DHCS

California Department of
HealthCareServices

Whole Person Care
Legacy Lead Entity Pilot
Expansion Application

Expansion Application due March 1, 2017

Section 1: WPC Lead Entity and Participating Entity Information

1.1 Whole Person Care Pilot Lead Entity and Contact Person (STC 117.b.i)

Organization Name	Ventura County Health Care Agency
Type of Entity (from lead entity description above)	Designated Public Hospital
Contact Person	Johnson K. Gill
Contact Person Title	Deputy Director, Population Health Management and Clinical
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1.2 Participating Entities

The Ventura County Health Care Agency's (VCHCA) Whole Person Care (WPC) pilot, titled the ***Ventura County Whole Person Care Connect Pilot,*** focuses on the individual needs of the target population (TP) while bringing together all of the necessary resources to achieve WPC stated goals and positively impacting health outcomes from the patients' perspective (see Concept Diagram in Attachment A).

The VCHCA is a comprehensive county-operated health system serving a low-income population through its county-wide network of 19 FQHCs, two county-hosted One-Stop homeless centers, 12 California state-licensed clinics, eight mental health clinics, six alcohol and drug clinics, two acute care hospitals (Designated Public Hospitals), seven urgent care facilities, two public health clinics, Emergency Medical Services, Medical Examiner, and the Ventura County Health Care Plan, a county-owned Health Maintenance Organization. VCHCA's role in the WPC Pilot is as the Lead Entity. In this role as the Lead Entity, the organization will:

1. Be the main communication facilitator
2. Hold, direct, and report on collaborative meetings and Plan-Do-Study-Act (PDSA) quality improvement (QI) processes
3. Develop project infrastructure, including administrative and technology initiatives
4. Provide metric tracking, analysis, and reporting

VCHCA will also operate as the following required organizations: Health Services Agency/Department, Specialty Mental Health Agency/Department, and Public

Agency/Department. The Specialty Mental Health and Public Agency operations are described in the required organizations listing that follows in this section. The healthcare services (see attached Workflow Diagram in Attachment B) that VCHCA will provide to project participants include:

1. *WPC Centralized Care Coordination:* A centralized Care Coordination Team (CCT) will connect the new communication and data technology infrastructure and the *Integrated Care Plan* with providers within the VCHCA, other public entities, and community partners. The CCT will also provide field-based coordination and integration support as required by providers. A Care Coordination Manager leads the CCT, as well as the Engagement Teams and the CHWs. The CCT will include: nine (9) Care Managers (1.0 FTE Lead Care Coordination Manager, 3.2 FTE Registered Nurses [RN], 3.2 FTE Licensed Clinical Social Workers [LCSW]), and 1.6 FTE behavioral health specialists (see Section 1.2.3 below).

2. *WPC Care Coordination through Outreach:* Three Engagement Teams (based out of three retrofitted mobile health vans) will: facilitate integration of services, coordinate outreach and engagement of participants, determine immediate care needs, provide needed prescriptions, offer enrollment and assessment services, connect services with community-based providers, and ensure that there are no gaps between the Integrated Care Plan and the provision of planned services. The teams will be effective in connecting with participants who predominantly access services outside of the VCHCA. Each Engagement Team will include: 1.0 FTE Care Coordination Manager, 1.0 FTE Nurse Practitioner, and 1.0 FTE Clinic Assistants (MAs) (2.0 FTE MAs in PYs 3-5).

3. *WPC Care Coordination through Field-Based Care Coordinators:* Part of the CCT, 28.0 FTE CHWs in PY2 (30.6 FTE in PYs 3-5) are field-based staff members who have a close understanding of the target population and Ventura County communities, and are culturally/linguistically similar and/or competent with the participants they serve. This trusting relationship will enable them to serve as a liaison, link, and intermediary between health, behavioral health, social services, and community resources to facilitate access to services and improve the quality of service delivery. CHWs will build individual and community capacity by increasing the TP's health knowledge and self-sufficiency through a range of activities such as outreach, community education, informal counseling, social support, and advocacy. Under established protocols, CHWs will:

    a. Meet participants where care can be the most integrated for that participant (i.e., clinic, One-Stop Center, supportive/transitional housing).
    b. Administer the *Universal Consent Form,* the *WPC Vulnerability Index* (see Attachment C), and the *WPC Comprehensive Assessment,* which incorporates demographic information, information needed for project enrollment, and social needs such enhanced care coordination. This information will initiate WPC enrollment, which will be consolidated in the electronic *Integrated Care Plan* platform along with assessments, tests, screening results, and sub-care plans from system-wide WPC care providers.
    c. Coordinate and facilitate an initial appointment with a primary care provider (PCP) to assess health care, mental health, and substance abuse treatment needs and to serve as the lead for the participant's Patient-Centered Medical Home (PCMH). PCPs will refer participants with behavioral health needs who cannot be cared for within the primary

care/behavioral health integrated care clinic to the Ventura County Behavioral Health Department (i.e., above mild-to-moderate mental health conditions).

d. Provide troubleshooting, relationship building, system navigation, and crisis intervention.

e. Connect participants with services and advocate for them among partners and community resources.

f. Assist participants in overcoming barriers to access care plan services such as transportation (taxi vouchers, bus tokens, non-emergency medical transport), motivation, language, etc.

g. Work with Care Managers across systems to synchronize, prioritize, integrate, eliminate duplicative services, and adapt the care plan as indicated.

h. Contact and work with families and caregivers to support improvement and assist when emergencies arise.

i. Ensure that care providers are connected through real-time communications about changes in needs or care.

The CHWs will also operate, in collaboration with community providers, the Outreach Care Pods located in areas where the homeless population congregates, such as next to homeless shelters and food distribution sites. An Outreach Care Pod will be located at three sites geographically dispersed across the county, which will include shower and exam spaces as well as tent areas for intake and delivery of social services. A series of community events at the Outreach Care Pods each year will enable these WPC staff to collaborate with social services and community-based partners who will provide basic needs, such as fresh produce, clothing, haircuts, veterinary service for companion animals, etc. Together, WPC services and in-kind supports will effectively meet the homeless populations' multiple complex needs in one location.

4. *Recuperative Care Services:* VCHCA will work in collaboration with the National Health Foundation to provide recuperative care services at a Salvation Army transitional living facility, including 24-hour on-site medical supervision and supportive services focused on a successful discharge from recuperative care to appropriate housing. The Salvation Army's partnership with the countywide continuum of care will provide linkages to emergency shelter, transitional housing, and permanent housing options for patients served by this program. This WPC service will be billed as Fee-for-Service based on occupied bed days.

Few activities planned within the WPC pilot duplicate those that are funded through the Medi-Cal Targeted Case Management program, but 5% of the Care Coordination Team (CCT) PMPM budget will be discounted to take into account the small overlap (see Section 3.1). Other existing services that will be provided to the WPC participants according to their Integrated Care Plan include the following:

5. *Health Care for the Homeless (HCH) Program:* Since 2002, VCHCA has been operating a HCH program serving area homeless persons. Medical teams provide services at 16 sites, including two One-Stop Centers, in eight cities. Services include primary and preventive

health care and assessments, and referrals for mental health, substance abuse, and social services. Linkages include multiple social services, housing supports, and non-medical support services. Historically, the care for these patients has not been centrally coordinated. Through the WPC pilot, an electronic centralized care coordination system that tracks service linkages and communicates in real time with the CCT will eliminate gaps and breakdowns in services. Communication alerts will direct care to the appropriate response level and interventions.

6. *Primary and Preventive Care:* VCHCA has 19 primary care FQHCs and 14 clinics providing both primary and specialty care services, with integrated behavioral health professionals located in many clinics. These clinics provide more than 530,000 outpatient visits annually and are located in nine geographically dispersed communities. They are served by 693 physicians and 87 allied health professionals (inpatient and outpatient). VCHCA also operates a renowned UCLA-affiliated Family Medicine Residency program (ranked #2 nationally).[1] This vast network of venues and providers will be integral in meeting the needs of the TP. With the assistance of the clinic staff and the CCT, the use of a *real-time secure messaging system,* which is part of a secure web-based telemedicine platform, will be a conduit via which TP needs are communicated and addressed with PCPs.

7. *Emergency/Urgent Care:* Ventura County Medical Center (VCMC) is a 180-bed hospital with an additional 43-bed Inpatient Psychiatric Unit. Santa Paula Hospital, also operated by the VCHCA, has 49 beds. Seven urgent care centers provide services that help offset Emergency Department (ED) utilization. Patient engagement and early intervention in a well-coordinated environment is the key to managing participants. Keeping the lines of communication open between the TP and CHWs will be the first line of defense against unnecessary utilization of urgent/emergent services.

8. *Specialty Services:* VCHCA clinics provide 60 specialty services. VCMC also offers high quality specialty services, including Neonatal ICU, Level II Adult Trauma Center, and Palliative Care Program. However, access to many of these specialty services remains a challenge. Improving access to specialty care will continue through PRIME projects 1.2, 1.3, 2.2, and 2.3. The WPC project will utilize the real-time secure messaging system between PCPs and specialty services for the WPC TP, and work with GCHP and specialty services to fast-track care, where necessary.

Required Organizations: 1. Medi-Cal Managed Care Health Plan
Organization Name: Gold Coast Health Plan
Contact Name and Title: Nancy Wharfield, MD, Associate Chief Medical Officer
Entity Description and Role in WPC: Gold Coast Health Plan (GCHP) is County Organized Health System (COHS) governed by the Ventura County Medi-Cal Managed Care Commission, serving more than 206,000 Medi-Cal beneficiaries living in Ventura County. GCHP's role in WPC efforts will be as a collaborator and to provide data sharing, assistance in the assessment of appropriate technologies, and coordination of care enhancement. GCHP will provide the following data:
1. Utilization and cost of care data for the defined county-wide TP, including:

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[1] Doximity, Inc. (2016.) Residency Navigator: Family Medicine. Available at:
https://residency.doximity.com/programs?residency_specialty_id=43&sort_by=reputation

       a. Inpatient
       b. Emergency Department
       c. Pharmacy
       d. Diagnosis codes (ICDs)
       e. Mild to moderate Behavioral Health
2. Risk stratification analytics using the Johns Hopkins ACG tool

GCHP will support WPC technology needs by:
1. Providing guidance around the assessment of technology infrastructure requirements
2. Integrating relevant GCHP data with selected WPC technology
3. Promoting the adoption of electronic information sharing in the provider community which includes medical, behavioral, and county-based services to address social determinants of health outcomes

Finally, GCHP will contribute to WPC coordination of care efforts through Care Manager RNs and Social Worker collaboration with the WPC team in the development and execution of treatment plans for the TP which address all aspects of health outcomes.

Required Organizations: 2. Specialty Mental Health Agency/Department
Organization Name: Ventura County Health Care Agency – Ventura County Behavioral Health Department
Contact Name and Title: Elaine Crandall, Director
Entity Description and Role in WPC: The Ventura County Behavioral Health Department (VCBH) is a service delivery system that provides a full array of services and supports that promote the wellness and recovery of individuals by providing and supporting comprehensive mental health and substance abuse services through its six alcohol and drug clinics; eight mental health clinics for adults, youth and families; residential facilities; and psychiatric facilities, and at various community-based locations. Programs and services are provided both directly and with contracted community partners. VCBH's role in the WPC Pilot is: to serve as a project collaborator, to provide care management of behavioral health services, and to provide integrated substance abuse and mental health services for WPC participants, including the following:

1. *WPC Centralized Care Coordination:* Part of the CCT, 4.8 FTE VCBH Care Managers (see Section 1.2.2 above) will support behavioral health care coordination for participants. These staff will include Licensed Mental Health Professionals (LMFT or LCSW) and Substance Abuse Specialists.
2. *Screening, Triage, Assessment, & Referral (STAR) (Mental Health):* The STAR system coordinates access to services so that consumers receive timely, appropriate, and consistent information, thorough screening, triage, assessments, and/or linkage to appropriate mental health services and supports in an efficient, high quality, culturally sensitive manner countywide.

3. *Adult Mental Health Services, Clinic-Based (Mental Health):* Provides individual and group therapy, case management, crisis intervention, rehabilitation services, and medication management.
4. *Youth and Family Mental Health Services, Clinic-Based (Mental Health):* Provides individual and group therapy, case management, crisis intervention, rehabilitation services, parenting support, and medication management.
5. *Adult Intensive (Mental Health):* Empowering Partners through Integrative Community Services (EPICS) provides comprehensive, intensive, "whatever it takes" services for those consumers with intensive needs who most frequently utilize higher levels of care (inpatient hospitalization and other locked settings, or residential treatment placements), who are at high risk to require those levels of care without intervention, and who have been historically underserved in the mental health system due to a variety of barriers that make access to traditional services challenging.
6. *Adult Assisted Outpatient Treatment Services (Mental Health):* The AOT services are designed to provide intensive outreach to individuals who may be treatment resistant. In some instances, services may be court-ordered.
7. *Adult and Children Mobile Crisis Response Team (Mental Health):* Crisis intervention and stabilization services are available 24/7 to individuals who are experiencing an urgent or emergent mental health crisis. *Via* mobile field response and/or by telephone, the multi-disciplinary Crisis Team provides rapid mental health services that are supportive and strength-based in nature and that assist the individual to remain in the least restrictive level of care possible.
8. *Crisis Residential Treatment (CRT) (Mental Health):* The licensed 15-bed program serves adults (ages 18-59) throughout the county as an alternative to hospitalization for individuals presenting with sub-acute psychiatric symptoms and possible co-occurring disorders in the least restrictive environment possible, up to 90 days, leading to a reduction in involuntary hospitalizations, incarcerations, and homelessness.
9. *Crisis Stabilization Unit and Short-Term Crisis Residential Program (Mental Health):* This program provides a missing link in the children's crisis continuum of care by offering children and their families a safe, supportive, and home-like environment that meets crisis needs in their home community. The goal of the service is to reduce hospitalization and recidivism.
10. *Short-Term Social Rehabilitation (Mental Health):* Provides adults and transitional-age youth licensed, unlocked residential treatment facility services for up to 18 months.
11. *Mental Health Rehabilitation Center (Mental Health):* The licensed 16-bed program serves adults who receive rehabilitation services in a locked residential environment with a goal of stepping down into a lower level of care within a 12- to 18-month period (opening late 2016).
12. *Peer Support Specialists & Recovery Coaches (Mental Health):* This program provides training, advocacy, and direct service for and by peers and family members through several programs. Recovery Coaches, who are individuals with "lived experience," assist in engaging persons in treatment who have traditionally been un-served and underserved, while helping to ensure that the concepts of empowerment, wellness and recovery are incorporated into services.

13. *Adult and Transitional Age Youth Wellness & Recovery Centers (Mental Health):* These centers are alternative clinic programs serving adults and transitional-age youth who are recovering from mental illness, and often also substance abuse, who are at risk of homelessness, incarceration, and increasing severity of mental illness or addiction.
14. *Older Adult Full Service Partnership (Mental Health):* The Older Adult Program provides rich, community-based, mobile, in-home services including psychiatric treatment, case management (i.e., linkage to housing, benefits, health care, and rehabilitation services), skill-building services to decrease functional impairments, individual and group treatment crisis intervention, recovery and wellness programs, and advocacy and referrals for medical, dental, legal, and benefits support services and community agencies.
15. *Transitional-Age Youth Services (Mental Health):* Treatment and rehabilitation services are designed and provided for persons ages 18-26. The determination between employment and/or receipt of disability benefits is a focus in seeking to promote self-sufficiency for this age group.
16. *Residential Services (Mental Health):* Case management is provided to support a client's stability in their home environment and residential treatment programs. Note that WPC funds will only be used for allowable costs that include individual housing transition services and individual housing and tenancy sustaining services in alignment with the CMCS Informational Bulletin. Residential services and room and board are not covered under WPC.
17. *Transformational Liaisons (Mental Health):* Liaisons assist in navigating a complex system, and providing direction, referrals, and monthly orientation meetings.
18. *Adult Outpatient and Residential Treatment Services (Substance Abuse Services):* Adult Services provides individual and group counseling, family counseling, community referrals, co-occurring disorders programs for individuals with substance use and a mental health diagnosis, programs for court-mandated individuals, drug testing, confidential treatment services, education and support services, intensive outpatient programs for women and children, residential treatment and detoxification referrals, and crisis intervention.
19. *Driving Under the Influence Programs (Substance Abuse Services):* A First Offender DUI Program and a Multiple Offender DUI Program are provided for individuals convicted of driving under the influence. The program consists of education sessions, and group and individual counseling.
20. *Other Programs:* VCBH also offers outreach, prevention and early intervention, and education services.

Required Organizations: 3. Public Agency/Department
Organization Name: Ventura County Health Care Agency – Ventura County Public Health Department (VCPH)
Contact Name and Title: Rigoberto Vargas, Director
Entity Description and Role in WPC: VCPH provides a host of services benefiting Ventura County residents, including: two Public Health clinics; community nursing; Emergency Medical Services (EMS); health coverage assistance; health promotion/education; HIV/AIDS center; Maternal Child Adolescent Health programs: Women, Infants and Children (WIC) programs; and smoking cessation

classes, among other services. VCPH's role in the WPC Pilot is to serve as a project collaborator, provide care management to participants utilizing services, and to provide participants the following services:

1. *Tobacco Cessation:* VCPH provides "Call it Quits" classes consisting of 1.5 hours smoking cessation sessions that present tools for a successful quit. The program offers group classes, telephone counseling, one-to-one assistance, free Nicotine Replacement Therapy (NRT), and education for family and friends about how to best help the quitter. Since many of the TP are tobacco users, VCPH will conduct tobacco cessation programs for this population.
2. *Ventura One-Stop Center:* Houses center operations and provides eligibility assistance, screening, immunizations, medical/behavioral health assessments, WIC benefits, and referrals. Based on the initial needs assessment of the TP, the services offered through this program will be made available and coordinated through the centralized Care Coordination Team (CCT).

Required Organizations: 4. Public Agency/Department
Organization Name: Ventura County Human Services Agency (VCHSA)
Contact Name and Title: Barry Zimmerman, Director
Entity Description and Role in WPC: The VCHSA provides public services that help protect children and vulnerable adults, and assists with food, housing, health care, and employment. VCHSA's role in the WPC is to serve as a collaborator and to provide the following services to the target population, as needed:

1. *Homeless Services:* Provides mobile outreach and intensive case management to homeless individuals and families; links individuals and families to homeless prevention, rapid re-housing, and housing support programs; and connects homeless adults and families with children to the county's transitional living centers, as appropriate.
2. *CalFresh:* Helps people with little or no income buy nutritious groceries with an electronic benefit transfer (EBT) card.
3. *CalWORKs:* Assists low-income or unemployed parents with dependent children by providing temporary financial assistance, subsidized child care, and employment-focused services.
4. *Child Welfare Services:* Provides protection and case management for children who are at risk of or have been physically, sexually, or emotionally abused, neglected, or exploited.
5. *Employment Services:* Provides training, recruitment, and job search assistance at centers throughout the county.
6. *General Relief:* Provides eligible adults with short-term assistance, which is considered a loan, for basic living needs such as housing or utility payments.
7. *Health Care Enrollment:* Provides access to Medi-Cal and Affordable Care Act coverage options for qualifying individuals and families.
8. *In-Home Supportive Services (IHSS):* Assists elderly and disabled individuals to remain safely in their homes by connecting them with providers who help with personal care, housekeeping, shopping, and errands.
9. *Public Administrator/Public Guardian:* Provides bill-paying and income-management support to clients of Ventura County Behavioral Health who receive benefits from Social

Security; oversees the care of people, including the elderly and those who are gravely disabled due to mental illness, who are unable to care for themselves.

10. *Veteran Services:* Assists veterans and their dependents, including spouses and children of disabled veterans, with accessing benefits and services; and provides advocacy for those who served in the armed forces*.*
11. *Youth Services:* Provides Independent Living preparation and extended Foster Care services to youth who are or have been in foster care.
12. *Adult Protective Services*: Responds to allegations of abuse and neglect of dependent adults and seniors; and provides voluntary case management services.

Required Organizations: 5. Public Agency/Department
Organization Name: Ventura County Probation Agency
Contact Name and Title: Mark Varela, Chief Probation Officer
Entity Description and Role in WPC: The Ventura County Probation Agency (Probation) is charged by the courts with the direct supervision of approximately 15,500 adult offenders and 2,500 juvenile offenders on probation, as well as performing two mandated functions: the preparation of sentencing reports for the courts and the operation of the juvenile justice facilities. Probation's role in the WPC Pilot is as a collaborator and to provide data about utilization of services by participants. If a participant becomes institutionalized and in the custody of the Probation Agency, the WPC CCT will work with the Probation team on the appropriate continuum of care. The teams will ensure that the participant receives continued WPC care as established in the Integrated Care Plan upon release. The Probation team will be made aware of a WPC participant coming into their system ahead of time, and the CCT will be made aware that a participant has been institutionalized through the HL7 Admit, Discharge, Transfer (ADT) alert system within the enterprise Care Coordination platform, and vice versa.

Required Organizations: 6. Public Agency/Department
Organization Name: Ventura County Sheriff's Office
Contact Name and Title: Ron Nelson, Commander
Entity Description and Role in WPC: Five of the county's ten incorporated cities contract with the Sheriff's Office to provide police services. These cities, plus the unincorporated areas of the county, make up nearly half of the county's population and 95% of its land area. The services provided by the department range from maintaining the county jail system to providing traditional police services. The department utilizes the Community Oriented Policing and Problem Solving (COPPS) philosophy, promoting proactive problem-solving and police-community partnerships. The department's role in the WPC Pilot is to participate as a collaborative partner; notify the collaborative through the community organization portal concerning any encounter that participants have with the Sheriff's Office; and provide data about the number of arrests, confinements, and causes. The Sheriff's Office will notify the CCT that a participant has been arrested or otherwise involved with the Sheriff's Office through a HL7 ADT alert system within the enterprise Care Coordination platform.

Required Organizations: 7. Public Agency/Department

Organization Name: Area Housing Authority of the County of Ventura
Contact Name and Title: Michael Nigh, Executive Director
Entity Description and Role in WPC: The mission of Area Housing Authority of the County of Ventura is to be a leader providing opportunities and assistance to people in need of affordable housing through development, acquisitions, and partnerships. Through its work with several city-level housing authorities, the Area Housing Authority provides and develops quality affordable housing for eligible low-income residents of Ventura County and establishes strong partnerships necessary for customers to achieve personal goals related to: literacy and education, health and wellness, and job training and employment leading to personal growth and economic self-sufficiency. The organization's role in the WPC pilot is as a collaborative member, care management partner, and to provide the following services:

1. *WPC Housing Support and Transition Services:* The Area Housing Authority and city partners will provide:
   a. *Individual Housing Transition Services:* Tenancy screening, housing assessment, housing plan development, housing application assistance, resource identification, move-in support, crisis plan development, housing search, transportation assistance, and assistance in establishing the household, such as setting up utilities and arranging for furnishings.
   b. *Individual Housing and Tenancy Sustaining Services:* Identification/intervention of behaviors that may jeopardize housing status, education, coaching, resolving disputes, advocating, ongoing plan review and training.
2. *Section 8 Program Housing:* Voucher program that pays 30%-40% of housing costs.
3. *Low-Rent Public Housing:* Access to 335 conventional units and 157 units in housing complexes throughout the county, with rents based on adjusted gross income.
4. *Affordable Housing:* Access to 486 units of tax credit financed affordable housing.
5. *Family Self-Sufficiency Program:* A five-year case management program that allows residents to reach economic self-sufficiency for HUD program participants and establish an escrow savings account.
6. *Resident Opportunities and Self-Sufficiency:* Provides coordinators to connect residents with needed services, including: education/lifelong learning, tutoring/homework services, scholarship programs, college applications, career paths, life skills, certification programs, English as a Second Language (ESL), work experience, banking and budgeting, sports programs, and nutrition.

Note that WPC funds will only be used to support individual housing transition services and individual housing and tenancy sustaining services in alignment with the CMCS Informational Bulletin dated June 26, 2015, and will not be used for room and board.

Additional Organizations: 8. Public Agency/Department
Organization Name: Ventura County Transportation Commission
Contact Name and Title: Darren Kettle, Executive Director
Entity Description and Role in WPC: The Ventura County Transportation Commission (VCTC) is a regional transportation planning agency working in close partnership with each of the county's ten

cities and the rural unincorporated areas. VCTC's inter-city bus service provides connections between the cities of Ventura County and between neighboring Santa Barbara and Los Angeles counties. The role of VCTC is as a collaborative partner that will provide bus tokens/passes to enable participants to access project resources and alleviate transportation as a barrier to access.

Required Organizations: 9. Community Partner
Organization Name: Project Understanding
Contact Name and Title: Benjamin Unseth, Executive Director
Entity Description and Role in WPC: Project Understanding focuses on ensuring that homeless and at-risk families are housed and fed. The organization's role in the WPC pilot is as a collaborative member and to provide essential assistance programs to participants, including:

1. *Supportive Housing Opportunities In A Residential Environment (SHORE)* – The goal of this program is to assist those who desire to end their homelessness. SHORE at the WAV is Case Management of previously homeless families and individuals in permanent, supportive housing apartments subsidized by Section 8 funds.
2. *Homeless to Home (H2H):* Field case management services to homeless individuals who desire to change their life situation for the better.
3. *Tender Life Maternity Home:* Provides homeless pregnant women with safe housing and support services that promote self-sufficiency.
4. *Food Pantry:* Provides groceries once a month to families whose budget cannot support the purchase of their own. Donations may include in-kind, non-perishables, fresh vegetables and fruits, and money designated for food.

Required Organizations: 10. Community Partner
Organization Name: FOODShare, Inc.
Contact Name and Title: Susan Haverland, Vice President, Program & Services
Entity Description and Role in WPC: FOOD Share distributes millions of pounds of healthy food every year through its own programs as well as through distributions via partner agencies. The organization's role in the WPC pilot is as a collaborative member and to provide data about resource utilization, care management, and to provide the following services to participants:

1. Assist in applying for CalFresh benefits.
2. Community Market Program distribution of fresh produce free-of-charge via a monthly mobile delivery service throughout the county.
3. FOOD Share and Friends Mobile Pantry provides food for persons in need who lack access to food pantries or other vital services and supports that FOOD Share and its collaborators offer. In addition to food, the Mobile Pantry provides a traveling source of information and links neighborhoods to nutrition education programs, health services, financial literacy programs, employment/income assistance programs, and housing resources.

Required Organizations: 11. Community Partner
Organization Name: Ventura County St. Vincent de Paul
Contact Name and Title: Sharon Fleur, President, SVdP-OLA Conference

Entity Description and Role in WPC: The Society of St. Vincent de Paul is a faith-based charity that offers tangible assistance to those in need on a person-to-person basis. Assistance includes intervention, consultation, and fiscal support. Nationally, 12 million persons are helped annually by Vincentians in the United States. The organization's role in the WPC pilot is as a collaborative member and to provide essential Ventura County St. Vincent de Paul assistance programs to participants, including:

1. *Community Center Services:* A number of community services are offered to assist low-income families and individuals in meeting basic needs, such as: obtaining housing; employment support; education and training; nutrition, and exercise; women and men social issues; free or low-cost legal clinics for immigration and other civil matters; financial literacy and credit counseling; housing resources including a monthly housing fair and information about tenant/owner rights and responsibilities; adult education and employment, including computer labs; small business development; and case management, advice, and other support.
2. *Men's Advancement Program:* Provides males with transitional housing, clothing, living opportunities, and case management services to provide support and direction toward finding more permanent housing. Individuals are assigned to weekly case management sessions, job training, group meetings, and ongoing counseling.
3. *Housing Assistance:* Provides access to shelter, transitional housing, and eviction prevention resources.
4. *Housing Prevention and Intervention:* Provides access to services such as landlord/tenant mediation and emergency rental funds.
5. *Employment and Education Assistance:* Works with local employers and non-profits in Ventura to help the unemployed and people who work part time.
6. *Ventura County Winter Shelters:* Winter shelters are offered in the cities of Ventura and Oxnard, California, from December 1st to March 31st each year.

Other Community Organizations Providing Services: Through Ventura County's vast network of services, the WPC pilot Care Coordination Team will access services based on a participant's unique needs and geographic location in the county to reduce barriers to services. Although the following entities have not yet provided Letters of Participation, the organizations listed below are expected to be a part of the WPC Collaborative and will be instrumental in the project's success and support its goals and strategies. Attachment D lists the many services that will be accessed from countywide resources. (Letters for "Other Community Organizations" not attached nor required, but all "Required Participating Entities'" letters are provided.)

Additional Organizations: 12. Public Agency/Department
Organization Name: Workforce Investment Board/Job and Career Centers
Entity Description and Role in WPC: The vision of the Workforce Investment Board is that Ventura County will have a high-quality, appropriately skilled workforce that is ready and able to support the changing business needs of employers in a dynamic, competitive, global economic environment. The regional workforce strategy is focused on ongoing skills attainment that is supportive of regional growth industry sectors and clusters and enabled by a braided, leveraged

workforce system that addresses business-driven demands and worker needs for steady employment. The organization's role in the WPC pilot is as a contributing community partner and to provide participants job and career support services and training. The county's two American Job and Career Centers provide a direct link to resources that help job seekers choose and pursue careers. The centers offer job listings, career guidance, labor market information, training and education resources, and tools for job preparation. Staff helps job seekers match their skills to available jobs or transition to new careers. Other support services and training are available at no cost and include:

1. Use of computers, printers, and fax machines
2. Help with resumes and interviewing
3. Job listings and employer information
4. Employee recruitments
5. Information on careers and growing occupations
6. On-the-job training and skill certifications
7. Career workshops
8. Assistance with tuition and books
9. Customized training
10. Access to unemployment insurance benefits
11. Online resource access to CalJOBS

Additional Organizations: 13. Community Partner
Organization Name: Ventura County Rescue Mission Alliance
Contact Name and Title: John Saltee, Director
Entity Description and Role in WPC: The Ventura County Rescue Mission Alliance is a faith-based non-profit charity that offers refuge, recovery, and restoration services to the poor and needy in Ventura County. The role of the Rescue Mission is to serve as a contributing community partner and to provide the following services:

1. *Lighthouse for Women and Children:* A transitional living program with 112 beds offers shelter, intervention, substance abuse recovery, case management, education, life skills development, vocational training, employment, and transitional housing.
2. *Men's Emergency Shelter:* An emergency shelter is offered for men who can stay up to 10 consecutive nights.
3. *Men's Recovery Program:* A free, ten-month, residential, Christian-based recovery program is offered that provides biblically-based structure and applied discipline for learning to live while overcoming difficulties. The program provides individual counseling and case management as well as daily classes that include: Christian 12 Steps, anger management, and classes dealing with biblical and spiritual issues.
4. *Meals and clothing assistance*.

Additional Organizations: 14. Community Partner
Organization Name: Ventura County Salvation Army
Entity Description and Role in WPC: Ventura County Salvation Army is a faith-based charity with the goal of doing the most good possible for those in need, with a focus on feeding the hungry, housing the homeless, and changing the lives of individuals and families. The organization's role in

the WPC pilot is as a contributing community partner and to provide participants the following services:

1. *Recuperative Care Site:* The Salvation Army will provide a 12-bed recuperative care site at an existing transitional living center in the City of Ventura that will be available for homeless WPC participants discharged from VCHCA and other four area hospitals. This site will be operated by the National Health Foundation through WPC funding.
2. *Dental Clinic:* Services offered free-of-charge include oral examinations, fillings, simple extractions, and X-rays; dental cleanings are referred to Oxnard College's Dental Hygiene program.
3. *Transitional Living Center:* Short-term housing that also provides case management and supportive services, such as counseling, self-sufficiency education, permanent housing assistance, and information on employment services, job training, and public assistance.
4. *Homeless to Home Program:* A collaborative partnership between The Salvation Army, Project Understanding, and the Turning Point Foundation, the program provides case management that focuses on assisting individuals in obtaining and maintaining a secure income, physical and mental stability, and safe housing. Services include life skills and employment readiness training, assistance with transportation to interviews and work, street outreach, and housing stability services with financial assistance when available.
5. *Winter Homeless Shelter:* Supports the efforts of the West Ventura County winter homeless shelter, providing cots and meals for homeless individuals during the time when the local armory is unavailable.
6. *Safety Net Services:* Provides rent and utility assistance as well as transportation and clothing vouchers.
7. *Food Pantry:* Provides weekly feedings to seniors confined to their homes, sit-down meals to clients during Thanksgiving and Christmas, and more than 200 food baskets per month.

Additional Organizations: **15. Community Partner**
Organization Name: **National Health Foundation**
Contact Name and Title: **Kelly Bruno, President and CEO**
Entity Description and Role in WPC: The National Health Foundation's (NHF) mission is to improve the health of individuals and underserved communities by taking action on the social determinants of health and bridging gaps in the healthcare system. NHF has Recuperative Care Centers located in three Southern California regions (Mid-City/Los Angeles, La Puente/San Gabriel Valley, and Buena Park/Orange County). These centers provide hospitals a discharge option for homeless patients who are not sick enough to remain in the hospital, but too sick for the shelter, streets, or other unstable living situations. The centers provide aftercare to homeless patients in a safe and clean environment to recover, receive medical oversight, support in attending follow-up appointments, and connections to supportive services and housing options.

The organization's role in the WPC pilot is as a contributing partner and to provide the following services to participants:

1. Medical Oversight: The NHF will establish and deliver medical oversight services for WPC

participants admitted into the recuperative care program. Medical oversight services include: coordinating and facilitating medical care after hospital discharge, arranging post-discharge medical appointments, and providing education about self-care and medication management. The actual length of stay will be determined on a case-by-case basis in consultation with the referring hospital but is estimated at 10-14 days with options for extensions as needed.

2. Care Management: The NHF, in collaboration with Salvation Army, will case manage each patient to determine his/her eligibility for social services and temporary/permanent housing programs. Upon discharge from the recuperative care program, the NHF will, on a best-efforts basis, connect each patient to an alternative facility, shelter, or permanent housing. NHF will also coordinate with VCHCA Whole Person Care Coordination teams to ensure a seamless transition to ongoing medical, behavioral, nutritional, and social services support provided by these teams.

3. Reporting: The NHF will provide VCHCA with monthly patient-bed utilization reports and patient discharge disposition information to ensure that VCHCA is fully utilizing its allocated number of bed days as well as to track the success of the recuperative care program.

4. Intake services: The NHF will provide intake services to include screening patients for recuperative care eligibility and collecting completed applications from participating hospitals. The NHF will accept or deny the patient within four business hours of receiving the completed application. The NHF will arrange patient acceptance into the recuperative care program with the referring hospital admission department.

5. Outreach and Training: The NHF will conduct ongoing outreach and training to all participating hospitals about the recuperative care program.

Additional Organizations: 16. Community Partner
Organization Name: Not One More
Contact Name and Title: Pat Montoya, President
Entity Description and Role in WPC: Not One More is a non-profit community organization dedicated to providing support to community members and their families who are struggling with addiction within their lives. The organization's role in the WPC pilot is as a contributing community partner and to provide the following services to participants:

1. Help bridge the gap between the cost of rehabilitation and insurance coverage through scholarships and gifts.
2. Assist individuals and families in navigating the insurance, rehabilitation, and services systems.
3. Provide low- or no-cost intervention services.
4. Operate a 24/7 web-based resource center with information about drugs, recovery, and where participants can turn in a time of crisis.
5. Provide an active grief outreach program.

