services	Operations and clinical leadership from appropriate partner organizations, preferably CMO	As needed, and at a minimum, quarterly

Organizational Chart:



At the initial meeting of the Steering Committee, participating entities will develop a work plan for review/approval by the Executive Committee. Our intention is to hold meetings in person if possible, but will also leverage conference call and webinar capabilities. The Executive Committee will also request a standing reporting line on the monthly Sacramento County Medi-Cal Managed Care Advisory Committee, allowing WPC activities to be known throughout all sectors engaging Medi-Cal beneficiaries.

To create opportunities for public feedback, the City will create WPC section on the City's website, where pertinent program documents will be accessible to the public. In addition, the City will create an e-Gov system whereby interested parties can sign up for email alerts on the WPC program, and provide direct feedback to the City. On at least an annual basis, the Program Director will prepare an annual report to be presented to the City Council in open session. All health care partners, those who have signed up on the City's e-Gov list and the general public will be invited to attend and provide comment on the annual report to the Council.

2.3 Target Population(s)

City of Sacramento WPC Pilot will serve Medi-Cal beneficiaries with repeated incidents of avoidable ED use and/or hospital admissions, and those who are currently experiencing homelessness or are at risk of homelessness.

As of September 2016, Sacramento County has a Medi-Cal population of 472,000. Based on a zip code level assessment of county Medi-Cal eligibility data, we estimate 300,000 (64%) of the county's Medi-Cal beneficiaries are in the City of Sacramento.[7] Many will need housing supports to ensure they can remain healthy and stable in the community. To be eligible for this pilot, beneficiaries must reside in Sacramento County, be Medi-Cal enrolled or eligible, and have two or more ED visits or inpatient hospitalizations OR one ED visit and two or more comorbid conditions requiring care coordination and case management.

Based on eligibility criteria, we further refine this population to focus on the homeless or those at risk of homelessness, as this population: 1) face a myriad of challenges maintaining their health and have multiple comorbid conditions to manage, which is further exacerbated by unstable housing, 2) has significant unmet health needs, and 3) is a population the City currently engages with. From the 2015 homeless Point-in-Time count, we estimate that 0.18% of the total County population is homeless at a given point in time (2,659 individuals), and that, over the course of a year, approximately twice as many people will experience homelessness. Applying these same assumptions to the City-only population, we estimate that at least 882 people are homeless in the City of Sacramento at any point in time and that, over the course of a year, 1,764 people experience homelessness in the City. This is the larger pool from which our WPC pilot will target outreach and referral services.

---

[7] State of California, Department of Health Care Services Research and Analytics Studies Division, Medi-Cal Certified Eligible Data Table by County and Aid Code Groups for Month of Eligibility November 2016, Report Date: March 2017. Available online at: http://www.dhcs.ca.gov/dataandstats/statistics/Pages/Medi-Cal-Certified-EligiblesRecentTrends.aspx

We will work with plans to develop a target list of potential pilot enrollees. This includes working with each managed care plan (MCP) to pull data on our target population on a quarterly basis that includes information on existence of a mental illness, substance use disorder (SUD), or chronic physical health conditions, in addition to other pertinent patient information, such as location (if available), primary care provider, etc. This data will be scrubbed and analyzed to develop a target list for outreach teams by a WPC Data Review Team, comprising of representatives from the MCP, data manager, clinician and other WPC personnel, operating as a subset of the Data/Population Health Workgroup.

As Sacramento is a Targeted Case Management (TCM) county, the pilot's population will not be eligible for TCM. To ensure no service duplication, the list will be shared with the County's TCM coordinator and with the MCPs to coordinate and prevent the outside possibility of enrolling beneficiaries who may be receiving TCM. We will work with all partners to ensure all applicable privacy laws are followed.

Outreach teams will use target lists provided by the WPC Review Team to locate potential clients. Best practice models, such as motivational interviewing, and State of Change approaches will be reviewed and incorporated to build relationships with clients and overcome barriers to accepting services.

Target Population: Size

The Sacramento WPC pilot is designed to align services based on vulnerability and acuity of need, providing only that which is needed to ensure the health and stability of the population. The pilot focuses services to high utilizers that are also homeless or at risk of homelessness, with the goal of improving this population's access to care and health outcomes. As indicated in Section 2.1, this population suffers from multiple co-morbid conditions, including behavioral health needs, and access care in expensive acute care settings. The intensive care coordination and case management supports provided through this pilot are designed to help this population manage their chronic conditions and address their health needs in a comprehensive and preventative manner, while addressing social determinants of health, such as housing. Of the above population, we estimate that roughly 1,000 or 20% of the county's total homeless population will be high utilizers of the healthcare system and reasonably meet eligibility criteria for the WPC pilot as not all of the homeless population will:

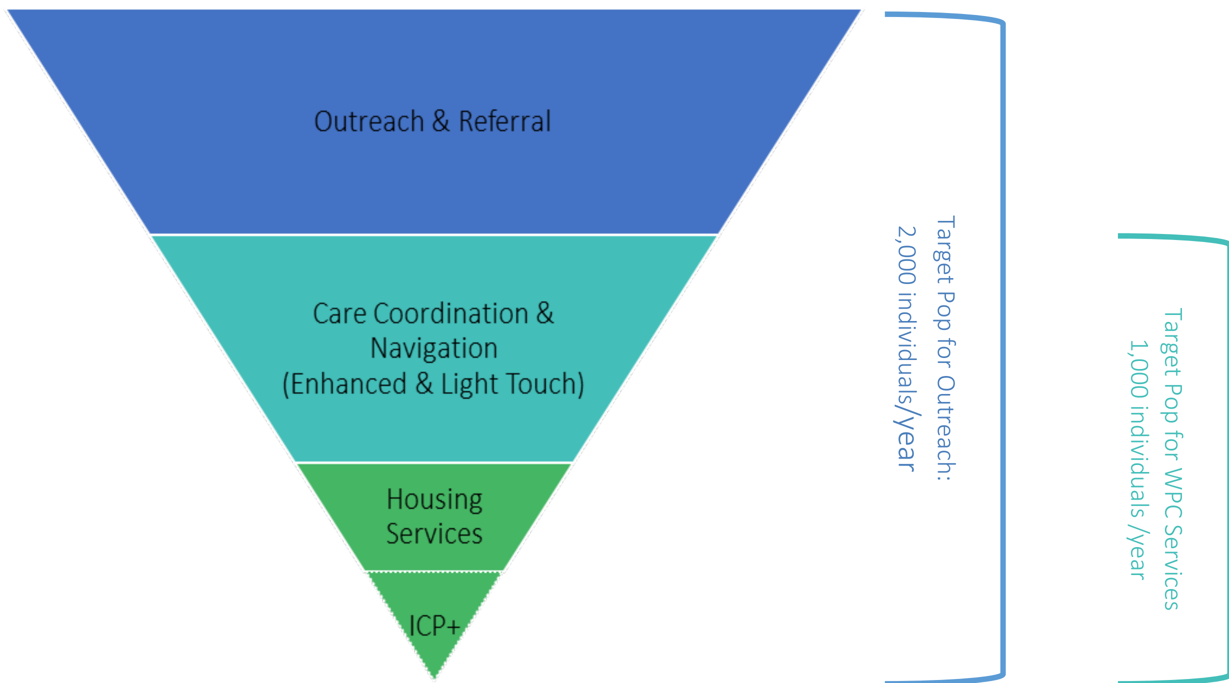
1. Be eligible and willing to participate in the program; and
2. Be eligible for Medi-Cal; and
3. Have unmet health needs causing them to present at EDs and/or local clinics; and
4. Be able to be found through outreach efforts.

Based on current Medi-Cal beneficiaries estimated to be in the City of Sacramento, counts of beneficiaries currently presenting in the EDs as frequent users, and estimates on counts from current homeless outreach and shelter providers, we will conduct outreach to 350 individuals in PY2 and 2,000 individuals annually in PY3 through PY5, many of whom will require multiple attempts before successful referral and enrollment into the pilot. We estimate needing 800 attempts in PY2 and 5,000 attempts PY3-5 (2-3 attempts per individual, many in hard to reach locations) to find these individuals by the outreach teams, deployed in clinical and community-based settings. Those not eligible for the pilot will be provided light touch referrals to programs addressing unmet needs (coverage, social services, etc.). Of those eligible in the program:

- 1,000 eligible individuals will be identified with unmet case management and care management needs and will be enrolled in the WPC pilot. Of these 1,000 members enrolled in WPC:
  - 500 will need intensive case management and care management services.
  - 500 will need lower level case management and care management services.
- Of these 1,000 members enrolled in WPC, 500 will be experiencing homelessness or be at risk of homelessness, and will be eligible for intensive housing services in addition to their care management services. Based on experience from the homeless continuum of care, we anticipate that approximately half (or 250) will "self-resolve" each year (e.g. move back with friends/family, secure an apartment on their own, etc.).
  - For homeless participants identified in the ED with acute medical needs, but ready for discharge, they may be provided respite care through the ICP+ FFS program, and then connected with permanent housing services upon recovery.

Over the course of the demonstration, our WPC pilot will impact a total of 6,350 individuals through outreach. The outreach component of WPC will touch a broad range of individuals, focusing on those most frequent users of emergency medical services. However, based on experience with this population in other outreach programs, we anticipate that approximately 30% of those contacted will either not be eligible or will refuse services, leading to delivery of WPC services to a projected 4,386 unduplicated individuals.

These populations are nested as follows:



The Sacramento WPC pilot services are "nested" to both ensure that members can access the depth of services needed for their particular situation and that the program provides only what is needed to ensure long-term health and housing stability. The pilot will tailor the intensity of services to the needs of each client, rather than use a defined formula. This will be achieved by assigning each of the pilot enrollees to a WPC Coordinator, who will serve as a link between outreach teams, providers and MCPs. The WPC Coordinators will also provide higher intensity support services for beneficiaries to access other social services, such as CalFresh, legal aid, etc., such as filing out applications, accompanying them to appropriate appointments, etc.

