1 Lead Entity and Partnership Development

1.1 Lead Entity and Contact Person

Organization Name	County of Sonoma-Department of Health Services Behavioral Health Division
Type of Entity	County agency
Contact Person	Michael Kennedy
Contact Person Title	Director, Behavioral Health Division
Telephone	(707) 565-4850
Email Address	Michael.Kennedy@sonoma-county.org
Mailing Address	3322 Chanate Road, Santa Rosa, CA 95404

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	Partnership Health Plan California	Lynn Scuri Regional Director	• Bi-directional Data, Data analysis, data infrastructure development • Access to services in health plan • Assist in care coordination • Member of steering committee
2. Health Services Agency	Sonoma County Department of Health Services	Rod Stroud Interim Assistant Director	• Admin support • Data Analyst – gathering, analyzing, reporting data • Bi-directional data infrastructure development and data sharing • Member of steering committee
3. Specialty Mental Health Agency	Sonoma County Behavioral Health Division	Susan Castillo Section Manager	• CIP – manage the program/staff provide services • Bi-directional data infrastructure development and data

Required Organizations	Organization Name	Contact Name and Title	Entity Description and Role in WPC
			sharing • Facilitate access to other mental health service • Member of steering committee
4. Public Agency	Sonoma County Human Services Department	Karen Fies Director	• Eligibility determination • Access to benefits & services • Refer clients to WPC Pilot • Collect and submit data and participate in bi-directional data sharing • Member of steering committee
5. Public Housing Authority (If housing services are provided, include the public housing authority)	Sonoma County Community Development Commission	Jenny Abramson Homeless & Community Services Manager	• Collaborate with CIP to help access and maintain housing for clients • Collaborate with SC BHD in pursuing initiatives to increase available housing resources • Refer clients to the WPC Pilot • Collect and submit data and participate in bi-directional data sharing and review • Member of steering committee

Required Organizations	Organization Name	Contact Name and Title	Entity Description and Role in WPC
6. Community Partner #1	Santa Rosa Community Health Centers	Kai Nissley, Chief Operating Officer	• Collaborate with CIP staff to coordinate care • Collect and submit data and participate in bi-directional data sharing and review • Provide nurse outreach and engagement staff as part of the WPC Pilot team • Member of steering committee
7. Community Partner #2	Petaluma Health Center	Pedro Toledo Chief Operating Officer	• Collaborate with CIP staff to coordinate care • Collect and submit data and participate in bi-directional data sharing and review • Provide nurse outreach and engagement staff as part of the WPC Pilot team • Member of steering committee
8. Community Partner	West County Community Health Centers	Jed Heibel Homeless Services Program Manager	• Collaborate with CIP staff to coordinate care • Collect and submit data and participate in bi-directional data sharing and review • Provide nurse outreach and engagement staff as part of the WPC Pilot

Required Organizations	Organization Name	Contact Name and Title	Entity Description and Role in WPC
			team • Member of steering committee
9. Community Partner	Alexander Valley Health Center	Deborah Howell CEO	• Collaborate with CIP staff to coordinate care • Collect and submit data and participate in bi-directional data sharing and review Provide nurse outreach and engagement staff as part of the WPC Pilot team • Member of steering committee
10. Community Partner	Alliance Medical Center	Alex Armstrong Chief Executive Officer	• Collaborate with CIP staff to coordinate care • Collect and submit data and participate in bi-directional data sharing and review • Provide nurse outreach and engagement staff as part of the WPC Pilot team • Member of steering committee
11. Community Partner	Sonoma Valley Health Center	Kathryn Nevard Development Director	• Collaborate with CIP staff to coordinate care • Collect and submit data and participate in bi-directional data sharing and review • Provide nurse outreach and engagement staff as

Required Organizations	Organization Name	Contact Name and Title	Entity Description and Role in WPC
			part of the WPC Pilot team • Member of steering committee
12. Community Partner	The Palm Inn – Catholic Charities	Jenny Lynn Holmes Director of Shelter & Housing Services	• Host CIP staff • Collaborate with CIP staff in identifying and engaging clients • Provide housing and housing support to homeless veterans • Collect and submit data and participate in bi-directional data sharing and review
13. Community Partner	Center Point-DAAC	John Challis, VP Director of DAAC	• Short Term Recuperative Care Services • Collect and submit data and participate in bi-directional data sharing and review

The project also includes the following ancillary participants that will support and be integrated into program services and activities:

Local Hospitals

- Petaluma Health Care District
- St. Joseph's Memorial Hospital Santa Rosa
- Sutter Medical Center Santa Rosa
- Kaiser Permanente Hospital Santa Rosa

Local Law Enforcement Agencies

- Santa Rosa PD
- Sonoma County Sheriff's Department
- Petaluma PD
- Cloverdale PD

- Sonoma County Probation Department

1.3 Letters of Participation and Support

Letters of Participation and Support are included in the proposal attachments.

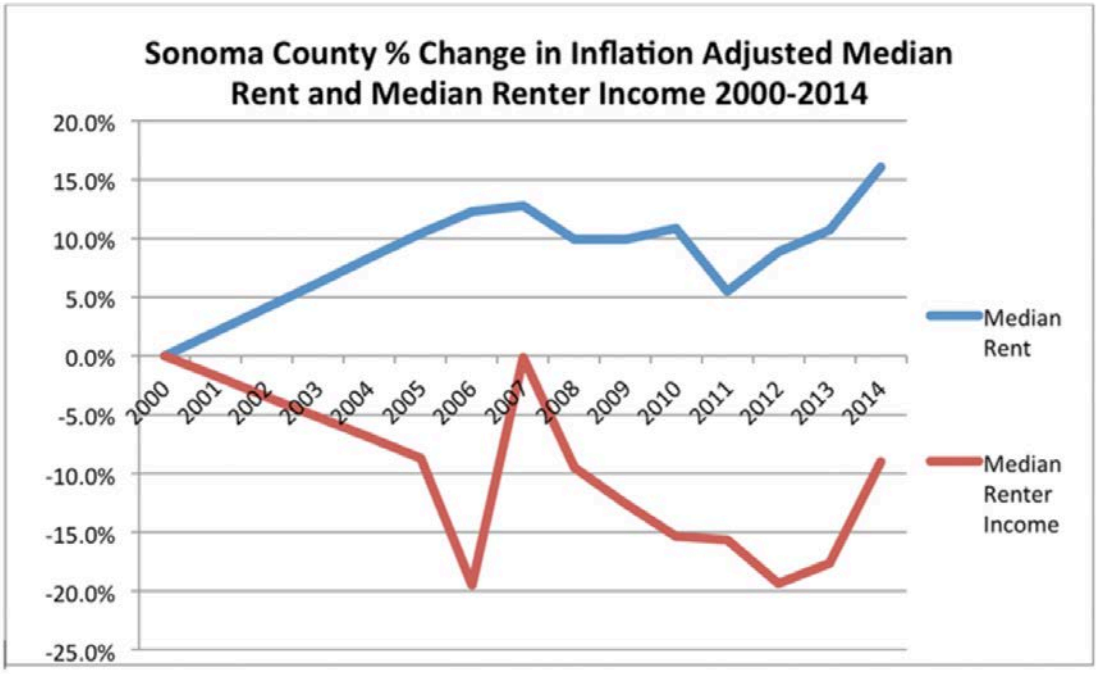
2 General Information and Target Population

2.1 Geographic Area, Community and Target Population Needs

Sonoma County has approximately 502,146 residents according to the most recent U.S. Census data.[1] The county has a total area of 1,768 square miles of which 1,576 square miles is land, and the remaining water. Sonoma County is a mix of rural and urban areas, with a large portion of the county being used for agricultural purposes. About 80 percent of non-pasture agricultural land in the county is used for growing grapes; winemaking is an important contributor to the Sonoma economy.

Rising rents and declining incomes are making it increasingly difficult for Sonoma residents to be able to afford housing.[2] While the unemployment rate in Sonoma County, as of December 2016, was just 3.7 percent, significantly lower than the state average of 5 percent, many residents struggle to afford basic needs such as housing. With the median income at $63,799, and the average annual rent at $19,000, the average resident spends about 30 percent of his income on housing and low-income residents spend a much higher percentage. Notably, over two-thirds of homeless Sonoma County residents claimed "affordable rent" as the main reason for losing permanent housing, in a 2015 survey.[3]

[1] 2015 data from www.census.gov, accessed on 2/20/2017. Data for 2016 note yet available.
[2] http://chpc.net/news/why-sonoma-county-workers-cant-afford-the-rent/
[3] http://www.sierraclub.org/redwood/blog/2016/03/wages-and-housing-why-sonoma-county-workers-can-t-afford-rent



According to HUD estimates, the rate of homelessness in Sonoma County is nearly twice the national average.[4] The County's 2016 homeless point in time count identified 2,906 homeless, with 1,906 unsheltered, and a total annual number of unique episodes of homeless of 6,876.[5] Based upon national data indicating that 33 percent of the homeless population has a serious mental illness, there are an estimated 757 individuals with serious mental illness who are homeless, with 2,269 unique episodes of homelessness each year in Sonoma County. And, while the county saw a 19 percent decrease in alcohol and drug-related non-fatal hospital visits, it still reported the third highest number of visits across comparable counties.[6]

How Other Participating Entities Took Part in Defining the Vision and Structure for the WPC Pilot

The Sonoma County Behavioral Health Division (BHD) engaged potential participating entities in multiple meetings to create a vision for the Sonoma County WPC Pilot, drawing upon their unique knowledge and experience to inform the structure of the program. The planning process included a multi-stakeholder data analysis effort in order to develop a solid understanding of

[4] Based on the nationwide point in time count, the proportion of the population that was homeless in Sonoma County in 2016 was 5.7%, in contrast to 3.0% for the state of California, and 1.7% nationally. Source: The 2016 Annual Homeless Assessment Report (AHAR) to Congress, November 2016, U.S. Department of Housing and Urban Development.
[5] Sonoma County 2016 Homeless Point in Time Count, Sonoma County Community Development Commission.
[6] http://edb.sonoma-county.org/documents/sotc_2016/2016_Abridged_Indicators_Web_Draf_ADA.pdf

the problem as well as the opportunities to address gaps in the current county health care systems efforts to serve the target population.

General Description of the WPC Pilot, its Structure, the Target Population and how it will address the Needs of the Target Population

The proposed WPC Pilot will target Medi-Cal beneficiaries who are homeless and/or at risk of homelessness, who have a serious mental illness; have other co-occurring health conditions, including substance use disorders; are high users of emergency services; and are served by multiple agencies. The pilot will place a particular focus on elderly individuals, since they face the longest waits for appropriate placement, and create a significant cost burden on the health care system. The pilot's high-touch, on-the-ground approach will help connect participants to the important health care services they need.
Because individuals in the more rural areas of the county are significantly underserved, a key strategy of the proposed pilot is to enhance and expand services in these rural areas outside of the city of Santa Rosa. Table 1 identifies the frequency of receipt of mental health services in relation to the total number of beneficiaries in each region of the county, clearly indicating the need to expand service capacity in these outlying areas.[7]

Table 1. Mental Health Service Rates for Unique Medi-Cal Clients with Sonoma County Zip Codes by Region, FY15-16

Region	Frequency	Enrolled Medi-Cal Population	Rate per 1,000 population
City of Santa Rosa/Center Region	2,552	55,023	46.4
Western Region	333	8,580	38.8
Southern Region	753	22,068	34.1
Northern Region	344	11,790	29.2
South East Region	151	7,575	19.9
Sonoma County	4,133	105,036	39.3

Through this pilot, Sonoma County proposes to expand the County's Community Intervention Program (CIP), which provides outreach to disparate and historically underserved populations

[7] Medi-Cal Clients Served by Region from Sonoma County AVATA Encounter/Services Data base – FY 15-16; Medi-Cal Beneficiaries by Region - Medi-Cal Enrollment from CalWin as of January 2016, Compiled by Sonoma County Human Services Department, Planning, Research, Evaluation, and Engagement Section.

in an effort to engage them in mental health services, as well as to expand community health center partner outreach and case management capacity. The additional staff hired through this pilot expansion of CIP will allow Sonoma County to increase the provision of CIP services throughout the County by placing staff in the County's outlying regions as well as increasing services within the County's hub of Santa Rosa. Through this pilot, CIP will reach, identify, and engage more individuals in need of specialty services who live in geographically isolated areas.

Reducing Avoidable Utilization of Other System Components and Addressing Systemic Problems

While Sonoma County residents as a whole are relatively healthy, the proposed target population makes inefficient use of hospitals and emergency departments, and causes major strains on the overall county health care and other systems. The proposed WPC Pilot is intended to address the undue burden that this small number of individuals places on local health, human service and criminal justice systems. Through close collaboration with local police departments, the County Sherriff's Department, and the Probation Department, this pilot will ensure a reduction in avoidable utilization of jails by the WPC target population. Strong partnerships with local health clinics, insurers and hospitals will also enable the pilot will address overall system problems and bridge gaps in services for this high need population. For example, Sonoma County Behavioral Health currently provides a number of services within the county's main detention facility. The Sherriff's Department and the BHD currently share data in a bi-directional manner including information regarding jail recidivism. One of the BHD's staff works as a discharge planner within the jail setting to facilitate access to services upon release. These and many other ongoing working relationships will be leveraged to enhance the ability of the pilot to identify and engage clients.