Additional Organizations: 17. Community Partner
Organization Name: Jewish Family Services
Contact Name and Title: Debra Hide, Director

Entity Description and Role in WPC: Jewish Family Services is a faith-based charity with a mission to encourage and support the quality and continuity of individual, family, and community life guided by the ethical and spiritual values of Judaism. The organization's role in the WPC pilot is as a contributing partner and to provide the following services to participants:

1. *Homeless Outreach:* Provides a social worker, operating out of the One-Stop Program, who works with homeless persons on the street to assist them in accessing medical care, shelter, and mental health services.
2. *Clinic Counseling:* Individual, group, couples, and family therapy are provided to people of all ages for clients who are struggling with a variety of issues, including depression, anxiety and trauma.
3. *Rental Assistance for Families:* Provides rental assistance for women and children at risk of becoming homeless, based on need and available funds.
4. *Justice Clinic*: A monthly clinic is offered where an attorney reviews legal paperwork and gives legal advice.
5. *Senior Case Management*: A voluntary service for seniors, giving access to social workers who assess seniors' needs, develop case management plans, and connect seniors with referrals and links to community agencies.

Additional Organizations: 18. Community Partner
Organization Name: Interface Children & Family Services
Contact Name and Title: Erik Sternad, Executive Director
Entity Description and Role in WPC: Interface's mission is to strengthen children, families, and communities to be safe, healthy, and thriving. To establish a foundation of violence prevention and mental health, Interface offers family strengthening resources, centers and services: family violence intervention through a Family Violence Response Team; Safe Haven Emergency Shelter; Safe Journey Transitional Shelter; women's support groups; individual, family, and youth mental health assessments, treatment planning, and counseling; youth services, including crisis intervention, case management and after care, family mediation, emancipation information, life skills and youth development activities, and shelter assessment. Interface will provide needed information for care managers and CHWs to access the county resources to address the unique needs of each participant through its 2-1-1 Information and Referral Hotline. This hotline connects more than 20,000 Ventura County callers each year with information about services available to them, including: basic needs resources (i.e., food, clothing, and shelter), physical and mental health resources, domestic violence services, substance abuse services, employment support, rent and utility assistance, senior services, services for persons with disabilities, support for children, youth and families, legal assistance, and much more.

1.3 Letters of Participation and Support

The WPC pilot is a county-wide effort, bringing together the major service providers that can affect health outcomes and service utilization by positively impacting the social determinants of health, health disparities, and access to needed services. Letters of Participation are provided by all required and optional entities listed in Section 1.2. Letters of Support are also provided for this

needed pilot by influential community physician groups who currently are devoted to providing services to the underserved and are committed to achieving the Triple Aim for the TP through the WPC pilot. These provider groups are listed below and are dispersed among the county's geographic areas where the TP experiences the greatest needs. Deanna Handel, the Whole Person Care Program Manager, may be contacted for access to the letters at Ventura County Healthcare Agency, 5851 Thille St., Ventura, CA 93003; (805)339-1120 (office); (805)827-1610 (cell).

1. Ventura County Continuum of Care Alliance
2. Las Islas Family Medical Group, Oxnard, Miguel Cervantes, MD, Medical Director
3. Magnolia Family Medical Center, Oxnard, Stan Patterson, MD, Medical Director
4. Santa Paula West & Hospital Clinic, Santa Paula, Lisa Solinas, MD, Medical Director
5. West Ventura Medical Clinic, Ventura, Ramsey Ulrich, MD, Medical Director
6. National Health Foundation, Kelly Bruno, President and C.E.O.
7. City of Ventura, Mark Watkins, City Manager
8. Oxnard Police Department, Scott Whitney, Chief
9. City of Ventura Police Department, Gerald Foreman, Sargeant
10. Office of the Public Defender, County of Ventura, Rod Kodman, Chief Deputy
11. Ventura County Animal Services, Tara Diller, Director

Section 2: General Information and Target Population

2.1 Geographic Area, Community and Target Population Needs

Geographic Area: Ventura County, the service area, is a large dispersed coastal region northwest of Los Angeles with a population of 850,536 residents[2] and more than 206,000 Medi-Cal Managed Care beneficiaries.[3] It is the 12th most populated of California's 58 counties with ten incorporated cities in 1,843 square miles.

Need for WPC Pilot: In 2015, 1,821 GCHP members had four or more ED visits and/or two or more inpatient admissions. Although this comprised just 0.9% of beneficiaries, they accounted for 9.9% of costs. Twenty-eight percent of these utilizers are homeless, and this group averaged 17.1 encounters in the VCHCA system in 2015 versus an overall average of 5.4 encounters among average beneficiaries. Among VCHCA's highest utilizers in 2015: 27.7% are currently or recently homeless, 40.5% have mental health disorders, 24.4% have substance abuse disorders, and 97.3% have multiple chronic conditions. The 2015 Ventura County Homeless Count identified 1,417 homeless persons in Ventura County during their point- in-time survey.[4] The 2015 Homeless Count survey identified the following self-reported needs among the homeless population: 31.8% were chronically homeless, 24.3% reported chronic health conditions, and 13.9% reported mental health problems. However, among those who self-reported to be _chronically_ homeless, 37% had mental health problems, 52% had a chronic illness, 51% had substance use disorder (SUD), and 36% were released by a correctional facility after a court-ordered sentence in the past year. This sub-population cross-reference clearly indicated that the persons with the greatest needs require services that access multiple social, health, and behavioral health systems.

The social determinants of health exacerbate the health and behavioral health conditions that are generally elevated among the high utilizer population. Thus, focusing only on health/behavioral health care resolutions alone leaves out key causal factors in high utilizers. For many of the individuals with the highest rates of healthcare utilization, lack of stable housing is a primary driver of poor health outcomes and high cost.

Health care, behavioral health care, and social services are fragmented in Ventura County with multiple funding streams, eligibility requirements, and portals for entry. Two county One-Stop Centers have been provided through 330(h) funding (see Section 1.2.2), but care coordination is

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[2]U.S. Census. QuickFacts, Ventura County, California. Population estimates July 1, 2015. Available at: https://www.census.gov/quickfacts/table/PST045214/06111.

[3] Gold Coast Health Plan. Ventura County Medi-Cal Managed Care Commission. Available at: https://www.goldcoasthealthplan.org/about-us/ventura-county-medi-cal-managed-care-commission.aspx.

[4] Ventura County. (2015.) Homeless County and Subpopulation Survey: Final Report. Available at: http://www.cityofventura.net/files/file/VC_Homeless_Count_Survey_2015.pdf.

limited based on assessed needs. The result is that these Ventura County health systems are individually functioning as "silos of excellence," but the experience can feel overwhelming and confusing for a patient interacting with uncoordinated systems, as s/he might receive mixed messages from multiple providers, which may include more than one care manager.

Participating Entities Vision and Structure: The vision of the ***Ventura County Whole Person Care Connect*** pilot project is to implement a collaborative/integrated approach to the coordination of health, behavioral health, and social services in a holistic, patient-centered manner with the goals of improved health outcomes and more efficient and effective use of resources. The collaborative has been meeting since January 2016 to focus on: 1) developing the project vision based on WPC model best practices gleaned from literature reviews[5] and attendance at WPC statewide collaborative meetings; 2) identifying the target population through a data-driven collaborative approach; 3) developing a communication plan/model; 4) defining the structure and entities needed for a wraparound model of patient-centered care; 5) aligning health, behavioral health, and social services interests and establishing shared goals and accountability; and 6) collaboratively developing the initial project design plans to respond to the WPC application.

WPC Pilot General Description: The WPC pilot design is based on best practices and is consistent with recent findings included in WPC studies of successful frameworks that incorporate a focused target population, collaborative leadership, patient-centered care, coordination of services across systems, shared data, and financial flexibility.[6] The project incorporates these elements in a patient-centered, holistic model, evidence-based care coordination design[7] with the following components:

- Client support and care management through the WPC Care Coordination Team (CCT) who will work across service providers and multidisciplinary teams
- Enterprise architecture providing technological integration and coordination through a centralized care coordination platform, real-time secure messaging, eReferrals, integrated care plan platform, health registry, and data warehouse to support quality improvements
- Prioritization of access to services based on a Vulnerability Index
- Addressing participants' immediate and ongoing basic needs for shelter and housing supports, transportation, healthy food, clothing, personal items, etc.
- Recuperative care services for homeless participants who are discharged from area hospitals, but are too ill to recover on the streets.
- Life skills support/development and self-management education

WPC Pilot Structure: The project structure integrates different organizational service structures

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[5] Maxwell, 2014.

[6] Tobey R, Maxwell J, Bateman C, Barron C. (Sept. 2014.) *Opportunities for Whole-Person Care in California.* John Snow, Inc., California Association of Public Hospitals and Health Systems, and the California Health Care Safety Net Institue. Available at: http://www.dhcs.ca.gov/provgovpart/Documents/Waiver%20Renewal/Workforce1_WPC2_JSI.pdf.

[7] Families USA. (April 2013.) *The Promise of Care Coordination: Transforming Health Care Delivery. Available* at: http://familiesusa.org/sites/default/files/product_documents/Care-Coordination.pdf.

into a singular collaborative structure guided by a Lead Entity and collaborative governance with agreed upon bylaws and protocols. This proposed project will include five structural elements present in successful WPC models: 1) a care coordinator (CHW) who is part of a Care Coordination Team (CCT) overseeing patients' care across settings; 2) a multidisciplinary health/behavioral health care team; 3) care collaborators (community partners); 4) technology to improve provider integration, care coordination, and patient monitoring; and 5) provider incentives (see Attachment E: Organizational Structure).[8]

During Pilot Year 2 (beginning July 1, 2017), VCHCA proposes to launch three WPC system improvements designed to facilitate the achievement of project goals and metrics as well as better serve pilot participants through improved quality of care. These improvements include the following:

- Implementation of a recuperative care program (medical respite) to assist homeless participants in recovering from inpatient hospital stays after being discharged when they are too ill to recover in unstable environments or on the streets. The recuperative care program is expected to increase the WPC participant population (caseload) to 840 in Year 2, and 880 in each of Years 3-5.
- Establishment of Outreach Care Pod sites that will be located in three geographically dispersed locations where the homeless population congregates, such as homeless shelters and food distribution locations. The Outreach Care Pods will be container boxes equipped with showers and exam areas, along with tents for intake and eligibility screening for social services. The Outreach Care Pods will be staffed by CHWs from the Field-Based Care Coordination Team. A series of community events at the Outreach Care Pods each year will enable these WPC staff to collaborate with social services and community-based partners who will provide basic needs, such as fresh produce, clothing, haircuts, veterinary service for companion animals, etc. Together, WPC services and community supports will effectively meet the homeless populations' multiple complex needs in one location.
- Expansion of data-sharing technologies in Year 2 to facilitate WPC program data collection with organizations outside the VCHCA that are involved in the recuperative care program. These organizations include the National Health Foundation, Salvation Army, and in Years 3-5, the four area hospitals involved in the program. Improvements/expansions of the Integrated Care Plan will include data related to services provided by social service and other community organizations.

WPC Pilot Target Population: The target population is drawn from GCHP beneficiaries who are the highest utilizers of ED and inpatient hospital services across Ventura County. For 2015, this population was 1,821 individuals or 0.9% of GCHP's membership. The target population is comprised of 48% White, 45% Hispanic/Latino, and 7% other race/ethnicities.

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[8] Choudhury JS, Subramanian S, D'Sa S, Rajamani G. (2013) *Healthcare for Complex Populations: The Power of Whole-Person Care.* Strategy &. Available at: http://www.strategyand.pwc.com/media/file/Strategyand_Healthcare-for- Complex-Populations.pdf.

How the WPC Pilot Addresses Target Population Needs: For the target population, poverty, unstable housing, unemployment food insecurity, and lack of transportation serve as stressors and structural/social barriers that can cause, exacerbate, and complicate the treatment of health/behavioral health conditions, leading to greatly diminished health status. There is growing agreement that considering social determinants of health concurrently with health and behavioral health conditions is critical to both achieving Triple Aim goals and reducing health disparities in communities.[9,10] Well-designed, targeted care coordination can improve outcomes for everyone: patients, providers, and payers.[11]

The Year 2 proposed quality improvements to the pilot will address a number of target population needs:

1. Recuperative care programs provide post-acute medical care for homeless persons who are too ill or frail to recover from a physical illness on the streets, but for whom hospital care is no longer medically necessary. Recuperative care is effective in improving post-acute care health outcomes, improving care, and reducing costs to the health care system.[12] An analysis of 2016 discharges of homeless patients from the Ventura County Medical Center reveals a significant need for recuperative care. Among the 1,174 unduplicated discharges for Medi-Cal eligible homeless patients, top physical diagnoses of potential concern for readmission that would benefit from recuperative care include:
   - Alcoholic cirrhosis of liver
   - Alcohol induced acute pancreatitis
   - Alcohol dependence with withdrawal
   - Cerebral infarction
   - Sepsis or endocarditis with streptococci, staphylococci
   - Complications from uncontrolled diabetes

2. The lack of access to showers limits homeless persons' abilities to be admitted to shelters, causes avoidance of the public, and keeps them from gainful employment. Similar programs

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[9] The John D. and Catherine T. MacArthur Foundation Research Network on Socioeconomic Status and Health. (2009.) *Reaching for a Healthier Life: Facts on Socioeconomic Status and Health in the U.S.* Available at: http://www.macses.ucsf.edu/downloads/Reaching_for_a_Healthier_Life.pdf

[10] RWJF Commission to Build a Healthier America. (2013.) *Overcoming Obstacles to Health in 2013 and Beyond.* Princeton, NJ: The Robert Wood Johnson Foundation. Available at: http://www.rwjf.org/content/dam/farm/reports/reports/2013/rwjf406474.

[11] U.S. Department of Health and Human Services, Agency for Healthcare Research and Quality. (2015.) *Care Coordination.* Available at: http://www.ahrq.gov/professionals/prevention-chronic-care/improve/coordination/index.html.

[12] National Health Care for the Homeless Council. (April 2011.) Medical Respite Care: Reducing Costs and Improving Care. Available at: http://www.nhchc.org/wp-content/uploads/2011/09/RespiteCostFinal.pdf.

around the country have found that offering showers engages clients in services and meaningfully restores dignity and hope, catalyzing the return to wellness. The combination of screening services, social services, and showers at one location will enable staff to optimize the homeless population's health while improving access to social services in a one-stop center where the greatest number of homeless congregate. The infection rates for tuberculosis, lice, and scabies affects the homeless population's ability to access services. For example, many Ventura County homeless are refused admittance to the winter shelters due to scabies or tuberculosis. There were 33 active tuberculosis cases in Ventura County in 2016 that required six months of follow up from the Ventura County Public Health Department. The Public Health Department also saw 103 homeless patients in its Tuberculosis Specialty Clinic in 2016. The tuberculosis incidence rate is 6.0 cases per 100,000 residents.[13] Epidemiologic studies of homeless populations have reported the following prevalence rates for infectious diseases: 1.2%–6.8% for active tuberculosis, 3.8%–56% for scabies, and 7%–22% for body louse infestation.[14] In a 2014 San Francisco study, 34.9% of the homeless population had body and/or head lice.[15] The Outreach Care Pods sites will mitigate these issues in the field prior to participants' accessing shelter services.

3. The Ventura County Homeless Count and Survey demonstrated that 23.3% of the homeless population counted self-reported that they suffered from mental health problems, and 24.6% reported that they were substance users.[16] National studies demonstrated higher prevalence of these problems, indicated that 38% of homeless persons were dependent on alcohol, 26% abused other drugs, and 25% suffers from some form of _severe_ mental illness.[17]

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[13] Healthy Communities Institute. (2014.) Health Matters in VC. Based on Ventura County Public Health data. Available at: http://www.healthmattersinvc.org/index.php?module=Indicators&controller=index&action=view&indicatorId=518&localeId=293.

[14] Badiaga S, Raoult D, Brouqui P. Preventing and controlling emerging and reemerging transmissible disease in the homeless. _Emerg Infect Dis._ 2008 Sep; 14(9): 1353–1359. Available at: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2603102/.

[15] Bonilla DL, Cole-Porse C, Kjemtrup A, Osikowicz L, Kosoy M. Risk factors for human lice and bartonellosis among the homeless, San Francisco, California, USA. _Emerg Infect Dis._ 2014 Oct; 20(10): 1645-51. Available at: https://www.ncbi.nlm.nih.gov/pubmed/25280380.

[16] The Institute for Urban Initiatives. (April 2016.) _Ventura County 2016 Homeless Court and Subpopulation Survey:_ Final Report. Available at: http://www.venturacoc.org/images/VC_2016_Homeless_Count_and_Survey_Final_Report.compressed.pdf

[17] National Coalition for the Homeless. (July 2009.) Mental Illness and Homelessness. Available at: http://www.nationalhomeless.org/factsheets/Mental_Illness.pdf. Substance Abuse and Homelessness. Available at: http://www.nationalhomeless.org/factsheets/addiction.pdf.

4. Collecting and sharing patient health information, in alignment with HIPAA requirements, with other facilities can significantly improve individual patient outcomes as well as population health, including informing population health goals, quality measurement, and public safety.[18] Patients often obtain health care services from multiple health care providers in multiple locations, including hospitals, independent physician offices, post-acute care facilities, pharmacies, retail clinics, labs and imaging facilities, among others. To more deeply understand patients' conditions and provide the best care possible, sharing data among providers across the continuum and with patients themselves is critical.[19]

How the WPC Pilot Reduces Avoidable Utilization: The Outreach Care Pod sites utilized by the Field-Based Care Coordination CHWs and community partners will reduce utilization of emergent and urgent care by the homeless population by bringing WPC services directly to areas where the homeless already congregate through regular community events staffed by the Field-Based Care Coordination Team CHWs and community partners. Community partners will provide a host of social services through a community-based one-stop model. By connecting these outreach services to a network of permanent primary and behavioral care clinics, managed through care coordination, assessed health/mental health conditions can be addressed before they become acute requiring higher levels of care. Care coordination across divergent systems has been shown in studies to reduce utilization of inpatient days by up to 25% and ED services by 33%, and increase wellness and prevention visits by 300%.[20] Care coordination, combined with data sharing and real-time communications, will result in participants receiving the right care at the appropriate level of utilization addressing unique needs through facilitated connections with providers trained to address the needs while avoiding duplication of services and providing timely interventions. Improved health outcomes, increased use of preventive services, and access to services to address the social determinants of health will decrease costly overutilization of services. Further, integrated and comprehensive housing support services will facilitate lower utilization of system components due to those key services' influence on health outcomes.[21]

Individuals experiencing homelessness have disproportionate rates of acute and chronic illnesses, which drive high rates of hospital utilization. Lack of housing for this population complicates discharge

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[18] Diamond C, Mostashari, Shirky C. Collecting and sharing data for population health: A new paradigm. *Health Aff.* March/April 2009 vol. 28 no. 2 454-466. Available at: http://content.healthaffairs.org/content/28/2/454.full.

[19] American Hospital Association. (2015.) *Why Interoperability Matters.* Available at: http://www.aha.org/content/15/interoperabilitymatters.pdf.

[20] AHC Media. (2016.) *Case Managers and Decreasing ED Visits.* Available at: http://www.ahcmedia.com/articles/137698-care-coordination-with-cms-results-in-33-decrease-in-ed-visits.

[21] CSH: The Source for Housing Solutions. (July 2014.) *Housing is the Best Medicine: Supportive Housing and the Social Determinants of Health.* Available at: http://www.csh.org/wp-content/uploads/2014/07/SocialDeterminantsofHealth_2014.pdf.

planning and subsequent recovery, leading to high rates of hospital re-admission as well. This utilization pattern has substantial cost implications for the health care system. Research conducted by the *National Health Foundation* in 2007 concluded that hospitals in Los Angeles County kept homeless patients in their hospitals up to four additional days due to the lack of safe and appropriate discharge options.[22] A 2006 study found that homeless patients who used medical respite services experienced fewer hospital days (3.4 vs. 8.1 days), a reduction in emergency department utilization, and an increase in outpatient clinic visits.[23]

How the WPC Pilot Addresses Current System Problems: Earlier this year, the WPC Collaborative conducted an inventory to understand what care coordination efforts exist and the strength and weaknesses of current systems. While Ventura County has many assets in its systems, partnerships, and current and future initiatives, the collaborative identified some significant system problems that the pilot will overcome or mitigate, including: siloed services, lack of communication between systems, lack of consistent data collected, and multiple, disjointed needs assessments. These gaps will be mitigated through service integration/coordination, communication protocols and technologies, data consolidation through warehousing, and assessments unified to create care plans.

Upon ramp up of the WPC pilot in Year 2, Plan-Do-Study-Act (PDSA) processes were initiated to determine quality improvements to the VCHCA model that would improve care as well as the ability to meet project goals and metrics. The stakeholders identified the three new improvements that would fill the gaps in the model as originally designed.

The proposed recuperative care program will fill an existing gap in the continuum of care for people who are experiencing homelessness. Often, homeless individuals are discharged from a hospital following treatment with instructions to rest, and complete a course of medication, wound care, or other treatment until they are fully recuperated. However, recuperation on the street is extremely difficult if not nearly impossible. When many of these patients are discharged from a hospital, they are offered a hotel voucher to provide a safe environment while they recover. This is a very short-term solution, which does not address any medical needs a patient has during that timeframe. The recuperative care program will offer a safe environment as well as medical personnel to provide oversight during recovery and assistance locating temporary and/or permanent housing. In addition to PDSA processes, a 2016 one-month focused study of post-acute care provided for Ventura County homeless persons who were discharged to an outpatient setting, skilled nursing facility, or home health services revealed that Medi-Cal reimbursement for acute care services among the population studied is significantly less than the reimbursement for these post-acute treatment options. The study considered various resolutions and recommended implementing a recuperative care program.

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[22] Bruno K, Grigsby J. (2012.) *Recuperative Care: 2012 Summary Report.* National Health Foundation. Available at: https://www.nhfca.org/reports/Recup%20Report%20final%208%2012.pdf.

[23] Buckanan D, Doblin B, Sai T, Garcia P. (2006.) The effects of respite care for homeless patients: A cohort study. *American Journal of Public Health,* 96(7), 1278-1281. Available at: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1483848/.

Recuperative care services do not currently exist in Ventura County, creating a gap in services for homeless persons who are discharged from area hospitals.

The need for Outreach Care Pods was originally identified by a collaborative needs assessment effort to determine existing gaps in services for Ventura County's homeless population. This collaborative effort involved countywide stakeholders, including county clinics, local city governments, and police departments, and other community organizations serving the homeless. Ventura County also has a lack of available shower facilities for homeless persons, which limits this population's ability to access shelters and participate in the broader community. One-Stop Centers for the homeless are in fixed locations in VCHCA clinical sites, but offer no shower facilities and limited social services. The Outreach Care Pods sites will provide multiple services at areas where the homeless population transits or congregates across the county, thereby improving access to care coordination through the WPC model as well as social services, including showers and access to food services and resources.

Overarching Vision – Improving Collaboration: The Ventura County WPC Connect project will build upon existing efforts in the community (see Section 3.1) and improve collaboration among participating WPC pilot entities through collaborative leadership, integration (Section 2.2), coordination structures (Section 3.1), and shared data (Section 3.2). Successful collaborative leadership methods[24] will enable participating entities to develop a unified county-level approach to WPC that will successfully align resources, secure commitment from stakeholders, and implement a pilot project that will accomplish proposed performance measures/metrics. Three key components for successful collaborative leadership are integrated into the project: structured coordination, defined roles, and clear understanding of each partner's needs and measures of success.[25]

Overarching Vision – Providing Learnings: The VCHCA will participate with statewide learning collaboratives and bi-weekly/months calls among statewide pilot lead entities to share best practices, and share information with other pilot entities as requested. At the pilot's conclusion, learnings will inform local future WPC efforts (see External Communication Plan in Section 2.2).

Overarching Vision – Building Sustainable Infrastructure: Sustainable infrastructure that supports communications across systems will be built by:
- Creating a unified organization using a collaborative leadership approach that fosters relationships and trust among WPC system providers
- Establishing shared data technologies and a data warehouse
- Increasing integration of services for high-risk patients
- Implementing real-time communications protocols and technologies
- Developing a locally defined care coordination model (see Section 3.1)

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[24] Cantor J, Tobey R, Greenberg E. (November 2015.) *Developing Safety-Net Care Management in California: An Opportunity for Whole-Person Care.* JSI Research and Training Institute, Inc. Available at: http://www.jsi.com/JSIInternet/Inc/Common/_download_pub.cfm?id=16370&lid=3.
[25] Cantor, 2015.

Pilot Sustainability: This infrastructure and the proposed interventions will be sustained by the initial investment of resources including: 1) VCHCA and DHCS combined funding to establish data systems and technologies for data sharing, reporting, and quality improvement; 2) relationships, collaborations, and agreements that do not require funding to support; and 3) the pilot's integration of services that address the social determinants of health that will lower service utilization resulting in significant cost-savings within all systems. For example, evidence shows that high-cost individuals do not become lower cost over time if they remain homeless.[26] Ensuring that participants are housed can result in a significant reduction in the use of major services, ranging from 28% to 79%.[27] These cost-savings will enable participating entities to fund pilot model components, such as the cost of CHWs and informaticists, as the project moves from the pilot phase to full implementation after waiver funding is terminated.

2.2 Communication Plan

WPC Pilot *Communication Process:* *Communication among the lead entity and participating entities* will occur through monthly collaborative meetings; collaborative-wide informational and quality improvement emails; site visits; PSDA activities; monthly data reports about utilization, cost, and metric progress; integrated care plan development; and expansion of technologies, including a centralized care collaboration platform, electronic care plan, eReferrals, real-time secure messaging, HL7 ADT alerts, and real-time dashboards with key indicators for the WPC Connect target population (see Section 3.1). The VCHCA will hold an educational conference upon funding among participating entities that will review all funding requirements and expectations. Communications between the DHCS and VCHCA that define/clarify requirements will be shared at regular collaborative meetings and provided in writing. Written agreements between individual entities and the lead entity will clearly outline each organization's obligations. The communications infrastructure will be sustained through established communication protocols, data sharing and reporting technologies, bylaws, relationships, and cost-savings from project interventions.

Integration will be promoted by: 1) community-based care coordination (CHWs); 2) web-based, real-time care coordination and care plan platforms; 3) and care coordination administered through a centralized CCT (see Section 3.1). The pilot will *minimize silos* through a unified vision and goals, increased integrative structures, collaborative bylaws, data sharing technologies and protocols, improved relationships/trust across system providers, regular communications/meetings among

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[26] Flaming D, Toros H, Burns P. (2015.) *Home Not Found: The Cost of Homelessness in Silicon Valley.* Economic Roundtable, underwritten by Destination: Home and the County of Santa Clara. Available at: http://destinationhomescc.org/wp-content/uploads/2015/05/er_homenotfound_report_6.pdf.

[27] United States Interagency Council on Homelessness. (June 2015.) Opening Doors: Federal Strategic Plan to Prevent and End Homelessness. Available at: http://dev2.usich.gov/resources/uploads/asset_library/USICH_OpeningDoors_Amendment2015_FINAL.pdf.

participating and lead entities, and alternative financial options for incentives and payments. The key to minimizing silos is a shared platform through integrated enterprise solutions that will create a community care collaborative process driving a virtually integrated delivery network.

Decisions will be made in consultation with the participating entities through collaborative leadership decision-making processes (see Governance Structure below).

Regular meetings will be calendared each project year to facilitate collaborative planning and attendance by participating entities. Leadership team meetings will occur at least biweekly and WPC Collaborative meetings will occur monthly prior to services implementation and the schedule will be adjusted after implementation as indicated, with leadership and collaborative meetings occurring at least monthly. The WPC Administrative Assistant will serve as scribe at each meeting, recording the list of attendees, developing and maintaining agendas, and recording minutes. At least annual stakeholder meetings will be held beginning after Year 2 to report results, challenges, and successes.

Governance Structure: The _pilot will be organized_ through collaborative leadership and systematic coordination among entities. The governance structure: 1) identifies clear roles among the participating entities in providing services and implementing interventions (see Section 1.2), 2) defines financing arrangements (see Section 5), 3) outlines communication protocols and requirements (see above), and 4) sets decision-making authority and practices (see below). WPC partnership bylaws delineate governance, decision-making processes, communication protocols, partner protocols for failing to meet goals, and business structures.

Decision-making authority related to system design and quality improvement will reside with the WPC pilot leadership team, composed of champions/key representatives from each of the participating entities. The leadership team will make decisions by consensus and/or according to bylaw procedures once drafted.

Participating entities will be involved in decision-making through leadership team involvement; entity progress reports outlining barriers, successes, and recommendations for pilot adaptations; input at WPC collaborative and stakeholder meetings and conferences; collaboration processes; PDSA activities for project improvements (see Section 4.2); integrated plan development; and through collaboration via care coordination platforms. Shared decision-making processes will be utilized for project-related decisions (under the constraints of the award) and, as indicated, participant selection and care planning decisions.

Main Point of Contact: The main point of contact to support and coordinate with participating entities will be the WPC Project Director, who will be hired upon approval of the application. Until that time, the main point of contact will be Johnson K. Gill, the VCHCA Deputy Director of Population Health Management and Clinical Integration.

External Communication Plan: The VCHCA will develop materials (i.e., PowerPoint presentations, pilot study results and analysis documents) based on DHCS annual and final reports to provide annual (post-Year 1) county-wide conferences about WPC, which will be used in other formats and settings (i.e., website pages, participating entity data sharing, statewide WPC conferences, professional conferences). The goals of these efforts will be to improve collaboration and rapport among participating entities, engage stakeholder organizations in joining local WPC efforts, draw input into quality improvement processes, compare results to other pilots, and drive pilot sustainability efforts. These learnings will also provide information crucial to future local efforts, both within the county and as a model for other counties to emulate or understand through "lessons learned." Beneficiaries will be linked to an assigned CHW who will communicate the project services and information to the participants, and help them navigate WPC services. Providers will be trained in WPC and other project-related topics and provided communications via the project's enterprise network (see Section 3.1) and with communication between the CHW and provider and/or care manager.

2.3 Target Population(s)

Target Population: The target population is the high-utilizing GCHP beneficiaries with at least four ED visits and/or two inpatient visits (ages 18 and older). For 2015, this high-utilizer population was 1,820 individuals, 1,612 of whom were seen through VCHCA. This is 1.1% of VCHCA's 147,744 ED/hospital patients in 2015. Once identified, the target population will be stratified for risk using the project's WPC Vulnerability Index to ensure enrollment prioritization of the highest risk of this population, which is predominantly homeless persons, those at risk of homelessness, and/or persons with SUD or mental illness. It is anticipated that 2,280 total Medi-Cal beneficiaries will be served over the five-year project period, with ongoing enrollment of 880-participant caseload. It is estimated that at least 440 participants per year (beginning year 3) will cycle out of the project due to improvements in outcomes "graduating" the participant out of the project, reduction in overall risk that transitions the participant to Targeted Case Management services, dropped enrollment, re-location, death, etc. It is estimated that 1,612 total Medi-Cal beneficiaries will be eligible for the pilot in the geographic area (based on 2015 totals) in the first project year. Some will not be served because of lack of consent or low overall risk based on the *WPC Vulnerability Index.* Only Medi-Cal beneficiaries will be served by the pilot.

Collaboration with Participating Entities to Identify the Target Population: The target population was identified through a collaborative data approach to identify common patients who frequently access urgent and emergent services at the ED, inpatient hospitals, FQHC and Public Health clinics, urgent care centers, behavioral health clinics, crisis response team, and EMS. The Lead Entity was responsible for designing the data analysis approach, leading collaborators in identifying specific data to be queried, analyzing data to determine commonality across sectors, and determining which of the five possible target populations created the greatest system utilization/cost.

Enrollment Cap: An enrollment cap of a 1,000-participant caseload is anticipated once the pilot is fully implemented. VCHCA will notify DHCS within 90 days of imposing the enrollment cap and

will submit to DHCS approval. The rationale for the proposed cap is that project effectiveness will only be achieved if it remains within the maximum caseload of 40 individuals per CHW for complex care models in order to accomplish care goals. A waitlist will be established for eligible participants wishing to be enrolled, and patients will be enrolled and opted in on a rolling basis. The process for establishing and administering the enrollment cap will include: 1) identification for eligibility based on risk stratification, contact by a CHW, and collecting a signed Universal Consent form; 2) notification of being placed of the wait list, with referral and information on care services available based on assessments within the VCHCA until the candidate can be enrolled in the project; and 3) notification of eligibility for enrollment when a spot is open. Enrollment from wait lists will be based on a combination of risk level and time on the wait list.

Methodology to Identify the Target Population: A collaborative data approach was utilized to identify the target population's use of health care and behavioral health services. Data analysis of GCHP, behavioral health, VCHSA, and HCH records; the 2015 Homeless Count; the VCHCA 2013 Health Care Needs Assessment; collaborative data from community resources regarding homeless and mentally ill service access outside of VCHCA; and Ventura County studies/literature reviews were used inform data analysis. The WPC Collaborative and key leaders reviewed the analysis to determine the characteristics and needs of the highest utilizers, from which a target population was determined.

Among the crucial determining factors were the characteristics of the beneficiaries. The high-utilizing GCHP beneficiaries with at least four ED visits and/or two inpatient visits were 1,820 individuals in 2015, 1,554 of whom were seen through VCHCA. Among VCHCA's highest utilizers: 27.7% are currently or recently homeless, 40.5% have mental health disorders, 24.4% have substance abuse disorders, and 97.3% have multiple chronic conditions (see Need above). Among the homeless target population, 56.8% had eight or more physical health encounters and 28.4% had eight or more behavioral health encounters, with 49.0% treated at both health/behavioral health facilities. Among this population, 47.6% had no preventive care visit with either an FQHC or Public Health clinic. These characteristics demonstrated that the high utilization target population has risk factors across all five WPC populations, but persons currently or recently experiencing homelessness are a particularly needy sub-population that shows high incidences of each of the other risk factors.

Data analysis revealed that the high utilizers were often homeless, but other sub-populations (mentally ill, those with SUD, and those with multiple chronic conditions) were also frequently represented among the highest utilizers. High-risk conditions that require care management to optimize outcomes were also present among this population, according to data results: 11.3% had kidney disease, end-stage renal disease; 12.2% had heart disease, heart surgery; and 14.6% had liver disease, cirrhosis. VCHSA data identified the high-levels of social service utilization among the identified target population. Among the target population identified, 49.7% were also in the VCHSA system because they receive CalFresh (food assistance, formerly SNAP) and/or CalWORKS (cash assistance) and/or assistance for the homeless as tracked by the Homeless Management Information System (HMIS); 40% receive at least CalFresh.

It was determined collaboratively by key leaders, therefore, that prioritizing the target population to those most in need of services (highest risk) would most effectively impact the utilization of health, behavioral health, and social service systems. A risk stratification strategy was developed to ensure that not only homeless persons accessed WPC services, but also those in other populations who most often use hospital ED/inpatient services. It is anticipated that homeless beneficiaries will be a large proportion of the proposed target population, since 98.4% of this group is also part of at least one other high-risk sub- population.

Beneficiary Identification: Through the WPC Utilization and Outcomes Monitoring System (UOMS), participants will be identified who access the VCHCA ED four or more times in a year and/or access inpatient services two or more times in a year. Other collaborators will provide queries of their systems to   determine high utilizers, which will be cross-referenced with the GCHP data. A Waiver Analytics Team will determine common outliers. Risk stratification will be achieved through predictive analytics based on a risk   algorithm (see Attachment F). Once identified potential participants will be enrolled into the Health Registry, WPC Integrated Care Plan platform, as well as into a specialized platform for WPC community partners to provide alerts to providers and collect data.