WPC activities will focus on a group of no more than 1,000 Medi-Cal beneficiaries at a time who are the high users of multiple urgent, emergent, and hospital service systems. This enrollment cap has been identified to ensure appropriate staff to patient ratios for effective care coordination. Once the enrollment cap of 1,000 enrollees is reached, enrollment shall remain at 1,000 at all times during the year. As participants leave the pilot, the next eligible individual on the waiting list will be contacted to enroll in the WPC. There will be no less than 1,000 participants at any given time after PY 2 if a waiting list exists. We estimate this pilot to serve 4,386 unduplicated individuals, assuming 1/2 of the participants stay in the pilot for a year and half stay in the pilot for six months.

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

3.1 Services, Interventions, and Care Coordination

The Whole Person Care (WPC) pilot allows the City of Sacramento to seamlessly integrate the spectrum of medical services and social support services into one coordinated service delivery continuum. Homelessness and use of hospital EDs for primary care are symptoms of a larger challenge for WPC enrollees, and the WPC pilot aims to address these underlying social determinants of health that exacerbate conditions and symptoms. Utilizing multiple entries into the WPC Pilot, beneficiaries will receive intensive support matching their unique level of need. As beneficiaries move through the various WPC Pilot interventions they will gain new knowledge of their disease states, how to appropriately access primary care and behavioral health care, increased connection with local community and other social supports, and be housed in safe and healthy environments.

The WPC pilot has four key activities, offered based on the presenting needs of the clients, as shown in the diagram on page 23 and detailed below.

1. <u>Outreach and Referral</u> (FFS, available for all clients)
   Outreach navigators embedded in the community, where high utilizers, both homeless and non-homeless are likely to present. Outreach navigators are the "front door" to the WPC pilot, identifying potentially eligible individuals and referring them to a WPC Coordinator for eligibility determination and enrollment into the program. We anticipate multiple attempts will be required for one successful enrollment given the difficulty in reaching and engaging our target population. There are three ways a client may interact with the outreach component:
   - <u>From Health Care Settings:</u> For those potential clients who present in a health care setting, either an ED or a partner FQHC, the on-site outreach navigator will identify and refer that client immediately to the WPC Care Coordinator. The WPC Care Coordinator will ensure that after the client's immediate, acute health needs are met, and that the individual is assessed for eligibility. If the person is eligible, the WPC Coordinator will enroll him/her into the WPC pilot and ensure wrap-around services are provided to help sustain the client's health.
   - <u>From Community Settings:</u> The WPC pilot also aims to serve vulnerable clients who are frequent and inappropriate users of emergency services, but do not have access to an established regular source of care, such as a medical home. To help identify these potential clients *<u>before</u>* they have a medical emergency, the

WPC pilot includes outreach components in three systems that are the City's "front line" for vulnerable populations: Sacramento Police Impact Team, Sacramento Fire Department and the publicly funded emergency shelter system. Each of these systems regularly collects client level data and will submit this data on a weekly basis to the data manager, who will combine these data sets, confirm eligibility for the WPC pilot and identify those clients who are the most frequent users of not only these systems, but also the health care systems. Newly enrolled participants will be assigned a WPC Coordinator by the data manager and analyst, who will conduct follow-up and needed support services. Referrals from these outreach contacts will not be in "real time", in that a third party will be responsible for data integration and analysis; as they currently do, should one of these outreach contacts identify a person with an immediate acute care crisis, they will make a referral to the ED, where the person can be captured by the on-site outreach staff for WPC pilot eligibility.

- Warm Hand-off from 211: Recognizing that some vulnerable populations, especially those who are not literally homeless, will not likely present to the Police Impact Team, Fire Department, or at an emergency shelter, the WPC pilot includes outreach components in the community's 211 call center service. When potential clients call 211 with questions about health care, mental health or substance abuse support, 211 will provide a short assessment to determine possible eligibility and make a referral to the WPC pilot.

Those who receive outreach services, regardless if enrolled in the pilot, will be provided screening and referrals to appropriate health and social service programs to address barriers to care and other social needs. These referrals would include, as appropriate:

- Appropriate health coverage program
- CalFresh
- CalWORKs
- General Assistance
- Housing support
- Local transportation support programs
- Other local support programs

Sacramento's WPC pilot will also support referral into dental assistance. People who are homeless or at-risk for homelessness frequently have considerable oral health concerns, including the need for dental treatment

and oral hygiene education. Intensive case management can help mitigate this need, including mitigation of unnecessary ED visits due to pain and tooth abscesses. By addressing oral health needs, people often experience a renewed self-esteem, can better consume meals, have increased confidence in speaking, and are apt to be more readily employable.

2. Care Coordination (two PMPM bundles, one higher intensity and one lower intensity)
   All clients will be provided care coordination and case management services appropriate to their particular needs. Delivery of services will begin upon enrollment, whether the client is unsheltered, in ICP+ beds, in a shelter or housed, and will be designed to be flexible and responsive to the clients' needs. Services offered through care coordination include:
   - Care coordinator
   - Street outreach nurse
   - Medical legal partnership
   - Coordination of behavioral health services
   - Coordination of substance abuse services
   - Patient health education
   - More extensive enrollment supports (filling out forms, accompanying the patient to appointments, etc.)

   The WPC Pilot will employ centralized Contracted Care Coordinators, providing services in-person and through telephonic case management services. These care coordinators will collaborate with the client's primary care provider and any existing case managers to develop a Community Care Plan. Focusing on the highest risk patients, the WPC Care Coordination Team will additionally:

   - Remove barriers to facilitate timely connections to needed services, which may include medical care, conservatorship, intensive case management, mental health and substance abuse services;
   - Ensure other providers are alerted to the client's elevated status;
   - Dispatch outreach workers to locate individuals in the streets or pickup wherever they present; and
   - Provide case management services and continuously monitor the client until they are fully engaged in care and no longer need supportive services.

   There are two bundles for care coordination as described below, one of higher intensity and one of lower intensity. The trigger for both Care Coordination PMPM bundles begins by being enrolled into WPC; intensity level would be determined by the patient's care team and established in

their care plan. The acuity of health needs varies during the entire engagement of a client and the intensity can vary depending on the client's present condition. Patients in the **higher intensity care coordination bundle** will be managed by robust case management teams. Patients in this tier have complex medical, behavioral health and housing needs that require long-term intensive and comprehensive case management services. This tier will include any enrollee who is assessed to require enhanced support services to maintain independence in the community, many of whom require housing for medical stability, and their care coordination contains a clinical component.

Patients in the **lower intensity care coordination bundle** also have complex medical needs; however, the drivers for increased inappropriate system utilization are social in nature and therefore will be address by the appropriate social case manager and supporting team members. Many of these patients may start in the higher intensity care coordination bundle, and, over time, as their clinical needs are addressed, move to the lower intensity bundle.

As patients in the higher intensity bundle progress in their care management, we anticipate that their acuity levels will lower over time. Patients in both bundles will be assessed periodically (at minimum every three months) for appropriateness of fit, or when the patient's condition changes in a way that warrants a review. As their need for high intensity services reduce, patients in the higher intensity bundle will be placed into the lower intensity care coordination bundle. Should their acuity levels increase, they can be re-enrolled into the higher intensity bundle. Discontinuation of the PMPM bundle eligibility occur when a person has not received any enhanced care coordination services in the last 60 days or when he/she is dis-enrolled and/or no longer a Medi-Cal beneficiary.

In addition to the above services, for WPC clients who are experiencing homelessness, these additional services are available:

3. <u>Interim Care Program +</u> (FFS, available for those enrolled who are homeless and being discharged from an ED with on-going medical needs)
   The Interim Care Program + (ICP+) provides short-term residential care for individuals who are homeless and who are recovering from an acute illness or injury and whose condition would be exacerbated by living on the streets, in a shelter, or other unsuitable places. ICP+ services will include 24/7 health monitoring (general oversight of medical condition, monitoring of vital signs, wound care, medication monitoring, etc.); assistance with activities of daily living (bathing, dressing, grooming, wheel chair transfers, etc.);

development and monitoring of a comprehensive homeless care support services plan; and coordination with permanent housing providers to support the transition of clients to permanent housing. Recuperative care is an important component of the transition to permanent supportive housing for individuals with complex health and behavioral health conditions who need to recover in a stable environment where they can access medical care and other supportive services.

All clients referred into an ICP+ bed will be linked with a care coordinator to assist with their on-going medical care after stabilization and to refer them to the housing coordination program to help secure permanent housing.

4. Housing Support Services Program (PMPM bundle, available for those enrolled who are homeless or at-risk of homelessness)
   For those clients who are homeless or imminently at risk of homelessness, the care coordinator will complete the Vulnerability Index Service Prioritization Decision Assistance Tool (VI-SPDAT), which is Sacramento's assessment tool for housing placement. The care coordinator will make a referral to the WPC Housing Support Services Program, which will offer an array of housing related supportive services, including:
   - Housing search
   - Landlord relations
   - 24/7 landlord response line
   - Legal support
   - Payment of deposits
   - Purchase of furniture
   - Administration and payment of damage funds
   - Administration of rent subsidies

3.2 Data Sharing

The WPC pilot allows an exceptional opportunity to develop a data sharing platform that will enable care coordination across multiple software platforms. Currently, data tracking beneficiaries care is held in multiple systems including distinct insurance carriers' electronic health records, distinct health care providers' electronic health records, distinct hospital systems' electronic health records, the Sacramento County Homeless Management Information System (HMIS), and many others. Sacramento Covered currently has data sharing agreements with each of the five hospitals in the City of Sacramento to coordinate medical care, and is expanding this system to include measurement of barriers to care. Given that these agreements are already in place, the WPC pilot will support the

expansion and operation of the Sacramento Covered system to include all data points necessary to measure the efficacy of the WPC pilot. While the core of the WPC data system will emphasize health outcomes, the system will be set up to also incorporate data from HMIS, Sacramento Police, Sacramento Fire and 211 to integrate social service outcomes and public safety outcomes of the WPC program.

Participating entities will be incentivized to share data through the use of incentive payments through the WPC Pilot. Each participating entity will opt-in to the data sharing system through the use of agreements that list what specific information is expected to be shared from each interaction with WPC Pilot participants. Providers who do not participate in data sharing will not be eligible for any WPC funds.

The participating entities will comply with all state and federal regulatory controls, and will ensure that individual access to the data sharing system will meet HIPAA requirements for securing pilot participant information and personal health information at all times. The data sharing system will be developed in PY2.