Strengthening Existing Efforts and Building Sustainable Infrastructure

Planning for the WPC Pilot has already helped to strengthen relationships of participating entities, as they come together to work towards shared goals of improving the county health care system. This WPC pilot will enable participating entities to expand their existing collaborations, to further integrate services, build a more robust infrastructure, and share data across systems to create a stronger county health care system. This pilot program's focus on results and performance-based pay for success will enable the County to pay particular attention to what is working, where there is room for improvement, and how the collaboration of community partners can learn from this work and improve future efforts. As a result of this pilot, Sonoma will be able to increase the sustainability of its services and reduce avoidable medical costs, leading to increased savings.

2.2 Communication Plan

Communications Process, Integration Efforts, and Meetings

The County of Sonoma Department of Health Services Behavioral Health Division (BHD) will be the lead agency for the WPC pilot, with Director, Michael Kennedy, as the main point of

contact. BHD will support and coordinate all participating entities throughout the WPC pilot, and will organize quarterly WPC Steering Committee meetings. A key representative from each participating entity (listed in the table in section 1.2) will serve on the Steering Committee to review pilot progress and to plan for future work. These regular meetings will help to ensure that silos are minimized and that all involved parties are collaborating effectively to maximize efficiency and reach of the WPC pilot services. Topics to be covered at each meeting will include implementation and operations review, evaluation progress, metrics and measurement, communications and decision-making, and updates of any relevant policy or program changes. Regular WPC pilot communication among participating entities will also include frequent check-ins by phone, email, and both online and in-person meetings.

Governance Structure and Decision-Making

Specific workgroups, comprised of key representatives of both County and partner agency staff, will be established and chaired following the successful award of this grant. Workgroups will meet separately, at least every other month, to address key focus areas of the WPC pilot, including IT Infrastructure, Data Workgroup, and overall Operations and Coordination. The Operations and Coordination Team will meet most frequently, will be led by the BHD Section Manager and CIP Program Manager, and will be responsible for day-to-day management of the WPC pilot. The Team will develop a metrics dashboard to track pilot progress and share results with all Steering Committee representatives on a bi-monthly basis. The Committee will use these reports to learn of pilot progress and to make decisions when course corrections are necessary. The WPC Data Workgroup (WPC-DW) will develop the agreements, protocols, procedures, policies, metrics, definitions, and goals of the data collection involved in the pilot. From the County, staff serving on the WPC-DW Workgroup will include the Department's Compliance Officer, Privacy Officer, ISD Manager, Information Systems Specialist, Program Managers, and Program Leads. Partnering agencies will be required to assign relevant representatives to the workgroup. Input from County Counsel will be utilized when needed.

BHD will serve as the lead decision-maker and will be ultimately responsible for the implementation and oversight of the Sonoma WPC pilot. All participating entities will share in voting processes, advising on the direction of the pilot when changes or decisions need to be made. These decisions will occur at bi-monthly meetings, with relevant minutes and meeting materials distributed beforehand so that representatives will be well informed before a vote is called.

External communications

External communications are also integral to the success of this project, as public awareness is critical to understanding issues that affect this target population and how important these services are to their health outcomes. BHD will regularly post quarterly tracking reports to its website and will share broadly with other County departments and commissions. BHD will also organize occasional press releases around the WPC pilot successes and will invite beneficiaries

and community members to attend public meetings in order to ask questions or offer feedback about the program.

2.3 Target Population

Target Population

The target population for the Sonoma WPC Pilot consists of Medi-Cal beneficiaries who are homeless and/or at risk of homelessness who have a serious mental illness and at least one of the following characteristics:

- Have other co-occurring health conditions, including substance use disorders;
- Are high users of emergency services; and
- Are served by multiple agencies.

The project will place a particular focus on elderly individuals who are hard to place, since they often face the longest waits for appropriate placement, and as a result create a significant cost burden on the health care system.

How Lead Entity Collaborated with Partners to Identify Target Population

Through a series of proposal development planning meetings, the Behavioral Health Division collaborated with multiple partners engaged in the delivery of health, mental health, substance abuse, housing, and other supportive services to identify the target population. To reach this decision, the partners considered those populations currently at greatest risk, the current gaps in services, as well as the existing resources and drew upon the extensive expertise and experience of each partner as well as the range and depth of available countywide statistics.

Methodology Used to Identify the Target Population

In general, Sonoma WPC program will address a target population of individuals who are homeless and who have complex health and/or behavioral health conditions. Sonoma WPC will focus on the subset of Sonoma residents who are the most vulnerable including those who are homeless, have a chronic health condition, severe mental illness, and/or chronic substance use.

Through a series of workgroups and meetings, Sonoma collaborated closely with other participating entities to define the target population including representatives from the County's Federally Qualified Health Clinics, Community Based Behavioral Health Service Providers, Managed Care Plan, and the Community Development Commission. Each of these partners has identified reducing homelessness and linking homeless individuals to services and resources as a top priority and were partners in development of this WPC program. In order to forecast clients served, CIP utilization data for CY 16 was pulled by the Behavioral Health Division from the County's SWITS encounter data base. In addition, in order to develop a holistic assessment of the estimated impact of the expanded provision of services,

data/information was provided to the Behavioral Health Division by Sonoma County's Managed Care Plan (Partnership Health Plan) and the County's Community Development Commission (CDC) which, specifically, related to the most recent Continuum of Care Homeless Count which included data from the Homeless Management Information Systems (HMIS). The group was able to come to consensus on the target population. The method involved examining the data as a group and determining the factors that could lead to stabilization of a large number of high risk, sick homeless individuals. The data demonstrated the need for sufficient support services and efficient linkages to health care services.

The methodology was based upon the following risk factors, which result in significant cost burden to the health care system in Sonoma County: homeless, length of time experiencing homelessness, co-occurring health conditions including substance use disorders and serious mental illness, use of urgent/emergent services, and use of multiple healthcare systems.

The number of unique clients was adjusted to reflect a more comprehensive assessment process. This baseline was applied to the proposed staffing expansion to estimate the number of clients the enhanced program and staffing might serve.

The projections assume a significant increase in clients served from PY 2 to PY 3 reflecting the ramp up and full implementation of the pilot. For PY 4 and PY 5, projections assume a 15% and 10% increase in new clients with a 6.5% and 2.1% attrition rate resulting in net increases in clients of 9% and 8% respectively.

Numbers to be served in each category

The table below indicates the service goals in Program Years 2 thought 5, and the total service goal for the entire project period.

Table 2. Proposed Service Goals for WPC Pilot Target Populations in Program Years 2 through 5					
Target Population	**PY 2**	**PY 3**	**PY 4**	**PY 5**	**Total**
WPC Target Population Unique Clients	370	890	960	1030	3,040

Sonoma was able to access more detailed data from multiple data systems to estimate the number of unduplicated clients to be served. Additional information that was available was the prevalence of co-occurring, housing status, and services at multiple agencies within the SCBH system of care. In addition to utilizing data collected through our two data systems used within our division for Mental Health Services and Substance Use Disorder Services, SCBH was provided data from Sonoma County's local managed care organization (Partnership Health) and data sourced from the local Homeless Management Information System (HMIS) application. The data was aggregated and "matches" were flagged. These matches were then analyzed and inflated to account for either incorrect "non-matches" or the understanding that some unique individuals may be accessing services that are only tracked in a single system even though the need is there given what we know about how prevalent severe and persistent mental illness (SPMI) is within the general population. Population data related to SPMI was analyzed as was the last several years of Sonoma County's Homeless Count. This data was used to build assumptions related to what our anticipated increases would be.

The projections assume a significant increase in clients served from PY 2 to PY 3 reflecting the ramp up and full implementation of the pilot. For PY 4 and PY 5, projections assume a 15% and 10% increase in new clients with a 6.5% and 2.1% attrition rate resulting in net increases in clients of 9% and 8% respectively.

The formula used to estimate the number of individuals served by the expanded CIP program associated with our WPC application was based upon the growth in the number of staff that will be assigned to the program. The number of direct services staff assigned to the County's CIP program is currently 9.5. We would add 15.2 direct service staff for 24.7 FTE. This results in an increase multiplier of 2.6. Multiplying that number (2.6) in with the most recent number of unique clients served by our CIP program (370) from the County's SWITS system, which tracks encounter data (370 X 2.6 = 962). The number of clients was then adjusted to reflect staff conducting a more comprehensive assessment process. This baseline was applied to the proposed staffing expansion to estimate the number of clients the enhanced program and staffing would serve which is estimated at 890 per year.

Therefore, PY 2 was based on the current CIP data of 370 client served. PY 3, with full ramp up in the first full year of the program is estimated to be 890 served based on the above formula. The addition of approximately 70 individuals annually was developed through looking at historic growth rates in our CIP program where we expanded into new locations. Due to our planned expansion of CIP into eight new cities, we felt the need to build our estimates with an

expansion factor based upon our prior experiences. In analyzing our CIP data, it was determined that a growth rate of 70 seemed like a reasonable amount.

In PY 4 and PY 5, approximately 70 clients will be added on an annual basis for total client counts of 960 and 1,030 estimated client served with approximately 3.250 total clients served. Over the life of the program, approximately 3,040 unique individuals will be served.

3 Services, Interventions, Care Coordination, and Data Sharing (Steve)

3.1 Services, Interventions, and Care Coordination

Sonoma County seeks to achieve the following goals through funding from the Whole Person Care Pilot program:

- Enhance services to Medi-Cal Beneficiaries with serious mental illness;
- Increase access to non-Medi-Cal services in regions of the county that are underserved;
- Strengthen collaboration with community partners;
- More effectively engage clients who are historically difficult to serve; and
- Reduce the impact of homelessness for individuals with mental illness and on community partners serving them.

The WPC Pilot will employ the "Plan-Do-Study-Act" or PDSA methodology to evaluate whether or not these overall goals are being achieved and to guide changes in administrative structure, data sharing and analysis, and clinical services and care management to improve performance. Taken together, achievement of these goals will enable Sonoma County to both improve the quality of care being provided to individuals who are intensive users of medical and mental health resources, while at the same time reducing the cost by providing individualized treatment that enables individuals to stabilize at a higher level of functioning.

Services Available to Beneficiaries through the Sonoma County WPC Pilot not Covered by Medi-Cal

Sonoma County proposes to carry out an expansion and enhancement of its Community Intervention Program (CIP), in order to most effectively implement WPC Pilot activities. The CIP and its community partners, already play an important role in providing resources to individuals in the target population in Sonoma County. Services will be offered in Spanish, when appropriate. In addition, funds will be directed to community health center partners for outreach and case management that will enable them to strengthen their participation in the CIP.

The WPC pilot will provide outreach and engagement services, Short Term Recuperative Care Services, and intensive case management services to Medi-Cal beneficiaries. The CIP currently provides outreach and service linkage to historically underserved populations in an effort to engage people and facilitate access to services and supports available to them. For the WPC Pilot, the outreach and engagement services and Short Term Recuperative Care Services are in the FFS Services budget section, and the Intensive Care Management services are budgeted in the PMPM Bundle section.

The fee for service outreach and engagement will be provided by place-based teams in distinct geographic areas in Sonoma County. The engagement and outreach teams will in include BHD staff (licensed clinicians, para-professional staff, and Peer Housing Navigation specialists) and nursing staff from the participating community health centers. Services will be provided in the field and in locations where homeless individuals live and/or receive services (e.g., homeless serving organizations and shelters, substance use disorders treatment programs, low-income housing projects, community health centers and a local free clinic, and encampments throughout the county). CIP staff also respond to calls from law enforcement and family members and loved ones of people who are struggling with behavioral health issues. The new WPC teams will continue this practice and expand to areas currently not covered. They work with law enforcement and shelter staff to identify and engage individuals in need of service.

Outreach and engagement staff will receive referrals from community partners (jail, homeless providers, local law enforcement agencies, hospital emergency rooms, and agencies serving veterans). In addition, cost and utilization data from Partnership Health Plan is being used to identify specific beneficiaries for outreach. Specifically, Partnership Health Plan of California (the Medi-Cal managed care plan in Sonoma County), provided data showing the top 10% of beneficiaries by total cost of services and, those beneficiaries with 2 or more hospital admissions and 3 or more emergency room visits in 12 months. Of the top 10% beneficiaries in total costs (5,134 beneficiaries), 3,356 had a diagnosis of major depression, psychosis, substance use disorder, and/or bi-polar disorder. Of those beneficiaries who were hospitalized and/or used emergency services (329), 83% were identified as having a mental health and/or substance use disorder. BHD is using this data to identify specific individuals for outreach and to establish baselines related to hospitalization and emergency room use.

Outreach and Engagement: Outreach and engagement services will focus on identifying potential clients, attempting to engage the clients to establish rapport by meeting the client where they are and attempting to understand their needs and interests, providing health education, cursory health, mental health, and substance use assessments, information about services available. The intended outcomes for the outreach and engagement services are to create interest on the part of individuals they encounter, link them to services in the community, and/or to enroll the client in the WPC case management services.

Outreach and engagement (OE) staff will focus on Medi-Cal beneficiaries who are homeless or at risk of homelessness who have a mental illness and may have co-occurring health conditions and/or substance use disorders and who are high users of services and served by multiple

agencies. OE staff will work with clients that meet this criteria for up to 6 months before referring the client to other outreach teams not part of the WPC Pilot. Clients will move out of OE services when staff determine that further outreach is unlikely to result in clients moving on to other services or, when outreach is successful and the clients move on to other services, including WPC intensive case management services. OE services serve as the intake point for access to the WPC Short Term Recuperative Care Services and to the bundled intensive case management services. The goal is to provide outreach and engagement to a total of 3,040 clients over the entire 5 years of the pilot. The WPC Pilot will employ the PDSA methodology for evaluating the effectiveness of these services and to plan and implement changes designed to improve outcomes (see *PDSA Method and Metric*).