Beneficiary Outreach: Any provider who the potential participant accesses will be aware of the patient's eligibility for project inclusion. Providers, care managers, clinical staff, and community partners will be trained about the project and referral protocols. Mobile outreach staff (Engagement Teams and Field-Based Care Coordination CHWs) who provide Fee-for-Service outreach for persons not yet enrolled) will reach out to those who are identified in a variety of settings, such as clinics, EDs, One-Stops, homeless congregation locations, shelters, transitional housing, etc. The Engagement Teams and CHWs will be trained in motivational interviewing and trauma-informed care to engage the person in motivation to change. The addition of the recuperative care program in Year 2 will allow the project to expand beyond VCHCA's target population to include those served by other community hospitals. CHWs will assess patients who are admitted into the recuperative care program from other local hospitals. If they meet the eligibility criteria, they will be enrolled into the WPC programs. It is anticipated that this will add 40 additional participants in Year 2 and 80 additional participants in each of Years 3-5, totaling 280 additional participants, or 2,280 over the project. Two (2.0 FTEs) CHWs will be added to the Field-Based Care Coordination Team to provide caseload capacity for these additional beneficiaries. The recuperative care program is expected to serve 296 patients each year, 226 of whom will be Medi-Cal eligible WPC participants; 80 of these will be new to the WPC program each year from other area hospitals and the remainder will be already participating through VCHCA identification.

The CHWs will outline the project's features and potential benefits. The WPC Universal Consent Form will be signed by the participant. After consent, the CHW will complete the *WPC Comprehensive Assessment,* which will be a tool that determines health, behavioral health, and social needs, and incorporates the Vulnerability Index. The *WPC Vulnerability Index* assessment will prioritize participants for project inclusion. This Vulnerability Index will be a hybrid of assessments

from other evidence-based programs,[28] but designed to specifically identify persons who have an increased risk of expensive, frequent service utilization that can be affected by WPC (see Attachment C). The WPC Comprehensive Assessment will be adapted from the National Alliance to End Homelessness Comprehensive Assessment Tool[29] to align with the project's target population. This information will be used as the basis for participant prioritization and integrated care plan development. The Waiver Data Analytics Team will notify the participant's existing providers and pull assessment and care plan information into the *Integrated Care Plan* platform. The CCT will engage these care providers to further develop a consolidated care plan and assess other care providers/managers based on assessed needs. Other community partners' case managers, eligibility staff, and outreach workers will also be trained to engage potential participants to ensure that the WPC CHWs are leveraged by the countywide outreach resources.

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[28] O'Connell J. *Vulnerability Index: Prioritizing the Street Homeless Population by Mortality Risk.* Boston Healthcare for the Homeless Program. Available at: http://www.jedc.org/forms/Vulnerability%20Index.pdf.

[29] National Alliance to End Homelessness. (2014.) *Comprehensive Assessment Tool.* Available at: http://www.endhomelessness.org/library/entry/alliance-coordinated-assessment-tool-set.

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

3.1 Services, Interventions, and Care Coordination

WPC Pilot Services for Beneficiaries: The non-Medi-Cal services that will be provided to the target population are based on: the 2015 homeless count and survey,[30] the 2013 VCHCA needs assessment,[31] evidence-based practices based on the target population needs through literature reviews, county HCH program lessons learned, and experience from collaborative partners serving the target population. All services will be offered to all participants based on assessed needs (see Attachments A and B, the Concept Diagram and Workflow Diagram).

Medical Services: Medical services provided through *VCHCA's* FQHCs, hospitals, and specialty care providers are Medi-Cal funded (see Section 1.2.2). Services provided by VCHCA through the WPC project include the following:

1. *WPC Centralized Care Coordination:* A centralized Care Coordination Team (CCT) will connect the new communication and data technology infrastructure and the *Integrated Care Plan* with providers within the VCHCA, other public entities, and community partners. The CCT will oversee the day-to-day activity of ensuring the participants are appropriately identified, enrolled, and linked to resources. This centralized staff will have access to a multi-level, interdisciplinary support team of subject matter experts who will advise WPC staff about appropriate resources, services, and interventions, including PCPs, specialists, pharmacists, nurses, behavioral health specialists, housing services representatives, social service representatives, etc. The CCT will also provide field-based coordination and integration support as required by providers. The CCT will include: 9.0 FTE Care Managers (1.0 FTE Lead Care Coordinator, 3.2 FTE Registered Nurses [RN] and 4.8 FTE behavioral health specialists (see Section 1.2.3 below). 28.0 FTE Community Health Workers (CHWs) in PY 2 and 30.6 FTE CHWs in PYs 3-5 will also be a part of the CCT.

2. *WPC Care Coordination through Outreach:* Three Engagement Teams (based out of retrofitted mobile health vans) will facilitate integration of services, outreach and engagement of participants, determine immediate care needs, provide needed prescriptions, offer enrollment and assessment services, connect services with community-based providers, and ensure that there are no gaps between the Integrated Care Plan and the provision of planned services. The team will be effective in connecting with participants

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[30] Colletti J, Herrera S. (April 2015.) *Ventura County 2015 Homeless Count and Subpopulation Survey: Final Report.* Institute for Urban Initiatives. Available at: http://www.cityofventura.net/files/file/VC_Homeless_Count_Survey_2015.pdf.

[31] Ventura County Health Care Agency. (November 2013.) *Transforming Ventura County Communities: Understanding the Health Status and Needs of Ventura County.* Available at: http://www.vchca.org/docs/public-health/transforming-vc_-report_final.pdf?sfvrsn=0.

who predominantly access services outside of the VCHCA. Each Engagement Team will include: one (1) Care Coordination Manager, one (1) Nurse Practitioner, and one (1) MA. One(1 FTE) additional MA will be added to the team resources in Years 3-5 to facilitate flexibility with connections to the other two teams.

3. *WPC Care Coordination through Field-Based Care Coordinators:* CHWs 28.0 FTE in PY2 and 30.6 FTE in PYs 3-5, who are part of the CCT, will be field-based staff members who have a close understanding of the target population and Ventura County communities, and are culturally/linguistically similar and/or competent with the participants they serve. This trusting relationship will enable them to serve as a liaison, link, and intermediary between health, behavioral health, social services, and the community resources to facilitate access to services and improve the quality of service delivery. CHWs will build individual and community capacity by increasing health knowledge and self-sufficiency through a range of activities such as outreach, community education, informal counseling, social support, and advocacy. CHWs will administer the WPC Comprehensive Assessment, connect with the CCT to identify needed services, initiate the WPC Integrated Care Plan with the CCT based on the Comprehensive Assessment, link participants with community resources, reduce access barriers, provide in-person ongoing care management and support, and work with system-wide care managers to provide care (see Section 1.2.2). Project Year 3 will have an increase in the number of CHWs by 2.0 FTEs to expand the caseload capacity to incorporate additional participants identified in the recuperative care program who were discharged from area hospitals other than VCHCA hospitals; and an increase in the number of CHWs by 7.8 FTEs to provide for the operation of the Outreach Care Pods. This totals 30.6 FTEs in Years 3-5.

4. *WPC Care Coordination through Outreach Care Pods:* Outreach Care Pods will be located in areas where the homeless population congregates, such as next to homeless shelters, parks, and food distribution sites. An Outreach Care Pod will be located at three sites geographically dispersed across the county in Year 2 with three additional Pods located in the county in Years 3-5. The Outreach Care Pods will be retrofitted container boxes that will include exam/social service spaces and showers. The CHWs, in collaboration with community partners, will facilitate the integration of services at community events. In addition, a team of community partners will incorporate social services, such as fresh produce and clothing, to ensure that the services offered at community events effectively meet the homeless populations' multiple complex needs in one location. CHWs will also utilize the Outreach Care Pods to access the homeless population they are assigned in their caseload during their regular outreach and care coordination activities on an ongoing basis. This "center of operations" for CHW outreach for homeless participants will improve the ability of the program to remain in contact with these participants to ensure they are accessing the services in their Integrated Care Plan, thereby improving program retention and outcomes.

5. As part of the Year 2 re-application, VCHCA proposes to implement recuperative care services for homeless WPC participants who are discharged from area hospitals, but are unable to

effectively recover from their injury or illness on the streets. The Recuperative Care Center will be a 12-bed facility located at the *Salvation Army's* transitional living center in the city of Ventura. The Recuperative Care Center services will be operated through a contract with the *National Health Foundation (NHF)* through the Fee-for-Service Bundle on a per bed day basis. This contract will allow WPC participants who are discharged from VCHCA, Los Robles Medical Center, St. Johns Hospital, Simi Valley Hospital, and Community Memorial Hospital to be admitted into the recuperative care program. At a projected 90% occupancy rate due to acceptances and discharges, cleaning and sanitation, and other services; 3,548 total available bed days of care annually; and an estimated 12-day average length of stay, the recuperative care program is expected to serve 226 WPC participants annually.

The program will also allow the WPC program to serve 80 additional members of the target population per year (280 total over the course of the pilot) by opening up access to persons who are Medi-Cal beneficiaries who meet program eligibility requirements and who are discharged from the other four hospitals into the Recuperative Care Center. The VCHCA currently only has the ability to access data from internal technology to determine the eligible recipients. An expansion in data sharing capabilities will enable the WPC pilot to collect service, performance, and outcome data from the NHF and four participating hospitals (see Section 3.2 Data Sharing). CHWs will assess all patients who are admitted into the recuperative care program to determine if they are eligible for inclusion, have them sign a consent form to access their medical information, contact the discharging hospital for applicable eligibility information, and enroll them in the WPC program.

The services provided by NHF include the following:

a. *Medical Oversight:* Medical oversight services include: coordinating and facilitating medical care after hospital discharge, arranging post-discharge medical appointments, and providing education about self-care and medication management. The actual length of stay will be determined on a case-by-case basis in consultation with the referring hospital.

b. *Care Management:* Services include case management of each patient to determine his/her eligibility for social services and temporary/permanent housing programs. Upon discharge from the recuperative care program, the NHF will, on a best-efforts basis, connect each patient to an alternative facility, shelter, or permanent housing.

c. *Reporting:* The NHF will provide VCHCA with monthly patient-bed utilization reports and patient discharge disposition information to ensure that VCHCA is fully utilizing its allocated number of bed days as well as to track the success of the recuperative care program.

d. *Intake Services:* Intake services will include screening potential clients and collecting completed applications from participating hospitals. The NHF will accept or deny the patient within four business hours of receiving the completed application. The NHF will arrange patient acceptance into the recuperative care program with the referring hospital admission department.

e. *Outreach and Training:* The NHF will conduct ongoing outreach and training to all

participating hospitals about the recuperative care program.

Coordination of specific medical services provided through the recuperative care program include: wound care and infection control, pain management, ambulation/physical therapy, medication monitoring, patient education (disease management and prevention), ongoing assessments and monitoring, and discharge planning. Support services will include: benefit and entitlement acquisition, case management, housing applications, linkages to appropriate behavioral health services if needed, and counseling. The CCT will facilitate care coordination and planning with the WPC program through on-site Outreach Team contacts.

Best practices will be utilized by the recuperative care program, including: 1) limiting recuperative care program admission decisions to four hours or less; 2) determining service levels (number of post-acute days of stay) for medical oversight at intake in consultation with the acute care provider; 3) reporting patient outcomes to the referring hospital and the patient's primary care provider; 4) ensuring regular feedback to hospitals; 5) ensuring accurate, real-time data; and 6) having a process to adjust expected lengths of stay.[32]

PCPs/clinical staff, CCT, and CHWs will be trained in complex care patient management, assessing patients' ability to participate in care coordination, WPC components/model, care transitions, cultural competency, and reporting services and outcomes. Participants will have access to a multidisciplinary care team that is unique to each participant, including PCPs, psychiatrists, nurses, specialists, therapists, and behavioral health professionals. The WPC Project Director and Care Managers will integrate existing HCH program, co- located primary care/behavioral health services, PCMH-based care, and One-Stop Center services with the pilot's services to leverage existing resources and optimize pilot funding.

VCHCA Public Health Department will provide tobacco cessation classes and access to One-Stop Center services in the city of Ventura (see Section 1.2.4).

<u>Behavioral Services</u>: A host of mental health and substance abuse services will be provided by the *Ventura County Behavioral Health Department* (VCBH) outside of Medi-Cal funding streams (see Section 1.2.3.). In addition, 4.8 FTE VCBH Care Managers who are part of the CCT (see Section 1.2.2 above) will support behavioral health care coordination for participants. The role of the VCBH Care Managers is to integrate behavioral health services with other medical, social, and non-medical services according to the Integrated Care Plan. The centralized behavioral health specialists will: 1) interact with CHWs, patients, physicians, behavioral health professionals, social service providers, and community partners to ensure that behavioral health protective factors are integrated with all aspects of care; 2) track service utilization, health outcomes, and care plan changes; 3) work closely with field-based CHWs to ensure timely behavioral health care; 4) bring all care providers to serve the participant during urgent/emergent behavioral health situations; 5) ensure behavioral health services are accessible in primary care settings; and other services as indicated. At least one Care Manager will

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[32] Bruno K. (2012.)

be a Licensed Mental Health Professional (LMFT or LCSW) and at least one will be a Substance Abuse Specialist.

Other non-Medi-Cal services include those that are provided through the Mental Health Services Act, Realignment Funds, SAMHSA and other grants, County General Funds, Veteran's Administration, and other sources. SAMHSA grants include Projects for Assistance in Transition from Homelessness (PATH) funding for case management and outreach. Integration with primary care is also provided through a co-located behavioral health professional in some clinics.

Social Services: Social services will address participants' immediate and ongoing basic needs for shelter and housing transition and tenancy services, transportation (taxi vouchers, bus tokens, non-emergency medical transport), healthy food, clothing, and personal items. The role of the use of social services is to stabilize the participant's ability to acquire resources for daily living to improve protective factors that affect health outcomes. The _Human Services Agency_ will provide multiple social services through existing community resources, including: CalFresh, CalWORKs, Child Welfare Services, Employment Services, General Relief, Health Care Enrollment, Homeless Services, Transitional Housing, In-Home Supportive Services, Public Guardian, Veteran Services, Youth Services, and Adult Protective Services (see Section 1.2.6). CHWs will connect participants with other existing community resources, as indicated through comprehensive needs assessments, such as:
1. Housing transition and tenancy services/housing (_Housing Authority, St. Vincent De Paul, Rescue Mission Alliance, Salvation Army, Project Understanding_)
2. Food banks/vouchers (_FOOD Share, Rescue Mission Alliance, Salvation Army, Project Understanding_)
3. Clothing (_Rescue Mission Alliance, Salvation Army_)
4. Support groups (_Rescue Mission Alliance, Salvation Army_)

Through the WPC project, the additional services that will be provided will be:
1. _Ventura County Housing Authority_ housing transition and tenancy support services (see description below). National Health Foundation will also provide supportive housing services for the recuperative care population in collaboration with VCHCA.
2. _Ventura County Transportation Commission_ bus vouchers will be provided to participants as needed to maintain health stability and access services according to their care plan, and pilot funded only if not funded through Medi-Cal.

In the Year 2 re-application proposal, social services will also be provided by utilizing three retro-fitted container boxes (six in Years 3-5) to be used as Outreach Care Pods to facilitate services to the homeless WPC population. The Pod sites will have shower stalls, screening/exam rooms, and tents erected for social services to allow partnering agencies during community events to offer their services on site at locations where the homeless population transits or congregates. These services will include access to fresh produce, clothing, hygiene products, eligibility assistance, veterinary care for companion animals, haircuts and other services as partners are available. Partner on-site social service schedules for community events will be developed by the collaborative.

Non-Medical Services: The role of non-medical services is to prepare the participants for project disenrollment in a manner that will ensure stability and success. As participants transition to self-sufficiency, they will take part in life skills and job readiness training. St. Vincent De Paul will provide participants skills training for independent living, including budget management, cooking and nutrition, maintenance of living space, transportation, goal-setting, and personal empowerment. Job readiness training will be provided by two county Workforce Investment Board Job and Career Centers and will include soft skills training (i.e., communication, resume writing, job applications, interviews), job readiness/career development (i.e., construction, office operations, nursing, computer technicians, and maintenance), and job search/placement assistance. The CHWs will assist with housing navigation and accessing life skills training. These services will be provided through existing community resources, and not funded through the WPC project (see Letters of Participation). Non-medical care and ongoing support will be provided by the CHWs, community/partner outreach workers, and family/caregivers, as indicated by the need.

Services Suiting Needs of Beneficiaries: To accomplish WPC (STC 112) goals, best practices will be incorporated into the model. Studies demonstrate that providing stable affordable housing coupled with "high touch" supports that connect people with chronic health challenges to a network of comprehensive primary, behavioral health, and other services can improve health, increase survival rates, foster mental health recovery, and reduce alcohol and drug use among formerly homeless individuals.[33] Access to safe, quality, affordable housing – and the supports necessary to maintain that housing – constitute one of the most basic and powerful social determinants of health.[34]

At the heart of the pilot design is care coordination through trauma-focused and patient-centered care that is tailored to meet the needs of the individual, taking into account the unique and complex array of social, behavioral, and physical health needs among the target population. Studies demonstrate that patient-centered interventions involving care management and coordination among high-risk homeless persons reduce inpatient admissions by 37% (in one study) and ED visits overall.[35]

Individuals experiencing homelessness have disproportionate rates of acute and chronic illnesses, which drive high rates of hospital utilization. Lack of housing for this population complicates discharge planning and subsequent recovery, leading to high rates of hospital re-admission. Recuperative care allows homeless patients to recover more fully, decreasing hospital utilization rates.[36] Mobile

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[33] Nardone M, Cho R, Moses K. (June 2012.) *Medicaid-Financed Services in Supportive Housing for High-Need Homeless Beneficiaries: The Business Case.* Center for Health Care Strategies, Inc. Available at: http://www.csh.org/wp-content/uploads/2012/06/SH-Medicaid-Bz-Case_Final.pdf.

[34] CSH, 2014.

[35] Raven MC, Doran KM, Kostrowski S, Gillespie CC, Elbel BD. *An intervention to improve care and reduce costs for high-risk patients with frequent hospital admissions: a pilot study.* BMC Health Serv Res. 2011 Oct 13;11:270. Available at: http://www.ncbi.nlm.nih.gov/pubmed/21995329.

[36] National Health Care for the Homeless Council. (September 2011.) *Medicaid Reimbursement for Medical Respite Services; Policy Analysis.* Available at: http://www.nhchc.org/wp-

homeless services have the capability to increase the ability of the homeless population to move out of homelessness.[37] Social needs can often complicate medical care; health and social service integration can increase positive experiences among patients, reduce per capital cost, and improve health outcomes.[38]

Network of Providers: The provider network (participating entities) is listed in the Services section above alongside the services they provide, and is also listed in Section 1.2. A more expansive network of community partners will be accessed by CCT through the county's 2-1-1 community resources directory hotline to connect participants to resources that address each participant's unique needs (see Attachment D).

Housing Services: Linkages to housing services will be determined through initial and ongoing assessments and will be an essential part of the Integrated Care Plan. CHWs will ensure that homeless participants have access to the county's resources of shelters and transitional living facilities for immediate needs, and will utilize motivational interviewing to keep participants off the streets. The care plan and the participant's stratification risk will indicate the need for services. Care Managers will connect participants with transitional housing services to develop a long-term answer to ensure that health outcomes are maximized. Supportive housing services will also be provided for participants in the recuperative care program by the *National Health Foundation.*

As indicated in Section 2.1 and described in the CMCS Informational Bulletin,[39] housing services will include: individual housing transition services and individual housing and tenancy sustaining services. Housing support services provided by the Area Housing Authority of the County of Ventura and city housing authority partners will include a host of housing supports including: developing housing plans, housing searches, paperwork and legal support, relationship-building with landlords, setting up utilities, etc. Housing authorities will prioritize the project's homeless participants for housing vouchers. *Residential Services (Mental Health):* Case management is provided to support a client's stability in their home environment and residential treatment programs. Note that WPC funds will only be used for allowable costs that include individual housing transition services and individual housing and tenancy sustaining services in alignment with the CMCS Informational Bulletin. Residential services and room and board are not covered under WPC.

content/uploads/2011/09/Sept2011.pdf.

[37] Williams H, Dame D, Brown M, Mazziotti D. (October 2016.) *Portland Homeless Facility Feasibility Study.* Oregon Harbor of Hope. Available at: https://oregonharborofhope.org/wp-content/uploads/2016/11/Feasibililty-Study_Revised-10.08.16.pdf.

[38] Craig C, Eby D, Whittington J. (2011.) *Care Coordination model: Better care at lower cost for people with multiple health and social needs.* IHI Innovation Series white paper. Cambridge, MA: Institute for Healthcare Improvement; 2011. Available at: http://www.ihi.org/resources/pages/ihiwhitepapers/ihicarecoordinationmodelwhitepaper.aspx.

[39] Wachino V. (June 26, 2015.) *Coverage of Housing-Related Activities and Services for Individuals with Disabilities.* CMCS Informational Bulletin. Centers for Medicare & Medicaid Services. Available at: https://www.medicaid.gov/federal-policy-guidance/downloads/CIB-06-26-2015.pdf.

Housing services will link participants with a range of options based on the participant's immediate and long-term needs, health, and the timeframe for housing stability, including emergency shelters, treatment/rehab/skilled nursing facilities, transitional housing, rapid re-housing, Section 8 housing vouchers, and veterans' housing support. Linkages between the VCHCA homeless services and housing authorities/services will facilitate housing stability by ensuring participants maintain sheltered residence. Through regular communication of each participant's housing status by the CHW, partners can intervene quickly if there is a change in status.

The Collaborative will evaluate the need and purposes for a housing pool in project year 3. A housing pool will utilize a phased-in approach to assist in ensuring sustainability. The WPC Collaborative will determine the sources, structure, and eligibility priorities of the housing pool during project year 2. It is anticipated that the housing pool will work by collecting funds through a variety of VCHCA and community-based resources (to be decided at a later time by the Collaborative), determining the need and readiness for housing of participants through a standardized assessment. No housing pool administrative or other costs are included in the WPC budget, nor will any WPC funds be used for the housing pool.

Interventions/Strategies to Integrate Services: Innovative and new technologies support project staff in integrating services. Project interventions include:

1. The web-based Integrated Care Plan, that will consolidate assessments, incorporate care plans from diverse system providers, and develop a comprehensive WPC plan.
2. The web-based *WPC Care Coordination* platform that will maintain the participant repository, care coordination system, data repository, and the project eReferral system, providing real-time communication.
3. A *WPC Community Partner* platform will link outside providers with care coordination while protecting personal health information (PHI).
4. *Real-Time Secure Messaging,* a web-based telemedicine consultation system, will allow PCPs, specialists, CCT, CHWs, mobile van outreach staff, and other VCHCA system providers to securely share health information and discuss patient care (Phase 2).
5. A *data warehouse, the* WPC Utilization and Outcomes Monitoring System (UOMS), will be used to consolidate EHR, behavioral health, VCHSA social services, and health registry data.
6. The *WPC Health Registry, a* population health management tool, enables providers to use data- driven, evidence-based clinical decision making possible. Dashboards will allow providers, CCT, and CHWs to track their participant's needs.
7. CHWs will integrate services through outreach and coordination with participants and system providers.
8. The centralized *Care Coordination Team* will integrate services as defined by the *Integrated Care Plan.*
9. The recuperative care program will link hospital care across VCHCA and four other area hospitals with the WPC program by integrating CHW care coordination services into the program, ensuring smooth transitions out of post-acute care.
10. The community events at the Outreach Care Pod sites will integrate WPC services with those

offered by community partners, thereby increasing access to services for WPC homeless participants.

Prior Experience in Implementing WPC Pilot: VCHCA has experience with projects with similar goals and components, including:

1. EHR platform development in alignment with Meaningful Use Stage 2 requirements and certifications
2. 2015 Health Care Innovation Award project that provides care coordination and infrastructure improvements to the EHR to serve Ventura County residents with COPD
3. PHS 330(h) HCH Program since 2002, with multiple expansions and improvements
4. Expansion to serve all beneficiaries in FQHCs through PHS 330(e) funding
5. Multiple grant-funded SAMHSA programs, including Project for Assistance in Transition from Homelessness (PATH), Mental Health Triage, Drug Court, and other funding.
6. Community Transformation project providing food security, safety, and the emotional and social wellness of residents

Existing Program/Infrastructure to be Leveraged: Participants will have access to a medical home utilizing National Committee for Quality Assurance (NCQA) Patient-Centered Medical Home (PCMH) model practices, with Health Home service integration to be braided with project services when Ventura County's program application round/approval is complete. The HCH program has established a network of health care providers and services that address the unique needs of homeless persons, with linkages to behavioral health services. One-Stop Centers consolidate multiple services in a single location to facilitate WPC system navigation. These existing services are integral to the WPC project's success. The existing EHR system data will provide input to the new technology platforms.

Concurrent initiatives being implemented or expected to be implemented include PRIME projects, FQHC, HCH, and, in future years, Health Homes. The WPC project will be braided with these initiatives to ensure that strategies and services are non-duplicative and leveraged. PRIME's Complex Care project, for example, with bring together a taskforce to implement strategies and data infrastructure, which will be integrated with WPC. All PRIME projects are interdependent with WPC, affecting system-wide changes, integrating care across settings, and coordinating care so that each project can operate optimally.

Engaging and Connecting Individuals to Services: PCPs, clinic staff, and CHWs are/will be trained in motivational interviewing and trauma-informed care to facilitate patient engagement (see Outreach in Section 2.3). CHWs will be adept at developing trust, trained in cultural competence, and be culturally/linguistically appropriate for each participant. As part of primary care assessment, participants will be evaluated for suitability for care management. Connecting participants to services will be accomplished through CHW outreach, CCT and CHW links with appropriate providers who are expert in addressing specific needs, and connectivity through the Care Coordination and Integrated Care Plan platforms. CHWs and Engagement Teams will ensure that participants are identified and connected to project services.

Improving Health Outcomes: The interventions will improve health outcomes by: 1) linking services that directly affect the social determinants of health with primary and behavioral health services, 2) combining   evidence-based care coordination strategies with enterprise technology solutions to ensure real-time communications and improved access to needed services, 3) connecting centralized care coordination management with field-based care coordination to better serve a high-risk population and that can access participants in settings that best suit their needs, and 4) developing infrastructure that will provide ongoing measurement of individual and population health, and input to drive PDSA processes and continuous quality improvement strategies. (See Section 2.1 – How the WPC Pilot Addresses Target Population Needs.)

Decreasing Avoidable Emergency Department/Inpatient Utilization: Care coordination models with key functional elements have proven to decrease both ED and inpatient utilization, while increasing clinic visits.[40,41,42] Use of telemedicine has been shown to improve coordination of services, provider agreements/knowledge, and access to care, leading to more appropriate use of resources.[43] There are several promising studies showing that community health work is an effective tool for reducing health disparities, improving health, and reducing the cost of health care.[44] Recuperative care (medical respite) programs have been shown to reduce both inpatient utilization and length of stay among homeless patients.[45] Discharge to a homeless respite program was associated with an approximately 50% reduction in the odds of readmission at 90 days post-discharge,

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[40] Mann, C. (2014.) *Reducing Nonurgent Use of Emergency Departments and Improving Appropriate Care in Appropriate Settings.* Department of Health & Human Services. Centers for Medicare & Medicaid Services. CMCS Informational Bulletin. Available at: https://www.medicaid.gov/Federal-Policy-Guidance/Downloads/CIB-01-16-14.pdf.

[41] Wilder Research. (2014.) *Hospital to Home: Reducing Avoidable Hospital Emergency Department Visits While Improving Stability and Health.* Available at: https://www.wilder.org/Wilder-Research/Publications/Studies/Hospital%20to%20Home/Reducing%20Avoidable%20Hospital%20Emergency%20Department%20Visits%20While%20Improving%20Housing%20Stability%20and%20Health,%20Full%20Report.pdf.

[42] New England Healthcare Institute. (March 2010.) A Matter of Urgency: Reducing Emergency Department Overuse. Available at: http://www.nehi.net/writable/publication_files/file/nehi_ed_overuse_issue_brief_032610finaledits.pdf.

[43] Hersh WR, Hickam DH, Severance SM, Dana TL, Krages KP, Helfand M. *Telemedicine for the Medicare Population: Update Evidence Report/Technology Assessment No. 131* (Prepared by the Oregon Evidence-based Practice Center under Contract No. 290-02-0024.) AHRQ Publication No. 06-E007. Rockville, MD: Agency for Healthcare Research and Quality. February 2006. Available at: http://archive.ahrq.gov/downloads/pub/evidence/pdf/telemedup/telemedup.pdf.

[44] Valesky K. (June 2011.) Community Health Workers in Health Care for the Homeless: A Guide for Administrators. National Health Care for the Homeless Council. Available at: http://www.nhchc.org/wp-content/uploads/2011/09/CHWguide.pdf.

[45] Bruno K. (2012.)

compared to discharge to streets and shelters.[46]

Decreasing Avoidable Utilization of other Systems: One of the key objectives is utilizing the "right care" to address needs, especially those social determinants of health needs that are so impactful on health outcomes. The project will assign provider care managers within each system to specifically address needs in the *Integrated Care Plan.* CHWs will help participants to link the planned services to experts in addressing their needs. This will reduce utilization of other systems by reducing the number of duplicative services, decreasing access to services not suited to meeting a participant's needs, providing integrated services when applicable at the primary care clinic and One-Stop Centers, and developing a comprehensive set of services with specific providers assigned. CHW care coordination services will enable the WPC program to serve the homeless participants at community events at the Outreach Care Pod sites, reducing their need to travel to various social service locations for basic needs. Due to their lack of resources and transportation barriers, navigating multiple agencies to access all the services that they need greatly diminishes the homeless population's ability to improve health outcomes.

Plan-Do-Study-Act (PDSA) Process: The *Model for Improvement[47]* will drive system-wide improvement, and PDSA methodology[48] will be the basis for testing quality improvement processes and change management. The WPC administrators/management and the Waiver Analytics Team will be consistently monitoring project progress, both in relation specifically to PDSA cycles and through dashboards tracing overall quality indicators. Outlier data and notable trends will indicate opportunities for quality improvement. Needed changes will be identified through root cause analysis, development of change concepts, and Lean processes. Value stream mapping will help to identify the needed change and change concept. Once a targeted change is identified, PDSA processes will test the proposed change to determine if it will be successful, the degree of change expected, and the costs and other impacts associated with the change. Change will be carried out through incremental tests of change, and change modifications through iterative PDSA cycles (see Section 4.2). A Quality Improvement Coordinator will drive PDSA processes, work with leaders to implement and test change, tie VCHCA quality improvement processes and committees in with PDSA processes, use participant feedback to drive improvements, and interact with project staff to optimize the quality of services. PDSA processes will take place at the collaboration and individual systems level (i.e., administrative, field-based, centralized care coordination, mobile engagement, technology, providers) at least monthly to ensure that continuous quality improvement provides excellence in care.

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[46] Kertesz S, Posner M, O'Connell J, Swain S, Mullins A, Shwartz M, Ash A. Post-hospital medical respite care and hospital readmission of homeless persons. *J Prev Interv Community.* 2009; 37(2): 129–142. Available at: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2702998/.

[47] Langley GL, Moen R, Nolan KM, Nolan TW, Norman CL, Provost LP*. The Improvement Guide: A Practical Approach to Enhancing Organizational Performance* (2nd edition). San Francisco: Jossey-Bass Publishers; 2009.

[48] Institute for Healthcare Improvement. (2016.) *How to Improve: Science of Improvement: Testing Changes.* Available at: http://www.ihi.org/resources/Pages/HowtoImprove/default.aspx.

Care Coordination Administration: The WPC pilot will be led by an administrative team that will conduct WPC Collaborative activities and oversee the CCT services. This team will include the Project Director, co- Medical Directors (a PCP and a psychiatrist), Financial Manager, Quality Improvement Coordinator, Informaticist, Database Analyst, and an Administrative Assistant. Care coordination will be administered through a centralized CCT comprised of the WPC Care Managers, CHWs, and Engagement Teams, all led by the Care Coordination Manager. The CCT will oversee the day-to-day activity of ensuring the participants are appropriately identified, enrolled, and linked to resources. This centralized   staff will have access to a multi-level, interdisciplinary support team of subject matter experts who will   advise WPC staff about appropriate resources, services, and interventions, including PCPs, specialists, pharmacists, nurses, behavioral health specialists, housing services representatives, social service representatives, etc. System providers and/or this support team will assist in developing system-specific care plans that will be consolidated into the Integrated Care Plan that the CHW will utilize in the field. The intent of these service subject matter specialists is to be able to collaborate with external resources and organizations to best meet the participants' needs. The CCT, subject matter experts, and Care Coordination   platform will support external/remote access for the CHWs who directly engage with the patients.

Participating entities will be responsible for providing case managers to link participant care with WPC care plans and resources; providing data on utilization, cost, and outcomes; and linking with new collaboration platforms to plan and execute services. Care coordination will be *linked with other participating entities* through the *WPC Care Collaboration* platform, *eReferral* technologies, *Real-Time Secure Messaging* telemedicine consultation services, access to an *Integrated Care Plan* platform, and communication with assigned CHWs. *Care coordination will be seamless* to the beneficiary by integrating key care coordination administrative elements:[49] 1) structured coordination with regularly scheduled contacts and co-location of some key services; 2) defined roles and systems that facilitate participants being provided rapid access to partners with appropriate training and expertise when problem situations arise; and 3) understanding how each partner perceives similar needs. Because it is anticipated that participants will to move along a continuum of health/behavioral health and other social service needs over time, a single lead entity/CHW and single funding stream for WPC services will facilitate more seamless patient care.

Targeted Case Management Program Overlap: Ventura County is currently in the planning stages of implementing Targeted Case Management (Welfare and Institutions Code §14132.44). VCHCA will have a staged approach to build Targeted Case Management. The initial phase will include a revamping of the current referral system to initially begin providing TCM referral and related activities services in 2017. Once the referral system is tested and proven, VCHCA will phase in comprehensive assessment and periodic reassessment, development of a specific care plan, and monitoring and follow-up activities over the following three years. Targeted Case Management in Ventura County will be focused on inpatient services and transitioning individuals to a community setting. Once implemented, there is expected to be very little overlap between Targeting Case Management and the Whole Person Care pilot. The PMPM Care Coordination bundle in the budget,

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[49] Cantor, 2015.

therefore, has been discounted by 5% to take this small degree of overlap into account.

The plan to eliminate duplication of services between the two programs is by integrating alerts into the Health Registry when a potential participant is about to be dually enrolled. Other mechanisms will also be established in the identification and enrollment process, including key questions on the Integrated Assessment form. The lead Care Coordination Manager of the CCT will be responsible for identifying targeted individuals, reviewing the Health Registry to determine if identified potential participants are utilizing Targeted Case Management services prior to enrollment, working with the Targeted Case Management Program Administrator to ensure that all persons at risk are being served by one or the other program as applicable based on their condition in alignment with the specified and divergent eligibility of the target populations to the two programs, and conducting PDSA processes focused on avoiding duplication of services in Whole Person Care and Targeted Case Management programs.

The target population for Targeted Case Management will be medically fragile individuals, with multiple diagnoses. Such individuals must also be at risk for medical compromise due to one of the following conditions:

- Failure to take advantage of necessary health care services, or
- Non-compliance with their prescribed medical regime, or
- An inability to coordinate multiple medical, social and other services due to the existence of an unstable medical condition in need of stabilization, or
- An inability to understand medical directions because of comprehension barriers, or
- A lack of community support system to assist in appropriate follow-up care at home, or
- Substance abuse, or
- A victim of abuse, neglect or violence; and
- In need of assistance in accessing necessary medical, social, educational, or other services, when comprehensive case management is not being provided elsewhere.

The target population for the Whole Person Care Pilot, however, is the highest utilizers of Ventura County ED, inpatient hospital services who have at least four ED visits and/or two inpatient visits, and are using additional services such as Behavioral Health, Public Health, Social Services, and may be in and out of the justice system due to SUD or mental illness. The identified participants will also have risk factors for readmission. The distinction is different because the targeting mechanism is different. Targeted Case Management will evaluate participants based on the above conditions, rather than high utilization of multiple systems (HUMS). Although a very small percentage of this population may overlap, the Whole Person Care pilot will have electronic alerts built into the enterprise Health Registry to notify the CCT of eligibility in other care systems.

