Whole Person Care Agreement

Attachment A

Whole Person Care Pilot Application

Original Application Submitted July 1, 2016

Revised Application Submitted October 20, 2016

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	Entity Description and Role in WPC
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	Entity Description and Role in WPC
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 Care Program 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. 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	Entity Description and Role in WPC
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. 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	Entity Description and Role in WPC
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 Care Coordinator; recipient of HUD funding. Administrative lead for the 10-Year Plan to end homelessness in Monterey and San Benito Counties. Serves as lead agency for the 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, and will not share data or attend case management meetings.

Additional Organizations (Opt)	Organization Name	Contact Name and Title	Entity Description and Role in WPC
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	Identification & referrals of persons with mental illness and are homeless 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.

Additional Organizations (Opt)	Organization Name	Contact Name and Title	Entity Description and Role in WPC
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. 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.

Additional Organizations (Opt)	Organization Name	Contact Name and Title	Entity Description and Role in WPC
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. 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.

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 with no medical health home (including those released from jail) and having 3 or more of the following characteristics: diagnosed mental illness, 4 or more MHU admissions in the prior year, diagnosed SUD, 2 or more chronic health diagnoses, 3 or more ED visits within the prior 6 months, 2 or more hospital admissions within the prior 6 months, or 5 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.

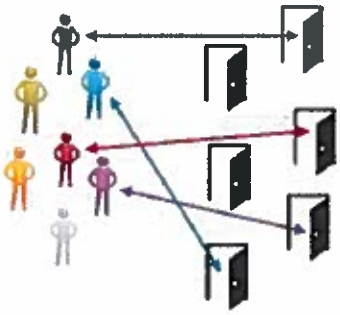
The WPC Pilot structure will integrate the management and resources of existing safety net hospital and primary care/specialty clinics, public health nursing teams, Housing Authority, Department of Social Services, Behavioral Health, and the Coalition of Homeless Services Providers (CHSP) with a proposed system of community health workers who will provide high-utilization patients with case management, individual health improvement plans, and warm handoffs to linked services. Oversight for the new

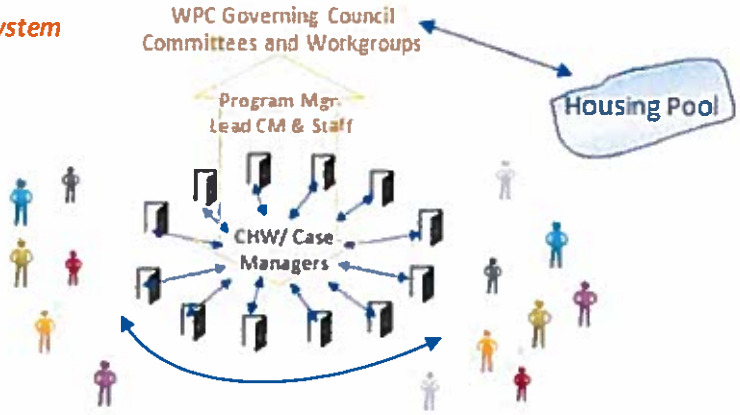
community health worker system will be provided by MCHD Director of Nursing and staff. Overarching will be a representing governance structure headed by the WPC Pilot Executive Committee. The housing pool, which will not be funded through the WPC, will be managed by the CHSP Leadership Council. The WPC 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.

WPC Status Quo and Linked Care Coordination System





Status Quo: Some people find some doors to service, some don't. People enter a door to service, and then exit the same door... and later, the cycle repeats.

WPC: More people find some doors to service due to increased outreach. CHW/case managers create individual care plans. Service portals are linked to each other; referral follow up, results, and outcomes are tracked in one accessible system. WPC Partners make up the Governing Council, responsible for finance, operations, evaluation, and management of the housing pool.

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 the following characteristics: diagnosed substance abuse history, diagnosed mental illness, and lack of a medical health home. Further criteria include having four or more MHU admissions in the prior year, two or more chronic health diagnoses, three or more ED visits within the prior 6 months, two or more hospital admissions within the prior 6 months, or five 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 strategies already existing in Monterey County are:

• CHW/case managers for high utilizers (providing physical and mental health, social services, and housing fields) • HIE, currently functioning between multiple hospitals and outpatient clinics, with other FQHC and behavioral health providers in upcoming phases • Integrated (physical and mental health) clinics	• Permanent supportive and transitional housing (physical/mental health and substance use fields) • Medical respite housing on the Monterey Peninsula • The Coalition of Homeless Services Providers (using Vi-SPDAT, CARS, HMIS, HIC and PIT systems and assessments) • Veterans housing and case management

The WPC services 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. The proposed Infrastructure grant will assist with financing a housing community that will provide High Utilizer Support Resources through the provision of permanent supportive housing for high utilizers of the health care system. Housing, in combination with onsite case management services, will improve health outcomes of these members by facilitating access to appropriate care.

