1.1 Whole Person Care Pilot Lead Entity and Contact Person

Organization Name	County of San Diego, Health and Human Services Agency
Type of Entity (from lead entity description above)	County
Contact Person	Nick Macchione, FACHE*
Contact Person Title	Director, Health and Human Services Agency
Telephone	(619) 515-6545
Email Address	Nick.Macchione@sdcounty.ca.gov
Mailing Address	1600 Pacific Highway, Suite XX San Diego, CA 92101

*For technical questions, please contact:
Susan Bower, MSW, MPH
Assistant Director, Integrative Services
(619) 338-2713
Susan.Bower@sdcounty.ca.gov

1.2 Participating Entities

Required Organization	Organization Name	Contact Name and Title	Entity Description and Role in WPC
1. Medi-Cal managed care health plan	Molina Healthcare	Kristin Garrett Montgomery, MPH/Associate Vice President, Market Leader	**Entity Description**: Medi-Cal Managed Care Plan serving San Diego **Role in WPC:** • Participate in Governance Structure and Communication Process • Assist in the development, implementation, evaluation, and sustainability plans • Provide data necessary for the identification of the target population, project implementation, operation and learning • Authorize Complex Care Managers to coordinate with the WPW System Integration Teams

Required Organization	Organization Name	Contact Name and Title	Entity Description and Role in WPC
2. Health Services Agency/ Department 3. Specialty Mental Health Agency/ Department	Health and Human Services Agency	Nick Macchione, FACHE/Director	**Entity Description:** Oversees health and human services for the region, including public health, behavioral health (including specialty mental health), housing and community development (the county's housing authority), child welfare, eligibility, aging and independent services **Role in WPC:** • Lead entity • Lead and facilitate the development of the pilot, implementation, evaluation, and sustainability plans • Procure and monitor contracted services • Provide overall coordination and monitoring of the project • Coordinate communication with the community and with partnering entities • Facilitate and staff project governance and oversight structures
4. Public Agency/ Department (if housing services are provided, must include the public housing authority)	San Diego Housing Commission	Melissa Peterman/Vice President Homeless Housing Innovations Department	**Entity Description**: City of San Diego's Housing Authority **Role in WPC:** • Participate in Governance Structure and Communication Process • Assist in the development of the pilot, implementation, evaluation, and sustainability plans • Support the pilot's efforts to link existing housing resources through the CAHP system • Identify new housing resources over the course of the pilot that can be linked to the System Integration Teams • Includes pilot's target population in landlord recruitment and engagement strategies

Required Organization	Organization Name	Contact Name and Title	Entity Description and Role in WPC
5. Community Partner 1	211 San Diego and the Community Information Exchange	Camey Christenson/Vice President of Business and Partnership Development	**Entity Description**: Resource and information hub that connects people with community health and disaster services. The Community Information Exchange allows for the sharing of data across social services and the healthcare arenas to facilitate care coordination. **Role in WPC:** • Participate in Governance Structure and Communication Process • Assist in the development of the pilot, implementation, evaluation, and sustainability plans • Add context that will help project partners achieve the triple aim of improved patient care experience, better outcomes and reduced cost • Participate in target population identification and engagement • Client tracking and outcome reporting
6. Community Partner 2	San Diego Health Connect	Debbie Kennedy/VP of Operations	**Entity Description**: Connects doctors, health care systems, clinics and other health stakeholders so they can share critical health information by delivering a Health Information Exchange (HIE) that serves the entire community. **Role in WPC:** • Participate in Governance Structure and Communication Process • Assist in the development, implementation, evaluation, and sustainability plans • Lead role in Management Committee WPW Partner Data Sharing Workgroup • Provide access to the HIE to the Clinical Review Team who prioritize the Pilot Participant List

Additional Organizations (Optional)	Organization Name	Contact Name and Title	Entity Description and Role in WPC
7. Medi-Cal Managed Care Plan 2	Community Health Group	Ann Warren/Chief Compliance and Regulatory Affairs	**Entity Description**: Medi-Cal Managed Care Plan serving San Diego **Role in WPC:** • Participate in Governance Structure and Communication Process • Assist in the development, implementation, evaluation, and sustainability plans • Provide data necessary for the identification of the target population, project implementation, operation and learning • Authorize Complex Care Managers to coordinate with the WPW System Integration Teams
8. Medi-Cal Managed Care Plan 3	Care 1st	Kimberly Fritz/GMC Administrator, San Diego	**Entity Description**: Medi-Cal Managed Care Plan serving San Diego **Role in WPC:** • Participate in Governance Structure and Communication Process • Assist in the development, implementation, evaluation, and sustainability plans • Provide data necessary for the identification of the target population, project implementation, operation and learning • Authorize Complex Care Managers to coordinate with the WPW System Integration Teams
9. Medi-Cal Managed Care Plan 4	Health Net	Abbie Trotten/Director, Government Programs, Policy Strategies, Initiatives	**Entity Description**: Medi-Cal Managed Care Plan serving San Diego **Role in WPC:** • Participate in Governance Structure and Communication Process • Assist in the development, implementation, evaluation, and sustainability plans • Provide data necessary for the identification of the target population, project implementation, operation and learning • Authorize Complex Care Managers to coordinate with the WPW System Integration Teams

Additional Organizations (Optional)	Organization Name	Contact Name and Title	Entity Description and Role in WPC
10. Medi-Cal Managed Care Plan 5	Kaiser	Ann Thompson, RN, MBA/State Programs Manager	**Entity Description**: Medi-Cal Managed Care Plan serving San Diego **Role in WPC:** • Participate in Governance Structure and Communication Process • Assist in the development, implementation, evaluation, and sustainability plans • Provide data necessary for the identification of the target population, project implementation, operation and learning • Authorize Complex Care Managers to coordinate with the WPW System Integration Teams
11. Medi-Cal Managed Care Plan 6	United Healthcare	William W Henning, DO/ Chief Medical Officer	**Entity Description**: Medi-Cal Managed Care Plan serving San Diego **Role in WPC:** • Participate in Governance Structure and Communication Process • Assist in the development, implementation, evaluation, and sustainability plans • Provide data necessary for the identification of the target population, project implementation, operation and learning • Authorize Complex Care Managers to coordinate with the WPW System Integration Teams
12. Medi-Cal Managed Care Plan 7	Aetna	Jeffrey Dziedzic/ Implementation Chief Operating Officer	**Entity Description**: Medi-Cal Managed Care Plan serving San Diego **Role in WPC:** • Participate in Governance Structure and Communication Process • Assist in the development, implementation, evaluation, and sustainability plans • Provide data necessary for the identification of the target population, project implementation, operation and learning • Authorize Complex Care Managers to coordinate with the WPW System Integration Teams

Additional Organizations (Optional)	Organization Name	Contact Name and Title	Entity Description and Role in WPC
13. Public Agency/ Department 2	Public Safety Group	Dorothy Thrush/Chief Operating Officer	**Entity Description**: The County group that provides regional leadership for public safety and criminal justice administration, with an emphasis on collaborative, evidence-based and community-focused programs and practices. **Role in WPC:** • Participate in Governance Structure and Communication Process • Assist in the development of the pilot, implementation, evaluation, and sustainability plans • Participate in data sharing as feasible to measure outcomes and measure the effectiveness of interventions
14. Community Partner 3	Alliance Healthcare Foundation	Nancy Sasaki/CEO	**Entity Description**: Philanthropic foundation that works to advance the health and wellness for the most vulnerable – the poor, working poor, children and homeless in San Diego and Imperial Counties. **Role in WPC:** • Participate in Governance Structure and Communication Process • Assist in the development of the pilot, implementation, evaluation, and sustainability plans • Disseminate information about the project to other members of the philanthropic community
15. Community Partner 4	Legal Aid Society/Center for Consumer Health Education and Advocacy	Greg Knoll/Executive Director and Chief Counsel	**Entity Description**: Helps educate the community about health care benefits, and advocates to improve health care systems as a whole. **Role in WPC:** • Participate in Governance Structure and Communication Process • Assist in the development of the pilot, implementation, evaluation, and sustainability plans • Assisting in identifying gaps in services and addressing challenges identified through the Pilot

Section 2: General Information and Target Population

2.1 Geographic Area, Community and Target Population Needs

Community Description and Need: San Diego County includes 3.3 million residents and encompasses 4,526 square miles. In 2015, San Diego County ranked fourth in the nation in the number of individuals experiencing homelessness. Recently on a single night in January 2016, 8,692 people were homelessness with 57% living outside. Of the unsheltered, 1,087 were identified as chronically homeless. Data from San Diego's Homeless Management Information System (HMIS) revealed that 10,642 homeless single adults served in any part of the homeless assistance system in 2015 reported being enrolled in Medi-Cal. San Diego County's experience with the Low Income Health Program (LIHP), our "Bridge to Reform" that preceded Medi-Cal expansion, showed that homeless individuals accounted for 19% of the total costs while representing only 13% of the total LIHP population. In addition, the LIHP data identified a small concentration of very expensive homeless patients with most having a mental illness and at least one other chronic condition. The high cost of housing in the region contributes to housing instability and risk of homelessness, especially among individuals with a mental health condition or substance use disorder. In 2015, Zillow ranked San Diego one of the six most unaffordable markets in the US. According to the 2014 American Community Survey, 55% of San Diego renters are rent-burdened which places them at significant risk for homelessness.

Project Background and Scope: As lead entity, the County of San Diego's Health and Human Services Agency (HHSA) will operate the Whole Person Care pilot, which reflecting our focus on wellness will be known locally as the Whole Person Wellness (WPW) Pilot. The pilot will provide an opportunity to develop a systematic and comprehensive approach to addressing Medi-Cal beneficiaries who are high-cost, frequent users of Emergency Departments and/or inpatient services, and are currently experiencing homelessness or are at risk of homelessness. In addition, the target population will have one or more of the following conditions: serious mental illness (SMI), substance use disorder and/ or a chronic physical health condition. It is anticipated that at least 1000 clients will be served over the pilot period.

The following factors demonstrate San Diego's readiness for a project of this nature and scope:

1. **Alignment with Regional Vision:** San Diego has adopted an overall framework, *Live Well San Diego,* to drive collective efforts to create a region that is healthy, safe and thriving for all residents. In addition to fully aligning with *Live Well San Diego,* WPW fully supports the Regional Continuum of Care Council's (RCCC) mission and goals of using a Housing First approach to find a permanent home for our most vulnerable residents. Recognizing the need to ensure housing and service integration for people with serious mental illness, the Board of Supervisors established Project One for All (POFA), a County initiative with the goal that 100% of people with SMI and experiencing homelessness will be housed with intensive wraparound services. POFA has galvanized both the health and housing sectors to work together to braid housing and services, recognizing someone cannot achieve health without a home. POFA will be leveraged with the WPW Pilot.

2. **Past and Current Efforts with Similar Populations:** The WPW Pilot leverages past and current efforts to provide services to the costliest individuals while decreasing costs of the health care and criminal justice systems. Project 25, a pilot program funded through United Way, the City of San Diego, and the County from 2011 to 2015, has had tremendous success. An evaluation conducted by Point Loma Nazarene University highlighted that the 28 participants cost the

community $3.5 million in the year prior to enrollment and that by the conclusion of Year 2, costs had decreased by 72% and produced an overall net savings of $3.7 million. In 2015, Project 25 expanded to serve high-cost, high utilizing homeless members referred and funded by four of the local Medi-Cal Managed Care Health Plans (MCP's) participating in this WPW Pilot. In addition to Project 25, San Diego has rich experience in coordinating community- based care through participation as one of seven counties in the CCI Cal Medi-Connect program for dual eligible beneficiaries. .