Further, the identification of Whole Person Care participants will be conducted through predictive analytics based on a risk algorithm. Mobile outreach staff (Engagement Teams and CHWs on a Fee-for-Services basis) will reach out to the identified potential participants in the field in a variety of settings, such as clinics, EDs, One-Stops, homeless congregation locations, shelters, transitional

housing, etc. This population needs an intensive comprehensive care management approach with a direct path to medical and behavioral health, housing, and nutrition services, among other social and community services, rather than simple referrals. Behavioral health specialists for both mental health and substance abuse are care managers within the Whole Person Care system itself, rather than referral resources outside the WPC team, where the systems are already impacted and unable to provide the intense care to WPC participants to break the cycle of failed outcomes. The Whole Person Care target population is a group that requires intervention at a neutral location where they are comfortable. Physical and emotional comfort will be provided through motivational interviewing by an ethnically/linguistically compatible outreach worker. The Targeted Case Management participants, who will not be served by Whole Person Care, will be identified as a result of an inpatient hospital stay and a condition assessment by Registered Nurses, and the identification is based on medical need. These two populations, therefore, have little overlap.

Whole Person Care is focused on care management in an outpatient environment using a "whatever it takes" wraparound approach. It provides a more intensive model of care than Targeted Case Management which will be more limited in scope. A team of care managers, comprised of Registered Nurses, LCSWs or LMFTs, and CHWs, will be assigned to individuals who will work with them on a one-to-one basis to overcome obstacles to utilizing appropriate levels of services, rather than the ED or inpatient services, and will do so in the community setting. They will not have access to Targeted Case Management services, which will be a step below their level of need. Whole Person Care will incorporate mechanisms in the identification and enrollment process, managed by the CCT Lead Care Coordinator, to ensure that those patients identified as eligible for the Whole Person Care pilot do not have the same condition requirements as Targeted Case Management.

One-System Wraparound Care: Participating entities will work together to create one system that provides wrap-around care coordination for participants by building a Care Coordination platform and CCT that will consolidate care under one wraparound system that incorporates all elements of care, including those affecting the social determinants of health. The Outreach Care Pods sites will also facilitate wraparound care for homeless participants by integrating WPC services directly in the field during community events. The WPC project incorporates key elements of a highly-functioning wrap-around model, including community partnerships, individualized care planning, access to needed supports and subject matter experts, a collaborative process, fiscal policies and sustainability, and accountability.[50]

3.2 Data Sharing

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[50] Walker JS, Bruns EJ, and The National Wraparound Initiative Advisory Group. (2008). *Phases and Activities of the Wraparound Process: The Resource Guide to Wraparound.* Portland, OR: National Wrap-around Initiative, Research and Training Center for Family Support and Children's Mental Health. Available at: http://nwi.pdx.edu/NWI-book/Chapters/Walker-4a.1-(phases-and-activities).pdf.

Data Sharing Between Entities: Data sharing will occur between entities through a centralized enterprise web-based solution offering real-time notification and communication interfaces that will promote collaboration. Participants will sign a Universal Consent Form, allowing their data to be shared among entities for the purpose of care coordination. Data sharing will occur via the following modalities (see the Data Sharing Structure in Attachment G):

1. *Care Coordination Platform:* Member enrollment repository, member data repository, and care coordination system will be shared with all providers across systems in alignment with PHI/PI regulations.
2. *Community Partner Care Coordination Platform:* This platform will link to the Care Coordination platform so that participating entities outside of the VCHCA system can connect to care coordination resources and the CCT.
3. *Integrated Care Plan:* This web-based care plan will include the CHW-administered Comprehensive Assessment Tool, provider assessments and care plans (sub-care plans), Vulnerability Index information, participants' goals and needs, tasks that need to be accomplished, and referrals.
4. *Secure Messaging:* This system will facilitate documented and secure communication to assist with the patients' needs. As necessary, the CHW will use secure messaging to seek clinical advice to assess urgent needs and guidance to direct the patient to proper care and services. This system will be linked to the care coordination platform, which will allow messages to be readily accessed by care team members.

Data sharing development will be overseen by the WPC IT developer, ongoing processes and data quality overseen by the WPC Database Analyst, and data reporting and analysis overseen by the WPC Informaticist.

Data to be Shared: Data shared will be used to evaluate individual as well as population progress, track utilization and cost over time, track universal and variant metric progress, facilitate care coordination, improve the quality of care, and improve access to care. Four major spheres of data will be shared: eligibility, health, behavioral health (including mental health and substance use), and social services (including utilization of county services and community-based social services such as housing). Health and behavioral health outcomes (and other performance and process metrics) will be measured to evaluate the project impact. Data regarding services provided through the recuperative care program (i.e., services provided while at the center, 90-day readmission rates); services provided at the Outreach Care Pod community events and new client engagement numbers will be shared among WPC staff and partner organizations through the WPC Collaborative.

In accordance with state and federal law and Exhibit A: HIPAA Business Associate Addendum, only VCHCA departments' staff responsible for participant care (primary care, hospitals, behavioral health, and public health), VCHSA, and contracted health care/behavioral health partners will have access to PHI information though additional IT development for sharing beyond the VCHCA network. This data sharing will begin in Year 2 with expansion funds for recuperative care, Outreach Care Pods, and community events with partnering agencies. Year 3, 4 and 5 data sharing expansion phases will enable

the project to share data with health care networks outside of VCHCA. The DCHS reporting variables, including utilization, cost, and outcomes, will be shared by all systems to the WPC data warehouse (see Section 4.1). Data to be shared (between approved persons and according to regulations) include: participant characteristics/basic information, assessments, care plan information with updated pertinent results and medications, utilization data including cost and units of service, referral information, health outcomes, Data to be shared with community partners include: participant names, referral information, utilization of resource data, and outcome of service, such as a housed participant, involvement in support groups, completion of employment training, etc. In addition, the communication plan will ensure that all participating entities in the collaboration are provided population health information to keep them aware of ongoing project progress (see Section 2.2).

Infrastructure/Data Sharing Evolution: The first phase (Year 2) will launch the operation of Care Coordination and Integrated Care Plan platforms and UOMS. Data sharing within the VCHCA departments will be initiated. Needs assessments for technology development and planning for data sharing among project and collaborative partners will be developed. During this development process, data sharing will occur through secure email systems and/or through reports distributed at meetings.

Data-sharing technologies in will be expanded in Year 2 to facilitate WPC program data collection with organizations outside the VCHCA that are involved in the recuperative care program. These organizations include the National Health Foundation, Salvation Army, and in Years 3-5, the four area hospitals involved in the program. Improvements/expansions of the Integrated Care Plan are also need to include data related to nutritional, behavioral health, and other assessments at community events.

Creation of a data system and integration with the Care Coordination Platform for the recuperative care program and community events will involve time and support from the platform vendor as well as staff hours from the VCHCA IT Director, the Behavioral Health Director of Technical Projects, and WPC staff. Connections will be made with IT counterparts from local clinic systems and hospitals outside of VCHCA to discuss data sharing needs and approaches. A data feed will be set up from the recuperative care program, with cooperation sought from participating systems for ongoing tracking of the population.

The second phase (Years 3-5) will launch the sub-modules developed in Year 2 such as data-sharing technology with the Recuperative Care Center and partnering hospitals, integration of management practice guidelines surrounding the identified health issues of the target population; integration of provider task reminders; development of the health registry that taps into the EHR; coordination and refinement of the data query system for data mining and reporting; stratification and predictive modeling; and workflow and notification alerts. Data sharing technologies with project partners will be developed, tested, and launched.

The final phase (Years 4-5) will expand the developed technologies to standardize data sharing among health care systems countywide to enable health care providers and administrators to collect accurate

population data. Data sharing protocols and development between the pilot and other health care systems outside of the VCHCA and outside of the pilot (i.e., Clinicas, St. Johns, Community Memorial, Los Robles) that are serving Ventura County beneficiaries will widen the capacity to compile utilization and potential participant information. Determining the cost savings to the system of housing and other social service supports will be crucial in sustainability planning and alternative flexible financing methods.

Tools to Support Data Sharing: Commonly utilized tools across the integrated system will facilitate data sharing by creating a standard by which data can recorded, reported, and analyzed. These tools include: the EHR; the health registry; the Vulnerability Index; SDOH assessment tool; Office of the National Coordinator (ONC) Direct protocols; HL7 fast healthcare interoperability resources (FHIR); auto-alerts about patient escalations, such as ED or hospital admissions, arrests, or institutionalization; and Care Coordination, and Integrated Care Plan interfaces.

Capacities Currently in Place: Current capacities include the EHR, VCBH Insight data mining platform, limited telemedicine capabilities, and data query resources that currently have no interoperability. Existing gaps include a lack of: data sharing capabilities outside of the VCHCA excepting very limited data that can be acquired through Public Health officer request, coordinated care technologies, data mining and data merging/blending systems, comprehensive telemedicine capabilities, and eReferral capabilities. The project will build the infrastructure needed to enable these capabilities and sustain data sharing after the conclusion of the pilot.

New Development to Support Data Sharing: New development to support data sharing includes: 1) enterprise technologies phased into the data sharing system, including the participant utilization and risk query system, Care Coordination platform, Integrated Care Plan platform, and telemedicine; 2) interfaces and tools to support data sharing; 3) development of the WPC data warehouse (UOMS) including data loading and merging workflows and data quality checks; 4) data architecture, requirements, governance, collection, monitoring, and analysis protocols to support infrastructure development; and 5) role-based application security; and 6) data masking, encryption at rest, and removal of sensitive data if and when non-privileged sharing is necessary. Additional annual IT development costs will be needed to plan, design, and implement the expanded Care Coordination platform; integrate data sharing with the recuperative care program and partnering hospitals; incorporate social services provided at the Outreach Care Pod sites; and integrate assessments (as applicable) from partnering agencies at community events. To facilitate the Year 2 planning and development and Year 3-5 expansion of data sharing with the National Health Foundation and four area hospitals to ensure that project metrics and performance measure are adequately reported, additional funds for IT development are included in the expansion application during Years 2-5.

Timeline/Implementation Plan:
Year 1: Secure contracts with vendors to develop the enterprise data system, collaborative development and agreements pertaining to data sharing protocols.
Year 2: Audit systems to determine data structure needs, develop data governance protocols, develop data technology infrastructure for the Integrated Care Plan and Care Coordination platform

(member repository, data repository, interfaces); beta test system; launch pilot data sharing system (3rd quarter); develop the Outcome and Utilization Monitoring System data warehouse; determine data sharing needs of project partners; plan partner data sharing technology implementation.

Year 3: Implement data-sharing technology with the Recuperative Care Center; develop technology infrastructure, test, and launch eReferral; and develop, test, and launch partner data sharing technologies.

Year 4 and 5: Implement data-sharing technology with partnering hospitals; integrate care coordination of social and other services with WPC technologies. Continue to implement quality improvement processes and adapt systems to be responsive to the project's requirements to provide quality care, collect and share data, and enable provider collaboration; and expand data sharing capabilities to health care providers outside of the VCHCA system.

Building a Sustainable Data Infrastructure: When completed, this data infrastructure will: be sustainable through the initial investment in technology; have a phased implementation that will overcome challenges as development is ongoing; offer safe encrypted data access through secure tunnels to provide comprehensive provider-to-provider connectivity; provide cost savings to the system by lowering expensive avoidable utilization that will enable VCHCA to maintain the ongoing cost of the data sharing system; develop a health registry that will further inform countywide care providers and community partners about target population needs; and develop a data warehouse that will enable data sharing and coordination.

Data Governance: The WPC data governance structure will be a system of decision rights and accountabilities for information-related processes that determine which of the participating entities and their staff can take what actions with what information, and when, under what circumstances, using what methods. Driving this governance is the WPC collaborative decision-making processes, the technology requirements of the new enterprise systems, and PHI/PI, HIPAA, DHCA, and other legal and regulatory requirements. The data governance will be designed to create rules, resolve conflicts, and provide for ongoing activity, as well as ensure that data is safe through data-at-rest and data-in-motion encryption, data file change archiving, limited access to approved users, and other data security measures. The approach will be to audit existing data systems, determine collaborative partners, assess data access needs and system compatibility, and design a data architecture that accounts for regulatory requirements. In addition, the approach will develop protocols for onboarding new data/systems, audit existing systems, and classify systems and data for the degree of governance needed.

Anticipated Challenges: Challenges include those associated with privacy concerns, legal concerns, different patient/client identifiers, and non-compatible IT systems. These will be overcome by: 1) enlisting support of the DHCS and California Association of Public Hospitals (CAPH) to work with the network of providers to overcome the barriers associated with concerns of violating privacy and other data sharing regulatory requirements, identifying perceived versus real barriers, and building clarification and consensus; 2) launching a comprehensive audit of each provider's systems to determine common keys and attributes; 3) consulting with legal counsel for each participating entity to ensure data is shared legally and responsibly; 4) designing data

sharing systems such as surrogate identification coding or data match algorithms from which various systems with different patient identifiers can access the same patient record or transmit data about the same participant while keeping their own files secure; 5) designing unique platforms for non-compatible systems through a data hub that conforms the data across systems; and 6) developing data quality logic to monitor the potentially evolving formats of incoming data and passing it through data governance protocols (before it potentially merges and disrupts historical formats and records).

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

4.1 Performance Measures

Performance Measures: The performance measures will provide information that determine project progress, inform quality improvement processes, and achieve targeted quality and administrative improvement benchmarks (STC 112e), as follows:

YEAR 1
WPC Pilot:
1. *Short-Term Process Measure:* By 12/31/16, complete contract with enterprise vendor to develop IT infrastructure, as measured by a signed contract.
2. *Long-Term Outcome Measure:* By 12/31/16, finalize measurement of baseline metrics, as measured by baseline metrics reported to DHCS.

Medi-Cal Managed Care Health Plan Gold Coast (GCHP); Health Services Agency, Specialty Mental Health Agency or Department – VCHCA; Public Agency or Department – Ventura County Housing Authority, Sheriff's Office, Probation Department; WPC Community Partners:
1. *Short-Term Process Measure: By* 12/31/16, complete MOUs/contracts to deliver services to participants, as measured by signed documents.
2. *Long-Term Outcome Measure:* By 12/31/16, develop WPC Collaborative policies, procedures, and bylaws, as measured by finalized document approved in minutes.

YEAR 2
WPC Pilot:
1. *Short-Term Process Measure:* By 7/1/17, complete phase 1 infrastructure development, as measured by completed system testing reports.
2. *Short-Term Process Measure:* By 10/1/2017, launch PDSA processes to improve the project as reported by metrics, as measured by PDSA reports.
3. *Long-Term Outcome Measure:* By 12/31/17, the project will be serving a caseload of at least 600 enrolled participants, as measured by UOMS reports.

Gold Coast Health Plan
1. *Short-Term Process Measure:* By 6/1/17, supply required GCHP utilization and cost data to enable the VCHCA and the IT enterprise contractor to develop a reporting system for the WPC project to identify high-utilizing beneficiaries, measure project progress, report metrics, and inform quality improvement processes (PDSA), as measured by completed data system testing reports.

VCHCA/Lead Entity:
1. *Short-Term Process Measure:* By 7/1/2017, hire and train WPC staff, as measured by employment records/contracts.
2. *Short-Term Process Measure:* By 7/1/2017, initiate WPC enrollment and project services, as measured by signed consent forms.

3. *Long-Term Outcome Measure:* By 12/31/17, CHWs will have at least 600 encounters with identified potential participants to conduct enrollment processes, as measured by signed Universal Consent forms.

Public Agencies/Community Partners:
1. *Short-Term Process Measure:* By 6/1/17, the community partners/agencies will work with VCHCA and the IT enterprise contractor to audit data systems, determine data merging requirements,   and develop a data sharing platform, as measured by completed system testing reports.
2. *Long-Term Outcome Measure:* By 12/31/17, at least 60% of participants who have been enrolled for three or more months have accessed public/community resources in alignment with the Integrated Care Plan, as measured by UOMS reports.

YEARS 3-5
WPC Pilot:
1. *Short-Term Process Measure:* By 12/31/18, complete phase 2 infrastructure development, as measured by completed system testing reports; by 7/1/20, complete phase 3 infrastructure development, as measured by completed system testing reports.
2. *Short-Term Process Measure:* At least quarterly, conduct PDSA for universal and variant metrics, make improvements based on identified gaps, and document process, as measured by PDSA reports.
3. *Long-Term Outcome Measure:* Serve a project total of 1,320 participants by 12/31/18, 1,800 participants by 12/31/19, 2,280 and by 12/31/20 (cumulative), as measured by UOMS reports.

Gold Coast Health Plan:
1. *Short-Term Process Measure:* At least quarterly, supply required GCHP utilization data to enable WPC staff to measure project progress, conduct quality improvement processes, and report to DHCS, as measured by produced GCHP data reports.
2. *Long-Term Outcome Measure:* By 7/1/20, will promote the integration of utilization data from health care and behavioral health, social services providers outside of the VCHCA system into the data reporting system, as measured by UOMS reports.

VCHCA/Lead Entity:
1. *Short-Term Process Measure:* By 7/1/18, develop a plan to align and integrate PRIME and other VCHCA initiatives with WPC, as documented in the DHCS mid-year report.
2. *Long-Term Outcome Measure:* By 12/31/20, WPC will be launched as a sustained ongoing program of VCHCA, as measured by VCHCA fiscal and clinical outcomes reports that are in line with Population Health Management strategies based on the Triple Aim.

Public Entities/Community Partners:
1. *Short-Term Process Measure:* At least monthly, the community partners/agencies will report utilization and outcome data through the Community Partner platform, as measured by centralized Coordinated Care reports.
2. *Long-Term Outcome Measure:* By the end of each reporting period, at least 80% of participants who have been enrolled for three or more months have accessed

public/community resources in alignment with their Integrated Care Plan, as measured by UOMS reports.

Overarching Vision of Performance Measures: The performance measures are designed to ensure that the key project processes and outcomes are identified and benchmarked to determine goal achievement. The performance measures are connected to interventions by including: infrastructure, service, and administrative measures, and measures identified by each participating entity. The performance measures are connected to the target population by measuring processes designed to impact target population needs; outcomes can only be achieved if the target population accesses services among participating entities determined by assessed needs.

Tracking and Documenting WPC Pilot Progress: The UOMS used by the Waiver Analytics Team will assist in identifying participants, tracking utilization, providing input to PDSA processes, determining health outcomes, and monitoring project performance progress and metrics (see Section 4.2). The WPC Informaticist will track the project progress over time (trending) from data provided by participating entities through monthly UOMS reports. Gold Coast Health Plan, UOMS, PDSA, and Care Coordination reports will inform project monitoring. The WPC Administrative Assistant will prepare monthly performance measure reports to enable tracking by the Project Director. Monthly WPC Project Reports will be derived from multiple data sources and will be used to report to the collaborative and the leadership team at meetings, where performance will be evaluated. VCHCA will submit mid-year and annual reports in alignment with Attachment GG to document progress, identify barriers and challenges, and outline how successes were achieved.

Tracking and Documenting Participating Entity Progress: Participating entities will be required to document service utilization and outcomes through the Community Partner platform, which feeds directly to the Care Coordination platform data registry. Tracking will occur monthly and be included in the WPC Project Reports.

4.1.   Universal Metrics

☒ **Health Outcomes Measures**

☒ **Administrative Measures**

WPC Pilot Goals: VCHCA will align the pilot's universal metric goals with DHCS's evaluation requirements. Preliminarily, VCHCA proposes the following goals:

Metric i. Health Outcomes Goal i.1: ED visits will maintain baseline measurements in project Year 2, be reduced among enrolled participants by at least 10% from baseline in project Year 3, will be reduced at least 15% from baseline in Year 4, and will be reduced at least 20% from baseline in project Year 5. (Adults and total only. No children in the project.) (Pay for Outcome metric.)

Metric i. Health Outcomes Goal i.2: ED visits will maintain baseline measurements in project Year 2, be reduced among enrolled participants by at least 15% from baseline in project Year 3, will be reduced at least 20% from baseline in Year 4, and will be reduced at least 25% from baseline in project Year 5. (Adults and total only. No children in the project.) (Pay for Outcome metric.)

Metric i. Health Outcomes Goal i.3: ED visits will maintain baseline measurements in project Year 2, be reduced among enrolled participants by at least 20% from baseline in project Year 3, will be reduced at least 25% from baseline in Year 4, and will be reduced at least 30% from baseline in project Year 5. (Adults and total only. No children in the project.) (Pay for Outcome metric.)

Metric i. Health Outcomes Goal i.4: At least quarterly, the ED visit metric will be measured for enrolled participants. A PDSA cycle will be used to make changes and measure ED visit results. (Pay for Reporting metric.)

Metric ii. Health Outcomes Goal ii.1: Inpatient utilization will maintain baseline measurements in project Year 2, be reduced among enrolled participants by at least 10% from baseline in project Year 3, and will be reduced at least 15% from baseline in project Year 4, and will be reduced at least 20% from baseline in project Year 5. (Adults and total only. No children in the project.) (Pay for Outcome metric.)

Metric ii. Health Outcomes Goal ii.2: Inpatient utilization will maintain baseline measurements in project Year 2, be reduced among enrolled participants by at least 15% from baseline in project Year 3, and will be reduced at least 20% from baseline in project Year 4, and will be reduced at least 25% from baseline in project Year 5. (Adults and total only. No children in the project.) (Pay for Outcome metric.)

Metric ii. Health Outcomes Goal ii.3: Inpatient utilization will maintain baseline measurements in project Year 2, be reduced among enrolled participants by at least 20% from baseline in project Year 3, and will be reduced at least 25% from baseline in project Year 4, and will be reduced at least 30% from baseline in project Year 5. (Adults and total only. No children in the project.) (Pay for Outcome metric.)

Metric ii. Health Outcomes Goal ii.4: At least quarterly, number of inpatient encounters and lengths of stay will be measured for those enrolled in the project. PDSA will be used to measure and make changes to improve the inpatient utilization metric. (Pay for Reporting metric.)

Metric iii. Health Outcomes Goal iii: Participants will have a follow-up visit within 30 days of discharge among those who had an ED visit with a primary diagnosis of mental illness. The follow-up visit will be an outpatient visit, intensive outpatient encounter, or partial hospitalization with a primary diagnosis of a mental health disorder and/or to a behavioral health facility. The goal will be to maintain baseline measurements in project Year 2, be improved among enrolled participants by at least 5% from baseline in project Year 3, will be improved by at least 10% from baseline in project Year 4, and will be improved at least 15% from baseline in project Year 5. (Adults and total only. No

children in the project.) (Pay for Outcome metric.)

Metric iv. Health Outcomes Goal iv.1: Participants with a new episode of alcohol or other drug (AOD) dependence initiate treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter, or partial hospitalization within 14 days of the diagnosis. The goal will be to maintain baseline measurements in project Year 2, be improved among enrolled participants by at least 5% from baseline in project Year 3, improved by at least 10% from baseline in project Year 4, and will be improved at least 15% baseline in project Year 5. (Adults and total only. No children in the project.) (Pay for Outcome metric.)

Metric iv. Health Outcomes Goal iv.2: Participants with a new episode of alcohol or other drug (AOD) dependence who initiated treatment and who had two or more additional services with a diagnosis of AOD within 30 days of the initiation visit. The goal will be to maintain baseline measurements in project Year 2, be improved among enrolled participants by at least 5% from baseline in project Year 3, be improved at least 10% from baseline in project Year 4, and be improved at least 15% baseline in project Year 5. (Adults and total only. No children in the project.)

Metric v. Health Outcomes Goal v1: At least 60% of participants will have a comprehensive care plan, accessible by the entire care team, within 30 days of enrollment into the WPC Pilot. (Incentive metric)

Metric v. Health Outcomes Goal v.2: At least 80% of participants will have an updated comprehensive care plan, within 30 days of the participant's anniversary of participation in the pilot (to be conducted annually). (Incentive metric)

Metric v. Health Outcomes Goal v.3: At least quarterly, PDSA will be used to measure and make changes about the comprehensive care plan metric. (Pay for Reporting metric)

Metric vi. Administrative Metric Goal vi.1: No later than July 1, 2017, the Lead Entity will submit documentation demonstrating the establishment of care coordination, case management, and referral policies and procedures across the WPC Pilot lead and all participating entities which provide for streamlined participant case management. (Pay for Reporting metric)

Metric vi. Administrative Metric Goal vi.2: No later than July 1, 2017, the Lead Entity will develop and implement monitoring procedures for oversight of how the policies and procedures for care coordination, case management, and referral policies are operationalized. (Pay for Reporting metric)

Metric vi. Administrative Metric Goal vi.3: At least quarterly, the Lead Entity will review monitoring procedures for care coordination, case management, and referral policies to determine if any needed modifications to the monitoring procedures are needed. (Pay for Reporting metric)

Metric vi. Administrative Metric Goal vi.4: At least semi-annually, PDSA will be used to measure and make changes about the monitoring procedures for care coordination, case management, and referral policies metric. (Pay for Reporting metric)

Metric vi. Administrative Metric Goal vi.5: No later than July 1, 2017, the Lead Entity will develop a method to compile and analyze information and findings from the monitoring procedures for care coordination, case management, and referral policies and procedures; and will develop a process to modify the policies and procedures for care coordination, case management, and referral policies in a streamlined manner and within a reasonable timeframe. (Pay for Reporting metric)

Metric vii. Administrative Metric Goal vii.1: No later than July 1, 2017, the Lead Entity will submit documentation demonstrating the establishment of data and information sharing policies and procedures policies and procedures across the WPC Pilot lead and all participating entities which provide for streamlined participant case management. (Pay for Reporting metric)

Metric vii. Administrative Metric Goal vii.2: No later than July 1, 2017, the Lead Entity will develop and implement monitoring procedures for oversight of how the policies and procedures for data and information sharing are operationalized. (Pay for Reporting metric)

Metric vii. Administrative Metric Goal vii.3: At least quarterly, the Lead Entity will review monitoring procedures for data and information sharing policies and procedures to determine if any needed modifications to the monitoring procedures are needed. (Pay for Reporting metric)

Metric vii. Administrative Metric Goal vii.4: At least semi-annually, PDSA will be used to measure and make changes about the monitoring procedures for the data and information sharing policies and procedures metric. (Pay for Reporting metric)

Metric vii. Administrative Metric Goal vii.5: No later than July 1, 2017, the Lead Entity will develop a method to compile and analyze information and findings from the monitoring procedures for data and information sharing policies and procedures; and will develop a process to update the data and information sharing policies and procedures in a streamlined manner and within a reasonable timeframe. (Pay for Reporting metric)

4.1.a Variant Metrics

The variant metrics were selected in accordance with the WPC Variant Metric Template. Metric goals are designed to provide aggressive benchmarks that will optimize project pilot valuation.

Variant Metrics	PY 1	PY 2	PY 3	PY 4	PY 5
Administrative Metric: Percentage of CHWs receiving quarterly in-service training based on gaps identified through field work via PDSA	N/A	60%	65%	70%	75%

Health Outcomes Metric. Comprehensive Diabetes Care: HbA1c Poor Control <8%: Percentage of patients 18 - 75 years of age with Diabetes (type 1 and type 2) who had Hemoglobin A1c <8.0% during the measurement period	N/A	Maintain Baseline	+5% of baseline	+10% of baseline	+15% of baseline
Health Outcomes Metric. NQF 0710: Depression Remission at 12 Months: Percentage of patients aged 18 and older with a diagnosis of major depression or dysthymia and an initial PHQ-9 score greater than 9 during an outpatient encounter who achieve remission at twelve months as demonstrated by a twelve month (+/- 60 days) PHQ-9 score of less than 5	N/A	Maintain Baseline	+5% of baseline	+10% of baseline	+15% of baseline
Health Outcomes Metric. NQF 0104: Suicide Risk Assessment: Percentage of patients aged 18 years and older with a new diagnosis or recurrent episode of major depressive disorder (MDD) who had suicide risk assessment completed at each visit in which a new diagnosis or recurrent episode was	N/A	Maintain Baseline	+5% of baseline	+10% of baseline	+15% of baseline
Housing Metric. Housing Services: Percentage of homeless receiving housing services in the project year that were referred for housing	N/A	50%	55%	60%	65%
Optional Metric: Percentage of participants who have at least six encounters with a CSW during the project year.	N/A	50%	55%	60%	65%
Optional Metric: Percentage of participants who receive recuperative care services who are not readmitted to the ED or as an inpatient within 90 days of discharge.	N/A	50%	55%	60%	65%

4.2 Data Analysis, Reporting and Quality Improvement

Data Collection: Data collection will be consolidated into the Utilization and Outcome Monitoring System (UOMS) data warehouse to determine the effectiveness of service strategies and the impact they have on participants' health outcomes. This central repository used for data analysis and reporting will derive its data from the CC platform data repository, EHR, and health registry. A standardized data collection procedure and protocols through standardized forms, data variables, and system data entry requirements will be developed to ensure data validity. A separate database will collect project fiscal, staffing, infrastructure development, and other administrative data, such as income/expense statements, project monitoring, PDSA data, etc.

Reporting: Reporting will occur through standardized reports from the CC platform and UOMS data

warehouse utilizing dashboards. These reports will inform data analysis processes and the development of the monthly WPC Project Status reports, PDSA reports, DHCS reports, and WPC fiscal reports, among other reports. For the DHCS mid-year and annual reports, the project will report on all Universal and Variant metrics, and describe early trends, potential explanations, and plans to incorporate lessons into a continual cycle of performance improvement (using a PDSA methodology) during project years 2 and 3. In project years 4 and 5, the project will additionally report on the direction of the changes shown in the health outcomes data, if changes are in the predicted direction, what contributed to the improvement or hindrance, and how interventions will be adapted to improve performance. Collaborative reporting will take place at monthly meetings where WPC Project Status reports will be presented, through email updates, and through quarterly trainings. Project reports will also be used to inform stakeholders and other national pilot project managers through the WPC learnings (see Section 2.2).

Analysis: Analysis will occur on multiple levels to ensure that the project is being implemented as intended and that the quality improvement procedures (PDSA) optimize the quality of care. The WPC Informaticist, with support from the Data Analytics Team, will analyze the data to determine outliers or negative trends, and report the analyses to the Project and Medical Directors and Care Managers. Data analysis will be conducted by: 1) comparing data and to quality improvement goals, metrics, performance goals, and DHCS expectations; 2) examining the underlying causes behind the data collected; 3) comparing results to standardized measures/goals (i.e., HEDIS, Health People 2020); 4) comparing trends by monitoring results over time; 5) collecting additional data as needed; and 6) ensuring that the data is collected consistently, thoroughly, and in alignment with the data collection plan and protocols. Tools will assist in analytics, such as the use of run and control charts to understand variation, *Lean (Six Sigma) processes*[51] and tools, and trending charts. VCHCA will work with the independent evaluator to adapt the data analysis design and incorporate any additional data variables that will measure the six evaluation requirements of the pilot program.

Data analysis will also be instrumental in developing the sustainability plan once the five-year pilot project is complete. Much of sustainability funding is expected to come from dramatic cost savings derived from diminished utilization of systems and technology enabled platforms developed for decision support. Estimates of the annual public sector costs of an "average" high-utilizing homeless individual are as high as $150,000 but vary depending on population criteria and methodology.[52] Well over half of these costs are consistently determined to be incurred by health systems.[53]

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[51] Mahalik P. (2016.) *Learning to Think Lean: Six Steps with Review Points.* iSixSigma. Available at: https://www.isixsigma.com/methodology/lean-methodology/learning-think-lean-six-steps-review-points/.

[52] Cantor, 2015.

[53] Culhane DP, Parker WD, Poppe B, et al. (2007.) *Accountability, Cost-Effectiveness, and Program Performance: Progress since 1998.* Available at: http://aspe.hhs.gov/hsp/homelessness/symposium07/culhane/.

Existing and New Data Sources: Existing data sources are the EHRs, VCHCA administrative database (i.e., employment records and clinical/hospital QI), fiscal database, and Gold Coast Health Plan beneficiary outcome and utilization database. New data sources will include the CC platform; Community Partner platform; UOMS; WPC Project Status database (i.e., staff training, infrastructure development status, and collaborative records); and the Health Registry. Second round data sources include data derived from the National Health Foundation and area hospitals who are partnering in the recuperative care program, first through reports to VCHCA's WPC staff and then through data sharing technology developed in Year 3. Social and other services provided through community events at Outreach Care Pod sites will be captured by CHWs and integrated into an adapted the data reporting system. The data reporting system will also incorporate data from any community event nutritional assessments provided by community partners and have a nutritional component in the Integrated Care Plan.

Data Capacity Timeline: Data capacity will be developed in year 2, quarters 1 and 2 to enable the project services to launch in the 3rd quarter (see Section 3.2).

Quality Improvement/Change Management Approach: The project will utilize and report PDSA processes and changes, which will not only be used for Universal and Variant metrics, but also to inform quality improvements throughout the project. As indicated in Attachment MM, the pilot will utilize the DHCS template's change-management plan, including a mechanism for identifying needed adjustments, a process for carrying out each change, a process for observing and learning from the implemented change(s) and their implications, and a process to determine necessary modifications to the change based on the study results and implement them. National agencies have extensively analyzed change management and quality improvement processes which are effective among Medicaid care collaboratives and providers.[54] The *Model for Improvement*[55] will be used for change management, which includes setting aims, establishing measures, selecting changes, testing changes, implementing changes, and communicating/disseminating changes. Quality improvement and change will use a team approach both for the collaborative and the pilot staff utilizing PDSA methods.

Identifying Needed Adjustments: The *Model for Improvement* identifies what change is needed by determining intended accomplishments, if the change is an improvement, and which changes will result in improvement. Reports from data collection will be analyzed by the WPC Informaticist,

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[54] Griffith K, Moore E, Berger C, Kennedy H, Martinez-Vidal E, Neese-Todd S, Crystal S, Finnerty M. (2014.) *Implementing a State-Level Quality Improvement Collaborative: A Resource Guide From the Medicaid Network for Evidence-Based Treatment (MEDNET).* U.S. Department of Health and Human Services, Agency for Healthcare Research and Quality. AHRQ Publication No. 14(15)-0064-EF. Available at: http://www.ahrq.gov/sites/default/files/wysiwyg/professionals/quality-patient-safety/quality-resources/tools/mednetresourceguide/mednetresourcedguide.pdf.

[55] U.S. Department of Health and Human Services, Health Resources and Services Administration. (2016.) *Testing for Improvement.* Available at: http://www.hrsa.gov/quality/toolbox/methodology/testingforimprovement/part2.html.

who will report statistical progress and any change in causal factors indicated from the data. *Root Cause Analysis* will assist in planning tests of change. *Change concepts* will be developed and focus on methods of correcting outliers or making other improvements, such as improving work flow, the participant interface with the project, and services, as well as managing time better, error proofing, etc. These concepts will be developed collaboratively through creative thinking techniques, brainstorming, affinity analysis, and evidence-based practice research. *Lean processes* that identify the "value" of potential changes will be utilized, including determining the necessity, cost, purpose of the change, and barriers to change, etc.

Value Stream Mapping will help identify the needed change and change concept, and ensure that the change will add value to the project and close the gap between expectations and the current status. Data to inform needed adjustments will be collected from a variety of sources. For example, the Gold Coast Health Plan HEDIS reports will inform metric improvements and field questions from CHWs will inform training improvements.

