County of Monterey
Contract No. 16-14184-MO-27

WHOLE PERSON CARE AGREEMENT- Amendment A-01 Round Two

The overarching goal of the Whole Person Care (WPC) Pilot program is the coordination of health, behavioral health, and social services, as applicable, in a patient-centered manner with the goals of improved beneficiary health and wellbeing through more efficient and effective use of resources.

The Department of Health Care Services (DHCS) published a Request for Application (RFA) relating to the WPC Pilot Program on January 13, 2017. County of Monterey submitted its WPC application (Attachment A), in response to DHCS' RFA on March 1, 2017. DHCS accepted County of Monterey's WPC application to the RFA on June 12, 2017 with an allocation of (see table below) in federal financial participation available for each calendar year for the WPC pilot beginning in program year one through program year five subject to the signing of this Agreement.

Total Funds PY 1 - PY 5			
PY	Federal Financial Participation	Local Non-federal Funds	Total Funds
PY 1	$2,683,463	$2,683,463	$5,366,926
PY 2	$3,197,823	$3,197,823	$6,395,646
PY 3	$3,712,183	$3,712,183	$7,424,366
PY 4	$3,712,183	$3,712,183	$7,424,366
PY 5	$3,712,183	$3,712,183	$7,424,366

The parties agree:

A. That "Section 6: Attestations and Certification" of Attachment A shall be amended and replaced by the following:

Section 6: Attestations and Certification
6.1 Attestation

I certify that, as the representative of the WPC pilot lead entity, I agree to the following conditions:

1. The WPC pilot lead entity will help develop and participate in regular learning collaboratives to share best practices among pilot entities, per STC 119.

2. The intergovernmental transfer (IGT) funds will qualify for federal financial participation per 42 CFR 433, subpart B, and will not be derived from impermissible sources, such as recycled Medicaid payments, federal money excluded from use as a state match, impermissible taxes, and non-bona fide provider-related donations, per STC 126.a. Sources of non-federal funding shall not include provider taxes or donations impermissible under section 1903(w), impermissible intergovernmental transfers from providers, or federal funds

received from federal programs other than Medicaid (unless expressly authorized by federal statute to be used for claiming purposes, and the federal Medicaid funding is credited to the other federal funding source). For this purpose, federal funds do not include PRIME payments, patient care revenue received as payment for services rendered under programs such as the Designated State Health Programs, Medicare, or Medicaid

3. Within 30 days determining the interim or final payments due based on the mid-year and annual reports, DHCS will issue requests to the WPC pilot for the necessary IGT amounts. The WPC pilot shall make IGT of funds to DHCS in the amount specified within 7 days of receiving the state's request. If the IGTs are made within the requested timeframe, the payment will be paid within 14 days after the transfers are made.

4. This Agreement between DHCS and the WPC pilot lead entity constitutes the agreement that specifies the WPC pilot requirements, including a data sharing agreement, per STC 118. [See Exhibit A "HIPAA Business Associate Addendum (BAA)" of this Application.] The BAA will apply to the transfer and access of Protected Health Information (PHI) and Personal Information (PI) should the need for sharing such data arise. The DHCS BAA applies to any entity that is acting in a business associate capacity as defined by HIPAA specifically for the purpose of the WPC pilot's operation and evaluation.

5. The WPC pilot will report and submit timely and complete data to DHCS in a format specified by the state. Incomplete and/or non-timely data submissions may lead to a financial penalty after multiple occurrences and technical assistance is provided by the state.

6. The WPC pilot shall submit mid-year and annual reports in a manner specified by DHCS and according to the dates outlined in Attachment GG. The WPC pilot payments shall be contingent on whether progress toward the WPC pilot requirements approved in this application has been made.

7. The WPC pilot will meet with evaluators to assess the WPC pilot.

8. Payments for WPC pilots will be contingent on certain deliverables or achievements; payments will not be distributed, or may be recouped, if pilots fail to demonstrate achievement or submission of deliverables. Funding for PY1 will be available for this submitted and approved WPC pilot application and for reporting baseline data; this funding is in support of the initial identification of the target population and other coordination and planning activities that were necessary for the submission of a successful application. Funding for PY2 through PY5 shall be made available based on the activities and interventions described in the approved WPC Pilot application. (STC 126). Federal funding received shall be returned if the WPC pilot, or a component of it as determined by the state, is not subsequently implemented.

9. If the individual WPC pilot applicant receives its maximum approved pilot year budget funding before the end of the pilot year, the individual WPC pilot will continue to provide WPC pilot services to enrolled WPC pilot participants at levels established in the approved WPC pilot application through the end of the pilot year.

10. WPC Pilot payments shall not be earned or payable for activities otherwise coverable or directly reimbursable by Medi-Cal.

11. The WPC lead entity has reviewed and compared the activities in the proposed WPC pilot application to its county's Medi-Cal Targeted Case Management Program (TCM), and has made appropriate adjustments to reduce the request for WPC funds as necessary to ensure that the WPC pilot funding for activities and interactions of their care coordination teams do not duplicate payments under the county's TCM benefit. The WPC lead entity has provided documentation for the adjustment(s) in the approved application which was accepted in accordance with DHCS guidance provided to the lead entity during the DHCS application review process.

12. The lead entity will respond to general inquiries from the state pertaining to the WPC pilot within one business day after acknowledging receipt, and provide requested information within five business days, unless an alternate timeline is approved or determined necessary by DHCS. DHCS will consider reasonable timelines that will be dependent on the type and severity of the information when making such requests.

13. The lead entity understands that the state of California must abide by all requirements outlined in the STCs and Attachments GG, HH, and MM. The state may suspend or terminate a WPC pilot if corrective action has been imposed and persistent poor performance continues. Should a WPC pilot be terminated, the state shall provide notice to the pilot and request a close-out plan due to the state within 30 calendar days, unless significant harm to beneficiaries is occurring, in which case the state may request a close-out plan within 10 business days. All state requirements regarding pilot termination can be found in Attachment HH.

☑ I hereby certify that all information provided in this application is true and accurate to the best of my knowledge, and that this application has been completed based on a good faith understanding of WPC pilot program participation requirements as specified in the Medi-Cal 2020 waiver STCs, Attachments GG, HH and MM, and the DHCS Frequently Asked Questions document.

B. WPC Pilot Program Agreement

Notice

All inquiries and notices relating to this Agreement should be directed to the representatives listed below. Either party may make changes to the information below by giving written notice to the other party. Said changes shall not require an amendment to this Contract.

The Agreement representatives during the term of this Agreement will be:

Department of Health Care Services	WPC Pilot Lead Entity
Managed Care Quality & Monitoring Division	Monterey County Health Department
Attention: Bob Baxter	Attention: Elsa M. Jimenez, MPP
Telephone: (916) 319-9707	Telephone: (831) 755-4526

As a condition for participation in the WPC Pilot program, the WPC pilot lead entity (referred to as "Contractor" below) agrees to comply with all of the following terms and conditions, and with all of the terms and conditions included on any attachment(s) hereto, which is/are incorporated herein by reference:

1. **Nondiscrimination.** Pursuant to Affordable Care Act section 1557 (42 U.S.C. section 18116), during the performance of this Contract, Contractor shall not, and shall also require and ensure its subcontractors, providers, agents, and employees to not, cause an individual, beneficiary, or applicant to be excluded on the grounds prohibited under Title VI of the Civil Rights Act of 1964 (42 U.S.C. 2000d et seq.), Title IX of the Education Amendments of 1972 (20 U.S.C. 1681 et seq.), the Age Discrimination Act of 1975 (42 U.S.C. 6101 et seq.), or section 504 of the Rehabilitation Act of 1973 (29 U.S.C. 794), or subject to any other applicable State and Federal laws, from participation in, be denied the benefits of, or be subjected to discrimination under, any health program or activity offered through DHCS.

2. **Term and Termination.** This Agreement will be effective from the date both DHCS and Contractor have executed this Agreement and terminate on June 30, 2021 unless the application is renewed or the WPC Pilot program is extended, or the WPC pilot is terminated in accordance with procedures established pursuant to STC 120 and Attachment HH thereof.

3. **Compliance with Laws and Regulations.** Contractor agrees to, and shall also require and ensure its subcontractors to, comply with all applicable provisions of Chapters 7 and 8 of the Welfare and Institutions Code, and any applicable rules or regulations promulgated by DHCS pursuant to these chapters. Contractor agrees to, and shall also requires its subcontractors to, comply with all federal laws and regulations governing and regulating the Medicaid program.

4. **Fraud and Abuse.** Contractor agrees, and shall also require its subcontractors to agree, that it shall not engage in or commit fraud or abuse. "Fraud" means intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or herself or some other person. "Abuse" means provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the

Medicaid program or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care.

5. **Governing Law.** This Agreement shall be governed by and interpreted in accordance with the laws of the State of California.

6. **Complete Integration.** This Agreement, including any attachments or documents incorporated herein by express reference is intended to be a complete integration and there are no prior or contemporaneous different or additional agreements pertaining to the subject matters of this Agreement.

7. **Amendment.** No alteration or variation of the terms or provisions of this Agreement shall be valid unless made in writing and signed by the parties to this Agreement, and no oral understanding or agreement not set forth in this Agreement, shall be binding on the parties to this Agreement.

8. **Discrepancy or Inconsistency.** If there is a discrepancy or inconsistency in the terms of this Agreement and Attachment A, then this Agreement controls.

Signature of WPC Lead Entity Representative

Date 06/14/2017

Name: Elsa M. Jimenez, MPP

Title: Director of Health

Signature of DHCS Representative

Date 6/27/17

Name: Mari Cantwell

Title: Chief Deputy Director, Health Care Programs

Reviewed as to fiscal provisions

Auditor-Controller
County of Monterey 6-13-17

APPROVED AS TO
DEPUTY COUNTY
COUNTY OF MON

Exhibit A – Health Insurance Portability and Accountability Act (HIPAA Business Associate Addendum (BAA)

I. Recitals

A. This Contract (Agreement) has been determined to constitute a business associate relationship under the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191 ("HIPAA"), the Health Information Technology for Economic and Clinical Health Act, Public Law 111-005 ('the HITECH Act"), 42 U.S.C. section 17921 et seq., and their implementing privacy and security regulations at 45 CFR Parts 160 and 164 ("the HIPAA regulations").

B. The Department of Health Care Services ("DHCS") wishes to disclose to Business Associate certain information pursuant to the terms of this Agreement, some of which may constitute Protected Health Information ("PHI"), including protected health information in electronic media ("ePHI"), under federal law, and personal information ("PI") under state law.

C. As set forth in this Agreement, Contractor, here and after, is the Business Associate of DHCS acting on DHCS' behalf and provides services, arranges, performs or assists in the performance of functions or activities on behalf of DHCS and creates, receives, maintains, transmits, uses or discloses PHI and PI. DHCS and Business Associate are each a party to this Agreement and are collectively referred to as the "parties."

D. The purpose of this Addendum is to protect the privacy and security of the PHI and PI that may be created, received, maintained, transmitted, used or disclosed pursuant to this Agreement, and to comply with certain standards and requirements of HIPAA, the HITECH Act and the HIPAA regulations, including, but not limited to, the requirement that DHCS must enter into a contract containing specific requirements with Contractor prior to the disclosure of PHI to Contractor, as set forth in 45 CFR Parts 160 and 164 and the HITECH Act, and the Final Omnibus Rule as well as the Alcohol and Drug Abuse patient records confidentiality law 42 CFR Part 2, and any other applicable state or federal law or regulation. 42 CFR section 2.1(b)(2)(B) allows for the disclosure of such records to qualified personnel for the purpose of conducting management or financial audits, or program evaluation. 42 CFR Section 2.53(d) provides that patient identifying information disclosed under this section may be disclosed only back to the program from which it was obtained and used only to carry out an audit or evaluation purpose or to investigate or prosecute criminal or other activities, as authorized by an appropriate court order.

E. The terms used in this Addendum, but not otherwise defined, shall have the same meanings as those terms have in the HIPAA regulations. Any reference to statutory or regulatory language shall be to such language as in effect or as amended.

II. Definitions

A. Breach shall have the meaning given to such term under HIPAA, the HITECH Act, the HIPAA regulations, and the Final Omnibus Rule.

B. Business Associate shall have the meaning given to such term under HIPAA, the HITECH Act, the HIPAA regulations, and the final Omnibus Rule.

C. Covered Entity shall have the meaning given to such term under HIPAA, the HITECH Act, the HIPAA regulations, and Final Omnibus Rule.

D. Electronic Health Record shall have the meaning given to such term in the HITECH Act, including, but not limited to, 42 U.S.C Section 17921 and implementing regulations.

E. Electronic Protected Health Information (ePHI) means individually identifiable health information transmitted by electronic media or maintained in electronic media, including but not limited to electronic media as set forth under 45 CFR section 160.103.

F. Individually Identifiable Health Information means health information, including demographic information collected from an individual, that is created or received by a health care provider, health plan, employer or health care clearinghouse, and relates to the past, present or future physical or mental health or condition of an individual, the provision of health care to an individual, or the past, present, or future payment for the provision of health care to an individual, that identifies the individual or where there is a reasonable basis to believe the information can be used to identify the individual, as set forth under 45 CFR section 160.103.

G. Privacy Rule shall mean the HIPAA Regulation that is found at 45 CFR Parts 160 and 164.

H. Personal Information shall have the meaning given to such term in California Civil Code section 1798.29.

I. Protected Health Information means individually identifiable health information that is transmitted by electronic media, maintained in electronic media, or is transmitted or maintained in any other form or medium, as set forth under 45 CFR section 160.103.

J. Required by law, as set forth under 45 CFR section 164.103, means a mandate contained in law that compels an entity to make a use or disclosure of PHI that is enforceable in a court of law. This includes, but is not limited to, court orders and court-ordered warrants, subpoenas or summons issued by a court, grand jury, a governmental or tribal inspector general, or an administrative body authorized to require the production of information, and a civil or an authorized investigative demand. It also includes Medicare conditions of participation with respect to health care providers participating in the program, and statutes or regulations that require the production of information, including statutes or regulations that require such information if payment is sought under a government program providing public benefits.

K. Secretary means the Secretary of the U.S. Department of Health and Human Services ("HHS") or the Secretary's designee.

L. Security Incident means the attempted or successful unauthorized access, use, disclosure, modification, or destruction of PHI or PI, or confidential data that is essential to the ongoing operation of the Business Associate's organization and intended for internal use; or interference with system operations in an information system.

M. Security Rule shall mean the HIPAA regulation that is found at 45 CFR Parts 160 and 164.

N. Unsecured PHI shall have the meaning given to such term under the HITECH Act, 42 U.S.C. section 17932(h), any guidance issued pursuant to such Act, and the HIPAA regulations.

III. Terms of Agreement

A. Permitted Uses and Disclosures of PHI by Business Associate

Permitted Uses and Disclosures. Except as otherwise indicated in this Addendum, Business Associate may use or disclose PHI only to perform functions, activities or services specified in this Agreement, for, or on behalf of DHCS, provided that such use or disclosure would not violate the HIPAA regulations, if done by DHCS. Any such use or disclosure must, to the extent practicable, be limited to the limited data set, as defined in 45 CFR section 164.514(e)(2), or, if needed, to the minimum necessary to accomplish the intended purpose of such use or disclosure, in compliance with the HITECH Act and any guidance issued pursuant to such Act, the HIPAA regulations, the Final Omnibus Rule and 42 CFR Part 2.

1. Specific Use and Disclosure Provisions. Except as otherwise indicated in this Addendum, Business Associate may:

a. Use and disclose for management and administration. Use and disclose PHI for the proper management and administration of the Business Associate provided that such disclosures are required by law, or the Business Associate obtains reasonable assurances from the person to whom the information is disclosed that it will remain confidential and will be used or further disclosed only as required by law or for the purpose for which it was disclosed to the person, and the person notifies the Business Associate of any instances of which it is aware that the confidentiality of the information has been breached.

b. Provision of Data Aggregation Services. Use PHI to provide data aggregation services to DHCS. Data aggregation means the combining of PHI created or received by the Business Associate on behalf of DHCS with PHI received by the Business Associate in its capacity as the Business Associate of another covered entity, to permit data analyses that relate to the health care operations of DHCS.

B. Prohibited Uses and Disclosures

1. Business Associate shall not disclose PHI about an individual to a health plan for payment or health care operations purposes if the PHI pertains solely to a health care item or service for which the health care provider involved has been paid out of pocket in full and the individual requests such restriction, in accordance with 42 U.S.C. section 17935(a) and 45 CFR section 164.522(a).

2. Business Associate shall not directly or indirectly receive remuneration in exchange for PHI, except with the prior written consent of DHCS and as permitted by 42 U.S.C. section 17935(d)(2).

C. Responsibilities of Business Associate

Business Associate agrees:

1. Nondisclosure. Not to use or disclose Protected Health Information (PHI) other than as permitted or required by this Agreement or as required by law.

2. Safeguards. To implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the PHI, including electronic PHI, that it creates, receives, maintains, uses or transmits on behalf of DHCS, in compliance with 45 CFR sections 164.308, 164.310 and 164.312, and to prevent use or disclosure of PHI other than as provided for by this Agreement. Business Associate shall implement reasonable and appropriate policies and procedures to comply with the standards, implementation specifications and other requirements of 45 CFR section 164, subpart C, in compliance with 45 CFR section 164.316. Business Associate shall develop and maintain a written information privacy

and security program that includes administrative, technical and physical safeguards appropriate to the size and complexity of the Business Associate's operations and the nature and scope of its activities, and which incorporates the requirements of section 3, Security, below. Business Associate will provide DHCS with its current and updated policies.

3. Security. To take any and all steps necessary to ensure the continuous security of all computerized data systems containing PHI and/or PI, and to protect paper documents containing PHI and/or PI. These steps shall include, at a minimum:

    a. Complying with all of the data system security precautions listed in Attachment A, the Business Associate Data Security Requirements;

    b. Achieving and maintaining compliance with the HIPAA Security Rule (45 CFR Parts 160 and 164), as necessary in conducting operations on behalf of DHCS under this Agreement;

    c. Providing a level and scope of security that is at least comparable to the level and scope of security established by the Office of Management and Budget in OMB Circular No. A-130, Appendix III - Security of Federal Automated Information Systems, which sets forth guidelines for automated information systems in Federal agencies; and

    d. In case of a conflict between any of the security standards contained in any of these enumerated sources of security standards, the most stringent shall apply. The most stringent means that safeguard which provides the highest level of protection to PHI from unauthorized disclosure. Further, Business Associate must comply with changes to these standards that occur after the effective date of this Agreement.

    Business Associate shall designate a Security Officer to oversee its data security program who shall be responsible for carrying out the requirements of this section and for communicating on security matters with DHCS.

D. Mitigation of Harmful Effects. To mitigate, to the extent practicable, any harmful effect that is known to Business Associate of a use or disclosure of PHI by Business Associate or its subcontractors in violation of the requirements of this Addendum.

E. Business Associate's Agents and Subcontractors.

1. To enter into written agreements with any agents, including subcontractors and vendors, to whom Business Associate provides PHI or PI received from or created or received by Business Associate on behalf of DHCS, that impose

the same restrictions and conditions on such agents, subcontractors and vendors that apply to Business Associate with respect to such PHI and PI under this Addendum, and that comply with all applicable provisions of HIPAA, the HITECH Act the HIPAA regulations, and the Final Omnibus Rule, including the requirement that any agents, subcontractors or vendors implement reasonable and appropriate administrative, physical, and technical safeguards to protect such PHI and PI. Business associates are directly liable under the HIPAA Rules and subject to civil and, in some cases, criminal penalties for making uses and disclosures of protected health information that are not authorized by its contract or required by law. A business associate also is directly liable and subject to civil penalties for failing to safeguard electronic protected health information in accordance with the HIPAA Security Rule. A "business associate" also is a subcontractor that creates, receives, maintains, or transmits protected health information on behalf of another business associate. Business Associate shall incorporate, when applicable, the relevant provisions of this Addendum into each subcontract or subaward to such agents, subcontractors and vendors, including the requirement that any security incidents or breaches of unsecured PHI or PI be reported to Business Associate.

2. In accordance with 45 CFR section 164.504(e)(1)(ii), upon Business Associate's knowledge of a material breach or violation by its subcontractor of the agreement between Business Associate and the subcontractor, Business Associate shall:

    a. Provide an opportunity for the subcontractor to cure the breach or end the violation and terminate the agreement if the subcontractor does not cure the breach or end the violation within the time specified by DHCS; or
    b. Immediately terminate the agreement if the subcontractor has breached a material term of the agreement and cure is not possible.

F. Availability of Information to DHCS and Individuals. To provide access and information:

1. To provide access as DHCS may require, and in the time and manner designated by DHCS (upon reasonable notice and during Business Associate's normal business hours) to PHI in a Designated Record Set, to DHCS (or, as directed by DHCS), to an Individual, in accordance with 45 CFR section 164.524. Designated Record Set means the group of records maintained for DHCS that includes medical, dental and billing records about individuals; enrollment, payment, claims adjudication, and case or medical management systems maintained for DHCS health plans; or those records used to make decisions about individuals on behalf of DHCS. Business Associate shall use the forms and processes developed by DHCS for this purpose and shall respond to requests for access to records transmitted by

DHCS within fifteen (15) calendar days of receipt of the request by producing the records or verifying that there are none.

2. If Business Associate maintains an Electronic Health Record with PHI, and an individual requests a copy of such information in an electronic format, Business Associate shall provide such information in an electronic format to enable DHCS to fulfill its obligations under the HITECH Act, including but not limited to, 42 U.S.C. section 17935(e).

3. If Business Associate receives data from DHCS that was provided to DHCS by the Social Security Administration, upon request by DHCS, Business Associate shall provide DHCS with a list of all employees, contractors and agents who have access to the Social Security data, including employees, contractors and agents of its subcontractors and agents.

G. Amendment of PHI. To make any amendment(s) to PHI that DHCS directs or agrees to pursuant to 45 CFR section 164.526, in the time and manner designated by DHCS.

H. Internal Practices. To make Business Associate's internal practices, books and records relating to the use and disclosure of PHI received from DHCS, or created or received by Business Associate on behalf of DHCS, available to DHCS or to the Secretary of the U.S. Department of Health and Human Services in a time and manner designated by DHCS or by the Secretary, for purposes of determining DHCS' compliance with the HIPAA regulations. If any information needed for this purpose is in the exclusive possession of any other entity or person and the other entity or person fails or refuses to furnish the information to Business Associate, Business Associate shall so certify to DHCS and shall set forth the efforts it made to obtain the information.

I. Documentation of Disclosures. To document and make available to DHCS or (at the direction of DHCS) to an Individual such disclosures of PHI, and information related to such disclosures, necessary to respond to a proper request by the subject Individual for an accounting of disclosures of PHI, in accordance with the HITECH Act and its implementing regulations, including but not limited to 45 CFR section 164.528 and 42 U.S.C. section 17935(c). If Business Associate maintains electronic health records for DHCS as of January 1, 2009, Business Associate must provide an accounting of disclosures, including those disclosures for treatment, payment or health care operations, effective with disclosures on or after January 1, 2014. If Business Associate acquires electronic health records for DHCS after January 1, 2009, Business Associate must provide an accounting of disclosures, including those disclosures for treatment, payment or health care operations, effective with disclosures on or after the date the electronic health record is acquired, or on or after January 1, 2011, whichever date is later. The

electronic accounting of disclosures shall be for disclosures during the three years prior to the request for an accounting.

J. Breaches and Security Incidents. During the term of this Agreement, Business Associate agrees to implement reasonable systems for the discovery and prompt reporting of any breach or security incident, and to take the following steps:

1. Notice to DHCS. (1) To notify DHCS immediately upon the discovery of a suspected security incident that involves data provided to DHCS by the Social Security Administration. This notification will be by telephone call plus email or fax upon the discovery of the breach. (2) To notify DHCS within 24 hours by email or fax of the discovery of unsecured PHI or PI in electronic media or in any other media if the PHI or PI was, or is reasonably believed to have been, accessed or acquired by an unauthorized person, any suspected security incident, intrusion or unauthorized access, use or disclosure of PHI or PI in violation of this Agreement and this Addendum, or potential loss of confidential data affecting this Agreement. A breach shall be treated as discovered by Business Associate as of the first day on which the breach is known, or by exercising reasonable diligence would have been known, to any person (other than the person committing the breach) who is an employee, officer or other agent of Business Associate.

   Notice shall be provided to the DHCS Program Contract Manager, the DHCS Privacy Officer and the DHCS Information Security Officer. If the incident occurs after business hours or on a weekend or holiday and involves data provided to DHCS by the Social Security Administration, notice shall be provided by calling the DHCS EITS Service Desk. Notice shall be made using the "DHCS Privacy Incident Report" form, including all information known at the time. Business Associate shall use the most current version of this form, which is posted on the DHCS Privacy Office website (www.dhcs.ca.gov, then select "Privacy" in the left column and then "Business Use" near the middle of the page) or use this link: http://www.dhcs.ca.gov/formsandpubs/laws/priv/Pages/DHCSBusinessAssociatesOnly.aspx

   Upon discovery of a breach or suspected security incident, intrusion or unauthorized access, use or disclosure of PHI or PI, Business Associate shall take:

   a. Prompt corrective action to mitigate any risks or damages involved with the breach and to protect the operating environment; and
   b. Any action pertaining to such unauthorized disclosure required by applicable Federal and State laws and regulations.

2. Investigation and Investigation Report. To immediately investigate such security incident, breach, or unauthorized access, use or disclosure of PHI

or PI. If the initial report did not include all of the requested information marked with an asterisk, then within 72 hours of the discovery, Business Associate shall submit an updated "DHCS Privacy Incident Report" containing the information marked with an asterisk and all other applicable information listed on the form, to the extent known at that time, to the DHCS Program Contract Manager, the DHCS Privacy Officer, and the DHCS Information Security Officer:

3. Complete Report. To provide a complete report of the investigation to the DHCS Program Contract Manager, the DHCS Privacy Officer, and the DHCS Information Security Officer within ten (10) working days of the discovery of the breach or unauthorized use or disclosure. If all of the required information was not included in either the initial report, or the Investigation Report, then a separate Complete Report must be submitted. The report shall be submitted on the "DHCS Privacy Incident Report" form and shall include an assessment of all known factors relevant to a determination of whether a breach occurred under applicable provisions of HIPAA, the HITECH Act, the HIPAA regulations and/or state law. The report shall also include a full, detailed corrective action plan, including information on measures that were taken to halt and/or contain the improper use or disclosure. If DHCS requests information in addition to that listed on the "DHCS Privacy Incident Report" form, Business Associate shall make reasonable efforts to provide DHCS with such information. If necessary, a Supplemental Report may be used to submit revised or additional information after the completed report is submitted, by submitting the revised or additional information on an updated "DHCS Privacy Incident Report" form. DHCS will review and approve or disapprove the determination of whether a breach occurred, is reportable to the appropriate entities, if individual notifications are required, and the corrective action plan.

4. Notification of Individuals. If the cause of a breach of PHI or PI is attributable to Business Associate or its subcontractors, agents or vendors, Business Associate shall notify individuals of the breach or unauthorized use or disclosure when notification is required under state or federal law and shall pay any costs of such notifications, as well as any costs associated with the breach. The notifications shall comply with the requirements set forth in 42 U.S.C. section 17932 and its implementing regulations, including, but not limited to, the requirement that the notifications be made without unreasonable delay and in no event later than 60 calendar days. The DHCS Program Contract Manager, the DHCS Privacy Officer, and the DHCS Information Security Officer shall approve the time, manner and content of any such notifications and their review and approval must be obtained before the notifications are made.

5. Responsibility for Reporting of Breaches. If the cause of a breach of PHI or PI is attributable to Business Associate or its agents, subcontractors or vendors, Business Associate is responsible for all required reporting of the breach as specified in 42 U.S.C. section 17932 and its implementing regulations, including notification to media outlets and to the Secretary. If a breach of unsecured PHI involves more than 500 residents of the State of California or its jurisdiction, Business Associate shall notify the Secretary of the breach immediately upon discovery of the breach. If Business Associate has reason to believe that duplicate reporting of the same breach or incident may occur because its subcontractors, agents or vendors may report the breach or incident to DHCS in addition to Business Associate, Business Associate shall notify DHCS, and DHCS and Business Associate may take appropriate action to prevent duplicate reporting. The breach reporting requirements of this paragraph are in addition to the reporting requirements set forth in subsection 1, above.

6. DHCS Contact Information. To direct communications to the above referenced DHCS staff, the Contractor shall initiate contact as indicated herein. DHCS reserves the right to make changes to the contact information below by giving written notice to the Contractor. Said changes shall not require an amendment to this Addendum or the Agreement to which it is incorporated.

DHCS Contract Contact	**DHCS Privacy Officer**	**DHCS Information Security Officer**
Chief, Coordinated Care Program Section	Privacy Officer c/o: Office of HIPAA Compliance Department of Health Care Services P.O. Box 997413, MS 4722 Sacramento, CA 95899-7413 Email: privacyofficer@dhcs.ca.gov Telephone: (916) 445-4646 Fax: (916) 440-7680	Information Security Officer DHCS Information Security Office P.O. Box 997413, MS 6400 Sacramento, CA 95899-7413 Email: iso@dhcs.ca.gov Fax: (916) 440-5537 Telephone: EITS Service Desk (916) 440-7000 or (800) 579-0874

K. Termination of Agreement. In accordance with Section 13404(b) of the HITECH Act and to the extent required by the HIPAA regulations, if Business Associate knows of a material breach or violation by DHCS of this Addendum, it shall take the following steps:

1. Provide an opportunity for DHCS to cure the breach or end the violation and terminate the Agreement if DHCS does not cure the breach or end the violation within the time specified by Business Associate; or
2. Immediately terminate the Agreement if DHCS has breached a material term of the Addendum and cure is not possible.

L. Due Diligence. Business Associate shall exercise due diligence and shall take reasonable steps to ensure that it remains in compliance with this Addendum and is in compliance with applicable provisions of HIPAA, the HITECH Act and the HIPAA regulations, and that its agents, subcontractors and vendors are in compliance with their obligations as required by this Addendum.