Short Term Recuperative Care Services: Short Term Recuperative Care Services will be provided through an existing contract between the BHD and Center Point – Drug Abuse Alternatives Center (DAAC). DAAC operates a 24 hour residential, social model detoxification and sobering facility. Through WPC, the equivalent of 5 beds will be made available to clients referred by either the OE staff or the intensive case management staff (ICM). Clients referred for short term recuperative care services will meet eligibility requirements for OE and/or ICM services. That is, they will be Medi-Cal beneficiaries who have a substance use disorder and are in need of detoxification services and have a co-occurring mental illness. Clients who are determined to be a danger to others or self and/or gravely disabled will be referred to either the county's Crisis Stabilization Unit or to an inpatient psychiatric hospital.

Currently, the average length of stay for clients in the DAAC social model detoxification services is 3.5 days. During this time clients receive support and assistance as they go through the process of withdrawal and sobering. Staff also engage clients to develop rapport and to facilitate referral for ongoing treatment services. For WPC clients, DAAC staff will coordinate with the appropriate WPC staff to facilitate ongoing care following discharge. Clients will be discharged when the detoxification process is completed. BHD projects 2,700 total admissions over the 5 years of the pilot representing 2,160 unique individuals. The WPC Pilot will employ the PDSA methodology for evaluating the effectiveness of these services and to plan and implement changes designed to improve outcomes (see *PDSA Method and Metric*).

Intensive Case Management: Target population clients (Medi-Cal beneficiaries who have a serious mental illness and are homeless or at risk of homelessness and who may have a co-occurring substance use disorder or other health condition and may be high users of emergency services and/or served by multiple agencies) who are engaged by OE staff and agree to participate in the ICM services will be enrolled and assigned to an ICM team. Clients referred to ICM services will have significant functional impairments and need intensive services to remain in care and benefit from services.

ICM teams will include BHD staff (licensed clinicians, para-professional staff, and Peer Housing Navigation specialists) and nursing staff from the participating community health centers. The ICM teams will be led by a BHD staff who will take responsibility for ensuring that the team meets regularly (at least weekly) to review status of clients and to plan and coordinate

interventions and supports. Each participating community health center will assign a specific nursing staff person to work with each of the regional ICM teams. The team structure will facilitate linkage, ongoing daily communication between team members, and efficient care coordination and management.

The case management services will concentrate on supporting ongoing participation in services on the part of enrollees, actively support clients in accessing services and benefits. The staff to client ratio will be 1 to 20 for the ICM services. Interventions will include care coordination of primary and/or specialty health care, care coordination of specialty mental health services, coordination of homeless services, tenancy support and advocacy, and navigation support specifically for homeless services, advocacy for enrolled clients in accessing other services and benefits, client education related to physical health conditions and care, use of medications, motivational support and activities designed to establish rapport and maintain the therapeutic alliance between staff and clients, and other supportive services as needed. BHD projects that of the 3,040 unique clients served over the life of the project, 2,432 will be referred and enrolled in to the ICM services. Clients will be discharged from ICM services when they have achieved stability in housing, primary health care, and behavioral health services up to 6 months or 1 year. The WPC Pilot will employ the PDSA methodology for evaluating the effectiveness of these services and to plan and implement changes designed to improve outcomes (see *PDSA Method and Metric*).

PDSA Method and Metrics: Thirteen metrics will be tracked and reported to support evaluation of outcomes produced by the proposed services and interventions. WPC staff will gather and report on each of these metrics monthly. The Operations/Coordination Team, data team, and quality improvement staff will review data on a monthly basis to track the status of progress towards metric goals.

When data indicates that achievement of a goal is in jeopardy, these staff will begin the process of looking for root causes for the lack of performance employing the PDSA method to evaluate provision of services and the administration of the pilot. A strategy will be developed designed to improve performance. These change strategies will be presented to the Steering Committee for approval and then implemented. Each month thereafter, the data will be tracked to determine if the change had the desired impact.

The WPC Pilot will use a centralized data base to support and facilitate the bi-directional sharing of data. Staff will collect client related data and clinical documentation using a unified software platform and “forms.” The WPC Pilot staffing includes individuals dedicated to collecting data from outside data sources (e.g., Sheriff’s Department if needed), overseeing data collection and making sure the required data is being input by the OE and ICM Teams, analyzing data and preparing reports and other devices for communicating data, ensuring the integrity of the data, and preparing reports to DHCS (see also page 18).

The proposed WPC Pilot Service Strategy includes the following components:

(1) Increase Capacity and Geographic Coverage

The Sonoma County WPC Pilot will increase outreach and engagement with services through the addition of staff at the following satellite locations:

- Northern Region – Cloverdale and Healdsburg
- Eastern Region – Sonoma Valley
- Southern Region – Petaluma and Rohnert Park
- Western Region – Guerneville and Sebastopol
- County Center – Santa Rosa (increasing capacity)

Adding capacity at these outlying regional sites and increasing capacity within the County Center Hub will increase the accessibility and provision of specialty mental health, supports, and/or treatment services to targeted individuals in communities where this access has been historically limited.

(2) Enhance Service Delivery Through Staff Additions

Expansion of staff capacity within the CIP and community health center partners will enable the Sonoma County WPC Pilot to enhance delivery of the services listed below:

- Ongoing outreach and engagement
- Long term service planning and case management in the effort to link clients to services
- Ongoing support and consultation to other providers interacting with enrolled clients
- Housing support services including assistance in accessing housing and retaining housing
- Enhanced collaboration with HSD and hospital EDs – focus on elderly clients with MI who are difficult to place

(3) Expand Availability of Specialized Treatment

The project budget includes funds for the following specialized services that have been identified as effective in improving outcomes for the target population:

- Provision of short term recuperative care beds to enable individuals to take an initial step in ending the cycle of Alcohol and Substance Abuse
- Intensive Case Management as outlined in the Housing First model
- Addition of outreach and engagement by registered nurses as part of the field-based outreach teams
- Addition of registered nurses as part of the Intensive Case Management team

Suitability of Services to the Target Population

As indicated in Section 2.1, utilization data for Medi-Care shows significant disparities in the current rate of access to services across different regions of the county. Building capacity at regional CIP sites and community health centers will help to address the needs of these unreached members of the target population. The target population for the proposed WPC Pilot can be difficult to engage and link to services, and for this reason, a significant portion of program funding will be directed towards expanding outreach capacity within the CIP and its partners.

Provider Network and Who Will Deliver Services

Service delivery for the proposed WPC Pilot will be provided by licensed behavioral health clinicians, para-professional behavioral health staff, peer support housing advocates, and registered nurses. A majority of services for the proposed program will be carried out by newly hired Behavioral Health Division staff, who will work within the existing CIP structure to provide outreach, determine eligibility, deliver peer support, and offer case management. Pilot implementation will draw on the prior experience and expertise of six community health center partners (See Table in Section 1.2) that will play a key role in the delivery of services, by providing a health home to program clients, working with CIP staff on care coordination, and adding nurse outreach staff to connect with the target population. The County will also contract with a community-based partner Center Point – Drug Abuse Alternatives Center to deliver detoxification services using a social model and leverage existing infrastructure to support the pilot.

Description of Housing-Related Services

Because housing represents a critical component in enabling the target population to achieve a stable life, the proposed WPC Pilot will incorporate Peer Housing Navigators who will assess the housing status and needs of clients, assist clients to access existing housing resources, develop a plan to move toward permanent housing, or provide supports and education to help individuals currently in housing maintain their housing status. Sonoma County WPC participants will have the advantage of being able to access a number of housing-related programs that are already being implemented in Sonoma County or are in the planning stage. These include: the "No Place Like Home" initiative, a $2 billion bond program supported by MHSA funding that is designed to provide affordable housing to the target population of homeless individuals or individuals who are at risk of homelessness and who are living with a serious mental illness; support from the new Drug Medi-Cal Organized Delivery System for 40 new sober living environment beds for Medi-Cal members who are currently homeless, with repeated ED use, two or more chronic conditions, or a history of mental health and substance use disorders; a pending application for funding through Proposition 47 for a total of 35 new supportive housing beds for individuals with mental health and/or substance use disorders; and ongoing discussions with the Partnership Health Plan regarding a collaboration related to support for housing for members of the target population in Sonoma County.

Interventions Employed to Integrate Services for the Target Population

The specific purpose of the proposed interventions is to help engage and connect individuals to medical, behavioral health and social supports, in order to improve their health outcomes and decrease the avoidable use of emergency department, hospital inpatient and other systems. The existing CIP already provides for this kind of integration, by bringing together diverse partners that offer a range of health, mental health, and supportive services. Under the CIP model, the Sonoma County Behavioral Health Division and Santa Rosa Community Health Centers have already implemented bi-directional referral processes and coordination based on the 4 Quadrant Model, which has resulted in clients establishing medical homes and moving within the system to receive the right level of behavioral health care. The proposed partners and activities will continue to strengthen this coordination, particularly in the outlying regions of the county, by enhancing training and consultation for CIP and community health center staff, increasing bi-directional referrals, and focusing on warm handoffs that increase the likelihood that clients will engage with services they need.

3.2 Data Sharing

How Data Sharing will occur Between Participating Entities

Given the multiple project partners and the vast geographic area covered by this pilot, the move to centralize data is critical in reaching pilot goals. Sonoma will develop data sharing agreements between participating entities; such as Memorandums of Understanding (MOUs), Data Sharing Agreements, Business Associates Agreements, and/or Contracts. In addition, Sonoma may develop a Data Management Plan as part of this project. The Data Workgroup will play an integral role in data sharing between participating entities; identifying and assigning “user roles” in order to manage access levels for different types of users. The IT System Administrator will create user logins and program appropriate roles into the data system, as directed.

Compliance with State and Federal Laws

There is a national, state, and local effort to encourage more integrated and coordinated patient care to promote better outcomes and more effective treatment. One way to do this is for providers to share patient health information through a health information exchange ("HIE"), as long as behavioral health providers can disclose patient health information without violating confidentiality laws. Sonoma will ensure compliance with the following regulations as it develops data sharing agreements

FEDERAL	STATE
HIPAA (Health Insurance Portability & Accountability Act of 1996)	IPA (Information Practices Act of 1977)

FEDERAL	STATE
HITECH (Health Information Technology for Economic & Clinical Health Act of 2009)	CMIA (Confidentiality of Medical Information Act)
42 CFR Part 2 (Confidentiality of Alcohol and Drug treatment and Rehabilitation Act of 1987)	LPS (Lantermans-Petris Short Act)
	PAHRA (Patient Access to Health Records Act)

As the data sharing infrastructure is developed, the WPC-DW will pass them through the "filter" of all relevant laws and regulations, then referencing relevant concepts, ideas, and considerations. This will reinforce the need to establish a mechanism for sharing necessary information pertaining to the target population services.

Existing and Proposed Tools for Supporting Data Sharing

The County has identified two possible IT solutions for allowing data sharing to occur. These possible solutions are as follows:

- **Web Infrastructure for Treatment Services (WITS)**: WITS is a web-based application provided by Far East Industry or FEI that captures client services data (substance abuse and mental health); the platform provides the flexibility, security, and compatibility necessary for a universal data system. WITS satisfies mandatory government reporting requirements, facilitates multi-provider collaboration, and includes billing capabilities and an integrated contract management module. Its design involves clinical, administrative and reporting modules organized by the workflow process, providing customization control. Sonoma and community-based providers have been using Sonoma's version, SWITS (Sonoma Web Infrastructure for Treatment Services), since 2006 for Substance Use Disorder Services. In 2015, BHD began implementing a custom WITS module, a Performance Management Reporting System for non Medi-Cal mental health services.

- **Health Information Exchange (HIE)**: HIEs allows health care professionals and patients to appropriately access and securely share patient records electronically. Sonoma currently has a Mirth Device as one of its IT/ISD resources and is currently assessing it capabilities to determine the feasibility of utilizing this as the HIE for the project.

Timeline for Development of Data Sharing Infrastructure

Table 3: Data Sharing Infrastructure Timeline	
Activity	**Date Completed**
Notice of Award Received	7/1/2017
County of Sonoma Notifies DHCS of Acceptance of Award	7/12/2017
Convene WPC-DW Kickoff Meeting (held every two weeks thereafter)	7/26/2017
Identify Data Points (Outcomes & Goals)	8/15/2017

Contact Software Vendor to Engage in Planning	8/22/2017
Develop Data Sharing Protocols & Processes	8/26/2017
Draft Data Sharing Agreements	9/2/2017
Finalize Mapping Data System & "Roughing Out" Enhancement	9/14/2017
Send Enhancement Request to Software Vendor	9/16/2017
Complete Software Enhancements	11/15/2017
Start Training to New IT/ISD Protocols & Procedures	11/22/2017
Execute Data Sharing Agreements	12/1/2017
Complete Training	12/22/2017
Go Live	1/1/2018

Either IT solution/structure or combination of the two will support bi-directional data sharing. The WPC Steering Committee will make a decision in PY 1 and begin work to on implementation as soon as possible. The intent is to implement the system in January 2018.

Participating entities will input data in to the shared data base and have access to data as needed and based on system permission granted to support bi-directional data sharing. For data related to the operation and/or outcomes for the pilot, data will be aggregated and made available monthly. For clinical information and documentation, the ultimate goal is to have the information available in real time in order to facilitate coordination between staff providing services. OE and ICM staff will have access to the clinical documentation of those clients on being served by their team based on their designation in the system. Clients well be assigned to teams based on the region in which they live and/or region in which they wish to receive services. Should a client transfer to another team, permission to access the clinical records of the client will be added to the staff serving the client.