As our pilot demonstrates improved outcomes and generates savings, a return on investment (ROI) assessment will be conducted with partnering plans and providers to develop opportunities for future funding. Data governance will be developed through the IT committees in collaboration with partners. The IT committee will be tasked with assessing data sharing approaches and platforms, choosing one that can be aligned and implemented in the tight timeframe of the pilot. Ideally, this approach will find synergy with the broader health information exchange conversation currently taking place in the county. However, should the committee find that those approaches are not feasible or that the local Health Information Exchange (HIE) conversation timeline does not align with our pilot's timeframe, the committee will work to find reasonable alternatives such as secure messaging or online portals.

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

4.1 Performance Measures

Our proposed model brings together diverse stakeholders in the region and aligns objectives and approaches to create a streamlined system that includes mutually reinforcing and coordinated set of services to achieve our desired outcomes of reducing avoidable utilization and improving the health outcomes of our homeless population. Working together and across silos is key to serving our target population, which has extremely complex health and social service needs.

Vision for Performance Measurement

Sacramento's WPC pilot will demonstrate performance through a series of progress and outcome measures (collectively, performance measures). Progress measures will track implementation progress to ensure that the pilot is on track to developing infrastructure and processes to achieve outcome measures. Outcome measures will demonstrate the extent that the pilot is successful in achieving pilot goals.

Our chosen universal and variant performance metrics will focus on measuring the combined effect of the series of complementary interventions, rather than looking at the outcomes of individual programs separately. We chose this approach to acknowledge that change can come from the interaction of many strategies that are implemented in a synergistic fashion, and may not be attributable to any single intervention alone. Therefore, many of the measures presented below are proposed to be attributable to the total WPC effort and the interventions that will be implemented by all types of participating entities. As such, the recommended metrics are tied to multiple inputs rather than a single linear effort.

Monitoring approach

We propose collecting and analyzing data for all participants who are enrolled in WPC pilot across service partners, looking at the degree to which new services succeed in filling gaps and meeting beneficiary needs across the larger system. Data for these measures will be collected and analyzed in a systematic and timely way to document the impact and outcomes of this pilot, identify issues and areas for improvement, and inform the refinement of pilot processes and intervention utilizing Plan-Do-Study-Act (PDSA) cycles. We are also interested in learning what is needed for the various program components to maximize ROI, produce cost savings that are evidenced in conjunction with improved health-related quality of life for participants and eventually be able to pay for themselves. Reducing unnecessary hospitalizations through care diversion to less intensive services is expected to result in the most significant cost savings since inpatient stays are among the most expensive of interventions. Ultimately, we want to know if we are comprehensively addressing the multi-faceted needs of the target population in a manner that does not overburden the service delivery system, addresses social determinants of health and root causes of illness, and promotes health equity.

We intend to monitor both short-term process and ongoing outcome measures, as well as provide indicators that will inform the development of PDSA cycles. Responsibility for collecting process and outcome data is shared among the lead entity and participating community partners. A data manager and data analyst will be responsible for developing policies and procedures for data sharing and collection. Through the IT and reporting committee, we will adapt existing data

collection tools and protocols for measuring performance over the five-year pilot period with partners in PY2. Each participating entity will collect and report service provision and participant outcome data pertaining to performance metrics and other pertinent indicators (e.g., quantitative and qualitative case and claims data; social determinants of health) to a data manager for this pilot to support care coordination, service delivery, and local monitoring efforts on a quarterly basis at a minimum. Given that the WPC population is expected to change each year as participants come in and out of the system, the overall unit of analysis will remain at the systems level.

4.1.a Universal Metrics

Universal Metric	PY1	PY2	PY3	PY4	PY5	Reporting Entities
U1. Ambulatory Care-Reduce ER Visits (HEDIS)	Establish Baseline	Maintain Baseline	Reduce ER Visits Decrease 5% over Baseline	Reduce ER Visits Decrease 10% over Baseline	Reduce ER Visits Decrease 15% over Baseline	Hospitals
U2. Reduce Inpatient Utilization – General Hospital/Acute Care (HEDIS)	Establish Baseline	Maintain Baseline	Reduce ER Visits Decrease 5% over Baseline	Reduce ER Visits Decrease 10% over Baseline	Reduce ER Visits Decrease 15% over Baseline	Hospitals
U3. Follow Up After Hospitalization for Mental Illness (HEDIS)	Establish Baseline	Maintain Baseline	5% increase from baseline of consumers who have a minimum of four outpatient mental health visits after discharge from hospital	10% increase from baseline of consumers who have a minimum of four outpatient mental health visits after discharge from hospital	15% increase from baseline of consumers who have a minimum of four outpatient mental health visits after discharge from hospital	N/A

Universal Metric	PY1	PY2	PY3	PY4	PY5	Reporting Entities
U4. Initiation & Engagement of Alcohol and Other Drug Dependence Treatment (HEDIS)	Establish Baseline	Maintain Baseline	Of those enrolled, 5% increase from baseline in the number of referrals to treatment	Of those enrolled, 10% increase from baseline in the number of referrals to treatment	Of those enrolled, 15% increase from baseline in the number of referrals to treatment	N/A

Universal Administrative Metric	PY1	PY2	PY3	PY4	PY5	Reporting Entities
U5. Proportion of participating beneficiaries with a comprehensive care plan, accessible by the entire care team	N/A	Establish policies and procedures for care coordination, case management and referral infrastructure.	Monitor, review and revise policies & procedures as needed. Document PDSA utilization.	Monitor, review and revise policies & procedures as needed. Document PDSA utilization.	Monitor, review and revise policies & procedures as needed. Document PDSA utilization.	All partners engaging in service delivery

Universal Administrative Metric	PY1	PY2	PY3	PY4	PY5	Reporting Entities
U6. Care Coordination, case management, and referral infrastructure	N/A	Establish care coordination, case management and referral policies & procedures Submit and receive approval for policies & procedures from State	50% of partners in compliance with policies & procedures. For those not in compliance, use PDSA, continue to evaluate and determine if any modifications are needed.	60% of partners in compliance with policies & procedures. For those not in compliance, use PDSA, continue to evaluate and determine if any modifications are needed.	70% of partners in compliance with policies & procedures. For those not in compliance, use PDSA, continue to evaluate and determine if any modifications are needed.	All partners engaging in service delivery
U7. Data and information sharing infrastructure	N/A	Establish policies and procedures for data information and sharing infrastructure. Document PDSA utilization.	Monitor, review and revise policies & procedures as needed. Document PDSA utilization.	Monitor, review and revise policies & procedures as needed. Document PDSA utilization.	Monitor, review and revise policies & procedures as needed. Document PDSA utilization.	All partners engaging in service delivery

4.1.b Variant Metrics

Variant metrics were chosen for their impact on care coordination throughout the region, and to help measure the increased health outcomes of WPC Pilot participants. Variant Metric 1 was chosen to ensure ongoing engagement of partners and stakeholders. Variant Metric 2 tracks reduction in avoidable admissions, demonstrating that we are finding our target population and providing appropriate supports to ensure they are healthy in the community and not needing to seek care in EDs. Variant Metrics 3 and 4 demonstrate appropriate uptake in housing supports and allow us to measure the pilot's ability to house and stabilize our target population. Variant Metric 5 allows us to track beneficiary satisfaction with the services received through the pilot and self-reported health status.

List the Numerator and denominator specifically as stated in Attachment MM.

Variant Metric	Numerator	Denominator	PY1	PY2	PY3	PY4	PY5	Reporting Entity
V1: Administrative Metric *Engagement Measure*	# of meetings held that is documented	Total # of meetings held	Establish meeting frequency	50% of meetings documented (attendance and minutes)	60% of meetings documented (attendance and minutes)	70% of meetings documented (attendance and minutes)	80% of meetings documented (attendance and minutes)	Pilot Project Management Team
V2: Health Outcomes: 30 Day All Cause Readmission	Count of 30-day Readmission	Count of Index Hospital Stay (HIS)	Establish Baseline	Maintain Baseline	Decrease 5% over Baseline	Decrease 10% over Baseline	Decrease 15% over Baseline	Hospitals

Variant Metric	Numerator	Denominator	PY1	PY2	PY3	PY4	PY5	Reporting Entity
V3: Housing: Permanent Housing	# of participants who were homeless at entry and referred to housing supports who were housed in permanent housing within three months of enrollment	# of participants who were homeless at entry and referred to housing supports	Establish Baseline	Maintain Baseline	Increase 5% over Baseline	Increase 10% over Baseline	Increase 15% over Baseline	Sacramento Steps Forward

Variant Metric	Numerator	Denominator	PY1	PY2	PY3	PY4	PY5	Reporting Entity
V4: Housing: Housing Services	# of participants referred to housing services that receive services	# of participants referred to housing services	Establish Baseline	Maintain Baseline	Increase 5% over Baseline	Increase 10% over Baseline	Increase 15% over Baseline	All partners engaging in service delivery
V5: Overall Beneficiary Health	Total score of the Likert scale response of WPC participants who responded to a health status survey during the reporting period	Total number of WPC participants who responded to a health status survey during the reporting period	Establish Baseline	Maintain Baseline	Increase 5% over Baseline	Increase 10% over Baseline	Increase 15% over Baseline	All partners engaging in service delivery

As most of our healthcare partners have never worked with the City on a health initiative before, we will work closely with our partners to develop an appropriate process for tracking and documenting progress. The pilot will also employ a data manager and a data analyst to collect and regularly report on pilot progress. They will be responsible for developing appropriate reports and dashboards to support partners during the pilot to ensure goals are met.

4.2 Data Analysis, Reporting and Quality Improvement

The WPC Pilot participating entities will work in close collaboration during the minimum monthly meetings to review thoroughly the activities, data sharing, reporting, and outcomes. Additional assessments and reports, such as ROI analysis, will be conducted by data personnel and consultants to inform the work and provide key information for pilot improvement processes. Reviewing the ROI will be paramount to establishing successes and identifying challenges throughout the pilot years. The PDSA cycle will be used as a predictive and universal improvement tool for all the participating entities.

Modifications and change will respond to lessons learned in the PDSA cycles, and all modifications will be validated using the same PDSA cycle as well.