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, 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 progresstoward 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.
Case Management	**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.
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 carecoordination. 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.

Category	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.	
Housing	**Monterey County Housing Authority** will provide technical assistance to the WPC Pilot Governing Group and focus population referrals to the WPC Pilot. **MidPen Housing** will provide a permanent supportive housing community that will include high utilizer case management and individual plans to improve physical/mental health and strengthen social supports. MidPen Housing has extensive experience in housing a variety of populations, including High Utilizer populations, in San Mateo and Santa Clara Counties. **Interim Inc.** will provide affordable housing for people with mental illness, outreach to homeless persons with mental illness, wellness navigators to serve the WPC Pilot enrollees with mental illness, and residential treatment with peer support.	
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.	

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, willinclude 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.

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 7 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 improve health outcomes. Transportation to and from appointments **other than those involving Medi-Cal reimbursement** will be arranged (bus, taxi) as needed to assure success.

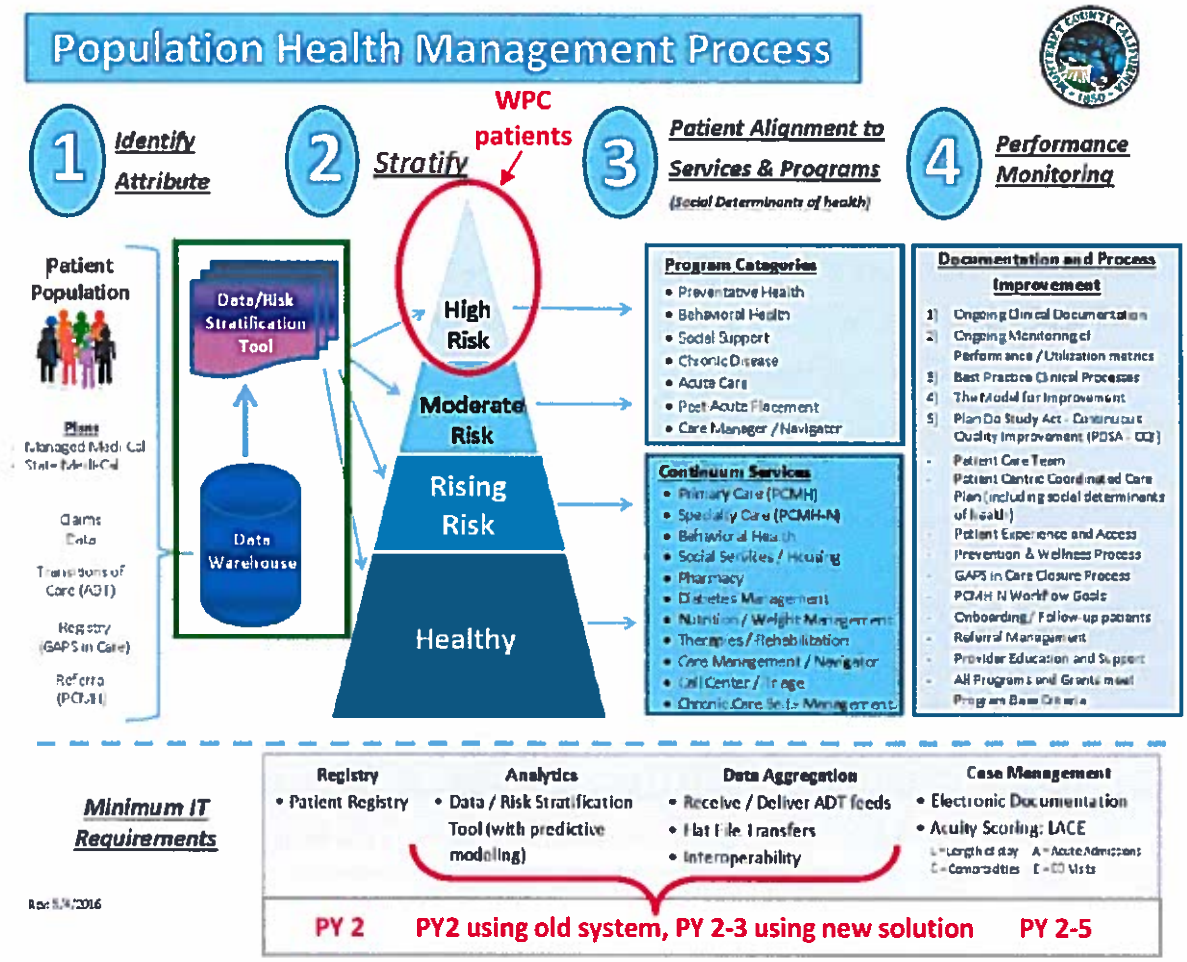
In addition to facilitating case coordination activities, the core team will provide training and education to participants on self-management techniques, nutrition and physical activity, how to advocate and take active role in the management of their conditions, health literacy, and chronic/communicable/wellness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

Care Coordination: The MCHD Pubic Health Bureau's 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.