Building Sustainable Infrastructure

The design, development, and implementation of the complete WPC data sharing structure/system will be completed during the pilot period. The use of an existing data system will minimize the need for extensive modifications or procurement of additional assets. Once data is available for analysis, Sonoma County will estimate continuation costs and evaluate cost savings realized through the pilot to develop a realistic sustainability plan that includes support for ongoing system enhancements. The use of a full time dedicated Data Analyst assigned to the WPC Team will help to ensure the ongoing sustainability of this project.

Data Governance Structure

The BHD Director will oversee the Sonoma WPC data program team, appointing a member of the senior management team to serve as the designee responsible for regular status updates and briefings. The DHS Compliance Officer and DHS Privacy Officer will approve the data sharing agreements, protocols, procedures, and policies prior to the infrastructure “going live.” Additional members of the team will include the DHS ISD Manager, a Department Information

Systems Specialist (system administrator), a Data Analyst, the QI Manager, and a Health Program Manager.

Anticipated Challenges and Strategies

The primary challenge of Sonoma's WPC project will be to effectively, appropriately, and legally share BHD data with participating entities. As indicated above, the development of MOUs and data sharing agreements between participating entities and the County of Sonoma will require input from several stakeholders including County Counsel, Compliance, Privacy, ISD/IT, Program and Community Partners. The condensed timeline will be monitored and the data infrastructure timeline strictly followed.

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

4.1 Performance Measures

Tracking and documentation is a critical component to the success of the Sonoma WPC pilot. Throughout the Sonoma WPC pilot, all participating entities and agencies will participate in regular reporting on performance metrics, develop an understanding of the purpose and goals of the pilot through performance tracking, follow and learn from progress reports by other partner entities, and gain insight into how the pilot program leads the County of Sonoma to develop a highly effective case management system, to experience reductions in ED visits by high users, and to achieve more stable housing solutions for the target population.

Throughout the lifetime of this pilot, BHD will oversee the performance tracking system. This includes the overall WPC pilot performance measures as well as those specific to participating entities; all metrics are described in the tables in Section 4.1 below. The types of participating entities that will be tracked include administrative departments, hospitals, medical clinics, mental health service providers, and housing and housing support services providers. Entities will designate internal staff to be responsible for progress reporting on process and outcome metrics, and those staff will provide those data to the BHD on a monthly basis. Data analysts from the BHD and Redwood Community Health Coalition will be the primary staff developing forms, assisting participating entities with collecting and reporting data, and regularly organizing and analyzing data to pull into performance reports. Through charts, graphs, and other data illustrations, these reports will highlight overall pilot progress as well as progress by each participating entity, and will be shared at regular Steering Committee meetings for reflection, celebration, and decision-making on changes to the program when necessary.

For each program year and for each metric, Sonoma WPC identifies key quantitative targets. For the overall WPC pilot, **short-term process measures include:**
1) Establishing care coordination,

2) Conducting effective case management,

3) Creating referral policies and procedures across all partner entities, and

4) Continuing use of PDSA and application of lessons learned.

Ongoing outcome measures for the pilot include:

1) Increasing the numbers of WPC high utilizers who receive coordinated case management and are followed for 12 months. Status updates on WPC participants will be provided on a quarterly basis.

2) Increasing number of beneficiaries with a comprehensive care plan.

Health outcome metrics include:

1) Increasing the percentages of WPC Pilot high utilizers who have follow up medical, mental health, and SUD appointment no later than 30 days from date of release from jail or discharge from hospital,

2) Reducing the number of WPC Pilot high utilizers hospital readmissions within one year of WPC Pilot enrollment, and

3) Reducing ED use by WPC Pilot high utilizers.

Sonoma WPC also assigns outcome metrics for participating entities, including *hospital providers (ED and in-patient), medical and mental health providers, and housing and housing supportive services providers*, described in the charts below.

4.1.a Universal Metrics

- ✓ **Health Outcomes Measures**
- ✓ **Administrative Measures**

4.1.a Universal Metrics	PY 2	PY 3	PY 4	PY 5
Universal Metric 1: Administrative Metric - Proportion of participating beneficiaries with a comprehensive care plan within 30 days of WPC enrollment	50% participants	60% participants	70% participants	80% participants
Universal Metric 2: Administrative Metric - Proportion of participating beneficiaries with a comprehensive care plan within 30 days of beneficiary's anniversary of pilot participation	50% participants	60% participants	70% participants	80% participants
Universal Metric 3:	STC MM	Semi Annual	Implement	Review

4.1.a Universal Metrics	PY 2	PY 3	PY 4	PY 5
Administrative Metric - Care coordination, case management, and referral infrastructure	'V1.1.b' P&P completed by 10/1/17;	PDSA begun in this area'V1.1.c' methodology designed and implemented by 1/1/18	review of established P&Ps and process; identify areas for improvement and develop plans for improvement	impact of redesigned P&Ps and processes and identify areas for improvement and plan redesigned processes for services and systems going forward
Universal Metric 4: Administrative Metric - Data and Information Sharing Infrastructure	Initiate use of HIE and Collaborative Care Platform 1/1/18. Open for 50% enrolled	Maintain and improve HIE/ Collaborative Care Platform, train new Care Team members as needed and appropriate. Open for 60% enrolled	Maintain and improve HIE/ Collaborative Care Platform, train new Care Team members as needed and appropriate. Open for 80% enrolled	Maintain and improve HIE/ Collaborative Care Platform, train new Care Team members as needed and appropriate. Open for 90% enrolled
Universal Metric 5: Health Outcome - *Ambulatory Care - Emergency Department Visits (HEDIS)*	Maintain baseline	5% reduction from PY 2	5% reduction from PY 3	5% reduction from PY 4
Universal Metric 6: Health Outcome - *Inpatient Utilization-General Hospital/ Acute Care (IPU) (HEDIS)*	Maintain baseline	5% reduction from PY 2	5% reduction from PY 3	5% reduction from PY 4
Universal Metric 7: Health Outcome - *Follow-up After Hospitalization for Mental Illness (FUH) (HEDIS)*	Maintain baseline	5% increase from PY 2	5% increase from PY 3	5% increase from PY 4
Universal Metric 8: Health	Maintain	5% increase	5% increase	5% increase

4.1.a Universal Metrics	PY 2	PY 3	PY 4	PY 5
Outcome - *Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET) (HEDIS)*	baseline	from PY 2	from PY 3	from PY 4

4.1.b Variant Metrics

4.1.b Variant Metrics	Numerator	Denominator	PY 2	PY 3	PY 4	PY 5
Variant Metric 1: Administrative - Care team meetings established and held	N/A	N/A	Care team meetings held for 75% WPC	Meetings held for 80% participants	Meetings held for 85% participants	Meetings held for 90% participants
Variant Metric 2: Health outcomes- 30 day All Cause Readmissions	Count of 30-day readmission	Count of index hospital stay (HIS)	Maintain baseline count of index hospital stay (HIS) that are readmitted within 30 days	5% reduction in readmissions from PY2	5% reduction in readmissions from PY3	5% reduction in readmissions from PY4
Variant Metric 3: Health outcomes- Decrease Jail Recidivism (note: BHD doesn't use PHQ-9 Questionnaire to track Depression remission)	Total number of incarcerations of WPC participants during the reporting period.	Total number of WPC participants during the reporting period.	Establish baseline count of total number of WPC participants who were incarcerated during the WPC reporting period	5% reduction in number of incarcerated WPC participants from PY2	5% reduction in incarcerations from PY3	5% reduction in incarcerations from PY4
Variant Metric 4: Health outcomes - SMI Population: Suicide Risk	Patients who had suicide risk assessment completed at each	All patients aged 18 years and older with a new diagnosis or	50% of WPC SMI participants with a new diagnosis or recurrent	10% increase from PY2 of participants	5% increase from PY3	5% increase from PY4

4.1.b Variant Metrics	Numerator	Denominator	PY 2	PY 3	PY 4	PY 5
Assessment (NQF: 0104)	visit.	recurrent episode of Major Depressive Disorder.	episode of Major Depressive Disorder complete a suicide risk assessment at each visit	completing risk assessments		
Variant Metric 5: Housing outcomes - Percent of homeless receiving housing services that were referred for housing services	Number of participants referred for housing services that receive services	Number of participants referred for housing services.	Maintain baseline of the number of participants referred for housing services that receive services	10% increase from PY 2	5% increase from PY 3	5% increase from PY 4

4.2 Data Analysis, Reporting and Quality Improvement

Plan for Ongoing Data Collection, Reporting, and Analysis

In order to monitor the Sonoma WPC pilot's progress towards impacting the target population's health outcomes and the overall return on investment, partners will implement a coordinated and connected data collection, reporting, and analysis plan. The pilot will use data to identify and describe the target population, establish a metrics baseline, track implementation progress and system outcomes over time, establish performance for reimbursement, and inform the quality improvement process for change during the lifetime of the project. The Sonoma WPC pilot will integrate existing and new data sources and systems. Through initial conversations, partner entities have identified and shared information on the data systems they use and which metrics they are already collecting data on. Sonoma WPC pilot will launch using a combination of AVATAR, SWITS, and other systems as appropriate to collect all relevant data on the target population and the pilot implementation. Eventually these systems will be consolidated in order to break down silos and integrate external data in order to generate an accurate and complete picture of the needs of our target population. Data collected regularly will include CIP data, Medi-Cal data, Partnership Health Plan of California data, and HPPE (Health, Policy, Planning and Evaluation) data.

The key tools in driving the continuous quality improvement process will be collection of accurate, real-time data and the available analytical support provided by data analyst staff provided by the Department of Health Services and the Redwood Coalition of Health Centers. Enhanced data collection and analytical capability will enable the Steering Committee and the operations staff to identify gaps in services, programmatic challenges, and other areas requiring change and/or improvement.

Metrics will be tracked and reported on monthly. Operations and Quality staff will use this data plus information regarding the implementation of services and any barriers being experienced to determine if a change in service structure or delivery is warranted. The team will develop recommendations for consideration by the Steering Committee. Approved changes will be monitored monthly to determine if the desired impact is being achieved using the metrics identified and information from staff providing services.

Metrics will be reported to the state semi-annually, using state-provided templates. The Operations and Coordination team will develop a standard reporting dashboard, accessible to all WPC partners, and used regularly during Steering Committee updates on the status of universal and variant targets. As described earlier in section 3.2, Sonoma has established a timeline for planning and developing new data infrastructure that will support this pilot's data sharing, as well as reporting and analysis, efforts.

Quality Improvement and Change Management Approach

The Operations and Coordination Team will oversee quality improvement efforts, with input from the WPC-DW Committee, and will report regularly to the Steering Committee. All quality improvement efforts will apply a PDSA (Plan-Do-Study-Act) methodology and will incorporate community partner input and collaboration. The Quality Improvement Manager, Data Scientist, and program managers as appropriate will lead these efforts within the Operations and Coordination Team. With the support of the WPC-DW Workgroup, the Operations and Coordination Team will be held responsible for data integrity, and will regularly inform the rest of the Steering Committee if/when pilot strategies are successful and the County and participating entities are meeting WPC goals. Positive, neutral, and negative returns on investments will be reported, along with relevant and strategic recommendations on possible programmatic/pilot adjustments.

Regular data analyses and review will help inform the Sonoma WPC pilot's quality improvement and change management efforts. As Sonoma plans for the future sustainability of the project, monitoring for cost efficiencies and inefficiencies will be particularly important. All WPC programs and services will be evaluated based on both the universal and variant metrics. Data analysts will ensure the ongoing tracking of cost avoidance strategies and cost savings from WPC services, and the Steering Committee will in turn decide where to apply those savings, for example to program infrastructure, service enhancement, and additional staff to support the project in future years. The Operations and Coordination Team will oversee and report to the

Steering Committee on all quality improvement efforts, with the WPC Pilot Director having ultimate decision-making power over changes to the pilot and partner activities.

Data will be aggregated and reviewed on a monthly basis by the Operations and Coordination Team (OCT). They will make reports to the Steering Committee at their bi-monthly meetings. OCT will view data looking for trends to identify opportunities for improvement. OCT staff will work with staff providing services and to design improvements to aspects of the pilot should trends show that outcomes are not being achieved. These recommended changes will be presented to the Steering Committee for consideration and approval. OCT staff will lead structured improvement initiatives that support training, technical assistance, and system redesign to accelerate the rate of learning and to assure continuity and consistency of change.

4.3 Participant Entity Monitoring

The WPC Data Workgroup (WPC-DW) will be responsible for the ongoing monitoring of participating entities and for informing the decision-making process when technical assistance, corrective actions, or termination need to be considered. This workgroup will regularly report to the Steering Committee and to the Sonoma WPC Director on universal and variant process and outcome metrics. The WPC-DW will initially meet monthly, and then bi-monthly once the processes for data collection and analysis are firmly in place. Summary reports provided at quarterly meetings will contain: process and outcome performance, case counts and case manager-to-client ratios, results of PDSA activities, and draft performance reports. By utilizing the pilot's universal data system, Sonoma will be able to track the delivery of CIP services by participating entities, the timely progress towards metric goals, and any areas for concern or improvement.

When concerns are identified, such as metric goals not being met or other presenting problems, the WPC-DW will inform the WPC Director who will subsequently determine whether technical assistance, support, corrective action, or termination is necessary. In cases where a partner organization is not meeting its obligations to the WPC Pilot, the WPC Director and Steering Committee will work with the partner to develop a plan of correction. Participating entities will be provided with technical assistance and support for an agreed-upon appropriate length of time before any corrective actions or terminations are necessary. If performance does not improve after an appropriate length of time for assistance and support, WPC agreements will be terminated.