3. **Ongoing Engagement of Cross Sector Stakeholders**: Building on initial community-wide planning that began in Fall 2014, the County of San Diego assembled a Pilot Planning Group with participation of all partners to prepare this proposal. The WPW Pilot will operate countywide working in conjunction with all seven of the region's MCPs. The County's Public Safety Group, in coordination with the Sheriff's Department, the District Attorney's Office, the Probation Department and others, will also be a key partner. Additionally, the County's Department of Housing & Community Development (HCD) and the San Diego Housing Commission (SDHC) are both on board as project partners. Together, these agencies manage the majority of affordable housing resources within the region. These cross-sector stakeholders will all be actively involved in the Governance Structure for Whole Person Wellness.

4. **Innovative Client-Focused Design:** The County of San Diego proposes an innovative design for the WPW Pilot through which newly created Service Integration Teams (SITs) will collaborate with WPW partners to facilitate delivery of the following approaches:
    - **Housing First (HF)** – the pilot will use an HF orientation to rapidly move individuals experiencing homelessness from the street, emergency shelter or unstable housing into permanent housing without the expectation to address sobriety or treatment adherence. Housing resources will be linked to the pilot through San Diego's coordinated entry system that prioritizes housing interventions based on acuity.
    - **Linkage to Primary Care Providers** – clients will be provided with timely, comprehensive and continuous medical care, including an immediate connection to a primary care provider, with the goal of supporting optimal health outcomes.
    - **Community Care Integration and Wraparound Services** – ensuring that clients have all of the professional services and natural supports they need to maintain housing stability and address social determinants of health.
    - **IT System Infrastructure –** creating a comprehensive integrated care plan model across systems for efficient and effective utilization of resources with a client- centered approach.

2.2 Communication Plan

The governance and communication plan for the WPW Pilot lays the foundation for a collaborative approach to decision making that supports effective project implementation and sustainability. County HHSA will have responsibility and authority for the project and will be the point of contact for other participating entities.

Planning and governance: An infrastructure consisting of an Advisory Council (AC) and Management Committee (MC) will implement decision making and communication strategies to minimize silos. Key representatives from partner organizations will meet monthly through Year 2 and then at least quarterly thereafter. Chaired by HHSA, AC will be responsible for: further defining and formalizing the shared vision for the pilot (assessing partner capabilities, infrastructure and system gaps); identifying and resolving challenges that can hinder progress; ensuring that project learnings are captured and articulated: and

identifying strategies for long term sustainability. The AC will assist the County in the procurement process to select the contractor/s to deliver pilot services and to ensure that state requirements are clearly articulated and addressed.

A separate MC will be created. The MC will be comprised of individuals responsible for implementing the vision and plan developed by the AC, and will include representation from each of the partnering entities. This group will meet at least monthly beginning in the Fall of Project Year 1. Separate working groups of the MC will be established to make decisions and communicate around specific project elements such as Clinical Review/Client Identification and Data Governance/Technology. The MC will be responsible for generating mid-year and annual reports.

Communication: Information about the pilot will be disseminated broadly via web postings and updates, press releases and interviews with local print, radio and television media. Summaries about participation and outcomes will be shared with service networks and partner organizations and will leverage the communication infrastructure offered by RCCC and *Live Well San Diego*. At the project level, Service Integration Teams (SITs) and data sharing mechanisms will serve to reduce silos and enhance communication.

Learning: HHSA will provide guidance and oversight for the implementation of a Community of Practice as well as a robust PDSA process that will examine WPW Pilot activities and provide recommendations for modifications and improvements. Representatives from partnering organizations will assist in the development of the PDSA processes and implementation. This process will result in documented learnings and feedback that will inform future efforts to scale up or replicate the project. See Training and Learning Plan provided within the Budget Narrative for an overview of how a Community of Practice will be supported.

Sustainability: The AC will establish a plan to articulate how the WPW Pilot can be sustained beyond the life of the program. San Diego County is unique in that our philanthropists have come together to create a funding pool in alignment with the values and direction of Funders Together to End Homelessness (a national organization). FTEH-SD has created a matrix of priorities they are interested in funding and believe are the highest priorities needed to make the systems change required to effectively end homelessness in San Diego County.

2.3 Target Population

Scope and Number: The target population for WPW will be Medi-Cal beneficiaries who are high-cost frequent users of ED and/or inpatient services identified by the Medi-Cal managed care plans, currently experiencing homelessness or at risk of homelessness as determined by linkage with San Diego's Homeless Management Information System (HMIS), and who have a mental health condition, a substance use disorder (SUD), or chronic physical health condition(s) determined through ICD-10 diagnostic information from the health plans and the County's mental health and substance use data bases. San Diego anticipates serving at least 1000 individuals over the course of the pilot.

Definition Methodology: San Diego triangulated the results from three different methodologies to estimate a population of approximately 1500 – 2000 individuals who would meet qualifying criteria as "high users". Given challenges related to documenting living situation, it is recognized that the prevalence of people experiencing homelessness in the analyses was underestimated.

1. Personally identified data from the County's mental health and substance use databases were merged with the Community Information Exchange (CIE) that included information on homeless individuals in Central San Diego. This analysis identified 1,679 individuals within this area of the County who were Medi-Cal beneficiaries, had a substance use disorder and/or Serious Mental Illness (SMI), and were homeless in 2015.
2. The complete claims database from San Diego's Low Income Health Program (LIHP), which HHSA operated and therefore had available, was analyzed for calendar year 2013. During the year, a total of 43,715 unduplicated patients received services, of whom nearly 6,000 were identified as homeless. "High-utilizers" were defined as individuals having paid claims of $20,000 or more with 5 or more ED visits or 3 inpatient admissions. A total of 1,299 individuals were identified, of whom 337 were homeless. Two-thirds of the total "high-utilizers" also had an SMI diagnosis.
3. Three MCP partners analyzed their claims databases to identify members who generated at least $40,000 in paid claims and had at least 5 ER visits or at least 3 inpatient hospitalizations in 2015. Through this review, a combined total of 1,487 unique individuals were identified across the three MCPs. Given the engagement of all seven MCPs (five current and two new), and the challenge of identifying individuals who are homeless or at-risk, the actual pool is likely to be significantly higher.

Plan for Identification and Outreach: The WPW Pilot defines a "high user" as an individual having more than $40,000 in Medi-Cal paid claims and at least 5 ED visits or 3 inpatient hospitalizations. The following exclusion criteria will also be applied using ICD codes that correlate to diagnosis of terminal illness (for example; terminal cancer, end-stage renal disease, and uncontrolled cirrhosis). The proposed methodology to identify the pool of potential individuals for enrollment will involve the following steps:

- Person- identified high user databases will be generated by each MCP that will include information on the existence of a mental illness, SUD, or chronic physical health conditions and if the individual is in an institutional setting, such as a Skilled Nursing Facility (SNF).
- The data will be merged with the HMIS system to identify individuals who are currently homeless or have recently accessed homeless services. The HMIS also contains results from the Vulnerability Index-Service Prioritization Decision Assistance Tool (VI-SPDAT), the region's common assessment tool that includes questions related to mental illness, SUD, and chronic physical health conditions in addition to questions related to living situation. The VI-SPDAT will assist in identifying the acuity of each individual.
- To identify those "at risk" of homelessness, the MCPs' high user data will be merged with County data systems to determine if an individual is currently in an institutional setting, such as jail, a psychiatric hospital or other mental health facility, or a substance use residential or detoxification program. At risk clients will also include those currently in SNF's who will not have stable housing at discharge and thus will become homeless.

The final list and accompanying data regarding each individual will be reviewed by a Clinical Review Team comprised of clinicians from the MCPs and HHSA to determine those individuals who will be prioritized for the pilot. Based on our current Targeted Case Management (TCM) model the WPW population is not eligible for TCM. As an additional safeguard to ensure no service duplication, the list will be reviewed by the County's TCM Coordinator and shared with the Medi-Cal managed care plans to prevent the outside possibility of enrolling beneficiaries who may be receiving TCM.

WPW SITs will use information provided by the Clinical Review Team, and assistance of the current network of Community Outreach Workers to locate potential clients. SITs will use best practice models such as Assertive Street Outreach, Motivational Interviewing, and Stage of Change Approach in order to build relationships with clients and overcome barriers to accepting services. It is anticipated that the majority of clients will enroll in the project within three months of intensive outreach. The budget narrative provides further description of WPW outreach and engagement efforts.

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

3.1 Services, Interventions, and Care Coordination

Care Coordination Roles and Linkages: HHSA will use a competitive procurement process to select an experienced community service organization to provide the Service Integration Teams (SITs), will oversee the performance of this contractor, and will guide the PDSA process (described in section 4.1). San Diego's network of providers represented through the partnering organizations, across health, housing, behavioral health, public safety and social service fields will support outreach and engagement, care coordination and housing support efforts. At the system design and planning level, networks will be linked through the AC, the RCCC, and the *Live Well San Diego* framework.

Care Coordination System and Approach: WPW Integrated care coordination services will be provided by 12 regionally based SITs. Each SIT will consist of 1 Social Worker (SW) and 1 Peer Support Specialist (PSS). These teams will be supported by 2 Registered Nurse (RN) Consultants, 4 Housing Navigators, a Project Manager, and analytic staff.

The primary goal of the SITs will be to help clients maintain stable housing and improve their health and quality of life by addressing their housing, health, mental health, substance use disorder and social service needs; engaging in meaningful activities; and building social and community relations. The SITs will achieve this goal by engaging clients, developing and monitoring a Comprehensive Care Plan (CCP) for each, and coordinating services across multiple systems, working collaboratively across all sectors in order to leverage services and avoid duplication of efforts.

The Pilot will tailor the intensity of services to the needs of each client rather than use a defined formula. However, the following phases represent an anticipated progression and have been used for planning and budgeting purposes:

> **Phase 1:** Estimated 1-3 months prior to enrollment: Intensive outreach and engagement resulting in enrollment;
> **Phase 2:** Months 1-3 of pilot enrollment: Intensive housing navigation, care coordination and development of CCP;
> **Phase 3:** Months 4-9 of pilot enrollment: Continued care coordination, monitoring of CCP, housing supports and tenancy sustaining services.
> **Phase 4:** Months 10-15 of pilot enrollment: Moderate care coordination etc.
> **Phase 5:** Months 16-27 of pilot enrollment: Lower level care coordination and follow-up.

See budget narrative for further detail on the components of each phase.

A caseload of 15-50 clients/SIT will be maintained with the greater ratio occurring when the caseload is comprised predominantly of clients who are in maintenance mode (Phases 4 and 5), and/or also engaged in POFA's Full Service Partnerships (FSP) that serve clients with serious mental illness who are

homeless.