The pilot will develop a centralized project management office which will develop and document a data collection, reporting, and analysis procedures. To the extent possible, analysis of ROI will be analyzed using claims and other data in partnership with plan and hospital partners. Data will be collected through the following sources:

Type of Entity	Data Source
Health Care Providers	Admissions and in-patient utilizations Clinical data as appropriate for care coordination and case management
Health Plans	Beneficiary data, claims data
Housing Partners	Housing services and housing placements
Community Partners	Outreach & enrollment data

In PY2 and potentially PY3, data will be collected through standardized reporting templates developed by the data manager and informed by partner feedback. The reporting templates will be designed to collect data aligned with metrics identified above and any additional data needed for managing

the pilot. Dashboards will be produced and analyzed to monitor performance, assess gaps and evaluate impact on outcomes.

During PY2, opportunities will be assessed to procure a data system to support collection of relevant data across services, interventions and existing data systems. This may include purchasing licenses for a software solution that can be implemented across agencies or adaptation of an existing data system.

Project managers and data manager will convene a utilization review team to review and inform data analysis and ongoing monitoring of performance. This committee will review data across provider entities, inform pilot activities and address areas for improvement.

4.3 Participant Entity Monitoring

City of Sacramento, as lead entity, will coordinate with the WPC Pilot program manager and other participating entities to ensure the pilot is running smoothly. The minimum monthly meetings will ensure the Pilot participants are being tracked and coordinated, the appropriate data is being shared and used appropriately, and the outcomes are being measured. The lead entity and program manager will work in concert to address challenges, should they arise, around technical assistance and/or corrective actions uncovered in the PDSA improvement cycles.

Participating entities will be established through a contractual agreement that will include the role of the entity in the pilot, services they are expected to provide (if applicable), data reporting requirements and frequency, and requirements for receiving funding through the pilot. Through our governance structure and through quality improvement (QI) staff, we will meet regularly with each partner to review performance.

Should issues be identified, we will meet privately with the partner entity to understand the issue, develop solutions, and implement a corrective action plan. Any unresolved issues will be elevated through QI to the Leadership Committee for discussion and resolution.

As mentioned above, a data manager and data analyst will support monitoring activity at the partner level, including analyzing data and comparing performance among providers of the same service. This data will be used to understand if there are any issues with a particular intervention or provider.

Providers identified as low performing will be provided with technical support by project managers to make necessary corrections. Our goal is to

collaborate with the provider to ensure that course corrections are made in a timely manner. However, if the provider is unable to demonstrate improved performance, additional action may be taken to support the provider, such as Corrective Action Notice requiring response specified timeframes, increased monitoring, and contract terminations should issues remain unresolved or underperformance jeopardizes the pilot.

Section 5: Financing

5.1 Financing Structure

Local funds for the pilot come from the City of Sacramento as well as local community benefit dollars and donations. Agreements will be established between the city and funding partners to transfer funds to the city. The City will transfer funds to the state through the intergovernmental transfer (IGT) process and receive matched funds, as illustrated in Section 5.2.

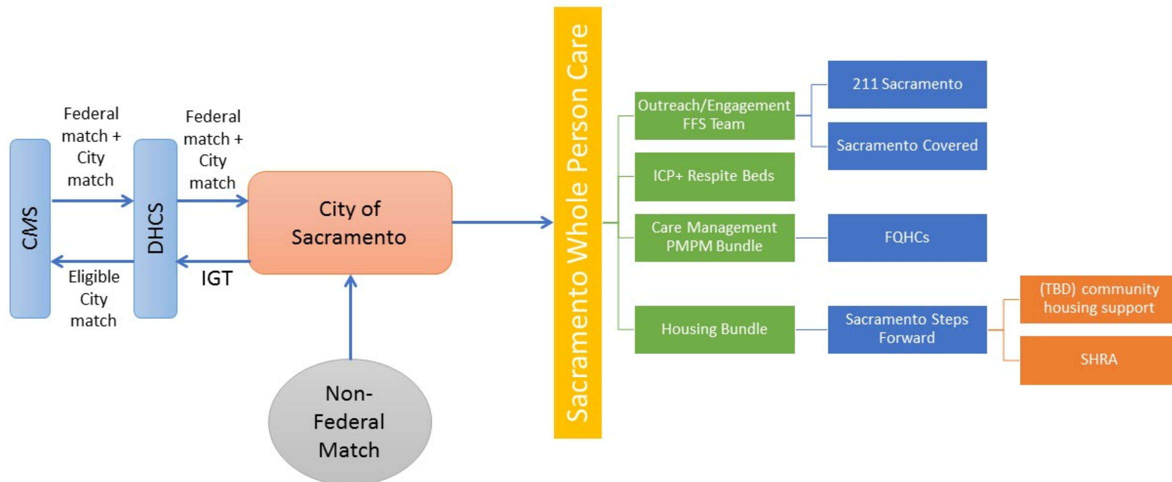
The City will procure contractors for program management, infrastructure, and service delivery. All payments made through the pilot will be defined through contracts with appropriate entities. Payments will be made in the form of:

1. Administrative and infrastructure payment based on contracted cost.
2. FFS payments
3. PMPM bundled payments
4. Incentive for participation and for supporting data reporting

Payments will be made on a monthly, quarterly or biannual basis as appropriate, based on invoices and reported deliverables. Contracts will include specific provisions detailing how funds will be distributed, including appropriate triggers. The City's accounting system will track payments on an ongoing basis. The pilot's Executive Committee will provide oversight of intake and payment of funds, and contractual agreements made.

Our pilot uses a mix of FFS payments and PMPM bundles approaches, which require health care provider participants to explore provision of services through alternative payment arrangements. An important component of project management and oversight will be supporting case management teams to track and measure efficacy and cost effectiveness of various services and approaches, and the impact of these services to reducing health care cost.

5.2 Funding Diagram



5.3 Non-federal Share

The City of Sacramento, as the lead entity, will be providing the entire non-federal share necessary to match the federal funding. The City will be using City General Funds and community benefit funding from the four health systems as the non-federal share. Community benefit funding is non-federal, local philanthropic dollars administered by the health systems to invest in community-based initiatives and projects.

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

Pursuant to STC 113, all WPC Pilot interventions will not duplicate services otherwise covered or directly reimbursed by traditional Medi-Cal payment systems. Potentially eligible individuals for the pilot will be screened for Medi-Cal eligibility to ensure Pilot participants are verified Medi-Cal beneficiaries. Those who are enrolled into the pilot will be provided case management services that will continue to track Medi-Cal eligibility. Sacramento's WPC proposal includes robust outreach and engagement services that all begin with an initial eligibility assessment, which will refer beneficiaries into WPC services and will assist non-beneficiaries using other means. The primary interventions in the WPC pilot – Outreach, Care Coordination, and Housing Navigation – are services not otherwise covered

or directly reimbursed by Medi-Cal, and the administrative infrastructure and delivery systems are being newly created to serve the beneficiary target population and support the pilots. Housing stabilization will be a core component of care coordination, but will be specific to non-medical care like assistance in working with landlord, connection to money management of other income supports, and organization of resources.

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

Based on initial comparisons, a majority of participants in homeless services in Sacramento self-identify as Medi-Cal beneficiaries or as eligible for Medi-Cal. However, those who are apparently within the target population who are not beneficiaries will be assisted by other community partners to establish eligibility or other assistance.

Protocols will be developed to ensure that WPC pilot funds will not duplicate services currently paid for by Medi-Cal. As new initiatives, such as Health Homes Program, come on board in the County, these protocols will be regularly updated to ensure non-duplication of payments and allowable use of federal financial participation.

Although Sacramento is a Targeted Case Management (TCM) county, the pilot's population and care coordination services will not be eligible for TCM. The enhanced care coordination approach in this pilot departs significantly from the encounter-based structure of TCM, and in the vast majority of cases the encounters between intervention and patients/clients/members would not be eligible for reimbursement under TCM, as the workers either would not meet the education/experience requirements for TCM case workers or the team members would be in a supervisory role and would have few, if any, direct contact with clients. Also, the scope of care support and coordination activities available through WPC is intended to be more robust than available through Medi-Cal TCM. WPC teams will engage in activities such as relationship building, peer support, motivational supports,

disease specific education, wellness education, and general reinforcement of health concepts, which are distinct from and outside the TCM benefit. They will also provide direct social and other services that would not be recognized as TCM, such as tenancy support. For these reasons, we conclude that the vast majority of WPC Pilot activities will not duplicate services available through Medi-Cal TCM.

However, in response to concerns of payment duplication, we have applied a TCM budget adjustment to the two service bundles for care coordination. The TCM budget adjustment can be found in the corresponding service description. As indicated in Section 2.3, to ensure no service duplication, the list will also be shared with the County's TCM coordinator and with the MCPs to coordinate and prevent the outside possibility of enrolling beneficiaries who may be receiving TCM.

5.5 Funding Request

Sacramento's WPC pilot budget consists of an administrative and delivery infrastructure, incentive payments, Per Member per Month (PMPM) bundle, Fee-For-Service (FFS), and Pay for Reporting and Pay for Outcomes. Funds shall be used to establish and operate the program, and incentivize participation and performance for WPC partners.

The structure of the program is to have WPC staff equipped to engage high-utilizing Medi-Cal beneficiaries, including those who are experiencing homelessness and coordinate their needs with multiple health and social providers, and maintain ongoing collaboration with the participant to ensure improved outcomes. The Sacramento WPC aims to serve people who otherwise have difficulty accessing and maintaining services, improving both the health and self-sufficiency of the individual and family, while reducing the impact of these beneficiaries on the health and human service systems of care. With intensive services targeted towards those most vulnerable, the WPC pilot expects participants to achieve a satisfactory level of self-reliance for health and social needs prior to successful program discharge.

Administrative Infrastructure

The items covered in this portion of the budget consist of administrative governance, positions required to run everyday activities of the pilot. The City will retain responsibility for overall fiscal and program management, but will use a team of consultants and subject matter experts to manage the day to day operations of the program. In that the City does not currently operate health programs in the community, use of consultants will allow for quick implementation without the necessity to create in-house capacity.