M. Sanctions and/or Penalties. Business Associate understands that a failure to comply with the provisions of HIPAA, the HITECH Act and the HIPAA regulations that are applicable to Business Associate may result in the imposition of sanctions and/or penalties on Business Associate under HIPAA, the HITECH Act and the HIPAA regulations.

IV. Obligations of DHCS

DHCS agrees to:

A. Notice of Privacy Practices. Provide Business Associate with the Notice of Privacy Practices that DHCS produces in accordance with 45 CFR section 164.520, as well as any changes to such notice. Visit the DHCS Privacy Office to view the most current Notice of Privacy Practices at: http://www.dhcs.ca.gov/formsandpubs/laws/priv/Pages/default.aspx or the DHCS website at www.dhcs.ca.gov (select "Privacy in the left column and "Notice of Privacy Practices" on the right side of the page).

B. Permission by Individuals for Use and Disclosure of PHI. Provide the Business Associate with any changes in, or revocation of, permission by an Individual to use or disclose PHI, if such changes affect the Business Associate's permitted or required uses and disclosures.

C. Notification of Restrictions. Notify the Business Associate of any restriction to the use or disclosure of PHI that DHCS has agreed to in accordance with 45 CFR section 164.522, to the extent that such restriction may affect the Business Associate's use or disclosure of PHI.

D. Requests Conflicting with HIPAA Rules. Not request the Business Associate to use or disclose PHI in any manner that would not be permissible under the HIPAA regulations if done by DHCS.

V. Audits, Inspection and Enforcement

A. From time to time, DHCS may inspect the facilities, systems, books and records of Business Associate to monitor compliance with this Agreement and this Addendum. Business Associate shall promptly remedy any violation of any provision of this Addendum and shall certify the same to the DHCS Privacy Officer in writing. The fact that DHCS inspects, or fails to inspect, or has the right to inspect, Business Associate's facilities, systems and procedures does not relieve Business Associate of its responsibility to comply with this Addendum, nor does DHCS':

1. Failure to detect or

2. Detection, but failure to notify Business Associate or require Business Associate's remediation of any unsatisfactory practices constitute acceptance of such practice or a waiver of DHCS' enforcement rights under this Agreement and this Addendum.

B. If Business Associate is the subject of an audit, compliance review, or complaint investigation by the Secretary or the Office of Civil Rights, U.S. Department of Health and Human Services, that is related to the performance of its obligations pursuant to this HIPAA Business Associate Addendum, Business Associate shall notify DHCS and provide DHCS with a copy of any PHI or PI that Business Associate provides to the Secretary or the Office of Civil Rights concurrently with providing such PHI or PI to the Secretary. Business Associate is responsible for any civil penalties assessed due to an audit or investigation of Business Associate, in accordance with 42 U.S.C. section 17934(c).

VI. Termination

A. Term. The Term of this Addendum shall commence as of the effective date of this Addendum and shall extend beyond the termination of the contract and shall terminate when all the PHI provided by DHCS to Business Associate, or created or received by Business Associate on behalf of DHCS, is destroyed or returned to DHCS, in accordance with 45 CFR 164.504(e)(2)(ii)(I).

B. Termination for Cause. In accordance with 45 CFR section 164.504(e)(1)(ii), upon DHCS' knowledge of a material breach or violation of this Addendum by Business Associate, DHCS shall:

1. Provide an opportunity for Business Associate to cure the breach or end the violation and terminate this Agreement if Business Associate does not cure the breach or end the violation within the time specified by DHCS; or

2. Immediately terminate this Agreement if Business Associate has breached a material term of this Addendum and cure is not possible.

C. Judicial or Administrative Proceedings. Business Associate will notify DHCS if it is named as a defendant in a criminal proceeding for a violation of HIPAA. DHCS may terminate this Agreement if Business Associate is found guilty of a criminal violation of HIPAA. DHCS may terminate this Agreement if a finding or stipulation that the Business Associate has violated any standard or requirement of HIPAA, or other security or privacy laws is made in any administrative or civil proceeding in which the Business Associate is a party or has been joined.

D. Effect of Termination. Upon termination or expiration of this Agreement for any reason, Business Associate shall return or destroy all PHI received from DHCS (or created or received by Business Associate on behalf of DHCS) that Business Associate still maintains in any form, and shall retain no copies of such PHI. If return or destruction is not feasible, Business Associate shall notify DHCS of the conditions that make the return or destruction infeasible, and DHCS and Business Associate shall determine the terms and conditions under which Business Associate may retain the PHI. Business Associate shall continue to extend the protections of this Addendum to such PHI, and shall limit further use of such PHI to those purposes that make the return or destruction of such PHI infeasible. This provision shall apply to PHI that is in the possession of subcontractors or agents of Business Associate.

VII. Miscellaneous Provisions

A. Disclaimer. DHCS makes no warranty or representation that compliance by Business Associate with this Addendum, HIPAA or the HIPAA regulations will be adequate or satisfactory for Business Associate's own purposes or that any information in Business Associate's possession or control, or transmitted or received by Business Associate, is or will be secure from unauthorized use or disclosure. Business Associate is solely responsible for all decisions made by Business Associate regarding the safeguarding of PHI.

B. Amendment. The parties acknowledge that federal and state laws relating to electronic data security and privacy are rapidly evolving and that amendment of this Addendum may be required to provide for procedures to ensure compliance with such developments. The parties specifically agree to take such action as is necessary to implement the standards and requirements of HIPAA, the HITECH Act, the HIPAA regulations and other applicable laws relating to the security or privacy of PHI. Upon DHCS' request, Business Associate agrees to promptly enter into negotiations with DHCS concerning an amendment to this Addendum embodying written assurances consistent with the standards and requirements of HIPAA, the HITECH Act, the HIPAA regulations or other applicable laws. DHCS may terminate this Agreement upon thirty (30) days written notice in the event:

1. Business Associate does not promptly enter into negotiations to amend this Addendum when requested by DHCS pursuant to this Section; or

2. Business Associate does not enter into an amendment providing assurances regarding the safeguarding of PHI that DHCS in its sole discretion, deems sufficient to satisfy the standards and requirements of HIPAA and the HIPAA regulations.

C. Assistance in Litigation or Administrative Proceedings. Business Associate shall make itself and any subcontractors, employees or agents assisting Business Associate in the performance of its obligations under this Agreement, available to DHCS at no cost to DHCS to testify as witnesses, or otherwise, in the event of litigation or administrative proceedings being commenced against DHCS, its directors, officers or employees based upon claimed violation of HIPAA, the HIPAA regulations or other laws relating to security and privacy, which involves inactions or actions by the Business Associate, except where Business Associate or its subcontractor, employee or agent is a named adverse party.

D. No Third-Party Beneficiaries. Nothing express or implied in the terms and conditions of this Addendum is intended to confer, nor shall anything herein confer, upon any person other than DHCS or Business Associate and their respective successors or assignees, any rights, remedies, obligations or liabilities whatsoever.

E. Interpretation. The terms and conditions in this Addendum shall be interpreted as broadly as necessary to implement and comply with HIPAA, the HITECH Act, the HIPAA regulations and applicable state laws. The parties agree that any ambiguity in the terms and conditions of this Addendum shall be resolved in favor of a meaning that complies and is consistent with HIPAA, the HITECH Act and the HIPAA regulations.

F. Regulatory References. A reference in the terms and conditions of this Addendum to a section in the HIPAA regulations means the section as in effect or as amended.

G. Survival. The respective rights and obligations of Business Associate under Section VI.D of this Addendum shall survive the termination or expiration of this Agreement.

H. No Waiver of Obligations. No change, waiver or discharge of any liability or obligation hereunder on any one or more occasions shall be deemed a waiver of performance of any continuing or other obligation, or shall prohibit enforcement of any obligation, on any other occasion.

HIPAA BAA
Attachment A
Business Associate Data Security Requirements

I. Personnel Controls

A. Employee Training. All workforce members who assist in the performance of functions or activities on behalf of DHCS, or access or disclose DHCS PHI or PI must complete information privacy and security training, at least annually, at Business Associate's expense. Each workforce member who receives information privacy and security training must sign a certification, indicating the member's name and the date on which the training was completed. These certifications must be retained for a period of six (6) years following contract termination.

B. Employee Discipline. Appropriate sanctions must be applied against workforce members who fail to comply with privacy policies and procedures or any provisions of these requirements, including termination of employment where appropriate.

C. Confidentiality Statement. All persons that will be working with DHCS PHI or PI must sign a confidentiality statement that includes, at a minimum, General Use, Security and Privacy Safeguards, Unacceptable Use, and Enforcement Policies. The statement must be signed by the workforce member prior to access to DHCS PHI or PI. The statement must be renewed annually. The Contractor shall retain each person's written confidentiality statement for DHCS inspection for a period of six (6) years following contract termination.

D. Background Check. Before a member of the workforce may access DHCS PHI or PI, a thorough background check of that worker must be conducted, with evaluation of the results to assure that there is no indication that the worker may present a risk to the security or integrity of confidential data or a risk for theft or misuse of confidential data. The Contractor shall retain each workforce member's background check documentation for a period of three (3) years following contract termination.

II. Technical Security Controls

A. Workstation/Laptop encryption. All workstations and laptops that process and/or store DHCS PHI or PI must be encrypted using a FIPS 140-2 certified algorithm which is 128bit or higher, such as Advanced Encryption Standard (AES). The encryption solution must be full disk unless approved by the DHCS Information Security Office.

B. Server Security. Servers containing unencrypted DHCS PHI or PI must have sufficient administrative, physical, and technical controls in place to protect that data, based upon a risk assessment/system security review.

C. Minimum Necessary. Only the minimum necessary amount of DHCS PHI or PI required to perform necessary business functions may be copied, downloaded, or exported.

D. Removable media devices. All electronic files that contain DHCS PHI or PI data must be encrypted when stored on any removable media or portable device (i.e. USB thumb drives, floppies, CD/DVD, smartphones, backup tapes etc.). Encryption must be a FIPS 140-2 certified algorithm which is 128bit or higher, such as AES.

E. Antivirus software. All workstations, laptops and other systems that process and/or store DHCS PHI or PI must install and actively use comprehensive anti-virus software solution with automatic updates scheduled at least daily.

F. Patch Management. All workstations, laptops and other systems that process and/or store DHCS PHI or PI must have critical security patches applied, with system reboot if necessary. There must be a documented patch management process which determines installation timeframe based on risk assessment and vendor recommendations. At a maximum, all applicable patches must be installed within 30 days of vendor release.

G. User IDs and Password Controls. All users must be issued a unique user name for accessing DHCS PHI or PI. Username must be promptly disabled, deleted, or the password changed upon the transfer or termination of an employee with knowledge of the password, at maximum within 24 hours. Passwords are not to be shared. Passwords must be at least eight characters and must be a non-dictionary word. Passwords must not be stored in readable format on the computer. Passwords must be changed every 90 days, preferably every 60 days. Passwords must be changed if revealed or compromised. Passwords must be composed of characters from at least three of the following four groups from the standard keyboard:

- Upper case letters (A-Z)
- Lower case letters (a-z)
- Arabic numerals (0-9)
- Non-alphanumeric characters (punctuation symbols)

H. Data Destruction. When no longer needed, all DHCS PHI or PI must be cleared, purged, or destroyed consistent with NIST Special Publication 800-88, Guidelines for Media Sanitization such that the PHI or PI cannot be retrieved.

I. System Timeout. The system providing access to DHCS PHI or PI must provide an automatic timeout, requiring re-authentication of the user session after no more than 20 minutes of inactivity.

J. Warning Banners. All systems providing access to DHCS PHI or PI must display a warning banner stating that data is confidential, systems are logged, and system use is for business purposes only by authorized users. User must be directed to log off the system if they do not agree with these requirements.

K. System Logging. The system must maintain an automated audit trail which can identify the user or system process which initiates a request for DHCS PHI or PI, or which alters DHCS PHI or PI. The audit trail must be date and time stamped, must log both successful and failed accesses, must be read only, and must be restricted to authorized users. If DHCS PHI or PI is stored in a database, database logging functionality must be enabled. Audit trail data must be archived for at least 3 years after occurrence.

L. Access Controls. The system providing access to DHCS PHI or PI must use role based access controls for all user authentications, enforcing the principle of least privilege.

M. Transmission encryption. All data transmissions of DHCS PHI or PI outside the secure internal network must be encrypted using a FIPS 140-2 certified algorithm which is 128bit or higher, such as AES. Encryption can be end to end at the network level, or the data files containing PHI can be encrypted. This requirement pertains to any type of PHI or PI in motion such as website access, file transfer, and E-Mail.

N. Intrusion Detection. All systems involved in accessing, holding, transporting, and protecting DHCS PHI or PI that are accessible via the Internet must be protected by a comprehensive intrusion detection and prevention solution.

III. Audit Controls

A. System Security Review. All systems processing and/or storing DHCS PHI or PI must have at least an annual system risk assessment/security review which provides assurance that administrative, physical, and technical controls are functioning effectively and providing adequate levels of protection. Reviews should include vulnerability scanning tools.

B. Log Reviews. All systems processing and/or storing DHCS PHI or PI must have a routine procedure in place to review system logs for unauthorized access.

C. Change Control. All systems processing and/or storing DHCS PHI or PI must have a documented change control procedure that ensures separation of duties and protects the confidentiality, integrity and availability of data.

IV. Business Continuity / Disaster Recovery Controls

A. Emergency Mode Operation Plan. Contractor must establish a documented plan to enable continuation of critical business processes and protection of the security of electronic DHCS PHI or PI in the event of an emergency. Emergency means any circumstance or situation that causes normal computer operations to become unavailable for use in performing the work required under this Agreement for more than 24 hours.

B. Data Backup Plan. Contractor must have established documented procedures to backup DHCS PHI to maintain retrievable exact copies of DHCS PHI or PI. The plan must include a regular schedule for making backups, storing backups offsite, an inventory of backup media, and an estimate of the amount of time needed to restore DHCS PHI or PI should it be lost. At a minimum, the schedule must be a weekly full backup and monthly offsite storage of DHCS data.

V. Paper Document Controls

A. Supervision of Data. DHCS PHI or PI in paper form shall not be left unattended at any time, unless it is locked in a file cabinet, file room, desk or office. Unattended means that information is not being observed by an employee authorized to access the information. DHCS PHI or PI in paper form shall not be left unattended at any time in vehicles or planes and shall not be checked in baggage on commercial airplanes.

B. Escorting Visitors. Visitors to areas where DHCS PHI or PI is contained shall be escorted and DHCS PHI or PI shall be kept out of sight while visitors are in the area.

C. Confidential Destruction. DHCS PHI or PI must be disposed of through confidential means, such as cross cut shredding and pulverizing.

D. Removal of Data. DHCS PHI or PI must not be removed from the premises of the Contractor except with express written permission of DHCS.

E. Faxing. Faxes containing DHCS PHI or PI shall not be left unattended and fax machines shall be in secure areas. Faxes shall contain a confidentiality statement notifying persons receiving faxes in error to destroy them. Fax numbers shall be verified with the intended recipient before sending the fax.

F. Mailing. Mailings of DHCS PHI or PI shall be sealed and secured from damage or inappropriate viewing of PHI or PI to the extent possible. Mailings which include 500 or more individually identifiable records of DHCS PHI or PI in a single package shall be sent using a tracked mailing method which includes verification of delivery and receipt, unless the prior written permission of DHCS to use another method is obtained.

Whole Person Care Pilot Application

Original Application Submitted July 1, 2016

Revised Application Submitted October 20, 2016

Round 2 Application Submitted March 1, 2017

Section 1: WPC Lead Entity and Participating Entity Information

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

Organization Name	Monterey County Health Department (MCHD)
Type of Entity	County Health Department
Contact Person	Elsa Jimenez, MPH
Contact Person Title	Director of Health
Telephone	831-755-4526
Email Address	Jimenezem@co.monterey.ca.us
Mailing Address	1270 Natividad Road, Salinas CA 93906

1.2 Participating Entities

Required Organizations	Organization Name	Contact Name and Title	Contact Name and Title
1. Medi-Cal managed care health plan	Central California Alliance for Health (CCAH)	Alan McKay, CEO	Identify and refer qualifying Alliance Medi-Cal members, and provide related health outcome data. WPC partners will refer patients/clients to CCAH for insurance eligibility determination and coverage. CCAH will refer WPC-qualifying patients/clients to the WPC Pilot Program and the Program will then enroll or waitlist the patient/client according to acuity and Program capacity.

Required Organizations	Organization Name	Contact Name and Title	Contact Name and Title
2. Health Services Agency/Department	Monterey County Health Department: Administration, Clinic Services, Public Guardian, and Public Health Bureaus	Elsa Jimenez, Director of Health/ County Public Conservator Julie Edgcomb, Clinic Services Bureau Chief Dr. Ed Moreno, Health Officer/Public Health Bureau Chief	Non-federal share funder. Executive Sponsor/Lead Entity/ fiscal manager/Whole Person CareProgram Director/care coordination management. Identification & referrals of Medi-Cal enrollees with a combination of mental health (MI) diagnoses, multiple mental health unit (MHU) admittance, co- morbidity involving top 5 reasons for hospital emergency department (ED) and inpatient expenditures, frequent ED use, substance use disorder (SUD), and/or multiple prescription use. Provider of in-kind nurse CHW/case managers. Provider of health outcome data. Provider of physical location for service delivery. Provider of the Behavioral Health Integration Team MCHD Clinic Services (CS) and Public Health (PH) Bureaus are direct service providers and will bi-directionally share data through the eMPI and Case Management solutions. MCHD Director of Health will chair the Executive Committee for the WPC. The CS and PH will participate in monthly Governance and Executive Committee meetings, and in routine case management meetings as appropriate.

Required Organizations	Organization Name	Contact Name and Title	Contact Name and Title
3. Specialty Mental Health Agency	Monterey County Health Department, Behavioral Health Bureau	Dr. Amie Miller, Bureau Chief	Non-federal share funder. Identification & referrals of persons with a combination of mental illness, multiple MHU admittance, SUD, clients who are homeless or at-risk. User of Master Person Index. Provider of in-kind mental health CHW/case managers. Behavioral Health Bureau will operate the Hot Spotting effort. Provider of behavioral health outcome data. Provider of location for service delivery. MCHD Behavioral Health Bureau (BHB) is a direct service provider and will bi-directionally share data through the eMPI and Case Management solutions. The BHB will participate in monthly Governance and Executive Committee meetings, and in routine case management meetings as appropriate.
4. Public Agency	Monterey County Department of Social Services (DSS)	Elliot Robinson, Director	Non-federal share funder. Identification & referrals of persons who are homeless or at-risk; persons who are vulnerable without social supports. Provider of in-kind social worker CHW/case managers. Provider of social supports outcome data. Provider of physical location for service delivery. Monterey County Department of Social Services is a direct service provider. As a referring partner, they may be allowed to input data in a highly restrictive manner, or may be allowed view-only access to highly restrictive fields of patient-level data. DSS will participate in monthly Governance meetings, and in routine case management meetings as appropriate.

Required Organizations	Organization Name	Contact Name and Title	Contact Name and Title
5. Safety-net Hospital	Natividad Medical Center (NMC)	Dr. Debi Siljander, Medical Director of Clinical Integration and Integration Dr. Chad Harris, Chief Medical Information Officer	Non-federal share funder. Identification & referrals of Medi- Cal enrollees with a combination of MI diagnoses, multiple MHU admittance, co-morbidity involving top 5 reasons for hospital ED and inpatient expenditures, frequent ED use, SUD, homeless or at-risk, and/or multiple Rx use. Provider of health outcome data. User of shared Master Person Index. Provider of physical location for service delivery. Partner in coordinating discharge nurse case managers. NMC is a direct service provider and will bi-directionally share data through the eMPI and Case Management solutions. NMCB will participate in monthly Governance and Executive Committee meetings, and in routine case management meetings as appropriate.
6. Coalition of homeless services providers	Coalition of Homeless Services Providers (CHSP)	Katherine Thoeni, Executive Officer	HUD Continuum of CareCoordinator; recipient of HUD funding. Administrative lead for the 10-Year Plan to end homelessness in Monterey and San Benito Counties. Lead agency for HMIS, Housing Inventory Count, and Point in Time Count. Funded partner for staffing, operations, software licensing and subscription, training, and IT hardware. CHSP will participate in monthly Governance meetings and co-chair the monthly Executive Committee meetings. CHSP is not a direct service provider, will not share data or attend case management meetings.

Required Organizations	Organization Name	Contact Name and Title	Contact Name and Title
7. Housing, mental health, and addiction services	Community Homeless Solutions (CHS)	Reyes Bonilla, Executive Director	Provider of direct services for homeless, mentally ill, and/or drug addicted persons. Provider of social supports outcome data. Provider of physical location and mobile outreach for service delivery. Provider of in-kind social worker CHW/case managers. Funded partner for staffing and operational expenses, local travel (mobile outreach). CHS is a direct service provider and will input patient-level data into a siloed system that is a component of our Behavioral Health data system. CHS will participate in monthly Governance meetings and in routine case management meetings as appropriate.
8. Mobile outreach and social supports	Interim, Inc.	Barbara L. Mitchell, Executive Director	Operator of six-bed Respite Center for acute/post-acute medically fragile WPC enrollees; housing placement and support services for up to 20 enrollees; provider of targeted outreach, intercept, and referral. Identification & referrals of persons with mental illness and arehomeless or at-risk. Contributor of technical assistance in housing development. Provider of social supports outcome data. Provider of physical location for service delivery. Provider of in-kind social worker CHW/case managers. Interim is a direct service provider and will input patient-level data into a siloed system that is a component of our Behavioral Health data system. Interim will participate in monthly Governance meetings and in routine case management meetings as appropriate.

Required Organizations	Organization Name	Contact Name and Title	Contact Name and Title
9. Partner providing shelter, food, and an array of social services for individuals who are homeless or at-risk, potentially with co-morbidities, without social supports, or SUD.	Franciscan Workers of Junipero Serra (Dorothy's Place) Community Human Services Gathering for Women	Jill Allen, Exec. Director Robin McCray, Exec. Director Carol Greenwald, MSW, MPS, Director	These are referring agencies for homeless or at-risk persons who meet the criteria of the focus population; current providers of case management services; providers of physical locations for service delivery. The Franciscan Workers utilize the Vulnerability Assessment (Vi- SPDAT) to inform its case management services for approximately 65 persons. Funded partner for staffing, operational expenses, and training, and the Homeless Peer Navigator Program. The Franciscan Workers are direct service providers and will not share data. As a referring partner they may be allowed to input data in a highly restrictive manner, or may be allowed view-only access to highly restrictive fields of patient-level data. They may be invited to attend case management meetings as appropriate, and will be invited to attend Governance meetings. Community Human Services and Gathering for Women will be WPC referral sources.
10. Local law enforcement and probation	Monterey County Sheriff's Department and Probation Department	Stephen T. Bernal, Sheriff-Coroner Marcia Parsons, Chief Probation Officer	Identification & referrals of persons in jail who are pending release and who are homeless or at-risk, and who also have co-morbidity or SUD. The Probation Department is a referral source that will input patient-level data into a siloed system that is a component of our Behavioral Health data system. They may be invited to attend case management meetings as appropriate. They will be invited to attend Governance meetings.

Required Organizations	Organization Name	Contact Name and Title	Contact Name and Title
11. Housing Authority	Housing Authority of Monterey County	Jean Goebel, Executive Director	Provider of Housing Choice Vouchers (vouchers are not included in the proposed WPC Pilot Budget). Technical assistance for tax credit and other affordable housing programs, referring agency for persons homeless or at-risk. The Housing Authority is a direct service provider but will not share data. They will not attend case management meetings but will be invited to attend Governance meetings.
12. Affordable Housing Developer	MidPen Housing	Betsy Wilson, Director of Housing Development	Partner in the development of permanent supportive housing (developer and manager). Provider of physical location for service delivery. Operator of On-site housing sustainability services for up to 40 WPC enrollees. MidPen Housing is a direct service provider but will not share data. As a referring partner they may be allowed to input data in a highly restrictive manner, or may be allowed view-only access to highly restrictive fields of patient-level data. They will not attend case management meetings but will be invited to attend Governance meetings.
13. Substance Abuse Treatment Provider	SunStreet Centers	Anna Foglia Director	Operator of eight-bed Sobering Center

1.3 Letters of Participation and Support

Attached are letters of commitment from the following entities:

- Behavioral Health Bureau, MCHD
- Central California Alliance for Health
- Coalition of Homeless Services Providers
- Franciscan Workers of Junipero Serra (Dorothy's Place)
- Gathering for Women
- Housing Authority of Monterey County
- Interim, Inc.
- MidPen Housing
- Monterey County Department of Social Services
- Monterey County Probation Department
- Natividad Medical Center
- Public Health Bureau, MCHD
- Salinas City Manager
- Salinas Valley Memorial Healthcare System
- Supervisor Parker, County of Monterey

Section 2: General Information and Target Population

2.1 Geographic Area, Community and Target Population Needs

Geographic area and need: The 2015 Monterey County Homeless Census counted 2,308 homeless people in the county, with 71% being unsheltered and 9% in emergency shelter, 23% who said the cause of homelessness was alcohol or drug use (and 59% if they were chronically homeless), 28% reported having psychiatric or emotional conditions, 19% reported chronic health problems, and 77% had spent a night in jail in the last 12 months. County Behavioral Health staff served 1,179 clients with substance abuse disorders and 1,178 individuals over 18 years with serious or persistent mental health disorders in FY15. In Monterey County in 2014, 5.7% or 4,000 residents were <200% of the FPL and reported having serious psychological distress during the past year (CHIS, 2014).

Planning with participating entities: Our WPC partnership has met weekly since 3/30/16. Core participants include the MCHD Director, Clinic Services, Behavioral Health, and Public Health Bureau Chiefs, analysts, and IT experts; Monterey County Social Services Director and analysts; and NMC's Assistant Director, Operations Manager, MDs, and IT analysts. The group has collaboratively identified:

- WPC focus population definition and geographic scope
- WPC governance structure and tasks for WPC Pilot Executive Committee - chaired by the MCHD Director of Health, and the Workgroups (Data, Social & Clinical, Housing, Evaluation, and Finance Workgroups
- Mapping how WPC governance will interface with the Leadership Council of the Coalition of Homeless Services Providers (HUD fund recipients), their Lead Me Home 10-year Plan to create a comprehensive housing pipeline, and their Housing Management Information System (HMIS)
- Community partners that address social determinants of health
- Community partners who will act as WPC referring sources and WPC service locations
- Various health information solutions for data integration and reporting
- Sources for matching funds from county agencies and eligible community partners
- Use of Community Health Workers; certificate training for Community Health Workers
- Model for the NMC WPC population health management process

WPC Pilot, structure, target populations and addressing their needs: The County of Monterey has a population health model (which is included in the application) that addresses our strategy for population health management, including IT/Care Management needs. The WPC is a pilot in our high-risk population. The initial WPC focus population (high utilizers) will be exclusively homeless and chronically homeless Medi-Cal recipients or Medi-Cal eligible persons (including those released from jail) and having two or more of the following characteristics: diagnosed mental illness, two or more MHU admissions in the prior year, diagnosed SUD, two or more chronic health diagnoses, two or more ED visits within the prior twelve months, one or more hospital admissions within the prior twelve months, or two or more prescribed medications.

Medication categories include antidepressants, antipsychotics, mood stabilizers, diabetes medication, anti-hypertensives, cholesterol lowering medications, inhaled corticosteroids and bronchodilators, seizure medications and anticoagulants.

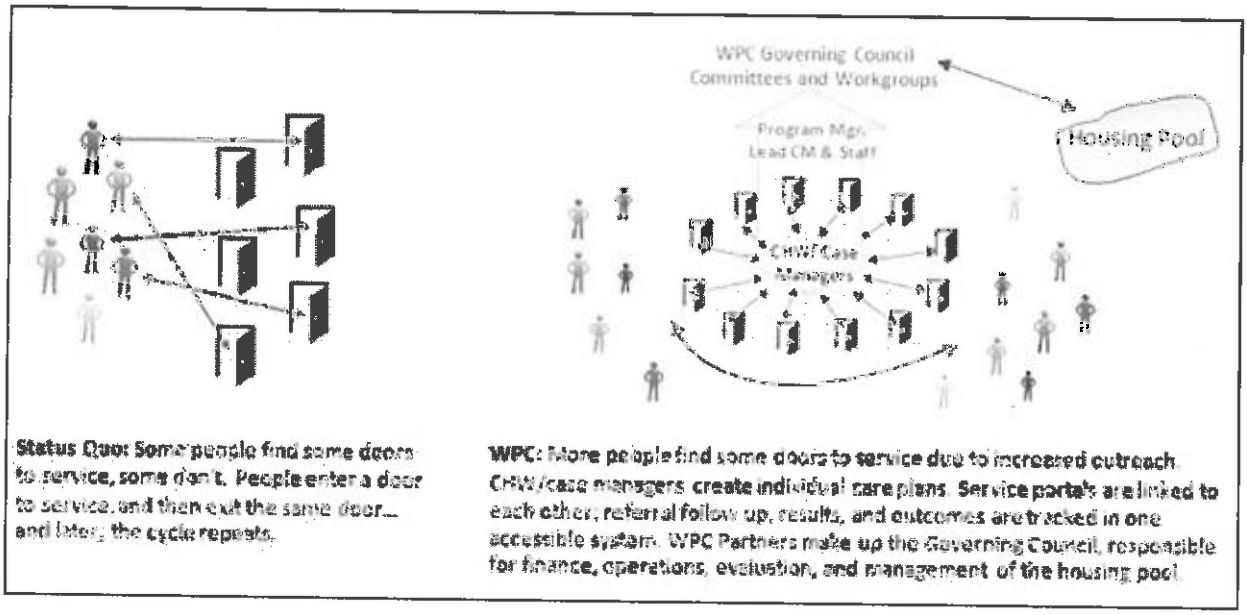
The WPC Pilot structure will integrate the management and resources of existing safety net hospital and primary care/specialty clinics, public health nursing teams, Housing Authority, Department of Social Services, Behavioral Health, and the Coalition of Homeless Services Providers (CHSP) with a proposed system of community health workers who will provide high-utilization patients with case management, individual health improvement plans, and warm handoffs to linked services. New elements to serve our target population include on-site housing sustainability services for up to 40 WPC enrollees who are living in permanent housing but still require supportive services to remain in place (Provider: MidPen Housing); six bed Respite Center for acute/post-acute medically fragile WPC enrollees; housing placement and support services for up to 20 WPC enrollees who are living in transitional housing for up to one year and need appropriate coping and living skills required to move into permanent housing (Provider: Interim, Inc. McHome), a hot spotting multi-disciplinary team providing intensive community-based clinical services to super-users referred by emergency departments and hospitals; an eight-bed Sobering Center for stays up to 23 hours (Provider: Sun Street Centers); and Targeted outreach and pre-enrollment intercept and referral (Provider: Interim, Inc. CSUMB). Oversight for the new community health worker system will be provided by MCHD Director of Nursing and staff. Overarching will be a representing governance structure headed by the WPC Pilot Executive Committee. The housing pool, which will not be funded through the WPC, will be managed by the CHSP Leadership Council. The WPC Pilot will strengthen the system of care in Monterey County by creating two essential components: a case management system, and a Master Person Index that can be accessed by all WPC partners. Monterey County's system of care has been in the process of developing a health information exchange for many years, and the WPC Pilot willbring that work to full fruition.