Equally important to the high-level tracking and overall performance management will be effective on-the-ground case management and infrastructure that enables oversight of care coordination and appropriate referrals. Participating entities will develop a plan for referral communications, policies, and procedures to ensure coordination between case managers and outreach workers / service providers connecting with the target population, such as weekly case review convened by BHD. Finally, all WPC Steering Committee and WPC-DW workgroup members will be encouraged to participate in available State Learning Collaborative opportunities as and when offered through the WPC program.

5 Financing

5.1 Financing Structure

Financing Structure of the WPC Pilot Including Distribution of Payments

Sonoma County's annual financing model for the WPC Pilot program leverages state and local funding as the match to pay for costs associated with the project. The financing (funding) sources are as follows:

Table 4: County Of Sonoma - WPC Annual Financing (Funding)

Source	Amount	%
Mental Health Services Act:	$1,951,517	46.73%
County General Fund:	$136,500	3.27%
Total non-federal funds	$2,088,017	50.00%

Oversight and Governance Structure for Intake and Payment of Funds, Including the Payment Timeline

The following is a description of the oversight and governance structures the County of Sonoma has in place for the intake and payment of funds.

- **For Payroll Expenditures** - Sonoma County uses an electronic timekeeping system ("Timesaver"). At the end of 2-week pay periods, employees and supervisors approve all-time records. Under the supervision of Auditor Controller-Treasurer-Tax Collector Department's Payroll division and the Information Systems Department, Timesaver data flows electronically to the Human Resources Management System ("HRMS", "eP") for processing and entry into the official County financial system. The Department of Health Services (DHS) Accounting department receives and reconciles the per-pay-period and quarterly payroll data. Labor data is also imported into the DHS internal cost accounting system (Dynamics GP), which is also reconciled quarterly to both the labor download and County EFS.

- **For Non Payroll Expenditures** - Purchase Orders (POs) are instigated using a DHS Non-Standard Supply Order Form. The order is approved by a field manager/supervisor and submitted to DHS Accounts Payable. An accountant approves the order for appropriation control before the order is placed. Accounting also matches invoices to the receiving doc, and Cost Accounting codes. Each accountant responsible for a Department ID being charged on the invoice must approve those charges. A pool of final approvers of Auditor Controller's staff review the invoice before being queued to the nightly check run. Expenditures are continually monitored by accountants and clerks for

inaccuracies, and are formally reviewed during midyear, 3rd quarter, and year-end reporting.

- **Receipt of Payments:** State check information and wire transfers are received by the County Treasury. Most State checks are sent to a lock-box and deposited in Sacramento. Interest allocation is calculated and distributed by Treasury Division of the Auditor Controller, Treasurer, & Tax Collector's Office. Monies are handled between the Treasury, the DHS A/R Accounting Technician, and the responsible Accountant (Department grants and allocations) or Account Clerk III (Behavioral Health Division Medi-Cal claiming) for coding. Deposits are approved by A/R Accounting through the Enterprise Financial System (EFS), before going to Treasury. The A/R Account Clerk II handles any discrepancies and, if necessary, contacts field offices for additional information. Deposits are submitted to the A/R Accounting Technician, and upon approval, the A/R Account Clerk II sends the deposit to the A/R Accountant. County Treasury completes daily reconciling of electronic deposits with cash and checks.

Payment Structure (PMPM vs. FFS) and Process (claims vs. scheduled bundled payments)
The payment structure Sonoma County will be utilizing for the WPC pilot project combines different mechanisms. The following is an outline of each year's payment mechanism:

Table 5: County of Sonoma - WPC Annual Mechanism for Payment

Payment Mechanism	PY 1	PY 2	PY 3	PY 4	PY 5
	% of Payment	% of Payment	% of Payment	% of Payment	% of Payment
Approved Application:	75%				
Submission of BL Data:	25%				
Admin. Infrastructure:		27%	11%	11%	11%
Delivery Infrastructure:		19%	12%	12%	12%
FFS:		23%	30%	30%	30%
PMPM:		29%	35%	35%	35%
Pay for Incentives:			1%	1%	1%
Pay for Reporting:			1%	1%	1%
Pay for Outcomes:		2%	8%	8%	8%
Total:	**100%**	**100%**	**100%**	**100%**	**100%**

Sonoma County will reimburse its contractors that are partnering with the county on this project on a monthly basis. Contractors will submit detailed "cost based" claims each month which will be reimbursed, and accounted for, through the normal county payment process.

Tracking of Payments

SCBH Fiscal will receive fully approved provider invoices from SCBH program staff, processing payments within County payment guidelines. SCBH Fiscal staff will track payments for each provider and balance to the Official County general ledger.

System Changes or New Systems Needed to Support Payment

As indicated in Section 3.2 – Data Sharing, the County of Sonoma anticipates utilizing the SWITS application to track both the number of individuals served through the WPC pilot each month (for PMPM) as well as the encounters that are provided to the individuals served (for FFS). The County anticipates, and has included this in the WPC budget, that enhancements/modifications will be needed to the SWITS application.

At this time SCBH Fiscal does not anticipate needing any additional systems to process payments to providers.

How Applicant will ensure that Funds are Sufficient to Provide Reimbursement

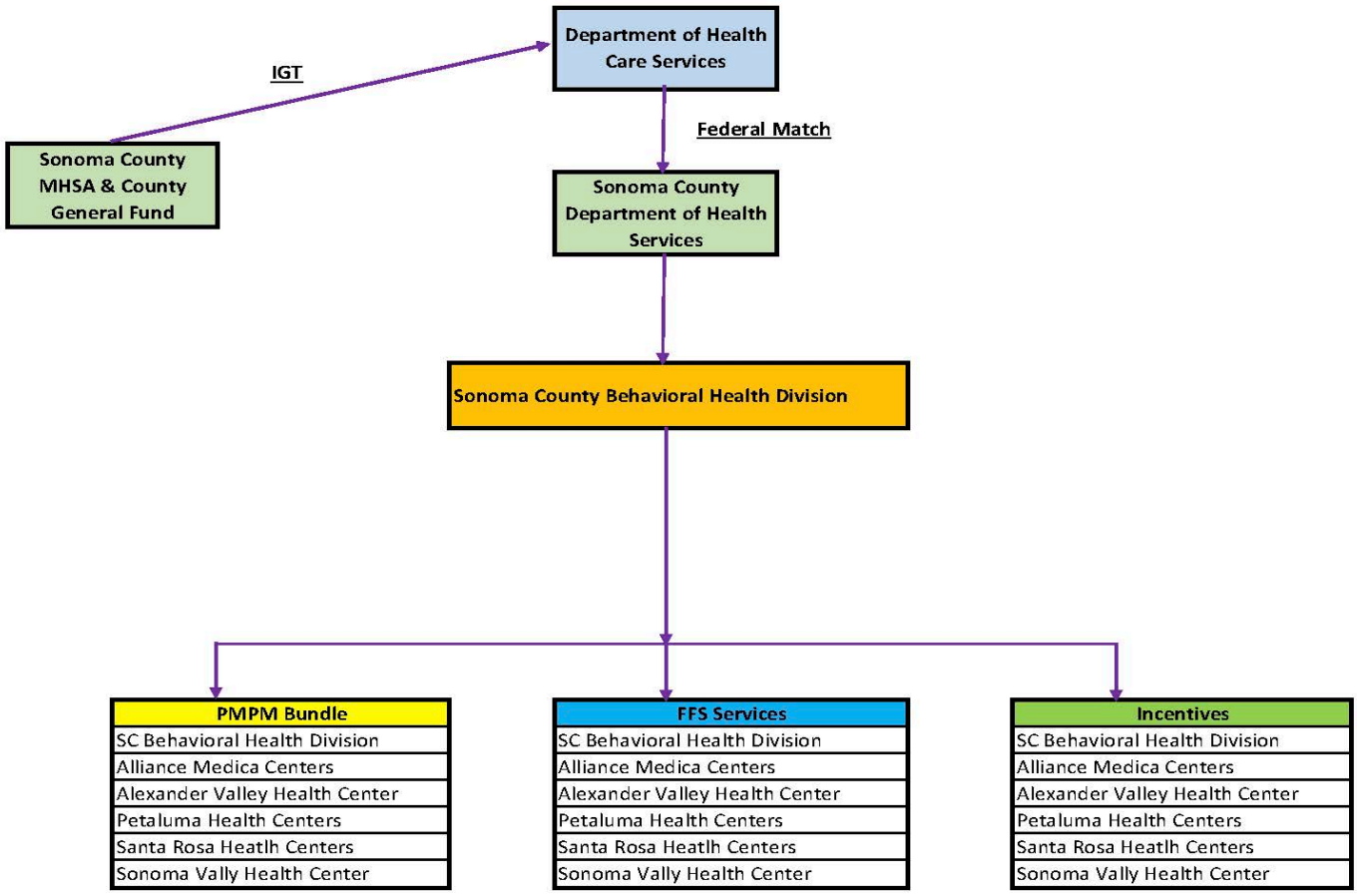
The County pays all expenditures out of a Special Revenue account, this account may have a negative cash balance. Once revenues or reimbursements are received they are deposited, offsetting any negative cash balance. This does not affect day-to-day business as the County as a whole maintains a positive cash balance.

How the Financing and Payment Approaches will Help Participants be Better Prepared for Value Based Payment Approaches in the Future

The Sonoma County WPC Pilot will serve as SCBH's first venture into value based payment models. The Division has long considered building outcomes and incentives into its reimbursement models for contractors. This will finally allow SCBH to test these approaches as well as develop the necessary infrastructure to enable this payment method. The Sonoma WPC Pilot will provide data that will help to inform such transitions for Medicaid programs in general. Through this pilot, SCBH will utilize various forms of bundled payments where participating entities, including the County of Sonoma, are responsible for better managing care for high-risk, high-volume populations, and have an incentive to develop and adopt clinical or administrative efficiencies. In addition, incentive payments and reporting requirements will encourage the tracking of outcomes and/or goals in key areas.

5.2 Funding Diagram

The funding diagram illustrating the flow of requested funds from DHCS and their distribution to other participating entities is attached and can be viewed below.



5.3 Non-Federal Share

Sonoma County will provide all of the required non-federal funding using County General Fund and Mental Health Services Act dollars.

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

The proposed Community Intervention Program (CIP) enhancement will focus on serving Medi-Cal beneficiaries. Individuals without Medi-Cal will be assessed and assisted, if appropriate, by eligibility staff who will process applications for those who are eligible. Those who are not eligible for Medi-Cal or who hesitate to sign up for benefits will continue to receive outreach services outside of the WPC Pilot.

The WPC Pilot will support infrastructure to integrate data in support of coordination of care between Sonoma County Behavioral Health, the community health centers, and hospital emergency departments.

The vast majority of the activities and interactions of the care coordination teams proposed for the WPC Pilot by Sonoma County will not duplicate Medi-Cal's targeted case management ("TCM") benefit and represent a more robust set of services than is allowed through the TCM benefit. Specifically, the WPC Pilot will provide outreach and engagement services, bundled intensive case management consisting of care coordination of primary and/or specialty health care, care coordination of specialty mental health services, coordination of homeless services, tenancy support and advocacy, and navigation support specifically for homeless services, advocacy for enrolled clients in accessing other services and benefits, client education related to physical health conditions and care, use of medications, motivational support and activities designed to establish rapport and maintain the therapeutic alliance between staff and clients, and other supportive services as needed, and short term recuperative care services. These services depart significantly from the encounter-based structure of TCM, and in the vast majority of cases the encounters between WPC staff and patients/clients/members would not be eligible for reimbursement under TCM. Moreover, the scope of care support and coordination activities available through WPC is intended to be more robust than available through Medi-Cal TCM (see above). WPC teams will engage in activities such as peer support, peer housing support, trust-building, motivational supports, disease specific education and general reinforcement of health concepts, housing services and supports navigation, and support in accessing benefits that are distinct from and outside the TCM benefit. WPC will also provide direct social and other services that would not be recognized as TCM, such as the provision of benefits advocacy and tenancy supports.

However, some of the services provided through the WPC pilot will be eligible under TCM. Sonoma County's proposal expands and enhances the existing CIP. Historically, 10% of the costs for CIP activities and services were covered through the Medi-Cal TCM program (calculated by dividing Medi-Cal funds received by total funding for the CIP). This is the method used for forecasting how much of the service provided in the WPC expansion might overlap with Medi-Cal TCM eligible. So, Sonoma County has applied a reduction of 10% in the costs associated with the outreach and engagement services and for the costs associated with the bundled intensive case management services.

5.5 Funding Request

The budget for Year 1 of the Sonoma County WPC Pilot is for the submission of the application and baseline data.

The Funding Request for the Sonoma County WPC Pilot is attached to this submission, and was developed using the template provided by DHCS. The budget identifies the yearly payment amounts proposed for each budget category identified by DHCS, the deliverables within each budget category for which payment will be provided, and the dollar amounts associated with

those deliverables. The budget narrative below summarizes the activities included in each program deliverable, the reason each deliverable was included in the pilot, and how the payment amount for each deliverable was calculated.

It is important to note that the benefits costs identified for all the Sonoma County staff positions have been determined by labor negotiations between the County and the unions representing County employees. In some cases, the value of benefits is fixed (e.g., health benefits). This results in variations in the percentage of total compensation by position. A staff person with a lower salary will likely have a higher percentage of total compensation related to benefits and conversely, staff with higher salaries will have a lower percentage of their total compensation in benefits.

For Sonoma County employees benefits include: health/dental/vision insurance, contribution to retirement, professional development allowance, FICA, long term disability insurance, life insurance, unemployment insurance, deferred compensation, and worker's compensation.