To ensure that the project management team is accessible to the local providers and vice-versa, the administrative infrastructure includes provisions for office space to house all team members, and include training and meeting locations. The Senior Program Analyst will report directly to the City's Program Director, and will be full time position in PY2, ramping down to part time once the program is fully operational. The Senior Program Analyst will be the lead in communication with community partners and ensuring that program design and policies adhere to the overall project design and City goals. The Senior Program Analyst will work in close coordination with the Senior Program Manager who will be responsible for all day-to-day aspects of WPC. The Senior Program Manager's duties include:

- Leads development of program policies and procedures
- Evaluates and monitors services and programs
- Formulates administrative controls and quality assurance procedures
- Develops community communication plan

There are also two analysts – a Program Analyst and a Quality Control Analyst - to support the Senior Program Manager. The Program Analyst will be primarily responsible for overseeing provider contracts, program deadlines and milestones, preparing communication to the providers and community and ensuring operational fidelity to program policies. The Quality Control Analyst will be responsible for regular tracking of outcome metrics and PDSA and reporting back to the Senior Program Manager on any data quality or data reporting/analysis issues. The program team will be supported by a data manager and data analyst, who will have responsibility to collect and analyze program data on an on-going basis, and provide technical assistance to providers to ensure that all outcomes are met. The data manager and data analyst will also support development of appropriate data sharing infrastructure in collaboration with provider partners. Finally, the team will include one financial analyst responsible for tracking expenditures in the program, payments for reporting and outcomes and tracking IGT payments. These include consultants to support clinical process redesign, IT, ROI assessment, etc. Staffing estimates (except for consultants) include overhead and benefits (30%). PY2 assumes higher level of staffing as significant work is needed to establish the program, hire project management staff, bring partners together to develop a comprehensive approach, etc.

Staff Roles & Responsibilities

Description	Role
Program Director	Overall project oversight; reports directly to Steering Committee
Senior Program Analyst	Support the Program Director; responsible for communication to all community partners
Administrative Assistant	Schedule all subcommittee meetings, including preparation of materials, minutes & follow up
Sr. Program Manager	Day to day operational oversight for WPC pilot
Program Analyst	Support to the Program Manager; monitor contract performance, operations and project timeline
Quality Control Analyst	Support Program Manager, responsible for quality review and improvement activities, including PDSA
Data Manager	Oversee collection, analysis and reporting of data on all metrics
Data Analyst	Support Data Manager
Clinical Subject Matter Expert	Support clinical program design and implementation

In addition, the Administrative Infrastructure budget includes IT for program staff (one time cost) – including $1500 per staff for 10 staff to provide laptops, related software, peripherals, etc. It also includes funding for office space for program staff (roughly 10 people) which would require roughly 2500 sq. ft. and related office setup of $50,000 for furniture, printer, conference equipment, etc. (estimates established in consultation with local realtor). We also include funds for meetings that would cover space rental, AV, etc. as we anticipate needing to meet in neutral locations that accommodate for appropriate breakouts. The cost breakdown for these services is detailed below.

Item	Year 2	Year 3	Year 4	Year 5
Program Director	$83,838	$41,919	$41,919	$41,919
Program Sr. Analyst	$60,000	$30,000	$30,000	$30,000
Administrative Assistant	$35,000	$17,500	-	-
Financial Analyst	$ 62,500	$62,500	$31,250	$31,250
Sr. Program Manager	$90,000	$180,000	$180,000	$180,000
Program Analyst	$55,000	$110,000	$110,000	$110,000
Quality Control Analyst	$55,000	$110,000	$110,000	$110,000
Data Manager	$75,000	$150,000	$150,000	$150,000

Item	Year 2	Year 3	Year 4	Year 5
Data Analyst	$62,500	$125,000	$125,000	$125,000
Clinical Subject Matter Expert	$135,000	$135,000	$135,000	$135,000
Meeting Costs (Space, AV, etc.)	$30,000	$60,000	$20,000	$20,000
IT for Program Staff	$15,000	-	-	-
Office Setup (furniture, printer, etc.)	$50,000	-	-	-
Office Space Rental	$60,000	$120,000	$120,000	$120,000
Indirect Costs (5%)	$43,442	$57,096	$52,659	$52,659

Delivery Infrastructure

Items included in this portion of the budget consist of those infrastructure items necessary to deliver the actual outcomes expected in this pilot. The care coordination/case management software includes developing and/or purchasing a project management system during program year two, along with a data aggregation system for sharing of actionable data to establish engagement plans, bi-directional sharing of information, and planning tools. The system built or purchased for year two will consist of a project management tool for WPC team members to input participants, baseline data, and track interactions/interventions, supporting care coordination and bi-directional data sharing across the pilot. The delivery infrastructure also includes the costs of a community resource database, to ensure a community-wide open resource is available to connect beneficiaries to the services they need to stay healthy in the community. We envision this database will be used across the delivery system and by all pilot participants. The estimate for this IT purchase assumes startup, licensing and maintenance for a cloud-based system. These estimates were derived in consultation with health information technology (HIT) experts and sized based on experiences of similar communities.

This budget also includes funds for services related to operationalizing the pilot, including specific expertise needed to ensure program integrity. This includes legal support (negotiating contracts, document prep, risk management, etc.), financial support (setting up billing cycles, support for IGT and other financial transactions, etc.), as well as subject matter experts on HIT, data sharing, HIE, population health management, social/behavioral health experts, and other operational and clinical experts. As the program evolves, the type of subject matter experts needed to support the project will evolve as well. Initially, these subject matter experts will be critical to

facilitating and resolving issues that have created barriers to HIE in Sacramento, supporting the implementation of care coordination/case management software with partners, and providing expertise and guidance on best practices and approaches to support the City's implementation. Towards the end of the pilot, we will need technical support for ROI assessments. They will be available as needed throughout the project where their expertise will facilitate the pilot to reach its goals under tight timeframes.

In addition to the software, the PY2 delivery infrastructure includes the purchase of 16 new hospital beds for the ICP+ program. The ICP+ serves members exiting EDs with acute medical needs, and hospital beds are needed to ensure their ability to be discharged from the hospital and receive the necessary care.

Item	Description	PY2 Costs
Care Coordination/Case Management Software	Bi-directional software, allowing input, reporting and analysis of all WPC data	$1,000,000
Community Resource Database	Allows access for WPC partners to input client level data into the Care Coordination/Case Management software	$50,000
Legal support services	Contract support for WPC pilot, including negotiating contracts, documentation prep, etc.). Reports to Program Director and Deputy City Attorney.	$115,000
Financial support services	Financial management support for WPC pilot, including IGT support, funds flow, fiscal management & budgeting. Reports to Program Director and the City's appointed financial manager.	$75,000
Consulting Subject Matter Experts	Subject matter experts supporting the City to address key issues such as HIE, population health, ROI assessments, etc.	$200,000
Hospital Beds	Beds for the ICP+ Respite Center	$20,000

Incentive Payments

The City of Sacramento is in a unique position compared to other WPC pilots in California as cities have limited engagement with health care providers and plans due to the role of city vs. county. This WPC pilot is an unprecedented opportunity for a city to develop a comprehensive approach to integrate health and housing, but will require new modes of engagement by all participants.

Therefore, we are using these incentive payments to encourage timely action by participating entities to: 1) engage with the city as a new health care partner, 2) support the City in implementation of this pilot, 3) develop and deploy standardized tools for screening for health and housing, with a focus on social determinants, 4) engage in a comprehensive regional strategy for treating and supporting our target population, 5) share data necessary to achieve desired outcomes, and 6) support reporting. Incentive payments will be used to support partners in the implementation of this pilot and encourage actions critical to achieving the goals of the pilot. Funds will be distributed based on level of engagement and participation defined in contractual agreements between the City and partners, and paid out at the end of the PY.

Maximum incentive payments can be made to partners as follows:

Organization Type	Max Allocation Per Program Year	Max Allocation per Partner
Hospitals (4 entities)	$400,000	Up to $100,000
Managed Care Plans (6 entities)	$600,000	Up to $100,000
Other Community-Based Organizations (PY2: 5 entities & PY3-5: 4 entities): • **Government Agencies** • **Clinics** • **Other non-profits orgs**	PY2: $1,250,000 PY3: $1,000,000 PY4: $ 620,000 PY5: $ 620,000	PY2: Up to $250,000 PY3: Up to $250,000 PY4: Up to $155,000 PY5: Up to $155,000

The amounts listed on the table above are maximums to be requested, per PY, based upon the entity's performance, as well as the maximum allocation across all partners in that category. The maximum allocation per partner is earned by meeting incentives listed in the table below, which specifies a number of incentives by type, the corresponding thresholds that the entity

must meet, and the specific amount earned by meeting that threshold. Individual unique thresholds and their corresponding dollar allocation by year are numerated. To earn the total amount available to them, the partner must meet all of the incentives and thresholds listed.

For example, across all hospitals in our region, $400,000 is the maximum allocation per PY that can be distributed by the pilot. A partnering hospital system can earn a maximum incentive payment allocation of $100,000 per PY. To earn the $100,000 in PY3, the hospital will need to meet individual incentives identified in the table below and on subsequent pages. In this example, using WPC Governance Participation as the incentive, the hospital would need to participate in Steering Committee meetings and would earn $5,000 for attending 50% of the meetings and another $5,000 for hitting the 75% meeting attendance threshold, achieving $10,000 out of the total $100,000 available. The hospital would go on to meet other incentives listed to reach their total $100,000 available incentive payment.