Services Description:

- **Integrated care coordination:** The following services will be available to all clients as part of a comprehensive approach to care integration provided by the SITs:
  - The SW will conduct a comprehensive strengths-based assessment and trauma screening and will work with each client to develop an Integrated Comprehensive Care Plan (CCP).
  - The SW will access data portals, including ConnectWellSD, HIE, CIE, and the HMIS, to identify various services the client is involved with in order to coordinate care.
  - When appropriate as part of the CCP, the SWs will facilitate multidisciplinary team (MDT) meetings, inviting individuals who are working with their clients from other systems (MCP case manager, probation officer, substance use counselor, housing case manager, etc.) to work with the client to support goals that promote "Whole Person Wellness".
  - The SW and/or PSS will facilitate access to services and supports across systems to establish safety and stability and address social determinants of health through making contact with providers, advocating and modeling self-advocacy skills, helping clients make appointments, complete required paperwork, accompanying and/or transporting to services and connecting to resources such as CalFresh and other entitlement programs.
  - RNs will serve as the link between the SITs and the MCPs, in the event that the MCP has not identified a Complex Case Manager (CCM) and the SIT team needs assistance on accessing services to support medical needs to mitigate unnecessary ED use. Once a WPW client is linked to the CCM, the SIT will defer to the CCM, unless a situation arises that was not anticipated. The RN will track client referrals, actions taken and report to the WPW team. The RNs will be available to attend interdisciplinary care team meetings if needed, to help assure integrated, consistent service delivery in a unique coordinated comprehensive care management model for all enrollees.
  - The client will transition into a maintenance mode once he/she has established strong connections to needed services and supports. Follow-up contact will be made with the client and/or a designated member of the MDT (i.e. Housing Navigator, Medical Social Worker) to monitor progress/continued engagement during this and the CCP will reflect encounters / client progress.
  - SITs will use an electronic case management tool, which will be the foundation for the CCP, for documenting and tracking of encounters, interventions and client engagement. The case management tool will be accessible to the MDT to ensure timely communication and care coordination.

- **Housing Resources and Housing Transition Services:** The SITs, with the support of Housing Navigators, will assist clients in accessing appropriate housing interventions to ensure they have safe, stable homes. Upon enrollment, the client's housing status will be assessed by the SIT using the region's common housing assessment tool. Results from the tool will be entered into the Coordinated Assessment and Housing Placement (CAHP) system to match the client to housing resources. The region has prioritized housing resources for individuals who have high acuity and are chronically homeless. The SITs will either coordinate with the client's existing housing navigator or provide housing transition and navigation services once a housing resource is identified. These transition/navigation services may include assessment for preferences and barriers to successful tenancy, housing search and identification, assistance with the housing application process, obtaining the necessary documents to be housing ready, and move-in assistance. A flexible housing pool will be locally established through funding from various entities in the region, and will provide a resource to support developing housing for people experiencing homelessness, including Whole Person Wellness clients. No WPW Pilot funds will be used for the housing pool.

- **Tenancy Sustaining Services:** The SIT's tenancy sustaining services will be modeled after the evidence-based practice Critical Time Intervention (CTI) that is comprised of three phases: Transition, Try-Out, and Transfer of Care. In the Transition Phase the goal will be to provide intense support and begin to connect the client to supports that will assume primary housing services beyond the SIT's involvement. During the Try-Out Phase the SITs will monitor and strengthen the clients housing support systems and networks, and by the Transition Phase the SIT will begin to terminate services and ensure other support networks are adequately in place. Tenancy sustaining services during the three phases may include identification and intervention for behaviors that may jeopardize housing, education on tenant and landlord rights and responsibilities, supporting the client in developing and maintaining relationships with landlords, linkage with other community based resources, and reviewing and updating housing plan, and ongoing training in being a good tenant.

Appropriateness of services to the target population: In developing the WPW Pilot model, partners incorporated best practices (i.e. Housing First, Recovery Oriented, Wrap-around), lessons learned through current programs and services in San Diego, knowledge of the target population and strengths/weaknesses of the Continuum of Care in the region. The major finding was that individuals are challenged with navigating multiple systems, either alone or assisted by multiple discipline-specific case managers. Proposed WPW services address this need via an approach that is comprehensive, client centered, trauma informed and culturally competent. Interventions will be tailored to meet individual needs, respecting the role of the client to be a decision maker in the care planning process and ensuring coordination of care.

Likelihood of success (including housing stability): The WPW Pilot combines all of the elements required to provide a successful coordinated care approach for the target population: collaborative leadership and meaningful coordination across public and private systems; capacity to share data across systems; demonstrated prior success and commitment to meeting the needs of these individuals; and use of evidence-based practices.

Likelihood of housing stability is ensured through the Pilot strategy of linking with the CAHP system to prioritize access to available housing solutions for WPW Pilot clients and by providing housing transition services and tenancy supports.

Alignment with other initiatives: The WPW Pilot is fully aligned with County of San Diego's *Live Well San Diego* framework, County supported projects such as POFA and with the efforts of the RCCC which promotes and coordinates a community-wide commitment to ending homelessness and is responsible for operating a HUD- mandated coordinated entry system to prioritize all housing resources in the community and to match them to individuals and families based on their assessed need.

Infrastructure needed: The WPW Pilot will benefit from existing technology infrastructure offered through HIE, CIE, and ConnectWellSD, with the addition of a Case Management Module and new connectivity that will allow the SIT to access and share client information in a manner that supports improved outcomes for the client and project success.

Testing new intervention: The WPW Pilot represents an opportunity for San Diego County stakeholders to work across systems in a manner and scale that has not been possible until now. Other initiatives have focused on a more narrowly defined target population with the majority of services provided "in-house" by a single contracted partner who addresses only isolated, point-in- time client needs based on funding source (for example, TCM) or only in the confines of a particular system. WPW tests the Integrated Care model under more challenging, yet more realistic and sustainable conditions via linking

to a network of community partners across a variety of specialty disciplines.

3.2 Data Sharing

Current System and Vision: Currently San Diego has a robust data infrastructure including ConnectWellSD, Community Information Exchange (CIE), San Diego Health Connect (SDHC), Homeless Management Information System (HMIS), and the MCP's databases. Although at an advantage with these systems in operation, they currently exist in silos. ConnectWellSD is a County-wide effort to put *Live Well San Diego* into action and is intended to be an electronic information sharing hub that will allow County staff and contractors from different systems to share client-specific information with each other to provide better, more efficient service. It will connect mental health services, alcohol and drug services, eligibility services, public health, aging and independence services, housing and community development, and probation. CIE, operated under 211-San Diego, includes a variety of social services, along with City of San Diego Emergency Medical Services. SDHC operates the region's Health Information Exchange (HIE) with data from the various hospitals, health systems, and clinics, county-wide. HMIS contains HUD-mandated data on individuals and families accessing homeless assistance and is also the platform for the region's CAHP system. The long-term vision is to share information bi-directionally throughout the major systems for the target population.

Privacy Protocols: HHSA and partners will determine the minimum information necessary to be shared to effectively accomplish data sharing tasks. Since information will include protected health information, including substance use and mental health, HHSA as the lead entity will ensure that the data sharing protocols comply with all state and federal laws. At this time, all of the data systems have robust policies and procedures around privacy and security in place, providing a solid foundation for any additional data sharing policies and procedures to ensure both compliance with state and federal laws as well as success of the pilot. Protocols will be developed to support the following functions:

Development of the Pilot Participant List and Baseline Data

1. MCPs will generate a data extract of their high-cost frequent users in CY 2015 using agreed upon selection criteria. Data will be provided to HHSA.
2. HHSA will cross reference MCP data with HMIS to identify homeless status, along with HHSA databases to identify those with SMI and/or SUD.
3. HHSA will develop the Pilot Participant List consisting of high-cost frequent users who are homeless or at risk and have SMI, SUD, or chronic physical health conditions.
4. The AC will establish a Clinical Review Team to set criteria and priorities for selecting individuals from the Pilot Participant List and assigning them to SITs for outreach.
5. Baseline data will be developed for the Pilot Participant List to be submitted to DHCS by December 31, 2016.
6. Every 3 – 6 months, based on client flow in the pilot, the MCPs will conduct another data run which will be crossed referenced with HMIS and HHSA databases to determine new high-risk, high-utilizers to add to the master Pilot Participant List. The CRT will meet to review the revised list and assign to SITs for outreach. Individuals identified and previously assigned to SITs will be removed from the updated Pilot Participant List. Additionally, individuals who refuse to participate in the pilot will be removed from the list after 6 months of intense outreach and education.

Outreach and Engagement

1. SITs will use the list to identify clients for outreach. Individuals on the list will be shared with

community outreach partners to assist in outreach efforts. Each SIT will start with 20 identified potential WPW clients. The SIT will receive a new list of 20 potential participants from the CRT every 3-6 months based on clients flow.

2. During outreach, SIT's will ask the client about opting in to CIE to facilitate access to social service information.
3. SITs will access HMIS to view housing and homeless services the client has been engaged with.
4. Engagement will be complete when the client agrees to enroll in the pilot and consents to share treatment information across all providers.

Housing Transition, Care Coordination, and Tenancy Services

1. SITs will use ConnectWellSD Case Management tool to support interaction with primary care providers, BHS programs, housing, and social services.
2. HIE will set up an electronic alert to the SIT team when a client accesses an area hospital.

In addition, data sharing privacy protocols will be developed for outcome tracking and evaluation efforts for the pilot. HHSA will ensure necessary BAA's and consent forms are in place with data sharing partners to support robust evaluation activities. Specifics on the type of data shared will be explained in section 4.2.

Implementation Plan: It is expected that the generation of the Pilot Participant List and baseline data will happen in Fall of 2016. The data infrastructure to conduct outcome tracking and reporting will use existing systems with the expectation that over the course of the pilot ConnectWellSD, HIE, CIE, and HMIS can be linked electronically for more robust reporting and enhanced care coordination.

Data Governance: The WPW Management Committee, will create a Data Governance Work Group chaired by HHSA, and include members from HIE, CIE, HMIS, and MCPs. Issues such as developing information technology infrastructure, privacy and security policies and procedures, engaging SITs in the development of web-based interactive care coordination modules, incorporating telehealth capability, as well as data collection and outcome reporting, will be key focus points for the group. The group will also solicit feedback from partners' legal and IT staff, as well as SIT's as needed.

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

4.1 Performance Measures

Overarching vision: The WPW Pilot performance measures will be collected and analyzed in a purposeful, systematic and timely manner to document the effectiveness and impact of the pilot, identifying areas needing change and improvement, and informing future replication efforts.

Overall Plan: WPW Pilot performance measures will include:

(1) Short-term process measures that will track outcomes and whether these outcomes differ from those proposed in the pilot implementation plan.
(2) Outcome measures that will track the extent to which the WPW Pilot is successful in achieving its goals as defined below -

- ✓ Improve coordination across participating entities, including data and information sharing
- ✓ Improve beneficiary physical and behavioral health outcomes
- ✓ Reduce avoidable utilization of emergency and inpatient services
- ✓ Increase access to social services
- ✓ Improve housing stability

Information on WPW Pilot performance measures is organized as follows:
Tables below: Provide short-term process measures for each type of participating entity and the WPC pilot as a whole, organized by demonstration year and subsequent pilot years.

Sections 4.1a and 4.1b: Identify ongoing outcome measures, universal and variant which align with requirements outlined in Attachment MM and support attainment of project goals.