Reducing avoidable utilization of other systems: With WPC comprehensive case management, EDs, hospitals, and MHUs will experience reduced utilization by the focus population, and associated cost savings. Primary and specialty clinics, urgent cares, SUD and mental health providers, health educators, and an array of social services providers will see an increase in service requests from the focus population.

How current system problems will be addressed: Currently, high ED/hospital utilizers enter one door to a medical, social, or housing provider, and then exit the same door. Services between high utilizer supporting agencies/organizations are *not linked*. The new WPC system *will link* a high ED/hospital utilizer to enter any of a multitude of doors that will lead to a CHW/case manager who will provide trauma-informed, individualized service coordination, backed by a health/social determinants data sharing system, and

governed by a structure of public/private medical, social, and housing entities and a 10-year plan to address homelessness.

Graphic: How current system problems will be addressed



WPC Status Quo and Linked Care Coordination System

Vision for building/strengthening collaborative community partners:

Monterey County leaders, under the auspices of the Coalition for Homeless Services Provider (CHSP), in a multi-organizational, multi-governmental, and multi-sector relationship, have worked closely since 2010 to create wrap-around services for high utilizers, specifically those who are homeless. As a powerful governing structure, CHSP with MCHD and the WPC Pilot will bring the hospital, primary and specialty care, and mental health sectors into this coordinated system, thereby strengthening the homeless continuum of care with health and prevention. The connection of coordinated health and social CHW/case managers to housing and basic needs providers will bind and strengthen two systems into one that is far more effective for the focus population. WPC Pilot will also bring a shared information technology platform for health outcome data exchange that, when interfaced with the HMIS, will greatly increase the efficiency of our efforts.

Vision for sharing lessons learned:

Past Centers for Disease Control and Prevention (CDC) grants convened awardees to share lessons learned in a format similar to Communities of Practice. MCHD and our core WPC Pilot partners would be willing participants in such a convening. MCHD annually presents program process and outcomes at American

Public Health Association and American Evaluation Association conferences and will share our WPC Pilot successes and challenges in those venues.

Vision for sustainable infrastructure (communications/delivery system) beyond the Pilot phase: Monterey County's WPC Pilot will benefit from MCHD's use of the Spectrum of Prevention and upstream practices for more than a decade to develop long-term improvements and comprehensive, sustainable change, as evidenced by our Health in All Policies achievements. Monterey County collaboratives use Collective Impact for numerous health, education, and social community initiatives, and MCHD has an FSG- trained Collective Impact expert on its executive leadership team. An internal team of evaluation professionals have been working within MCHD for 12 years; their WPC process and outcome evaluations will greatly inform WPC longevity planning and logistical improvements.

The investment in building the infrastructure to facilitate real time data sharing and exchange will be sustained beyond the pilot to continue benefitting care coordination and management of high cost utilizers that enter the system, as the shared case management solution across multi-sector entities will improve care coordination.

2.2 Communication Plan

The governance structure, with MCHD as the Lead Entity/Pilot Care Coordinator and the Coalition of Homeless Services Providers as the coordinator of partnering social services/housing CHW/case managers, will convene regularly scheduled monthly meetings of partner representatives to manage the Pilot's operational integrity, problem-solving, communication/idea sharing, decision-making, participate in PDSA and evaluation activities, and progress toward milestone achievements. The WPC Pilot Executive Committee will meet with the same frequency to track the work of ad hoc workgroups. Other Executive Committee responsibilities are to oversee contracts; operate the CHW/case management system, Master Person Index, and shared data platform; develop policies/procedures; address compliance, monitor evaluation results, and apply PDSA improvements to the WPC Pilot operations. Workgroups will consist of finance, external communications, Data, Social & Clinical, Housing, and Evaluation.

Decision-making will be by the Executive Committee with input from the broader WPC Pilot Workgroups. A successive governance plan will be incorporated in the WPC Pilot collaborative MOU that will be signed by all partners. The WPC Pilot administrative functions will be headed by the MCHD Program Director with expertise in collective impact methods. The WPC Pilot partners will use the Microsoft Office Suite and the

Google Docs suite of communication tools (Docs, Sheets, Slides, Forms, Drawings); the FranklinCovey formats for agenda/minutes, 5-minute meeting planner and 5-minute presentation planner; Free Conference Call and SKYPE for off-site case review participants; Survey Monkey for voting processes; and SmartBoards in conference rooms.

2.3 Target Population(s)

Our WPC Pilot focus population will be exclusively homeless and chronically homeless Medi-Cal recipients or Medi-Cal eligible persons (including those released from jail) who have two or more of the following characteristics: two or more MHU admissions in the prior year, two or more chronic health diagnoses, two or more ED visits within the prior twelve months, one or more hospital admissions within the prior twelve months, or two or more prescribed medications. Medication categories include antidepressants, antipsychotics, mood stabilizers, diabetes medication, antihypertensives, cholesterol lowering medications, inhaled corticosteroids and bronchodilators, seizure medications and anticoagulants. The intent is to enroll and assign to case workers to 500 individuals for the duration of the WPC Pilot. After the first year of full operation, we may broaden the focus population intake criteria.

The definition of "homeless" we are using for the WPC Pilot is the HUD McKinney-Vento Homeless Assistance Act definition:

A single individual (or head of household) with a disabling condition who has either:

- Experienced homelessness for longer than a year, during which time the individual may have lived in a shelter, Safe Haven, or a place not meant for human habitation.
- Or experienced homelessness four or more times in the last three years.

The definition of "chronically homeless" we are using for the WPC Pilot is the 2016 HUD HEARTH definition:

A homeless individual with a disability who lives either in a place not meant for human habitation, a safe haven, or in an emergency shelter, or in an institutional care facility if the individual has been living in the facility for fewer than 90 days and had been living in a place not meant for human habitation, a safe haven, or in an emergency shelter immediately before entering the institutional care facility. The individual or family has a head of household with a diagnosable:

- Substance use disorder, serious mental illness, developmental disability, post-traumatic stress disorder, cognitive impairments resulting from a brain injury, or chronic physical

illness or disability.

The individual also must have been living as described above continuously for at least 12 months, or on at least four separate occasions in the last 3 years, where the combined occasions total a length of time of at least 12 months. Each period separating the occasions must include at least 7 nights of living in a situation other than a place not meant for human habitation, in an emergency shelter, or in a safe haven.

Individuals who are homeless usually have a co-occurring mental health and substance use disorder as shown by the 2016 data assessment of homeless individuals displaced from encampments in Chinatown area of Salinas, California. That study showed that 50% of the homeless population had medical needs, 14% had mental health needs, and 26% had substance use disorder needs (these percentages are not exclusive).

For baseline data collection that will be due March 2017, we have already conducted preliminary work to help identify our target population, which includes an independent review of Managed Medi-Cal claims and health status, behavioral health claims and health status data, Clinic Services claims and health status data, and HMIS data. Data sets will be queried to identify the high cost utilizers and then stratified for homeless, mental health, SUD to identify top 500 individuals meeting WPC Pilot selection criteria. A major challenge identified is ability to share data amongst all participating entities. As such, concurrently with independent review and stratification of each of these disparate data sets, the Executive Team is in discussions with legal counsel regarding provisions for a shared MOU to be signed by all participating entities to facilitate data sharing and integration activities during the Pilot years. Once MOUs are executed with all participating entities, data sharing activities will be implemented to facilitate the identification of 500 high utilizers accessing multi systems who will be invited to participate in WPC Pilot (we expect as much as 50% may be lost to service during the course of their first 12 months in the program).

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

The WPC services and strategies below describe commitments of the core WPC Pilot partners with expectations to decrease avoidable ED and hospitalization by high user groups. We will intake about 500 individuals for the duration of the WPC Pilot who will use all services. Intake for comprehensive

and coordinated case management for the high utilizers, and greater high utilizers housing resources, will occur on a rolling basis. Monterey believes that housing, in combination with onsite case management services, will improve health outcomes of these members by facilitating access to appropriate care. Services are intended to meet these needs.

Outreach and Ancillary Services:

- The Mobile Outreach Team will be operated by a provider of direct services to homeless, mentally ill, and/or drug addicted persons, using professional Social Workers/Case Managers.
- Homeless Persons Peer Navigator (HPPN) Program, operated by the Franciscan Workers of Junipero Serra, will employ paid homeless or previously homeless persons to reach potential WPC enrollees living in the City of Salinas and Monterey Peninsula encampments, to facilitate their enrollment in WPC. WPC candidates typically have difficulty trusting and communicating with people perceived to be in authority. Therefore, the Navigators, due to their familiarity with the WPC population, will specifically address chronically homeless persons who are well-adapted to living outside of mainstream social norms. Our expectation is that the Peer Navigators will be successful with populations that are unknown and inaccessible by other means (such as through the Targeted Outreach effort described below).
- Targeted Outreach to potential and enrolled WPC persons in City of Salinas neighborhood that is most frequented by the focus population. Targeted Outreach staff will refer potential WPC enrollees to coordinated case managers for enrollment. For WPC enrollees, Targeted Outreach staff will provide instructional sessions that include stress management, grief and loss, life skills, nutrition, health and healing, job seeking skills, and conflict resolution, among others. The Team consists of CSUMB Master of Social Work candidates who will orient their trainings on pathways to housing and employment. In contrast, the Mobile Outreach Team, operated by a provider of direct services using professional Social Workers/ Case Managers, will concentrate their efforts beyond and outside of the geographic areas in which Peer Navigators and Targeted Outreach teams are working.
- The Behavioral Health (BH) Team will work with clients being released from jail or an Institution of Mental Health Disease (IMD) to enroll in the WPC program. The BH Team's primary responsibility will be to establish a relationship and ultimately building the level of trust necessary in obtaining consent from to participate in the WPC Pilot. Clients will be enrolled in the WPC pilot program upon release and will be dis-enrolled as needed if they return to an institution from the community following enrollment. It is expected that the BH Team will work with these individuals up to 90 days after

release. An incentive payment per enrollment/re-enrollment is proposed upon completion of the initial assessment.

Case Management Services:

- CHW/case managers for high utilizers (providing physical and mental health, social services, and housing fields).
- A "Hot Spotting" multi-disciplinary case management strategy to address super-utilizers with the most intensive and comprehensive case management. Hot Spotting clients will be referred from emergency departments and hospitals, and will be served at the highest levels physical and mental health services for an average of 3 months.

Temporary Medical Recovery Housing:

- Medical Respite Center, located on the Monterey Peninsula, consisting of six beds for acute/post-acute medically fragile WPC enrollees.
- Sobering Center, located in the City of Salinas, consisting of up to 8 beds for stays of up to 23 hours.

Housing Support Services:

- Permanent supportive and transitional housing(physical/mental health and substance use fields)
- On-site Housing Placement Support and Sustainability services for up to 40 WPC enrollees who are living in permanent housing, but still require supportive services to remain in place. These 40 WPC enrollees will be living in a professionally-operated facility for persons with mental illness, located in the City of Salinas.
- Housing Placement and Support services for up to 20 WPC enrollees who are living in transitional housing for up to one year and need appropriate coping and living skills required to move into permanent housing. These 20 WPC enrollees will be living in a professionally-operated facility for persons with mental illness, located on the Monterey County coast. In contrast, Community Based Case Management Services (a multi-discipline team of MCHD case managers), will provide WPC-enrollees with referrals to possible housing solutions that may be temporary or transitional solutions in the greater Salinas, North County, South County, or Monterey Peninsula.

Housing-related services: The Coalition of Homeless Services Providers (CHSP) is a funded partner in the WPC Pilot, serving the designated HUD Homeless Continuum of Care Coordinator. Individuals meeting the target population and enrolled in the WPC Pilot will be referred to the CHSP providers' staff for assessment and linkage to most appropriate housing service for individual. The WPC Pilot Program Director will work closely with the identified CHSP service provider to assure individuals' needs for housing services are met. Pilot projects funds will used for coordinating housing services to meet the needs of the pilot participants. These coordinated housing support services, funded through CARS and community-based case management budget items, will include assessment of housing needs, matching with most appropriate housing service provider, tenant education and coaching, onsite intense case management services for tenants, and landlord training and coaching to assure success of housing placement.

Sobering Center: When an immediate need is identified, an eight-bed Sobering Center and a respite center will be available for individuals. The county will utilize an eight bed Sobering Center. This center will allow the County to reduce incarcerations, minimize hospitalizations and assist active, chronic and serial inebriates by providing a path to recovery in a safe and welcoming environment.

Housing Pool: While the establishment of a housing pool with the Coalition of Homeless Services Providers as the fiscal agent will be explored, no WPC funds will be used to create or maintain it. Partners will include MCHD, DSS, CHS, several nonprofit organizations, and property owners. The goal of the Monterey County Housing Pool Program (HPP), a supportive housing rental subsidy program, will be to "scattered site" supportive housing units that provide stable housing options for vulnerable individuals and families, with an emphasis on those transitioning from homelessness or institutional settings.

Components of the HPP are already underway and led by CHSP. CHSP is the lead for the Coordinated Entry System which uses an evidence-based assessment tool (VI-SPDAT) to "rank" the vulnerability of homeless individuals and families and place them on a Master List. Programs that receive HUD/VA/ESG funding will replace standard waiting lists and streamline program enrollment to those that are most vulnerable. CHSP also has a Housing Pipeline Committee which works with landlords to accept households with economic classification of 0-30% of the American Median Income (AMI) and works to track housing development

projects and look for opportunities to increase housing unit availability for vulnerable individuals. For example, CHSP partners are or will employ Housing specialists who work with landlords to accept clients into housing. Another method to be explored as part of the Coalition's work is where the Committee works with landlords to create a potential list for a housing pool and notify WPC partners of available unit(s) on a monthly basis. If a WPC client is on the Master List and identified as being up for potential housing, WPC partners will work with CHSP or a designated partner to negotiate lease terms for that client. The case managers in the WPC program will work with identified prospective tenant WPC clients and coordinate all move-in components (lease, security deposit, rent payment, move-in). The WPC client will be followed up with on-going housing retention and case management services through WPC and landlords will be supported with a single point-of-contact with CHSP or the designated partner for all tenant issues as well as having high occupancy rates and on-time rental payments. CHSP or the designated partner will be part of the WPC team working through the case manager with the WPC client.

Specific Interventions and Strategies: MCHD's Public Health Bureau CHW/case managers will conduct a comprehensive assessment to be adapted from existing tools used in public health and behavioral health of individuals referred from local hospitals and public safety entities once participation agreements are in place. MCHD CHW/case managers will serve as the lead care coordinators, providing referrals to other partner CHW/case managers for specialty services. MCHD CHW/case managers will also provide transportation, facilitate linkage and referrals, and serve as patient navigators. All supporting CHW/case managers will have access to the case management solution gaining access to real time information on participant status.

Bidirectional integration of CHW/case managers with specialties in physical health, mental health, substance use disorder, social services, housing, housing supports, and life skills will ensure the WPC Pilot program high utilizer enrollees receive a wide variety of needed services that keep the healthy, out of EDs and hospitals, and housed in more stable environments.

Through the Coalition of Homeless Service Providers, participants will undergo a screening and housing assessment process to determine participants' preferences and help surface any potential barriers to successful tenancy. Assessment findings will be used to build an individualized housing support plan. Data will be tracked in the HMIS. In addition, these screening tools will facilitate prioritization of limited

supportive and permanent housing resources. Based on assessment findings and housing support plan, participants will be linked to most appropriate housing service provider for facilitation with completion of applications and/or search process for securing financing and housing. Housing service providers will support tenant to successfully maintain tenancy once housing is secured by providing education and training to tenant and landlord on responsibilities, rights, and role of tenant and landlord. The assigned housing coordinator will provide coaching to the tenant on how to maintain good working relationships with landlords, assist in resolving any disputes that arise between landlord and tenant, and be as hands on as needed to maintain tenancy. The housing coordinator will maintain an active relationship with the participants' CHW/case manager.

The CHW/case manager will help participants schedule a follow up medical and mental health and SUD appointment as soon as possible but no later than 30 days from date of release from jail or discharge from hospital. If a participant does not have an established primary care physician or medical home, the case manager will help facilitate establishment of one at one of the seven MCHD Clinic Services clinic sites. Linkage to primary care and mental health services is critical in assuring participants are seen regularly by their provider and are able to get prescriptions and other necessary clinical procedures completed to improvehealth outcomes. Transportation to and from appointments other than those involving Medi-Cal reimbursement will be arranged (bus, taxi) as needed to assure success.

In addition to facilitating case coordination activities, the core team will provide training and education to participants on self-management techniques, nutrition and physical activity, how to advocate and take active role in the management of their conditions, health literacy, and chronic/communicable/wellness health topics as needed for participant to improve health outcome.

Care Coordination: The MCHD Pubic Health Bureau is Director of Nursing with serve as the WPC Pilot Program Director, and will supervise the lead case management and community health worker team serving program participants on cross system care coordination efforts. Referrals for care coordination services will come from various service providers with initial focus on prioritizing referrals from local hospitals and public safety entities.

CHW/case managers will coordinate with Natividad Medical Center and Salinas Valley Memorial Healthcare System staff during discharge planning activities for those individuals identified to be homeless

and meeting one or more of the criteria. CHW/case managers will meet with individual to evaluate interest in participating in the Program. By becoming involved at the time of discharge planning, a more appropriate transition plan is in place prior to participant being discharged from hospital. Elements to be included as part of discharge planning include completion by CHW/case managers, a comprehensive healthcare, behavioral health, housing, and LTSS assessment; coordination with Coalition for Homeless Services Providers for completion of housing assessment with vulnerability scoring matrix, prioritization of referral for short and/or permanent supportive housing services for participants with highest vulnerability scores; scheduling follow up appointment with primary care provider or linkage to a primary care provider if one is not secured; referral to behavioral health service provider; and referral to services providers for other social needs identified in comprehensive assessment. In addition, case management staff will work closely with Sheriff-Coroner's Office staff to provide similar array of assessment, linkage, and referral services to those individuals identified as homeless and meeting one or more of the criteria within 30-45 days of their release date. No services will be provided to the individual while he/she is incarcerated. Case management staff will provide criteria to the Sheriff-Coroner's staff for referral purposes upon the prisoner release.

The Public Health CHW/case managers will serve as lead care coordinators (core team) for individuals enrolled in the pilot project. They will conduct initial comprehensive assessment using tool adapted from those used in the behavioral health system and public health system that captures medical, social, and behavioral needs. The core team will provide referrals to service providers, coordinate with service providers to assure referral is met, arrange for transportation by bus or taxi needed to appointments that are not covered by Medi-Cal, and re-assess individual as needed to assure all needs are identified and a service plan is in place. The core team will continue to work closely with clients to assure consistent stability in their health, behavior, and housing outcomes to prevent relapse. If client is on probation, core team will work with public safety staff to assure client's needs are being met in an effort to reduce recidivism.

Hot Spotting Team:

1. MCHD Behavioral health will provide a multi-disciplinary team providing intensive community based clinical services to super-utilizers. A "Hot Spotting" team, consisting of a public health nurse, public guardian deputy, behavioral health aid, psychiatric social worker, and social worker, will provide comprehensive case management for highest utilizers of Emergency Departments and Hospitals,

thereby diverting these WPC enrollees from over-utilizing these and other publicly-funded agencies. The Interdisciplinary team will formulate care plan, assess the home situation, address safety or environmental concerns, and troubleshoot medication/adherence issues. The care plan is implemented through clinic, home, or telephonic encounters with Nurse Practitioner or Social Worker. The Interdisciplinary Team meets weekly with the care management team to go over cases and assess when clients can transition to a lower level of care. It is estimated each client in this setting will be served for up 90 days from initial contact.

The hot spotting team members will specifically perform the following functions:

a. RN: When patients are hospitalized, the RN visits inpatients and helps with their care coordination post-discharge, following the Coleman care transitions model. Home visits are done post discharge to coordinate care.
b. Case Managers and or Behavioral Health Aids: The care management (CM) team does an initial assessment in the home including home safety evaluation. The team meets with the interdisciplinary consult team to create a care plan.
    i. CM team visits newly enrolled patients each week and attends their medical appointments
    ii. A face-to-face home visit occurs after any emergency department visit or hospitalization
    iii. Case Managers teach their patients how to navigate the system and provide the following resources:
    iv. Provides assistance in accessing available transportation
    v. Provides warm handoffs where appropriate
    vi. May also help a patient obtain Social Security disability and needed support
c. The psychiatric social worker will help develop a diagnostic formulation with these very complex clients where the treatment needs are unclear. Additionally, they will use motivational interviewing, an evidence based practice, to help clients who do not want to engage in care see the benefits of treatment. The psychiatric social worker will work with the team and the client to look at barriers to medication compliance. The psychiatric social worker will develop a diagnostic formulation that will facilitate linkage to a lower level of care after the hot spotting team has stabilized the client.

d. The public guardian deputy will be an integral member of the hot spotting team. The deputy will be responsible for assessing and making determination as to whether public guardianship/conservatorship criteria is met for each WPC enrollee to assure appropriate level of care is provided for individual to assure his/her health and safety

Interim, Inc. will provide discrete but coordinated services which include Housing Placement Services, Respite Center care coordination, and pre-enrollment outreach for interception and referral.

Additionally, these partners have committed to program governance, data sharing, program evaluation, and other activities to achieve the Pilot's intended outcomes.

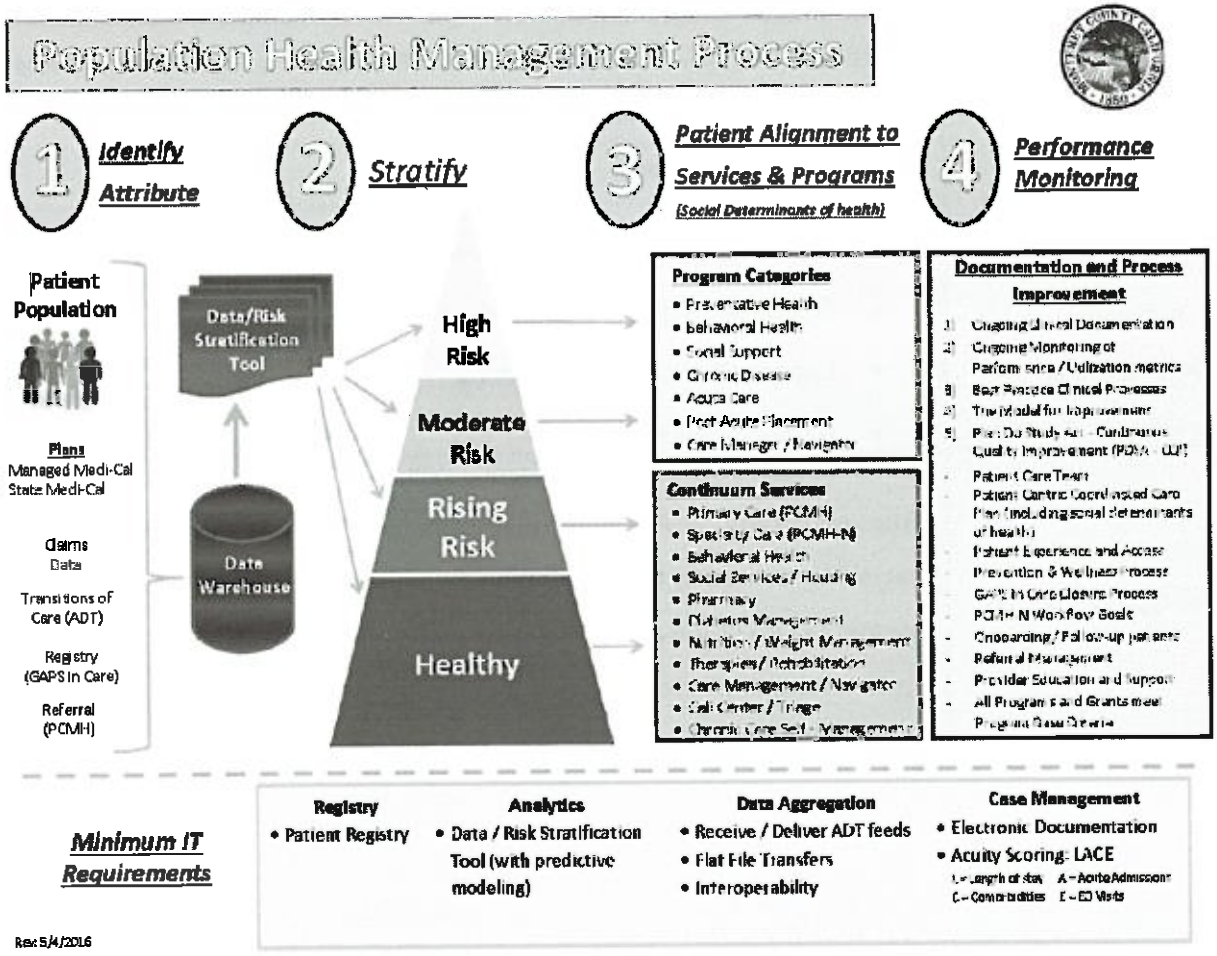
Category	Services
Lead Entity	**Monterey County Health Department** will provide financial management and accountability, convene the WPC Pilot Executive Committee, provide overall WPC Pilot project management oversee nursing case worker and CHW/case manager workforce; lead PDSA monitor outcomes and reporting activities, manage the Pilot's operational integrity, problem-solving, communication/idea sharing, decision-making, participate in PDSA and evaluation activities, and progress toward milestone achievements. Provisions by MCHD Public Health Bureau will be delivered through non-federally funded sources.
Referrals from Hospitals	**Natividad Medical Center,** our county's safety-net hospital, will provide the WPC program with non-federal matching funds (NMC and SVMHS), patient referrals, nurse CHW/case managers, data contribution to the Master Person Index, and a physical location for providing case management supports to the focus population. Provisions by NMC will be delivered through non-federally funded sources. Community Health Innovations (Community Hospital of the Monterey Peninsula), and Salinas Valley Memorial Healthcare System will provide patient referrals.
Health Plan	**Central California Alliance for Health** will provide claims data and health outcome data to monitor progress of Pilot participants.

Category	Services
Case Management, including a "Hot Spotting" Team	**MCHD Behavioral Health Bureau** will provide non-federally funded case management support services to individuals with severe mental illness; provide non-federal matching funds; track and monitor mental health and SUD outcomes; provide physical location for service provision. The Bureau will provide a multi-disciplinary "hot spotting" strategy to address super-utilizers with the most intensive and comprehensive case management.
Case Management	**MCHD Public Health Bureau** commits to provide its Director of Public Health Nursing as the WPC Pilot Program Director, and a team of registered nurses, licensed vocational nurses, and Community Health Worker/Patient Navigators as the core of the physical health care coordination. Provisions by MCHD Public Health Bureau will be delivered through non-federally funded sources. MCHD is assigning a Business Technology Analyst III to oversee data integration and quality control, and a Public Health Epidemiologist to provide data analysis and reporting.
Case Management	**Community Human Services (CHS)** is a funded partner that will provide staffing and mobile outreach efforts to reconnect chronically homeless individuals who meet other WPC care criteria with the care coordination system.
Social Services	**Monterey County Department of Social Services** (DSS) will provide the WPC program with non-federal matching funds, social workers, and a physical location for providing case management supports to the focus population.
Social Services	**Coalition of Homeless Service Providers,** as the designated HUD Homeless Continuum of Care coordinator, will serve as lead agency for the CARS, HMIS, HIC, and PIT.

Category	Services
Housing, Including Housing Placement	**Monterey County Housing Authority** will provide technical assistance to the WPC Pilot Governing Group and focus population referrals to the WPC Pilot. **Interim Inc.** will provide housing placement and support services for up to 20 enrollees annually
Sobering Center	**Sun Street Centers** will provide an eight-bed Sobering Center for stays up to 23 hours. This center will allow the County to reduce incarcerations, minimize hospitalizations and assist active, chronic and serial inebriates by providing a path to recovery in a safe and welcoming environment.
Respite Center	**Interim Inc.** will provide a six-bed Respite Center for acute and post-acute medically fragile WPC enrollees. This will provide acute and post-acute medical care for individuals, primarily those who are homeless or those with unstable living situations, who are too ill or frail to recover from a physical illness or injury in their usual living environment but are not ill enough to be in a hospital.
On-site Housing Sustainability Services	**MidPen:** On-site housing sustainability services for up to 40 WPC enrollees who are living in permanent housing but still require supportive services to remain in place. Within a housing development for residents who are "high utilizers" with severe mental illness. MidPen will provide proactive and consistent on-site support services and crisis intervention for up to 40 WPC enrollees to contribute to the housing stability and reduction in the over use of county services. Specifically, services include crisis intervention, case management, workforce development, computer learning, financial education, health and wellness education for WPC enrollees with histories of homelessness, mental illness, substance use, co-occurring disorders, and chronic health conditions. MidPen Housing has extensive experience in housing a variety of populations, including High Utilizer populations, in San Mateo and Santa Clara Counties.