Carrying Out Change: The *Model for Improvement* approach includes two key concepts – incremental tests of change and benefits of testing changes before implementation. The PDSA cycle uses the scientific method for action-oriented learning by planning tests, evaluating change, observing the results, and acting on what is learned. Carrying out change involves planning: stating the objective, making predictions, developing a testing plan. This process is followed by carrying out the test and documenting problems and observations. PDSA tests will: be made under various conditions, be based on data over time, and use comparison studies and/or random sampling as applicable.

Observing/Learning from Change: The study of change will occur through the data collection, reporting, and analysis cycle. Data will be compared to predictions and results will be summarized and collaboratively reflected upon by stakeholders to determine if the implemented change was successful or if modifications are required. Linked PDSAs will be used to broaden the test of a change and ensure that special conditions are not missed during the observation phase, as indicated.

Determining Change Modifications/Implementation: Change modifications will be accomplished through the application of a sequence of iterative PDSA cycles. The use of quantitative data at monthly or more frequent data intervals will inform the progression of cycles. The team will continue linking tests and refining the changes until new/modified strategies are ready for broader implementation. People are more willing to test for a change when they know the change(s) can and will be modified as needed. Linking small tests of change helps an organization to overcome its natural resistance to change and helps promote buy-in from the staff/stakeholders. An improvement tracking tool will be developed (similar to the Institute for Healthcare Improvement's [IHI] Improvement Tracker Tool[56]) to enable the collaborative, staff, and stakeholders to see how each specific change has transformed the project.

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[56] Institute for Healthcare Improvement. (2016.) *Improvement Tracker.* Available at: http://app.ihi.org/Workspace/tracker/.

4.3 Participant Entity Monitoring

Monitoring Participating Entities: Services and interventions provided by participating entities will be conducted under the parameters of the Letters of Agreement and/or contracts (as appropriate), and WPC bylaws, which will be established during project years 1-2. As the Lead Entity, VCHCA will ensure that participating entities' actions are aligned with the DHCS requirements, applicable state and federal laws, contracts, and the bylaws. The Community Partner platform will collect data about service utilization and outcomes coordination with the Integrated Care Plan entities outside of the VCHCA. This platform will communicate with the UOMS centralized dashboard that will monitor progress of all participating entities on predetermined metrics and goals. This will enable the Waiver Analytics Team, WPC Informaticist, and Project Director to monitor community partner participant services and outcomes in an integrated manner along with data from departments within the VCHCA. Monitoring will also occur through entity reports/presentations at WPC collaborative meetings, site visits, and fiscal reports.

Making Participating Entities Adjustments: In alignment with Attachment HH and the requirements for lead entities, Letters of Agreement/contracts will specify similar requirements for participating entities to hold them equally accountable for the success of the pilot. Participating entities will also work collaboratively with VCHCA in change management surrounding the overall pilot and its individual components utilizing PDSA methods. PDSA will inform any adjustments needed among participating entities (see Section 4.2).

Providing Technical Assistance: If a deficiency is identified by the VCHCA through the entity's progress reports, the status of performance measure accomplishment, or other means, VCHCA will provide technical assistance to the participating entity. Technical assistance will consist of site visits, re-education of pilot requirements, review of Letters of Support/contracts, problem-solving coordination, PDSA methods for quality improvement, data support staff assistance, and other methods as determined by the nature of the problem. DHCS technical assistance will be requested if needed.

Imposing Corrective Action: Ventura County has an extensive history of facilitating collaborative partnerships to benefit the population. VCHCA values these relationships and will make every effort to ensure that partners are aligned with pilot requirements. However, VCHCA will not allow the deficiencies of a participating entity to endanger accomplishment of project goals or effectiveness of services to participants. In alignment with Attachment HH, if the participating entity continues to demonstrate poor performance/deficiencies, a corrective action plan (CAP) will be developed and submitted to DHCS. The CAP will be developed in partnership between the participating entity and the lead entity, with final approval required by both. The CAP will include specific milestones and timelines for improvement. The Project Director will examine CAP progress reports prepared by the participating entity to determine if milestones are being reached.

Termination: If substantial progress has not been made in achieving CAP milestones, participating entities will be subject to a reduction in service provision (to be replaced by other entities as applicable) or termination. The decision to terminate a participating entity will only be made with DHCS approval, and all participating entities will be notified. Similar to pilot termination, VCHCA provide a 30-day notice to the participating entity. VCHCA will develop a close-out plan that incorporates similar elements as those discussed in Attachment HH designed to protect beneficiaries from the impact of the termination, such as notification of all pilot participants of changes, pilot benefits, etc.

Section 5: Financing

5.1 Financing Structure

Financing Structure of the WPC Pilot: The VCHCA Finance Department (Lead Entity's department) will assign a Waiver Financial Manager to the WPC project and serve as the project's fiduciary agent, operating in coordination with the Project Director. The department will initiate inter-governmental transfer (IGT) transactions, account for funds received from DHCS, maintain funds, distribute payments among the participating entities, and produce timely reporting on financial transactions, balances, and metrics.

Distribution of Pilot Payments: The pilot will distribute payments to the participating partners using a combined approach of Fee-For-Service (FFS), bundled service payments, pay for reporting and outcomes, and incentives as documented by contracts between the parties. Each partner's requirements will be delineated in MOUs and/or contracts as appropriate, specifying the metrics, objectives, payments, timing, monitoring, reporting, and corrective procedures necessary. The metrics and objectives achieved will be documented with a ledger of payments disbursed and reported to the WPC Leadership Team and to the DHCS.

Financing Arrangements: The agreements between the Lead Entity and the community partners will be structured to accommodate the IGTs and funding flows between the pilot funding and the DHCS. The Leadership Team may authorize distributions under contract to a participating entity in advance of funding received from the DHCS if required, which will be funded using an internal transfer to the WPC pilot fund from the Ventura County General Fund, and repaid upon DHCS funding.

Savings Arrangements: Savings generated through the project may be used to fund expansion activities as determined by the Leadership Team, following the guidelines of DHCS for permissible uses of generated savings, and will be reported to the DHCS as part of the required reporting cycle.

Oversight and Governance: The WPC Collaborative, guided by the Lead Entity, will draft, review, and accept bylaws and procedures during years 1-2. These bylaws will the process for confirming the amounts of IGTs, accepting/certifying the payment requests received from participants, handling/reporting any financing and savings amounts, and matching payment requests from entities against the entities' metrics, goals, and required reporting. The finance section of the bylaws will outline timing and procedures to review income and expense statements, auditing requirements, and other checks and balances in alignment with generally accepted accounting principles (GAAP). Fiscal oversight will be accomplished by the Waiver Financial Manager, CFO, Project Director, and the Collaborative, with specific

oversight responsibilities assigned to each.

Payment Timeline: Processes incorporated into the WPC Collaborative's bylaws and procedures will determine the timing of the acceptance, review, and payment of invoices from participants. Shortly after the award, and each year during the pilot's operation, when notified by DHCS or according to scheduled timelines, the Lead Entity will prepare a total annual request amount that specifies budgeted payments for each proposed funded element, including infrastructure, data collection, interventions, and outcomes. The Lead Entity will also include a report on all projected payments (amounts and timing) during the current period and will prepare an IGT to the upon DHCS notification.

Payment Structure: Each participant's payment structure, whether FFS, PMPM/bundled service payments, pay for reporting/outcomes, incentives, or other arrangements in combination, will be set forth by agreement and accessible to the Finance Department to validate each payment request. Each partner's objectives and metrics will be outlined in MOUs and/or contracts as appropriate.

Payment Process: In alignment with governance requirements, the Finance Department will issue payments either timed with the receipt of funds from DHCS, or paid by invoice in accordance with both procedures and contracts. The Finance Department will coordinate with the Lead Entity and Leadership Team concerning metric certification that must be met prior to the payment being disbursed. Payments for PMPM bundles will be made according to the schedule determined by the collaborative bylaws and procedures, including review of associated requests and reports of metrics being met.

Payment Tracking: The Finance Department will keep segregated accounting of IGTs, funds received from the DHCS, and all funds disbursed to participating entities. Reporting of these amounts and identifying specific payments to entities by reporting period will be part of the annual audits and be made available to the DHCS. The Leadership Team will conduct quarterly reviews, and the Project Director monthly reviews, of payment dispersal.

Payment Infrastructure: The VCHCA Finance Department is well structured currently to act as fiduciary and disburser of funds for the WPC project. Any new capabilities necessary and appropriate to tie metrics/performance goals into the disbursement process will be specified and developed during project Year 1. A Waiver Financial Manager will support accounting and payment tracking.

Ensuring Funding Sufficiency: Funding sufficiency will be ensured by segregated accounting that incorporates the IGT outbound funds, receipts from DHCS, payments to participants, and accumulation of savings. Disbursement prior to the receipt of funds will be done only

under circumstances dictated in the collaborative bylaws and procedures, and reviewed prior to disbursement. Budget-versus-actual comparisons will be distributed at least monthly to the Project Director, who will refer any possible over-expenditures to the Leadership Team and initiate corrective action, if necessary.

Approaching Value-Based Payment Systems: The VCHCA is already in the process of implementing a value-based payment system through a CMS Health Care Innovation Award project focusing on COPD patients. This hybrid payment model uses an innovative design providing a bundled "front end" to CMS/non-CMS payers, while structuring payouts to providers specific/appropriate to the care setting. The pilot's contractual relationships with participating entities will be structured to encourage such designs. By favoring pay for performance over fee-for-service structures, the project will both meet the requirements of the DHCS and will expand the adoption of value-based payment options across the health/behavioral health care systems' programs. Financing and payment approaches will help participants to better prepare for future roll-outs through the project's wrap-around nature that provides better care and greater access. Participants will be taught about the value-based payment systems used, emphasizing the greater access to care provided by such approaches and the broad array of services made available for prevention, assistance, and interventions in the issues faced by the target population.

5.2 Funding Diagram

Funding Diagram Attached: See Attachment H: Funding Diagram reflecting the flow and disbursement of funds from the DHCS through the Lead Entity's Finance Department with oversight from the WPC Leadership Team.

5.3 Non-Federal Share

Non-Federal Share: Funding for IGT remissions to the DHCS will be derived from the following non-federal entities and sources:
1. County of Ventura government activities including Public Protection, Public Ways and Facilities, Health and Sanitation Services, Public Assistance, and Education.
2. Business-type county entity sources including the Medical Center, Department of Airports, Waterworks Districts – Water and Sewer Divisions, Parks Department, Channel Islands Harbor, the County Health Care Plan, and the Oak View District.
3. Citizens, local businesses, and non-profit organizations will provide substantial direct revenue in the form of taxes, fees, grants, and disbursements.

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

WPC Pilot and VCHCA Services: The funding associated with the WPC pilot will augment the services provided by the VCHCA's two hospitals, 19 FQHC clinics, and broad array of departments serving and caring for Ventura County residents. The model not only connects high-utilizing patients to care-giving solutions, it also connects the many departments, partners, and community resources into a unified, integrated, coordinated system that will deliver high quality care. The model will influence health care provision to high-risk populations, integrating the clinic staff, CCT, and new technology that includes a Care Coordination platform aligned with a platform for community partners meeting PHI/PI requirements, a secure real-time messaging system, a health registry, eReferral, and a data warehouse. This integrated approach to system-wide delivery of needed health care, behavioral health, and social supports will influence the model of service delivery across systems throughout the county. This affect will catapult future endeavors for countywide collaboration and care coordination to unite public and private resources for the benefit of high-risk populations.

Payment Compliance with STC 113: The Lead Entity will ensure that the provisions of STC 113 will be followed assiduously, including: 1) infrastructure to integrate services among local entities that serve the TP; 2) services not otherwise covered or directly reimbursed by Medi-Cal to improve care for the TP, such as housing components; and 3) other strategies to improve integration, reduce avoidable health care services utilization, and improve health outcomes. The collaborative focused on provisions 1-3 during project design planning to ensure that the project's architecture met DHCS's expectations. Provision 2 will guide the Waiver Financial Manager in the tracking and disbursement of payments to the participating entities as they meet performance targets. The Finance Department currently manages the billing and receipt of Medi-Cal-related payments, and is ideally positioned to ensure that the funds for the IGTs associated with the WPC pilot are appropriately sourced and in compliance with STC 113 and with WPC pilot requirements.

Non-Duplication of Payments: The Finance Department will avoid duplication of payments thorough its central position as the project fiduciary, its management of all payment activities of the VCHCA, and its full understanding and management of the payments to and receipt of funds from all private, federal, and state funds including Medi-Cal. The Waiver Financial Manager will review records of payments prior to disbursement to ensure that each payment to any participating entity is matched to invoices aligned to funding requirements.

Targeted Case Management Non-Duplication of Services: As indicated in Section 3.1, Targeted Case Management Program Overlap, there are few anticipated activities and interactions of the care coordination teams that would duplicate Medi-Cal's targeted case management (TCM) benefit due to the nature of the specific target population and

planned interventions. Specifically, centralized care coordination Care Manager infrastructure, web-based Integrated Care Plan, infrastructure that provides technology-assisted care coordination, and risk stratification methods for identifying participants depart significantly from the encounter-based structure of TCM. In cases when there are encounters between the CHWs and Engagement Teams with the participants, the service would not be eligible for reimbursement under TCM, as the CHWs and outreach staff would not meet the education/experience requirements for TCM case workers or the Nurse Practitioner would be in a supervisory role and would have few, if any, direct contact with clients. Moreover, the scope of care support and coordination activities available through WPC is intended to be more robust than available through Medi-Cal TCM. WPC teams will engage in activities such as peer support, trust-building, motivational interviewing, disease specific education, and general reinforcement of health concepts, which 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 transitional housing support services. For these reasons, the budget has accounted for a 5% overlap for the work of the lead Care Coordination Manager in identifying targeted individuals, reviewing the Health Registry to determine if identified potential participants are utilizing Targeted Case Management services prior to enrollment, working with the Targeted Case Management Program Administrator to ensure that all persons at risk are being served by one or the other program as applicable based on their condition in alignment with the specified and divergent eligibility of the target populations to the two programs, and avoiding duplication of services in Whole Person Care and Targeted Case Management programs. Medi-Cal TCM is not currently operating in Ventura County, and its services are in the planning stage. An anticipated launch date is still to be determined.

The plan to eliminate duplication of services between the two programs once Targeted Case Management is launched is by integrating alerts into the Health Registry when a potential participant is about to be dually enrolled. Other mechanisms will also be established in the identification and enrollment process, including key questions on the Integrated Assessment form. The lead Care Coordination Manager of the CCT will be responsible for identifying targeted individuals, reviewing the Health Registry to determine if identified potential participants are utilizing Targeted Case Management services prior to enrollment, working with the Targeted Case Management Program Administrator to ensure that all persons at risk are being served by one or the other program as applicable based on their condition in alignment with the specified and divergent eligibility of the target populations to the two programs, and conducting PDSA processes focused on avoiding duplication of services in Whole Person Care and Targeted Case Management programs.

Federal Financial Participation Limited to Medi-Cal Beneficiaries: Only Medi-Cal

beneficiaries will receive direct benefits from the requested through pilot funding. The beneficiary identification and enrollment process ensures that only beneficiaries are identified as potential participants.

5.5 Funding Request

Please see the attached Budget Narrative in the file labeled VCHCA WPC Budget Narrative.

5.5   Funding Request — Budget Narrative

<u>**Legacy Lead Entity Pilot Expansion Application – Overall Budget and Year 2 Changes:**</u>

The following budget provides the categorical totals for the Legacy Expansion Application:

Budget Category	Legacy Y1	Y2 LTD	Change Y2	Legacy Y3	Legacy Y4	Legacy Y5
		11,201,219	20,984,988	22,402,437	22,402,437	22,402,437
Administrative Infrastructure	-	1,400,651	2,714,719	2,325,664	2,317,864	2,317,864
Delivery Infrastructure	-	1,159,930	2,190,412	1,922,132	1,329,932	1,329,932
Incentive Payments	-	543,875	975,975	1,954,950	1,954,950	1,954,950
FFS Services	-	520,257	655,409	793,861	793,861	793,861
PMPM Bundle	-	2,426,506	4,473,473	7,155,831	7,155,831	7,155,831
Pay For Reporting	-	1,875,000	3,750,000	2,500,000	2,500,000	2,500,000
Pay for Outcomes	-	3,275,000	6,225,000	5,750,000	6,350,000	6,350,000

The following Budget Narrative for Year 2 (original 2016 application changes) describes the expansion costs in the total year budget from which the Legacy 2017 application is taken.

<u>**Overall Considerations:**</u>

No Unallowable Payments: None of the budget years for this pilot include costs for services reimbursable with Medi-Cal or other federal funding resources.

Enrollment: In Year 2, the first phase of the technology infrastructure will be functioning, and participants will be enrolled to meet the project goal of 840 participants total by month 12. Waiting lists will be started (with DHCS approval) of potential participants as the target enrollment is met. During Years 3-5, it is expected that attrition will reduce the number of participants, which will need to be replaced by new participants from the waiting list. The attrition rate is anticipated to be approximately 420 in Year 2 and 440 participants in Years 3-5, consisting primarily of participant reassessment and project "graduation" due to improvements in risk factors and health outcomes, and a reduction in risk factors that would transition them into the Targeted Case Management program. Other reasons for this attrition will also be dropouts, participant mortality, or inability to continue due to other factors such as institutionalization or departure from the area.

<u>**YEAR 2**</u>

This budget year incorporates both first and second round activities as described below in this Year 2 section. All activities will be operated as described in Year 2. In Round 2 expansion activities, during the last six months of the year (July 1, 2017 – December 31, 2017), there will be the addition of Outreach Care Pods in areas where the WPC homeless population congregate to be operated by the Field-Based Care Coordination CHWs. There will be three Outreach Care Pod sites in Year 2, expanded to 6 in Years 3-5. Also during the Round 2, a Recuperative Care Program will be launched

and operated during the final 6 months (Year 2 LTD) of Year 2. This is designed to address the needs of the WPC participants when they are discharged from the hospital, but are still too ill to recover on their own, which especially affects the homeless population. Later years are addressed in detail below.

Year 2

Administrative Infrastructure

Administrative Infrastructure					
Item	Max Amount Per Unit	Max Units	Max WPC Fund Amount - Round 2	Max WPC Fund Amount - Round 1	Differences
Program Director	164,835	1.00	164,835	164,835	-
Informaticist	127,178	1.60	203,485	203,485	
Database Analyst	100,850	1.60	161,360	161,360	-
Administrative Assistant	70,069	1.00	70,069	70,069	-
Medical Director (Primary Care)	224,300	0.50	112,150	112,150	-
Behavioral Health Director (Psychiatric)	441,697	0.50	220,849	220,849	-
WPC Financial Manager	167,388	1.00	167,388	167,388	-
QI Coordinator	124,398	1.00	124,398	124,398	-
Legal Counsel	140	120.00	16,800	16,800	-
Office supplies, per person	300	58.00	17,400	14,400	3,000
Mobile Van	50,000	3.00	150,000	150,000	-
Medical Van Conversion	15,000	3.00	45,000	45,000	-
Cubicles	5,000	25.00	125,000	125,000	-
Cellphones - Administrative	700	6.00	4,200	4,200	-
Cellphone - Care Coordination Team	700	50.00	35,000	28,700	6,300
Desktop Computers, Administrative	1,165	12.00	13,980	13,980	-
Desktop Computers, Care Coordination Staff	1,165	9.00	10,485	10,485	-
Laptop Computers, Care Coordination Staff	1,250	50.00	62,500	51,250	11,250
Printers, Network Server	6,000	2.00	12,000	12,000	-
Learning Collaborative Travel	1,000	16.00	16,000	0	16,000
Indirect Rate at 5% (Round 1)	18,635,750	0.05	931,788	931,788	-
Indirect Rate at 5% (Round 2)*	1,000,643	0.05	50,032	0	50,032
*Difference in Direct Less Incentives, Reporting, Outcomes					

Program Director: The Program Director (tbd) will be the main point of contact to support and coordinate with participating entities. The Program Director will lead the VCHCA service delivery and administrative teams, conduct WPC Collaborative activities, oversee technology infrastructure development, monitor project progress to metrics and performance measure, liaison with stakeholders, and facilitate system integration across providers. The annual salary is $164,835 including fringe benefits at 1.0 FTE in each of Years 2 through 5.

Informaticist: The Informaticist is responsible for monitoring system performance, tracking metrics/performance goals, analyzing data, determining outliers, and reporting to the Project Director and QI Coordinator concerning project successes and areas in need of quality improvement.

The annual salary $127,178 x 1.6 FTE = $203,485 including fringe benefits at 1.6 FTE for Years 2 through 5.

Database Analyst: The Database Analyst (tbd) is responsible for maintaining the validity and security of the project databases, ensuring HIPAA compliance, providing reliable verifiable quality data, and incorporating data from all participating entities. The annual salary is $100,850 x 1.6 FTE = $161,360 including fringe benefits in each of Years 2 through 5.

Administrative Assistant: The WPC Administrative Assistant (tbd) will prepare monthly WPC Project Status reports to enable tracking by the Project Director, serve as scribe at each Collaborative meeting, maintain WPC records, and assist the Program Director in maintaining effective communications with the WPC Collaborative, partners, and staff. The annual salary is $70,069 including fringe benefits at 1.0 FTE in each of Years 2 through 5.

Medical Director (Primary Care): The PCP Medical Director will work with Care Coordination staff/teams to design and maintain project services and interventions that are aligned with clinical care standards, resolve issues that arise, direct care coordination for participants that present with unusual circumstances, integrate medical care with other needed services to ensure the administration of a holistic and patient-centered model of care, and maintain a high quality of primary care for project participants. The annual salary is $224,300 including fringe benefits for each of Years 2 through 5 at 0.5 FTE for an annual cost of $112,150.

Behavioral Health Director (Psychiatrist): The Psychiatrist Medical Director is the behavioral health counterpart to the PCP Medical Director. The Psychiatrist Medical Director will work with Care Coordination staff/teams to design and implement project services and interventions that are aligned with clinical care standards, direct care coordination for participants that present with unusual psychiatric circumstances, integrate behavioral health care with other needed services to ensure the administration of a holistic and patient-centered model of care, and maintain a high quality of behavioral health care for project participants. The annual salary is $441,697 including fringe benefits for each of Years 2 through 5 at 0.5 FTE for an annual cost of $220,849.

WPC Financial Manager: The WPC Financial Manager will ensure that the flow of funds are directed as proposed, ensure all accounting principles are upheld on the project, and meet all DCHS requirements from fiscal management and reporting. The annual salary is $167,388 including fringe benefits at 1.0 FTE in each of Years 2 through 5, for an annual cost of $167,388.

QI Coordinator: The Quality Improvement Coordinator will direct quality improvement processes using the Model for Improvement, orchestrate and direct the reporting of PDSA processes and changes, monitor improvements made, conduct iterative PDSA cycles, and work with staff, partners, and the collaborative to facilitate PDSA testing and changes. As indicated in Attachment MM, the QI Coordinator will utilize the DHCS template's change-management plan, including a mechanism for identifying needed adjustments, a process for carrying out each change, a process for observing and learning from the implemented change(s) and their implications, and a process to determine

necessary modifications to the change based on the study results and implement them. The annual salary is $124,398 including fringe benefits at 1.0 FTE in each of Years 2 through 5.

Legal Counsel: The Legal Counsel will develop and review contracts between the Lead Entity and the participants, develop the release documents and similar legal documents and advise on compliance with all regulatory agencies and legal jurisdictions that could impact the project. The compensation is $140 per hour including fringe benefits, with an expected usage of ten hours per month and an annual cost of
$16,800 in each of years 2 through 5 with an FTE of approximately 0.06.

Non-Staff Expenses

Office supplies, per person: Each member of the project team has been allocated $300 in office supplies, a number derived from internal studies conducted at VCHCA over a period of years. The total cost of office supplies in Year 2 is $300 per person x 58 persons = $17,400.

Mobile Health Vans: These three cargo vans, when retrofitted to support two examination rooms, will facilitate integration of services, outreach, and engagement of participants, determining immediate care needs, provide needed prescriptions, offer enrollment and assessment services, connect services with community-based providers, and ensure that there are no gaps between the Integrated Care Plan and the provision of planned services. The teams using these vans will be effective in connecting with the highest risk participants who are homeless, do not show up to appointments, do not abide by the care plan or physician instructions, and/or who access services outside of the VCHCA. The cost of the vehicles is derived from a review of prices for an appropriately configured, high-roofline, extended-wheelbase cargo van from local sources. The total cost for the vehicle is three cargo vans at $50,000 = $150,000 in Year 2.

Medical Van Conversion: The conversion is required to change three empty cargo vans into mobile health units with two interior spaces suitable to examinations, with some additional seating and storage. The cost will be 3 x $15,000 conversion (estimated) for a total cost of $45,000 in Year 2.

Cubicles: These modular office cubicles include the desk, storage, walls, and chair necessary to make the empty office space into one suitable for the data-intensive work. Space provided by these 19 cubicles will support the work of the administrative staff, Care Managers, and field/mobile staff when they are in- office. This Year 2 cost is $5,000 per cubicle installed x 25 cubicles = $125,000.

Cellphones – Administration: Administrative staff will have a cellphone that set up for secure, encrypted data communications. These devices are $700 each and include a full set of office accessories and software for accessing administrative functions. This Year 2 cost is $700 per cellphone x 6 cellphones =
$4,200.

Cellphones – Care Coordination Teams: Each care coordination staff member across the three

teams requires a cell phone to enable them to connect with the CCT, each other, providers, and community resources to align care with the Integrated Care Plan. Year 2 cost is 50 cellphones x $700 per cellphone
= $35,000.

Desktop Computers, Administration/Care Managers: A standard desktop computer, monitor, and mouse will be needed by the 12 administrative staff and Care Managers access the central databases to conduct and monitor project activities and facilitate participant care. The total cost for Year 2 is 12 desktop computers x $1,165 per computer = $13,980.

Desktop Computers, Field Staff: There will be **nine** standard desktop computer configurations that will be used by CHWs when they are in the WPC offices to facilitate participant care coordination. This cost will be 9 computers x $1,165 per computer = $10,485 for Year 2.

Laptop Computers, Care Coordination Staff: Laptops are required for the 28.0 FTE CHWs (including part-time staff), nine Engagement Team staff members, and seven care coordination staff to allow them to connect with the Integrated Care Plan, enrollment system, and web-based system resources. This total cost is 50 laptops x $1,250 per laptop = $62,500 in Year 2.

Printers, Network Server: These heavy-duty professional grade printers will serve the printing, scanning, faxing, and administrative needs the WPC staff. These printers will cover printing needs at the main WPC offices. Total costs are 2 printers x $6,000 per printer = $12,000 in Year 2.

Learning Collaborative Travel: Costs associated with travel for administrative staff and partnering agencies were approved for the Round 2 application through a WPC Working Group email on February 27, 2017 from Allison Homewood. Learning collaborative travel costs are expected to be $1,000 per person x 4 persons x $1,000 (airfare, hotel, per diem, car rental) = $16,000 per year.

Indirect Rate at 5%: The indirect rate is 5% of direct costs. For Year 2, this total includes 5% of direct costs of $18,635,750 x 5% = $931,788, plus the Round 2 indirect costs. The total indirect cost for Round 2, Year 2 is the increase in direct charges, excluding incentives, reporting, and outcomes categories, of $1,000,643 x 5% "de minimus" indirect rate = $50,032.

Delivery Infrastructure

Item	Max Amount Per Unit	Max Units	Max WPC Fund Amount - Round 2	Max WPC Fund Amount - Round 1	Differences
Centralized Enterprise Infrastructure	671,000	1	671,000	671,000	-
Centralized Enterprise Contract	25,000	9	225,000	225,000	-
IT Development	623,729	1	623,729	592,494	31,235
WPC Connect Infrastructure	200,000	1	200,000	200,000	-
WPC Connect Contract	25,000	9	225,000	225,000	-
Health Registry	129,500	1	129,500	129,500	-
Health Registry Contract	2,250	8	18,000	18,000	-
Care Pod Set-Up Supplies/Contract/Operating Costs	16,364	6	98,183		98,183

Enterprise WPC Infrastructure: This vendor provided technology will build the data sharing and project monitoring/reporting infrastructure, as illustrated in Attachment G. It is a web-based solution offering real-time notification and communication interfaces that will promote collaboration. The Phase I cost in Year 2 includes site licenses, training, interfacing, and customization to adapt it to system infrastructure needs. This total cost is $671,000 in Year 2.

Enterprise WPC Contract: The ongoing maintenance and operation of the enterprise infrastructure will be provided by the vendor at a monthly contract of $25,000 per month x 9 months in Year 2 = $225,000.

IT Development: The IT Developer team (tbd) will direct new technology data requirement development, plan for the architecture design, audit vendor systems, develop governance rules, develop EHR interfaces, and liaison with the vendor for implementation. The IT Developer team will train staff about system implementation and operation, train WPC Collaborative members about data sharing, and address any problems that arise from this process. The total projected cost for the Year 2 development contract is $623,729. The $31,235 in additional IT development costs are to facilitate the increased data sharing and care coordination platform requirements that will enable data sharing among the National Health Foundation and four area hospitals participating in the recuperative care program, and the additional data elements needed for the Integrated Care Plan and care coordination platform to integrate services, including social services. This functionality will be phased over PY 2-5.

WPC Connect Infrastructure: This one-time cost to provide infrastructure technology and integrate it with current systems will enable communication across systems to facilitate VCHCA and community partner communications, telemedicine, and information sharing. This cost is expected to be $200,000 in Year 2.

WPC Connect Contract: This is a monthly license for the communication infrastructure that allows access to the databases and reports across the collaborative partners, CCT, and field personnel. The total cost in Year 2 is 1 license at $25,000 per month x 9 months = $225,000.

Health Registry: This system is a crucial support element for the technology infrastructure to enable effective care coordination. This population health management tool enables providers to use data- driven, evidence-based clinical decision making. Dashboards will allow providers, CCT, and CHWs to track their participant's needs. The total cost of the Health Registry in Year 2 is 1 site-wide license at $129,500
= $129,500.

Health Registry Contract: The maintenance and support fee for the Health Registry is calculated at $2,250 per month x 8 months = $18,000 in Year 2.

Outreach Care Pod Set-up Supplies, Contract, and Operating Costs: Outreach Care Pods, operated by the Field-Based Care Coordination staff, will be located in areas where the homeless population congregates, such as next to homeless shelters and food distribution sites. A Outreach Care Pod will be located at three sites geographically dispersed across the county in PY 2, and expanded to six sites in PY 3-5. Each site will include shower and exam spaces as well as tent areas for intake and delivery of social services. Ongoing operating costs for the Pod sites include a shower/treatment unit (container boxes that has been retrofitted to serve the homeless participants)($26,640 PY2, $106,560 PY 3-5), disposable shower units ($5,400 PY2, $21,600 PY 3-5), black water service to disposal of used shower water ($11,963 PY 2, $47,575 PY 3-5), hygiene supplies (soap, shampoo, towels, etc.) ($18,000 PY 2, $72,000 PY 3-5), and costs to move units to other locations as indicated ($3,000 PY 2, $6,000 PY 3-5). To enable the Field-Based Care Coordination team and partners to provide services to the WPC homeless population, additional supplies are needed to operate the site and to provide showers for participants. These supplies include: triage/service tents (6 sites x $2,500 = $15,000); generators (6 sites x $1,390/generator = $8,340); chairs (12 chairs x 6 sites x $20/chair = $1,440); tables (3 tables per site x 6 sites x $100/table = $1,800); banners/signs (1 per site x 6 sites x $500 = $3,000); pop-up shades (6 sites x $100 = $600); storage lockers (1 per site x 6 sites x $500 = 3,000).

Year 2
Incentive Payments

Item	Max Amount Per Unit	Max Units	Max WPC Fund Amount - Round 2	Max WPC Fund Amount - Round 1	Differences
Housing support services	175	2,377	415,975	396,200	19,775
At least 60% of patients will have care plan within 30 days	500	504	252,000	240,000	12,000
At least 50% follow-up after MD ED visit	500	420	210,000	200,000	10,000
Meeting attendance expense coverage	100	280	28,000	28,000	-
Care Pod Community Service Events	10,000	7	70,000		70,000

Housing Support Services: During Y2, the project will provide incentive payments to the Area Housing Authority (a public housing entity) for its services in assisting and educating homeless participants with the goal of housing. To achieve this incentive payment, the Housing Authority will provide Individual Housing Transition Services, including tenancy screening, housing assessment, housing plan development, housing application assistance, resource identification, move-in support, crisis

plan development, housing search , and assistance in establishing the household, such as setting up utilities and arranging for furnishings. The Area Housing Authority will also provide participants with Individual Housing and Tenancy Sustaining Services, including identification/intervention of behaviors that may jeopardize housing status, education, coaching, resolving disputes, advocating, ongoing plan review and training. This total cost is 2,377 incentive payments of $175 = $415,975 in Year 2. An increase in the units and costs for housing support is due to the increase in the number of participants.

Care Plan Incentives: The primary care providers will receive a $100 incentive payment for developing and making available a comprehensive care plan for newly recruited participants within 30 days of their enrollment in the Pilot system, and the lead entity will receive a $400 incentive. The goal is to accomplish this for 60% of the participants, totaling 840 participants 60% x $500 = $252,000 in Year 2. An increase in the units and costs for care plan incentives is due to the increase in the number of participants.

Mental Health ED visit followed-up within 30 days: In support of Universal Metric iii.1, this incentive is paid to the behavioral health clinicians for achieving this follow up (after an Emergency Department visit with a Mental Health related diagnosis) in the allotted time. The anticipated payouts will be for 420 participants (50% of participants) x a $100 incentive payout, and the lead entity will receive a $400 incentive = $210,000 in Year 2. An increase in the units and costs for mental health ED follow-up incentives is due to the increase in the number of participants.

Meeting attendance for Collaborative partners: To support the representatives of participating entities, a stipend of $100 per month will be provided to attend monthly meetings. The total cost is $100 per month x 14 meetings x 20 partners = $28,000 in Year 2, and $100 per month x 12 meetings x 20 partners = $24,000 in Years 3-5.

Outreach Care Pod Community Service Events: An incentive will be provided to utilize the Outreach Care Pod sites to engage community partners, including primary care, behavioral health, and oral health providers; Ventura County Human Services Agency eligibility, enrollment, and outreach staff; social services providers, including those that provide food, haircuts, clothing, etc.; and other service agencies with a mission to support the homeless population. The total cost is $10,000 per event x 7 events in PY 2 (six months) = $70,000; and $10,000 x 12 events in PY 3-5 = $150,000.

Year 2
Fee for Services

FFS Services					
Item	Max Amount Per Unit	Max Units	Max WPC Fund Amount - Round 2	Max WPC Fund Amount - Round 1	Differences
Recuperative Care Program Monthly Fees/Operating Costs	129.40	1,775	229,680	0	229,680
Mobile Outreach Services	168.94	2,520	425,729	270,304	155,425

Recuperative Care Program Services Fees: National Health Foundation charges a total of $319,000

for the six months of operations in Year 2 for both the WPC Medi-Cal population and other populations. When discounted to include only WPC participants in the request, it is anticipated that 90% of the population will be Medi-Cal eligible:

Recuperative Care Client/Bed Day Estimates	
Bed Days (total available)	4,380
Occupancy Rate 90%	3,942
MediCal Eligibile 90%	3,548
Program Bed Days - Year 2	1,774
Program Bed Days - Years 3-5	3,548

The Recuperative Care service fees are 1,774 bed days x $129.40 per day = $229,680 for six months of operation in Year 2, Round 2. The program will be operating during the entire six months of Year 2.

Recuperative Care Program Operating Costs: These costs are derived from the following budget from the National Health Foundation which describes the total cost of the program, including those costs not assigned to Medi-Cal eligible patients in the WPC program. WPC Recuperative Care Program fund with be used only for WPC program-eligible beneficiaries.