Overall Pilot – All Participating Entities (including community technology partners)

Year	Short-Term Process
1	o Participate in AC and MC meetings o Coordinate data systems o Conduct cross system advocacy and education o Provide and review baseline data o Participate on Clinical Review Team
2-5	Same as year 1 plus o Participate in PDSA processes o Provide data to support project implementation, operations and learning

County HHSA

Year	Short-Term Process
1	o Coordinate AC and MC meetings o Develop Pilot Participant List and baseline data o Participate on Clinical Review Team
2-5	o Coordinate AC and MC meetings o Oversee PDSA process o Collect data on pilot participant scores on the MDD and NFQ 0104 (baseline year 2, comparisons years 3-5) o Execute and monitor contract/s with community provider o Provide appropriate BHS interventions for WPW clients o Refresh the Pilot Participant List every 3-6 months based on client flow o Participate on Clinical Review Team o Submit project reports

Contracted Community Provider/s (TBD)

Year	Short-Term Process
2-5	o Negotiate contract (year 2) o Hire and train SITs (year 2) o Conduct outreach and engagement o Complete common comprehensive assessment o Develop comprehensive care plan (CCP) o Provide integrated care coordination services o Provide maintenance and follow-up services o Link with Complex Case Management team o Participate in CAHP system and connect clients to housing resources o Implement tenancy sustaining services

Public Safety Group

Year	Short-Term Process
1	o Provide baseline data
2-5	o Coordinate community supervision and reentry services to co-enrolled WPW clients o Contribute to development of CCP o Provide appropriate public safety interventions for WPW clients

MCPs

Year	Short-Term Process
1	o Identify potential clients and provide baseline data o Participate on Clinical Review Team
2-5	o Continue to identify potential clients o Participate on Clinical Review Team o Participate in care integration with SITs o Link with community partners to support CCPs o Establish and maintain the care delivery network to ensure primary care access

Housing Authorities

Year	Short-Term Process
1	o Identify housing resources
2-5	o Oversee contracts with community providers who provide housing services o Leverage existing community based housing resources through the CAHP system o Identify new housing resources that can be linked to the SITs o Conduct landlord engagement strategies

The plan for tracking will be use of an integrated case management tool developed in collaboration with ConnectWell San Diego, HIE, and 211-CIE, that will be used to coordinate care and track clients. HMIS will be used to track housing related measures. Other tools and methods used to track progress on the above measures will include meeting agendas, minutes and attendance records; contract monitoring reports; PDSA analyses. See response to 4.2.

The PDSA approach for continuous improvement will be applied both qualitatively and quantitatively for data analysis and recommendations for design or system improvement. Incorporating PDSA into AC and MC team meetings will help create an iterative learning environment to improve programs and identify any gaps or opportunities in the following areas; service delivery, staff capacity, health and behavioral health outcomes, information systems, client satisfaction and partnership engagement. HHSA will support process improvement by providing quantitative data and qualitative feedback from participating entities, including the SITs, as well as having the SITs gather feedback from the clients using a standard basic questionnaire at program completion.

4.1.a Universal Metrics:

Please check the boxes below to acknowledge that all WPC pilots must track and report the following universal metrics.

X Health Outcomes Measures

X Administrative Measures

**For metrics that maintain the same target percentage across project years, the number of clients served each year will increase.*

Health Outcomes		**Targets by year**				
Metric	**Measure**	**Year 1**	**Year 2**	**Year 3**	**Year 4**	**Year 5**
Ambulatory Care - Emergency Department Visits	(1) Number of avoidable ED visits by new WPW clients during their first 12 months of enrollment compared to 12 months immediately prior to pilot enrollment	N/A	Decreased by 30%	Decreased by 30%	Decreased by 30%	Decreased by 30%
	(2) Number of avoidable ED visits by existing WPW clients in their 2nd, 3rd, or 4th year in the pilot compared to prior year utilization	N/A	N/A	Decreased by 10%	Decreased by 10%	Decreased by 10%
Inpatient Utilization - General Hospital/Acute Care	(3) Number of avoidable days spent in the hospital by new WPW clients during their first 12 months of enrollment compared to the 12 months immediately prior to pilot enrollment.	N/A	Decreased by 30%	Decreased by 30%	Decreased by 30%	Decreased by 30%
	(4) Number of avoidable days spent in the hospital by existing WPW clients in their 2nd, 3rd, or 4th year in the pilot compared to prior year utilization	N/A	N/A	Decreased by 10%	Decreased by 10%	Decreased by 10%
Follow-Up After Hospitalization for Mental Illness	(5) Percentage of WPW clients who receive follow-up contact within 14 days after hospitalization for mental illness.	N/A	85%	87%	90%	90%

Health Outcomes		**Targets by year**				
Initiation and Engagement of Alcohol and Other Drug Treatment	6) Percentage of new WPW clients with an identified substance use disorder who initiate treatment within 30 days of enrollment in the WPW Pilot.	N/A	35%	35%	35%	35%

Administrative Outcomes		Targets by year				
Metric	**Measure**	**Year 1**	**Year 2**	**Year 3**	**Year 4**	**Year 5**
Comprehensive Coordination Plan	(6) Proportion of participating beneficiaries with a CCP, accessible by the entire care team, within 30 days of enrollment in the WPC Pilot	NA	95%	95%	95%	95%
Care coordination, case management, and referral infrastructure	(7) Documentation submitted to DHCS within established timeline demonstrating establishment of care coordination, case management, and referral policies and procedures which provide for streamlined beneficiary case management.	Completed	N/A	N/A	N/A	N/A
	(8) Regular review conducted to monitor procedures for oversight of how these policies and procedures are being operationalized and conduct PDSA as a method to obtain feedback and shared learning.	N/A	Reviews indicates 100%	Reviews indicates 100%	Reviews indicates 100%	Reviews indicates 100%
	(9) A method to compile and analyze information and findings from the monitoring procedures and a process to modify the policies and procedures in a streamlined manner and within a reasonable timeframe.	Completed	N/A	N/A	N/A	N/A
Data and information sharing infrastructure	(10)Documentation submitted to DHCS within established timeline demonstrating the establishment of data and information sharing policies and procedures which provide for streamlined beneficiary care coordination, case management, monitoring, and strategic improvements.	Completed	N/A	N/A	N/A	N/A
	(11)Regular review conducted to monitor procedures for oversight of how these policies and procedures are being operationalized.	N/A	Reviews indicates 100%	Reviews indicates 100%	Reviews indicates 100%	Reviews indicates 100%

Data and information sharing infrastructure	(12)A method to compile and analyze information and findings from the monitoring procedures and a process to modify the policies and procedures in a streamlined manner and within a reasonable timeframe.	Completed	N/A	N/A	N/A	N/A

4.1.b Variant Metrics:

The following table identifies preliminary variant metrics selected for San Diego County. Targets have been provided where the partners have sufficient information on which to base their estimates. In many cases these estimates cannot be provided until baseline data is collected. San Diego County proposes to have measures that track percentage improvements over baseline – these improvements are
anticipated to be a) significant given the intensity of the intervention and b) increase over time given learnings provided through the PDSA process. Given that there are no services provided in year 1 there are no targets for that year.

Metric	Measure	Year 2	Year 3	Year 4	Year 5
Variant Metric 1: Administrative Outcome	Complete and accurate data for the month entered into the data system by the 10th of the month following the reporting period by the contractor.	√ Increase 80% over baseline	√ Increase 85% over baseline	√ Increase 90% over baseline	√ Increase 95% over baseline
Variant Metric 2: Decrease Jail Recidivism	Number of incarcerations of WPW participants during the reporting period will decrease as measured by the total number of incarcerations divided by the total number of WPW participants enrolled in the reporting period.	√ Decrease by 5% over baseline	√ Decrease by 5% over previous year	√ Decrease by 5% over previous year	√ Decrease by 5% over previous year
Variant Metric 3: Depression Remission at 12 months	Depression Remission among WPW participants will be measured by the percentage of WPW participants who achieved remission at twelve months as demonstrated by a twelve month (+/- 30 days) PHQ-9 score of less than five out of all participants aged 18 and older with a diagnosis of a major depression or dysthymia and an initial PHQ-9 score greater than nine during an outpatient encounter.	√ Increase 35% over baseline	√ Increase 40% over baseline	√ Increase 45% over baseline	√ Increase 50% over baseline

Metric	Measure	Year 2	Year 3	Year 4	Year 5
Variant Metric 4: SMI Population	Suicide Risk Assessment- Percentage of WPW clients who had a suicide risk assessment completed at each visit out of all WPW clients with a new diagnosis or recurrent episode of Major Depressive Disorder.	√ Increase 35% over baseline	√ Increase 40% over baseline	√ Increase 45% over baseline	√ Increase 50% over baseline
Variant Metric 5: Permanent Housing	Percentage of WPW clients who are permanently housed for greater than 6 months measured by the number of participants in housing over 6 months out of the number of participants in housing for at least 6 months	√ Increase 40% over baseline	√ Increase 45% over baseline	√ Increase 50% over baseline	√ Increase 55% over baseline
Variant Metric 9: Housing Outcome	Percentage of new WPW clients who were homeless or in shelter become permanently housed within three months of enrolling in the project.	√ 50%	√ 50%	√ 50%	√ 50%

Pay for Outcome Metrics

Metric	Measure	Year 2	Year 3	Year 4	Year 5
Variant Metric 6: Other Outcome	Number of hospital days new WPW clients are in San Diego County Psychiatric Hospital during their first 12 months of enrollment as compared to 12 months immediately prior to enrollment.	√ Decreased by 20%	√ Decreased by 20%	√ Decreased by 20%	√ Decreased by 20%
Variant Metric 7: Other Outcome	Number of hospital days existing WPW clients in their 2nd, 3rd, or 4th year in the pilot are in San Diego County Psychiatric Hospital as compared to prior year utilization.	N/A	√ Decreased by 5%	√ Decreased by 5%	√ Decreased by 5%
Variant Metric 8: Health Outcome	Percentage of new Whole Person Wellness (WPW) clients seen by a primary care provider within 60 days of enrollment in the program.	√ 80%	√ 80%	√ 80%	√ 80%

4.2 Data Analysis, Reporting and Quality Improvement

Overview: San Diego County has considerable existing capacity and infrastructure in the area of data collection, tracking and sharing. Measuring the universal and variant metrics proposed in the WPW pilot will require outcome data sharing from the Care Management tool, MCP's, the HMIS, and the Sheriff's Department's Jail Information Management System (JIMS). Data from the MCP's, HMIS, and JIMS will be used to perform return on investment evaluations. ConnectWellSD will also be used to collect, track, and

report on client outcomes, specifically around the service interventions and strategies and participant health outcomes. Data will be collected to track progress in delivering short-term process measures. All data will be integrated within required reports and shared with DHCS and local stakeholders. The Data Governance/Technology Work Group of the MC will be responsible for developing new reporting tools and processes that support the needs of the WPW Pilot starting in year 1 as described in section 3.2.

Data collection, analysis and reporting plan

Short-term process and administrative measures: The County HHSA Program Coordinator will be responsible for collecting, tracking and reporting upon measures relating to system development (i.e. care coordination, case management and referral infrastructure), capacity building and quality improvement (training and implementation of PDSA process). Tools used will include meeting agendas, minutes, attendance records, and monthly progress logs.

The contracted service provider/s will designate a Program Manager or other individual to be responsible for collecting, tracking and reporting upon short-term process and administrative measures such as relating to number of clients engaged and their characteristics, as well as the types and units of services provided. Data will be collected on an ongoing basis and will be compiled by the Contractor within a monthly report, due by the 10th of the month following the reporting period. The contracted service provider/s will participate as a member of the WPW Management Committee.

Universal and Variant Outcome Measures (other than administrative measures): The analysis and reporting plan for the following measures is that each entity will provide their data reports to the MC who will review and analyze the information on an ongoing basis throughout the duration of the project. Areas of under-performance will be identified and analyzed by the MC and through the PDSA process to address challenges and barriers. Progress reports will be created by members of the MC and shared with the AC. The AC will review reports and provide their feedback and recommendations to the MC.
All project outcome data will be compiled every 6 months by HHSA to be able to report on pilot performance. HHSA will analyze data related to the pilot and complete mandatory reporting and evaluating performance of pilot interventions/entities compared to baseline/goals/best practices/other pilot sites/clients not in pilot population. HHSA will develop data sharing agreements immediately to be able to conduct outcome reporting and evaluation for the pilot.