Infrastructure Development:

Administrative Infrastructure

Costs for Administrative Infrastructure include personnel costs for Sonoma County and its health center partners, administrative costs for health center partners, data sharing system development costs, and administrative services and supplies. These include the following:

PY 2 Administrative Infrastructure Budget

Total Administrative infrastructure development costs in PY2 equal $557,597 and include the following:

FEI or Other Development Costs: Includes the amount of $300,000 to support the development of a health information data sharing system that will enable program partners to share of data necessary to carry out the project and measure progress on the identified metrics.

Other Hardware/Software Costs: Includes the amount of $75,395 for the cost of hardware and software required to carry out data collection and sharing.

Sonoma County BHD Data Analyst (0.75 FTE): Responsible for collecting, analyzing and reporting data regarding program outcomes. Annual compensation of $165,005 x 0.75 FTE=$123,754.

Project Management (0.285 FTE): Administrative oversight of the project in PY2 will be provided by an Administrative Services Officer II within the Behavioral Health Division. Annual compensation of $205,080 x 0.285 FTE =$58,448.

Administrative Infrastructure Costs PY 2			
Administrative Infrastructure	**FTE or Units**	**Salary/Unit Cost**	**Annual Costs**
Sonoma County Data Analyst	0.75	165,005	123,754
Project Management - ASO II	0.285	205,080	58,448
FEI or other Development Costs	1.00	300,000	300,000
Other IT Hardware Costs	1.00	75,396	75,395
		Total	**$557,597**

PY3 through PY5 Administrative Infrastructure Budget

Total Administrative Infrastructure costs for Program Years 3 through 5 equal **$455,957** per year, and include the following:

Sonoma County BHD Data Analyst (1.5 FTE): Responsible for collecting, analyzing and reporting data related to program outcomes. Annual compensation of $165,005 ($95,222 salary + $69,783 benefits) x 1.5 FTE=$247,508.

RCHC Data Analyst (0.75 FTE): This position, based at community partner Redwood Community Health Coalition (RCHC), will support the collection, analysis and reporting of data regarding program outcomes. Annual compensation of $92,250 ($75,000 salaries + $17,259 benefits) x 0.75 FTE = $69,188.

RCHC Administrative Assistant (0.2 FTE): This position will provide administrative support to the Data Analyst at RCHC. Annual compensation of $51,660 ($42,000 salary + $9,660 benefits) x 0.2 FTE = $10,332.

RCHC IT MU Specialist (0.25 FTE): This position will offer information technology support related to data sharing by program partners. Annual compensation of $97,785 ($79,500 salary + $18,285 benefits) x 0.25 FTE = $24,446.

RCHC CMO/CMIO (0.2 FTE): Funding for the RCHC Chief Medical Officer/Chief Medical information Officer will enable RCHC to provide administrative oversight and support for the proposed WPC Pilot. Annual compensation of $153,920 (this is a contracted service with no benefits included in the compensation) x 0.2 FTE = $30,784

Community Health Center Partner Administrative Costs: The proposed budget includes funds for administrative costs for four of the CHC partners. These include the following amounts:

- Santa Rosa Community Health Centers = $5,047
- West County Community Health Centers = $4,225
- Petaluma Health Center = $7,905
- Alexander Valley Health Center = $4,535

Sonoma County Services & Supplies: Services and supplies costs for Sonoma County are allocated based upon the number of FTEs associated with a given project. The cost for services and supplies for a 1.0 FTE staff position equals $34,658, and includes the following:

- Administrative Services = $11,799
- Facility costs and rent = $8,429
- IT, Telecomm and phone = $6,882
- Cost Allocation Plan-OMB A-87 = $3,984
- Insurance = $2,041
- HRMS = $979
- Printing and office supplies = $544

For the 1.5 FTE County Data Analyst staffing for administrative infrastructure in PY3 through PY5, the corresponding cost for services and supplies equals $34,658 x 1.5 FTE = $51,986.

Administrative Infrastructure Annual Costs PY 3 through PY 5			
Administrative Infrastructure	**FTE or Units**	**Salary/Unit Cost**	**Annual Costs**
Sonoma County Data Analyst	1.50	165,005	247,508
RCHC Data Analyst	0.75	92,250	69,188
RCHC Admin Assistant	0.20	51,660	10,332
RCHC IT MU Specialist	0.25	97,785	24,446
RCHC Contracted CMO/CMIO	0.20	153,920	30,784
SC Services & Supplies	1.50	34,658	51,987
Subtotal Direct Costs			434,245
WCCHCs Admin	1.00	4,225	4,225
SRCHCs Admin	1.00	5,047	5,047
PHCs Admin	1.00	7,905	7,905
AVHC Admin	1.00	4,535	4,535
Subtotal Indirect Costs – 5%		21,712	21,712
		Grand Total	**$455,957**

Delivery Infrastructure

Costs for the WPC Pilot Delivery Infrastructure include personnel costs for Sonoma County and its health center partners, indirect costs for health center partners, data sharing system development costs, and associated services and supplies. These include the following:

PY 2 Delivery Infrastructure Budget

Total Delivery Infrastructure costs for PY 2 equal $392,236, and include the following:

Behavioral Health Specialist (0.5 FTE): The Delivery Infrastructure budget for PY 2 includes the cost for a full-time Behavioral Health Specialist for the six-month period of PY 2. This individual will be responsible for providing clinical supervision to staff serving program participants. Annual compensation of $156,772 ($101,774 salary + $54,998 benefits) x 0.5 FTE = $78,386.

Eligibility Worker (0.5 FTE): An Eligibility Worker will be hired full time for the six-month period of PY 2 to interview and assess the eligibility of potential participants in the WPC Pilot. This function supports clients being served in both the fee for service outreach and engagement as well as the bundled intensive case management services. Annual compensation of $114,700 ($66,588 salary + $48,112 benefits) x 0.5 FTE = $57,350.

Vehicles for use by outreach staff: The proposed PY 2 budget includes the cost of 6 vehicles for use by WPC Pilot outreach staff to enable them to travel to remove areas of the county. Total cost is calculated at 6 vehicles x $27,000 = $162,000.

Tablets/Computers: The total cost for 13 tablets and 13 computers is $52,000. The cost of tablets for use by program staff, including peer counselors, is calculated at 13 tablets x $1,500 per unit = $19,500. The cost of computers for use by program staff, including peer counselors, is calculated at 13 computers x $2,500 per unit = $32,500.

Desks and Chairs: The cost of desks and chairs for program staff is calculated at $2,500 per set x 17 sets = $42,500.

Delivery Infrastructure Costs for PY 2			
Delivery Infrastructure	**FTE or Units**	**Salary/Unit Cost**	**Annual Costs**
Behavioral Health Clinical Specialist	0.5	156,772	78,386
Eligibility Worker II	0.5	114,700	57,350
Vehicles	6.00	27,000	162,000
Tablets/Computers	26.00	2,000	52,000
Desks/Chairs	17.00	2,500	42,500
		Total	**$392,236**

PY 3 through PY 5 Delivery Infrastructure Budget

Total Delivery Infrastructure costs for the WPC Pilot in PY 3 through 5 equals $518,456 per year, and include the following:

Behavioral Health Specialist (1.0 FTE): The Delivery Infrastructure budget for PY 3 through 5 includes the cost for a full-time Behavioral Health Specialist. This individual will be responsible for providing clinical supervision to staff serving program participants. Annual compensation of $156,772 (101,774 salary + 54,998 benefits) x 1.0 FTE = $156,772.

Eligibility Worker (1.0 FTE): An Eligibility Worker will be hired to interview and assess the eligibility of potential participants in the WPC Pilot. This function supports clients being served in both the fee for service outreach and engagement as well as the bundled intensive case management services. Annual compensation of $114,700 ($66,588 + 48,112) x 1.0 FTE = $114,700.

Senior Office Assistant (1.0 FTE): Program costs for Delivery Infrastructure include a full-time Senior Office Assistant, responsible for providing administrative support to service delivery staff. Annual compensation of $95,678 ($50,461 + $45,217) x 1.0 FTE = $95,678.

AMC Behavioral Health Supervision (0.1 FTE): Delivery infrastructure costs for PY 3 through 5 include a 0.1 FTE senior clinician to provide clinical supervision AMC staff. Annual Compensation of $166,400 x 0.1 FTE = $16,640 ($12,480 salary + $4,160 benefits).

Travel Costs for CHC Partners: The PY 3 through PY 5 budget includes the following annual amounts for travel costs for CHC Partners:

- Santa Rosa Community Health Centers = $1,627
- West County Community Health Centers = $642
- Petaluma Health Center = $3,736

Indirect Costs for CHC Partners: The PY 3 through PY 5 budget includes the following annual amounts for indirect costs for CHC partners:

- Santa Rosa Community Health Centers = $17,034
- Sonoma Valley Community Health Centers = $7,654

Sonoma County Services & Supplies: As indicated above, services and supplies costs for Sonoma County are allocated based upon the number of FTEs associated with a particular project. The cost for services and supplies for a 1.0 FTE staff position equals $34,658, and includes the items identified previously.
Based upon the 3.0 FTE positions allocated to the Delivery Infrastructure for PY 3 through PY 5, the associated cost for services and supplies equals $34,658 x 3.0 FTE = $103,974.

Delivery Infrastructure Annual Costs PY 3 through PY 5			
Delivery Infrastructure	**FTE or Units**	**Salary/Unit Cost**	**Annual Costs**
Behavioral Health Clinical Specialist	1.00	156,772	156,772
Senior Office Assistant	1.00	95,678	95,678
Eligibility Worker II	1.00	114,700	114,700
WCCHCs Mileage	1,200	0.535	642
AMC BH Supervision	0.10	166,400	16,640
SRCHCs Mileage	3,041	0.535	1,627
PHC Travel	1.00	3,736	3,736
SC Services & Supplies	3.00	34,658	103,974
Subtotal Direct Costs			493,768
SRCHCs Indirect	1.00	17,034	17,034
SVCHC Indirect	1.00	7,654	7,654
Subtotal Indirect Costs			24,688
		Grand Total	**$518,457**

Incentive Payments for Downstream Providers

The Sonoma County WPC Pilot Budget includes payments to partner providers for their achievement of specified deliverables that are essential to the success of the project. These Incentive Payments are described below.

PY 2 Incentive Payments Budget

Incentive payments are not included in the budget for Program Year 2.

PY 3 through 5 Incentive Payments Budget

The Sonoma County WPC Pilot budget includes the amount of $60,000 in each of Program Years 3 through 5. Incentives are to be provided to the six community health centers for the hiring

and retention of nurse outreach and engagement and case management staff. Each community health center will be eligible for a maximum $10,000 incentive payment each PY based on their ability to hire and retain WPC Pilot staff. Each health center will be evaluated individually and will be able to earn their incentive based on their individual performance whether or not the other health centers achieved their staffing goals.

Health Center	Incentive Available by Goal Achieved		
	60%	70%	80%
Alexander Valley Health Center	$ 6,000	$ 7,000	$ 10,000
Alliance Medical Centers	$ 6,000	$ 7,000	$ 10,000
Petaluma Health Centers	$ 6,000	$ 7,000	$ 10,000
Santa Rosa Health Centers	$ 6,000	$ 7,000	$ 10,000
Sonoma Valley Health Center	$ 6,000	$ 7,000	$ 10,000
West County Community Health Centers	$ 6,000	$ 7,000	$ 10,000

At the end of each PY, invoices submitted by each health center will be used to determine the percentage of time during the PY that their positions available through the WPC were filled. The amount of the incentive payment will be determined by the percentages listed in the table above.

The success of the WPC pilot is dependent on the full participation of the clinical teams made up of behavioral health staff from the BHD and nursing staff from the health centers. These teams provide a focal point for the collaboration, bi-directional clinical services, integration of health and behavioral health services, and the foundation for data gathering and bi-directional data sharing. These incentives are designed to reward the health centers for prioritizing the hiring and retention of staff assigned to the WPC Pilot.

Fee for Service Services

PY 2 Fee For Service Budget

The total Fee-For-Service Budget for Program Year 2 equals $488,484. This amount includes the following items:

Outreach and Engagement Services: These services will play a key role in enabling clients to access services, particularly in regions of the county where mental health and other services are underutilized. Calculations for the cost of this activity are based upon an estimated total of 8,500 units of service x $48.56 per unit = $412,760, and includes the items listed below.

Senior Client Support Specialists: The FFS budget for PY 2 includes the cost for 2 full-time Behavioral Health Specialists. These Specialists will be responsible for ensuring that program participants are able to fully access needed services. Annual compensation of $117,171 ($64,688 salary + $52,483 benefits) x 2.0 FTE = a cost of $234,342 per year.

Peer Advocates (Client Support Spec): The FFS budget includes funds for 2 full-time Peer Advocates, who will provide supportive services to participants informed by their own participation in similar kinds of programming. Annual compensation of $93,734 ($51,147 salary + $42,587 benefits) x 2.0 FTE = a cost of $187,468 per year.

Behavioral Health Clinician: The FFS budget for PY 2 includes the cost of 1.28 FTE BH Clinicians, who will provide clinical case management for participants. Annual compensation of $155,493 ($87,922 salary + $67,571) x 1.28 FTE = a cost of $199,031 per year.

Outreach Nursing Staff at Partner CHCs: The proposed FFS budget includes outreach nursing staff located at each of the six partner community health centers, who will contributed to efforts to engage the target population in needed services.