Category	Services
Outreach and Interception	**Interim, Inc.** will provide Targeted Outreach, pre-enrollment intercept, and referral for homeless populations located within the neighborhood of concentrated homeless services providers. The team will provide counseling to WPC-enrollees with a focus on pathways to housing and employment. Activities will include instructional sessions for stress management, grief and loss, life skills, nutrition, health and healing, job seeking skills, and conflict resolution, among others.
Additional Referring Organizations	• Monterey County Sheriff/Probation Depts. • Franciscan Workers (Dorothy's Place) • Community Homeless Solutions • Gathering for Women
Pilot Governance	**MCHD** will act as the Lead Entity for the WPC Pilot care coordination effort. MCHD and CHSP will form an overarching Executive Committee that will be chaired by the MCHD Director of Health and comprised by representatives of the partnering agencies. The Executive Committee will be supported by designated staff and standing Work Groups.

The graphic below illustrates the WPC patient flow from identification through stratification, WPC services, and MCHD WPC pilot performance monitoring. In Program Year 2 our patient identification will be implemented through a manual operation based on data extraction from disparate systems. We expect our eMPI and Case Management solutions to be in place and fully operational in approximately PY 2-3. At that time, the illustrated Data/Risk Stratification Tool and Data Warehouse elements (boxed in green) will work as depicted below.



3.1 Data Sharing

MCHD has formed a Data Workgroup represented by key participant agencies and stakeholders. The Data Work group are developing an IT plan that aligns with and addresses the overall Monterey Countypopulation health and Longitudinal care strategy including that of the PRIME initiative. This IT plan is comprised of data aggregation, registry, analytics and care management solutions. The workgroup understands the challenges of agency collaboration, data aggregation, and the proprietary systems and data sources that may be effective and functional individually but collectively siloed systems. In addition, each of the systems has individual data privacy requirements. The workgroup has identified the following objectives to be addressed as part of this project and has developed the following implementation plan.

I. Formal Agency Participation Agreement needed: Memorandum of Understanding (MOU) thatwill include the roles/responsibilities of each agency that will participate. Master Data Sharing Agreement that will be a subset of the MOU or a stand-alone with agencies added during the development of the pilot program. Understanding the challenges that exist with data governance, data sharing, and the legal boundaries that exist, MCHD has taken the initiative to engage County Counsel and outside Counsel that serve as subject matter experts in meeting HIPAA requirements and the boundaries surrounding the sharing of Substance Abuse information. This due diligence in ensuring that legal counsel is involved to better prepare the County to address the program requirements, and conduct the technical assessment of potential care coordination solutions, while factoring in the critical component in successfully implementing a unified solution that enables interoperability amongst multiple agencies. Funds for legal services provided by outside counsel (subject matter experts) for data sharing agreements in support of our Master Data Sharing Agreement are included in MCHD's WPC Pilot application.

II. Proprietary Program/Service Assessment: Technology requirements to be developed will include an assessment of participating agencies' existing resources for service providers, contacts, information, and referral options that will define the workflow in an automated solution. This will evolve into the WPC Pilot's Program Director for the care coordination solution.

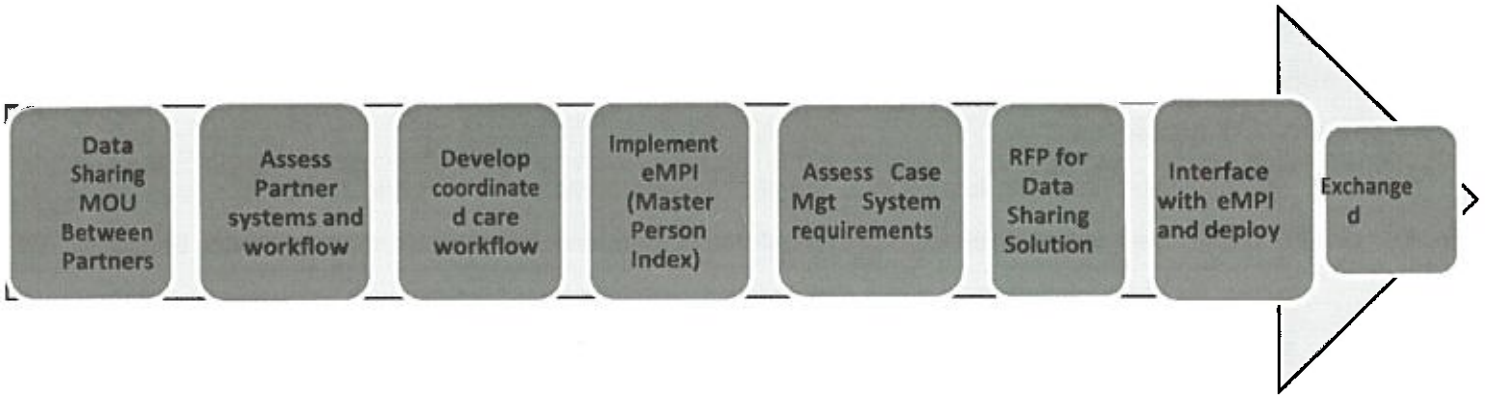
a. Technical Assessment of Source Data: The participating agencies have proprietary systems developed and in use for their agencies service provision. Although independently they are robust systems, they are siloed. To ensure the success of this pilot program, a unified Case Management Solution that is data source agnostic will enable this pilot program to begin tracking the program participants and develop clear multi-disciplinary workflows. Accountability, reporting, and the measurement of outcomes require a

unified solution utilized by all of the participating agencies.

b. MCHD takes a project implementation approach with lessons learned after working through the development of current data interfaces connecting proprietary systems that share only discreet data elements and tables necessary to meet the programmatic requirements and better monitor data across multiple platforms. These individual use cases has enabled MCHD to consider the logistics, the legal parameters proprietary to each dataset, and the subsequent value of monitoring the outcomes. Integrated services across multiple disciplines to maintain continuity of care has been the impetus for previous individual data sharing projects.

c. The experiences in implementing the existing interfaces and projects in progress enables collaboration within multi-disciplinary teams both programmatically and technically. This has enabled MCHD to recognize the challenges of data sharing and data governance that may often impede program deployment and impact the provision of effective case management across disparate systems. This pilot project will enable MCHD to be agile in determining the solutions needed with a technical approach to build a scalable solution that will support the provision of case management across the participating agencies.

III. Protected Health Information in a multi-disciplinary/multi-agency pilot program will require data security and data privacy protocols incorporated into the workflow, application access with role based access defined, and participant consent for data sharing necessary only for the provision of services. MCHD has included County Counsel and outside counsel throughout the course of the development of this proposal and is in the process of developing Health Information Technology (HIT) Policies that support the recent HIT security assessment conducted by a consultant. The MOU that will ensue will define clear agency participation and defined role-based data access controls that will include: Organization, Employee, Role, Access Level, and Functions with a recurring audit plan that meets the requirement of the County of Monterey Data Security Policy.



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

4.1. Performance Measures

The performance measures for each our WPC Pilot participating partners, grouped by entity type, are presented in the tables below. The entity types include Administration, hospitals, medical clinics, mental health service providers, and housing and housing support services providers. We have identified quantitative targets for each program year.

For the Pilot program itself, our process measures are

- establishing care coordination
- conducting effective case management
- creating referral policies and procedures across all partner entities
- continuing use of PDSA and application of lessons learned

The Pilot's quantifiable outcome measures are:

- increases in the numbers of WPC high utilizers who receive at least 12 months of coordinated case management
- The increasing number of beneficiaries with a comprehensive care plan

The quantifiable standard health outcome metrics across all five program years are:

- increases in the percentages of WPC Pilot high utilizers who have follow up medical, mental health, and SUD appointment no later than 30 days from date of release from jail or discharge from hospital
- reductions in WPC Pilot high utilizers hospital readmissions within one year of WPC Pilot enrollment
- reduction in ED use by WPC Pilot high utilizers

Other quantitative outcome measures are listed for hospital providers (ED and in-patient metrics), medical and mental health providers, and housing and housing supportive services providers. Each of the MCHD WPC Pilot interventions and our focus population are represented in these performance measures. Our overarching vision is for all partner agencies to accurately participate in reporting their performance data, have knowledge of the performance outcomes achieved by other partner entities, and have understanding of how the Pilot is achieving its overall objectives of developing a fully-functioning coordinated case management system, reductions in ED and hospitalizations by high utilizers, and more

stable housing solutions for the Pilot's focus population.

MCHD analysts will provide all partner entities with data reporting forms, and MCHD analysts will house and analyze data using Excel spreadsheets for the Executive Team's interpretation. Performance measure results, by individual partner, aggregated by function, and aggregated for the Pilot overall, will be posted to a Google Docs platform that will be accessible by all partner entities. If results are less than satisfactory, a PDSA process will be exercised to discover what barriers, bottlenecks, resource challenges, or other impediments can be facilitated.

On a quarterly basis, MCHD analysts will provide the Pilot's Executive Team with tables, charts, and graphs for easily understood visualizations of progress toward the Pilot's goals. Quarterly reports, consisting of the above plus narrative regarding the Executive Committee's interpretation and next steps to be taken, will also be submitted to DHCS at required intervals. Annual reports will be drawn from these materials. Annual reports will be shared with all community stakeholders, posted on publically accessible places, and shared with public health and evaluation communities of practice.

1.1.a Universal Metrics

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

Universal Metrics - Health Outcomes and Administrative Metrics

Metrics	PY 1	PY 2	PY 3	PY 4	PY 5
i. Health Outcomes Ambulatory Care – Adult ED Visits (HEDIS)* (measured by aggregated focus population visits)	Adult ED Visits: Establish baseline	Adult ED Visits: Maintain baseline	Adult ED Visits: 5% decrease from prior PY	Adult ED Visits: 5% decrease from prior PY	Adult ED Visits: 5% decrease from prior PY
ii Health Outcomes Adult Inpatient Utilization-General Hospital/Acute Care (IPU) (HEDIS)* (measured by aggregated focus population inpatient days)	Adult Inpatient utilization: Establish baseline	Adult Inpatient utilization: Maintain baseline	Adult Inpatient utilization: 5% decrease from prior PY	Adult Inpatient utilization: 5% decrease from prior PY	Adult Inpatient utilization: 5% decrease from prior PY
iii Health Outcomes Follow-up After Hospitalization for Mental Illness (Adults) (FUH) (HEDIS) (measured by the number of dischargedclients given a follow up appointment within 7 days and a treatment plan within 30 days)	Adult Follow up After Hospitalization for Mental Illness: Establish baseline	Adult Follow up After Hospitalization for Mental Illness: Maintain baseline	Adult Follow up After Hospitalization for Mental Illness: 5% increase from prior PY	Adult Follow up After Hospitalization for Mental Illness: 5% increase from prior PY	Adult Follow up After Hospitalization for Mental Illness: 5% increase from prior PY
iv Health Outcomes Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (Adults) (IET) (HEDIS) (measured by the numberof focus population who have been informed of SUD services and been given an SUD assessment)	Initiation and engagement of AOD for Adults: Establish baseline	Initiation and engagement of AOD for Adults: Maintain baseline	Initiation and engagement of AOD for Adults: 5% increase from prior PY	Initiation and engagement of AOD for Adults: 5% increase from prior PY	Initiation and engagement of AOD for Adults: 5% increase from prior PY

*Includes quarterly utilization of PDSA with measurement and necessary changes.

Universal Metrics - Health Outcomes and Administrative Metrics - continued

Metrics	PY 1	PY 2	PY 3	PY 4	PY 5
v. Administrative: Proportion of participating beneficiaries with a comprehensive care plan, accessible by the entire care team, within 30 days of: 1. Enrollment into the WPC Pilot* 2. The beneficiary's anniversary of participation in the Pilot (to be conducted annually)*	1. Enrollment into WPC Pilot: x=baseline % 2. Beneficiary's anniversary of participation in the Pilot: x=baseline	1. Enrollment into WPC Pilot: x= 100% 2. Beneficiary's anniversary of participation in the Pilot: x=baseline + 5%	1. Enrollment into WPC Pilot: x= 100% 2. Beneficiary's anniversary of participation in the Pilot: x=baseline + 10%	1. Enrollment into WPC Pilot: x= 100% 2. Beneficiary's anniversary of participation in the Pilot: x=baseline + 15%	1. Enrollment into WPC Pilot: x= 100% 2. Beneficiary's anniversary of participation in the Pilot: x=baseline + 20%
vi. Administrative: a. Care coordination, case management, and referral infrastructure* *Reporting Partners: Lead entity (MCHD) and the Coalition of Homeless Services Providers*	Submission of documents establishing care coordination, case management, referral policies and procedures across all partners: complete or materially complete by end of PY1	Number of WPC high utilizers who receive at least 12 months of coordinated case management: 50 Beneficiaries with a comprehensive care plan: 100	Number of WPC high utilizers who receive at least 12 months of coordinated case management: 55 Beneficiaries with a comprehensive care plan: 110	Number of WPC high utilizers who receive at least 12 months of coordinated case management: 70 Beneficiaries with a comprehensive care plan: 140	Number of WPC high utilizers who receive at least 12 months of coordinated case management: 75 Beneficiaries with a comprehensive care plan: 150

*Includes quarterly utilization of PDSA with measurement and necessary changes.

Universal Metrics - Health Outcomes and Administrative Metrics - continued

Metrics	PY 1	PY 2	PY 3	PY 4	PY 5
vi. Administrative: b. Monitoring procedures for oversight of how the policies and procedures set forth in iv.1a are being operationalized, including a regular review to determine any needed qualifications. **	Upon completion of all documents establishing care coordination, case management, and referral policies and procedures, PDSA will be utilized semi-annually	PDSA will be utilized semi-annually	PDSA will be utilized semi-annually	PDSA will be utilized semi-annually	PDSA will be utilized semi-annually
C. compile and analyze information and findings from the monitoring procedures set forth in iv.1b.	Upon monitoring the completed documents establishing care coordination, case management, and referral policies and procedures, findings will be will be compiled and analyzed semi-annually, and a PDSA will be utilized semi-annually to modify such as needed.	Findings will be will be compiled and analyzed semi-annually, and a PDSA will be utilized semi-annually to modify such as needed.	Findings will be will be compiled and analyzed semi-annually, and a PDSA will be utilized semi-annually to modify such as needed.	Findings will be will be compiled and analyzed semi-annually, and a PDSA will be utilized semi-annually to modify such as needed.	Findings will be will be compiled and analyzed semi-annually, and a PDSA will be utilized semi-annually to modify such as needed.

** Includes semi-annual utilization of PDSA with measurement and necessary changes.

Universal Metrics - Health Outcomes and Administrative Metrics - continued

Metrics	PY 1	PY 2	PY 3	PY 4	PY 5
vii. Administrative: a. Submit documents demonstrating data and information sharing policies and procedures across the WPC Pilot lead and all participating entities. b. Monitor procedures for oversight of how the policies and procedures set forth in v.1(a) are operationalized – including a regular review to determine any needed modifications** c. Compile and analyze information and findings from the monitoring procedures set forth in v.1(b)	a. documents demonstrating data sharing policies and procedures will be submitted at the end of PY1 b. PDSA will be utilized semi-annually to determine any needed modifications c. PDSA will be used semi-annually to update policies and procedures as needed	a. Lead agency will provide proof of all participating agency use of data and information sharing policies and procedures. b. PDSA will be utilized semi-annually to determine any needed modifications c. PDSA will be used semi-annually to update policies and procedures as needed	a. Lead agency will provide proof of all participating agency use of data and information sharing policies and procedures. b. PDSA will be utilized semi-annually to determine any needed modifications c. PDSA will be used semi-annually to update policies and procedures as needed	a. Lead agency will provide proof of all participating agency use of data and information sharing policies and procedures. b. PDSA will be utilized semi-annually to determine any needed modifications c. PDSA will be used semi-annually to update policies and procedures as needed	a. Lead agency will provide proof of all participating agency use of data and information sharing policies and procedures. b. PDSA will be utilized semi-annually to determine any needed modifications c. PDSA will be used semi-annually to update policies and procedures as needed

** Includes semi-annual utilization of PDSA with measurement and necessary changes.

Variant Metrics

Variant Metric	PY 1	PY 2	PY 3	PY 4	PY 5
Health outcomes metrics across all five programyears *Reporting Partners: Hospitals, mental health providers, medical provider, and comprehensive case managers*	Health Outcomes: Timely case management enrollment Target population: All WPC Pilot Participants Numerator: Follow up medical, mental health, and SUDappointments no later than 30 days from date of release from jail or discharge from hospital. Denominator: All WPC Pilot Participants PY 1: 80%	Health Outcomes: Timely case management enrollment Target population: All WPC Pilot Participants Numerator: Follow up medical, mental health, and SUDappointments no later than 30 days from date of release from jail or discharge from hospital. Denominator: All WPC Pilot Participants PY 2: Maintain baseline of 80%	Health Outcomes: Timely case management enrollment Target population: All WPC Pilot Participants Numerator: Follow up medical, mental health, and SUDappointments no later than 30 days from date of release from jail or discharge from hospital. Denominator: All WPC Pilot Participants PY 3: 5% increase from prior PY	Health Outcomes: Timely case management enrollment Target population: All WPC Pilot Participants Numerator: Follow up medical, mental health, and SUDappointments no later than 30 days from date of release from jail or discharge from hospital. Denominator: All WPC Pilot Participants PY4: 5% increase from prior PY	Health Outcomes: Timely case management enrollment Target population: All WPC Pilot Participants Numerator: Follow up medical, mental health, and SUDappointments no later than 30 days from date of release from jail or discharge from hospital. Denominator: All WPC Pilot Participants PY 5: 5% increase from prior PY
	Health Outcomes: 30 day All Cause Hospital Readmissions Target population: All WPC Pilot Participants Numerator: Count of 30-day readmission Denominator: Count of index hospital stay (HIS) PY1: Establish baseline	Health Outcomes: 30 day All Cause Hospital Readmissions Target population: All WPC Pilot Participants Numerator: Count of 30-day readmission Denominator: Count of index hospital stay (HIS) PY2: Maintain baseline	Health Outcomes: 30 day All Cause Hospital Readmissions Target population: All WPC Pilot Participants Numerator: Count of 30-day readmission Denominator: Count of index hospital stay (HIS) PY3: 5% decrease from prior PY	Health Outcomes: 30 day All Cause Hospital Readmissions Target population: All WPC Pilot Participants Numerator: Count of 30-day readmission Denominator: Count of index hospital stay (HIS) PY4: 5% decrease from prior PY	Health Outcomes: 30 day All Cause Hospital Readmissions Target population: All WPC Pilot Participants Numerator: Count of 30-day readmission Denominator: Count of index hospital stay (HIS) PY5: 5% decrease from prior PY

Variant Metrics – continued

Health Outcome Metric - Coordinated Case management Use of PDSA: quarterly in PY 2-5	Health Outcomes: coordinated case management Target population: All WPC Pilot participants Numerator: All WPC Pilot participants Denominator: All WPC Pilot participants PY1: Fully define the scope of comprehensive case management, provider roles, and management systems.	Health Outcomes: coordinated case management Target population: All WPC Pilot participants Numerator: All WPC Pilot participants Denominator: All WPC Pilot participants PY1: 100 WPC participants receive at least 12months of coordinated case management. 200 WPC participants have a comprehensive care plan	Health Outcomes: coordinated case management Target population: All WPC Pilot participants Numerator: All WPC Pilot participants Denominator: All WPC Pilot participants PY1: 200 WPC participants receive at least 12months of coordinated case management. 300 WPC participants have a comprehensive care plan	Health Outcomes: coordinated case management Target population: All WPC Pilot participants Numerator: All WPC Pilot participants Denominator: All WPC Pilot participants PY1: 300 WPC participants receive at least 12months of coordinated case management. 400 WPC participants have a comprehensive care plan	Health Outcomes: coordinated case management Target population: All WPC Pilot participants Numerator: All WPC Pilot participants Denominator: All WPC Pilot participants PY1:300 WPC participants receive at least 12months of coordinated case management. 500 WPC participants have a comprehensive care plan
Health Outcome Metric - Hospital Coordination *Reporting Partners: Hospital providers(ED and in-patient)*	Health Outcomes: hospital coordination Target population: All WPC Pilot participants Numerator: All WPC Pilot participants Denominator: All WPC Pilot participants PY1: Medication list provided on discharge: 0% Timely documentation transition toclinics/PCP: 0% MHU re- hospitalization within 30 days: Establish baseline	Health Outcomes: hospital coordination Target population: All WPC Pilot participants Numerator: All WPC Pilot participants Denominator: All WPC Pilot participants PY1: Medication list provided on discharge: 5% Timely documentation transition toclinics/PCP: 5% MHU re- hospitalization within 30 days: Maintain baseline	Health Outcomes: coordinated case management Target population: All WPC Pilot participants Numerator: All WPC Pilot participants Denominator: All WPC Pilot participants PY1: Medication list provided on discharge: 10% Timely documentation transition toclinics/PCP: 10% MHU re- hospitalization within 30 days: 5% decrease from prior PY	Health Outcomes: coordinated case management Target population: All WPC Pilot participants Numerator: All WPC Pilot participants Denominator: All WPC Pilot participants PY1: Medication list provided on discharge: 15% Timely documentation transition toclinics/PCP: 15% MHU re- hospitalization within 30 days: 5% decrease from prior PY	Health Outcomes: coordinated case management Target population: All WPC Pilot participants Numerator: All WPC Pilot participants Denominator: All WPC Pilot participants PY1: Medication listprovided on discharge: 20% Timely documentation transition to clinics/PCP: 20% MHU re- hospitalization within 30 days: 5% decrease from prior PY

Variant Metrics - continued

Health Outcome Metrics: Depression and SMI Reporting Partners: medical clinics and mental health services providers	Health Outcome: Required for Pilots using PHQ-9 Target population: WPC participants with depression diagnosis Numerator: Adults who achieved remission at twelve months as demonstrated by a twelve month (+/- 30 days) PHQ-9 score of less than five Denominator: Adults age 18 and older with a diagnosis of major depression or dysthymia and an initial PHQ-9 score greater than nine during an outpatient encounter	Health Outcome: Required use of PHQ-9 Target population: WPC participants with depression diagnosis Numerator: Adults who achieved remission at twelve months as demonstrated by a twelve month (+/- 30 days) PHQ-9 score of less than five Denominator: Adults age 18 and older with a diagnosis of major depression or dysthymia and an initial PHQ-9 score greater than nine during an outpatient encounter PY2: baseline-1 time	Health Outcome: Required use of PHQ-9 Target population: WPC participants with depression diagnosis Numerator: Adults who achieved remission at twelve months as demonstrated by a twelve month (+/- 30 days) PHQ-9 score of less than five Denominator: Adults age 18 and older with a diagnosis of major depression or dysthymia and an initial PHQ-9 score greater than nine during an outpatient encounter PY1: baseline-2 times	Health Outcome: Required use of PHQ-9 Target population: WPC participants with depression diagnosis Numerator: Adults who achieved remission at twelve months as demonstrated by a twelve month (+/- 30 days) PHQ-9 score of less than five Denominator: Adults age 18 and older with a diagnosis of major depression or dysthymia and an initial PHQ-9 score greater than nine during an outpatient encounter PY1: baseline-3 times	Health Outcome: Required use of PHQ-9 Target population: WPC participants with depression diagnosis Numerator: Adults who achieved remission at twelve months as demonstrated by a twelve month (+/- 30 days) PHQ-9 score of less than five Denominator: Adults age 18 and older with a diagnosis of major depression or dysthymia and an initial PHQ-9 score greater than nine during an outpatient encounter PY1: baseline-4 times
	Health Outcome: Required for Pilots with SMI population Target population: WPC participants with risk of suicide Numerator: Patients who had suicide risk assessment completed at each visit Denominator: All patients aged 18 years and older with a new diagnosis or recurrent episode of Major Depressive Disorder PY1: 60%	Health Outcome: Required for Pilots with SMI population Target population: WPC participants with risk of suicide Numerator: Patients who had suicide risk assessment completed at each visit Denominator: All patients aged 18 years and older with a new diagnosis or recurrent episode of Major Depressive Disorder PY2: Maintain baseline of 60%	Health Outcome: Required for Pilots with SMI population Target population: WPC participants with risk of suicide Numerator: Patients who had suicide risk assessment completed at each visit Denominator: All patients aged 18 years and older with a new diagnosis or recurrent episode of Major Depressive Disorder PY3: 5% increase from prior PY	Health Outcome: Required for Pilots with SMI population Target population: WPC participants with risk of suicide Numerator: Patients who had suicide risk assessment completed at each visit Denominator: All patients aged 18 years and older with a new diagnosis or recurrent episode of Major Depressive Disorder PY4: 5% increase from prior PY	Health Outcome: Required for Pilots with SMI population Target population: WPC participants with risk of suicide Numerator: Patients who had suicide risk assessment completed at each visit Denominator: All patients aged 18 years and older with a new diagnosis or recurrent episode of Major Depressive Disorder PY5: 5% increase from prior PY

Variant Metrics – continued

Health Outcome Metric - Disease Prevention and self-management Reporting Partners: medical clinics and providers	Health Outcome: HbA1c Poor Control <8% across all program years Target population: WPC participants with diabetes diagnosis Numerator: Within the denominator, WPC Pilot participants who had poorly controlled diabetes (HbA1c ><8%) Denominator: WPC Participants 18-75 years of age with diabetes (type 1 and type 2) PY1: 50%	Health Outcome: HbA1c Poor Control <8% across all program years Target population: WPC Participants with diabetes diagnosis Numerator: Within the denominator, WPC Pilot participants who had poorly controlled diabetes (HbA1c ><8%) Denominator: WPC Participants 18-75 years of age with diabetes (type 1 and type 2) PY2: Maintain baseline of 50%	Health Outcome: HbA1c Poor Control <8% across all program years Target population: WPC Participants with diabetes diagnosis Numerator: Within the denominator, WPC Pilot participants who had poorly controlled diabetes (HbA1c ><8%) Denominator: WPC Participants 18-75 years of age with diabetes (type 1 and type 2) PY3: 5% decrease from prior PY	Health Outcome: HbA1c Poor Control <8% across all program years Target population: WPC Participants with diabetes diagnosis Numerator: Within the denominator, WPC Pilot participants who had poorly controlled diabetes (HbA1c ><8%) Denominator: WPC Participants 18-75 years of age with diabetes (type 1 and type 2) PY4: 5% decrease from prior PY	Health Outcome: HbA1c Poor Control <8% across all program years Target population: WPC Participants with diabetes diagnosis Numerator: Within the denominator, WPC Pilot participants who had poorly controlled diabetes (HbA1c ><8%) Denominator: WPC Participants 18-75 years of age with diabetes (type 1 and type 2) PY5: 5% decrease from prior PY

Variant Metrics – continued

Health Outcome Metric - Disease Prevention and self-management Reporting Partners: medical clinics and providers	Health Outcome: Control blood pressure across all program years Target population: WPC participants with hypertension diagnosis Numerator: Within the denominator, WPC Pilot participants whose BP was adequately controlled during the measurement year based on the following criteria: • Members age 18-59 with BP <140/90 mm Hg • Members age 60-85 with diabetes diagnosis and BP <140/90 mm Hg • Members age 60-85 with diabetes diagnosis and BP <150/90 mm Hg Denominator: Members age 18-85 with hypertension PY1: 50%	Health Outcome: Control blood pressure across all program years Target population: WPC participants with hypertension diagnosis Numerator: Within the denominator, WPC Pilot participants whose BP was adequately controlled during the measurement year based on the following criteria: • Members age 18-59 with BP <140/90 mm Hg • Members age 60-85 with diabetes diagnosis and BP <140/90 mm Hg • Members age 60-85 with diabetes diagnosis and BP <150/90 mm Hg Denominator: Members age 18-85 with hypertension PY2: Maintain baseline of 50%	Health Outcome: Control blood pressure across all program years Target population: WPC participants with hypertension diagnosis Numerator: Within the denominator, WPC Pilot participants whose BP was adequately controlled during the measurement year based on the following criteria: • Members age 18-59 with BP <140/90 mm Hg • Members age 60-85 with diabetes diagnosis and BP <140/90 mm Hg • Members age 60-85 with diabetes diagnosis and BP <150/90 mm Hg Denominator: Members age 18-85 with hypertension PY3: 5% increase from prior PY	Health Outcome: Control blood pressure across all program years Target population: WPC participants with hypertension diagnosis Numerator: Within the denominator, WPC Pilot participants whose BP was adequately controlled during the measurement year based on the following criteria: • Members age 18-59 with BP <140/90 mm Hg • Members age 60-85 with diabetes diagnosis and BP <140/90 mm Hg • Members age 60-85 with diabetes diagnosis and BP <150/90 mm Hg Denominator: Members age 18-85 with hypertension PY4: 5% increase from prior PY	Health Outcome: Control blood pressure across all program years Target population: WPC participants with hypertension diagnosis Numerator: Within the denominator, WPC Pilot participants whose BP was adequately controlled during the measurement year based on the following criteria: • Members age 18-59 with BP <140/90 mm Hg • Members age 60-85 with diabetes diagnosis and BP <140/90 mm Hg • Members age 60-85 with diabetes diagnosis and BP <150/90 mm Hg Denominator: Members age 18-85 with hypertension PY5: 5% increase from prior PY

Health Outcome Metric - Disease Prevention and self-management Reporting Partners: mental health providers	Health Outcome: Substance abuse Prevention Target population: All WPC participants with substance use disorder Numerator: WPC population receiving tobacco assessment and substance use assessment and counseling Denominator: All WPC participants with substance use disorder PY1: Tobacco Assessment and Counseling: 60% Alcohol and Drug Misuse (SBIRT): 60%	Health Outcome: Substance abuse Prevention Target population: All WPC participants with substance use disorder Numerator: WPC population receiving tobacco assessment and substance use assessment and counseling Denominator: All WPC participants with substance use disorder PY1: Tobacco Assessment and Counseling: 65% Alcohol and Drug Misuse (SBIRT): 65%	Health Outcome: Substance abuse Prevention Target population: All WPC participants with substance use disorder Numerator: WPC population receiving tobacco assessment and substance use assessment and counseling Denominator: All WPC participants with substance use disorder PY1: Tobacco Assessment and Counseling: 70% Alcohol and Drug Misuse (SBIRT): 70%	Health Outcome: Substance abuse Prevention Target population: All WPC participants with substance use disorder Numerator: WPC population receiving tobacco assessment and substance use assessment and counseling Denominator: All WPC participants with substance use disorder PY1: Tobacco Assessment and Counseling: 75% Alcohol and Drug Misuse (SBIRT): 75%	Health Outcome: Substance abuse Prevention Target population: All WPC participants with substance use disorder Numerator: WPC population receiving tobacco assessment and substance use assessment and counseling Denominator: All WPC participants with substance use disorder PY1: Tobacco Assessment and Counseling: 80% Alcohol and Drug Misuse (SBIRT): 80%

Variant Metrics - continued

Variant Metric	PY 1	PY 2	PY 3	PY 4	PY 5
Housing Services for homeless/at-risk homeless participants	Health Outcome: Housing Services Target population: WPC participants who are homeless or at risk for homelessness Numerator: Number of participants referred for housing services that receive services Denominator: Number of participants referred for housing services that receive services PY1: baseline	Health Outcome: Housing Services Target population: WPC participants who are homeless or at risk for homelessness Numerator: Number of participants referred for housing services that receive services Denominator: Number of participants referred for housing services that receive services PY1: 20 people	Health Outcome: Housing Services Target population: WPC participants who are homeless or at risk for homelessness Numerator: Number of participants referred for housing services that receive services Denominator: Number of participants referred for housing services that receive services PY1: 30 people	Health Outcome: Housing Services Target population: WPC participants who are homeless or at risk for homelessness Numerator: Number of participants referred for housing services that receive services Denominator: Number of participants referred for housing services that receive services PY1: 40 people	Health Outcome: Housing Services Target population: WPC participants who are homeless or at risk for homelessness Numerator: Number of participants referred for housing services that receive services Denominator: Number of participants referred for housing services that receive services PY1: 40+ people
Housing-Specific Metric: Develop 40 permanent supportive rental housing units for focus population in the "ground zero" location for chronic homelessness in Monterey County. Staff the site with 2-3 qualified, fulltime case managers with 1 living on site. *Reporting Partners: Housing support services providers*	Health Outcome: Housing Services Target population: WPC participants who are homeless or at risk for homelessness Numerator: Number of participants referred for housing services that receive services Denominator: Number of participants referred for housing services that receive services PY1: Pre-development	Health Outcome: Housing Services Target population: WPC participants who are homeless or at risk for homelessness Numerator: Number of participants referred for housing services that receive services Denominator: Number of participants referred for housing services that receive services PY2: Secure financing; design 40 units for permanentsupportive housing.	Health Outcome: Housing Services Target population: WPC participants who are homeless or at risk for homelessness Numerator: Number of participants referred for housing services that receive services Denominator: Number of participants referred for housing services that receive services PY3: Construction and tenant pre-identification	Health Outcome: Housing Services Target population: WPC participants who are homeless or at risk for homelessness Numerator: Number of participants referred for housing services that receive services Denominator: Number of participants referred for housing services that receive services PY4:Tenant move-in. Achieve 100% lease-up. Begin case management and wide array of supportive services.	Health Outcome: Housing Services Target population: WPC participants who are homeless or at risk for homelessness Numerator: Number of participants referred for housing services that receive services Denominator: Number of participants referred for housing services that receive services PY5: Ongoing case management at the housing site with 70% retention rate.