Universal Measures	Data Collection Plan
(1) And (2) Number of avoidable ED visits by WPW clients	Data collected and reported by MCPs on a monthly basis
(2) And (3) Number of avoidable days spent in the hospital by WPW clients	
(3) Percentage of WPW clients who receive follow-up contact within 14 days after hospitalization for mental illness.	Data collected by SITs on an ongoing basis and entered/shared via the Care Management tool.
(4) Percentage of WPW clients with an identified substance use disorder who initiate treatment within 30 days of enrollment in the WPW pilot.	

Variant Measure	Data Collection Plan
Variant Metric 2: Number of incarcerations of WPW participants during the reporting period will decrease as measured by the total number of incarcerations divided by the total number of WPW participants enrolled in the reporting period.	Data collected by the Sheriff and the SIT
Variant Metric 3: Depression Remission among WPW participants will be measured by the percentage of WPW participants who achieved remission at twelve months as demonstrated by a twelve month (+/- 30 days) PHQ-9 score of less than five out of all participants aged 18 and older with a diagnosis of a major depression or dysthymia and an initial PHQ-9 score greater than nine during an outpatient encounter.	Data collected by BHS on a monthly basis (via their contracted service providers).
Variant Metric 4: Suicide Risk Assessment- Percentage of WPW clients who had a suicide risk assessment completed at each visit out of all WPW clients with a new diagnosis or recurrent episode of Major Depressive Disorder.	Data collected by SIT on an ongoing basis and entered/shared via Care Management Tool.
Variant Metric 5: Percentage of WPW clients who remain stably housed as measured by maintaining permanent housing at 6 months, following being housed, or if exiting housing, they exit to another permanent housing destination. The number housed each year will increase based on the number of people enrolled.	Data collected by SIT and verified through the HMIS
Variant Metric 6: Number of hospital days WPW clients are in San Diego County Psychiatric hospital	Data collected by BHS and entered/shared via Cerner the Care Management tool.
Variant Metric 8: Percentage of new Whole Person Wellness (WPW) clients seen by a primary care provider within 60 days of enrollment in the program.	Data collected by SIT and entered into Care Management tool

Plan Do Study Act: HHSA will use the PDSA model to improve the interventions and services over the life of the pilot. Through agreement with WPW partners HHSA has established a set of outcome measures for the pilot as well as a desired target or change expected. PDSA is woven into the fabric of HHSA departments and staff continually uses data to inform processes and to ensure data driven decision making within the programs. The County of San Diego, HHSA Public Health Services recently received Public Health Accreditation by the Public Health Accreditation Board (PHAB). One of the highlights from this PHAB report identified a" strong commitment to a culture of improvement". Performance management and quality improvement has been in place in Public Health Services for ten years.

BHS also has a robust Quality Improvement department in which annual goals are developed in multiple areas including that services are client centered; services are safe; services are effective; services are efficient and accessible; services are equitable; and services are timely. These goals are then evaluated in the development of future goals to ensure a continuous improvement model. In addition, two Performance Improvement Projects are conducted annually, based on BHS' extensive data, to ensure the ongoing quality improvement of services and programs. The pilot will draw from subject matter experts, such as these teams, for their expertise as needed.

Sustainability Planning: Project reports that will include analysis of data regarding client outcomes and return on investment will be carefully reviewed by the AC and the information will be used to inform the WPW Pilot Sustainability Plan. Data presentations will be made to FTEH-SD who are represented on the AC by Alliance Healthcare Foundation.

4.3 Participant Entity Monitoring

HHSA will conduct regular ongoing monitoring of the WPW partners throughout the course of the pilot. HHSA will monitor partner performance measures outlined in section 4 as well as all Universal and Variant measures using the PDSA process outlined in section 4.2. The WPW AC will meet regularly and part of each meeting will include reviewing partner performance measures and Universal and Variant metrics. For concerns regarding partner performance measures outlined in section 4, HHSA will meet privately with partners to understand the issue and brainstorm solutions. If solutions cannot be generated or overcome, HHSA will elevate the concern to the AC for discussion. Most of the monitoring will be performed on the contracted provider/s operating the SIT's. HHSA will use the Project Coordinator and Data Analyst to support provider/s monitoring activities. HHSA will analyze data across SIT's and compare performance among providers of the same service. HHSA will use data to understand if there is an issue with a particular intervention or provider. Again if performance concerns arise, HHSA will meet privately with the provider/s to try and understand what is happening and make necessary corrections. For low performing provider/s, HHSA will provide needed support in the form of technical assistance to make the necessary corrections. It is the hope that the through discussions and the receipt of technical assistance that the provider/s will improve performance and that it is sustained over time. However, if the provider/s do not demonstrate improved performance a course of corrective action may need to be taken. This process may include a Corrective Action Notice requiring a response within a specified period of time, increased monitoring of the contractor, and if issues or underperformance continues to be unacceptable, it could ultimately result in contract termination.

Section 5: Financing

5.1 Financing Structure

Financing Structure: HHSA shall pay costs as incurred for WPW infrastructure and activities from the County General Fund (GF). HHSA will contract with one or more community partners to provide Service Integration Team (SIT) coordinated care services and will pay the contractor(s) per the terms of their contract(s). HHSA will expend funds on approved WPW activities prior to payment by DHCS. Upon receipt of earned payments from DHCS, HHSA will reimburse the General Fund (GF) for funds expended as follows:

- Infrastructure, FFS, PMPM payments – reimburse HHSA GF for program administration and payments to Pilot service providers.
- Incentives – reimburse HHSA GF for payments to SIT contractor.
- Pay for Metric Reporting – reimburse HHSA GF for reinvestment in IT infrastructure to support the pilot.

- Outcome Metric payments –
    - 90% reserved by HHSA to reinvest in the program to support projects to enhance Pilot IT infrastructure and help ensure the program is fully funded during the pilot period;
    - 10% paid to SIT contractor;

HHSA will reinvest any cost savings from the PMPM bundled services in remaining approved activities/infrastructure to ensure financial sustainability throughout the Pilot period.

Administrative Oversight: HHSA administrative staff will review and approve Contractor invoices. Per County policy, payments shall only be authorized to contractors upon verification of receipt of goods and/or services for each service period. In addition, County policy requires staff to conduct an annual in-depth invoice review or site visit to ensure contractor compliance with funding source and County requirements. Site visits may include a "ride along" to observe contractor performance in the field.

WPW administrative staff and HHSA's centralized fiscal unit will coordinate in preparing mid-year and annual reports to DHCS and any follow-up requests for information required for Pilot reimbursement. HHSA fiscal staff and the County's Auditor and Controller's office are experienced in processing IGT transfers under the voluntary rate range IGT program.

Administrative staff shall maintain a monthly expenditure and revenue tracking report and present the financial condition of the Pilot to the Management Committee quarterly. The Pilot will be subject to the County's quarterly budget review/monitoring processes. Pilot inflows and outflows will be subject the County's internal controls and audit procedures.

Payment Timeline: HHSA shall submit reports to DHCS and transfer IGT payments to DHCS within all required timeframes. IGT payments will be made semi-annually based on deliverables completed and metric outcomes achieved Year 1 IGT payments will occur in 2017 and will be based on the application and baseline data deliverables.

Per County policy, County Pilot contractors shall be paid net-30 from the date of receipt of the invoice and documented satisfactory receipt of goods and/or services outlined in the contract.

Payment Structure:
For HHSA's claim to DHCS:

- Infrastructure payments: costs incurred for the approved deliverable.
- Fee-for-service (FFS): FFS rate multiplied by number of units completed.
- PMPM bundled payments: PMPM rate multiplied by number of clients served per month.
- Incentive payments: costs incurred for payments made to SIT contractor.
- Pay-for-reporting: payment upon timely and complete submission to the State of all required data elements to calculate all universal and variant health outcome metrics and variant SMI and housing metrics.
- Metric outcomes: payment earned for achievement of identified metric outcomes.

For HHSA's payment to Pilot service providers:
SIT contractor:

- Outreach & Engagement: fee-for-service rate multiplied by the number of client encounters
- Enrollment: enrollment phase specific PMPM rate multiplied by the number of clients served each month in each enrollment phase.
- Incentives: payments earned.

- Metric outcomes: 10% of approved payment received from DHCS.

IT vendors:

- Design: labor rate multiplied by labor hours, plus reimbursement for materials, licenses, etc.
- Maintenance and Operations: monthly usage fee.
- Case Management System: license fee multiplied by number of licenses.

Payment Process:

HHSA's Claim to DHCS: HHSA will comply with all DHCS stated reporting timelines and IGT transfer processes in order to receive WPW payments earned.

Contractor's Claim to HHSA: contractor shall submit an invoice to HHSA. Upon verification of receipt of services, invoice calculation, and availability of funds, HHSA shall remit payment to contractor.

Payment Tracking: County uses Oracle as its system of record. The Pilot will be assigned a unique Project number used to track all related revenues and expenses. Expenses may be sub-categorized within the project using unique task numbers. The project number and task numbers are used for retrieving data and creating reports from the system. Invoices for services rendered by HHSA are tracked in the County's accounts receivable system. When payment is made, the payment will be matched to the receivable and credited to the appropriate revenue account using the project and task identifiers noted above.

Invoices for services provided to HHSA are tracked in the County's accounts payable system. Upon receipt of the invoice, staff verifies receipt of deliverables, checks balance of encumbrance, approves invoice for payment and submits invoice to accounts payable.

Current systems will be able to support payment for the Pilot. A new case management system will assist in the tracking and verification of encounters, member months and outcomes achieved necessary to report on for payment.

Sufficiency of Funds: WPW Administrative staff will monitor financials monthly and utilize trending analysis to identify variances from the expected flow of funds and immediately investigate discrepancies. Staff will submit a financial report to the Management Committee quarterly to include year-to-date and projected revenues and expenses and loss mitigation efforts, if applicable. HHSA has identified one-time contingency funds to cover Pilot expenses should certain outcomes or deliverables not be fully achieved, resulting in receiving lower than anticipated Pilot funding.

Value-Based Payment Approaches: Linking contractor payments to deliverables increases provider accountability for achieving joint outcomes. In combining a FFS, PMPM and incentive/outcome structure for the contracted integrated care coordination services, a blend of output and outcomes will be rewarded. HHSA will incentivize the contractor for exceptional performance in core processes critical to the path of success for the Pilot, while paying a PMPM to ensure funding for the contractor is rightsized to the caseload. Using payment structures like the one proposed in this program will enable HHSA to continue its transition from cost-based reimbursement to a more collaborative, deliverables/outcomes based model.

5.2 Funding Diagram

Attach a funding diagram illustrating the flow of requested funds from DHCS to the lead entity and other participating entities. (Attachment) (STC 117.b.xviii)

5.3 Non-Federal Share

HHSA, as the lead entity, will be providing the entire non-federal share necessary to match the federal Pilot funds. HHSA will primarily be using un-securitized tobacco funds, which is in alignment with the County's Board of Supervisors Policy requiring tobacco funds to be used for healthcare-based programs. HHSA may also leverage MHSA funds as approved in the annual MHSA Plan as well as Realignment funds, prior year voluntary rate range IGT funds, and Agency Fund Balance. Any and all funds used will meet all requirements to qualify for federal financial participation under the IGT process.