- **West County Community Health Centers Outreach RN:** Annual compensation of $104,000 ($83,200 salary + $20,800 benefits) x 0.4 FTE = $41,600 per year.
- **Santa Rosa Community Health Centers Outreach RN:** Annual compensation of $111,009 ($92,498 salary + $18,511 benefits) x 0.8 FTE = $88,807 per year.
- **Alexander Valley Community Health Centers Outreach RN:** Annual compensation of $112,300 ($93,600 salary + $18,700 benefits) x 0.4 FTE = $44,920 per year.
- **Petaluma Community Health Center Outreach RN:** Annual compensation of $99,221($78,065 salary + $21,156 benefits) x 0.6 FTE = $59,533 per year.
- **Sonoma Valley Community Health Centers Outreach LVN:** Annual compensation of $77,813 ($60,320 salary + $17,493 benefits) x 0.4 FTE = $31,125 per year.
- **Alliance Medical Center Outreach RN:** Annual compensation of $114,400 ($85,800 salary + $28,600 benefits) x 0.2 FTE = $22,880 per year.

Sonoma County Services & Supplies: As indicated previously, and itemized on page 28, services and supplies costs for Sonoma County are allocated based upon the number of FTEs associated with a given project. Based upon the cost for services and supplies for a 1.0 FTE Sonoma County staff position of $34,639, the associated cost for services and supplies for FFS Outreach and Engagement staff is calculated as $34,639 x 5.28 FTE = $182,894 per year.

FFS Costs PY 2 - Outreach and Engagement Costs for a Full Year			
FFS Services Cost Components	**FTE or Units**	**Salary/Unit Cost**	**Annual Costs**
Senior Client Support Specialist	2.00	117,171	234,342
Peer Advocates (Client Support Spec)	2.00	93,734	187,468
Behavioral Health Clinician	1.28	155,493	199,031
WCCHCs Outreach RN	0.40	104,000	41,600
SRCHCs Outreach RN	0.80	111,009	88,807
AVCHCs Outreach RN	0.40	112,300	44,920
PCHCs Outreach RN	0.60	99,222	59,533
SVCHCs Outreach LVN	0.40	77,813	31,125
AMC Outreach RN	0.20	114,400	22,880
SC Services & Supplies	5.28	34,639	182,894
Total Costs Making up FFS Cost basis			$1,092,600

The costs above represent the costs that make up the FFS OE costs for a full year. These total annual costs for providing FFS OE were divided by the projected annual units of service (22,500) to establish a cost per unit of $48.56. The annual units of service were calculated using actual service activity for the current CIP staffing and then adjusted to reflect the WPC OE FTE.

In order to estimate actual costs for PY 2, units of service were forecast for the period (8,500). The calculated unit costs based on a full year of services and costs is $48.56 per unit. As a result, total costs for FFS OE in PY 2 is $412,760. The table below summarizes these calculations.

Medi-Cal TCM Services Adjustment: Based on past experience with the CIP, estimate that 10% of FFS Services will be Medi-Cal eligible through the TCM program. The 10% adjustment = ($41,276)

FFS PY 2 – Outreach and Engagement – Calculated Costs			
	Units	**Unit Cost**	**Total Cost**
PY 2 UOS, Unit Cost, OE Costs	8,500	$48.56	$412,760
Medi-Cal TCM Services Adjustment			(41,276)
Total OE FFS Costs PY 2			$371,484

Short Term Recuperative Care Services: The cost of this service is based upon an estimated 900 units (days) of service x $130/day = $117,000. The units of service (bed days) were calculated based on an estimate of 257 admissions and the average length of stay of 3.5 days. The daily rate is based on actual costs for the operation of the existing services under a contract with BHD.

FFS Services PY 2 – Short Term Recuperative Care Services	**Units**	**Unit Cost**	
Contracted Costs	900	$130	117,000
Total Short Term Recuperative Care Services FFS Costs			**$117,000**

PY 3 through 5 Fee-For-Service Budget

The total Fee-For-Service Budget for Program Years 3 through 5 equals $1,256,340 per year. This amount includes the following:

Outreach and Engagement Service

These services will play a key role in enabling clients to access services, particularly in regions of the county where mental health and other services are underutilized. Calculations for the cost of this activity are based upon an estimated total of 22,500 units of service x $48.56 per unit = $1,092, 600. These costs are based upon calculations of the cost of outreach to a similar population under the CIP program, and include the items identified below.

Senior Client Support Specialists: The FFS budget for PY 3 through 5 includes the cost for 2 full-time Behavioral Health Specialists. These Specialists will be responsible for ensuring that program participants are able to fully access needed services. Annual compensation of $117,171 ($64,688 salary + $52,483 benefits) x 2.0 FTE = a cost of $234,342 per year.

Peer Advocates (Client Support Spec): The FFS budget includes funds for 2 full-time Peer Advocates, who will provide supportive services to participants informed by their own participation in similar kinds of programming. Annual compensation of $93,734 ($51,147 salary + $42,587 benefits) x 2.0 FTE = a cost of $187,468 per year.

Behavioral Health Clinician: The FFS budget for PY 3 through 5 includes the cost of 1.28 FTE BH Clinicians, who will provide clinical case management for participants. Annual compensation of $155,493 ($87,922 salary + $67,571) x 1.28 FTE = a cost of $199,031 per year.

Outreach Nursing Staff at Partner CHCs: The proposed FFS budget includes outreach nursing staff located at each of the six partner community health centers, who will contributed to efforts to engage the target population in needed services.

- **West County Community Health Centers Outreach RN:** Annual compensation of $104,000 ($83,200 salary + $20,800 benefits) x 0.4 FTE = $41,600 per year.
- **Santa Rosa Community Health Centers Outreach RN:** Annual compensation of $111,009 ($92,498 salary + $18,511 benefits) x 0.8 FTE = $88,807 per year.
- **Alexander Valley Community Health Centers Outreach RN:** Annual compensation of $112,300 ($93,600 salary + $18,700 benefits) x 0.4 FTE = $44,920 per year.
- **Petaluma Community Health Center Outreach RN:** Annual compensation of $99,221($78,065 salary + $21,156 benefits) x 0.6 FTE = $59,533 per year.
- **Sonoma Valley Community Health Centers Outreach LVN:** Annual compensation of $77,813 ($60,320 salary + $17,493 benefits) x 0.4 FTE = $31,125 per year.
- **Alliance Medical Center Outreach RN:** Annual compensation of $114,400 ($85,800 salary + $28,600 benefits) x 0.2 FTE = $22,880 per year.

Sonoma County Services & Supplies: As indicated previously, and itemized on page 28, services and supplies costs for Sonoma County are allocated based upon the number of FTEs associated with a given project. Based upon the cost for services and supplies for a 1.0 FTE Sonoma County staff position of $34,639, the associated cost for services and supplies for FFS Outreach and Engagement staff is calculated as $34,639 x 5.28 FTE = $182,894.

FFS Annual Costs PY 3 through 5 – Outreach and Engagement Costs for a Full Year			
FFS Services	**FTE or Units**	**Salary/Unit Cost**	**Annual Costs**
Senior Client Support Specialist	2.00	117,171	234,342

FFS Annual Costs PY 3 through 5 – Outreach and Engagement Costs for a Full Year			
FFS Services	**FTE or Units**	**Salary/Unit Cost**	**Annual Costs**
Peer Advocates (Client Support Spec)	2.00	93,734	187,468
Behavioral Health Clinician	1.28	155,493	199,031
WCCHCs Outreach RN	0.40	104,000	41,600
SRCHCs Outreach RN	0.80	111,009	88,807
AVCHCs Outreach RN	0.40	112,300	44,920
PCHCs Outreach RN	0.60	99,222	59,533
SVCHCs Outreach LVN	0.40	77,813	31,125
AMC Outreach RN	0.20	114,400	22,880
SC Services & Supplies	5.28	34,639	182,894
		Total	**$1,092,600**

Medi-Cal TCM Services Adjustment: Based on past experience with the CIP, estimate that 10% of FFS Services will be Medi-Cal eligible through the TCM program. The 10% adjustment = ($109,260)

FFS PY 3 - 5 – Outreach and Engagement – Calculated Costs			
	Units	**Unit Cost**	**Total Cost**
PY 3 – 5 UOS, Unit Cost, OE Costs	22,500	$48.56	1,092,600
Medi-Cal TCM Services Adjustment			(109,260)
Total OE FFS Costs PY 3-5			$983,340

Short Term Recuperative Care Services: The cost of this service is based upon an estimated 2,100 units (days) of service x $130/day = $273,000 per year. The calculation of units of service was based on the assumption of 600 admissions with an average length of stay of 3.5 days. The daily rate is based on actual costs for the operation of the existing services under a contract with BHD.

FFS Services – Short Term Recuperative Care Services	Units	Unit Costs	Annual Costs
Recuperative Services	2,100	130	273,000
Total Short Term Recuperative Care Services FFS Costs			**$273,000**

PMPM Bundle

PY 2 PMPM Bundle Budget

The ICM services will be financed through the PMPM bundle. The IMC services will include care coordination of primary and/or specialty health care, care coordination of specialty mental health services, coordination of homeless services, tenancy support and advocacy, and navigation support specifically for homeless services, advocacy for enrolled clients in accessing

other services and benefits, client education related to physical health conditions and care, use of medications, motivational support and activities designed to establish rapport and maintain the therapeutic alliance between staff and clients, and other supportive services as needed. Clients enrolled in ICM may receive OE services in order to re-engage them. Clients receiving ICM services may also be referred to and receive Short Term Recuperative Care Services. All clients enrolled in ICM will receive housing support depending on their specific needs including linkage to housing services, tenancy services and advocacy. ICM staff will provide ongoing monitoring of client needs including their housing status. These clients are high need/high acuity. As noted in describing the target population analysis, the top 10% of beneficiaries in total costs (5,134 beneficiaries) included 3,356 had a diagnosis of major depression, psychosis, substance use disorder, and/or bi-polar disorder. Of those beneficiaries who were hospitalized and/or used emergency services (329), 83% were identified as having a mental health and/or substance use disorder.

The total PMPM Bundle Budget for a full year equals $1,639,200. To establish a PMPM rate, Sonoma County forecast member months for an average year. The forecast member months of 1,200 were divided into the annual cost for this service bundle to establish a per-member-per month cost of $1,366.

For PY 2, the estimated member months is 500 resulting in total costs of $683,300. Applying the Medi-Cal TCM overlap adjustment of -10%, the net total costs for PY 2 for the PMPM Intensive Case Management services is $614,700

The costs that make up the basis for the PMPM calculation are listed below.

Intensive Case Management Bundle: The proposed cost for the Intensive Case Management Bundle in PY 2 is $683,000, based upon a calculation of 500 member months x $1,366 per unit of service. The PY 2 Intensive Case Management Bundle includes the costs identified below.

Senior Client Support Specialists: The FFS budget for PY 3 through 5 includes the cost for 3 full-time Senior Client Support Specialists. These Specialists will be responsible for ensuring that program participants are able to fully access needed services. Annual compensation of $117,171 ($64,688 salary + $52,483 benefits) x 3.0 FTE = a cost of $351,513 per year.

Peer Advocates (Client Support Spec): The FFS budget includes funds for 3 full-time Peer Advocates, who will provide supportive services to participants informed by their own participation in similar kinds of programming. Annual compensation of $93,734 ($51,147 salary + $42,587 benefits) x 3.0 FTE = a cost of $281,202 per year.

Behavioral Health Clinician: The FFS budget for PY 3 through 5 includes the cost of 1.92 FTE BH Clinicians, who will provide clinical case management for participants. Annual compensation of $155,493 ($87,922 salary + $67,571) x 1.92 FTE = a cost of $298,547 per year.

Outreach Nursing Staff at Partner CHCs: The proposed FFS budget includes outreach nursing staff located at each of the six partner community health centers, who will contributed to efforts to engage the target population in needed services.

- **West County Community Health Centers Outreach RN:** Annual compensation of $104,000 ($83,200 salary + $20,800 benefits) x 0.6 FTE = $62,400 per year.
- **Santa Rosa Community Health Centers Outreach RNs:** Annual compensation of $111,009 ($92,498 salary + $18,511 benefits) x 1.2 FTE = $133,211 per year.
- **Alexander Valley Community Health Centers Outreach RN:** Annual compensation of $112,300 ($93,600 salary + $18,700 benefits) x 0.6 FTE = $67,380 per year.
- **Petaluma Community Health Center Outreach RN:** Annual compensation of $99,221 ($78,065 salary + $21,156 benefits) x 0.9 FTE = $89,299 per year.
- **Sonoma Valley Community Health Centers Outreach LVN:** Annual compensation of $77,813 ($60,320 salary + $17,493 benefits) x 0.6 FTE = $46,688 per year.
- **Alliance Medical Center Outreach RN:** Annual compensation of $114,400 ($85,800 salary + $28,600 benefits) x 0.3 FTE = $34,320 per year.

Sonoma County Services & Supplies: As indicated previously, and itemized on page 25, services and supplies costs for Sonoma County are allocated based upon the number of FTEs associated with a given project. Based upon the cost for services and supplies for a 1.0 FTE Sonoma County staff position of $34,677, the associated cost for services and supplies for FFS Outreach and Engagement staff is calculated as $34,677 x 7.92 FTE = $274,640.