4.2 Data Analysis, Reporting and Quality Improvement

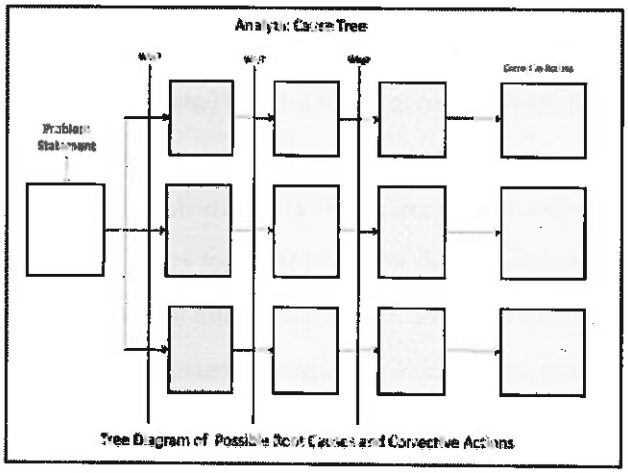
Ongoing data collection, reporting, and analysis of the WPC Pilot's interventions, strategies, participant health outcomes, and return on investment will be accomplished using existing and new data sources. Initial partnership work has included identification of current universal and potential variant metrics that are maintained in each partner's data system (data systems are displayed in the table below)

WPC Pilot Partner	Current Database(s)	Using Identity Matching Tool?	Future User of Case Management Tool
Monterey County Health Department, Nurse Case Management and Clinic Services	EPIC	In process	Yes
Monterey County Health Department Behavioral Health Bureau	Avatar	In process	Yes
Monterey County Department of Social Services	Automated Welfare System, Consortium IV	Future goal	Yes
Natividad Medical Center	Meditech	Yes	Yes
Coalition of Homeless Services Provider	Homeless Management Information System	Future goal	Yes
Interim, Inc.	Avatar	In process	Yes
Franciscan Workers of Junipero Serra	HMIS	Future goal	Yes
Monterey County Sheriff's Department	TrakNet, Automated Fingerprint Identification System	Future goal	Yes
Monterey County Probation Department	Smart Probation	Future goal	Yes

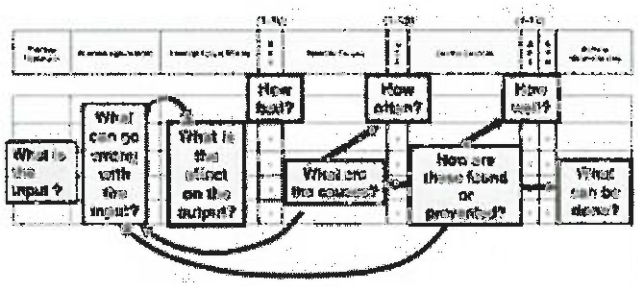
Initially, Epidemiologists will develop an analytic approach, including the program questions and fields to track from the various data sets from the participating partners. Algorithms will be developed using the partner's datasets and used to query them to track individuals in each system that match the Pilot criteria and are enrolled in the Pilot. Within the first year, the participating health care partners will have an Identity Matching Tool (Master Person Index) to track individuals enrolled in the Pilot and have developed an RFP for a Case Management System and contracted with a company to use their unified case management solution for the WPC Pilot.

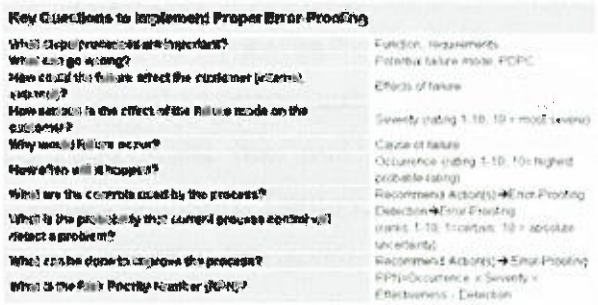
Data sharing agreements will be developed over the first year to enable partners to share patient data. The solution will be how the patient-centered coordinated care plan is developed and onboarding/follow-up, referral management, and social determinants outcomes are monitored by the WPC Pilot Program Director, CHW/case managers, Social Workers, and other service providers. The solution will provide population level reports as well as individual case tracking. The reports will be used as part of the data analysis to determine the effectiveness of the Pilot's interventions and strategies, along with the data collected as part of quality improvement and change management (outlined below). In addition, while initially patient outcomes will be monitored from individual databases, the goal will be to use the Identity Matching Tool to create a data warehouse for tracking Pilot outcomes. Several of the MCHD partners identified for the WPC Pilot have work diligently for the last several years to bring siloed data systems together for analysis of root causes, determining factors, and bigger picture solutions. For example, MCHD's Behavioral Health Bureau and the DSS Children's Welfare System have been engaged since 2010 to share data between their respective data systems for the purpose of developing an informed view of Monterey County's foster youth population. The result has been a Memorandum of Understanding to share data for dependent children, a matching algorithm, and a monthly manual matching process for almost 500 children and youth in foster care. These collaborators are also now participating in the national Stewards of Change program and discussions on integration have begun to use their Human Services2.0 Handbook. This process will be the framework for producing the integrated population level data for the WPC Pilot data analysis and reporting approach. Algorithms will be developed by MCHD epidemiologists using SAS analytics and resulting analyses used by the Executive and Case Management Teams for quality improvement and change management.

MCHD uses Plan-Do-Study-Act (PDSA) as its quality improvement (QI) process since 2011, per MCHD's Performance Management and Quality Improvement Plan developed in support of national Public Health Accreditation. This plan uses the Turning Point Performance Management System Framework. More than 130 MCHD directors, managers, and lead staff have formal PDSA and QI training in a "Train the Trainers" model and have worked on at least one QI team.



Managers have exercised PDSA as an iterative process,with involvement of MCHD's internal evaluators who analyze collected process and outcome data. MCHD has had Public Health Foundation under contract for the past 3 years, providing instruction and refresher courses in using program performance measurement and corrective action tools, such as the Diagnostic Force Field Analysis, the Analytic Cause Tree (above), and Error Proofing technique (below). Other tools and forms provided by DHCS for Pilot improvement and reporting will be employed.





In its change management process, the WPC Pilot Executive Team will use the Toolkit developed by Harvard's Technology and Entrepreneurship Center's Leadership for a Networked World, the Human Services Value Curve. This model provides a roadmap for improving human services outcomes, value, and legitimacy through a lens of four different business models. It comes with 20 different assessment tools to help develop a transformative approach to collaborative, creative and innovative service delivery. In addition, the team will develop a risk communications plan for all interested parties (internal and external partners), a risk management plan, a timeline for the stages of the Pilot, a status reporting tool, regular checkpoints for conversations with key individuals in the Pilot, and a staged implementation/deployment plan for the Pilot. The MCHD WPC Pilot has already had several months of critical discussions and planning sessions and achieved significant buy-in to the Pilot plan (see letters of support). These planning and implementation meetings will continue after the Pilot launches as part of the change management process. The iterative quality improvement process will also provide periodic reports that will be used to do midcourse corrections or any necessary modifications to the Pilot implementation process. The Pilot team will use the data collection tools outlined above to track metrics, and will combine these metrics with survey and assessment tools developed for the project by the evaluation team to identify and implement needed adjustments to the program.

4.3 Participant Entity Monitoring

The MCHD WPC Pilot Program Director, a subset of CHW/case managers, representatives of the Executive Committee, and evaluators with PDSA and QI training experience will constitute an Evaluation Workgroup to conduct and oversee ongoing monitoring, analysis, and corrective activities related to the Pilot's universal and variant metrics. Process measures will be used in the Pilot's first year, and outcome measures will be initiated once the Master Person Index is fully functional. Process measures will include fidelity to the Executive Committees functionality, Pilot's timeline, Year 1 contracted deliverables (Master Person Index, Case Management System), implementation of the Pilot communication plan, and partnership referral readiness. In Pilot Year 1, the Evaluation Workgroup will meet bimonthly, and designated members will participate in annual State Learning Collaborative in-person activities held during years 2-5.

A critical element to the Pilot's success will be implementation of the case management tool and subsequent oversight of the care coordination, case management, and referral infrastructure. This will include referral communications, policies and procedures between the CHW/case managers and personal navigators. Our WPC Pilot Program Director, who is MCHD's Director of Nursing, will be responsible for other existing case management initiatives serving individuals with chronic physical health conditions including diabetes and obesity, first time at risk mothers, and newborns.

We envision a weekly case review format convened by the WPC Pilot Program Director. The Evaluation Workgroup will have available to them all the management tools described above in 2.2 Communication Plan. The Evaluation Workgroup updates will be a standing item on the Executive Committee's monthly agenda, and written summary reports will be issued quarterly. Summary reports will contain, among other items, process and outcome performance, case counts and case manager-to-client ratios, results of PDSA activities using the State-developed template, and draft reports prepared for DHCS.

Corrective actions will be formally issued to vendors, contractors, or partners when root causes to barriers and process efficiencies have been identified. The MCHD WPC Pilot may terminate agreements or contracts should persistent poor performance continue.

Section 5: Financing

5.1 Financing Structure

The Executive Team will oversee the intake and payment of funds as guided by the Finance workgroup. The Program Director will serve as the Contract Analyst and assure administrative procedures are followed. MCHD will develop MOUs or Agreements with non-federal funding partners and subcontracting agencies with clear scope of work deliverables and payment provisions. Subcontracted agencies will submit quarterly invoices based on MOU or Agreement Payment Provisions which may be bundled, fee for services, or incentive-based as outlined in the attached budget worksheets and narratives.

Existing MCHD Administration fiscal staff will establish purchase orders and process payments as approved by the Program Director in accordance with County Auditor-Controller policies and procedures. Additionally, fiscal staff will develop an excel worksheet tracking tool identifying non-federal funders and funded partners, annual amounts, receipt and disbursement of funds by fiscal year. The Program Director will work closely with Finance Workgroup as related to payment provisions in executed MOUs and Agreements.

The Finance Workgroup will have representatives from each of the non-federal funding partners including MCHD Clinic Services, Behavioral Health and Public Health Bureaus; Monterey County Department of Social Services; Monterey County's Natividad Medical Center; Salinas Valley Memorial Healthcare System; and other key participating entities. The Finance workgroup will initially meet monthly initially and later, quarterly, once MOUs are in place to monitor progress in meeting deliverables and budgeted services, funding contributed for IGT and flow of funds to participating entities once payments are made by DHCS. For Years 2 – 5, mid-year and annual progress reports will be due to DHCS within 60 days of end of reporting period. DHCS will issue a request to MCHD for IGT funds within 30 days of determination of interim payment. MCHD will submit IGT within 7 days of receipt of DHCS payment request. DHCS will make payment to MCHD within 14 days of transfer of IGT. The Program Director and Finance Workgroup will assure compliance with DHCS timelines.

In order to assure funds committed are readily available and sufficient for WPC Pilot services, MCHD will establish specific accounting identifiers (program codes) in the County's financial system to track funds received and disbursement of funds for the WPC Pilot project. As noted above, the Program Director and Finance Workgroup will be responsible for assuring committed funds are received by non-federal share

partners and that funded partners are performing according to their MOU and Agreement scope of work and payment provisions. The non-federal share partners will transfer funds for the WPC Pilot in equal biannual disbursements by end of January and end of July for each of the five Pilot years as will be noted in respective MOU.

By investing in an infrastructure to support comprehensive care coordination and data sharing and exchange, we will create a foundation to support value based payment approaches in the future. Investing in strategies that focus on high risk high utilizers will reduce expenditures via reduced ED and inpatient stays, improved health outcomes, and savings and opportunities for reinvesting in prevention services. These strategies will better prepare the healthcare partners for imminent healthcare payment reform.

MCHD's WPC Pilot funding structure includes partner funding for collecting and reporting performance metrics. These numerical outcome and process reports will be facilitated through data collection methods and tools developed by MCHD's in-house evaluation analysts. Data will be reported by all WPC Pilot partners on a quarterly basis, and results will be rolled up from individual partner to partnership function, and then the Pilot overall. Pay for reporting is in three equal amounts for reporting depression/suicide risk assessment, ED visits, and avoidable hospitalizations, as we consider these three elements to be of equal value to reaching WPC Pilot goals. The pay-for-reporting amounts are consistent across program years 2-5.

5.1.1. IT Infrastructure Financing

The premise for the IT infrastructure is to determine the solutions essential for this project that would alleviate the need for source data systems to change but develop a program and data architecture that will enable existing systems to interface. In order to support a multi-agency and multi-disciplinary team pilot as proposed in this application, the data infrastructure in this proposal requires a case management solution that does not currently exist.

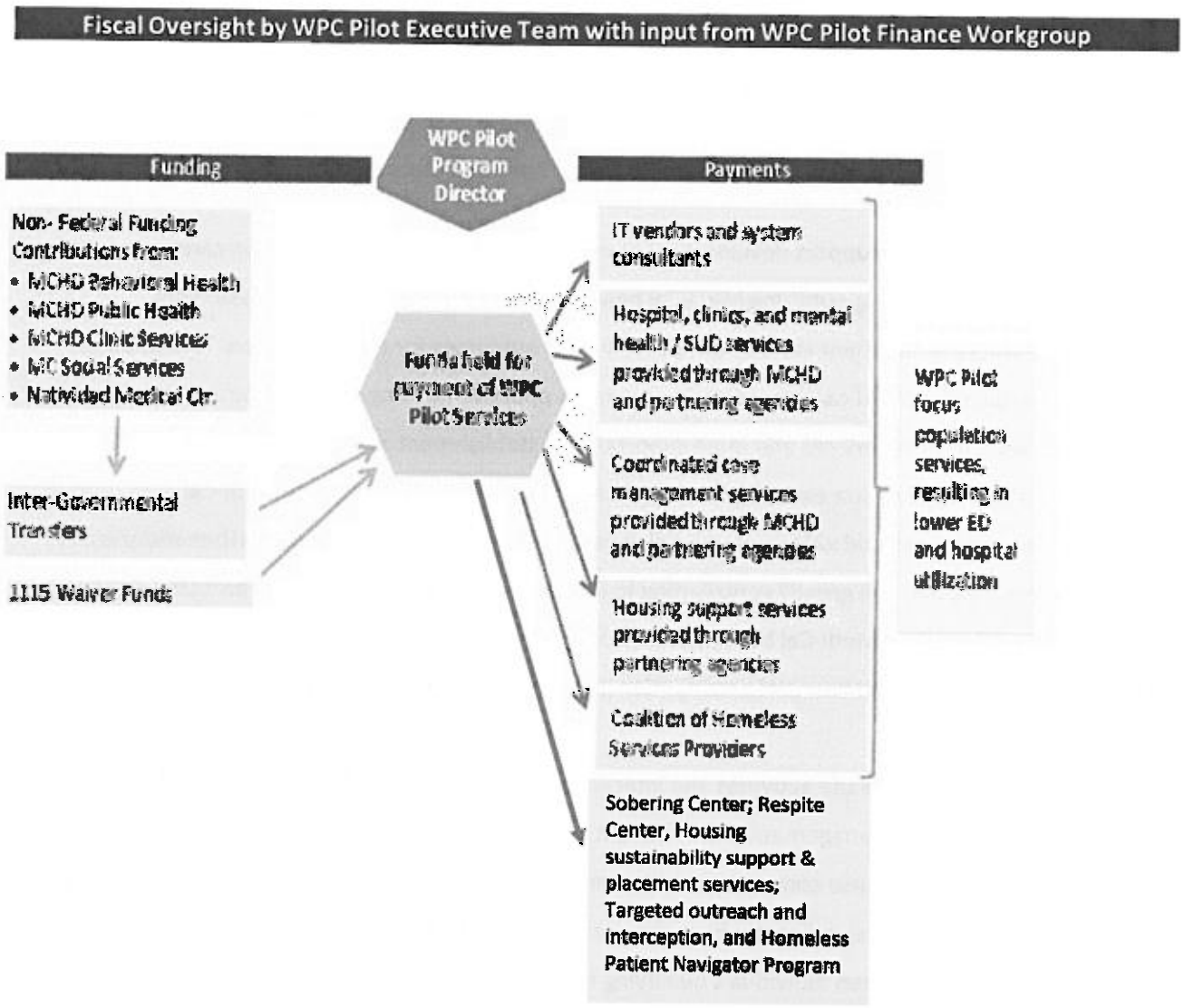
The case management system (CMS) will enable the program coordinators to access information across multiple data systems for individuals that are enrolled in the pilot program. The CMS will enable participating

agencies and program coordinators to query, input data, and track the services provides and resources available without needing to change the proprietary source systems of the participating agencies. The CMS and eMPI will enable the County to enroll individuals in the pilot program with the need to gain control of data across siloed systems to support major expansion of service delivery.

The recommended solution and the associated estimate will be defined as the county proceeds with the RFP required to engage a vendor and solution necessary to support this pilot program. The opportunity provided by this project enables the MCHD to implement a full solution with the estimated costs with the understanding that the challenges of aggregating data from source systems, develop a workflow that is symbiotic between agencies that have not traditionally participated in a data solution that enables service delivery across multiple service disciplines is indeed innovative. The approval of this recommended data infrastructure that does not exist will enable the MCHD to develop, refine, and ensure this pilot is sustainable beyond the program term. Although the estimated number of participants may appear to be conservative, a pilot program involving multiple agencies requires a phased approach with a focus on the development of the workflow across multiple independent data systems, the legality of sharing information of shared clients that are in grave need of seamless service delivery system, the program governance, and agency participation to include the roles/responsibilities first. This logistical approach will enable the County to then focus on increasing the number of clients served in the program.

5.2 Funding Diagram

Below is a diagram of the WPC Pilot Program funding stream illustrating how funds flow from federal and non-federal sources into a holding position where, as directed by the WPC Pilot Program Director, they are disbursed in payments to vendors, consultants, and partnering direct services providers. **Please note that no funds are sourced from or paid to CCAH, our managed care plan.**


Fiscal Oversight by WPC Pilot Executive Team with input from WPC Pilot Finance Workgroup
Funding
WPC Pilot Program Director
Payments
Non- Federal Funding Contributions from:
• MCHD Behavioral Health
• MCHD Public Health
• MCHD Clinic Services
• MC Social Services
• Natividad Medical Ctr.
Inter-Governmental Transfers
1115 Waiver Funds
Funds held for payment of WPC Pilot Services
IT vendors and system consultants
Hospital, clinics, and mental health / SUD services provided through MCHD and partnering agencies
Coordinated case management services provided through MCHD and partnering agencies
Housing support services provided through partnering agencies
Coalition of Homeless Services Providers
Sobering Center; Respite Center, Housing sustainability support & placement services; Targeted outreach and interception, and Homeless Patient Navigator Program
WPC Pilot focus population services, resulting in lower ED and hospital utilization

5.3 Non-Federal Share

Non-Federal shares to the WPC Pilot are committed from these partner entities:

Partners committing non-federal funds	Amounts
Monterey County Health Department	$1,422,863
Monterey County Dept. of Social Services	$465,600
Monterey County Natividad Medical Center	$795,000

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

The WPC pilot funding will support development of infrastructure necessary to improve care coordination for high risk, high utilizing Medi-Cal beneficiaries in an effort to reduce costs from avoidable ED visits and inpatient stays and improve health outcomes for this population. The funding will support establishment of care coordination teams, supportive housing supports, other critical coordinated wrap around services and most importantly, establishment of technology solutions to facilitate data sharing and data exchange amongst partnering agencies. These non Medi-Cal reimbursable services will add value to Medi-Cal covered services provided to Medi-Cal beneficiaries enrolled in the Pilot, and will greatly contributing to improved health outcomes. Pilot participants who have been identified to be Medi-Cal beneficiaries will be highlighted in electronic data systems, thereby assuring that federal financial participation is only for Medi-Cal beneficiaries.

Further, the vast majority of the activities and interactions of the care coordination teams will not duplicate Medi-Cal's targeted case management (TCM) benefit. Specifically, intensive case management of individuals' high ED and hospitalization use complicated with mental illness, addiction, co-morbidities and lack of a primary care home departs significantly from the encounter-based structure of TCM. In the vast majority of cases the encounters between individuals qualifying for intensive case management as described above, would not be eligible for reimbursement under TCM, as TCM workers either would not meet the education/experience requirements for TCM case workers/team members would be in a supervisory role and would have few, if any, direct contact with clients. Moreover, the scope of care support and coordination activities available through WPC is intended to be more robust than available through Medi-Cal TCM. WPC teams will engage in activities such as peer supports, trust-building, motivational supports,

disease specific education, and general reinforcement of health concepts, which are distinct from and outside the TCM benefit. WPC will also provide direct social and other services that would not be recognized as TCM, such as [food and nutrition supports, benefits advocacy or tenancy supports.

For these reasons, we have concluded that the vast majority of WPC Pilot activities will not duplicate services available through Medi-Cal TCM. As assurance, our WPC case managers will receive training and periodic reminders on the differences between TCM and WPC criteria, and be instructed that TCM will always be considered first, with WPC as the payer of last resort.

In response to concerns of duplication of payment, we have applied a TCM budget adjustment to several of the programs to reduce our request for WPC funds. Each TCM budget adjustment can be found in the corresponding service description.

5.5 Funding Request

Please see following pages for the Budget Summary and Budget Narrative.

Budget Summary

WPC Budget Template: Summary and Top Sheet

WPC Applicant Name:	Monterey County Health Department		
	Federal Funds *(Not to exceed 90M)*	IGT	Total Funds
Annual Budget Amount Requested	3,712,283	3,712,283	7,424,566

In PYs 3-5

PY 1 Budget Allocation (Note PY 1 Allocation is predetermined)	
PY 1 Total Budget	5,366,926
Approved Application (75%)	4,025,195
Submission of Baseline Data (25%)	1,341,732
PY 1 Total Check	OK

PY 2 Budget Allocation	
PY 2 Total Budget	6,395,646
Administrative Infrastructure	1,171,785
Delivery Infrastructure	1,058,833
Incentive Payments	1,256,000
FFS Services	507,512
PMPM Bundle	991,491
Pay For Reporting	1,010,025
Pay for Outcomes	400,000
PY 2 Total Check	OK

PY 3 Budget Allocation	
PY 3 Total Budget	7,424,566
Administrative Infrastructure	386,194
Delivery Infrastructure	805,160
Incentive Payments	1,312,000
FFS Services	1,525,923
PMPM Bundle	2,137,979
Pay For Reporting	857,310
Pay for Outcomes	400,000
PY 3 Total Check	OK

PY 4 Budget Allocation	
PY 4 Total Budget	7,424,566
Administrative Infrastructure	386,195
Delivery Infrastructure	896,336
Incentive Payments	1,312,000
FFS Services	1,525,923
PMPM Bundle	2,137,979
Pay For Reporting	766,134
Pay for Outcomes	400,000
PY 4 Total Check	OK

PY 5 Budget Allocation	
PY 5 Total Budget	7,424,566
Administrative Infrastructure	386,195
Delivery Infrastructure	896,336
Incentive Payments	1,312,000
FFS Services	1,525,923
PMPM Bundle	2,137,979
Pay For Reporting	766,134
Pay for Outcomes	400,000
PY 5 Total Check	OK

WPC Budget Narrative

WPC Applicant Name: **Monterey County Health Department**

Program Year 1	Budget Amount
Approved Application (75%)	4,025,194
Submission of Baseline Data (25%)	1,341,732
PY 1 Total Budget	**5,366,926**

PY 2 Administrative Infrastructure			
Staff	Annual Cost/Unit	Unit	Total
Project Manager (0.50 FTE) - Responsible for oversight and implementation of pilot project; contract oversight; supervises case managers; and receives direction from Pilot Executive Team. First 6 months included as administrative costs due to ramping up of staffing. Last 6 months included in PMPM bundle.	170,000	0.25	42,500
Assistant Project Manager (1.00 FTE) – To provide additional Pilot oversight and day-to-day staff and activities management based on expansion and quality needs. Responsible for providing policy direction in pilot project; contract oversight; and receives direction from Pilot Executive Team. Funding is for six months in PY 2, therefore, only requesting 0.50, it will be 1.00 in PY 3.	136,000	0.50	68,000
Project Assistant (1.0 FTE) - reports to Project Manager; day to day coordination of WPC Pilot services; staffs governance structure and workgroup. First 6 months included as administrative costs due to ramping up of staffing. Last 6 months included in PMPM bundle.	116,000	0.50	58,000
Complex Care Managers - PHNs (4.0 FTE) - Public Health Nurses responsible for comprehensive assessment, development of service plan, and case coordination for most complex patients; receives referrals from partner agencies; makes referrals to housing service providers; provide health education and health literacy; teaches patients self-management techniques and tools. First 6 months included as administrative costs due to ramping up of staffing. Last 6 months included in PMPM bundle.	150,000	2.00	300,000
Community Health Workers (4.0 FTE) - non clinical support staff responsible for providing transportation to non Medi-Cal covered services; serve as patient navigator; assist case manager in coordination activities. First 6 months included as administrative costs due to ramping up of staffing. Last 6 months included in PMPM bundle.	69,000	2.00	138,000

Business Technology/Data Analysts (2.0 FTE) - responsible for working with County and Department Information Technology Managers on IT solutions to be implemented; help identify IT solutions; perform complex data analytics; prepare customized programming as needed. One FTE: First 6 months included as administrative costs due to ramping up of staffing. Last 6 months included in Infrastructure costs. One FTE: 12 months in Administrative costs.	145,000	1.50	217,500
Public Health Epidemiologist II (1.0 FTE) - responsible for data analysis; reporting of evaluation metrics	125,000	0.50	62,500
Sub-total			886,500
Services/Supplies/Indirect Costs			
Data Processing and Telecommunications Support	2,500	6.75	16,875
Hardware and Software for staff	1,500	6.75	10,125
Local Travel/Training	10,000	0.50	5,000
Legal Services for data sharing agreements and software agreements	100,000	1.00	100,000
Travel costs for learning collaborative, 5 staff at $500 per trip two times a year	500	10.00	5,000
Training Curricula for Community Health Workers; purchase/development of curriculum; provision of certificated training program (included 100% in CHW line time in budget summary worksheet, PY2 Cell B12)	30,000	1.00	30,000
Purchase of Vehicle for conducting business and transportation of clients for non Medi-Cal Covered Services	30,000	2.00	60,000
General office supplies, printing, educational materials	5,000	0.50	2,500
Sub-total			229,500
Indirect Costs (5% of total Administrative Costs)	1,116,000	0.05	55,785
TOTAL ADMINISTRATIVE INFRASTRUCTURE			1,171,785