In recognition of the fact that there are market and financial incentives for hospital and plan outside of what is provided by WPC, and many of our community-based partners are government entities or non-profit, mission driven organizations with scarce resources, we included slightly higher amounts for other community-based partners, compared to hospitals and plans, per incentive. Our community-based partners in the Other Community-Based Organization category include government agencies and departments, clinics and other non-profit community-based organizations who are key partners critical to the success of this project. Partners earn incentives through the following ways identified in the table below:

Available Incentive	Incentive Detail	Maximum Amount Per PY Hospital	Maximum Amount Per PY Managed Care Plan	Maximum Amount Per PY Other Community-Based Partner
WPC Governance Participation	**All PYs:** Participate in WPC Steering Committee meetings (all PYs): 1. 50% attendance of meetings 2. 75% attendance of meetings	$10,000 per entity, as follows: 1. $5,000 2. $5,000	$10,000 per entity, as follows: 1. $5,000 2. $5,000	$10,000 per entity, as follows: 1. $5,000 2. $5,000

Available Incentive	Incentive Detail	Maximum Amount Per PY Hospital	Maximum Amount Per PY Managed Care Plan	Maximum Amount Per PY Other Community-Based Partner
Universal Screening Tool Development & Adoption	**PY2:** Engage in development & adoption of screening tool 1. 75% attendance of Committee meeting 2. Executive Committee adoption of tool **PY3-5:** Use Screening Tool 3. 50% beneficiaries screened annually 4. 75% beneficiaries screened annually	$10,000 per entity as follows: 1. $5,000 2. $5,000 3. $5,000 4. $5,000	$10,000 per entity, as follows: 1. $5,000 2. $5,000 3. N/A 4. N/A	$30,000/entity (PY2), $25,000/entity (PY3), $10,000/entity (PY4-5) as follows: 1. $10,000 (PY2) 2. $20,000 (PY2) 3. $12,500 (PY3), $5,000 (PY4-5) 4. $12,500 (PY3), $5,000 (PY4-5)

Available Incentive	Incentive Detail	Maximum Amount Per PY Hospital	Maximum Amount Per PY Managed Care Plan	Maximum Amount Per PY Other Community-Based Partner
Universal Consent Form Development & Adoption	**PY2:** Engage in development & adoption of consent form 1. 75% attendance of Committee meeting 2. Executive Committee adoption of form **PY3-5:** Use of Consent Form 3. 50% beneficiaries consented annually 4. 75% beneficiaries consented annually	$10,000 per entity, as follows: 1. $5,000 2. $5,000 3. $5,000 4. $5,000	$10,000 per entity, as follows: 1. $5,000 2. $5,000 3. N/A 4. N/A	$30,000/entity (PY2), $25,000/entity (PY3), $10,000/entity (PY4-5) as follows: 1. $10,000 (PY2) 2. $20,000 (PY2) 3. $12,500 (PY3), $5,000 (PY4-5) 4. $12,500 (PY3), $5,000 (PY4-5)

Available Incentive	Incentive Detail	Maximum Amount Per PY Hospital	Maximum Amount Per PY Managed Care Plan	Maximum Amount Per PY Other Community-Based Partner
WPC Clinical Protocols, Policies & Procedures	**PY2:** Engage in development of clinical protocols, policies & procedures 1. 75% attendance of Committee meeting 2. Executive Committee adoption of protocols, policies & procedures **PY3-5:** Integrate & deploy new protocols, policies & procedures 3. 50% beneficiaries screened annually 4. 75% beneficiaries screened annually	$10,000 per entity, as follows: 1. $5,000 2. $5,000 3. $5,000 4. $5,000	$10,000 per entity, as follows: 1. $5,000 2. $5,000 3. $5,000 4. $5,000	$30,000/entity (PY2-3), $10,000/entity (PY4-5) as follows: 1. $10,000 2. $20,000 3. $15,000 (PY3), $5,000 (PY4-5) 4. $15,000 (PY3), $5,000 (PY4-5)
Active Involvement in Barrier Identification & Resolution	**PY3-5 Only:** Support the early identification and resolution to all identified barriers to program implementation. 1. 25% participation 2. 50% participation 3. 75% participation 4. 90% participation	N/A	$20,000 per entity , as follows: 1. N/A 2. $10,000 3. $10,000 4. N/A	$40,000/entity (PY3), $20,000/entity (PY4-5) as follows: 1. $10,000 (PY3) 2. $10,000 (PY3-5) 3. $10,000 (PY3-5) 4. $10,000 (PY3)

Available Incentive	Incentive Detail	Maximum Amount Per PY Hospital	Maximum Amount Per PY Managed Care Plan	Maximum Amount Per PY Other Community-Based Partner
Referral Support – Target List Development	**All PYs:** Support target list development 1. Participate in at least 75% of target list workgroup meetings 2. Provide referrals to pilot (minimum 5 per month)	$25,000 per entity, as follows: 1. $10,000 2. $15,000	$25,000 per entity, as follows: 1. $10,000 2. $15,000	$80,000/entity (PY2), $50,000/entity (PY3) $25,000/entity (PY4-5) as follows: 1. $10,000 (all PYs) 2. $70,000 (PY2), $40,000 (PY3) $15,000 (PY4-5)

Available Incentive	Incentive Detail	Maximum Amount Per PY Hospital	Maximum Amount Per PY Managed Care Plan	Maximum Amount Per PY Other Community-Based Partner
Data Sharing (Planning & Adoption)	**PY2:** Support pilot to develop data sharing framework & approach 1. 75% attendance of Committee meeting 2. Support design, as evidenced by committee recommendations report to Executive Committee for adoption (partners to be identified in the report) 3. Executive Committee adoption of data sharing solution **PY3-5:** Adopt & use data sharing framework, including supporting timely submission and data integrity 4. Reach 50% of annual goal 5. Reach 75% of annual goal Annual Goals: 50% of WPC pilot patients have data shared in PY3, 60% in PY4, and 75% in PY5	$35,000 per entity, as follows: 1. $10,000 2. $12,500 3. $12,500 4. $17,500 5. $17,500	$35,000 per entity, as follows: 1. $10,000 2. $12,500 3. $12,500 4. $17,500 5. $17,500	$70,000 per entity, as follows: 1. $10,000 2. $30,000 3. $30,000 4. $35,000 5. $35,000

We also structured two incentives at higher amounts to spur quick action by partners to come to agreement on and support a data sharing approach, as well as support the pilot's ability to identify and resolve issues. Specifically:

- **Data Sharing:** Sacramento currently has several nascent and potentially competing health information exchange conversations. Our incentives for data sharing are intended to spur quick resolution and agreement on approach in PY2, and adoption/utilization for subsequent years. Accurate and timely care coordination data submission is extremely critical to WPC program success. Without accurate and timely data, WPC programs will not be able to provide accurate reporting establishing the benefit of the WPC approach. Tracking of data elements and their associated integrity will be extremely labor intensive. Each partner entity is expected to provide data for all enrolled WPC beneficiaries for whom they have data. Employees from all participating entities will work together with the WPC team to verify shared information and coordinate those items needed to provide the best outcome for the participants. For PY3, after the data sharing platform is deployed, each participating organization is expected to maintain data integrity for WPC beneficiary encounters. For each beneficiary encounter, each participating organization should enter beneficiary encounter data in the care coordination software within 30 days of encounter. Payment requests/issuance for participating organizations that do not enter encounter data for each WPC beneficiary will not be made.

- **Active involvement in barrier identification and resolution:** Critical to the success of the WPC program is the early identification and resolution to all identified barriers to services. To ensure reporting, we fund incentive payments to our partners for the active involvement in barrier identification, reporting, and resolution of program barriers. WPC is new in our region and we anticipate the need to adjust our approach over time. Failure to address barriers to services will critically hamper the program's ability to fill WPC beneficiary needs, as well as create negative experiences associated with the program. Identification of these barriers is also critical to the PDSA process. During the WPC Pilot Program it is expected that each participating organization identify, capture, and propose solutions to encountered barriers. This will allow for process improvement of the WPC program through the PDSA process. Participation includes capturing and reporting of identified barriers, developing associated solutions, and engaging with other partners at WPC

Committee meetings. The WPC Committee will capture participating organization attendance, identified barriers and their associated solutions, in the meeting minutes. These meeting minutes will be reviewed and discussed at each WPC Committee meeting. Each meeting agenda will include a PDSA line item for barrier process improvement. The Committee will review each barrier report; plan strategies for addressing identified barriers; implement corrective actions to address each barrier; monitor the applied corrective actions for efficacy; and adjust each corrective action according to the observed results. Performance for this incentive will be measured based on attendance to WPC meetings as documented in meeting minutes. Those unable to attend committee meetings who receive prior approval from the Pilot Director and who submit notes and suggestions prior to meeting will be counted as successfully fulfilling this metric.

Fee-For-Service Services

The Sacramento WPC pilot includes two FFS components: one for ICP+ Respite beds and one for Outreach and Referral.

ICP+ FFS: The ICP+ Program provides post-acute respite care, utilizing Registered Nurses and Licensed Vocational Nurses to provide monitoring, medication management, and oversight during homeless Medi-Cal beneficiaries' recuperation. This program operates a short-term sixty to ninety (60-90) day lay-in respite 24-hour shelter-based servicing clients who are currently experiencing homelessness post hospitalization and have no home to which they can be discharged. Beneficiaries have access to food, shelter and a clean environment. ICP+ also provides certified nursing assistants to help beneficiaries with activities of daily living such as bathing, ambulating and toileting that would not otherwise be covered or reimbursed by Medi-Cal. Nurses are available to monitor and help guide clients with medication refills, wound monitoring, and navigating the healthcare system. The ICP+ also has an extension program to avoid future and chronic hospital readmissions for the same disease state.

Budget Item	Annual Unit Cost	# FTEs	Total
Registered nurse supervisor	89,440	1	89,440
Case Manager	33,280	5	166,400
Administrative Coordinator	114,400	1	114,400

Budget Item	Annual Unit Cost	# FTEs	Total
Certified Nursing Assistants	33,280	8	266,240
Licensed Vocational Nurses	52,000	5	260,000
Support Staff	31,200	2	62,400
Personnel Subtotal:			958,880
Benefits (30%)			287,664
Personnel TOTAL:			**1,246,544**
Laptops	1,500	22	33,000
Other Operating Costs, Materials, Equipment & Supplies	150,000	1	150,000
NON-PERSONNEL TOTAL:			**183,000**
Operating Cost for ICP+:			1,429,544
Overhead 5%:			71,477
TOTAL BUDGET:			**1,501,021**
Total # of Bed Nights/Year:			5840
FFS Rate:			257

Bed day costs would include bed rent services (space, cafeteria services, laundry services, etc.), and Nursing staff oversight (please see chart below for more information). Beneficiaries temporarily sheltered at the ICP+ will participate in intensive case management during their 60-90 day stay. The ICP+ case managers utilize multiple leased vehicles available for aid in transporting beneficiaries to necessary social support appointments. Additional operating costs, materials, equipment and supplies include office and ICP+ supplies ($18,000, which include bedding, medical supplies, etc.), equipment maintenance ($5,000), laundry ($12,000), staff training/development ($25,000), insurance ($20,000), and food/food preparation ($70,000). The dollars allocated in the WPC pilot budget will fund an average of 16 new ICP+ beds, not the existing beds in the community.