PMPM Bundle Costs PY 2 – Intensive Case Management for a Full Year			
PMPM Services	**FTE or Units**	**Salary/Unit Cost**	**Annual Costs**
Senior Client Support Specialist	3.00	117,171	351,513
Peer Advocates (Client Support Spec)	3.00	93,734	281,202
Behavioral Health Clinician	1.92	155,493	298,547
WCCHCs Outreach RN	0.60	104,000	62,400
SRCHCs Outreach RN	1.20	111,009	133,211
AVCHCs Outreach RN	0.60	112,300	67,380
PCHCs Outreach RN	0.90	99,222	89,299
SVCHCs Outreach LVN	0.60	77,813	46,688
AMC Outreach RN	0.30	114,400	34,320
SC Services & Supplies	7.92	34,677	274,640
Total Costs Making up PMPM basis			$1,639,200

PY 2 PMPM Bundled – Intensive Case Management Calculated Costs			
	MMs	PM Cost	Total Cost
PY 2 UOS, Unit Cost, OE Costs	500	$1,366	683,000
Medi-Cal TCM Services Adjustment			(68,300)
Total ICM Costs PY 2			$614,700

Medi-Cal TCM Services Adjustment: Based on past experience with the CIP, estimate that 10% of PMPM Services will be Medi-Cal eligible through the TCM program. The 10% adjustment = ($68,300)

PY 3 through 5 PMPM Bundle Budget

The total PMPM Bundle Budget for Program Years 3 through 5 equals $1,639,200 per year. Calculations for the cost of this budget element are based upon an estimated total of 1,200 units of service x $1,366 per unit = $1,639,200. These costs are based upon calculations of the cost of outreach to a similar population under the CIP program, and include the items identified below.

Senior Client Support Specialists: The FFS budget for PY 3 through 5 includes the cost for 3 full-time Senior Client Support Specialists. These Specialists will be responsible for ensuring that program participants are able to fully access needed services. Annual compensation of $117,171 ($64,688 salary + $52,483 benefits) x 3.0 FTE = a cost of $351,513 per year.

Peer Advocates (Client Support Spec): The FFS budget includes funds for 3 full-time Peer Advocates, who will provide supportive services to participants informed by their own participation in similar kinds of programming. Annual compensation of $93,734 ($51,147 salary + $42,587 benefits) x 3.0 FTE = a cost of $281,202 per year.

Behavioral Health Clinician: The FFS budget for PY 3 through 5 includes the cost of 1.92 FTE BH Clinicians, who will provide clinical case management for participants. Annual compensation of $155,493 ($87,922 salary + $67,571) x 1.92 FTE = a cost of $298,547 per year.

Outreach Nursing Staff at Partner CHCs: The proposed FFS budget includes outreach nursing staff located at each of the six partner community health centers, who will contributed to efforts to engage the target population in needed services.

- **West County Community Health Centers Outreach RN:** Annual compensation of $104,000 ($83,200 salary + $20,800 benefits) x 0.6 FTE = $62,400 per year.
- **Santa Rosa Community Health Centers Outreach RNs:** Annual compensation of $111,009 ($92,498 salary + $18,511 benefits) x 1.2 FTE = $133,211 per year.
- **Alexander Valley Community Health Centers Outreach RN:** Annual compensation of $112,300 ($93,600 salary + $18,700 benefits) x 0.6 FTE = $67,380 per year.

- **Petaluma Community Health Center Outreach RN:** Annual compensation of $99,221 ($78,065 salary + $21,156 benefits) x 0.9 FTE = $89,299 per year.
- **Sonoma Valley Community Health Centers Outreach LVN:** Annual compensation of $77,813 ($60,320 salary + $17,493 benefits) x 0.6 FTE = $46,688 per year.
- **Alliance Medical Center Outreach RN:** Annual compensation of $114,400 ($85,800 salary + $28,600 benefits) x 0.3 FTE = $34,320 per year.

Sonoma County Services & Supplies: As indicated previously, and itemized on page 25, services and supplies costs for Sonoma County are allocated based upon the number of FTEs associated with a given project. Based upon the cost for services and supplies for a 1.0 FTE Sonoma County staff position of $34,677, the associated cost for services and supplies for FFS Outreach and Engagement staff is calculated as $34,677 x 7.92 FTE = $274,640.

PMPM Bundle Annual Costs PY 3 through 5 – Intensive Case Management for a Full Year			
PMPM Services	**FTE or Units**	**Salary/Unit Cost**	**Annual Costs**
Senior Client Support Specialist	3.00	117,171	351,513
Peer Advocates (Client Support Spec)	3.00	93,734	281,202
Behavioral Health Clinician	1.92	155,493	298,547
WCCHCs Outreach RN	0.60	104,000	62,400
SRCHCs Outreach RN	1.20	111,009	133,211
AVCHCs Outreach RN	0.60	112,300	67,380
PCHCs Outreach RN	0.90	99,222	89,299
SVCHCs Outreach LVN	0.60	77,813	46,688
AMC Outreach RN	0.30	114,400	34,320
SC Services & Supplies	7.92	34,677	274,640
		Total	**$1,639,200**

PY 3 thru 5 PMPM Bundled – Intensive Case Management Calculated Costs			
	MMs	**PM Cost**	**Total Cost**
PY 2 UOS, Unit Cost, OE Costs	1,200	$1,366	1,639,200
Medi-Cal TCM Services Adjustment			(163,920)
Total ICM Costs PY 3-5			1,475,280

Medi-Cal TCM Services Adjustment: Based on past experience with the CIP, estimate that 10% of PMPM Services will be Medi-Cal eligible through the TCM program. The 10% adjustment = ($163,920)

Pay for Reporting

The Sonoma County WPC Pilot budget includes the amount of $60,000 in each of Program Years 3 through 5 to provide Pay for Reporting to community health centers as contracted partners.

These funds will be shared equally between the six participating community health center organizations.

Each of the health centers in the WPC Pilot are providing staff for fully integrated teams. Since the provision of services and the resulting reporting is also integrated. The OE and ICM teams will include staff from the lead entity, Sonoma County BHD, and each of the participating health centers. These teams will work together day to day, face to face. Reporting on each of the metrics will also be a shared responsibility. However, as the lead entity, Sonoma County BHD does want to reward and/or encourage the health center partners to do their part in gathering data and reporting on the metrics identified in the Pay for Outcomes. These were selected because of their importance as described in the Pay for Outcomes section.

The pay for reporting will be available to the health centers when the pilot submits the required reports at each 6 month milestone. As noted above, the reporting is not a separate responsibility or activity and the pay for reporting reflects this shared responsibility and reporting process. So, if the required reports are submitted at the mid-point of a period, each health center would receive $5,000 for reporting. The same would apply to the end of a PY with another $5,000 being available for each health center. The award reflects the performance of the pilot for the period in question and consequently, all mental health centers will receive their share of the pay for reporting or none will.

Pay for Outcomes

The Sonoma County WPC Pilot budget includes the amount of $35,000 for PY 2 and $350,000 in each of Program Years 3 through 5 to provide Pay for Outcomes to contracted partners. Pay for outcomes is available for the six community health center partners and the BHD.

Outcome payments will be available based on performance related to two universal metrics and three variant metrics. For PY 2, $35,000 will be available for variant metric 5 related to housing services. For PY 3 through 5 a total of $70,000 will be available for each metric. The payments will be shared equally between the six community health centers and the BHD. The table below summarizes the metrics and pay for outcomes available. The metrics represent the entire pilot and will be earned by all of the partners based on the status of each metric at the end of each PY.

Pay for Outcome Metric	PY 2 Funds	PY 3 Funds	PY 4 Funds	PY 5 Funds	Total Funds
Universal Metric 5: Health Outcome - Ambulatory Care - Emergency Department Visits (HEDIS)		$70,000	$70, 000	$ 70,000	$ 210,000

Pay for Outcome Metric	PY 2 Funds	PY 3 Funds	PY 4 Funds	PY 5 Funds	Total Funds
Universal Metric 6: Health Outcome - Inpatient Utilization-General Hospital/ Acute Care (IPU) (HEDIS)		70,000	70,000	70,000	210,000
Variant Metric 2: Health outcomes- 30 day All Cause Readmissions		70,000	70,000	70,000	210,000
Variant Metric 3: Health outcomes- Decrease Jail Recidivism		70,000	70,000	70,000	210,000
Variant Metric 5: Housing outcomes - Percent of homeless receiving housing services that were referred for housing services	35,000	70,000	70,000	70,000	245,000
Total	$ 35,000	$ 350,000	$ 350,000	$ 350,000	$1,085,000

Pay for Outcome Detail:

Universal Metric 5*: Health Outcome - Ambulatory Care - Emergency Department Visits (HEDIS)*: the overall goal for the WPC pilot includes increasing access to clinical services that will enhance client experience and reducing overall system costs. Reducing the use of emergency department services by WPC clients represents a significant opportunity to improve client experience and reduce overall costs and, support hospitals in providing higher quality emergency services to those who need them. Supporting an individual so that they do not experience crisis will eliminate the chaotic events that lead to an emergency department visit. It will reduce the demands often placed on law enforcement in these crises situations. It will eliminate the disruption that occurs in the lives of individuals with mental illness when they find themselves unable to cope.

The pilot will earn this pay for outcome when it can be demonstrated that the goal for the period is met as indicated below:

PY 3 5% reduction from baseline

PY 4	5% reduction from PY 3
PY 5	5% reduction from PY 4

Universal Metric 6*: Health Outcome - Inpatient Utilization-General*: As with emergency room utilization, hospital admission represents a high cost intervention and is disruptive to the lives of clients. Again, this metric was selected because it represents a clear opportunity to improve care and reduce costs.

The pilot will earn this pay for outcome when it can be demonstrated that the goal for the period is met as indicated below:

PY 3	5% reduction from baseline
PY 4	5% reduction from PY 3
PY 5	5% reduction from PY 4

Variant Metric 2*: Health outcomes- 30 day All Cause Readmissions*: While eliminating the avoidable use of emergency and hospital services represents a desired outcome, there will certainly be times when WPC clients are hospitalized. When this occurs, WPC staff will mobilize to work with hospital staff and clients to develop a discharge plan and to support the client upon discharge. This will include prioritizing contacts with clients post discharge and making sure clients receive services as soon as possible post discharge. The 30 day readmission rate is an indicator of the effectiveness of these interventions and can support the PDSA process.

The pilot will earn this pay for outcome when it can be demonstrated that the goal for the period is met as indicated below:

PY 3	5% reduction from baseline
PY 4	5% reduction from PY 3
PY 5	5% reduction from PY 4

Variant Metric 3*: Health outcomes- Decrease Jail Recidivism*: The process of incarceration for individuals with mental illness is traumatic and disruptive. Avoidable instances of incarceration put a burden on law enforcement resources and disrupt the lives of individuals and their families. Clearly there is nothing pleasant about being arrested and jailed, and could only be characterized as useful if it results in increased motivation for change on the part of the person incarcerated. In many cases, it can result in a decline in the health status of the individual.

This metric will help the pilot to evaluate the overall effectiveness of the interventions and supports provided to clients and to identify the need for changes.

The pilot will earn this pay for outcome when it can be demonstrated that the goal for the period is met as indicated below:

PY 3	5% reduction from baseline
PY 4	5% reduction from PY 3
PY 5	5% reduction from PY 4

Variant Metric 5*: Housing outcomes - Percent of homeless referred for housing services*: Having a place to live that is healthy and stable has been shown to significantly increase health status and to reduce the use of emergency and hospital services and the rate of incarceration. As a result, the Housing First initiative has been identified as a best practice for supporting individuals with mental illness.

How effective the pilot is in involving clients in the housing support services that will be offered and helping them to access housing services is expected to have a significant impact on the overall success of the pilot and the health status of clients.

The pilot will earn this pay for outcome when it can be demonstrated that the goal for the period is met as indicated below:

PY 2	Maintain baseline
PY 3	10% increase from baseline
PY 4	5% increase from PY 3
PY 5	5% increase from PY 4

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

New WPC Applicant Name:	*Sonoma County Behavioral Health Division*

	Federal Funds *(Not to exceed 90M)*	**IGT**	**Total Funds**
PY 1 Annual Budget Amount Requested	1,044,009	1,044,009	2,088,017
PY 2 Annual Budget Amount Requested	1,044,009	1,044,009	2,088,017
PYs 3-5 Annual Budget Amount Requested	2,088,017	2,088,017	4,176,034

Second Round PY 1 Budget Allocation (Note PY 1 Allocation is predetermined)	
PY 1 Total Budget	2,088,017
Approved Application (75%)	1,566,013
Submission of Baseline Data (25%)	522,004
PY 1 Total Check	OK
Does PY 1 Total = 50% of PY 3 Total?	Yes

Second Round PY 2 Budget Allocation	
PY 2 Total Budget	2,088,017
Administrative Infrastructure	557,597
Delivery Infrastructure	392,236
Incentive Payments	0
FFS Services	488,484
PMPM Bundle	614,700
Pay For Reporting	0
Pay for Outcomes	35,000
PY 2 Total Check	OK
Does PY 2 Total = 50% of PY 3 Total?	Yes

Second Round PY 3 Budget Allocation	
PY 3 Total Budget	4,176,034
Administrative Infrastructure	455,957
Delivery Infrastructure	518,457
Incentive Payments	60,000
FFS Services	1,256,340
PMPM Bundle	1,475,280
Pay For Reporting	60,000
Pay for Outcomes	350,000
PY 3 Total Check	OK

Second Round PY 4 Budget Allocation	
PY 4 Total Budget	4,176,034
Administrative Infrastructure	455,957
Delivery Infrastructure	518,457
Incentive Payments	60,000
FFS Services	1,256,340
PMPM Bundle	1,475,280
Pay For Reporting	60,000
Pay for Outcomes	350,000
PY 4 Total Check	OK

Second Round PY 5 Budget Allocation	
PY 5 Total Budget	4,176,034
Administrative Infrastructure	455,957
Delivery Infrastructure	518,457
Incentive Payments	60,000
FFS Services	1,256,340
PMPM Bundle	1,475,280
Pay For Reporting	60,000
Pay for Outcomes	350,000
PY 5 Total Check	OK