PY 2 Delivery Infrastructure			
	Annual Cost/Unit	Unit	Total
Information Technology Solutions and Staff			
Case Management Software - shared repository of case management data; ability to pull data from proprietary external data systems. Costs include: software license, implementation, hardware costs, training, professional services, vendor hosted and supported ($121,000 for solution). Business Technology/Data Analyst (1.0 FTE)- responsible for working with County and Department Information Technology Managers on IT solutions to be implemented; help identify IT solutions; perform complex data analytics; prepare customized programming as needed ($86,143). First 6 months included as Administrative costs due to ramping up of staffing. Last 6 months included in Infrastructure costs.	193,500	1	193,500
Coordinated Assessment and Referral System (CARS)/ Homeless Management System (HMIS) - primary support for housing assessment data for homeless and care coordination services; establish network of agencies; purchase software and support implementation; staff to *Lead Me Home* Committee; conducts homeless census. Costs include: staffing costs, operational expenses, software license and subscription; training; hardware costs	515,000	1	515,000
Sobering Center Facility Modification Expenses. (Sobering Center Services are listed under FFS). It includes costs for the modification of the facilities, and acquisition of the computers and phone system for the operation of the facility. These costs are requested on PY 2 only as one-time costs.	117,833	1	117,833
Computers	2,000	5	10,000
Phone System	5,000	1	5,000
Furniture and Fixtures	2,000	1	2,000
Building/Facility modifications to ensure location is appropriate for WPC enrollees including but not limited to building modifications to make the facility ADA-compliant including ramps, doors, safety bars, and restroom facilities	100,833	1	100,833

Community based Case Management Services - receive referrals from Core Case managers; conduct Vulnerability Assessment for homeless, connect homeless to Coordinated Assessment and Referral System, conduct case management services related to housing, refers clients to Coalition of Service Providers for placement. Costs include: staffing costs, operational expenses, training. PY2 is our startup year; therefore 50% of this item is included in Infrastructure and the remaining 50% is included in PMPM. It is anticipated there will be salary savings due to startup period; therefore PY 2 is lower than PYs 3-5.	200,000	1	200,000
Mobile Outreach Team - staffing mobile outreach efforts to reconnect chronically homeless individuals into care coordination system. Costs include: staffing costs; local travel; and operational costs. PY2 is our startup year; therefore 50% of this item is included in Infrastructure and the remaining 50% is included in PMPM. It is anticipated there will be savings due to startup period; therefore PY 2 is lower than PYs 3-5. Additionally, will take some time to enroll members thus not needing mobile outreach team until later in PY 2.	32,500	1	32,500
TOTAL DELIVERY INFRASTRUCTURE			1,058,833

PY 2 Incentive Payments			
Primary Care Clinic - payment for scheduling follow up appointment within 30 days of discharge from inpatient stay or release from jail; linkage to primary care medical home helps improve health outcomes, provides necessary resources and supports for ongoing medical treatment. Clinic will meet measure for 20 patients for second 6 months of year. Payment trigger: Monterey County Health Clinics will receive $20,000 per WPC enrollee scheduled for and successful participation in follow-up appointment within 30 days post discharge or release. Biannual payments will be made.	20,000	20	400,000
Hospital Incentive - payment for reduction in inpatient readmission rates within 30 days; referral to coordinated care services will improve health outcomes and reduce avoidable inpatient stays. Hospital will meet measure for 20 patients for second 6 months of year. Payment trigger: Natividad Medical Center will be eligible for $20,000 per WPC enrollee successfully linked to care coordination without a readmission within 30 days. Biannual payments will be made.	20,000	20	400,000
Behavioral Health Clinic - payment for reduction in mental health unit readmission rates within 30 days; follow up care improves health outcomes, provides necessary resources, and supports for ongoing mental health treatment and therapy. Behavioral Health will meet measure for 20 patients for second 6 months of year. Payment trigger: Monterey County Behavioral Health Clinics will receive $20,000 per WPC enrollee scheduled for and successful participation in follow-up appointment within 30 days post discharge or release. Biannual payments will be made.	20,000	20	400,000

Enrollment/re-enrollment of Individual Transitioning from IMD/Jail - payments for service integration of individuals by the County's Behavioral Health team (BH Team). The BH Team will be comprised of Social Workers and appropriate support (or contracted to community service providers) staff which will be funded directly by the County. As enrolling individuals in the Whole Person Care program will be challenging, the BH Team will work with clients being released from jail or an Institution of Mental Health Disease (IMD) to enroll in the WPC program. The BH Team's primary responsibility will be to establish a relationship and ultimately building the level of trust necessary in obtaining consent from to participate in the WPC Pilot. Clients will be enrolled in the WPC pilot program upon release and will be dis-enrolled as needed if they return to an institution from the community following enrollment. When individuals are re-released from the institution, they will be re-enrolled in the program. It is expected that the BH Team will work with these individuals up to 90 days after release. It is estimated a total of 56 people will be served per year, except in PY 2 where 28 people are estimated. Payment trigger: An incentive payment of $2,000 per enrollment/re-enrollment is proposed upon completion of the initial assessment to incentivize BH Team to work with this population, limited to one payment per enrollee per 12-month period.	2,000	28	56,000
TOTAL INCENTIVE PAYMENTS			1,256,000

PY 2 FFS Services			
Mobile Outreach Team - staffing mobile outreach efforts to reconnect chronically homeless individuals into care coordination system. Costs include: staffing costs; local travel; and operational costs. PY2 is our startup year; therefore 50% of this item is included in Infrastructure and the remaining 50% is included in PMPM. It is anticipated there will be savings due to startup period; therefore PY 2 is lower than PYs 3-5. Additionally, will take some time to enroll members thus not needing mobile outreach team until later in PY 2. Service will be reimbursed per encounter (attempt to locate and reconnect pilot participants to care coordination system as requested by Core Case Management Team). Reimbursements will be made quarterly.			
Staff			
Project Manager	85,000	0.05	4,250
Outreach Workers	59,000	0.40	23,600
Services/Supplies/Indirects			
Data Processing and Telecommunications Support and hardware and software	2,500	0.55	1,375
Local Travel/Training, vehicle maintenance	1,500	1.00	1,500
General office supplies, educational materials	381	1.00	381
Indirect Costs (5% of total Mobile Team)	27,850	0.05	1,393
Total Mobile Outreach Team			32,500
	# Encounters	Fee / Encounter	Total
Fee For Service (Per encounter or time spent outreaching to pilot members when lost to service)	61	532.78	32,500
Housing placement services and supports for up to 20 WPC enrollees annually. These services are for WPC enrollees who are living in transitional housing for up to one year and need appropriate coping and living skills required to move into permanent housing. During this time, enrollees will receive peer supports, counseling, skill development training, and other non-Medi-Cal assistance with daily living skills intended to preparing enrollees for discharge to transitional or permanent housing. Payment trigger: WPC enrollee per encounter each coaching session.			
Staff	Cost	Unit	

Program Counselor: provide housing and life skills assessments for WPC-enrollees; appropriate referrals to possible temporary or transitional solutions housing solutions	52,000	0.5	26,000
Program Supervisor: program oversight and accountability; program counselor oversight and guidance.	69,600	0.05	3,480
Counselor and Supervisor Benefits (stipend for basic health care - supervisor benefit is pro-rated)	20,636	0.5	10,318
Services and Supplies			
Participant Education Materials	4,000	0.5	2,000
Rental of facility	9,134	0.5	4,567
	# Encounters	Fee / Encounter	Total
	600	$77.275	46,365
Targeted outreach in the neighborhoods of highest potentially-WPC enrollees. The team will provide pre-enrollment intercept and outreach to engage and build trusting relationships that will lead to WPC enrollment. The budget for FFS for outreach and referral recognizes the higher level of training and multiple touches needed as our target population is amongst those who are hardest to reach. Engagement activities may include informational sessions regarding stress management, grief and loss, life skills, nutrition, health and healing, job seeking skills, and conflict resolution, among others. In contrast, the Mobile Outreach Team, operated by a provider of direct services using professional Social Workers/ Case Managers, will concentrate their efforts beyond and outside of the geographic areas in which Peer Navigators and Targeted Outreach teams are working.			
Contract with CSUMB to provide oversight and training to MSW students conducting Targeted Outreach and Education. MSW students refer potential WPC enrollees to WPC case managers for WPC eligibility assessment. For WPC enrollees, MSW students provide instructional sessions that include stress management, grief and loss, life skills, nutrition, health and healing, job seeking skills, and conflict resolution, among others. Contract includes:			
Faculty Coordinator salary	53040	0.5	26520

Faculty Coordinator health and retirement benefits @ 50% of salary	26520	0.5	13260
Field Program Supervisor: ensures reporting of activities as performed, monitors contract deliverables, and ensures services are provided within the terms of the contract. Cost is for 79 hours of supervision at $38 per hour for PY2, and 158 hours at $38 in PY3-5.	17319	0.5	8660
Field Program Supervisor health and retirement benefits @ 50% of salary	8660	0.5	4330
Participant educational session instructional materials	2948	0.5	1474
HMIS software fee	2500	0.5	1250
MSW student insurance costs for on-site service delivery	9210	0.5	2141
CSUMB Program Audit Costs	1819	0.5	910
CSUMB indirect costs @ 20%	24403	0.5	12202
	# Encounters	Fee / Encounter	
Total Targeted Outreach	246	288.22	70,745
Sobering Center: Provision of sobering center with 8 bed capacity. PY2 requesting only 1/2 a year funding. Total costs show 1/2 the costs below FTE x annual cost = total cost/2			
Program Manager	52,000	0.25	6,500
Certified Counselor	43,680	1.0	21,840
Intake Coordinator	43,680	1.0	21,840
Residential Coordinator	37,440	3.0	56,160
Reg Counselor	37,440	2.0	37,440
Medical Assistant	52,000	1.0	26,000
Program Coordinator	37,440	1.0	18,720
Payroll Taxes	33,930	1.0	16,965
Benefits	86,710	1.0	43,355
Sobering Center Facility Operating Expenses			
Administrative Expenses	10,000	0.5	5,000
Building Rent	36,000	0.5	8,000
Insurance	13,000	0.5	6,500
Electrical	5,000	0.5	2,500
Repair & Maintenance	3,600	0.5	1,800
Audit & Accounting	5,150	0.5	2,575
Contract Services	5,000	0.5	2,500
Janitorial Services	6,000	0.5	3,000
Staff Travel and Training	5,000	0.5	2,500

Garbage and Water	2,500	0.5	1,250
Household Supplies	2,700	0.5	1,350
Taxes and Fees	6,000	0.5	3,000
Legal Expenses	3,000	0.5	1,500
Telephone	3,000	0.5	1,500
Equipment Rental	3,000	0.5	1,500
Staff Screening	2,700	0.5	1,350
Office Supplies	2,600	0.5	1,300
Alarm	2,500	0.5	1,250
Printing and Publications	1,600	0.5	800
Drug/TB Testing	1,300	0.5	650
Cable/Internet	1,900	0.5	950
Membership Dues	800	0.5	400
Payroll processing	12,600	0.5	6,300
	# Encounters	Fee / Encounter	Total Cost
	1,460	216.65	316,303
Homeless Persons Peer Navigator Program: homeless or previously homeless persons will provide WPC-enrolled, post-released prisoners and other potential WPC-enrolled homeless persons who live in encampments and who have difficulty trusting and communicating with persons perceived to be in authority. Tasks include initiation and follow up (up to a year per person) using four part-time peer navigators, Peer Navigation training, peer navigator oversight, and interfacing with WPC PHN case managers. Each of the four peer navigators will have 10 encounters per week. Peer Navigators will follow up with the people they are tracking using cell phones that are provided to the WPC-enrollee. Our expectation is that the Peer Navigators will be successful with populations that are unknown and inaccessible by the Mobile Outreach Team. Additionally, the Mobile Outreach Team will be operated by a provider of direct services to homeless, mentally ill, and/or drug addicted persons using professional Social Workers/ Case Managers.			
Staff	cost	unit	

Peer Navigator: employed paid homeless or previously homeless persons to reach potential WPC enrollees living in the City of Salinas and Monterey Peninsula encampments, to facilitate their enrollment in WPC. = 4 navigators x 1,040 encounters x $20 per navigator	31.00	1,040	32,240
Peer Supervisor: Supervision of the Peer Navigators (hours worked, performance, coaching, communications, payroll) = 4 navigators x 1 hours of supervision per week x 52 weeks	23.00	140	3,220
Peer Supervisor Benefits (stipend for pro-rated basic health care)	2,280	0.5	1,140
Services and Supplies			
Payroll service, Navigator reporting forms	5,000	0.5	2,500
Rental of facility	5,000	0.5	2,500
	# Encounters	Fee / Encounter	Total
	1040	40.00	41,600
Totals FFS			507,512

PY 2 PMPM Bundles	Annual	Unit	Total
Community based Case Management Services - Housing Supports- receive referrals from Care Case managers; conduct Vulnerability Assessment for homeless, connect homeless to Coordinated Assessment and Referral System, conduct case management services related to housing, refers clients to Coalition of Service Providers for placement. Costs include: staffing costs, operational expenses, training. PY2 is our startup year; therefore 50% of this item is included in Infrastructure and the remaining 50% is included in PMPM. It is anticipated there will be salary savings due to startup period; therefore PY 2 is lower than PYs 3-5.	200,000	1	200,000
Complex Care Management Team			
Program focus is on patient centered coordination; transitional care interventions between services/systems; patient engagement; patient education on health topics, literacy, and self-management strategies; patient navigation services; and assurance referrals are made and kept. Total annual costs are split between Administrative and PMPM (6 months each).			
Staff			
Project Manager	170,000	0.25	42,500
Project Assistant	116,000	0.50	58,000
Case Managers	150,000	2.00	300,000
Community Health Workers	69,000	2.00	138,000
Services/Supplies/Indirects			
Data Processing and Telecommunications Support and hardware and software	4,000	4.75	19,000
Local Travel/Training	10,000	0.50	5,000
General office supplies, educational materials	5,000	0.50	2,500
Indirect Costs (5% of total Complex Care Mgmt. Team)	565,000	0.05	28,250
	Member Months	**PMPM Amount**	
Total Complex Care Management Team	**600**	**989**	**593,251**
Hot Spotting Team: Will serve 80 WPC-enrollees who are the highest utilizers with intensive, multidisciplinary, comprehensive services per month for a total of 480 PMPM units. Hot Spotting clients will be referred from ED and hospitals and will be served for 3 months. Cost per unit is $413. PY2 costs are for 1/2 a year only.			
Public Health Nurse	181,000	0.25	44,740

Public Guardian Deputy	130,000	0.25	32,500
Behavioral Health Aide	88,000	0.5	44,000
Psychiatric Social Worker II	158,000	0.25	39,500
Social Worker III	110,000	0.25	27,500
Services and Supplies	15,000	0.5	7,500
	Member Months	**PMPM Amount**	
Total Hot Spotting Team	**480**	**413**	**198,240**
Total PMPM			**$991,491**

PY 2 Pay for Reporting	Annual Cost/Unit	Unit	Total
Reporting Number of ED Visits - active monitoring of avoidable ED visits will help target care coordination services to appropriate clients to link to primary care medical home thus increasing appropriate use of ED. Payment trigger: Weekly reporting of ED visits by participating hospital. 50% of payment to be made every 6 months.	70,000	1	70,000
Reporting Number Inpatient Utilization - active monitoring of avoidable inpatient days will help target care coordination services to appropriate clients to link to primary care medical home thus increasing appropriate use of hospital inpatient services. Payment trigger: Weekly reporting of inpatient days by participating hospital. 50% of payment to be made every 6 months.	70,000	1	70,000
Reporting Follow up after hospitalization for mental illness - active monitoring of mental health unit days and linking patients to outpatient mental health services will increase avoidable mental health unit days. Payment trigger: Weekly reporting of follow up after hospitalization for mental illness. 50% of payment to be made every 6 months.	70,000	1	70,000
Reporting Number of participants who are informed of SUD services - initiation and engagement and completion of assessment of clients needing substance use disorder treatment services will increase likelihood of road to recovery. Payment trigger: Weekly reporting of SUD assessments completed. 50% of payment to be made every 6 months.	70,000	1	70,000
Reporting Number of participants enrolled into WPC and number with comprehensive care plan within 30 days of enrollment. Payment trigger: Monthly reporting of enrollees and development of comprehensive care plan. 50% of payment to be made every 6 months.	70,000	1	70,000
Reporting progress made towards meeting administrative procedures (policies and procedures, compilation and analysis of data, progress towards data sharing, etc.) Payment trigger: Bi-annual and annual reporting of progress towards and accomplishments of meeting administrative metrics. 50% of payment to be made every 6 months.	120,025	1	120,025

Reporting Health Outcome Metric: WPC participant will have comprehensive diabete3s care: HbA1c poor control > 9.0%. Payment trigger: Measure will be met for 50% or less of patients enrolled in WPC pilot. 50% of payment will be made every 6 months.	70,000	1	70,000
Reporting Percentage of Avoidable Hospitalizations - active monitoring of avoidable hospitalization visits will help target care coordination services to appropriate clients to link to primary care medical home. Payment trigger: Weekly reporting of inpatient stays by participating hospital. 50% of payment to be made every 6 months.	70,000	1	70,000
Health Outcome Metric-Hospital. Medication list provided at discharge. Payment trigger: Measure will be met for 50% or more of patients enrolled in WPC pilot. 50% of payment will be made every 6 months.	70,000	1	70,000
Health Outcome Metric-Hospital. Timely documentation transition to clinics/PCP. Payment trigger: Measure will be met for 5% or more of patients enrolled in WPC pilot. 50% of payment will be made every 6 months.	70,000	1	70,000
Health Outcome Metric-Hospital. Depression remission at 12 months. Payment trigger: Measure will be met for baseline minus 1% or more of patients enrolled in WPC pilot. 50% of payment will be made every 6 months.	70,000	1	70,000
Health Outcome Metric-Hospital. MHU re-hospitalization within 30 days. Payment trigger: Measure will be met for baseline minus 1% or more of patients enrolled in WPC pilot. 50% of payment will be made every 6 months.	70,000	1	70,000
Health Outcome Metric: Patients with controlled hypertension. Payment trigger: Measure will be met for 50% or more of patients enrolled in WPC pilot. 50% of payment will be made every 6 months.	70,000	1	70,000
Housing Metric - Reporting on progress towards developing 40 permanent supportive rental housing units for WPC population. Payment trigger: Metrics will be met annually as outlined in WPC proposal. 100% of payment will be annually.	50,000	1	50,000
TOTAL PAY FOR REPORTING			**1,010,025**

PY 2 Pay for Outcomes			
Pay for Outcomes	**Annual Cost/Unit**	**Unit**	**Total**
Health outcomes: 80% or greater follow up mental health, medical, and SUD appointment within 30 days post hospitalization improves compliance with discharge planning. Payment trigger: Measure will be met for 100% of patients enrolled in WPC pilot. 50% of payment to be made every 6 months.	75,000	1	75,000
Health Outcome Metric: Suicide Risk Assessment and Alcohol and Drug Misuse - SBIRT - compliance with using screening tools improves ability for care team to identify vulnerabilities and appropriately connect to care coordination, therapy, social supports, and other necessary services to prevent suicide and get into appropriate alcohol and drug treatment services; 100% compliance will reduce avoidable ED visits, Mental Health Unit stays, and improve health outcomes. Payment trigger: Tool will used with 60% of patients enrolled in WPC pilot. 50% of payment to be made every 6 months.	75,000	1	75,000
Health Outcome Metric: WPC participants will receive tobacco assessment and counseling. Payment trigger: Measure will be met for 90% or more of patients enrolled in WPC pilot. 50% of payment will be made every 6 months.	75,000	1	75,000
Health Outcome Metric: WPC participants will receive 12 months of coordinated case management. Payment trigger: Measure will be met for 25-40% or more of patients enrolled in WPC pilot. 50% of payment will be made every 6 months.	75,000	1	75,000
Health Outcome Metric: WPC participants will have a comprehensive care plan. Payment trigger: Measure will be met for 50% or more of patients enrolled in WPC pilot. 50% of payment will be made every 6 months.	100,000	1	100,000
TOTAL PAY FOR OUTCOMES			**400,000**

PY 3 Administrative Infrastructure			
Staff	Annual Cost/Unit	Unit	Total
Public Health Epidemiologist II - responsible for data analysis; reporting of evaluation metrics	125,000	0.50	62,500
Assistant Project Manager (1.00 FTE) - To provide additional Pilot oversight and day-to-day staff and activities management based on expansion and quality needs. Responsible for providing policy direction in pilot project; contract oversight; and receives direction from Pilot Executive Team.	136,000	1	136,000
Business Technology/Data Analyst (1.0 FTE) - responsible for working with County and Department Information Technology Managers on IT solutions to be implemented; help identify IT solutions; perform complex data analytics; prepare customized programming as needed	160,000	1.00	160,000
Sub-total			358,500
Services/Supplies/Indirect Costs			
Data Processing and Telecommunications Support	2,500	1.50	3,750
Travel costs for learning collaborative, 5 staff at $500 per trip two times a year	500	10	5,000
General office supplies, printing, educational materials	250	1.50	375
Indirect Costs (5% of total Admin Costs)	367,625	0.05	18,569
Sub-total			27,694
TOTAL ADMINISTRATIVE INFRASTRUCTURE			386,194

PY 3 Delivery Infrastructure	Annual Cost/Unit	Unit	Total
Information Technology Solutions			
Case Management Software - shared repository of case management data; ability to pull data from proprietary external data systems. Costs include: software license, implementation, hardware costs, training, professional services, vendor hosted and supported ($121,000 for solution). **Business Technology/Data Analyst (1.0 FTE)**- responsible for working with County and Department Information Technology Managers on IT solutions to be implemented; help identify IT solutions; perform complex data analytics; prepare customized programming as needed ($172,286).	293,286	1	293,286
Coordinated Assessment and Referral System (CARS)/ Homeless Management System (HMIS) - primary support for housing assessment data for homeless and care coordination services; establish network of agencies; purchase software and support implementation; staff to *Lead Me Home* Committee; conducts homeless census. Costs include: staffing costs, operational expenses, software license and subscription; training; hardware costs	511,874	1	511,874
TOTAL DELIVERY INFRASTRUCTURE			**805,160**

PY 3 Incentive Payments			
Primary Care Clinic - payment for scheduling follow up appointment within 30 days of discharge from inpatient stay or release from jail; linkage to primary care medical home helps improve health outcomes, provides necessary resources and supports for ongoing medical treatment. Clinic will meet measure for 20 patients for second 6 months of year. Payment trigger: Monterey County Health Clinics will receive $20,000 per WPC enrollee scheduled for and successful participation in follow-up appointment within 30 days post discharge or release. Biannual payments will be made.	20,000	20	400,000
Hospital Incentive - payment for reduction in inpatient readmission rates within 30 days; referral to coordinated care services will improve health outcomes and reduce avoidable inpatient stays. Hospital will meet measure for 20 patients for second 6 months of year. Payment trigger: Natividad Medical Center will be eligible for $20,000 per WPC enrollee successfully linked to care coordination without a readmission within 30 days. Biannual payments will be made.	20,000	20	400,000
Behavioral Health Clinic - payment for reduction in mental health unit readmission rates within 30 days; follow up care improves health outcomes, provides necessary resources, and supports for ongoing mental health treatment and therapy. Behavioral Health will meet measure for 20 patients for second 6 months of year. Payment trigger: Monterey County Behavioral Health Clinics will receive $20,000 per WPC enrollee scheduled for and successful participation in follow-up appointment within 30 days post discharge or release. Biannual payments will be made.	20,000	20	400,000

Enrollment/re-enrollment of Individual Transitioning from IMD/Jail - payments for service integration of individuals by the County's Behavioral Health team (BH Team). The BH Team will be comprised of Social Workers and appropriate support (or contracted to community service providers) staff which will be funded directly by the County. As enrolling individuals in the Whole Person Care program will be challenging, the BH Team will work with clients being released from jail or an Institution of Mental Health Disease (IMD) to enroll in the WPC program. The BH Team's primary responsibility will be to establish a relationship and ultimately building the level of trust necessary in obtaining consent from to participate in the WPC Pilot. Clients will be enrolled in the WPC pilot program upon release and will be dis-enrolled as needed if they return to an institution from the community following enrollment. When individuals are re-released from the institution, they will be re-enrolled in the program. It is expected that the BH Team will work with these individuals up to 90 days after release. It is estimated a total of 56 people will be served per year, except in PY 2 where 28 people are estimated. Payment trigger: An incentive payment of $2,000 per enrollment/re-enrollment is proposed upon completion of the initial assessment to incentivize BH Team to work with this population, limited to one payment per enrollee per 12-month period.	2,000	56	112,000
TOTAL INCENTIVE PAYMENTS			1,312,000

PY 3 FFS Services			
Mobile Outreach Team - staffing mobile outreach efforts to reconnect chronically homeless individuals into care coordination system. Costs include: staffing costs; local travel; and operational costs. PY2 is our startup year; therefore 50% of this item is included in Infrastructure and the remaining 50% is included in PMPM. It is anticipated there will be savings due to startup period; therefore PY 2 is lower than PYs 3-5. Additionally, will take some time to enroll members thus not needing mobile outreach team until later in PY 2. Service will be reimbursed per encounter (attempt to locate and reconnect pilot participants to care coordination system as requested by Core Case Management Team). Reimbursements will be made quarterly.			
Staff			
Project Manager	85,000	0.20	17,000
Outreach Workers	59,000	1.50	88,500
Services/Supplies/Indirects			
Data Processing and Telecommunications Support and hardware and software	2,500	1.70	4,250
Local Travel/Training, vehicle maintenance	8,974	1.00	8,974
General office supplies, educational materials	1,000	1.00	1,000
Indirect Costs (5% of total Mobile Team)	105,500	0.05	5,275
Total Mobile Outreach Team			**125,000**
	# Encounters	**Fee / Encounter**	**Total**
Fee For Service (Per encounter or time spent outreaching to pilot members when lost to service)	**235**	**532.78**	**125,000**
Respite Center: Program providing is acute and post-acute medical care for individuals, primarily those who are homeless or those with unstable living situations, who are too ill or frail to recover from a physical illness or injury in their usual living environment but are not ill enough to be in a hospital.			
Staff			
Executive Director	110,000	0.2	22,000
Medical Director	200,000	0.2	40,000
Case Managers	60,000	4.2	252,000
Services/Supplies/Indirect			
General office supplies, educational materials, printing, mailing, duplication	11,000	1.0	11,000

	# Encounters	Fee / Encounter	Total
	1971	164.89	324,998
Housing placement services and supports for up to 20 WPC enrollees annually. These services are for WPC enrollees who are living in transitional housing for up to one year and need appropriate coping and living skills required to move into permanent housing. During this time, enrollees will receive peer supports, counseling, skill development training, and other non-Medi-Cal assistance with daily living skills intended to preparing enrollees for discharge to transitional or permanent housing. Payment trigger: WPC enrollee per encounter each coaching session.			
Staff	**cost**	**unit**	
Program Counselor: provide housing and life skills assessments for WPC-enrollees; appropriate referrals to possible temporary or transitional solutions housing solutions	52,000	0.5	26,000
Program Supervisor: program oversight and accountability; program counselor oversight and guidance.	69,600	0.05	3,480
Counselor and Supervisor Benefits (stipend for basic health care - supervisor benefit is pro-rated)	20,636	.5	10,318
Services and Supplies			
Participant Education Materials	4,000	0.5	2,000
Rental of facility	9,134	0.5	4,567
	# Encounters	Fee / Encounter	Total
	1,200	77.275	92,730

Targeted outreach in the neighborhoods of highest potentially-WPC enrollees. The team will provide pre-enrollment intercept and outreach to engage and build trusting relationships that will lead to WPC enrollment. The budget for FFS for outreach and referral recognizes the higher level of training and multiple touches needed as our target population is amongst those who are hardest to reach. Engagement activities may include informational sessions regarding stress management, grief and loss, life skills, nutrition, health and healing, job seeking skills, and conflict resolution, among others. In contrast, the Mobile Outreach Team, operated by a provider of direct services using professional Social Workers/ Case Managers, will concentrate their efforts beyond and outside of the geographic areas in which Peer Navigators and Targeted Outreach teams are working.			
Contract with CSUMB to provide oversight and training to MSW students conducting Targeted Outreach and Education. MSW students refer potential WPC enrollees to WPC case managers for WPC eligibility assessment. For WPC enrollees, MSW students provide instructional sessions that include stress management, grief and loss, life skills, nutrition, health and healing, job seeking skills, and conflict resolution, among others. Contract includes:			
Faculty Coordinator salary	53040	1	26520
Faculty Coordinator health and retirement benefits @ 50% of salary	26520	1	13260
Field Program Supervisor: ensures reporting of activities as performed, monitors contract deliverables, and ensures services are provided within the terms of the contract. Cost is for 79 hours of supervision at $38 per hour for PY2, and 158 hours at $38 in PY3-5.	17319	1	8660
Field Program Supervisor health and retirement benefits @ 50% of salary	8660	1	4330
Participant educational session instructional materials	2948	1	1474
HMIS software fee	2500	1	1250
MSW student insurance costs for on-site service delivery	9210	1	2141
CSUMB Program Audit Costs	1819	1	910
CSUMB indirect costs @ 20%	24403	1	12202