Outreach FFS: The Outreach and Referral FFS will be charged when a patient engages in dialogue in a pre-enrollment period, as evidenced by a navigator connecting with the potential candidate by phone or in-person. The reality of many people living with complex medical conditions is that navigating the complex, layered, and often demanding healthcare system is a serious

impediment to care. While they experience functional impairment, they may not always meet medical necessity for the full scope of disability and supportive services that are needed to prevent further decline. It is also not uncommon for beneficiaries living with complex medical conditions to have multiple treatment providers and specialists, further complicating the demand on the beneficiary to navigate multiple systems with little-to-no success. The navigator will serve to educate individuals about the availability of health and social services programs, referring non-WPC eligible clients to those programs, and identify and refer WPC eligible clients in need of more intensive services offered by the WPC care management and housing bundles to the pilot.

The budget for FFS for outreach and referral recognizes the higher level of training and multiple touches needed as our target population is amongst those who are hardest to reach. Contracted costs to the providers listed below include outreach, enrollment, referral services, materials and supplies. This does not include payments for any care coordination services. Additional detail is provided below on our FFS calculation:

Budget Item	Annual Unit Cost	# FTEs/Units	Total
Salvation Army	511,000	1	511,000
Volunteers of America	355,000	1	355,000
211 Sacramento	140,000	1	140,000
Sacramento Covered	120,000	1	120,000
TOTAL BUDGET:			**1,126,000**
Total # of Estimated Attempts Needed to Reach 2000 Individuals:			5,000
FFS Rate:			225

The Volunteers of America (VOA)'s A Street Men's Shelter and Salvation Army Center of Hope Shelter are the two primary emergency shelters for single adults in Sacramento County. VOA has 80 beds for men and Salvation Army has 132 beds for men and women. Both shelters operate 24/7 and turnover beds, on average, every 60 days. Amounts for VOA above include staffing (1 FTE Program Supervisor, 4 FTE Coordinators, and 8 FTE Shift Monitors), benefits at 32%, and staff training. Amounts for Salvation Army above include staffing (1 FTE Program Supervisor, 6 FTE Coordinators, and

13 FTE Shift Monitors), benefits at 30%, and staff training. The higher rates for Salvation Army and Volunteers of America reflect higher volumes, 24/7 coverage, and shelter staffing patterns. WPC outreach staffing at each shelter will be responsible for assessment for WPC eligibility, data collection and reporting, and referral/connection to WPC care coordinators for eligible clients. Outreach shelter staff is also responsible for communicating with other WPC outreach personnel at clinics, hospitals and with mobile teams on the availability of shelter beds. We estimate roughly 1,500 referrals from the two shelters.

211 Sacramento is a free confidential information and referral service that is available 24 hours a day, seven days a week. Assistance is provided in multiple languages, and services are accessible to people with disabilities. Trained information and referral specialists can refer callers to a variety of services that best meets their need, and are supported by remote home-based agents. 211 Sacramento currently receives over 42,000 calls annually from Medi-Cal patients and over 50,000 calls annually from people seeking housing assistance. It is anticipated that less than 5% of those who call seeking housing assistance (~ 2,000) will be screened and referred to WPC. The amount above reflects staffing (2 FTE information & referral specialists, and 1 FTE remote home-based part time agents), benefits at 32%, training and phone/internet costs.

Sacramento Covered is a non-profit that coordinates broad-based collaborative public private partnerships focused on health insurance outreach, enrollment, retention, and utilization (OERU), enrolling over 75,000 children and adults in the Sacramento region into comprehensive health coverage programs since 1998. They have established a strong outreach network that has focuses on: (1) conduct targeted outreach to identify, educate and enroll eligible individuals and households in health coverage, and (2) assist individuals and families to navigate complex health systems and utilize care in appropriate settings. As part of this second focus, Sacramento Covered has outreach and enrollment navigators providing enrollment and referral supports in local EDs, currently serves 9,600 Medicaid individuals annually, of which we estimate 1,500 are potentially eligible for WPC and will be referred to the pilot. The allocated amount reflects staffing (2.5 FTE navigators), benefits at 30%, and staff training costs.

PMPM Bundle

This budget includes three PMPM bundles to cover the major services being provided to those participants enrolled into the WPC pilot.

Each potential participant in the pilot will be an active Medi-Cal enrollee and have scored within the highest range of a cross-system matching of individuals who: have repeated incidents of avoidable ED use, or hospital admissions or who are currently experiencing homelessness or are at risk of homelessness. Once an individual is identified as a WPC eligible participant, the participant will be assigned to a care coordinator to provide referrals to more intensive services, intensive case management, care coordination, navigation and referrals to community supports. Once the beneficiary is enrolled in the WPC pilot and has an established Primary Care Provider (PCP) and medical home, an assessment will be made in conjunction with their PCP and care team as to the level of intensity of case management service the individual needs. Once that assessment is made, they will be placed into either the higher or lower intensity care coordination and navigation bundle. A clinical review conducted at the 3-month mark to assess and adjust for the appropriate level and intensity of service. WPC participants receiving housing support will also have access to housing subsidies (paid for outside of WPC).

The Care Coordinator will document and provide feedback on developing and executing a plan to achieve designated goals for the participant. A participant is placed with a Care Coordinator once they are formally enrolled in the WPC pilot. At this point, the whole WPC team becomes fully engaged with the participant. It is expected that although some beneficiaries will require long-term assistance, the majority of beneficiaries will remain in the program for approximately 12 months. As a beneficiary is detached from the WPC team, the next qualified beneficiary from the waitlist will be contacted for enrollment. Both case management bundles include a mix of supportive services that can be provided by para-professionals and clinically trained and licensed professionals, as appropriate.

Higher Intensity Care Coordination Bundle: This bundle includes a higher level of intensity and density of services required to support the beneficiary at a 1:20 staff to client ratio, using case managers as the limiting factor. Based on this ratio, we can serve 500 individuals (25 case managers x 20 = 500). We anticipate individual beneficiaries to stay in this bundle three to six months, with a maximum of six consecutive months.

Services provided through this bundle include services like accompanying beneficiary to medical appointments, providing screening, intensive follow-up and supports, etc. Services such as supporting wound care, vital signs and blood glucose checks, and coaching for disease management, medication adherence, and addiction treatment delivered on the street directly to those most in need through street outreach nurses and

paraprofessional case managers is also included. Other services include connecting beneficiaries with primary care medical homes, ensuring they receive the appropriate level of care, facilitating connection to specialty care if needed, providing education on how to navigate the health care system, providing therapeutic listening, and linking the client with other needed services such as drug and alcohol treatment, housing assistance, and other social and community resources to address social determinants of health.

The bundle includes clinical case management and care coordination staffing, supervision of personnel, as well as equipment, laptops, cell phones and vehicles to support staff providing services. Laptops are estimated at $1500 cost to purchase + $500 maintenance (total $2,000 per laptop costs per person) divided across the demonstration years ($500 per year). Equipment and supplies include medical supplies, backpacks and portable equipment for street teams, screenings (i.e. TB tests), hygiene kits, sustenance, etc. (estimated at $110 per person x 500 served per year). Benefits are estimated at 30% of annual unit cost, and include health, dental, vision, retirement, and other fringe benefits. Case managers and street outreach registered nurses will be providing care coordination services – their salaries are included in the TCM adjustment of 5% reflected in the breakdown table below to provide for any potential duplication. The TCM adjustment of 5% is calculated based on staff cost.

Budget Item	Annual Unit Cost	# FTEs/Units	Total
Registered nurse supervisor	93,600	1	93,600
Therapists (LCSWs)	83,200	5	416,000
Certified Alcohol & Drug Counselors	58,240	3	174,720
Support staff	33,280	4	133,120
Data Coordinator	74,880	0.5	37,440
Case Managers	38,480	25	962,000
Street Outreach Registered Nurses	83,200	5	416,000
Personnel Subtotal:			2,232,880
Benefits (30%)			669,864
PERSONNEL TOTAL:			**2,902,744**
Laptops	500	43	21,500
Cell phones (Phones + Service)	780	43	33,540

Budget Item	Annual Unit Cost	# FTEs/Units	Total
Vehicle (Lease, Insurance + Mileage)	3,600	15	54,000
Equipment & Supplies	55,000	1	55,000
NON-PERSONNEL TOTAL:			**164,040**
Operating Cost:			3,066,784
Administration 5%:			153,339
TOTAL BUDGET:			**3,220,123**
Total # of Member Months/Year:			6,000
PMPM Rate for the Bundle:			537
TCM Adjustment of 5%:			**-68,900**

Lower Intensity Care Coordination Bundle: This bundle assumes a lower level of intensity of supports needed, primarily social in nature, not requiring clinical personnel, at a 1:25 staff to client ratio, using case managers as the limiting factor. Based on this ratio, we can serve 500 individuals (20 case managers x 25 = 500). We anticipate individual beneficiaries to stay in this bundle three to nine months, with a maximum of twelve consecutive months. Similar to above, case managers and street nurses will be providing care coordination services – their salaries are included in the TCM adjustment of 5% reflected in the breakdown table below to provide for any potential duplication of services. The TCM adjustment of 5% is calculated based on staff cost.

As this is a lower intensity of services, the care coordination team will work closely to ensure the beneficiary is continuing to access primary medical and mental health care, continuing to receive their Medically Assisted Treatments for alcohol and other drug treatment plans, and meet individual long-term health goals such as lowered blood pressure or reduced HgA1C levels. Laptops are estimated at $1500 cost to purchase + $500 maintenance (total $2,000 per laptop costs per person) divided across the demonstration years ($500 per year). Equipment and supplies include medical supplies, screenings (i.e. TB tests), hygiene kits, sustenance, etc. (estimated at $40 per person x 500 served per year). Benefits are estimated at 30% of annual unit cost, and include health, dental, vision, retirement, and other fringe benefits.