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

HHSA will pay for the provision of Pilot services from the County's General Fund. As Pilot funding is earned, the General Fund will be reimbursed using WPC payments received for infrastructure, services and a portion of what is received for meeting outcomes. HHSA will potentially utilize MHSA funds to pay for services as approved in the MHSA Plan. Any MHSA activities/funds approved for the Pilot will be unleveraged and available to draw down FFP under the Pilot. The same would apply to any Realignment funded activities.

Payments will comply with STC 113 in that they will support infrastructure approved in the Pilot application to promote integrated service delivery (such as the case management system that will provide an electronic vehicle for shared client management), and contracted coordination and integration services not otherwise reimbursed by Medi-Cal.

There will be no risk of receiving federal funds for services to people that are not Medi-Cal beneficiaries given the way the target population is being identified. The starting point for the target population served will be a list of high-utilizing, high cost Medi-Cal beneficiaries identified by the partnering MCPs. The list will then be further narrowed using other data systems to identify those who are homeless or at risk of homelessness and have a mental health condition, a substance use disorder, or chronic physical health condition(s). The resulting list will be prioritized and given to the SITs for outreach, engagement, and enrollment.

In addition, based on our current Targeted Case Management (TCM) model the WPC population is not eligible for TCM. As an additional safeguard to ensure no service duplication, the list of high-utilizing, high cost Medi-Cal beneficiaries identified for the Pilot will be reviewed by the County's TCM Coordinator and shared with the Medi-Cal managed care plans to prevent the outside possibility of enrolling beneficiaries who may be receiving TCM.

The contracted services to be provided as part of the Pilot will be clearly identified in the contractor's statement of work and will not include services reimbursed by Medi-Cal. SITs will be thoroughly trained on connecting clients to existing social, behavioral, housing and health services in order to fully leverage capacity in the community and not duplicate services. Existing County policies around annual in-depth invoice review or site visit to ensure contractor compliance with funding source and County requirements will apply.

Pilot participants will also have access to housing supports eligible for Pilot funding as well as rent subsidies and other housing funds not eligible for FFP. HHSA has a robust accounting system with strong processes and controls already in place to enable oversight and separate tracking of these funds. HHSA is currently exploring utilizing the Housing and Community Development (HCD) Department, which recently transferred to HHSA, to oversee and manage distribution of Pilot FFP funded and non-FFP funded housing supports using procedures currently established in HCD to manage, track and report on such

funds.

5.5 Funding Request
(Refer to submitted Excel template for budget by year and summary data.)

Budget Narrative
In Program Year 1, $8.72 million is budgeted for an approved application and submission of timely baseline data. Following is a description of items requested under infrastructure, services, incentive payments and outcome metric achievement payments for the four service years of the Pilot, Program Years 2017 – 2020.

Administrative Infrastructure:
The County of San Diego's Whole Person Wellness Pilot program will be supported by five staff years to provide program oversight and troubleshooting, data collection and reporting, deliverables monitoring, invoice payment and budget management support to the contracted Service Integration Teams (SITs) as follows:

1.0 Program Coordinator – provide oversight of the overall program, serve as Contracting Officer's Representative to contractor(s) hired to provide WPW deliverables, manage the Plan-Do-Study-Act (PDSA) process, and chair, participate on or provide support to the Advisory Council, Management Committee and Clinical Review Team as needed.

1.0 Principal Administrative Analyst (PAA) – provide day-to-day program management, coordinate fiscal reporting, review contractor claims, fund draw downs, conduct RFP for any required contractor(s), negotiate contract(s), review PDSA results and make recommendations for improvement, participate on or provide support to the Advisory Council and Management Committee as needed.

1.0 Administrative Analyst II – provide analytical and administrative program support, including but not limited to: extracting, compiling and analyzing data from various sources and creating reports to track and monitor the Program's progress in reaching milestones, monitoring PDSA cycles, tracking contractor(s) progress in meeting deliverables and alerting PAA of any discrepancies, tracking and monitoring program expenditures and revenues.

2.0 Public Health Nurse (RN) – provide clinical program support including but not limited to: ensuring timely medical service delivery for highest risk clients as it relates to chronic condition(s) and readmission risk; identifying medical linkage gaps; assisting in educating clients on various aspects of their care; serving on Clinical Care Review Team and participating in the review of the list of potential clients to determine which will be targeted for inclusion in the WPW pilot.

TABLE 1 - Administrative Infrastructure Annual Budget

Staff	Units	Wages	Benefits	Indirect Costs (5%)	Annual Cost Per Unit	Total Annual Budget for Program Years 2-5
Program Coordinator	1	$94,536	$65,201	$7,987	$167,724	$167,724
Principal Administrative Analyst	1	$87,797	$60,553	$7,418	$155,768	$155,768
Administrative Analyst II	1	$70,408	$48,562	$5,949	$124,919	$124,919
Public Health Nurse	2	$79,914	$55,116	$6,752	$141,782	$283,564
TOTAL PERSONNEL						**$731,975**

TABLE 2.0 – Delivery Infrastructure Annual Budget			
Item	**Units**	**Annual Cost Per Unit**	**Total**
Program Year 2-5 Ongoing Delivery Infrastructure			
Case Management Annual Licenses	60	$5,000	$300,000

TABLE 2.1 – Delivery Infrastructure Annual Budget			
Item	**Units**	**Annual Cost Per Unit**	**Total**
Program Year 2 One-Time Infrastructure			
SIT Team Orientation and Training	1	$15,000	$15,000
Establishment of Case Management System	1	$2,000,000	$2,000,000
Contract Awarded for System Integration Teams	1	$200,000	$200,000
Total Year 2 Budget for One-Time Infrastructure Set-Up			**$2,215,000**

TABLE 2.2 – Delivery Infrastructure Annual Budget			
Item	**Units**	**Annual Cost Per Unit**	**Total**
Program Year 3 One-Time Infrastructure			
Interface Deliverable	1	$1,000,000	$1,000,000
Total Year 3 Budget for One-Time Infrastructure Set-Up			**$1,000,000**

TABLE 2.3 – Delivery Infrastructure Annual Budget			
Item	**Units**	**Annual Cost Per Unit**	**Total**
Program Year 4 One-Time Infrastructure			
Analytics Deliverable	1	$1,000,000	$1,000,000
Collaborative Learning Session	1	$5,000	$5,000
Total Year 4 Budget for One-Time Infrastructure Set-Up			**$1,005,000**

Delivery Infrastructure: Following is a description of the infrastructure items is Tables 2.0 – 2.3 above that the WPW Pilot will leverage:

- SIT Team Orientation and Training (Program Year 2) **-** An initial orientation and training to include: "trauma-informed practice"; Motivational Interviewing; Case Management Module, HMIS, CIE, HIE, and the other information systems to be accessed; conducting assessments; data collection and reporting; and community resources. SITs, service and housing providers will meet quarterly throughout the Pilot to review "learnings" from all aspects of their interventions.
- Case Management System (Program Year 2) **-** In order to successfully coordinate care and track outcomes, the WPW Pilot will leverage an on-line electronic case management system. This system will enable SITs and other members of the multi-disciplinary team (health, behavioral health, housing, public safety) who are responsible for the Comprehensive Care Plan (CCP) to coordinate with one another for the client's care. Information will be shared related to progress monitoring, demographic, health-related, and service plan information. It will also support the ability to provide linkages, referrals, and consultations and will have reporting and documentation capabilities including a longitudinal record for each client that can be viewed in

various formats. A one-time cost for installation, configuration and customization of the case management system is included in Program Year 2017.

Annual Licenses for utilizing the system will be obtained for key administrative program personnel and each service integration team, managed care organization, behavioral health outreach and engagement contractor, and housing specialist working on the pilot. A budget to support 60 licenses is included.

- Contract Awarded for System Integration Teams (Program Year 2) **-** A procurement process will be completed in Year 2 to procure contracted services to deliver the integrated care coordination and tenancy sustaining services through the SITs. A payment equal to 5% of the expected contract amount for start-up costs is budgeted to be paid once the contract is executed.
- Interface Deliverable (Program Year 3) **-** The WPW Pilot will leverage the County's existing HIPAA-compliant ConnectWellSD information technology platform, which is designed to enable multiple service providers within the system to collaborate on providing care and services to clients. In order to address the specific goals of the WPW Pilot, certain modifications to the existing system will be necessary, including expanding interoperability with other data systems that will be used to manage overall care for WPW participants. This deliverable includes engaging source system vendor(s) to design the interface approach, the development of an interface control document (ICD), data mapping, developing the corresponding XML Schema Definition (XSD) document, design the data load process, receive and review sample data load(s), update the ICD and XSD as needed, validate data quality, develop, validate, and deploy the Service Oriented Architecture (SOA) Service(s), programming of the user interface for display of the data, mapping of the data to the user access model, which enables users to access to different data sets based on their user role, system integration testing, and user acceptance testing.
- Analytics Deliverable (Program Year 4) **-** This deliverable includes identification of data fields, identification and development of channels for delivery (e.g., dashboard, report, system alert, other), identification and development of required mechanisms for delivery (e.g., data cubes, data models, etc.), testing, and deployment. A one-time design and implementation cost is included in Program Year 2019. Analytics was sequenced at the end of the planned IT infrastructure projects in order to give the planning and governance committees more time to make an informed decision as to what data fields, reports and tools could be best utilized to serve this population going forward.
- Collaborative Learning Session (Program Year 4) – A 1 to 1.5 day Collaborative Learning meeting will be held for all partners to provide an opportunity to hear presentations by state and national experts on "best practices" relevant to the WPW Pilot, hold breakout sessions to explore these concepts in more detail, review accomplishments and challenges of the Pilot to date, and discuss future direction.

Incentive Payments: The following incentive payment budget is proposed for the Service Integration Teams (SITs) contractor/s. HHSA will make payments to the contractor out of the HHSA General Fund as the incentives are earned. The Pilot payments earned from the State for the incentives will reimburse HHSA's General Fund.

TABLE 3.0 – Annual Incentive Payment Budget For PY 2	Incentive Payment
80% of those in the outreach and engagement phase will be enrolled in the Pilot within 3 months of first encounter	$50,000
95% of those enrolled will have a comprehensive care plan, accessible by the entire care team, within 30 days of: 1. Enrollment into the Pilot 2. The beneficiary's anniversary of participation in the pilot	$50,000
Total Annual Incentive Payment Budget for Program Year 2	**$100,000**

TABLE 3.1 – Annual Incentive Payment Budget For PY 3 – PY 5	Incentive Payment
80% of those in the outreach and engagement phase will be enrolled in the Pilot within 3 months of first encounter	$100,000
95% of those enrolled will have a comprehensive care plan, accessible by the entire care team, within 30 days of: 1. Enrollment into the Pilot 2. The beneficiary's anniversary of participation in the pilot	$100,000
Total Annual Incentive Payment Budget for Program Years 3-5	**$200,000**

TABLE 3.2 – Annual Incentive Payment Budget				
	PY 2017	**PY 2018**	**PY 2019**	**PY 2020**
A one-time annual payment of $2,000 per enrollment/re-enrollment of an individual transitioning from an institutional setting (Jail/IMD)	$2,000	$2,000	$2,000	$2,000
Projected Number of Incentives Paid	124	58	62	70
Total Annual Incentive Payment Budget	$248,000	$116,000	$124,000	$140,000

At the outset, enrolling WPW eligible clients from the list of identified high utilizers will be critical. The SITs will have primary responsibility for locating the identified MCP members, establishing a relationship and ultimately building a level of trust that will culminate in obtaining consent to participate in the WPW Pilot, share data, and engage in services. In order to maximize the number of clients served and optimize the level of coordinated care provided, an incentive will be provided to the contractor for successfully achieving an average 80% enrollment rate, as demonstrated by completion of the initial assessment, within 3 months of the first encounter.