National Health Foundations Recuperative Care Program Costs

Personnel	
NHF Staff Salaries	$237,380
Fringe Benefits @ 33%	$78,335
Total:	**$315,715**
Program Expenses	
Rent (security)	$76,650
Security	$28,000
Enhanced Care Coordination	$41,680
Program Supplies	$5,000
Linen Service	$24,000
Office Supplies and Printing	$6,000
Telephone	$12,000
Cable	$6,000
Equipment	$5,000
Medical Supplies	$5,000
Outside staffing services	$5,000
Insurance	$5,000
Mileage	$4,000
Facility/Outdoors	$5,000
Staff Development/Culture	$5,000
Total:	**$233,330**
Subtotal:	**$549,045**
Indirect Costs 10%	$50,954.54
Startup-costs/ongoing licensing	$38,000.00
Total:	**$638,000**
WPC Program	
WPC Participants Annual Bed Days Cost – Year 2 (6 months)	**$229,680**
WPC Participants Annual Bed Days Cost – Years 3-5 (full year)	**$459,360**

Mobile Outreach Services: Mobile outreach services are those that identify and connect with non-participants who may be eligible for project services. Mobile outreach services, provided by the Engagement Team CSWs will support community outreach to identify persons who have been targeted by the risk stratification technology system (or are otherwise eligible based on assessment), introduce project services, get consent, develop initial assessments, attend to urgent needs, and connect them with a Field-Based Care Coordination CSW. In Year 2, these services will support project start-up and ensure that the full caseload is engaged in project services in month 5. These

services are calculated at $168.94 for each engagement of the Field-Based Care Coordination and Engagement teams (41 staff) x 2,520 engagements = $425,729. The increase in the number of engagements is due to an increase in the number of participants. Costs for the Mobile Outreach Services are the same as those for the PMPM bundle services (see below). The rate of $168.94 is based on the cost per average salary for each staff member (41) in each of the two bundles for these services during Year 2 ($6,926.54) with estimates of the number of non-eligible engagements prior to enrollment (2,520).

Year 2
Bundled PMPM Services

PMPM Bundle					
Item	*PMPM*	*Max Member Months*	*Max WPC Fund Amount - Round 2*	*Max WPC Fund Amount - Round 1*	*Differences*
Field-based Care Coordination Bundle	223.74	8,476	1,896,420	1,469,768	426,652
Care Coordination Bundle	269.69	6,720	1,721,692	1,769,653	(47,961)
Engagement Bundle	318.21	6,720	855,361	854,513	848

Services Provided Within Bundles: WPC Connect has three teams providing PMPM bundled services. The numbers above represent their anticipated delivery of their respective services. PMPM budget totals are calculated in alignment with the PMPM details shown by bundle below.

Medical Services: Health care related care management services are provided in each of the three bundles as CHWs facilitate field-based access to primary and specialty care services in the Field-based Care Coordination Bundle; Care Managers ensure that medical health care is integrated in a holistic model with other needed services and community resources; and mobile Engagement teams access hard-to-reach individuals who do not access health care as needed on a regular basis to determine their immediate need for services and facilitate rapid access to clinic-based care. No Medi-Cal funded services are provided by any of the PMPM bundles.

Behavioral Health Services: Although access regular, urgent, and emergent to behavioral health services is facilitated in the Field Based Care Coordination and Engagement Bundle, behavioral health specialists are embedded in the Care Coordination bundle, with the role of interacting with CHWs, patients, physicians, behavioral health professionals, social service providers, and community partners to ensure that behavioral health protective factors are integrated with all aspects of care; 2) tracking service utilization, behavioral health outcomes, and care plan changes; 3) working closely with field-based CHWs to ensure timely behavioral health care; 4) bringing all care providers to serve the participant during urgent/emergent behavioral health situations; 5) ensuring behavioral health services are accessible in primary care settings; and other services as indicated. At least one Care Manager will be a Licensed Mental Health Professional (LMFT or LCSW) and at least one will be a Substance Abuse Specialist.

Social Services: Direct social services are provided through the Care Coordination Bundle through enhanced care coordination to assist participants as needed to access needed services according to

their care plan. Housing transition and support services will be provided through incentives to the Ventura County Housing Authority. Social services are integrated with the new Outreach Care Pods by linking services with community-based organizations at Pod care sites, such as food, clothing, and other needed services.

Non-Medical Services: Although there are no direct non-medical services funded through the pilot, the CHWs and Care Managers within the Field-based Care Coordination and Care Coordination bundles will be facilitating access to life skills, job readiness, and job search/placement assistance.

Participant Eligibility, Duration, Discontinuation: The eligibility for the Field-Based Care Coordination and the Care Coordination bundles is the same as eligibility for the program: the high-utilizing GCHP beneficiaries with at least four ED visits and/or two inpatient visits (ages 18 and older). Risk stratification will then evaluate these candidates for risk according to the Vulnerability Index, which includes the presence of multiple diseases, mental illness, substance abuse, and homelessness. Those at highest risk are prioritized for enrollment. As a result, the Field-Based Care Coordinators (CHWs) maintain a maximum caseload of 40 participants. Through the centralized Care Coordination bundle, nine Care Managers service 880 participants, averaging 98 participants per Care Manager. The three Engagement Teams are expected to access 40% of participants. The each of the three Engagement Team Care Managers will see 112 participants (840 x 40% = 336/3 = 112) at least four times a year and link services with the other centralized Care Managers and CHWs.

All bundled services are complementary, meaning taken together, they form the continuum of services required to manage Whole Person Care for the pilot's highly fragile target population. For example, the eligibility for services for the Field-Based Care Coordination bundle and the Care Coordination bundle would be admittance to or termination from the pilot. These services work together to form comprehensive care coordination as the field-based CHWs' services are designed to support participants and aid access to and utilization of services. The centralized Care Managers' services, supported by the care coordination technology infrastructure, are designed to plan, implement, track, and follow-up on care; modify care plans based on changes to the participants' conditions; and liaise with care providers to ensure a comprehensive continuum of Whole Person Care. The combination of the two bundle of services, therefore, fund the project design components needed for all participants. Eligibility for the Engagement Bundle will be based on elevated risk. This will be determined by housing status (i.e., not sheltered), the number of missed appointments, and use of the ED, urgent care, or inpatient care. Those participants who are homeless and/or not accessing services at primary care and behavioral health clinics will receive Engagement team services for those who do not frequent areas surrounding the Outreach Care Pod sites. Specialized services from the Field-Based Care Coordination Team, Engagement Team, and community partners will be provided at Outreach Care Pod sites in areas that are congregation points for the homeless population, such as shelters and food distribution centers. Participants have the potential to receive services from all three bundles at the same time, but at minimum all participants will receive services from the Field-Based Care Coordination and the Care Coordination bundle during the same time frame. There is no duplication of services between these three bundles as each have a specific purpose and perform specific tasks and activities that the other bundled staff members do not

perform. The services also do not duplicate services eligible under the Targeted Case Management Program.

The duration of services will vary based on risk stratification of each participant. The project includes monthly review of care plans based on risk and annual complete care plan assessments. The factors that qualified the participant for the project will also be used to "graduate" participants from project participation. Participants who have had no ED visits and/or inpatient stays over the course of a year; demonstrate health improvements in alignment with project metrics; and consistently keep appointments will qualify them to be evaluated for project termination and transitional services to the Patient-Centered Medical Home to continue care. It is anticipated that 440 participants will graduate (420 in PY 2), be transferred to other care programs, such as Target Case Management, or otherwise discontinue services over the course of each project year. Due to the anticipated acuity of the participants' health and the severity of the mental health and substance abuse issues, it is expected that average duration of services will be approximately two years. The model places enrollment eligibility priority on the persons who are the most highly at risk for ED or inpatient stays. The participants are expected to have complex care needs on multiple levels that they will need to overcome during their enrollment. Discontinuation for Engagement Team Services will occur when the elevated risk is stabilized, i.e., keeping regular appointments, maintaining shelter, and abiding by provider instructions. Since the project's enrollment cap maintains the project caseload at 880 participants, the duration of services does not affect the per member per month calculations.

Differences Between Bundles: Three different teams provide specific services to address the unique needs of the WPC population. All bundled services are complementary and form the continuum of services required to manage this population. Each bundled service is unique as it provides specific services and/or serves specific sub-populations, as follows:

The **Field-Based Care Coordination Bundle** serves as the heart of the care management program, with each CHW being assigned a caseload of participants to manage and to ensure that they are accessing services. The CHWs are care managers and provide not only enrollment and care plan development assistance, but are responsible for ensuring that each assigned participant utilizes planned services and is progressing toward positive and permanent positive health outcomes. CHWs provide regular in-person/phone consultations as indicated by the intensity and immediacy of the participants' individual needs and progress. Due to the large number of the homeless population anticipated to be enrolled in the program, the CHWs will also operate the Outreach Service Pods, in collaboration with community partners, to ensure that CHWs have access to their assigned participant caseload and that the complex needs of the homeless population is being addressed. This outreach will ensure that there are no gaps between the Integrated Care Plan and the provision of planned services.

The **Care Coordination Bundle** team members are not field-based but work with WPC staff, participants, physicians, behavioral health specialists and other community-based resources to provide access to services, develop treatment plans, and assist CHWs in care management connections. This team helps to administer the program among all partnering entities on behalf of

the participants.

The *Engagement Bundle team* members are highly mobile utilizing mobile vans to engage and enroll new clients, determine immediate needs, facilitate integration of services, coordinate outreach and engagement of participants, offer enrollment and assessment services, connect services with community-based providers, and ensure that there are no gaps between the Integrated Care Plan and the provision of planned services. The teams will be effective in connecting with participants who are difficult to access or who predominantly access health care services outside of the VCHCA. Although these teams may serve homeless participants, they will be serving all WPC sub-populations. This team can go anywhere, such as ER and Recuperative Care sites to conduct outreach and enrollment into the WPC program, the jail at client release, in response to a law enforcement call for a homeless or mentally ill person, or requests from community providers.

Field-based Care Coordination Bundle: This team consists of a Care Coordination Manager and 28.0 FTE CHWs in Year 2 and 31.6 FTE CHWs in Years 3-5 who will administer the WPC Comprehensive Assessment, connect with the CCT to identify needed services, link participants with community resources, provide support for access, and work with system-wide care managers. The increase in Member Months is due to the addition of service engagements expected through the Outreach Care Pods. They are anticipated to reach 8,476 participant/months at a PMPM cost of $223.74, making the total cost $1,896,420 in Year 2.

The following table shows the breakout of how the PMPM cost was developed.

Field-based Care Coordination Bundle	Qty	Rate	Rate Description	Units Y2	Units Y3-Y5	Unit Description	Annual Cost per Unit	Total, Y2	Total, Y3-Y5
Staff									
Care Coordination Manager	173.333	$ 77.57	hours per month x per hour rate	8	12		$ 13,445	$ 107,564	$ 161,345
CHWs - Year 2	4,853.324	$ 34.43	Hours per mo. (28 FTE) x per hour rate	8	0	Month x 20.8 FTE persons	$ 167,100	$ 1,336,800	$ -
CHWs - Years 3-5	5,303.990	$ 34.43	Hours per mo. (30.6 FTE) x per hour rate	0	12	Month x 22.8 FTE persons	$ 182,616	$ -	$ 2,191,396
Infrastructure									
Rent (partial, 25% of 778 sq ft)	194.50	$ 2.10	Rent (25%) x cost per square foot	8	12	Months	$ 408	$ 3,268	$ 4,901
Wireless Contract - Cellphones - Year 2	28.00	$ 150.00	Contracts x cost per month	8	0	Cellphones - Admin	$ 4,200	$ 33,600	$ -
Wireless Contract - Cellphones - Years 3-5	31.00	$ 150.00	Contracts x cost per month	0	12	Cellphones - Admin	$ 4,650	$ -	$ 55,800
Wireless Contract Laptops - Year 2	28.00	$ 150.00	Cellphones - Mobile Team	8		Cellphones - Mobile Team	$ 4,200	$ 33,600	$ -
Wireless Contract Laptops - Years 3-5	31.00	$ 150.00	Cellphones - Mobile Team		12	Cellphones - Mobile Team	$ 4,650	$ -	$ 55,800
Care Coordinator Training (15%)	0.15	$ 10,500.00	Training per session, 4 per	6	4	2 per Q Y2, 1 per Q later	$ 1,575	$ 9,450	$ 6,300
Travel for CHWs - Year 2	85,449	$ 0.54	Miles, all CHWs per month	8		Months of travel 100 miles per day	$ 46,142	$ 369,140	$ -
Travel for CHWs - Years 3-5	96,704	$ 0.54	Miles, all CHWs per month		12	Months of travel 100 miles per day	$ 52,220	$ -	$ 626,639
Conference travel cost	1	$ 1,000.00	Per trip quarterly	2	4	Quarterly expenses	$ 1,000	$ 2,000	$ 4,000
	Portion in Bundle					Total		$ 1,896,420	$ 3,106,182
	Y2	Y3-Y5		Y2	Y3-Y5			Y2	Y3-Y5
Member Months	100%	100%		8,476	13,883	Member Months		$ 223.74	$ 223.74

This breakout addresses the differences between Y2, when there is eight months of direct services and Y3 through Y5 which are expected to have an attrition rate of 50% (or 440 of the 880 participants replaced per year).

The Care Coordinator shows a monthly hours figure and a rate per hour. This is multiplied by 8 months to achieve a total of $107,564 for Year 2, and $161,345 in later years.

The CHWs are calculated in the same manner, with the quantity being the number of hours that 28.0 FTE CHWs will work per month. This produces $1,336,800 for Year 2 (six months) and $2,191,396 for Years 3-5.

Rent: The 778 sq. ft. office rent is partially allocated to this team (25%, or 194.50 sq. ft.) and multiplied by $2.10 per sq. ft. for one month's rent. This is then multiplied by 8 months for Year 2 and 12 for subsequent years producing annual totals of $3,268 and $4,901 respectively. An increase in the amount of office space and a re-balancing of space allocation was needed because of the addition of staff.

Wireless Contracts – Cellphones/Laptops are the monthly service contracts for secure cellphone and laptop service with Internet hotspots, calculated at 28 cell phones x $150 x 8 months = $33,600 in Year 2 and 31 cell phones x $150 x 12 months = $55,800 in Years 3-5. Similarly, the wireless contracts for the laptops are calculated at 28 laptops phones x $150 x 8 months = $33,600 in Year 2 and 31 laptops x $150 x 12 months = $55,800 in Years 3-5.

Care Coordinator Training is also being allocated 15% to this team. The full-day training sessions in subsequent years will be conducted once per quarter, but during this start-up phase will have three per quarter. At a training session day cost of $10,500, this team is allocated half of the Year 2 cost or $9,450 and half of the four annual sessions of subsequent years or $6,300 for Years 3-5. This cost was re-allocated to incorporate the new care managers and balance the total cost versus the number of care managers in total.

Travel for CHWs is based the number of miles to be used per month by 28.0 FTE CHWs in Year 2 and 30.6 FTE CHW in Years 3-5 x $0.54 cents per mile federal rate for 2016. This results in 85,449 miles per month x $0.54 per mile = $46,142 per month in Year 2 and 52,220 per month in Years 3-5. In Year 2, eight months of this travel will apply totaling $369,140 then 12 months in subsequent Years 3-5 totaling $626,639.

Conference travel cost is allocated to each team to attend WPC conferences and meetings. A total of one person-trips per quarter x $1,000 estimated cost per person for the Care Coordination Manager. With two quarters in Year 2 and four in Years 3-5, the totals will work out to be $2,000 and $4,000 respectively.

	Portion in Bundle					Total		$ 1,896,420	$ 3,106,182
	Y2	Y3-Y5		Y2	Y3-Y5			Y2	Y3-Y5
Member Months	100%	100%		8,476	13,883	Member Months		$ 223.74	$ 223.74

Determining PMPM Cost: The Portion section in the lower part of the table (visible above) identifies what portion of the participant base that the team is expected to reach per month. This is multiplied against the total member months available (which are 8,476 for Year 2 and 13,883 for subsequent years). The result is used to divide the costs for Year 2 and Years 3-5 to produce the PMPM cost for this team. In this instance, the total cost of $1,896,420 in Year 2/,8,476 member months x 100% = $223.74 for Year 2. For the later years, $3,106,182/ 13,883 member months x 100% produces a PMPM of $223.74 in Years 3-5. (Rounding due to spreadsheet calculations.) An increase in member months is due to an increase in the total number of participants served combined with the addition of the Outreach Care Pods operated by the staff in this bundle that will result in increased participant engagements.

Care Coordination Bundle: This team is expected to reach 6,720 member months at a PMPM cost of $269.69 producing a cost of $1,721,692 for Year 2, and 10,560 member months at a PMPM cost of $269.69 producing a cost of $2,705,530 for Years 3-5.

Care Coordination Bundle	Qty	Rate	Rate Description	Units Y2	Units Y3-Y5	Unit Description	Annual Cost per Unit	Total, Y2	Total, Y3-Y5
Staff									
Care Coordination Manager	173.333	$ 77.57	hours per month x per hour rate	8	12		$ 13,445	$ 107,564	$ 161,345
Care Manager (LCSW/MA)	554.666	$ 58.94	hours x per hour	8	12		$ 32,692	$ 261,536	$ 392,304
Care Manager (RN)	554.666	$ 58.94	hours x per hour	8	12		$ 32,692	$ 261,536	$ 392,304
Care Manager (LMFT)	277.333	$ 58.94	hours x per hour	8	12		$ 16,346	$ 130,768	$ 196,152
Infrastructure									
Rent (partial, 50% of 778 sq ft)	389	$ 2.10	Allocated footage x cost per sf	8	12	Months	$ 817	$ 6,535	$ 9,803
Wireless Contract - Cellphones	10	$ 150.00	Contracts x cost per month	8	12	Cellphones - Admin	$ 1,500	$ 12,000	$ 18,000
Wireless Contract Laptops	10	$ 150.00	Contracts x cost per month	8	12	Cellphones - Mobile Team	$ 1,500	$ 12,000	$ 18,000
Care Coordinator Training (60%)	0.60	$ 10,500.00	Training, per session, 4 per	8	4	2 per Q Y2, 1 per Q later	$ 6,300	$ 50,400	$ 25,200
Conferences travel cost	10	$ 1,000.00	Per trip quarterly	2	4	Quarterly expenses	$ 10,000	$ 20,000	$ 40,000
Enhanced Care Coordination - Year 2	4,398	$ 27.00	80% of population (ramp up)	8		Enhanced care coordination	$ 118,746	$ 949,968	$ -
Enhanced Care Coordination - Years 3-5	4,922	$ 27.00	80% of population		12	Enhanced care coordination	$ 132,902	$ -	$ 1,594,818
						Subtotal	$ 366,940	$ 1,812,307	$ 2,847,927
						Less 5% TCM Allowance		$ (90,615)	$ (142,396)
						Total		$ 1,721,692	$ 2,705,530
	Y2	**Y3-Y5**		**Y2**	**Y3-Y5**			**Y2**	**Y3-Y5**
Member Months	95%	95%		6,720	10,560	Member Months		$ 269.69	$ 269.69

Care Coordination Bundle Table: This table is broken out the same way as the Field-based Care Coordination Team table just discussed. The primary differences are the number of staff, and the allocation of 50% of the rent, due to the team's centralized "in-office" base, and 60% of the training costs to this team. This cost was re-allocated to balance the total cost versus the number of

care managers in total.

Determining PMPM Cost: The Portion section in the lower part of the table identifies what portion of the participant base that the team is expected to reach per month. This is multiplied against the total member months available (which are 6,720 for Year 2 and 10,560 for subsequent years). The result is used to divide the costs and produce the PMPM cost for this team. In this instance, the total cost is $1,721,692/6,720 participant months x 95% = $269.69 PMPM for Year 2, and $2,705,530/10,560 participant months x 95% = $269.69 PMPM cost in Years 3-5. Totals in this bundle are affected by a small overlap with the Targeted Case Management Program, resulting in a reduction in total request funding. (Rounding due to spreadsheet calculations.)

Engagement Bundle

Engagement Bundle	Qty	Rate	Rate Description	Units Y2	Units Y3-Y5	Unit Description	Annual Cost per Unit	Total, Y2	Total, Y3-Y5
Staff									
Care Coordination Manager	519.999	$ 77.57	hours per month x per hour rate	8	12		$ 40,336	$ 322,691	$ 484,036
Nurse Practitioner (for mobile)	519.999	$ 77.57	hours per month x per hour rate	8	12		$ 40,336	$ 322,691	$ 484,036
Clinic Assistant (MA) Y2	519.999	$ 27.61	per month x per hour	8	0		$ 14,357	$ 114,857	$ -
Clinic Assistant (MA) Ys 3-5	693.332	$ 27.61	per month x per hour		12		$ 19,143	$ -	$ 229,715
Infrastructure									
Rent (partial, 25% of 778 sq ft)	194.50	$ 2.10	Allocated footage x cost per sf	8	12	Months	$ 408	$ 3,268	$ 4,901
Mobile van maintenance Y2	3	$ 2,104.38	Cost per mo. @ 0.54 cents	8	0	Months of service	$ 6,313	$ 50,505	$ -
Mobile van maintenance Ys 3-5	3	$ 2,157.80	Cost per mo. @ 0.54 cents		12	Months of service	$ 6,473	$ -	$ 77,681
Wireless Contract - Cellphones Y2	9	$ 150.00	Contracts x cost per month	8		Months of service	$ 1,350	$ 10,800	$ -
Wireless Contract - Cellphones Ys 3-5	10	$ 150.00	Contracts x cost per month		12	Months of service	$ 1,500	$ -	$ 18,000
Wireless Contract Laptops Y2	9	$ 150.00	Contracts x cost per month	8		Months of service	$ 1,350	$ 10,800	$ -
Wireless Contract Laptops Ys 3-5	10	$ 150.00	Contracts x cost per month		12	Months of service	$ 1,500	$ -	$ 18,000
Care Coordinator Training (25%)	0.25	$ 10,500.00	Training, per session, 4 per	6	6	2 per Q Y2, 6 per year Ys 3-5	$ 2,625	$ 15,750	$ 15,750
Collaborative travel cost (Y2)	2	$ 1,000.00	Per trip quarterly	2		Quarterly expenses	$ 2,000	$ 4,000	$ -
Collaborative travel cost (Ys 3-5)	3	$ 1,000.00	Per trip quarterly		4	Quarterly expenses	$ 3,000	$ -	$ 12,000
						Total		$ 855,361	$ 1,344,119
	Y2	**Y3-Y5**		**Y2**	**Y3-Y5**			**Y2**	**Y3-Y5**
Member Months	40%	40%		6,720	10,560	Member Months		$ 318.21	$ 318.21

Engagement Bundle Table: This table is broken out the same way as the previous two. The Engagement Teams have relatively small staff, but incur costs for the operation of the vehicles. Only 25% of the rent and training costs are allocated to this team.

Determining PMPM Cost: The Portion section in the lower part of the table identifies what portion of the participant base those teams are expected to reach per month. This is multiplied against the total member months available (which are 6,720 for Year 2 and 10,560 for subsequent years). The result is used to divide the costs for Year 2 and Years 3-5 to produce the PMPM cost for this team. In this

instance, the Engagement Teams are expected to reach 2,688 participant-months during Year 2 (6,720 x 40%). The cost using the breakout table is $855,361/6,720 participant months x 40% = PMPM cost of $318.21 for Year 2. For later years, Engagement Teams are expected to reach 4,224 participant-months during Years 3-5 (10,560 x 40%). The cost using the breakout table is $1,344,119/10,560 participant months x 40% = PMPM cost of $318.21. (Rounding due to spreadsheet calculations.)

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Year 2
Pay for Reporting

In the Pay for Reporting category for Year 2 are a number of milestones connected to demonstrating capabilities of the developing system. All Pay for Reporting will be paid to the Lead Entity which is responsible for reporting project progress. Pay for Reporting incentives will only be requested in Year 2.

Pay For Reporting				
Item	Incentive Payment for Achievement	Max WPC Fund Amount - Round 2	Max WPC Fund Amount - Round 1	Differences
UM i.4: The ED visit metric will be measured for enrolled participants at least quarterly.	250,000	250,000	250,000	-
UM ii.4: The number of inpatient encounters and lengths of stay will be measured for those enrolled in the project at least quarterly.	250,000	250,000	250,000	-
UM v3: PDSA will be used to measure and make changes about the comprehensive care plan metric at least quarterly.	250,000	250,000	250,000	-
Establishment of care coordination, case mgmt, referral policies	250,000	250,000	250,000	-
Implement oversight of care coordination, case mgmt, referral policies	250,000	250,000	250,000	-
Quarterly review of care coordination, case mgmt, referral policies	250,000	250,000	250,000	-
Semi-annual PDSA review of care coordination, case mgmt, referral policies	250,000	250,000	250,000	-
Compile, analyze PDSA results and modify policies for care coordination, case management, referral policies as indicated	250,000	250,000	250,000	-
Establish data/information sharing policies and procedures	250,000	250,000	250,000	-
Establish monitoring procedures for data/information sharing	250,000	250,000	250,000	-
Quarterly review of data/information sharing policies	250,000	250,000	250,000	-
Semi-annual PDSA review of data/information sharing policies	250,000	250,000	250,000	-
Compile, analyze PDSA results and modify policies for data/information sharing as indicated	250,000	250,000	250,000	-
Record and report housing authority follow-ups	250,000	250,000	250,000	-
At least 500 encounters, signed consent forms	250,000	250,000	250,000	-

Metric i. Health Outcomes Goal i.4: Measuring and PDSA process of ED visits: The achievement of this item in accordance with timelines will be reported to DCHS for an incentive payment of $250,000 paid to the lead entity.

Metric i. Health Outcomes Goal i.4: Measuring and PDSA process of inpatient utilization: The achievement of this item in accordance with timelines will be reported to DCHS for an incentive payment of $250,000 paid to the lead entity.

Metric v. Health Outcomes Goal v.3: Measuring and PDSA process of comprehensive care plan process: The achievement of this item in accordance with timelines will be reported to DCHS for an incentive payment of $250,000 paid to the lead entity.

Metric vi. Administrative Metric Goal vi.1: Establishment of care coordination, care

management, and referral policies: The achievement of this item in accordance with timelines will be reported to DCHS for an incentive payment of $250,000 paid to the lead entity.

Metric vi. Administrative Metric Goal vi.2: Implement oversight of care coordination, care management, and referral: The achievement of this item in accordance with timelines will be reported to DCHS for an incentive payment of $250,000 paid to the lead entity.

Metric vi. Administrative Metric Goal vi.3: Quarterly review of care coordination, care management, and referral policies: The achievement of this item in accordance with timelines will be reported to DCHS for an incentive payment of $250,000 paid to the lead entity.

Metric vi. Administrative Metric Goal vi.4: Semi-annual PDSA review of care coordination, care management, and referral policies: The achievement of this item in accordance with timelines will be reported to DCHS for an incentive payment of $250,000 paid to the lead entity.

Metric vi. Administrative Metric Goal vi.5: Demonstrate compiling and analysis of care coordination, care management, and referral data and the Quality Improvement process: The achievement of this item in accordance with timelines will be reported to DCHS for an incentive payment of $250,000 paid to the lead entity.

Metric vii. Administrative Metric Goal vii.1: Establish data and information sharing policies and procedures: The achievement of this item in accordance with timelines will be reported to DCHS for an incentive payment of $250,000 paid to the lead entity.

Metric vii. Administrative Metric Goal vii.2: Establish monitoring procedures for data and information sharing: The achievement of this item in accordance with timelines will be reported to DCHS for an incentive payment of $250,000 paid to the lead entity.

Metric vii. Administrative Metric Goal vii.3: Quarterly review of data and information sharing policies: The achievement of this item in accordance with timelines will be reported to DCHS for an incentive payment of $250,000 paid to the lead entity. The total amount paid will be based on the accomplishment of each deliverable on a quarterly basis at 4 quarters x $75,000.

Metric vii. Administrative Metric Goal vii.3: Semi-annual PDSA review of data and information sharing policies: The achievement of this item in accordance with timelines will be reported to DCHS for an incentive payment of $250,000 paid to the lead entity. The total amount paid will be based on the accomplishment of each review deliverable on a semi-annual basis at 2 per year x $125,000.

Metric vii. Administrative Metric Goal vii.5: Demonstrate compiling and analysis of above and QI processes: The achievement of this item in accordance with timelines will be reported to DCHS for an incentive payment of $250,000 paid to the lead entity. This incentive will be triggered if at

least 1,500 of the 1,698 anticipated encounters, types of services, and results with the Area Housing Authority are recorded and reported.

Housing authority's record for follow-ups: The achievement of this item in accordance with timelines will be reported to DCHS for an incentive payment of $250,000 paid to the lead entity. This incentive will be triggered if at least 2,000 of the 2,264 anticipated encounters, types of services, and results with the Area Housing Authority are recorded and reported.

At least 500 encounters as ascertained by signed consent forms: The status of this will be reported out and there is an incentive payment associated with this item of $250,000. The recording and reporting of a signed Universal Consent form will trigger this incentive, calculated at $312.50 x 800 participants = $250,000.

Year 2
Pay for Outcomes

Universal Metrics: The Pay for Outcomes has four Universal Metrics and two Variant Metrics in Year 2:

	Pay for Outcomes			
Item	Incentive Payment for Achievement	Max WPC Fund Amount - Round 2	Max WPC Fund Amount - Round 1	Differences
U. Metric i: ED visits - maintain baseline	750,000	750,000	750,000	-
U. Metric ii: Inpatient utilization - maintain baseline	750,000	750,000	750,000	-
U. Metric iii: Follow-up within 30 day post ED MH visit - maintain baseline	500,000	500,000	500,000	-
U. Metric iv.1: New AOD events treated within 14 days - maintain baseline	500,000	500,000	500,000	-
U. Metric iv.2: New AOD events get treatment and at least 2 services within 30 days. Maintain baseline	500,000	500,000	500,000	-
Variant M1: Percentage of participants that have at least six encounters with a CSW during the project year. At least 60% of participants.	500,000	500,000	500,000	-
Variant M2: Percentage of patients 18 - 75 years of age with Diabetes (type 1 or type 2) who had Hemoglobin A1c <8.0% during the measurement period. At least maintain baseline.	500,000	500,000	500,000	-
Variant M3: Percentage of adult patients age 18 and older with major depression or dysthymia and an initial PHQ-9 score > 9 who demonstrate remission at twelve months defined as PHQ-9 score less than 5. (NQF 0710). At least maintain baseline	500,000	500,000	500,000	-
Variant M4: Percentage of patients aged 18 years and older with a diagnosis of major depressive disorder (MDD) with a suicide risk assessment completed during the visit in which a new diagnosis or recurrent episode was identified. (NQF 0104) At least maintain baseline.	500,000	500,000	500,000	-
Variant M5: Percentage of homeless receiving housing services in the project year that referred for housing services. At least 50%.	450,000	450,000	450,000	-
Optional Variant M6: Percentage of participants who have at least six encounters with a CSW during the project year. At least 50%.	450,000	450,000	450,000	-
Optional Variant M7: Percentage of participants who received recuperative care services who are not admitted to the ED or as an inpatient within 90 days of discharge. At least 50%.	325,000	325,000	0	325,000

- *Metric i. Health Outcomes Goal i.1:* ED visits will maintain baseline measurements in project Year 2, be reduced among enrolled participants by at least 10% from baseline in project Year 3, will be reduced at least 15% from baseline in Year 4, and will be reduced at least 20% from baseline in project Year 5. This incentive of $750,000 will be triggered by maintaining or any reduction in baseline ED visits in Year 2.

- *Metric i. Health Outcomes Goal i.2:* ED visits will maintain baseline measurements in project Year 2, be reduced among enrolled participants by at least 15% from baseline in project Year 3, will be reduced at least 20% from baseline in Year 4, and will be reduced at least 25% from baseline in project Year 5. This incentive of $750,000 will be triggered by maintaining or any reduction in baseline ED visits in Year 2.

- *Metric i. Health Outcomes Goal i.3:* ED visits will maintain baseline measurements in

project Year 2, be reduced among enrolled participants by at least 20% from baseline in project Year 3, will be reduced at least 25% from baseline in Year 4, and will be reduced at least 30% from baseline in project Year 5. This incentive of $500,000 will be triggered by maintaining or any reduction in baseline ED visits in Year 2.

- *Metric ii. Health Outcomes Goal ii.1:* Inpatient utilization will maintain baseline measurements in project Year 2, be reduced among enrolled participants by at least 10% from baseline in project Year 3, and will be reduced at least 15% from baseline in project Year 4, and will be reduced at least 20% from baseline in project Year 5. This incentive of $500,000 will be triggered by maintaining or any reduction in baseline for inpatient utilization in Year 2.

- *Metric ii. Health Outcomes Goal ii.2:* Inpatient utilization will maintain baseline measurements in project Year 2, be reduced among enrolled participants by at least 15% from baseline in project Year 3, and will be reduced at least 20% from baseline in project Year 4, and will be reduced at least 25% from baseline in project Year 5. This incentive $500,000 will be triggered by maintaining or any reduction in baseline for inpatient utilization in Year 2.

- *Metric ii. Health Outcomes Goal ii.3:* Inpatient utilization will maintain baseline measurements in project Year 2, be reduced among enrolled participants by at least 20% from baseline in project Year 3, and will be reduced at least 25% from baseline in project Year 4, and will be reduced at least 30% from baseline in project Year 5. This incentive $500,000 will be triggered by maintaining or any reduction in baseline for inpatient utilization in Year 2.

- *Metric iii. Health Outcomes Goal iii:* Participants will have a follow-up visit within 30 days of discharge among those who had an ED visit with a primary diagnosis of mental illness. The follow-up visit will be an outpatient visit, intensive outpatient encounter, or partial hospitalization with a primary diagnosis of a mental health disorder and/or to a behavioral health facility. The goal will be to maintain baseline measurements in project Year 2, be improved among enrolled participants by at least 5% from baseline in project Year 3, be improved at least 10% from baseline in project Year 4, and be improved at least 15% from baseline in project Year 5. This incentive of $500,000 will be triggered by maintaining or any improvement in baseline for follow-up after mental health ED visits within 14 days in Year 2.

- *Metric iv. Health Outcomes Goal iv.1:* Participants with a new episode of alcohol or other drug (AOD) dependence initiate treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter, or partial hospitalization within 14 days of the diagnosis. The goal will be to maintain baseline measurements in project Year 2, be improved among enrolled participants by at least 5% from baseline in project Year 3, improved by at least 10% from baseline in project Year 4, and will be improved at least 15% baseline in project Year 5. This incentive of $500,000 will be triggered by maintaining or any improvement in baseline for treatment for AOD within 14 days in Year 2.

- *Metric iv. Health Outcomes Goal iv.2:* Participants with a new episode of alcohol or other drug (AOD) dependence who initiated treatment and who had two or more additional services with a diagnosis of AOD within 30 days of the initiation visit. The goal will be to

maintain baseline measurements in project Year 2, be improved among enrolled participants by at least 5% from baseline in project Year 3, be improved at least 10% from baseline in project Year 4, and be improved at least 15% baseline in project Year 5. This incentive of $500,000 will be triggered by maintaining or any improvement in baseline for treatment for AOD within 14 days in Year 2.