Budget Item	Annual Unit Cost	# FTEs/Units	Total
Registered nurse supervisor	93,600	1	93,600
Support staff	31,200	4	124,800
Data Coordinator	74,880	0.5	37,440
Case Managers	37,440	20	748,800
Street Outreach Registered Nurses	83,200	2	166,400
Personnel Subtotal:			1,171,040
Benefits (30%)			351,312
PERSONNEL TOTAL:			**1,522,352**
Laptops	500	27	13,500
Cell phones (Phones + Service)	780	27	21,060
Vehicle (Lease, Insurance + Mileage)	3,600	10	36,000
Equipment & Supplies	20,000	1	20,000
NON-PERSONNEL TOTAL:			**90,560**
Operating Cost:			1,612,912
Administration 5%:			80,646
TOTAL BUDGET:			**1,693,558**
Total # of Member Months/Year:			6,000
PMPM Rate for the Bundle:			282
TCM Adjustment of 5%:			**-45,760**

Housing Bundle: This bundle includes a host of housing support services, such as landlord relationship support, housing search, eviction prevention, dispute resolution, accompanying beneficiary to meetings, etc. Beneficiaries will receive case management specifically focusing on housing assistance and support. Housing case managers will work with beneficiaries to secure safe and healthy housing, coordinating with the local Continuum of Care and housing authorities. They will work closely with WPC care coordinators to ensure the beneficiaries' health and housing needs are met. Leased vehicles available for staff use to aid in transporting beneficiaries to necessary appointments is included in the budget. Once the beneficiary has secured housing, s/he will receive on-going and sustained tenancy retention case management. Tenancy retention will focus on education and intervention to support long-term successful housing, and avoid behaviors that would jeopardize housing. Beneficiaries receive crisis planning, assistance

identifying and intervening with destructive or risky behaviors, and on-going training on what it means to be a good tenant. Tenancy retention will address common first time tenant issues, etiquette, pro-social community behavior, and on-site handyman mentoring and assistance with light repairs.

This bundle also includes resources for a medical-legal partnership, to address legal issues that are creating barriers to care and left untreated, can have debilitating effects on individual and population health, which in turn increases health care utilization and costs. Civil legal needs are particularly acute among populations that most frequently use emergency health care services. The U.S. Department of Veteran Affairs' most recent survey of veterans who are homeless found that five of their top ten needs require legal assistance.[8] Another pilot study at Lancaster General Health found that 95 percent of the hospital's highest-need, highest-cost patients had two to three unmet civil legal needs, and that addressing those needs not only reduced hospital admissions, but reduced health care costs by 45 percent.[9] Addressing these civil legal needs that profoundly affect health for high utilizers is critical to ensure our target population's needs are met.

Resources are also allocated for laptops and cell phones to enhance the ability of this team to be mobile and working with our target population in the locations that best support their needs and minimize barriers. Laptops are estimated at $1500 cost to purchase + $500 maintenance (total $2,000 per laptop costs per person) divided across the demonstration years ($500 per year). Benefits are estimated at 30% of annual unit cost, and include health, dental, vision, retirement, and other fringe benefits. Housing supports are comprised of one-time costs per eligible enrollee who gets housed through this pilot (estimated 300 based on annual new housing slots available), and include deposits ($850 for first month's rent at fair market value), utility arrears ($75), furniture ($525) and other household goods (up

---

[8] U.S. Department of Veteran Affairs. "Community Homelessness Assessment, Local Education and Networking Groups (CHALENG) Fact Sheet." June 2016. Available online at: https://www.va.gov/HOMELESS/docs/CHALENG-2015-factsheet-FINAL-0616.pdf

[9] J. Martin, et al. "Embedding Civil Legal Aid Services In Care For High-Utilizing Patients Using Medical-Legal Partnership," Health Affairs Blog, April 2015. Available online at: http://healthaffairs.org/blog/2015/04/22/embedding-civil-legal-aid-services-in-care-for-high-utilizing-patients-using-medical-legal-partnership/

to $250). Funding is also available for additional office supplies (printing fliers, marketing materials, etc.) needed to support this program. Additional details are listed in the table below:

Budget Item	Annual Unit Cost	# FTEs/Units	Total
Housing Manager	124,800	1	124,800
Landlord Engagement	89,440	3	268,320
Housing Specialists	52,000	10	520,000
Data Coordinator	74,880	1	74,880
Medical Legal Partnership support	125,000	2	250,000
Personnel Subtotal:			1,238,000
Benefits (30%)			371,400
PERSONNEL TOTAL:			**1,609,400**
Laptops	500	17	8,500
Cell phones (Phones + Service)	780	17	13,260
Housing Supports (deposits, furniture, etc.)	510,000	1	350,000
Office Supplies	4,000	1	50,000
NON-PERSONNEL TOTAL:			**535,760**
Operating Cost:			2,145,160
Administration 5%:			107,258
TOTAL BUDGET:			**2,252,418**
Total # of Member Months/Year:			6,000
PMPM Rate for the Bundle:			375

Pay for Reporting

The WPC budget includes payments for reporting select universal and variant metrics and any additional information requested by the state and/or federal government. These reporting requirements include submission of data to support the following metrics:

Pay for Reporting Metric	PY2	PY3	PY4	PY5
Housing: Permanent Housing	$350,000	$300,000	$300,000	$300,000
Ambulatory Care – ED Visits (HEDIS)	$500,000	$450,000	$450,000	$450,000
Reduce Inpatient Utilization – General Hospital/Acute Care (HEDIS)	$500,000	$450,000	$450,000	$450,000

Pay for Reporting Metric	PY2	PY3	PY4	PY5
Health Outcomes: 30 Day All Cause Readmissions	$500,000	$450,000	$450,000	$450,000
Housing: Housing Services	$350,000	$300,000	$300,000	$300,000

Tiered payment is available based on timely reporting by the City for each metric. Full payment of this incentive will occur, if all data is submitted timely, as follows:

- 50% of total incentive for timely reporting of mid-year report
- 50% of total incentive for timely reporting of annual report.

Reporting accurate and timely data to DHCS will be critical for measuring progress and for continuously adapting the program to allow for the greatest chance of success through the PDSA process. It is anticipated that the City and its contracted staff will perform a significant amount of coordination among partners to ensure reports and data points not previously tracked are submitted timely and accurately. Payment to the City for performing this function will be made by DHCS in equal installments each for the mid-year and annual progress report upon timely and complete submission to the State of all required data elements to calculate these metrics. Payments earned will be reinvested by the City in systems to facilitate the sharing and reporting of data among partners.

Pay for Outcomes

We included payments for achievement on two outcome measures:

1. **30 Day All Cause Readmissions:** This incentive is available for the City for achieving at least a 5% reduction each year in hospital readmissions.
2. **Supportive Housing**: This incentive is available for the City for increasing the provision of supportive housing services to clients by at least 5% annually.

Available incentives are structured as follows:

Pay for Outcome Metric	PY2	PY3	PY4	PY5
Health Outcomes: 30 Day All Cause Readmissions	$98,640	$70,678	$57,584	$57,584
Housing Support Services	$98,640	$70,678	$57,584	$57,584

These modestly valued pay for outcome measures are budgeted for PY3-5, based on meeting improvements from baseline. The full value of the incentive can be earned annually by fully meeting the target as defined in the metric in Section 4.1. Reduced payments are available for partial performance relative to the proportion of the target met (e.g. an 80% payment will be achieved by meeting 80% of the target metric).

Per Attachment MM, WPC Pilots should be able to describe the direction of the changes in the data, noting: 1) improvement, anticipated or not, 2) interventions that are not having the results as predicted, and 3) unintended consequences of the WPC Pilot, both positive and negative. WPC Pilots are to report on all the Universal and Variant metrics, and at this point, should be able to describe early trends based on the strategies and interventions employed by the WPC Pilot. Also, the WPC pilot will need to determine what components of the pilot will be sustained or expanded past the WPC funding. Based on this information, the WPC pilot will need to determine what aspects of the Pilot need to be adapted, if any, to move toward the predicted and/or desired results, or improve on trends noted. This is a critical part of the Plan-Do-Study-Act process.

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

New WPC Applicant Name: *City of Sacramento*

	Federal Funds (Not to exceed 90M)	IGT	Total Funds
PY 1 Annual Budget Amount Requested	4,004,917.50	4,004,917.50	8,009,835.00
PY 2 Annual Budget Amount Requested	4,004,917.50	4,004,917.50	8,009,835.00
PYs 3-5 Annual Budget Amount Requested	8,009,835.00	8,009,835.00	16,019,670.00

Second Round PY 1 Budget Allocation (Note PY 1 Allocation is predetermined)	
PY 1 Total Budget	8,009,835.00
Approved Application (75%)	6,007,376.25
Submission of Baseline Data (25%)	2,002,458.75
PY 1 Total Check	OK

Second Round PY 2 Budget Allocation	
PY 2 Total Budget	8,009,835.00
Administrative Infrastructure	912,280.00
Delivery Infrastructure	1,848,000.00
Incentive Payments	2,250,000.00
FFS Services	448,056.00
PMPM Bundle	154,218.75
Pay For Reporting	2,200,000.00
Pay for Outcomes	197,280.25

Second Round PY 3 Budget Allocation	
PY 3 Total Budget	16,019,670.00
Administrative Infrastructure	1,199,015.00
Delivery Infrastructure	1,309,875.00
Incentive Payments	2,000,000.00
FFS Services	2,757,174.00
PMPM Bundle	6,662,250.00
Pay For Reporting	1,950,000.00
Pay for Outcomes	141,356.00

Second Round PY 4 Budget Allocation	
PY 4 Total Budget	16,019,670.00
Administrative Infrastructure	1,105,828.00
Delivery Infrastructure	1,069,000.00
Incentive Payments	1,620,000.00
FFS Services	2,757,174.00
PMPM Bundle	7,402,500.00
Pay For Reporting	1,950,000.00

Pay for Outcomes	115,168.00

Second Round PY 5 Budget Allocation	
PY 5 Total Budget	16,019,670.00
Administrative Infrastructure	1,105,828.00
Delivery Infrastructure	1,069,000.00
Incentive Payments	1,620,000.00
FFS Services	2,757,174.00
PMPM Bundle	7,402,500.00
Pay For Reporting	1,950,000.00
Pay for Outcomes	115,168.00