Once a client is enrolled, the SITs will need to work quickly to involve all relevant partners in the client's Comprehensive Care Plan (CCP) in order to have the most impact. Establishing and maintaining the CCP will be key to achieving good outcomes for the client. It also highlights the SITs role in identifying and leveraging resources and services in the broader community. The total incentive payment available to earn will be capped as a percentage of the final budget for the contracted SIT Teams.

As illustrated in Table 3.2, an additional incentive will be available to the SIT contractor/s when a client is enrolled from a stay in a jail or an Institution for Mental Disease (IMD). Presumably some of the WPW eligible clients will be residing in an IMD or in custody at the time of identification. Likewise, it is possible that some of the enrolled WPW clients might reenter a facility at some point during their participation in the program. No one will be enrolled into the Pilot until they have been released back into the community. Clients will be disenrolled as needed if they return to an institution from the community following initial enrollment. Therefore, the FFS outreach and engagement rate and PMPM rates will not apply to this population. The goal will be to engage/reengage these individuals into the program after release. It is

expected that the SIT Team will work with the client up to 90 days prior to release to help prepare, support and facilitate the transition back into the community. An incentive payment is proposed to support the contractor in engaging/reengaging the client as measured by whether they are able to successfully enroll/reenroll the client into the Pilot following release. A payment of $2,000 per enrollment upon completion of the initial assessment/reassessment is proposed to incentivize the contractor to work with and support this population, limited to one such payment per enrollee per 12-month period.

FFS Services Budget Component

The SITs will be responsible both for initial outreach and engagement as well as the ongoing integrated care coordination once they successfully enroll a client into the WPW Pilot. Because not all clients will enroll, and the SIT teams will be expected to maximize time conducting outreach to clients from the list of identified frequent users, a budget based on encounters is proposed. It is estimated that each SIT will be able to provide 10 encounters per case per month in the outreach and engagement phase. This takes into consideration that they will also be expected to provide crisis stabilization and other services as needed prior to enrollment, and will need time to learn about a potential client by building a composite based on service information in existing case management and data systems, as well as continue to build case documentation prior to enrollment.

The FFS encounter rate was built as follows:

1. Start with total projected annual costs for the 12 contracted SITs (See Table 14 at end of PMPM section for SIT contractor budget).
2. Allocate annual contracted costs according to the projected amount of time used by the SITs for the outreach and engagement phase vs. the subsequent care coordination phases (Tables 4 & 5). Outreach and engagement will comprise the majority of SIT workload in the first service year as the teams build their caseloads.
3. Calculate the expected encounters per year multiplying the number of case months expected in the outreach and engagement phase by 10 encounters. Divide the contracted costs for the outreach and engagement phase calculated in Table 5 by the number of encounters expected per year to arrive at a cost per encounter of $204 (Table 7).

TABLE 4 – Percent of Hours by Phase for SIT Teams

Phases	PY 2017	PY 2018	PY 2019	PY 2020
Outreach and Engagement Phase	58%	27%	29%	32%
Post Enrollment Care Coordination, Monitoring and Follow-up phases	42%	73%	71%	68%
Total	100%	100%	100%	100%

TABLE 5 – Costs Allocated By Phase

Phases	PY 2017	PY 2018	PY 2019	PY 2020
Outreach and Engagement Phase	$2,536,536	$1,188,096	$1,270,104	$1,426,572
Post Enrollment Care Coordination, Monitoring and Follow-up phases	$1,872,479	$3,223,077	$3,138,483	$2,983,293
Total costs per year*	$4,409,015	$4,411,173	$4,408,587	$4,409,865

* *Note: amounts differ slightly from Table 11 Proposed Annual Budget for SITs due to rounding*

TABLE 6 – Costs Allocated By Phase (% of Total Budget shown in Table 11)				
Phases	**PY 2017**	**PY 2018**	**PY 2019**	**PY 2020**
Outreach and Engagement Phase	58%	27%	29%	32%
Post Enrollment Care Coordination, Monitoring and Follow-up phases	42%	73%	71%	68%
Total costs per year*	100%	100%	100%	100%

TABLE 7 – Per Encounter Budget				
Phases	**PY 2017**	**PY 2018**	**PY 2019**	**PY 2020**
Average monthly cases in O/E phase	104	49	52	58
Number of encounters per month	1,036	485	519	583
Number of encounters per year	12,434	5,824	6,226	6,993
Costs per year for phase 1	$2,536,536	$1,188,096	$1,270,104	$1,426,572
Cost per encounter	**$204**	**$204**	**$204**	**$204**

PMPM Bundle for Service Integration Teams (SITs)

In addition to outreach and engagement, the SIT manages the life of the case after enrolling the client, including helping clients navigate and integrate a full range of services including housing supports, mental health services, substance use services, and health care services; serving as the central liaison for the client and all recommended service providers; maintaining ongoing proactive contact with clients to monitor progress and ensure long term successful outcomes; and reporting progress to the program administration team.

A SIT will be composed of 1 full-time equivalent (FTE) social worker and 1 FTE peer support specialist. Twelve teams are proposed in the budget and will have the support of 4 FTE Master's level Social Workers, 4 FTE Housing Navigators, and 2 FTE County Public Health Nurses (budgeted in Administrative Infrastructure). As mentioned under the FFS section and throughout Section 3 of the narrative, a SIT will continuously serve a client throughout various phases of service intensity for approximately 2.5 years from the point of initial outreach. Each team is expected to enroll approximately 90 cases over the life of the WPW Pilot. A contracted budget for 12 teams is included supporting enrollment of just over 1,000 people during the pilot period (Table 8). (See Table 14 included at the end of this section for the proposed budget for contracted services.)

TABLE 8 – Caseloads by Program Yr					
	PY 2017	**PY 2018**	**PY 2019**	**PY 2020**	**Total Project**
New Individuals Enrolled Each Year	414	194	208	233	1,049
Avg Mo Caseloads/Year/12 Teams	310	537	610	527	496
Outreach/Engagement Phase	104	49	52	58	65
Enrolled Care	206	488	558	469	431

As previously described, costs for the outreach and engagement phase have been removed from the contracted services budget and will be paid based on encounters. Costs for services provided after a client is enrolled in WPW will be paid as a bundled PMPM rate for integrated care coordination, housing resources and housing transition services, and tenancy support based on the client's stage in the program as determined by length of stay from the point of enrollment (phase 2 – phase 5). Clients'

needs will naturally fluctuate, but this payment structure reflects that as the SITs are successful in stabilizing and establishing a comprehensive support structure for the client, the relative time needed to monitor the case will decrease as the client's time on the caseload progresses.

The PMPM rates were built as follows:

1. Start with total projected annual costs for the service bundle provided by the 12 contracted SIT Teams (See Table 14 for SIT contractor budget).
2. Allocate annual contracted costs according to the projected amount of time used by the SIT Teams for the outreach and engagement phase vs. the subsequent care coordination phases (Tables 4 & 5 above).
3. Calculate the average monthly members and average monthly costs per year by phase for 12 teams using estimated hours required per phase and anticipated length of stay in each phase.

TABLE 9 – Average Monthly Members for all 12 Teams Combined

Phases	PY 2017	PY 2018	PY 2019	PY 2020
Phase 2	90	50	47	61
Phase 3	116	128	90	120
Phase 4	-	194	99	99
Phase 5	-	116	322	189
Total avg mo members	**206**	**488**	**558**	**469**

TABLE 10 – Average Monthly Costs for all 12 Teams Combined

Phases	PY 2017	PY 2018	PY 2019	PY 2020
Phase 2	$76,854	$42,684	$40,233	$51,987
Phase 3	$79,141	$87,229	$61,409	$81,694
Phase 4	$ -	$99,020	$50,390	$50,631
Phase 5	$ -	$39,571	$109,628	$64,298
Total avg mo cost	**$155,995**	**$268,504**	**$261,660**	**$248,610**

4. Calculate the PMPM rate by phase using Table 9 and Table 10 above. Table 11 below shows the PMPM rate by phase. An average monthly cost for services provided by the SIT team per case by phase is displayed. The average assumes that cases in which the SIT is able to enroll the client in a Full Service Partnership will require less time of the SIT across phases than those cases without the support of a Full Service Partnership.

   The PMPM rate will automatically decrease based on length of stay post enrollment. The number of months each rate is in effect is shown in the below table. While the rate will automatically shift based on length of stay, the SIT team will be expected to provide all necessary services required by the individual WPW client regardless of how long the client has been enrolled. The rate structure will incentivize the contractor to timely meet client goals for each phase.

TABLE 11 – PMPM Rates By Phase

Phases	PY 2017	PY 2018	PY 2019	PY 2020
Phase 1 (Outreach & Engagement) covered by FFS Budget Component				
Phase 2 (months 1-3 of pilot enrollment)	$851	$851	$851	$851
Phase 3 (months 4-9 of pilot enrollment)	$681	$681	$681	$681
Phase 4 (months 10-15 of pilot enrollment)	$ -	$511	$511	$511
Phase 5 (months 16-27 of pilot enrollment)	$ -	$340	$340	$340

TABLE 12 – Annual Post Enrollment Costs for 12 Teams

Phases	PY 2017	% of SIT Contract	PY 2018	% of SIT Contract	PY 2019	% of SIT Contract	PY 2020	% of SIT Contract
Phase 2	$922,514	21%	$512,372	12%	$482,575	11%	$623,838	14%
Phase 3	$949,965	22%	$1,047,082	24%	$736,571	17%	$980,319	22%
Phase 4	$0	0%	$1,188,619	27%	$604,403	14%	$607,567	14%
Phase 5	$0	0%	$475,004	11%	$1,314,934	30%	$771,569	17%
Total avg annual cost Post Enrollment	**$1,872,479**	**42%**	**$3,223,077**	**73%**	**$3,138,483**	**71%**	**$2,983,293**	**68%**
Phase 1 Outreach & Engagement	**$2,536,536**	**58%**	**$1,188,096**	**27%**	**$1,270,104**	**29%**	**$1,426,572**	**32%**
Total SIT Contract Costs	**$4,409,015**		**$4,411,173**		**$4,408,587**		**$4,409,865**	

Description of Phases

The SIT will consist of a Master's level social worker and a peer support specialist. The caseload ratios reflect the workload of the team. The SIT assigned to a client will remain with that client throughout the progression through the pilot phases to ensure continuity of care. As such, the ratio of SITs to client will vary, depending if a particular SIT has more clients in the earlier phases than in the latter phases. Additionally, the project plans to leverage Mental Health Services Act funding. It is projected that 50% of pilot clients will be engaged in Full Service Partnerships, funded through the Mental Health Services Act. Individuals enrolled in these programs will not need the intensive support of the SIT, with services primarily focused on overall support of the client and coordination with the Full Service Partnership.

Phase 1 - Outreach and Engagement (Anticipated to take an average of 3 months.Paid as a FFS rate.): The primary focus during Phase 1 is to develop a relationship with the potential client and begin to engage them in the project. During these initial months, the SIT will conduct active street outreach and collaborate with other outreach providers to locate the identified client, and establish rapport over time, using motivational interviewing and outreach techniques. This phase culminates in the client's

enrollment in the project as demonstrated by the completion of the client's initial assessment. The team to client ratio for Outreach and Engagement is 1:14.