	# Encounters	Fee / Encounter	
Total Targeted Outreach	**508**	**288.22**	**146,417**
On-Site Housing Sustainability Services (Mid Pen Housing)			
Proactive and consistent on-site support services and crisis intervention to reduce utilization of more expensive services. Through a contract with Mid Pen Services. The program size is 88 residential units with an estimated 40 units for the WPC population. Services include coordination with resident's primary care managers, advocacy, education services, and community building activities. In contrast, Community Based Case Management Services (a multi-discipline team of MCHD case managers), will provide WPC-enrollees with referrals to possible housing solutions that may be temporary or transitional solutions in the greater Salinas, North County, South County, or Monterey Peninsula.			
Case Managers (3 FTE at 254,000 * 43%)	109,220	1	109,120
Project Assistant (16,500 * 43%)	7,100	1	7,100
Supplies ($11,025 * 43%)	4,740	1	4,740
Total Mid Pen Housing Services			120,960
Member months (12 months)	40	480	252
Sobering Center Services: Provided for up to 24 hours within an 8 bed capacity facility. See Infrastructure Delivery for facility expenses.			
Program Manager	52,000	0.25	13,000
Certified Counselor	43,680	1	43,680
Intake Coordinator	43,680	1	43,680
Residential Coordinator	37,440	3	112,320
Registered Counselor	37,440	2	74,880
Medical Assistant	52,000	1	52,000
Program Coordinator	37,440	1	37,440
Payroll Taxes	33,930	1	33,930
Benefits	86,726	1	86,726
Sobering Center Facility Operating Expenses			
Administrative Expenses	10,000	0.5	5,000
Building Rent	36,000	0.5	8,000
Insurance	13,000	0.5	6,500
Electrical	5,000	0.5	2,500
Repair & Maintenance	3,600	0.5	1,800

Audit & Accounting	5,150	0.5	2,575
Contract Services	5,000	0.5	2,500
Janitorial Services	6,000	0.5	3,000
Staff Travel and Training	5,000	0.5	2,500
Garbage and Water	2,500	0.5	1,250
Household Supplies	2,700	0.5	1,350
Taxes and Fees	6,000	0.5	3,000
Legal Expenses	3,000	0.5	1,500
Telephone	3,000	0.5	1,500
Equipment Rental	3,000	0.5	1,500
Staff Screening	2,700	0.5	1,350
Office Supplies	2,600	0.5	1,300
Alarm	2,500	0.5	1,250
Printing and Publications	1,600	0.5	800
Drug/TB Testing	1,300	0.5	650
Cable/Internet	1,900	0.5	950
Membership Dues	800	0.5	400
Payroll processing	12,600	0.5	6,300
	# Encounters	**Fee / Encounter**	**Total**
	2920	**216.65**	**632,618**
Homeless Persons Peer Navigator Program: homeless or previously homeless persons will provide WPC-enrolled, post-released prisoners and other potential WPC-enrolled homeless persons who live in encampments and who have difficulty trusting and communicating with persons perceived to be in authority. Tasks include initiation and follow up (up to a year per person) using four part-time peer navigators, Peer Navigation training, peer navigator oversight, and interfacing with WPC PHN case managers. Each of the four peer navigators will have 10 encounters per week. Peer Navigators will follow up with the people they are tracking using cell phones that are provided to the WPC-enrollee. Our expectation is that the Peer Navigators will be successful with populations that are unknown and inaccessible by the Mobile Outreach Team. Additionally, the Mobile Outreach Team will be operated by a provider of direct services to homeless, mentally ill, and/or drug addicted persons using professional Social Workers/ Case Managers.			
Staff	Cost	Unit	

Peer Navigator: employed paid homeless or previously homeless persons to reach potential WPC enrollees living in the City of Salinas and Monterey Peninsula encampments, to facilitate their enrollment in WPC. = 4 navigators x 1,040 encounters x $20 per navigator	31.00	2,080	32,240
Peer Supervisor: Supervision of the Peer Navigators (hours worked, performance, coaching, communications, payroll) = 4 navigators x 1 hours of supervision per week x 52 weeks	23.00	280	3,220
Peer Supervisor Benefits (stipend for pro-rated basic health care)	2,280	1	1,140
Services and Supplies			
Payroll service, Navigator reporting forms	5,000	1	2,500
Rental of facility	5,000	1	2,500
	# Encounters	**Fee / Encounter**	**Total**
	2080	**40.00**	**83,200**
Total FFS			**1,525,923**

PY 3 PMPM Bundles	Annual	Unit	Total
Complex Care Management Team			
Program focus is on patient centered coordination; transitional care interventions between services/systems; patient engagement; patient education on health topics, literacy, and self-management strategies; patient navigation services; and assurance referrals are made and kept. Total annual costs are split between Administrative and PMPM (6 months each).			
Staff			
Project Manager	170,000	0.50	85,000
Project Assistant	116,000	1.00	116,000
Case Managers	150,000	4.00	600,000
Community Health Workers	69,000	4.00	276,000
Services/Supplies/Indirect			
Data Processing and Telecommunications Support and hardware and software	4,000	9.50	38,000
Local Travel/Training	10,000	1.00	10,000
General office supplies, educational materials	5,000	1.00	5,000
Indirect Costs (5% of total Complex Care Mgmt. Team)	1,130,000	0.05	56,500
	Member Months	**PMPM Amount**	
Total for Complex Care Management Team	**659**	**1,800**	**1,186,500**
Hot Spotting Team: Will serve 80 WPC-enrollees who are the highest utilizers with intensive, multidisciplinary, comprehensive services per month for a total of 480 PMPM units. Hot Spotting clients will be referred from ED and hospitals and will be served for 3 months. Cost per unit is $413.			
Public Health Nurse	181,000	0.5	90,500
Public Guardian Deputy	130,000	0.5	65,000
Behavioral Health Aide	88,000	1	88,000
Psychiatric Social Worker II	158,000	0.5	79,000
Social Worker III	110,000	0.5	55,000
Services and Supplies	15,000	1	15,000
Total Hot Spotting Team			591,527
	Member Months	**PMPM Amount**	

Total Hot Spotting Team	**960**	**413**	**396,479**
Community Based Case Management Services - Housing Support - receive referrals from Care Case managers; conduct Vulnerability Assessment for homeless, connect homeless to Coordinated Assessment and Referral System, conduct case management services related to housing, refers clients to Coalition of Homeless Service Providers for placement. Costs include: staffing costs, operational expenses, training.			
Staff			
Executive Director	110,000	0.25	27,500
Program Director	75,000	0.50	37,500
Clinical Supervisor	208,000	0.20	41,600
Case Managers	48,000	2.50	120,000
Advocates	45,000	4.85	218,250
Services/Supplies/Indirect			
General office supplies, educational materials, printing, mailing, duplication	15,000	1.00	15,000
Data Processing and Telecommunications Support and hardware and software	2,500	1.00	2,500
Facility costs, utilities	60,221	1.00	60,221
Local Travel	6,000	1.00	6,000
Indirect Costs (5% of total Community based Team)	528,571	0.05	26,429
	Member Months	**PMPM Amount**	
Total Community Based Case Management Services - Housing Support	**1,800**	**308**	**555,000**
TOTAL PMPM			**$2,137,979**

PY 3 Pay for Reporting			
Column1	**Annual Cost/Unit**	**Unit**	**Total**
Reporting Number of ED Visits - active monitoring of avoidable ED visits will help target care coordination services to appropriate clients to link to primary care medical home thus increasing appropriate use of ED. Payment trigger: Weekly reporting of ED visits by participating hospital. 50% of payment to be made every 6 months.	60,000	1	60,000
Reporting Number Inpatient Utilization - active monitoring of avoidable inpatient days will help target care coordination services to appropriate clients to link to primary care medical home thus increasing appropriate use of hospital inpatient services. Payment trigger: Weekly reporting of inpatient days by participating hospital. 50% of payment to be made every 6 months.	60,000	1	60,000
Reporting Follow up after hospitalization for mental illness - active monitoring of mental health unit days and linking patients to outpatient mental health services will increase avoidable mental health unit days. Payment trigger: Weekly reporting of follow up after hospitalization for mental illness. 50% of payment to be made every 6 months.	60,000	1	60,000
Reporting Number of participants who are informed of SUD services - initiation and engagement and completion of assessment of clients needing substance use disorder treatment services will increase likelihood of road to recovery. Payment trigger: Weekly reporting of SUD assessments completed. 50% of payment to be made every 6 months.	60,000	1	60,000
Reporting Number of participants enrolled into WPC and number with comprehensive care plan within 30 days of enrollment. Payment trigger: Monthly reporting of enrollees and development of comprehensive care plan. 50% of payment to be made every 6 months.	60,000	1	60,000
Reporting progress made towards meeting administrative procedures (policies and procedures, compilation and analysis of data, progress towards data sharing, etc.) Payment trigger: Bi-annual and annual reporting of progress towards and accomplishments of meeting administrative metrics. 50% of payment to be made every 6 months.	117,310	1	117,310

Reporting Health Outcome Metric: WPC participant will have comprehensive diabete3s care: HbA1c poor control > 9.0%. Payment trigger: Measure will be met for 50% or less of patients enrolled in WPC pilot. 50% of payment will be made every 6 months.	60,000	1	60,000
Reporting Percentage of Avoidable Hospitalizations - active monitoring of avoidable hospitalization visits will help target care coordination services to appropriate clients to link to primary care medical home. Payment trigger: Weekly reporting of inpatient stays by participating hospital. 50% of payment to be made every 6 months.	60,000	1	60,000
Health Outcome Metric-Hospital. Medication list provided at discharge. Payment trigger: Measure will be met for 50% or more of patients enrolled in WPC pilot. 50% of payment will be made every 6 months.	60,000	1	60,000
Health Outcome Metric-Hospital. Timely documentation transition to clinics/PCP. Payment trigger: Measure will be met for 5% or more of patients enrolled in WPC pilot. 50% of payment will be made every 6 months.	50,000	1	50,000
Health Outcome Metric-Hospital. Depression remission at 12 months. Payment trigger: Measure will be met for baseline minus 1% or more of patients enrolled in WPC pilot. 50% of payment will be made every 6 months.	50,000	1	50,000
Health Outcome Metric-Hospital. MHU re-hospitalization within 30 days. Payment trigger: Measure will be met for baseline minus 1% or more of patients enrolled in WPC pilot. 50% of payment will be made every 6 months.	50,000	1	50,000
Health Outcome Metric: Patients with controlled hypertension. Payment trigger: Measure will be met for 50% or more of patients enrolled in WPC pilot. 50% of payment will be made every 6 months.	60,000	1	60,000
Housing Metric - Reporting on progress towards developing 40 permanent supportive rental housing units for WPC population. Payment trigger: Metrics will be met annually as outlined in WPC proposal. 100% of payment will be annually.	50,000	1	50,000
TOTAL PAY FOR REPORTING			**857,310**

PY 3 Pay for Outcomes			
Pay for Outcomes	**Annual Cost/Unit**	**Unit**	**Total**
Health outcomes: 80% or greater follow up mental health, medical, and SUD appointment within 30 days post hospitalization improves compliance with discharge planning. Payment trigger: Measure will be met for 100% of patients enrolled in WPC pilot. 50% of payment to be made every 6 months.	75,000	1	75,000
Health Outcome Metric: Suicide Risk Assessment and Alcohol and Drug Misuse - SBIRT - compliance with using screening tools improves ability for care team to identify vulnerabilities and appropriately connect to care coordination, therapy, social supports, and other necessary services to prevent suicide and get into appropriate alcohol and drug treatment services; 100% compliance will reduce avoidable ED visits, Mental Health Unit stays, and improve health outcomes. Payment trigger: Tool will used with 60% of patients enrolled in WPC pilot. 50% of payment to be made every 6 months.	75,000	1	75,000
Health Outcome Metric: WPC participants will receive tobacco assessment and counseling. Payment trigger: Measure will be met for 90% or more of patients enrolled in WPC pilot. 50% of payment will be made every 6 months.	75,000	1	75,000
Health Outcome Metric: WPC participants will receive 12 months of coordinated case management. Payment trigger: Measure will be met for 25-40% or more of patients enrolled in WPC pilot. 50% of payment will be made every 6 months.	75,000	1	75,000
Health Outcome Metric: WPC participants will have a comprehensive care plan. Payment trigger: Measure will be met for 50% or more of patients enrolled in WPC pilot. 50% of payment will be made every 6 months.	100,000	1	100,000
TOTAL PAY FOR OUTCOMES			**400,000**

PYs 4-5 Administrative Infrastructure			
Staff	Annual Cost/Unit	Unit	Total
Public Health Epidemiologist II - responsible for data analysis; reporting of evaluation metrics	**125,000**	**0.50**	**62,500**
Assistant Project Manager (1.00 FTE) - To provide additional Pilot oversight and day-to-day staff and activities management based on expansion and quality needs. Responsible for providing policy direction in pilot project; contract oversight; and receives direction from Pilot Executive Team.	**136,000**	**1**	**136,000**
Business Technology/Data Analyst (1.0 FTE) - responsible for working with County and Department Information Technology Managers on IT solutions to be implemented; help identify IT solutions; perform complex data analytics; prepare customized programming as needed	**160,000**	**1.00**	**160,000**
Sub-total			358,500
Services/Supplies/Indirect Costs			
Data Processing and Telecommunications Support	**2,500**	**1.50**	**3,750**
Travel costs for learning collaborative, 5 staff at $500 per trip two times a year	**500**	**10**	**5,000**
General office supplies, printing, educational materials	**250**	**1.50**	**375**
Indirect Costs (5% of total Admin Costs)	**367,625**	**0.05**	**18,570**
Sub-total			**27,695**
TOTAL ADMINISTRATIVE INFRASTRUCTURE			**386,195**

PYs 4-5 Delivery Infrastructure			
	Annual Cost/Unit	**Unit**	**Total**
Information Technology Solutions			
Case Management Software - shared repository of case management data; ability to pull data from proprietary external data systems. Costs include: software license, implementation, hardware costs, training, professional services, vendor hosted and supported ($121,000 for solution). **Business Technology/Data Analyst (1.0 FTE)**- responsible for working with County and Department Information Technology Managers on IT solutions to be implemented; help identify IT solutions; perform complex data analytics; prepare customized programming as needed ($172,286).	293,286	1	293,286
Coordinated Assessment and Referral System (CARS)/ Homeless Management System (HMIS) - primary support for housing assessment data for homeless and care coordination services; establish network of agencies; purchase software and support implementation; staff to *Lead Me Home* Committee; conducts homeless census. Costs include: staffing costs, operational expenses, software license and subscription; training; hardware costs	603,050	1	603,050
TOTAL DELIVERY INFRASTRUCTURE			**896,336**

PYs 4-5 Incentive Payments			
Primary Care Clinic - payment for scheduling follow up appointment within 30 days of discharge from inpatient stay or release from jail; linkage to primary care medical home helps improve health outcomes, provides necessary resources and supports for ongoing medical treatment. Clinic will meet measure for 20 patients for second 6 months of year. Payment trigger: Monterey County Health Clinics will receive $20,000 per WPC enrollee scheduled for and successful participation in follow-up appointment within 30 days post discharge or release. Biannual payments will be made.	20,000	20	400,000
Hospital Incentive - payment for reduction in inpatient readmission rates within 30 days; referral to coordinated care services will improve health outcomes and reduce avoidable inpatient stays. Hospital will meet measure for 20 patients for second 6 months of year. Payment trigger: Natividad Medical Center will be eligible for $20,000 per WPC enrollee successfully linked to care coordination without a readmission within 30 days. Biannual payments will be made.	20,000	20	400,000
Behavioral Health Clinic - payment for reduction in mental health unit readmission rates within 30 days; follow up care improves health outcomes, provides necessary resources, and supports for ongoing mental health treatment and therapy. Behavioral Health will meet measure for 20 patients for second 6 months of year. Payment trigger: Monterey County Behavioral Health Clinics will receive $20,000 per WPC enrollee scheduled for and successful participation in follow-up appointment within 30 days post discharge or release. Biannual payments will be made.	20,000	20	400,000

Enrollment/re-enrollment of Individual Transitioning from IMD/Jail - payments for service integration of individuals by the County's Behavioral Health team (BH Team). The BH Team will be comprised of Social Workers and appropriate support (or contracted to community service providers) staff which will be funded directly by the County. As enrolling individuals in the Whole Person Care program will be challenging, the BH Team will work with clients being released from jail or an Institution of Mental Health Disease (IMD) to enroll in the WPC program. The BH Team's primary responsibility will be to establish a relationship and ultimately building the level of trust necessary in obtaining consent from to participate in the WPC Pilot. Clients will be enrolled in the WPC pilot program upon release and will be dis-enrolled as needed if they return to an institution from the community following enrollment. When individuals are re-released from the institution, they will be re-enrolled in the program. It is expected that the BH Team will work with these individuals up to 90 days after release. It is estimated a total of 56 people will be served per year, except in PY 2 where 28 people are estimated. Payment trigger: An incentive payment of $2,000 per enrollment/re-enrollment is proposed upon completion of the initial assessment to incentivize BH Team to work with this population, limited to one payment per enrollee per 12-month period.	2,000	56	112,000
TOTAL INCENTIVE PAYMENTS			**1,312,000**

PYs 4-5 FFS Services			
Mobile Outreach Team - staffing mobile outreach efforts to reconnect chronically homeless individuals into care coordination system. Costs include: staffing costs; local travel; and operational costs. PY2 is our startup year; therefore 50% of this item is included in Infrastructure and the remaining 50% is included in PMPM. It is anticipated there will be savings due to startup period; therefore PY 2 is lower than PYs 3-5. Additionally, will take some time to enroll members thus not needing mobile outreach team until later in PY 2. Service will be reimbursed per encounter (attempt to locate and reconnect pilot participants to care coordination system as requested by Core Case Management Team). Reimbursements will be made quarterly.			
Staff			
Project Manager	85,000	0.20	17,000
Outreach Workers	59,000	1.50	88,500
Services/Supplies/Indirects			
Data Processing and Telecommunications Support and hardware and software	2,500	1.70	4,250
Local Travel/Training, vehicle maintenance	8,974	1.00	8,974
General office supplies, educational materials	1,000	1.00	1,000
Indirect Costs (5% of total Mobile Team)	105,500	0.05	5,275
Total Mobile Outreach Team			**125,000**
	# Encounters	**Fee / Encounter**	**Total**
Fee For Service (Per encounter or time spent outreaching to pilot members when lost to service)	235	532.78	**125,000**
Respite Center: Program providing is acute and post-acute medical care for individuals, primarily those who are homeless or those with unstable living situations, who are too ill or frail to recover from a physical illness or injury in their usual living environment but are not ill enough to be in a hospital.			
Staff			
Executive Director	110,000	0.2	22,000
Medical Director	200,000	0.2	40,000
Case Managers	60,000	4.2	252,000
Services/Supplies/Indirect			
General office supplies, educational materials, printing, mailing, duplication	11,000	1	11,000
	# Encounters	**Fee / Encounter**	**Total**

	1971	164.89	324,998
Housing placement services and supports for up to 20 WPC enrollees annually. These services are for WPC enrollees who are living in transitional housing for up to one year and need appropriate coping and living skills required to move into permanent housing. During this time, enrollees will receive peer supports, counseling, skill development training, and other non-Medi-Cal assistance with daily living skills intended to preparing enrollees for discharge to transitional or permanent housing. Payment trigger: WPC enrollee per encounter each coaching session.			
Staff	**Cost**	**Unit**	
Program Counselor: provide housing and life skills assessments for WPC-enrollees; appropriate referrals to possible temporary or transitional solutions housing solutions	52,000	0.5	26,000
Program Supervisor: program oversight and accountability; program counselor oversight and guidance.	69,600	0.05	3,480
Counselor and Supervisor Benefits (stipend for basic health care - supervisor benefit is pro-rated)	20,636	.5	10,318
Services and Supplies			
Participant Education Materials	4,000	0.5	2,000
Rental of facility	9,134	0.5	4,567
	Fee/ Encounter	**# Encounters**	**Total**
	$77.275	**1,200**	**92,730**
Targeted outreach in the neighborhoods of highest potentially-WPC enrollees. The team will provide pre-enrollment intercept and outreach to engage and build trusting relationships that will lead to WPC enrollment. Engagement activities may include informational sessions regarding stress management, grief and loss, life skills, nutrition, health and healing, job seeking skills, and conflict resolution, among others. The budget for FFS for outreach and referral recognizes the higher level of training and multiple touches needed as our target population is amongst those who are hardest to reach. In contrast, the Mobile Outreach Team, operated by a provider of direct services using professional Social Workers/ Case Managers, will concentrate their efforts beyond and outside of the geographic areas in which Peer Navigators and Targeted Outreach teams are working.			

Contract with CSUMB to provide oversight and training to MSW students conducting Targeted Outreach and Education. MSW students refer potential WPC enrollees to WPC case managers for WPC eligibility assessment. For WPC enrollees, MSW students provide instructional sessions that include stress management, grief and loss, life skills, nutrition, health and healing, job seeking skills, and conflict resolution, among others. Contract includes:			
Faculty Coordinator salary	53040	1	26520
Faculty Coordinator health and retirement benefits @ 50% of salary	26520	1	13260
Field Program Supervisor: ensures reporting of activities as performed, monitors contract deliverables, and ensures services are provided within the terms of the contract. Cost is for 79 hours of supervision at $38 per hour for PY2, and 158 hours at $38 in PY3-5.	17319	1	8660
Field Program Supervisor health and retirement benefits @ 50% of salary	8660	1	4330
Participant educational session instructional materials	2948	1	1474
HMIS software fee	2500	1	1250
MSW student insurance costs for on-site service delivery	9210	1	2141
CSUMB Program Audit Costs	1819	1	910
CSUMB indirect costs @ 20%	24403	1	12202
	# Encounters	**Fee / Encounter**	
Total Targeted Outreach	**508**	**288.22**	**146,417**
On-Site Housing Sustainability Services (Mid Pen Housing)			
Proactive and consistent on-site support services and crisis intervention to reduce utilization of more expensive services. Through a contract with Mid Pen Services. The program size is 88 residential units with an estimated 40 units for the WPC population. Services include coordination with resident's primary care managers, advocacy, education services, and community building activities. In contrast, Community Based Case Management Services (a multi-discipline team of MCHD case managers), will provide WPC-enrollees with referrals to possible housing solutions that may be temporary or transitional solutions in the greater Salinas, North County, South County, or Monterey Peninsula.			
Case Managers (3 FTE at 254,000 * 43%)	109,220	1	109,120
Project Assistant (16,500 * 43%)	7,100	1	7,100
Supplies ($11,025 * 43%)	4,740	1	4,740

	# Encounters	Fee / Encounter	
Total Mid Pen Housing Services	**252**	**480**	**120,960**
Sobering Center Services: Provided for up to 24 hours within an 8 bed capacity facility. See Infrastructure Delivery for facility expenses.			
Program Manager	52,000	0.25	13,000
Certified Counselor	43,680	1	43,680
Intake Coordinator	43,680	1	43,680
Residential Coordinator	37,440	3	112,320
Registered Counselor	37,440	2	74,880
Medical Assistant	52,000	1	52,000
Program Coordinator	37,440	1	37,440
Payroll Taxes	33,930	1	33,930
Benefits	86,726	1	86,726
Sobering Center Facility Operating Expenses			
Administrative Expenses	10,000	0.5	5,000
Building Rent	36,000	0.5	8,000
Insurance	13,000	0.5	6,500
Electrical	5,000	0.5	2,500
Repair & Maintenance	3,600	0.5	1,800
Audit & Accounting	5,150	0.5	2,575
Contract Services	5,000	0.5	2,500
Janitorial Services	6,000	0.5	3,000
Staff Travel and Training	5,000	0.5	2,500
Garbage and Water	2,500	0.5	1,250
Household Supplies	2,700	0.5	1,350
Taxes and Fees	6,000	0.5	3,000
Legal Expenses	3,000	0.5	1,500
Telephone	3,000	0.5	1,500
Equipment Rental	3,000	0.5	1,500
Staff Screening	2,700	0.5	1,350
Office Supplies	2,600	0.5	1,300
Alarm	2,500	0.5	1,250
Printing and Publications	1,600	0.5	800
Drug/TB Testing	1,300	0.5	650
Cable/Internet	1,900	0.5	950
Membership Dues	800	0.5	400
Payroll processing	12,600	0.5	6,300
	# Encounters	**Fee / Encounter**	**Total**

	2920	**216.65**	**632,618**
Homeless Persons Peer Navigator Program: homeless or previously homeless persons will provide WPC-enrolled, post-released prisoners and other potential WPC-enrolled homeless persons who live in encampments and who have difficulty trusting and communicating with persons perceived to be in authority. Tasks include initiation and follow up (up to a year per person) using four part-time peer navigators, Peer Navigation training, peer navigator oversight, and interfacing with WPC PHN case managers. Each of the four peer navigators will have 10 encounters per week. Peer Navigators will follow up with the people they are tracking using cell phones that are provided to the WPC-enrollee. Our expectation is that the Peer Navigators will be successful with populations that are unknown and inaccessible by the Mobile Outreach Team. Additionally, the Mobile Outreach Team will be operated by a provider of direct services to homeless, mentally ill, and/or drug addicted persons using professional Social Workers/ Case Managers.			
Staff	**Cost**	**Unit**	
Peer Navigator: employed paid homeless or previously homeless persons to reach potential WPC enrollees living in the City of Salinas and Monterey Peninsula encampments, to facilitate their enrollment in WPC. = 4 navigators x 1,040 encounters x $20 per navigator	31.00	2,080	32,240
Peer Supervisor: Supervision of the Peer Navigators (hours worked, performance, coaching, communications, payroll) = 4 navigators x 1 hours of supervision per week x 52 weeks	23.00	280	3,220
Peer Supervisor Benefits (stipend for pro-rated basic health care)	2,280	1	1,140
Services and Supplies			
Payroll service, Navigator reporting forms	5,000	1	2,500
Rental of facility	5,000	1	2,500
	# Encounters	**Fee / Encounter**	**Total**
	2080	**40.00**	**83,200**
Total FFS			**1,525,922**

PYs 4-5 PMPM Bundles	Annual	Unit	Total
Complex Care Management Team			
Program focus is on patient centered coordination; transitional care interventions between services/systems; patient engagement; patient education on health topics, literacy, and self-management strategies; patient navigation services; and assurance referrals are made and kept. Total annual costs are split between Administrative and PMPM (6 months each).			
Staff			
Project Manager	170,000	0.50	85,000
Project Assistant	116,000	1.00	116,000
Case Managers	150,000	4.00	600,000
Community Health Workers	69,000	4.00	276,000
Services/Supplies/Indirect			
Data Processing and Telecommunications Support and hardware and software	4,000	9.50	38,000
Local Travel/Training	10,000	1.00	10,000
General office supplies, educational materials	5,000	1.00	5,000
Indirect Costs (5% of total Complex Care Mgmt. Team)	1,130,000	0.05	56,500
	Member Months	**PMPM Amount**	
Total Complex Care Management Team	**1,680**	**706**	**1,186,500**
Hot Spotting Team: Will serve 80 WPC-enrollees who are the highest utilizers with intensive, multidisciplinary, comprehensive services per month for a total of 480 PMPM units. Hot Spotting clients will be referred from ED and hospitals and will be served for 3 months. Cost per unit is $413.			
Public Health Nurse	181,000	0.5	90,500
Public Guardian Deputy	130,000	0.5	65,000
Behavioral Health Aide	88,000	1	88,000
Psychiatric Social Worker II	158,000	0.5	79,000
Social Worker III	110,000	0.5	55,000
Services and Supplies	15,000	1	15,000
	Member Months	**PMPM Amount**	
Total Hot Spotting Team	**960**	**413**	**396,479**

Community Based Case Management Services - Housing Support - receive referrals from Care Case managers; conduct Vulnerability Assessment for homeless, connect homeless to Coordinated Assessment and Referral System, conduct case management services related to housing, refers clients to Coalition of Homeless Service Providers for placement. Costs include: staffing costs, operational expenses, training.			
Staff			
Executive Director	110,000	0.25	27,500
Program Director	75,000	0.50	37,500
Clinical Supervisor	208,000	0.20	41,600
Case Managers	48,000	2.50	120,000
Advocates	45,000	4.85	218,250
Services/Supplies/Indirect			
General office supplies, educational materials, printing, mailing, duplication	15,000	1.00	15,000
Data Processing and Telecommunications Support and hardware and software	2,500	1.00	2,500
Facility costs, utilities	60,221	1.00	60,221
Local Travel	6,000	1.00	6,000
Indirect Costs (5% of total Community based Team)	528,571	0.05	26,429
	Member Months	**PMPM Amount**	
Total for Case Management-Housing Support	**1,800**	**308**	**555,000**
TOTAL PMPM			**$2,137,979**

PYs 4-5 Pay for Reporting			
Column1	**Annual Cost/Unit**	**Unit**	**Total**
Reporting Number of ED Visits - active monitoring of avoidable ED visits will help target care coordination services to appropriate clients to link to primary care medical home thus increasing appropriate use of ED. Payment trigger: Weekly reporting of ED visits by participating hospital. 50% of payment to be made every 6 months.	50,000	1	50,000
Reporting Number Inpatient Utilization - active monitoring of avoidable inpatient days will help target care coordination services to appropriate clients to link to primary care medical home thus increasing appropriate use of hospital inpatient services. Payment trigger: Weekly reporting of inpatient days by participating hospital. 50% of payment to be made every 6 months.	50,000	1	50,000
Reporting Follow up after hospitalization for mental illness - active monitoring of mental health unit days and linking patients to outpatient mental health services will increase avoidable mental health unit days. Payment trigger: Weekly reporting of follow up after hospitalization for mental illness. 50% of payment to be made every 6 months.	50,000	1	50,000
Reporting Number of participants who are informed of SUD services - initiation and engagement and completion of assessment of clients needing substance use disorder treatment services will increase likelihood of road to recovery. Payment trigger: Weekly reporting of SUD assessments completed. 50% of payment to be made every 6 months.	50,0000	1	50,000
Reporting Number of participants enrolled into WPC and number with comprehensive care plan within 30 days of enrollment. Payment trigger: Monthly reporting of enrollees and development of comprehensive care plan. 50% of payment to be made every 6 months.	50,000	1	50,000
Reporting progress made towards meeting administrative procedures (policies and procedures, compilation and analysis of data, progress towards data sharing, etc.) Payment trigger: Bi-annual and annual reporting of progress towards and accomplishments of meeting administrative metrics. 50% of payment to be made every 6 months.	116,134	1	116,134