Variant Metrics:

- ***Variant Metric M1:*** Percentage of CHWs receiving quarterly in-service training based on gaps identified through field work via PDSA improvement cycles. This incentive will be triggered if at least 60% of CHWs attend quarterly trainings in Year 2, at least 65% in Year 3, at least 70% in Year 4, and at least 75% in Year 5.
- ***Variant Metric M2***: Percentage of patients 18 - 75 years of age with Diabetes (type 1 or type 2) who had Hemoglobin A1c <8.0% during the measurement period. This incentive will be triggered if participants maintain or there is any improvement in baseline Hemoglobin A1c in Year 2, at least 5% improvement from baseline in Year 3, at least 10% improvement from baseline in Year 4, and at least 15% improvement from baseline in Year 5.
- ***Variant Metric M3:*** Percentage of adult patients age 18 and older with major depression or dysthymia and an initial PHQ-9 score > 9 who demonstrate remission at twelve months defined as PHQ-9 score less than 5. This incentive will be triggered if participants maintain or there is any improvement in baseline PHQ-9 > 9 in Year 2, at least 5% improvement from baseline in Year 3, at least 10% improvement from baseline in Year 4, and at least 15% improvement from baseline in Year 5.
- ***Variant Metric M4***: Percentage of patients aged 18 years and older with a diagnosis of major depressive disorder (MDD) with a suicide risk assessment completed during the visit in which a new diagnosis or recurrent episode was identified. This incentive will be triggered if participants maintain or there is any improvement in baseline suicide risk assessments administered in Year 2, at least 5% improvement from baseline in Year 3, at least 10% improvement from baseline in Year 4, and at least 15% improvement from baseline in Year 5.
- ***Variant Metric M5***: Percentage of homeless receiving housing services in the project year that referred for housing services. This incentive will be triggered if at least 50% of referred homeless receive housing services in Year 2, at least 55% in Year 3, at least 60% in Year 4, and at least 65% in Year 5.
- ***Variant Metric M6***: Percentage of participants who have at least six encounters with a CSW during the project year. This incentive will be triggered if at least 50% of referred homeless receive housing services in Year 2, at least 55% in Year 3, at least 60% in Year 4, and at least 65% in Year 5.
- ***Optional Variant M7:*** Percentage of participants who received recuperative care services who are not admitted to the ED or as an inpatient within 90 days of discharge. At least 50%. This incentive will be triggered if at least 50% of recuperative care patients are not admitted to the hospital within 90 days of discharge in Year 2, at least 55% in

Year 3, at least 60% in Year 4, and at least 65% in Year 5.

The discussion of Years 3 through 5 that follows in the next section will focus on the differences from Year 2.

YEARS 3-5

Year 3
Administrative Infrastructure

Item	Max Amount Per Unit	Max Units	Max WPC Fund Amount - Round 2	Max WPC Fund Amount - Round 1	Differences
Administrative Infrastructure					
Program Director	164,835	1.00	164,835	164,835	-
Informaticist	127,178	1.20	152,614	152,614	-
Databae Analyst	100,580	1.20	120,696	120,696	-
Administrative Assistant	70,069	1.00	70,069	70,069	-
Medical Director (Primary Care)	224,300	1.00	224,300	224,300	-
Medical Director (Psychiatric)	441,697	1.00	441,697	441,697	-
Waiver Financial Manager	167,388	1.00	167,388	167,388	-
QI Coordinator	124,398	1.00	124,398	124,398	-
Legal Counsel	140	120.00	16,800	16,800	-
Office Supplies, per person	300	62.00	18,600	12,300	6,300
Cellphones - New CHWs/MAs	700	4.00	2,800	0	2,800
Laptop Computers - New CHWs	1,250	4.00	5,000	0	5,000
Learning Collaborative Travel	1,000	16.00	16,000	0	16,000
Indirect Rate at 5% (Round 1)	18,635,750	0.05	931,788	931,788	
Indirect Rate at 5% (Round 2)*	2,211,476	0.05	110,574	0	110,574

*Difference in Direct Less Incentives, Reporting,
Outcomes

The staff calculations are all the same as Year 2**.** Of the non-staff expenses, only the office supplies and learning collaborative travel remain. New expenses for cell phones and laptops for the three additional CHWs added to the Field-Based Care Coordination Bundle and one additional MA added to the Engagement Bundle are included in this category in PY 3. Other expenses are absorbed into the PMPM bundles as discussed above or are one-time expenses.

Years 4-5
Administrative Infrastructure

Administrative Infrastructure					
Item	Max Amount Per Unit	Max Units	Max WPC Fund Amount - Round 2	Max WPC Fund Amount - Round 1	Differences
Program Director	164,835	1.00	164,835	164,835	-
Informaticist	127,178	1.60	203,485	203,485	(θ)
Database Analyst	100,850	1.60	160,928	160,928	-
Administrative Assistant	70,069	1.00	70,069	70,069	-
Medical Director (Primary Care)	224,300	0.50	112,150	112,150	-
Behavioral Health Director (Psychiatric)	441,697	0.50	220,849	220,849	-
WPC Financial Manager	167,388	1.00	167,388	167,388	-
QI Coordinator	124,398	1.00	124,398	124,398	-
Legal Counsel	140	120.00	16,800	16,800	-
Office Supplies per person	300	62.00	18,600	12,300	6,300
Learning Collaborative Travel	1,000	16.00	16,000	0	16,000
Indirect Rate at 5%	18,635,750	0.05	931,788	931,788	-
Indirect Rate at 5% (Round 2)*	2,211,476	0.05	110,574	0	110,574
*Difference in Direct Less Incentives, Reporting, Outcomes					

The staff calculations are all the same as PY 2 and 3. Of the non-staff expenses, only the office supplies and learning collaborative travel remain.

Year 3
Delivery Infrastructure

Delivery Infrastructure					
Item	Max Amount Per Unit	Max Units	Max WPC Fund Amount - Round 2	Max WPC Fund Amount - Round 1	Differences
Centralized Enterprise Infrastructure	297,950	1	297,950	297,950	-
Centralized Enterprise Contract	25,000	12	300,000	300,000	-
IT Development	743,447	1	743,447	610,783	132,664
WPC Connect Contract	25,000	12	300,000	300,000	-
Health Registry Contract	2,250	12	27,000	27,000	-
Care Pod Contract/Operating Costs	21,145	12	253,735		253,735

The Centralized Enterprise Infrastructure will provide vendor work, hardware, and software development to launch the Integrated Care Plan, data sharing, and other technology to support care management. The Centralized Enterprise Contract and WPC Connect Contract, both billed by the month, will be calculated at 12 months x $5,000 per month in Years 3-5. IT Development will be needed to integrate the Enterprise system with current technologies, define architecture, work with partnering entities to develop data sharing technologies, and develop data and reporting systems. The $132,664 in additional Round 2 IT development costs are to facilitate the increased data sharing and care coordination platform requirements that will enable data sharing among the National Health Foundation and four area hospitals participating in the recuperative care program, and the additional data elements needed for the Integrated Care Plan and care coordination platform to integrate services, including social services data. This functionality will be phased over PY 2-5. An increase in the number of Outreach Care Pod sites and the expansion to a full year of operations increases the total cost of this cost item; set-up supplies were included only in PY 2.

Years 4-5
Delivery Infrastructure

Delivery Infrastructure					
Item	Max Amount Per Unit	Max Units	Max WPC Fund Amount - Round 2	Max WPC Fund Amount - Round 1	Differences
Centralized Enterprise Contract	25,000	12	300,000	300,000	-
IT Development	449,197	1	449,197	308,733	140,464
WPC Connect Contract	25,000	12	300,000	300,000	-
Health Registry Contract	2,250	12	27,000	27,000	-
Care Pod Contract/Operating Costs	21,145	12	253,735		253,735

The Centralized Enterprise Infrastructure costs are concluded in Year 2, but IT Development continues through Phase II implementation to provide more advanced integrative capabilities to the data sharing and tracking are added, eReferral, and other improvements as discussed more fully in the application narrative. It is also anticipated that much of the PDSA processes will drive technology improvements to optimize the support of care management. In Year 3, the Phase II IT Development cost is $743,447in Year 3, then drops to $449,197 in Years 4-5 to maintain ongoing connectivity, integration, trouble shooting, and training within the system, and to initiate any additional needed changes identified through PDSA processes. The $140,464 in additional Round 2 IT development costs are to facilitate the increased data sharing and care coordination platform requirements that will enable data sharing among the National Health Foundation and four area hospitals participating in the recuperative care program, and the additional data elements needed for the Integrated Care Plan and care coordination platform to integrate community-based services, including social services data. This functionality will be phased over PY 2-5.

Years 3-5

Incentive Payments

Incentive Payments					
Item	Max Amount Per Unit	Max Units	Max WPC Fund Amount - Round 2	Max WPC Fund Amount - Round 1	Differences
Housing support services	150	5,713	856,950	779,100	77,850
At least 60% of patients will have care plan within 30 days	500	528	264,000	239,000	25,000
At least 80% of patients will have updated care plan within 30 days of anniversary	625	704	440,000	400,000	40,000
At least 50% follow-up after MD ED visit	500	440	220,000	200,000	20,000
Meeting attendance expense coverage	100	240	24,000	24,000	-
Care Pod Community Service Events	10,000	15	150,000		150,000

In Year 3-5, the incentives support a larger and complete patient population for the full year, totaling $1,954,950. The incentive categories remain the same, with the exception of the addition of Universal Metric v.2, which is that at least 80% of participants will have an updated comprehensive care plan, within 30 days of the participant's anniversary of participation in the pilot. A Year 3-5 increase in the number of participants increased the max units, which in turn increased the requested amount for incentive payments.

Years 3-5
Fee-for-Service

Item	Max Amount Per Unit	Max Units	Max WPC Fund Amount - Round 2	Max WPC Fund Amount - Round 1	Differences
FFS Services					
Recuperative Care Program Service Fees/Operating	129.47	3,548	459,360	0	459,360
Mobile Outreach Services	168.94	1,980	334,501	202,728	131,773

Fee-for-Service Costs: The recuperative care program will increase to 12 months of operation beginning in Year 3, from 6 months at the end of Year 2. The fees are for services provided by the National Health Foundation to provide recuperative care services to participants, which are $129.47 x 3,548 bed days = $459,360 in Years 3-5 (see detail in Year 2). Mobile outreach services, provided by the Engagement Team and CSWs, will continue to support community outreach to identify persons who have been targeted by the risk stratification technology system (or are otherwise eligible based on assessment), introduce project services, get consent, develop initial assessments, attend to urgent needs, and connect them with a Field-Based Care Coordination CSW. In Years 3-5, however, these services will be provided to fewer persons because in Year 2, the count is elevated to support filling the caseload. These services are calculated at $168.94 for each engagement of the Field-Based Care Coordination staff and Engagement Teams, which are expected to reach 1,980 engagements, totaling $334,501 in Years 3-5. The increase in participants will result in an increase in the number of engagements with the target population.

Years 3-5
PMPM Bundled Services

Item	PMPM	Max Member Months	Max WPC Fund Amount - Round 2	Max WPC Fund Amount - Round 1	Differences
PMPM Bundle					
Field-based Care Coordination Bundle	223.74	13,883	3,106,182	2,179,402	926,780
Care Coordination Bundle	269.69	10,560	2,705,530	2,651,510	54,020
Engagement Bundle	318.21	10,560	1,344,119	1,270,644	73,475

These bundles are in the same categories described earlier, but reflect an increase in the number of member months because of the larger patient base being served. There is anticipated to be 13,883 member months for the Field-Based Care Coordination Bundle versus 8,476 member months in Year 2, and 10,560 member months versus 6,720 member months in Year 2 for the Care Coordination and Engagement Bundles. The combined total for the three PMPM bundles is $7,060,766, which remains fixed at this level for Years 3 through 5.

Years 3-5
Pay for Reporting

	Pay For Reporting			
Item	Incentive Payment for Achievement	Max WPC Fund Amount - Round 2	Max WPC Fund Amount - Round 1	Differences
UM i.4: The ED visit metric will be measured for enrolled participants at least quarterly.	250,000	250,000	250,000	-
UM ii.4: The number of inpatient encounters and lengths of stay will be measured for those enrolled in the project at least quarterly.	250,000	250,000	250,000	-
UM v3: PDSA will be used to measure and make changes about the comprehensive care plan metric at least quarterly.	250,000	250,000	250,000	-
Quarterly review of care coordination, case mgmt, referral policies	250,000	250,000	250,000	-
Semi-annual PDSA review of care coordination, case mgmt, referral policies	250,000	250,000	250,000	-
Establish data/information sharing policies and procedures	250,000	250,000	250,000	-
Quarterly review of data/information sharing policies	250,000	250,000	250,000	-
Semi-annual PDSA review of data/information sharing policies	250,000	250,000	250,000	-
Record and report housing authority follow-ups	250,000	250,000	250,000	-
At least 500 encounters, signed consent forms	250,000	250,000	250,000	-

After Year 2 when policies have been established, then PDSA processes, and quarterly and semi-annual reviews remain to ensure that the quality of the services provided are maintained at the highest level. The one-time Pay for Reporting metrics that are omitted in Years 3-5 include Metrics vi.1, vi.2, vi.5, vii.1, vii.,2, and vii.5. All Pay for Reporting Metrics are proposed for $250,000, and triggered by achievement of the metric as indicated in Year 2.

Year 3
Pay for Outcomes

	Pay for Outcomes			
Item	Incentive Payment for Achievement	Max WPC Fund Amount - Round 2	Max WPC Fund Amount - Round 1	Differences
U. Metric i1: ED visits: At least 10% increase from	250,000	250,000	250,000	-
U. Metric i2: ED visits: At least 15% increase from	300,000	300,000	300,000	-
U. Metric i3: ED visits: At least 20% increase from	375,000	375,000	375,000	-
U. Metric ii1: Inpatient utilization: At least 10% increase from baseline.	250,000	250,000	250,000	-
U. Metric ii2: Inpatient utilization: At least 15% increase from baseline.	300,000	300,000	300,000	-
U. Metric ii3: Inpatient utilization: At least 20% increase from baseline.	375,000	375,000	375,000	-
U. Metric iii: Follow-up within 30 day post ED MH visit: At least 5% increase from baseline.	450,000	450,000	450,000	-
U. Metric iv.1: New AOD events treated within 14 days: At least 5% increase from baseline.	350,000	350,000	350,000	-
U. Metric iv.2: New AOD events get treatment and at least 2 services within 30 days. At least 5% increase from baseline.	350,000	350,000	350,000	-
Variant M1: Percentage of participants that have at least six encounters with a CSW during the project year. At least 65% of participants.	350,000	350,000	350,000	-
Variant M2: Percentage of patients 18 - 75 years of age with Diabetes (type 1 or type 2) who had Hemoglobin A1c <8.0% during the measurement period. At least 5% increase from baseline.	450,000	450,000	450,000	-
Variant M3: Percentage of adult patients age 18 and older with major depression or dysthymia and an initial PHQ-9 score > 9 who demonstrate remission at twelve months defined as PHQ-9 score less than 5. (NQF 0710). At least 5% increase from baseline.	450,000	450,000	450,000	-
Variant M4: Percentage of patients aged 18 years and older with a diagnosis of major depressive disorder (MDD) with a suicide risk assessment completed during the visit in which a new diagnosis or recurrent episode was identified. (NQF 0104) At least 5% increase from baseline.	450,000	450,000	450,000	-
Variant M5: Percentage of homeless receiving housing services in the project year that referred for housing services. At least 55%.	350,000	350,000	350,000	-
Optional Variant M6: Percentage of participants who have at least six encounters with a CSW during the project year. At least 55%.	350,000	350,000	350,000	-
Optional Variant M7: Percentage of participants who received recuperative care services who are not admitted to the ED or as an inpatient within 90 days of discharge. At least 55%.	350,000	350,000	0	350,000

Year 4
Pay for Outcomes

Item	Incentive Payment for Achievement	Max WPC Fund Amount - Round 2	Max WPC Fund Amount - Round 1	Differences
Pay for Outcomes				
U. Metric i1: ED visits: At least 15% increase from baseline.	250,000	250,000	250,000	-
U. Metric i2: ED visits: At least 20% increase from baseline.	300,000	300,000	300,000	-
U. Metric i3: ED visits: At least 25% increase from baseline.	350,000	350,000	350,000	-
U. Metric ii1: Inpatient utilization: At least 15% increase from baseline.	250,000	250,000	250,000	-
U. Metric ii2: Inpatient utilization: At least 20% increase from baseline.	350,000	350,000	350,000	-
U. Metric ii3: Inpatient utilization: At least 25% increase from baseline.	350,000	350,000	350,000	-
U. Metric iii: Follow-up within 30 day post ED MH visit: At least 10% increase from baseline.	550,000	750,000	750,000	-
U. Metric iv.1: New AOD events treated within 14 days: At least 10% increase from baseline.	350,000	350,000	350,000	-
U. Metric iv.2: New AOD events get treatment and at least 2 services within 30 days. At least 10% increase	400,000	350,000	350,000	-
Variant M1: Percentage of participants that have at least six encounters with a CSW during the project year. At least 70% of participants.	500,000	350,000	350,000	-
Variant M2: Percentage of patients 18 - 75 years of age with Diabetes (type 1 or type 2) who had Hemoglobin A1c <8.0% during the measurement period. At least 10% increase from baseline.	550,000	550,000	550,000	-
Variant M3: Percentage of adult patients age 18 and older with major depression or dysthymia and an initial PHQ-9 score > 9 who demonstrate remission at twelve months defined as PHQ-9 score less than 5. (NQF 0710). At least 10% increase from baseline.	550,000	550,000	550,000	-
Variant M4: Percentage of patients aged 18 years and older with a diagnosis of major depressive disorder (MDD) with a suicide risk assessment completed during the visit in which a new diagnosis or recurrent episode was identified. (NQF 0104) At least 10% increase from baseline.	550,000	550,000	550,000	-
Variant M5: Percentage of homeless receiving housing services in the project year that referred for housing services. At least 60%.	350,000	350,000	350,000	-
Optional Variant M6: Percentage of participants who have at least six encounters with a CSW during the project year. At least 60%.	350,000	350,000	350,000	-
Optional Variant M7: Percentage of participants who received recuperative care services who are not admitted to the ED or as an inpatient within 90 days of discharge. At least 60%.	350,000	350,000	0	350,000

Year 5
Pay for Outcomes

Item	Incentive Payment for Achievement	Max WPC Fund Amount - Round 2	Max WPC Fund Amount - Round 1	Differences
Pay for Outcomes				
U. Metric i1: ED visits: At least 20% increase from baseline	250,000	250,000	250,000	-
U. Metric i2: ED visits: At least 25% increase from baseline	300,000	300,000	300,000	-
U. Metric i3: ED visits: At least 30% increase from baseline	350,000	350,000	350,000	-
U. Metric ii1: Inpatient utilization: At least 20% increase from baseline	250,000	250,000	250,000	-
U. Metric ii2: Inpatient utilization: At least 25% increase from baseline	350,000	350,000	350,000	-
U. Metric ii3: Inpatient utilization: At least 30% increase from baseline	350,000	350,000	350,000	-
U. Metric iii: Follow-up within 30 day post ED MH visit: At least 15% increase from baseline.	550,000	750,000	750,000	-
U. Metric iv: New AOD events treated within 14 days: At least 15% increase from baseline.	350,000	350,000	350,000	-
U. Metric iv.2: New AOD events get treatment and at least 2 services within 30 days. At least 15% increase from baseline.	400,000	350,000	350,000	-
Variant M1: Percentage of participants that have at least six encounters with a CSW during the project year. At least 70% of participants.	500,000	350,000	350,000	-
Variant M2: Percentage of patients 18 - 75 years of age with Diabetes (type 1 or type 2) who had Hemoglobin A1c <8.0% during the measurement period. At least 15% increase from baseline.	550,000	550,000	550,000	-
Variant M3: Percentage of adult patients age 18 and older with major depression or dysthymia and an initial PHQ-9 score > 9 who demonstrate remission at twelve months defined as PHQ-9 score less than 5. (NQF 0710). At least 15% increase from baseline.	550,000	550,000	550,000	-
Variant M4: Percentage of patients aged 18 years and older with a diagnosis of major depressive disorder (MDD) with a suicide risk assessment completed during the visit in which a new diagnosis or recurrent episode was identified. (NQF 0104) At least 15% increase from baseline.	550,000	550,000	550,000	-
Variant M5: Percentage of homeless receiving housing services in the project year that referred for housing services. At least 65%.	350,000	350,000	350,000	-
Optional Variant M6: Percentage of participants who have at least six encounters with a CSW during the project year. At least 65%.	350,000	350,000	350,000	-
Optional Variant M7: Percentage of participants who received recuperative care services who are not admitted to the ED or as an inpatient within 90 days of discharge. At least 65%.	350,000	350,000	0	350,000

The Pay for Outcomes section has changed in Year 3 because additional metrics have been added

that pertain to the participant completing one year utilizing project services or were performance improvements year-over-year. The complete list of these metrics along with the corresponding year-to-year calculations follow.

The Pay for Outcomes has the same 11 Universal Metrics and seven Variant Metrics in Years 3-5 is listed and describe in Year 2. The differences are the progressive increase in percentages to achieve incentive payments. For most Pay for Outcomes categories, the goal for improvements over baseline measures is at least 5% improvements in Year 3, at least 10% in Year 4, and a least 15% in Year 5. The differences between these metrics are those that are defined according to baseline and those that are defined by a starting percentage in Year 2, including Variant Metrics 1, 5, 6, and 7. All metrics, however, increase in the achievement level by 5% per year.

The first two Universal Metrics i. and ii. are tiered and cumulative, meaning that there are three levels that can be reached to earn incentives. In the case of the proposed incentives for ED visits for example, if VCHCA only achieved a 10% reduction Year 3, then it would receive $250,000 in incentives for that metric. If, however, VCHCA achieved a 20% or greater reduction in Year 3, then it would receive the total of all three sub-metrics (10%, 15%, and 20%) or $925,000.

Attachments Table of Contents

Attachment A: Concept Diagram

Attachment B: Workflow Diagram

Attachment C: WPC Vulnerability Index

Attachment D: Ventura County Services Accessible by WPC Participants

Attachment E: Organizational Structure

Attachment F: Identification and Enrollment Diagram

Attachment G: Data Sharing Structure

Attachment H: Funding Diagram

Attachment A: Concept Diagram

Processes

Monitoring and Improvement

Community Partners with Wraparound Support

Real time Provider Support

Centralized Integrated Care Plan

Data Driven Care Management

Communication and Coordination

CHW Engagement

WPC TP

Comprehensive Assessment Tool

Access to Shared Platform

Analyst Support

VC Vulnerability Index

Tools

Secure Messaging, eReferral

Mobile Outreach Integration

Real time Electronic Dashboards

Attachment B: VCHCA WPC Connect Workflow

WPC Connect Target Population

Urgent and Emergent contacts with WPC TP

Regular level I contact for non emergent needs CHW's

Protocol Driven Connections to Community Resources

HL7 ADP Alert to CCT

CCT determines level of engagement

First Level Contact CHW

Second Level Contact Care Managers

Third Level Contact Medical Directors

Electronic Communication

Secure Messaging

e-Referral

Telemed Consult

Community Partners

VCVI
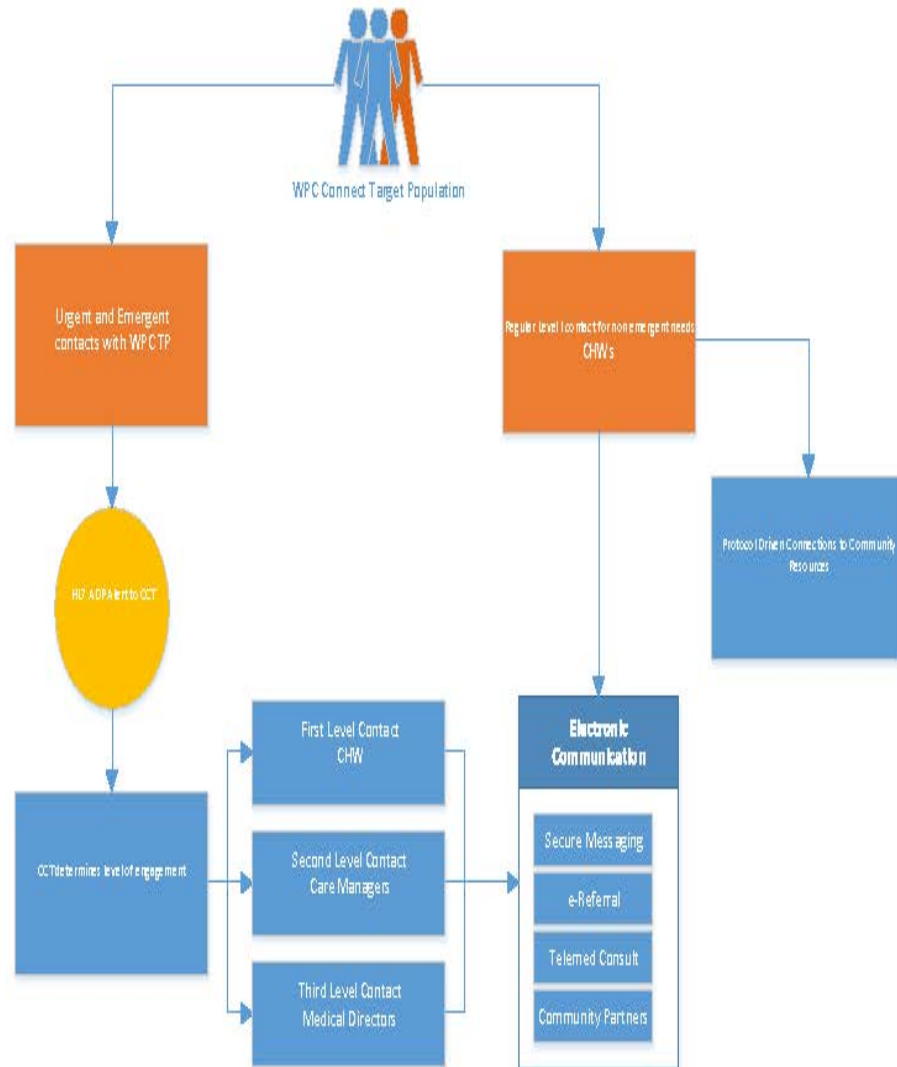
Vulnerability will be scored based on risk factors that place individuals at heightened risk for poor health outcomes. These factors will be weighted to stratify risk for priority in project enrollment among identified high utilizers.

3 points: Condition with significant threat to life or public health

1. Kidney disease / End Stage Renal Disease or Dialysis
2. Heart disease, Heart Surgery, Heart Failure
3. Liver disease or Cirrhosis
4. Cancer
5. HIV/ AIDS

2 points: Major condition with increased potential for harm

1. Homelessness
2. Age 60+
3. Physical mobility problems/Joint Disorders
4. Legally blind or deaf
5. Diabetes
6. Hepatitis C
7. COPD
8. Stroke

1 point: Health concern requiring management

1. 3 or more ER visits and/ or admissions in 3 months
2. Tuberculosis
3. Asthma
4. Mental health diagnosis
5. Substance abuse
6. Trimorbidity (health, mental health, substance abuse)
7. Hypertension

Thousand Oaks - Lutheran Social Services
80 E. Hillcrest Dr #101 497-6207

MEALS (also see Food)
Simi Valley - Samaritan Center (call for info)
280 Royal Ave 579-9166
Thousand Oaks - Lutheran Social Services
80 E. Hillcrest Dr #101 (call for info) 497-6207

MEDICAL
• Health Care for the Homeless 652-6694
Countywide
• Children's Medical/Dental Services 652-5960
• WIC (women, infants, children) 1-800-433-2611
Moorpark
• Family Care Center - 35 W. Los Angeles Ave. 529-4624
Simi Valley
• Public Health Department
  660 E. Los Angeles Ave 578-3675
• Sierra Vista Family Care Center
  127 E. Los Angeles Ave 582-4000
• Free Clinic of Simi Valley - 2060 Tapo St.
  (Tuesdays, 9 a.m. - 1 p.m.) 522-3733
• Simi Valley Hospital - 2975 Sycamore Dr...... 955-6000
Thousand Oaks
• Conejo Valley Family Medical Group
  125 W. Thousand Oaks Blvd. #300...... 481-9100
• Los Robles Hospital - 215 W. Janss Rd......497-2727
• Westminster Free Clinic - at the United Methodist
  Church - 1000 E. Janss Rd.
  (Wednesdays, 4 - 9 p.m.) 241-8366

MENTAL HEALTH
Countywide
• Adult Crisis Team - 24 hour 1-866-998-2243
• Mental Health Liaison 981-4227
  Bilingual Mental Health Liaison 981-3331
• NAMI (support / Advocacy) 641-2426
• RISE Team / OD Line 981-4233
• STAR (Access to Mental Health Services)
  1-866-998-2243
Simi Valley
• Ventura County Behavorial Health Clinic
  1227 E. Los Angeles Ave. - (also serves Moorpark)
  582-4075
Thousand Oaks
• Conejo Behavorial Health Clinic
  72 Moody Ct. 777-3500

SENIOR CITIZENS SERVICES
• 24-hour Helpline .... dial 211
• Adult Protective Services (abuse/neglect)...... 654-3200
• Area Agency on Aging
  646 County Square Dr. #100, Ventura 477-7300
• Mental Health, Older Adult Services 777-3500
• Ombudsman Services (visit nursing homes)...... 656-1986
• Senior Nutrition (meal site info) 477-7300

SHELTERS
Domestic Violence Shelters
• Coalition for Family Harmony 656-1111
  Spanish Hotline 1-800-300-2181
• Interface Children & Family Services....1-800-339-9597

Year-round Shelters
There are no year-round shelters in the Simi-Conejo area
• Lighthouse - (women & children) Oxnard 385-7200
• Rescue Mission - (men only)
  234 E. 6th St, Oxnard 487-1234
• Turning Point Foundation - Our Place Shelter (mentally ill)
  538 E. Thompson Blvd, Ventura................. 652-2151

Winter Shelters
• Simi Valley - P.A.D.S. (November - April) - call for information
  579-9166
• Thousand Oaks - Conejo Valley Winter Shelter
  (December - March) - call for information....... 497-6207

SHOWERS/TOILETS
• Rescue Mission - 234 E. 6th St, Oxnard........ 487-1234
• Samaritan Center - 280 Royal Ave, Simi Valley
  Monday - Thursday, 9 a.m. - noon............... 579-9166
• Lutheran Social Services (Monday - Friday, 9 a.m. - noon)
  80 E. Hillcrest Dr. #101, Thousand Oaks....... 497-6207

TRANSITIONAL HOUSING
• RAIN Transitional Living Center (families & singles)
  Camarillo - Applications call 383-7505
• Sarah's House (Maternity Home)................. 581-1910
• Tender Life (Maternity Home) 653-7471
• Veteran Transitional Housing (Ventura)...652-0000 x102

VETERANS' SERVICES
• County of Ventura Veteran Services
  5740 Ralston St. #300, Ventura................. 477-5155
• Department of Veterans Affairs - Outpatient Clinic
  Veterans Center - Counseling Services
  Monday - Friday, 8 a.m. - 4:30 p.m.
  4440 Calle Real, Santa Barbara .... (805) 683-1491

• Disabled Veterans Outreach (EDD)............... 582-8763
• Oxnard VA Outpatient Clinic
  2000 Outlet Ctr Dr. #225, Oxnard............. 604-6960
• Ventura Vet Center (Counseling)
  790 E. Santa Clara St. #1000.................. 585-1860
• Veteran's Home of Ventura
  10900 Telephone Rd, Ventura................... 659-7502
• Veteran Transitional Housing (Ventura)...652-0000 x102

YOUTH SERVICES
• Interface Youth Crisis Line / Shelter.......... 469-5882
• Interface Youth Services Drop-In Center
  Monday - Friday, 2 - 6 p.m.
  260 W. 4th St, Oxnard.......................... 469-5882
• Independent Living Program (former Foster Youth)
  654-3245
• Pacific Clinics, Transition Age Youth (TAY Tunnel)
  141 W. 5th St. #D, Oxnard..................... 240-2538
• Teen Runaway Helpline 1-800-RUN-AWAY
• Transitions (VC Behavioral Health)...... 1-866-998-2243

Most of the agencies listed can offer only limited, temporary assistance, depending on available funds. Refer to the Western Ventura County Resources brochure for resources available in other regions of the County.