Enrollment Phases

Phase 2 - Stabilization (Months 1-3 post- enrollment): This phase will revolve around client stabilization, and will consist of intensive client management and assistance. A priority will be identification of an appropriate housing intervention for the individual, and providing assistance in finding housing that best meets their needs. The SIT will join the client in visiting various housing providers, provide assistance in completing required forms, and educate the client on how to be a good tenant. In addition, this phase will include intensive care coordination for other services the individual may be involved with or need, such as physical and/or behavioral health services, access to benefits, assistance in meeting legal obligations, etc. The CCP will be developed in partnership with the client and will outline the client's needs, goals, and how the SIT will help the client achieve their goals. Completion of Phase 2 will be achieved with stable housing, and initial engagement in services as indicated on the CCP. The team to client ratio for the Enrollment Phase is 1:35.

Phase 3 - Maintenance (Months 4-9 post-enrollment): During this period of time, the SIT will continue to assist the client in accessing systems and services to meet their needs as identified on their CCP, including needs that arise unexpectedly. Housing supports will be provided in the areas of working with landlords to address any issues, continued education of the client on how to be a good tenant and positively resolve housing issues, and assisting with any changes in housing that become necessary. Completion of Phase 3 will be achieved when the client is fully engaged in services, maintained stable housing, and have demonstrated an ability to function independently with minimal SIT support. The ratio of SIT to client during the Maintenance Phase is 1:43

Phase 4 – Transition (Months 10-15 post-enrollment): Clients in this phase will maintain contact with their SIT, particularly when problems or issues arise, or when they are ready to set new goals for themselves. For example, in this phase, clients may need to access vocational and/or educational resources and need assistance in completing student loan applications, applying for community college or vocational education, etc. Similarly, clients may be involved in re-establishing relationships with family members and need coaching in interacting with people they have not had contact with for a prolonged period of time. Completion of the Transition phase is demonstrated when the client has established a strong support network, maintained stability in their living situation, their physical and/or behavioral health needs are stabilized and being maintained, and they have established a stable source of income or financial support. The ratio of SIT to client during the Transition Phase is anticipated to be 1:58.

Phase 5 – Aftercare (Months 16-27 post-enrollment): Clients in Phase 5 have demonstrated the ability to function independently and have a strong, ongoing support system. During this period of time the SITs will be available for clients as needed to provide general support, and assist clients in positively resolving any conflicts that may arise, continue to proactively address physical and behavioral health needs, and move forward in achieving their goals. The ratio of SIT to client during Phase 5 is anticipated to be 1:87.

Team Ratios to Client

Based on the program roll-out model, the average SIT caseload for the pilot is expected to be 41 cases per month per team. Table 13 displays the anticipated caseload per SIT by program year and phase. Average caseloads below will not match those listed by phase above since each team will be working with people who are at various phases of the program throughout each program year. As shown in the description of phases above, the beginning phases of participation require a lower case to SIT ratio, leading to a lower overall average monthly caseload in the first program year as compared to the

subsequent years.

TABLE 13 – Average Monthly Caseloads Per SIT (Consists of Peer Support Specialist & Social Worker)					
Phase	**PY 2017**	**PY 2018**	**PY 2019**	**PY 2020**	**Total Project**
Phase 1: Outreach/Engagement Phase	*9*	*4*	*4*	*5*	*5*
Phase 2: Stabilization	*8*	*4*	*4*	*5*	*5*
Phase 3: Maintenance	*10*	*11*	*8*	*10*	*9*
Phase 4: Transition	*0*	*16*	*8*	*8*	*8*
Phase 5: Aftercare	*0*	*10*	*27*	*16*	*13*
Total Avg Monthly Caseload/Team	**26**	**45**	**51**	**44**	**41**

TABLE 14- Proposed Annual Budget for 12 contracted System Integration Teams				
Budget Item	**Units**	**Annual Cost Per Unit**	**Total**	**Notes**
Staff				
Program Director	*1.00*	*$100,000*	*$100,000*	
B.A. level Social Worker	*12.00*	*$60,000*	*$720,000*	Social Worker on team with Peer Support Spec.
Housing Navigator	*4.00*	*$35,000*	*$140,000*	
Master's level	*4.00*	*$80,000*	*$320,000*	Support to SW/PSS Teams
Peer Support Specialist	*12.00*	*$35,000*	*$420,000*	Part of team with Social Worker
Medical Records/Care Coord	*1.00*	*$40,000*	*$40,000*	
Data Specialist	*2.00*	*$65,000*	*$130,000*	
Receptionist/Clerk	*1.00*	*$35,000*	*$35,000*	
(S) Salaries Subtotal	37.00		**$1,905,000**	
Benefit rate			*30%*	(S)x30%
(B) Benefits Subtotal			**$571,500**	
Leased Vehicles	*12.00*		*$72,000*	*Assumes $500 per month per team.*
Housing Supports	*1.00*		*$524,617*	*New clients @ $2000 per client to cover deposit, first month utilities and other WPC eligible move-in costs*
*Enhanced Care Coordination**	*1.00*		*$595,417*	*Monthly clients @ $100/month to cover screenings for housing or pre-employment (i.e. –TB tests), hygiene kits, sustenance, etc.*
Other Operating	*25%*		*$619,125*	(S+B)x25%
(O) Operating Subtotal			**$1,811,159**	
Indirect Rate			*5%*	(S+B)x5%
(I) Indirect Subtotal			**$123,825**	
Proposed Annual Budget			**$4,411,484**	

* *Enhanced Care Coordination funds are intended to be driven by client need and support client achievement of identified plan and treatment goals. Contractors shall apply the following guidelines for Enhanced Care Coordination fund usage and report usage monthly utilizing the Monthly Enhanced Care Coordination Funds Report. Contractors shall demonstrate that they have appropriate controls in place to manage these funds that include written and applied systems and processes. These funds are monies of last resort. Solutions such as the person's/family's personal resources, donations, low-cost or no-cost community service programs, etc., should always be explored first to meet the client needs. Examples of items purchased with Enhanced Care Coordination funds include: screenings for housing or pre-employment (i.e., –TB tests), hygiene kits, sustenance, etc. Not all clients may require or receive this funding. A budget amount of $100/case/month is proposed to cover the various items that might be needed. Existing contractors doing targeted outreach and engagement for our Behavioral Health Services department are currently averaging $700 per person per month including first and last month's rent, which is not captured under the Enhanced Care Coordination funds line item for the SIT contractor/s budget.*

Pay for Metric Reporting

Reporting accurate and timely data by HHSA to DHCS will be critical for measuring progress and for continuously adapting the program to allow for the greatest chance of success through the PDSA process. While HHSA uses its existing data systems in many cases, new reporting tools and data systems will also be put into place, including a shared Care Management Tool. It is anticipated that HHSA will perform a significant amount of coordination among partners to ensure reports and data points not previously tracked are submitted timely and accurately. A pay for reporting deliverable of $220,000 per year is budgeted to be valued at 5% of the services budget. Payment to HHSA for performing this function will be made by DHCS in installments of $110,000 each for the mid-year and annual progress report upon timely and complete submission to the State of all required data elements to calculate all universal and variant health outcome metrics and variant SMI and housing metrics. Payments earned will be reinvested by HHSA in systems to facilitate the sharing and reporting of data among partners.

Pay for Outcomes Budget Component

TABLE 15 – Pay For Outcomes Budget (dollars in millions)

Outcome Achievement Measure	PY 2016	PY 2017	PY 2018	PY 2019	PY 2020
Measure #1: Decrease number of avoidable days spent in the hospital by new WPW clients during their first 12 months of enrollment by 30% compared to the 12 months immediately prior to pilot enrollment (Universal Health Outcome Metric #3 from Section 4.1.a) *(Excludes Psychiatric Hospital)*			$0.45	$0.40	$0.50
Measure #2: Decrease number of avoidable days spent in the hospital by existing WPW clients in their 2nd, 3rd, or 4th year in the pilot by 10% compared to their prior year utilization (Universal Health Outcome Metric #4 from Section 4.1.a) *(Excludes Psychiatric Hospital)*				$0.20	$0.40
Measure #3: Decrease number of avoidable ED visits for new WPW clients during their first 12 months of enrollment by 30% compared to 12 months immediately prior to pilot enrollment (Universal Health Outcome Metric #1 from Section 4.1.a) *(Excludes Psychiatric Hospital)*			$0.45	$0.40	$0.40
Measure #4: Decrease number of avoidable ED visits of existing WPW clients in their 2nd, 3rd, or 4th year in the pilot by 10% compared to their prior year utilization (Universal Health Outcome Metric #2 from Section 4.1.a) *(Excludes Psychiatric Hospital)*				$0.13	$0.50
Measure #5: Decrease number of hospital days spent in the County of San Diego Psychiatric Hospital by new WPW clients during their first 12 months of enrollment by 20% compared to 12 months immediately prior to pilot enrollment (Variant Metric #6 from Section 4.1.b)			$0.45	$0.30	$0.30

Measure #6: Decrease number of hospital days existing WPW clients in their 2nd, 3rd, or 4th year in the pilot are in the County of San Diego Psychiatric Hospital by 5% as compared to prior year utilization (Variant Metric #7 from Section 4.1.b)				$0.32
Measure #7: 80% of new WPW clients will be seen by a primary care provider within 60 days of enrollment in the program (Variant Metric #8 from Section 4.1.b)		$0.39	$0.30	$0.30
Measure #8: Maintain baseline data for measure #1 and measure #3	$0.50			
Total Budget	**$0.50**	**$1.74**	**$1.73**	**$2.72**

Metrics chosen focused on a decrease in inpatient and outpatient utilization in the acute care hospital setting. Since the starting point of identification for participants in the WPW Pilot is based on high cost patients exceeding a threshold level of ED or inpatient services as determined by the partnering MCPs, the chosen utilization measures will cover the vast majority of participants in the pilot and therefore be most closely aligned to overall system savings as a result of the pilot's success. The measure also serves as a good proxy for success in other universal and metric areas being tracked.

Also added was a performance measure tied to a decrease in inpatient utilization for the County of San Diego Psychiatric Hospital. Partnering MCPs felt that it was important to consider system savings that would be achieved outside of the MCPs hospital systems.

One health process outcome tied to clients being seen by a primary care provider within 60 days of enrollment was also included.

Cost and utilization data from the County's prior experience with similar populations in the Low Income Health Program and Project 25 were analyzed to estimate the level of cost avoidance in meeting the target outcomes around inpatient utilization in the acute care hospital setting (Measure #1 and #2 on Table 15) as a way to gauge reasonableness of metric payments.

TABLE 16 – Projected Cost Avoidance (dollars in millions)

Program Year	Projected Clients reaching 12 mo enrollment anniversary	Projected Cost Avoidance: Measure #1 (avoidable days 12 mos prior to enrollment)	Projected Clients reaching 24 mo enrollment anniversary	Projected Cost Avoidance: Measure #2 (avoidable days - previous pilot yr)	Total Projected Cost Avoidance
PY 2016	N/A	$ -	-	$ -	$ -
PY 2017	N/A	$ -	-	$ -	$ -
PY 2018	414	$ 8.20	-	$ -	$8.20
PY 2019	194	$ 3.80	361	$1.70	$5.50
PY 2020	208	$ 4.10	201	$0.90	$5.00
Total	**816**	**$16.10**	**562**	**$2.60**	**$18.70**

While these projections will change when the County's baseline data is finalized, they still far exceed the budgeted outcome payments. Additionally, taking into consideration the outcome payments are for more than just acute care hospital inpatient days, the budgeted payment levels are reasonable.