Reporting Health Outcome Metric: WPC participant will have comprehensive diabete3s care: HbA1c poor control > 9.0%. Payment trigger: Measure will be met for 50% or less of patients enrolled in WPC pilot. 50% of payment will be made every 6 months.	50,000	1	50,000
Reporting Percentage of Avoidable Hospitalizations - active monitoring of avoidable hospitalization visits will help target care coordination services to appropriate clients to link to primary care medical home. Payment trigger: Weekly reporting of inpatient stays by participating hospital. 50% of payment to be made every 6 months.	50,000	1	50,000
Health Outcome Metric-Hospital. Medication list provided at discharge. Payment trigger: Measure will be met for 50% or more of patients enrolled in WPC pilot. 50% of payment will be made every 6 months.	50,000	1	50,000
Health Outcome Metric-Hospital. Timely documentation transition to clinics/PCP. Payment trigger: Measure will be met for 5% or more of patients enrolled in WPC pilot. 50% of payment will be made every 6 months.	50,000	1	50,000
Health Outcome Metric-Hospital. Depression remission at 12 months. Payment trigger: Measure will be met for baseline minus 1% or more of patients enrolled in WPC pilot. 50% of payment will be made every 6 months.	50,000	1	50,000
Health Outcome Metric-Hospital. MHU re-hospitalization within 30 days. Payment trigger: Measure will be met for baseline minus 1% or more of patients enrolled in WPC pilot. 50% of payment will be made every 6 months.	50,000	1	50,000
Health Outcome Metric: Patients with controlled hypertension. Payment trigger: Measure will be met for 50% or more of patients enrolled in WPC pilot. 50% of payment will be made every 6 months.	50,000	1	50,000
Housing Metric - Reporting on progress towards developing 40 permanent supportive rental housing units for WPC population. Payment trigger: Metrics will be met annually as outlined in WPC proposal. 100% of payment will be annually.	50,000	1	50,000
TOTAL PAY FOR REPORTING			**766,134**

PYs 4-5 Pay for Outcomes			
Pay for Outcomes	**Annual Cost/Unit**	**Unit**	**Total**
Health outcomes: 80% or greater follow up mental health, medical, and SUD appointment within 30 days post hospitalization improves compliance with discharge planning. Payment trigger: Measure will be met for 100% of patients enrolled in WPC pilot. 50% of payment to be made every 6 months.	75,000	1	75,000
Health Outcome Metric: Suicide Risk Assessment and Alcohol and Drug Misuse - SBIRT - compliance with using screening tools improves ability for care team to identify vulnerabilities and appropriately connect to care coordination, therapy, social supports, and other necessary services to prevent suicide and get into appropriate alcohol and drug treatment services; 100% compliance will reduce avoidable ED visits, Mental Health Unit stays, and improve health outcomes. Payment trigger: Tool will used with 60% of patients enrolled in WPC pilot. 50% of payment to be made every 6 months.	75,000	1	75,000
Health Outcome Metric: WPC participants will receive tobacco assessment and counseling. Payment trigger: Measure will be met for 90% or more of patients enrolled in WPC pilot. 50% of payment will be made every 6 months.	75,000	1	75,000
Health Outcome Metric: WPC participants will receive 12 months of coordinated case management. Payment trigger: Measure will be met for 25-40% or more of patients enrolled in WPC pilot. 50% of payment will be made every 6 months.	75,000	1	75,000
Health Outcome Metric: WPC participants will have a comprehensive care plan. Payment trigger: Measure will be met for 50% or more of patients enrolled in WPC pilot. 50% of payment will be made every 6 months.	100,000	1	100,000
TOTAL PAY FOR OUTCOMES			**400,000**

Letters of Support

Letters of support for the Monterey County Health Department Whole Person Care Pilot Application may be obtained from:

Patricia Zerounian, MPP
Management Analyst III
Monterey County Health Department
1270 Natividad Road
Salinas, CA 93906
831/755-4583
zerounianp@co.monterey.ca.us

June 23, 2016

Sarah Brooks, Deputy Director
Health Care Delivery Systems, Department of Health Care Services
P.O. Box 997413
Sacramento, CA 95899-7413

Regarding: Monterey County Health Department (MCHD) Application for Whole Person Care (WPC) Pilot

The Behavioral Health Bureau of the Monterey County Health Department is a partner in the MCHD application for Whole Person Care (WPC) Pilot, as a provider of referrals to the coordinated case management system, participant in the Health Information Exchange, contributor to the Patient Master Index, and provider of case managers specializing in mental health services for the focus population. We therefore offer this letter of commitment to the WPC Pilot and the California Department of Health Care Services.

The MCHD Behavioral Health Bureau will actively engage in the development and implementation of specific coordinated Whole Person Care initiatives, partnership governance, data sharing, and specific activities to support WPC evaluation and learning.

During the planning phase the Monterey County Whole Person Care Pilot, the Behavioral Health Bureau will agree to Memorandum of Understanding that will specifically detail our commitment to the WPC partnership.

Thank you for your consideration of the Monterey County Whole Person Care Pilot program grant application.

Sincerely,

Anne Miller, Ph. D.
Director, Behavioral Health Bureau

COALITION OF HOMELESS SERVICES PROVIDERS

[illegible] | www.[illegible]MontereyCounty.org

June 16, 2016

Sarah Brooks, Deputy Director
Health Care Delivery Systems, Department of Health Care Services
P.O. Box 997413
Sacramento, CA 95899-7413

Regarding: Monterey County Health Department (MCHD) Application for Whole Person Care (WPC) Pilot

Dear Ms. Brooks:

The Coalition of Homeless Services Providers is partnering with MCHD as a provider of technical assistance. We therefore offer this letter of commitment to the Monterey County Whole Person Care Pilot program and to the California Department of Health Care Services. As such, The Coalition of Homeless Services Providers will actively engage in the development and implementation of specific coordinated Whole Person Care initiatives, partnership governance, data sharing (as appropriate), and specific activities to support WPC evaluating and learning.

During the planning phase the Monterey County Whole Person Care Pilot program, The Coalition of Homeless Services Providers intends to execute a Memorandum of Understanding that will specifically detail our commitment to the WPC partnership. In general, The Coalition of Homeless Services Providers expects its role to be:

-Serve as lead agency for the Homeless Coordinated Assessment and Referral System (CARS)
-Serve as lead agency for the Homeless Management Information System (HMIS)
-Coordinate activities related to the local Housing Inventory Count (HIC) and Point in Time Count (PIT). Submit all required statistics and data to the U.S. Department of Housing and Urban Development (HUD)
-Serve as Monterey County designated Homeless Continuum of Care Coordinator

Thank you for your consideration of the Monterey County Whole Person Care Pilot program grant application.

Sincerely,

Katherine J. Thoeni
Executive Officer

June 23, 2016

Sarah Brooks, Deputy Director
Health Care Delivery Systems, Department of Health Care Services
PO Box 997413
Sacramento, CA 95899-7413

Re: Monterey County Health Department (MCHD) Application for Whole Person Care (WPC) Pilot

Franciscan Workers of Junipero Serra, dba Dorothy's Place, is partnering with MCHD as a partner providing shelter, food, and an array of social services for individuals who are homeless or at-risk, potentially with co-morbidities, without social supports, or Substance Use Disorder (SUD). We therefore offer this letter of commitment to the Monterey County Whole Person Care Pilot program and to the California Department of Health Care Services. As such, Franciscan Workers of Junipero Serra will actively engage in the development and implementation of specific coordinated Whole Person Care initiatives, partnership governance, data sharing (as appropriate), and specific activities to support WPC evaluating and learning.

During the planning phase of the Monterey County Whole Person Care Pilot program, Franciscan Workers of Junipero Serra intends to execute a Memorandum of Understanding that will specifically detail our commitment to the WPC partnership. In general, Franciscan Workers of Junipero Serra expects its role to be:

- County contractor for conducting the Vulnerability Assessment (VI-SPDAT) for homeless residents and connect health vulnerable homeless residents with the Coordinated Assessment and Referral System (CARS).
- A referring agency for homeless or at-risk persons admitted or discharged from care, having co-morbidities involving the top 5 reasons for hospital ED and inpatient expenditures, frequent ED use, SUD, and/or multiple Rx use.
- Service provider and case management entity with a 30 year history of being trusted by the chronically homeless population, a population identified as a WPC target population, and therefore a more effective liaison between healthcare providers and chronically homeless high users.
- Provider of basic needs, essential services and transitional housing that aids individuals who will experience homelessness upon release from institutions (such as hospital, sub-acute care facility, skilled nursing facility, rehabilitation facility, IMD, county jail, state prison or other).
- Provider of services and transitional housing for high user formerly jailed and incarcerated homeless clients that coordinates services with MC probation and parole officers.
- Provider of no cost daily prepared meals with menus that accommodate specific health needs in identified patients, and facilitator of on site nutrition and healthy eating education for chronically homeless persons.

- Provider of low barrier nightly emergency shelter for chronically homeless women, including those at-risk of sexual assault and violence, those suffering with moderate to serious mental illness and those with SUD.
- Provider of transitional shelter as an adjunct to out-patient IV drug treatment and health support for high-users that suffer from alcohol and substance use disorder.
- Identifier of persons with moderate to serious mental illness and homeless or at-risk of homelessness and provider of transition housing for those identified as a health support until permanent supportive housing can be acquired.
- Provider of a physical location for service delivery.
- Provider of in-kind social worker case managers.
- Provider of non-emergency transportation to primary care medical appointments for high users that frequently utilize emergency ambulance services and hospital ED visits instead of PCP visits.
- Provider of supports to assist homeless people in locating and maintaining medically necessary housing, including follow-on tenancy-based case management for one year after placement that includes individual housing and tenancy sustaining services, tenant and landlord education, and tenant coaching.
- Provider of Housing Authority approved case management to qualify chronically homeless clients for Homeless Preference Set Aside Housing Choice vouchers, including follow-on tenancy based case management for one year after placement that includes individual housing and tenancy sustaining services of tenant and landlord education, and tenant coaching.

Thank you for your consideration of the Monterey County Whole Person Care Pilot program grant application.

Sincerely,

Jill Allen

Jill Allen
Executive Director

Gathering for Women
P.O. Box 681 Monterey, CA 93942
831-241-0151
GatheringforWomen.org

June 24, 2016

Sarah Brooks, Deputy Director
Health Care Delivery Systems, Department of Health Care Services
P.O. Box 997413
Sacramento, CA 95899-7413

Regarding: Monterey County Health Department (MCHD) Application for Whole Person Care (WPC) Pilot

Gathering for Women – Monterey (GFW) is interested in partnering with MCHD as a provider of focus group services and as a non-federal funder. We therefore offer this letter of commitment to the Monterey County Whole Person Care Pilot program and to the California Department of Health Care Services. As such, GFW will engage in the development and implementation of specific coordinated Whole Person Care initiatives, partnership governance, data sharing (as appropriate), and specific activities to support WPC evaluating and learning.

During the planning phase the Monterey County Whole Person Care Pilot program, GFW intends to explore a Memorandum of Understanding that will specifically detail our commitment to the WPC partnership. In general, GFW expects its role to be as a referring agency for homeless or at-risk persons having co-morbidities involving the top 5 reasons for hospital ED and inpatient expenditures, frequent ED use, SUD, and/or multiple Rx use. We will also provide a physical location for service delivery.

Thank you for your consideration of the Monterey County Whole Person Care Pilot program grant application.

Yours truly,

Carol Greenwald
President/CEO
Gathering for Women - Monterey

HOUSING AUTHORITY
COUNTY OF MONTEREY

CENTRAL OFFICE
[illegible]
SALINAS, CA [illegible]
[illegible]
[illegible]
FAX 831 [illegible]
TDD 831 [illegible]

June 21, 2016

Sarah Brooks, Deputy Director
Health Care Delivery Systems, Department of Health Care Services
P.O. Box 997413
Sacramento, CA 95899-7413

Regarding: Monterey County Health Department (MCHD) Application for Whole Person Care (WPC) Pilot

The Housing Authority of the County of Monterey is partnering with MCHD as a provider of focus group services and provider of technical assistance. We therefore offer this letter of commitment to the Monterey County Whole Person Care Pilot program and to the California Department of Health Care Services. As such, the Housing Authority will actively engage in the development and implementation of specific coordinated Whole Person Care initiatives, partnership governance, data sharing (as appropriate), and specific activities to support WPC evaluating and learning.

During the planning phase the Monterey County Whole Person Care Pilot program, the Housing Authority intends to execute a Memorandum of Understanding that will specifically detail our commitment to the WPC partnership. In general, the Housing Authority expects its role to be:

- A provider of technical assistance since it is an affordable housing provider in the jurisdiction and a provider of homeless housing services
- A provider of rental assistance through the Housing Choice Voucher program
- Make referrals of homeless or at-risk persons

Thank you for your consideration of the Monterey County Whole Person Care Pilot program grant application.

Sincerely,

Jean L. Goebel
Executive Director

Vision Statement
To provide, administer, and create the quality affordable housing and related services to eligible residents of Monterey County.

inTerim
INCORPORATED Post Office Box 3222 ● Monterey, CA 93942 ● (831) 649-8533 ● fax (831) 647-9136 ● www.interimcare.org

June 22, 2016

Sarah Brooks, Deputy Director
Health Care Delivery Systems, Department of Health Care Services
P.O. Box 997413
Sacramento, CA 95899-7413

Regarding: Monterey County Health Department (MCHD) Application for Whole Person Care (WPC) Pilot

Interim Inc. is partnering with MCHD to identify and refer to the WPC Pilot persons with SMI who are homeless or at-risk. Interim Inc. will additionally contribute technical assistance toward the WPC housing development, provide social supports outcome data, provide a physical location for service delivery, and provide case managers to the coordinated system of care.

We therefore offer this letter of commitment to the Monterey County Whole Person Care Pilot program and to the California Department of Health Care Services. As such, Interim inc. will actively engage in the development and implementation of specific coordinated Whole Person Care initiatives, partnership governance, data sharing (as appropriate), and specific activities to support WPC evaluation and learning.

During the planning phase for Monterey County Whole Person Care Pilot program, Interim Inc. intends to execute a Memorandum of Understanding that will specifically detail our commitment to the WPC partnership. In general, Interim Inc. expects its role to be:

- Affordable housing partner for people with Serious Mental Illness
- Provider of outreach to homeless persons with SMI
- Peer supports and training of peer health/wellness navigator providers
- Residential treatment
- Supported education and employment services

Thank you for your consideration of the Monterey County Whole Person Care Pilot program grant application.

Sincerely,

Barbara L. Mitchell

Barbara L. Mitchell

Executive Director

MCDSS MONTEREY COUNTY
DEPARTMENT OF SOCIAL SERVICES
WORKING TOGETHER FOR OUR COMMUNITY

1000 South Main Street, Suite 216
Salinas, California 93901
ph 831.755.4448 fx 831.755.8477

Elliott Robinson, Director

June 20, 2016

Sarah Brooks, Deputy Director
Health Care Delivery Systems, Department of Health Care Services
P.O. Box 997413
Sacramento, CA 95899-7413

Regarding: Monterey County Health Department (MCHD) Application for Whole Person Care (WPC) Pilot.

The Monterey County Department of Social Services (MCDSS) administers approximately seventy programs and serves an estimated 170,000 residents of Monterey County. Department services include a variety of public assistance programs, employment services and social services for children and their families, adults with disabilities, seniors, and military veterans. Additionally, MCDSS is the designated agency responsible for the investigation of child, dependent adult and elder abuse and neglect in Monterey County.

MCDSS has extensive knowledge about the MCHD WPC Pilot focus population and is ready to collaborate in addressing the needs of county residents with high needs such as: those who are homeless or at risk for homelessness and/or have diagnosed mental illness; diagnosed substance abuse disorder; transitional foster care youth; two or more chronic health diagnoses; three or more emergency department visits within six months; extended hospital stay, five or more medications prescribed; two or more hospital admissions within 6 months; four or more mental health admissions per year, etc.

MCDSS is partnering with MCHD in the Monterey County Whole Person Care 5 Year Pilot as a provider of non-federal share funding, identification and referrals of individuals who are homeless or at risk, and individuals who are vulnerable with or without social supports. MCDSS is also committing to be a provider of in-kind social worker case managers and provider of social support outcome data and provider of a physical location for service delivery.

MCDSS therefore, offers this letter of commitment to the Monterey County Whole Person Care Pilot program and to the California Department of Health Care Services.

As a partner organization, MCDSS will actively engage in the development and implementation of specific coordinated Whole Person Care initiatives, including partnership with the Monterey County Health Department (MCHD) Application for Whole Person Care (WPC) Pilot, program governance, data sharing (as appropriate), and specific activities to support WPC evaluation and outcomes.

During the planning phase of the Monterey County Whole Person Care Pilot program, MCDSS intends to execute a Memorandum of Understanding that will specifically detail and formalize this commitment to the WPC partnership.

MCDSS expects its role to be critical in achieving the goals of the MCHD WPC Pilot. This Department believes that this is an unprecedented opportunity to provide access, increased coordination, and true collaboration to provide health and social services to vulnerable Medi-Cal beneficiaries in order to reduce inappropriate emergency room and hospital inpatient use, as well as to improve data sharing as appropriate with other agencies in the partnership.

Thank you for your consideration of the Monterey County Whole Person Care Pilot program grant application.

Sincerely,

Elliott C. Robinson
Director, Department of Social Services

MidPen HOUSING

Creating Communities, Changing Lives

June 22, 2016

Sarah Brooks, Deputy Director
Health Care Delivery Systems, Department of Health Care Services
P.O. Box 997413
Sacramento, CA 95899-7413

Regarding: Monterey County Health Department (MCHD) Application for Whole Person Care (WPC) Pilot

Dear Ms. Brooks:

MidPen Housing Corporation is partnering with MCHD as a developer and operator of affordable and permanent supportive housing. We therefore offer this letter of commitment to the Monterey County Whole Person Care Pilot program and to the California Department of Health Care Services. As such, MidPen Housing Corporation will actively engage in the development and implementation of specific coordinated Whole Person Care initiatives, partnership governance, data sharing (as appropriate), and specific activities to support WPC evaluating and learning.

During the planning phase the Monterey County Whole Person Care Pilot program, MidPen Housing Corporation intends to execute a Memorandum of Understanding that will specifically detail our commitment to the WPC partnership. In general, MidPen Housing Corporation expects its role to be:

- Partner in development of permanent supportive housing (serving as housing developer and property manager) receiving client referrals for housing.
- Member of WPC governing entity

Thank you for your consideration of the Monterey County Whole Person Care Pilot program grant application.

Sincerely,

Elizabeth Nahas Wilson
Director of Housing Development

MidPen Housing Corporation
MidPen Property Management Corporation
MidPen Resident Services Corporation
303 Vintage Park Drive, Suite 250
Foster City, CA 94404
T. 650.356.2900
F. 650.357.9766
E. info@midpen-housing.org
www.midpen-housing.org

Natividad
MEDICAL CENTER

June 24, 2016

Sarah Brooks, Deputy Director
Health Care Delivery Systems, Department of Health Care Services
P.O. Box 997413
Sacramento, CA 95899-7413

Regarding: Monterey County Health Department (MCHD) Application for Whole Person Care (WPC) Pilot

Natividad Medical Center is partnering as a designated public safety net hospital with MCHD in the Whole Person Care Pilot. We therefore offer this letter of commitment to the Monterey County Whole Person Care Pilot program and to the California Department of Health Care Services. As such, Natividad Medical Center will actively engage in the development and implementation of specific coordinated Whole Person Care initiatives, partnership governance, data sharing (as appropriate), and specific activities to support WPC evaluating and learning.

During the planning phase the Monterey County Whole Person Care Pilot program, Natividad Medical Center intends to execute a Memorandum of Understanding that will specifically detail our commitment to the WPC partnership. In general, Natividad Medical Center expects its role to be:

- Non-federal share funder
- Provider of physical location for service delivery
- Identification & referrals of Medi-Cal enrollees with a combination of MI diagnoses, multiple MHU admittance, co-morbidity involving top 5 reasons for hospital ED and inpatient expenditures, frequent ED use, SUD, homeless or at-risk, and/or multiple Rx use
- User of a shared Master Patient Index
- Provider of health outcome data
- Partner in coordinating discharge nurse case managers

Thank you for your consideration of the Monterey County Whole Person Care Pilot program grant application.

Sincerely,

Gary R. Gray, DO
Chief Executive Officer

1441 Constitution Boulevard
P.O. Box 81611
Salinas, CA 93912-1611
p: 831.755.4111

www.natividad.com

MONTEREY COUNTY
DEPARTMENT OF HEALTH Elsa Jimenez, Interim Director
ADMINISTRATION
EMERGENCY MEDICAL SERVICES
BEHAVIORAL HEALTH
ENVIRONMENTAL HEALTH/ANIMAL SERVICES
PUBLIC ADMINISTRATOR/PUBLIC GUARDIAN
CLINIC SERVICES
PUBLIC HEALTH

June 23, 2016

Sarah Brooks, Deputy Director
Health Care Delivery Systems, Department of Health Care Services
P.O. Box 997413
Sacramento, CA 95899-7413

Regarding: Monterey County Health Department (MCHD) Application for Whole Person Care (WPC) Pilot

The Public Health Bureau of the Monterey County Health Department is a partner in the MCHD application for Whole Person Care (WPC) Pilot, as a provider of referrals to the coordinated case management system, participant in the Health Information Exchange, contributor to the Patient Master Index, and provider of case managers specializing in physical health services for the focus population. We therefore offer this letter of commitment to the WPC Pilot and the California Department of Health Care Services.

The MCHD Public Health Bureau will actively engage in the development and implementation of specific coordinated Whole Person Care initiatives, partnership governance, data sharing, and specific activities to support WPC evaluation and learning.

During the planning phase of the Monterey County Whole Person Care Pilot, the Public Health Bureau will enter into a Memorandum of Understanding that will detail our commitment to the WPC Pilot.

Thank you for your consideration of the Monterey County Whole Person Care Pilot program grant application.

Sincerely,

Edward L. Moreno, M.D., M.P.H.
Health Officer and Director of Public Health

1270 Natividad Road Salinas, CA 93906 831/755-4500 www.natvhd.org

City of Salinas
OFFICE OF THE CITY MANAGER • 200 Lincoln Avenue • Salinas, California 93901
(831) 758-7201 • (831) 758-7368 (Fax) • www.ci.salinas.ca.us

June 30, 2016

Sarah Brooks, Deputy Director
Health Care Delivery Systems, Department of Health Care Services
P.O. Box 997413
Sacramento, CA 95899-7413

Regarding: Monterey County Health Department (MCHD) Application for Whole Person Care (WPC) Pilot

The City of Salinas is supportive of MCHD's application to the 1115 Waiver Whole Person (WPC) Pilot project. The City of Salinas experiences significant program needs related to persons who may qualify for the Whole Person Care Pilot program being proposed for Monterey County. As such, the City of Salinas will actively engage in the development and implementation of specific coordinated Whole Person Care initiatives, partnership governance, data sharing (as appropriate), and specific activities to support WPC evaluating and learning.

The City is the first responder to the needs of persons whom are eligible for Whole Person Care, and as such, several of its program needs relate to this first point of contact. On the Matrix, the City is part of the "#4 Public Agency" because it is the first place a resident will call when a person in need of Whole Person Care is identified by a member of the public. In support of this work, it is City staff that interact daily with encounters of this special need population in public spaces, public buildings, City parks, alleys and streets. Thirty-seven percent of the County's population resides in Salinas, and thus it is the City's Police Department that is the "enforcement" of "#9 Law Enforcement" on the Matrix. Salinas Police Department is need of better training that specifically addresses the unique culturally sensitive needs of this population when asked to enforce a disorderly conduct, a camp that is trespassing, or public inebriation, public urination and defecation of a mentally ill individual that may qualify for Whole Person Care. Adding a new category to the Matrix would be Salinas Fire. The Fire Department Paramedic teams respond to a multitude of health calls daily that are specifically related to persons in need of Whole Person Care addressing issues like Methicillin-resistant Staphylococcus aureus and other infectious disease, heroine toxicity treatment and other forms of drug overdoses, victims of street violent crimes, diabetic coma and heart attack. Housing and caring for this population is a great need for the Fire Department because it will reduce its call volume and reduce costs associated with the exposure that persons in need of Whole Person Care are subjected to and overcome by.

The whole City benefits by reducing the negative social impact that comes from watching the neediest population the City camp in unhealthy conditions without sanitation services of any kind. The whole region benefits by reducing the environmental impact (waste, human waste, biomedical waste) washed to the Monterey Bay Sanctuary every time it rains. There is no doubt the Whole City will benefit from Whole Person care.

The City will gladly execute a Memorandum of Understanding during the planning phase of the Monterey County Whole Person Care Pilot program. This Memorandum of Understanding will specifically detail our commitment to the WPC partnership. In general, the City of Salinas expects its role to be:

First Responder reports;
Camp Cleanup Reports, locations, engagement of social service responses and Status,
Leadership in culturally sensitive enforcement,
Facilitator between government agencies;
Applying as possible its own federal dollars to help alleviate the issues;
Continue as Co-chair of the County-wide "Lead Me Home Plan" and its implementation to eliminate homeless

Thank you for your consideration of the Monterey County Whole Person Care Pilot program grant application.

Sincerely,

Ray Corpuz
City Manager
City of Salinas

CC: Mayor and City Council
Department Directors

Salinas Valley Memorial Healthcare System
A Public Healthcare District

June 24, 2016

Sarah Brooks, Deputy Director
Health Care Delivery Systems, Department of Health Care Services
P.O. Box 997413
Sacramento, CA 95899-7413

Regarding: Monterey County Health Department (MCHD) Application for Whole Person Care (WPC) Pilot

Salinas Valley Memorial Hospital (SVMH) is partnering with MCHD on the Whole Person Care Pilot as a source of referrals of high utilization homeless persons for potential enrollment. We therefore offer this letter of commitment to the Monterey County Whole Person Care Pilot program and to the California Department of Health Care Services. As such, SVMH will actively engage in the development and implementation of specific coordinated Whole Person Care initiatives, partnership governance, data sharing (as appropriate), infrastructure development, and specific activities to support WPC evaluating and learning.

During the planning phase the Monterey County Whole Person Care Pilot program, SVMH intends to execute a Memorandum of Understanding that will specifically detail our commitment to the WPC partnership. In general, SVMH expects to:

- Identify and refer potential focus population patients to the WPC Pilot
- Provide input to the development of the Master Patient Index and care coordinator system

Thank you for your consideration of the Monterey County Whole Person Care Pilot program grant application.

Sincerely,

Allen Radner, MD
Chief Medical Officer

MONTEREY COUNTY

THE BOARD OF SUPERVISORS

JANE PARKER - Chair
SUPERVISOR - FOURTH DISTRICT
[illegible] - Chief of Staff

June 30, 2016

Sarah Brooks, Deputy Director
Health Care Delivery Systems, Department of Health Care Services
P.O. Box 997413
Sacramento, CA 95899-7413

RE: Monterey County Health Department (MCHD) Application for Whole Person Care (WPC) Pilot

Dear Sarah Brooks,

The Monterey County Board of Supervisors (Board) has an active interest in reducing homelessness and improving health outcomes for our county's underserved and vulnerable populations. The Board is supportive of Monterey County Health Department's (MCHD's) application to the 1115 Waiver Whole Person Care (WPC) Pilot project. The Board supports the involvement of the many county agencies that are collaborating on the application including the work and planning around the development and implementation of specific coordinated Whole Person Care initiatives, partnership governance, data sharing (as appropriate), and specific activities to support WPC evaluating and learning.

Thank you for your consideration of the Monterey County Whole Person Care Pilot program grant application.

Sincerely,

Jane Parker, Chair

[illegible] 1st Avenue, Marina, CA 93933 • [illegible] • [illegible]

WPC Budget Template: Summary and Top Sheet

WPC Applicant Name:	Monterey County Health Department		
	Federal Funds (Not to exceed 90%)	IGT	Total Funds
Annual Budget Amount Requested	2,683,463	2,683,463	5,366,926
Revised Annual Budget Amount Requested	3,712,283	3,712,283	7,424,566

PY 1 Budget Allocation (Note PY 1 Allocation is predetermined)	
PY 1 Total Budget	5,366,926
Approved Application (75%)	4,025,195
Submission of Baseline Data (25%)	1,341,732
PY 1 Total Check	OK

PY 2 Budget Allocation	
PY 2 Total Budget	6,395,646
Administrative Infrastructure	1,171,785
Delivery Infrastructure	1,058,833
Incentive Payments	1,256,000
FFS Services	507,512
PMPM Bundle	991,491
Pay For Reporting	1,010,025
Pay for Outomes	400,000
PY 2 Total Check	OK

PY 3 Budget Allocation	
PY 3 Total Budget	7,424,566
Administrative Infrastructure	386,194
Delivery Infrastructure	805,160
Incentive Payments	1,312,000
FFS Services	1,525,923
PMPM Bundle	2,137,979
Pay For Reporting	857,310
Pay for Outomes	400,000
PY 3 Total Check	OK

PY 4 Budget Allocation	
PY 4 Total Budget	7,424,566
Administrative Infrastructure	386,195
Delivery Infrastructure	896,336
Incentive Payments	1,312,000
FFS Services	1,525,922
PMPM Bundle	2,137,979
Pay For Reporting	766,134
Pay for Outomes	400,000
PY 4 Total Check	OK

PY 5 Budget Allocation	
PY 5 Total Budget	7,424,566
Administrative Infrastructure	386,195
Delivery Infrastructure	1,031,286
Incentive Payments	1,312,000
FFS Services	1,525,922
PMPM Bundle	2,137,979
Pay For Reporting	766,134
Pay for Outomes	400,000
PY 5 Total Check	OK