Resources
for Homeless People
Eastern Ventura County
Moorpark • Simi Valley
Thousand Oaks

COUNTY OF VENTURA

This information current as of
May 2016

ALCOHOL & DRUG SERVICES
• 24-hour Helpline .... dial 211
• County Alcohol/Drug Line 981-8200
• Alcoholics Anonymous – Countywide Info 389-1444
• Alanon 495-0270
• Simi Valley Center - 3150 Los Angeles Ave.... 577-1724
• Khepera House (men) treatment 653-2596
• Lighthouse Recovery (Oxnard) 385-7200
• Palmer Drug/Alcohol Abuse Program 482-1265
• Prototypes (women/children) 382-6296
• Rescue Mission (men) - 234 E. 6th St, Ox 487-1234
• Salvation Army – Canoga Park/ARC ...... (818) 883-6321
• Teen Challenge 648-3295
• Victory Outreach 988-4102

BENEFITS
• Human Services Agency (CalWORKs, General Relief,
  CalFresh [Food Stamps], Medi-Cal)
  Simi Valley - 2900 N. Madera Rd............. 584-4842
  Moorpark - 612B Spring Rd, #301........ 523-5444
  Thousand Oaks
  80 E. Hillcrest Dr #200....................... 449-7320
• Social Security - Countywide Registration
  1-800-772-1213
  T.O. Office - 322 E. Thousand Oaks Blvd.
  1-888-397-4807
• Unemployment Benefits Claims
  English 1-800-300-5616
  Spanish 1-800-326-8937

BUS
• ADA/Dial-A-Ride 583-6464
• Camarillo Area Transit 988-4228
• Gold Coast Transit - Countywide Transportation
  Information 1-800-438-1112
• Greyhound Bus 1-800-231-2222
• Simi Valley Transit 583-6456

CAMPGROUNDS
• County Park Information 654-3951
• State Park Info .... 968-1033 / 1-800-444-7275
• Camping
  Fillmore - Kenny Grove - 823 N. Oak 524-0750
  Santa Paula - Steckle Park - 8080 Mistletoe Rd.
  654-3951
• **Short-Term Camping** (14 days maximum)
  Moorpark - Oak Park - 901 Quimesa 654-3951
  Oxnard - McGrath St Beach - 2211 Harbor Blvd
  Ventura -
  Emma Wood - Rincon Parkway, Hwy 1 654-8444

Faria Beach - 4350 W. PCH........................ 654-3951
Hobson Park - 5210 W. Pacific Coast Hwy....... 654-3951
Lake Casitas - 11311 Santa Ana Rd................ 649-2233
Ventura Beach Resort - 800 W. Main St........... 643-9137

CHILDREN'S SERVICES
• Children's Crisis Team 1-866-431-2478
• Child Development Resources (CDR) (childcare, Head Start)
  485-7878
• Children & Family Services (abuse, adoption, foster care)
  582-8062
• Children's Medical Services 652-5960
• County Schools Homeless Education Project...... 437-1526
• School on Wheels (tutoring/supplies)....1-800-923-1100

CITIZENSHIP/IMMIGRATION
• El Concilio Del Condado
  301 S. "C" St, Oxnard..................... 486-9777 x232

CLOTHES
• Catholic Charities - 612 Spring Rd, Moorpark
  (Monday - Thursday 9 a.m. - noon)............. 529-0720
• Lutheran Social Services
  80 Hillcrest Dr #101, Thousand Oaks 497-6207
• Samaritan Center - 280 Royal Ave, Simi Valley
  (Monday - Thursday, 7 - 11 a.m.)............. 579-9166

DENTAL
• Children - referrals from CHDP................. 981-5291
• Clinicas Del Camino Real (fee for services)
  Oxnard - 650 Meta St....................... 487-5351
  Ventura - 200 S. Wells Rd.................. 659-0560
• Free Clinic of Simi Valley (call for appt.) 522-3733
• Salvation Army Free Clinic - Oxnard
  (call for appointment)......................... 483-9235

DISABLED PERSONS
• Department of Vocational Rehabilitation
  1701 Pacific Ave #120, Oxnard................ 385-2400
• Independent Living Resource Center 650-5993
• Tri-Counties Regional Center
  1900 Los Angeles Ave, Simi Valley 522-8030

DOMESTIC VIOLENCE
• Adult Abuse & Neglect 654-3200
• Child Abuse & Neglect............................ 654-3200
• Coalition for Family Harmony 656-1111
• Interface Children & Family Services.....1-800-636-6738

DROP-IN SERVICES
• One Stop Centers
  - Conejo Valley Family Medical Group - 125 W. Thousand
    Oaks Blvd, Thousand Oaks (Monday 9 a.m. - noon)
  - Sierra Vista Family Medical Clinic - 1227 E. LA Ave, Simi
    Valley (Monday 2 - 5 p.m.)
• Samaritan Center - 280 Royal Ave, Simi Valley - showers,
  clothing, mail, messages, job coach
  (Monday - Thursday, 9 a.m. - noon)............ 579-9166

EMPLOYMENT/JOB TRAINING
• California Conservation Corps (18-25 years) 278-2787
• Catholic Charities - 612 Spring Rd #101, Moorpark
  529-0720
• East County Job & Career Center
  2900 N. Madera Rd, Simi Valley............... 955-2282
• Goodwill Industries - 130 Lombard, Oxnard....... 981-0130
• Job Corps (16-24 yrs.)................... 1-800-733-5627
• Lutheran Social Services Re-employment Program
  80 E. Hillcrest Dr #101, Thousand Oaks
  call for appointment........................... 497-6207
• Moorpark Community Service Center
  612B Spring Rd #301........................... 523-5444
• Thousand Oaks Community Service Center
  80 E. Hillcrest Dr #200....................... 374-9006
• Unemployment Benefit Claims
  English 1-800-300-5616
  Spanish 1-800-326-8937

FOOD (also see Meals)
• FOOD Share - countywide food pantry
  (call for referral in your area)............... 983-7100
Moorpark
• Catholic Charities - 612 Spring Rd #101......... 529-0720
  (Mon – Thurs 9 am - 1:30 pm, Sat 9 am - 1 pm)
Simi Valley
• Salvation Army - 1407 E. Los Angeles Ave #P
  (Monday - Thursday, 10 am - 1 pm)............. 527-1070
Thousand Oaks
• Lutheran Social Services - 80 E. Hillcrest Dr #101 ... 497-6207
• Manna Conejo Valley Food Bank - 3020 Crescent Way (Tues
  11 am - 4 pm, Fri 10 am - 4 pm, Sat 10 am - 1 pm)
  497-4959

HOUSING/HOMELESS SERVICES
• Area Housing Authority (does NOT provide emergency
  housing) - serves Camarillo, Fillmore, Ojai, Moorpark, Simi
  Valley, Thousand Oaks and unincorporated areas
  1400 W. Hillcrest Dr, Newbury Park............ 480-9991
  or 1-800-800-2123

• Cabrillo Economic Development Corporation
  (affordable housing)........................... 659-3791
• Housing Rights Center 1-800-477-5977
• Catholic Charities - 612 Spring Rd #101, Moorpark
  529-0720
• HSA Homeless Services Program 385-1800
• HPRP Homeless Prevention & Rental Deposit . 385-8585
• Lutheran Social Services
  80 E. Hillcrest Dr. #101, TO.................. 497-6207
• Many Mansions / Housing Central (Mon. - Thurs.)
  1425 E. Thousand Oaks Blvd, TO............. 497-0344
• Mental Health Housing / STAR 1-866-998-2243
• Salvation Army
  1407 E. Los Angeles Ave #P, Simi 527-1070
• Samaritan Center - 280 Royal Ave, Simi Valley
  (mornings Mon. – Thurs.)..................... 579-9166
• St. Vincent de Paul 487-1558

INFORMATION AND REFERRAL
Dial 211 for info 24 hours/7 days/week about Community
Resources near you
• Area Agency on Aging (seniors) 477-7300
• County of Ventura 1-800-660-5474
• Homeless Services Program Info 385-1800

LAUNDRY
• Lutheran Social Services - 80 E. Hillcrest Dr #101,
  Thousand Oaks - (Mon. - Fri. mornings) 497-6207
• Samaritan Center - 280 Royal Ave, Simi Valley -
  (Monday - Thursday 7 a.m. - 11 a.m.)

LEGAL SERVICES
• Conejo Free Clinic - 80 E. Hillcrest Dr. #211, TO
  (call for information)........................... 497-3575
• Self Help Legal Access Center - 800 S. Victoria Ave,
  Ventura (Courthouse 1st floor)................. 654-3962
• Simi Free Clinic - 2060 Tapo St, Simi Valley
  (by appointment only)........................ 522-3733
Countywide
• California Rural Legal Assistance
  338 S. "A" St, Oxnard.......................... 483-8083
• Grey Law (60 yrs.+)
  290 Maple Court #128, Ventura............... 658-2266
• Housing Rights Center 1-800-477-5977

MAIL/MESSAGES
Moorpark - Catholic Charities
612 Spring Rd #101 529-0720
Simi Valley - Samaritan Center - 280 Royal Ave.
(mornings) 579-9166

- Self Help Legal Access Center Ventura
  800 S. Victoria Ave. (Courthouse, 1st fl) 654-3962

MAIL/MESSAGES
Oxnard
- Catholic Charities - 402 N. "A" St. 486-2900
- Community Action Program of Ventura County
  621 Richmond 436-4000

Ventura
- Catholic Charities - 303 N. Ventura Ave. 643-4694
- Turning Point Foundation (mentally ill)
  536 E. Thompson Blvd. 652-2151

MEALS (also see Food)
Oxnard
- Catholic Charities - sandwiches - 402 N. "A" St. Lyons
  Park - 9th & "G" St. - Sat & Sun. 8:30 a.m. - 1 p.m.
- Rescue Mission - 6th & Meta - Dinner 5:30 - 6 p.m.
  Mon - Fri 11 - 11:30 a.m. - Sat & Sun 12 - 12:30 p.m.

Santa Paula
- Many Meals - 121 Davis St. - Wed. 5 - 6 p.m.

Ventura
- Family to Family - 305 N. Ventura Ave.
  Mon, Wed, Fri 11:30am - 12:30pm - Sat, Sun 8 - 9am

MEDICAL
- Health Care for the Homeless 652-6694

Countywide
- Children's Medical/Dental Services 652-5960
- Ventura County Medical Center (VCMC)
  3291 Loma Vista Rd, Ventura 652-6000
- WIC (women, infants, children) ... 1-800-433-2611

Oxnard
- Clinicas del Camino Real - 650 Meta St 487-5351
- Las Flores Women's Center
  2500 S. "C" St, #B 385-9142
- Las Islas Medical Clinic
  325 W. Channel Islands Blvd 240-7000
- Public Health Clinic - 2500 S. "C" St 385-8652
- Salvation Army - 622 W. Wooley Rd. - free clinic
  Monday & Thursday 483-9235

Santa Paula
- Public Health Clinic - 620 W. Harvard 933-5505
- Santa Paula Hospital - 825 N. 10th St 933-8600

Ventura
- Clinicas del Camino Real - (dental & medical)
  200 S. Wells Rd 647-6322
- Public Health Clinic - 3147 Loma Vista Rd
  1-888-285-5012

MENTAL HEALTH
- Crisis Team - 24 hours 1-866-998-2243
- Rise Team / OD line 981-4233
- Mental Health Liaison 981-4227
  Bilingual Liaison 981-3331

- NAME (support / advocacy)
  5251 Verdugo Way #K, Camarillo 641-2426
- STAR (Access to Mental Health Svcs) ... 1-866-998-2243
- Turning Point Foundation
  New Visions Center 1065 E. Main, Ventura 652-0596
  Oxnard Club House - 426 W. 5th St. 247-0750
- Ventura County Mental Health Services
  4258 Telegraph Rd, Ventura 477-5700
  1911 Williams Drive, Oxnard 981-4200
  2500 S. "C" St. #C, Oxnard 385-9420
  333 W. Harvard Blvd, Santa Paula 933-8480

SENIOR CITIZENS SERVICES
- 24-hour Helpline .... dial 211
- Adult Protective Services (abuse/neglect) ... 654-3200
- Area Agency on Aging
  646 County Square Dr. #100, Ventura 477-7300
- Mental Health, Older Adult Services 777-3500
- Ombudsman Services (visit nursing homes) 656-1986
- Senior Nutrition (meal site information) 477-7300

SHELTERS
Domestic Violence Shelters:
- Coalition for Family Harmony 656-1111
  Spanish Hotline 1-800-300-2181
- Interface Children & Family Services 1-800-636-6738

Year-Round Shelters
- Rescue Mission - (men only) 234 E. 6th St, Oxnard 487-1234
- Turning Point Foundation - Our Place Shelter (mentally ill)
  538 E. Thompson Blvd, Ventura 652-2151
- Lighthouse - (women & children) 385-7200
- Women's Shelter/Kingdom Center, Oxnard ... 487-3445

Winter Shelters - (December - March)
- Ojai Valley Family Shelter - for info 804-7094
- West County Winter Shelter - for info 385-1800

SHOWERS/TOILETS
- Community Action Program of Ventura County
  621 Richmond, Oxnard 436-4000
- Our Place Shelter (mentally ill)
  538 E. Thompson Blvd, Ventura 652-2151
- Rescue Mission - 234 E. 6th St, Oxnard 487-1234

TRANSITIONAL HOUSING
- City Center - 837 E. Thompson Blvd, Ventura 628-9035
- Kingdom Center (Gabriel's House)
  1450 Rose Ave, Oxnard 487-3445
- Lighthouse Family Center, Oxnard 385-7200
- Lutheran Social Services TLC 497-6207
- RAIN Transitional Living Ctr, Camarillo - (families & singles)
  389-1308
  Call for an application 383-7505
- Salvation Army (families/single women) Ventura ... 648-4977
- Tender Life Maternity Home 653-7474

- Turning Point Countywide Supported Housing -
  Wooley House (Oxnard) 652-0596
  River Haven (Ventura) 652-2151
- Veterans Transitional Housing (Ventura) ... 652-0000x102

VETERANS' SERVICES
- County of Ventura Veteran Services
  5740 Ralston Street, #340, Ventura 477-5155
- Department of Veterans Affairs - Outpatient Clinic
  Veterans Center - Counseling Svcs Mon-Fri 8 am - 4:30 pm
  4440 Calle Real, Santa Barbara .... (805) 683-1491
- Disabled Veterans Outreach (EDD)
  635 S. Ventura Rd, Oxnard 382-8626
- Oxnard VA Outpatient Clinic
  2000 Outlet Center Dr. #225, Oxnard 604-6960
- Ventura Vet Center (Counseling)
  790 E. Santa Clara St #1000 585-1860
- Veteran's Home of Ventura
  10900 Telephone Rd, Ventura 659-7502
- Veterans Transitional Housing (Ventura) ... 652-0000 x102

YOUTH SERVICES
- Interface Youth Crisis Line / Shelter 469-5882
- Independent Living Prog (former Foster Youth) ... 654-3245
- Interface Youth Svcs Drop-In Center - Mon-Fri 2 - 6 p.m.
  260 W. 4th St, Oxnard 469-5882
- Pacific Clinics, Transition Aged Youth (TAY Tunnel)
  141 W. 5th St. #D, Oxnard 240-2538
- Teen Runaway Helpline 1-800-RUN-AWAY
- Transitions (VC Behavioral Health) ... 1-866-998-2243

Most of the agencies listed can offer only limited, temporary assistance, depending on available funds. Refer to the Eastern Ventura County Resources brochure for resources available in other regions of the County.

COUNTY OF VENTURA
This brochure was prepared by:
County of Ventura - Human Services Agency
Homeless Services Program
(805) 385-1800
www.vchsa.org

56-z5-076 (5/16)

Resources
for Homeless People
Western Ventura County

Camarillo • Fillmore • Ojai • Oxnard
Port Hueneme • Santa Paula • Ventura

This information current as of
May 2016

ALCOHOL & DRUG SERVICES
- 24-hour Helpline .... dial 211
- County Alcohol / Drug Line 981-8200
- Alcoholics Anonymous - countywide information
  389-1444
  Español (Spanish) 988-0329
- Al-anon 495-0270
- Oxnard Center - 1911 Williams Dr 981-9200
- Ventura Center - 24 E. Main St. 652-6919
- Khepera House - 330 N. Ventura Ave, Vta 653-2596
- Lighthouse Recovery 385-7200
- New Start for Moms - 1911 Williams St, Ox .. 981-9250
- Palmer Drug/Alcohol Abuse Program 482-1265
- Prototypes (women/children) 382-6296
- Rescue Mission (men) - 234 E. 6th St, Ox 487-1234
- Teen Challenge 648-1295
- Victory Outreach 988-4102

BENEFITS
- Human Services Agency (CalWORKs, General Relief,
  CalFresh [Food Stamps], Medi-Cal)
  Oxnard, Port Hueneme, Camarillo
  1400 Vanguard Dr, Oxnard 385-9363
  Santa Paula - 725 E. Main 933-8300
  Fillmore - 828 Ventura St. #200 524-8666
  Ventura & Ojai
  4651 Telephone Rd. #100, Ventura 658-4100
- Social Security - registration 1-800-772-1213
  Oxnard - 2000 Outlet Center Dr #250
  Ventura - 6477 Telephone Rd. #1
  Monday – Friday 9 a.m. - 3:30 p.m.
- Unemployment Benefits Claims
  English 1-800-300-5616
  Spanish 1-800-444-7275

BUS
- ADA / Dial-a-Ride 583-6464
- Gold Coast Transit - countywide transportation
  information 1-800-438-1112
- Camarillo Area Transit 988-4228
- Greyhound Bus - 201 E. 4th St, Oxnard 487-2707
  Information 1-800-231-2222
- Gold Coast Transit
  Oxnard 487-4222
  Ventura 643-3158

CAMPGROUNDS
- County Park Information 654-3951
- State Park Information 1-800-444-7275/968-1033
  Camping
  Fillmore - Kenny Grove - 823 N. Oak 524-0750
  Ojai - Lake Casitas - 11311 Santa Ana Rd. ... 649-2233
  Santa Paula - Steckle Park
  8080 Mistletoe Rd. 654-3951

- **Short-Term Camping** (14 days maximum)
  Ojai - Camp Comfort - 11969 N. Creek Rd 654-3951
  Oxnard - McGrath State Beach, 2211 Harbor Blvd
  Ventura -
  Emma Wood - Rincon Parkway, Hwy 1 654-8444
  Faria Beach - 4350 W. PCH 654-3951
  Hobson Park - 5210 W. PCH 654-3951
  Lake Casitas - 11311 Santa Ana Rd 649-2233
  Ventura Beach Resort - 800 W. Main St 643-9137

CHILDREN'S SERVICES
- Children's Crisis Team 1-866-431-2478
- Child Development Resources (CDR) (childcare, Head Start
  Preschool) 485-7878
- Children & Family Services (abuse/neglect, adoption, foster
  care) 654-3200
- Children's Dental 981-5281
- Children's Mental Health (access line) 1-800-671-0887
- County Schools Homeless Education Project 437-1526
- School on Wheels (tutoring/supplies) ... 1-800-923-1100

CITIZENSHIP/IMMIGRATION
- El Concilio Del Condado - 301 S. "C" St, Ox....486-9777 x232

DENTAL
- Children - referrals from CHDP 981-5291
- Clinicas Del Camino Real (fee for services) -
  Oxnard - 650 Meta St. 487-5351
  Ventura - 200 S. Wells Rd. 659-0560
- Oxnard Dental Group 278-9499
- Salvation Army Free Clinic - 622 W. Wooley Rd, Oxnard
  (call for appointment) 483-9235

DISABLED PERSONS
- Department of Vocational Rehabilitation
  1701 Pacific Ave. #120, Oxnard 385-2400
- Independent Living Resource Center
  1802 Eastman Ave. #112, Ventura 650-5993
- Tri-Counties Regional Center
  2401 E. Gonzales Rd. #100, Oxnard 485-3177

DOMESTIC VIOLENCE
- Adult Abuse & Neglect 654-3200
- Child Abuse & Neglect 654-3200
- Coalition for Family Harmony 656-1111
- Interface Children & Family Services 1-800-636-6738

DROP-IN SERVICES
- Community Action Program of Ventura County
  621 Richmond, Oxnard 436-4000
- Community Assistance Program - 108 Fox St, Ojai ... 640-3320
- One Stop Centers 652-6111
  Ox - CAP, 621 Richmond Ave. (Wed 8:30-11:30)
  Vta - Public Health Auditorium, 3147 Loma Vista (Tue10-1)

EMPLOYMENT/JOB TRAINING
- California Conservation Corps (18-25 yrs.) 278-2787
- Candelaria (Native Americans)
  1445 Donlon St. #18, Ventura 650-8352
- Center for Employment Training (CET) - 761 S. "C" St, Oxnard
  487-9821
- Community Action Agency - 621 Richmond, Oxnard .. 436-4000
- Employment Development Department (EDD)
  1400 Vanguard Drive, Oxnard 382-8610
- Employee Aptitude & Placement
  660 N. Ventura Ave, Ventura (M-F 9-11 a.m.) ... 648-5868
- Fillmore Community Service Center - 828 W. Ventura St,
  Fillmore 933-8300
- Goodwill Industries - 130 Lombard St, Oxnard 981-0130
- Job Corps (16-24 yrs.) 1-800-733-5627
- Labor Finders - 3431 Telegraph Rd, Ventura 650-6964
- Labor Ready - 731 St. Marys Dr, Oxnard 988-4650
  1963 E. Main St, Ventura 477-0418
- Santa Clara Valley Job & Career Center
  725 E. Main St, Santa Paula 933-8300
- Unemployment Benefit Claims - English ... 1-800-300-5616
  Spanish 1-800-326-8937
- Ventura Job & Career Center - 4651 Telephone Rd ... 654-3434
- Oxnard Job & Career Center - 1400 Vanguard Dr. ... 204-5100
- Workforce Development Board (WDB)
  1400 Vanguard Dr, Oxnard 204-5100

FOOD (also see Meals)
- FOOD Share - countywide food pantry info 983-7100
  Ojai
- Community Assistance Program - 108 Fox St ... 640-3320
  Oxnard
- Catholic Charities - 402 N. "A" St 486-2900
- Community Action of Ventura Co - 621 Richmond 436-4000
- Salvation Army (call first) - 622 W. Wooley Rd. ... 483-9235
- St. John's Outreach - 535 Cooper Rd. (pre-register) . 988-2651
  Santa Paula
- Community Assistance of Santa Paula (CASP)
  133 N. Mill St. (Monday) 525-8890
- Spirit of Santa Paula (Call first) 340-5025
  Ventura
- Catholic Charities - 303 N. Ventura Ave 643-4694

HOMELESS & HOUSING SERVICES
- Catholic Charities - 303 N. Ventura Ave, Ventura ... 643-4694
  402 N. "A" St, Oxnard 486-2900
- Cabrillo Economic Development Corporation
  (affordable housing) 659-3791
- Community Action Program
  621 Richmond, Oxnard 436-4000
- Housing Rights Center 1-800-477-5977
- HSA Homeless Services Program 385-1800
- HPRP Homeless Prevention & Rental Deposit ... 385-8585

- Many Mansions - Housing Central 497-0344
- Project Understanding
  2734 Johnson Dr, Ventura 652-1326
- St. Vincent de Paul 754-2089
- The Salvation Army, Safe Sleep Ventura 648-5032
- Turning Point Foundation (mentally ill)
  538 E. Thompson Blvd, Ventura 652-2151

HOUSING AUTHORITIES
(No emergency housing provided)
- Housing Rights Center 1-800-477-5977
- Area Housing Authority (Ojai & unincorporated areas)
  1400 W. Hillcrest Dr, Newbury Park 480-9991
  or 1-800-800-2123
- Oxnard Housing Authority - 1470 Colonia Rd.
  Public Housing 385-8114
  Sec 8 385-8097
- Port Hueneme Housing Authority
  250 N. Ventura Rd 986-6551
- Santa Paula Housing Authority
  15500 W. Telegraph Rd 525-3339
- Ventura Housing Authority
  Public Housing - 995 Riverside St 648-5008
  Section 8 - 11122 Snapdragon St, #100 647-5990

INFORMATION AND REFERRAL
Dial 211 for info 24 hours/7 days/week about Community
Resources near you
- Area Agency on Aging (seniors) 477-7300
- County of Ventura 1-800-660-5474
- Homeless Services Program Info 385-1800

LAUNDRY
- Community Action Program of Ventura County
  621 Richmond, Oxnard 436-4000
- Community Assistance Program
  108 Fox St, Ojai .... (805) 640-3320
- Laundry of Love V.C.
  Mission Plaza - 110 N. Olive - 1st Tues 5:30 - 8 p.m.
  Quik Wash - 9298 Telephone Rd. - 2nd Tues 5 - 7 p.m.
  2611 E. Thompson Blvd. - 3rd Tues 5:30 - 8 p.m.
- Turning Point Foundation (mentally ill)
  536 E. Thompson Blvd, Ventura 652-2151

LEGAL SERVICES
- California Bar Assn. Legal Clinic - (family law /tenant /
  landlord / bankruptcy) - Mon. - Fri. 650-7599
- California Rural Legal Assistance
  338 S. "A" St, Ox 483-8083
- Grey Law (60 yrs.+)
  290 Maple Ct #128, Ventura 658-2266
- Housing Rights Center 1-800-477-5977
- Jewish Family Services
  1915 E. Main St, Ventura 641-6565
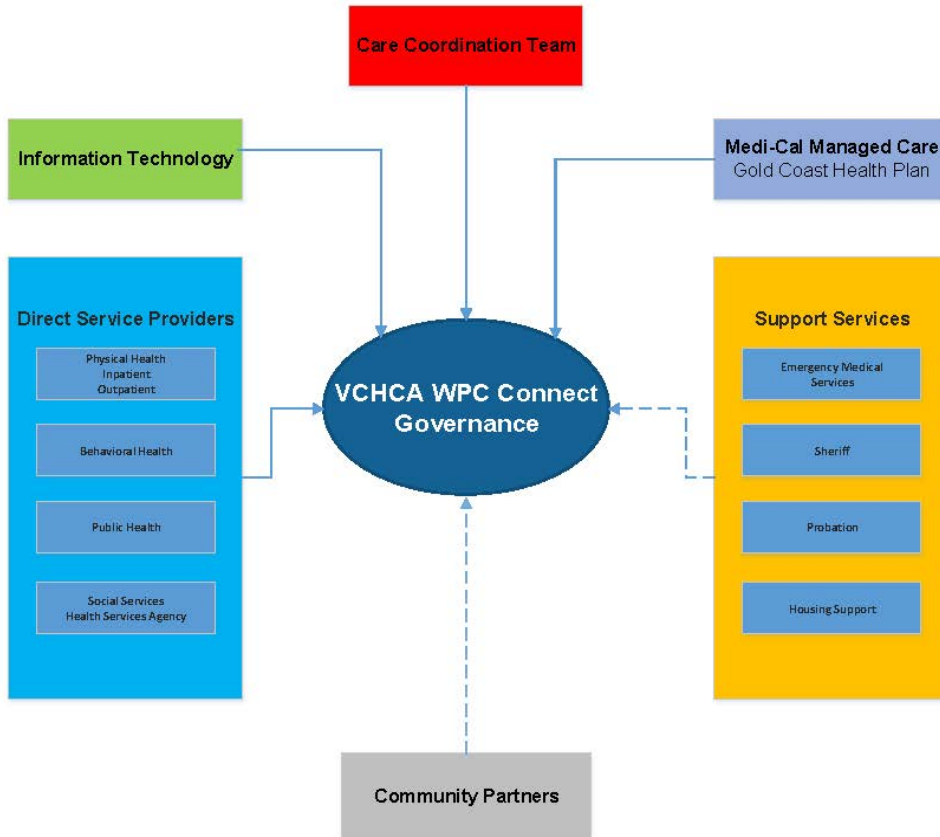
Attachment F VC WPC Identification and Enrollment Process

Gold Coast Health Plan High Utilizer Claims Data

Initial Data

Load Gold Coast High Utilizer Data File
- All Ventura County members eligible, not only those assigned to VCHCA
- Lists number of admits, ED visits and ancillary utilizations
- Categorical costs

VCHCA Collaborative Data Analytics for identifying TP

Data Analytics

Identify potential WPC patients based on target population criteria:
- High Utilizing Members - Repeated incidents of emergency use and/ or hospital admissions
- Collaborative identification for common patients across multiple county organizations
    Hospitals (VCMC, SPH); VCHCA clinics; VC Behavioral Health; VC Public Health clinics; VC Human Services Agency; Input from VC Law Enforcement and EMS

Risk Stratification Process

Target Population Identification

Frequent Impact Commonalities in the HUMS:
- Currently or recently experiencing homelessness
- Diagnosed with a mental health disorder
- Substance abuse
- Multiple chronic conditions

Based on data, high utilizer population had high instance of these commonalities.
Target population: *High utilizers who suffer from at least 1 of the commonalities.*

VC WPC Patient Repository

Defined Target Population

Defined TP uploaded into a common platform for Medical, Behavioral, and Social Services to access and develop an integrated care plan

Comprehensive Assessment

Vulnerability Index

Weighted Vulnerability Index Used to Assess Population Scoring:
- 3 points: condition with significant threat to life or public health
- 2 points: major condition with increased potential for harm
- 1 point: health concern requiring management

Enrollment

Universal Consent Form

Outreach

At Visits

Attachment G: Data Sharing Structure

Attachment G: Data Sharing Structure
The figure is a flow chart that has two entry points and shows connections between activities, resources, and data warehousing. Here the flow chart steps and linkages are represented as lists.

The flow chart has two different starting points, presented here as separate lists with numbered links. When a step has more than one possible next step or linkage, they are listed beneath it.
Entry Point A.
1. Gold Coast Eligibility
2. Information and Outreach
3. Risk Stratification, with an arrow leading down to
        a. Whole Person Care Platform box. Inside the box are three small boxes:
                i. Member Repository
                ii. Care Coordination
                iii. Data Repository

4. An arrow from the Whole Person Care Coordination Platform leads upward to the top of a set of nested and linked lists entitled "Ventura County Whole Person Care Collaborative." Connections between activities, resources, and systems are shown with nested information boxes, and arrows. The Ventura County Whole Person Care Collaborative Box contains two information sets:

        a. Whole Person Care Administration Functions includes:
                i. Collaborative coordination
                ii. Administration and Management
                iii. Analytics and Reporting
                iv. Plan-Do-Study-Act and Continuous Improvement

        b. Care Coordination Team contains four primary care activities, that are linked to relevant data tools and community resources.
                i. Primary Care and Psychiatry.
                        1. A two-way arrow links this to Data Wharehousing.
                        2. A two-way arrow links this to Medical and Psychiatric Network Resources.
                ii. Care Management (Registered Nurse, Social Worker, Behavioralist, Dependency Specialist)
                        1. A two-way arrow links this to Data Warehousing.
                        2. A two-way arrow links this to Care Management Network Resources.

                iii. Community Health Worker, Emergency Medical Services
                        1. A two-way arrow links this to Data Wharehousing.
                        2. A two-way arrow links this to Community Outreach Network Resources.

                iv. Community Based Organizations

1. A two-way arrow links this to Community Based Network Resources.

5. A two-way arrow leads from the Ventura County Whole Person Care Collaborative box to another list at the lower left:
   a. A cylindrical form holds the words Data Warehousing at the top. It is followed by four boxes:
      i. Electronic Health Record
      ii. Utilization and Outcomes Monitoring System
      iii. Health Registry
      iv. Care Coordination Platform

6. A two-way arrow connects the Ventura County Whole Person Care Collaborative box to an Integrated Care Plan list at the bottom that includes:
   a. Vulnerability Index
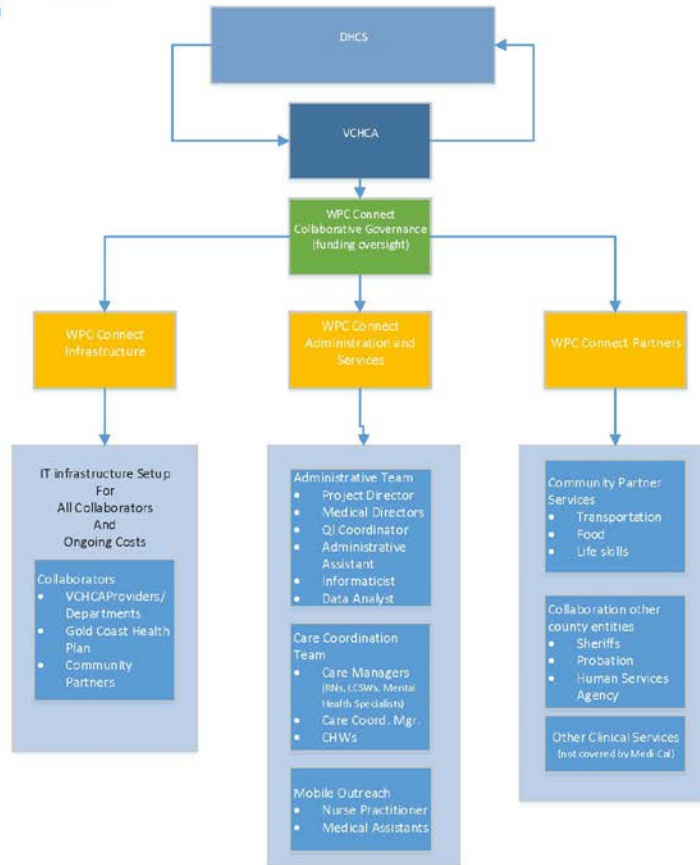   b. Sub-care Plans
   c. Goals/Needs
   d. Tasks/Referrals
A one-way arrow leads from this list box to the Data Warehousing cylinder to its left.

Entry Point B.
1. Patient Adverse Encounter with Field Worker, Emergency Department, Behavioral Health Emergency Department, Hospital.
2. HL7 ADT Interface is in a cloud-shaped form. Above it are the words "Visit Information sent via interface." Below it a broken line leads downward to three icons:
   a. Gold Coast Eligibility
   b. Notify Gold Coast of Member Hospital Event
   c. Gold Coast Health Plan.
3. An arrow connects HL7ADT to the
   a. Whole Person Care Platform box. Inside the box are three small boxes:
      i. Member Repository
      ii. Care Coordination
      iii. Data Repository

4. An arrow from the Whole Person Care Coordination Platform leads upward to the top of a set of nested and linked lists entitled "Ventura County Whole Person Care Collaborative." Connections between activities, resources, and systems are shown with nested information boxes, and arrows. The Ventura County Whole Person Care Collaborative Box contains two information sets:

   a. Whole Person Care Administration Functions includes:
      i. Collaborative coordination
      ii. Administration and Management
      iii. Analytics and Reporting
      iv. Plan-Do-Study-Act and Continuous Improvement

b. Care Coordination Team contains four primary care activities, each of which is linked to data tools and community resources. All are linked to the care plan activities list.
  i. Primary Care and Psychiatry.
    1. A two-way arrow links this to Data Warehousing.
    2. A two-way arrow links this to Medical and Psychiatric Network Resources.
  ii. Care Management (Registered Nurse, Social Worker, Behavioralist, Dependency Specialist)
    3. A two-way arrow links this to Data Wharehousing.
    4. A two-way arrow links this to Care Management Network Resources.
  iii. Community Health Worker, Emergency Medical Services
    3. A two-way arrow links this to Data Wharehousing.
    4. A two-way arrow links this to Community Outreach Network Resources.

  iv. Community Based Organizations
    2. A two-way arrow links this to Community Based Network Resources.

5. A two-way arrow leads from the Ventura County Whole Person Care Collaborative box to another list at the lower left:
  b. A cylindrical form holds the words Data Warehousing at the top. It is followed by four boxes:
    i. Electronic Health Record
    ii. Utilization and Outcomes Monitoring System
    iii. Health Registry
    iv. Care Coordination Platform

6. A two-way arrow connects the Ventura County Whole Person Care Collaborative box to an Integrated Care Plan list at the bottom that includes:
  a. Vulnerability Index
  b. Sub-care Plans
  c. Goals/Needs
  d. Tasks/Referrals
A one-way arrow leads from this list box to the Data Warehousing cylinder to its left.

VCHCA WPC Connect – Funding Diagram

DHCS

VCHCA

WPC Connect Collaborative Governance (funding oversight)

WPC Connect Infrastructure

WPC Connect Administration and Services

WPC Connect Partners

IT infrastructure Setup
For
All Collaborators
And
Ongoing Costs

Collaborators
- VCHCA Providers/ Departments
- Gold Coast Health Plan
- Community Partners

Administrative Team
- Project Director
- Medical Directors
- QI Coordinator
- Administrative Assistant
- Informaticist
- Data Analyst

Care Coordination Team
- Care Managers (RNs, LCSWs, Mental Health Specialists)
- Care Coord. Mgr.
- CHWs

Mobile Outreach
- Nurse Practitioner
- Medical Assistants

Community Partner Services
- Transportation
- Food
- Life skills

Collaboration other county entities
- Sheriffs
- Probation
- Human Services Agency

Other Clinical Services (not covered by Medi-Cal)

Ventura County Legacy Lead Entity
WPC Budget Template: Summary and Top Sheet

WPC Applicant Name: Ventura County Health Care Agency

	Federal Funds *(Not to exceed 90M)*	IGT	Total Funds
Annual Budget Amount Requested - Original PY1	9,783,769	9,783,769	19,567,538
Annual Budget Amount Requested - Revised PY 2	10,492,494	10,492,494	20,984,988
Annual Budget Amount Requested - Revised PY 3-5	11,201,219	11,201,219	22,402,437

2nd Round

PY 1 Budget Allocation (Note PY 1 Allocation is	
PY 1 Total Budget	19,567,538
Approved Application (75%)	14,675,654
Submission of Baseline Data (25%)	4,891,884
PY 1 Total Check	OK

PY 2 LTD Budget Allocation	
PY 2 Total Budget	11,201,219
Administrative Infrastructure	1,357,360
Delivery Infrastructure	1,095,206
Incentive Payments	487,988
FFS Services	327,705
PMPM Bundle	2,236,737
Pay For Reporting	1,875,000
Pay for Outcomes	3,112,500

PY 2 Budget Allocation	
PY 2 Total Budget	20,984,988
Administrative Infrastructure	2,714,719
Delivery Infrastructure	2,190,412
Incentive Payments	975,975
FFS Services	655,409
PMPM Bundle	4,473,473
Pay For Reporting	3,750,000
Pay for Outcomes	6,225,000
PY 2 Total Check	OK

PY 3 Budget Allocation	
PY 3 Total Budget	22,402,437
Administrative Infrastructure	2,325,664
Delivery Infrastructure	1,922,132
Incentive Payments	1,954,950
FFS Services	793,861
PMPM Bundle	7,155,831
Pay For Reporting	2,500,000
Pay for Outcomes	5,750,000
PY 3 Total Check	OK

PY 4 Budget Allocation	
PY 4 Total Budget	22,402,437
Administrative Infrastructure	2,317,864
Delivery Infrastructure	1,329,932
Incentive Payments	1,954,950
FFS Services	793,861
PMPM Bundle	7,155,831
Pay For Reporting	2,500,000
Pay for Outcomes	6,350,000
PY 4 Total Check	OK

PY 5 Budget Allocation	
PY 5 Total Budget	22,402,437
Administrative Infrastructure	2,317,864
Delivery Infrastructure	1,329,932
Incentive Payments	1,954,950
FFS Services	793,861
PMPM Bundle	7,155,831
Pay For Reporting	2,500,000
Pay for Outcomes	6,350,000
PY 5 Total Check	OK