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.


Population Health Management Process
1 Identify Attribute
2 Stratify
WPC patients
3 Patient Alignment to Services & Programs
(Social Determinants of health)
4 Performance Monitoring
Patient Population
Plans
Claims Data
Transitions of Care (ADT)
Registry (GAPS in Care)
Referra (PCMH)
Data/Risk Stratification Tool
Data Warehouse
High Risk
Moderate Risk
Rising Risk
Healthy
Program Categories
• Preventative Health
• Behavioral Health
• Social Support
• Chronic Disease
• Acute Care
• Post-Acute Placement
• Care Manager / Navigator
Continuum Services
• Primary Care (PCMH)
• Specialty Care (PCMH-N)
• Behavioral Health
• Social Services / Housing
• Pharmacy
• Diabetes Management
• Nutrition / Weight Management
• Therapies / Rehabilitation
• Care Management / Navigator
• Call Center / Triage
• Chronic Care Self-Management
Documentation and Process Improvement
1) Ongoing Clinical Documentation
2) Ongoing Monitoring of Performance / Utilization metrics
3) Best Practice Clinical Processes
4) The Model for Improvement
5) Plan Do Study Act - Continuous Quality Improvement (PDSA - CQI)
- Patient Care Team
- Patient Centric Coordinated Care Plan (including social determinants of health)
- Patient Experience and Access
- Prevention & Wellness Process
- GAPS in Care Closure Process
- PCMH N Workflow Goals
- Onboarding / Follow-up patients
- Referral Management
- Provider Education and Support
- All Programs and Grants meet Program Base Criteria
Minimum IT Requirements
Registry
• Patient Registry
Analytics
• Data / Risk Stratification Tool (with predictive modeling)
Data Aggregation
• Receive / Deliver ADT feeds
• Flat File Transfers
• Interoperability
Case Management
• Electronic Documentation
• Acuity Scoring: LACE
L = Length of stay A = Acute Admissions
C = Comorbidities E = ED Visits
PY 2
PY2 using old system, PY 2-3 using new solution
PY 2-5

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.

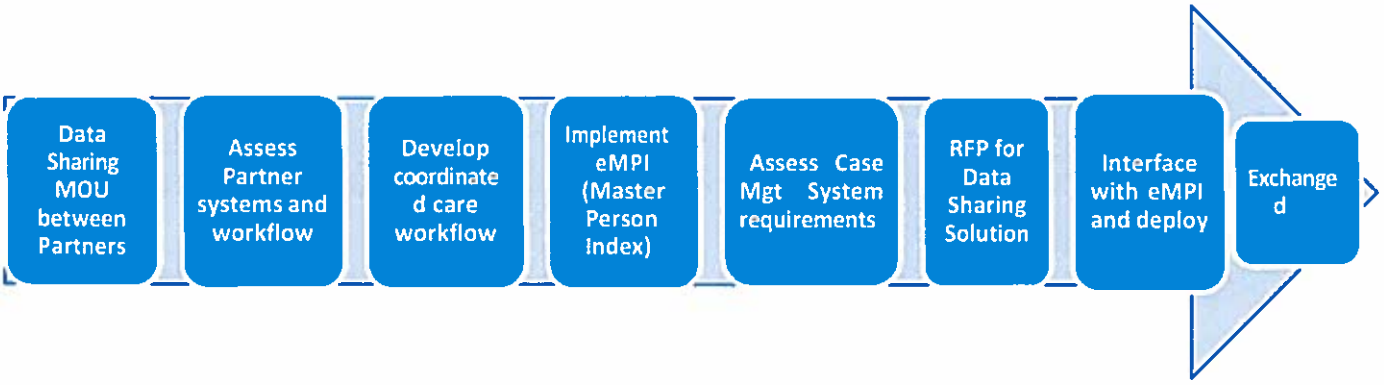
II. Proprietary Program/Service Assessment: Technology requirements to be developed will include an assessment of participating agencies' existing resources for service providers, contacts, information, and referral options that will define the workflow in an automated solution. This will evolve into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

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 requires a unified solution utilized by all of the participating agencies.

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.

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: **x=baseline**	Adult ED Visits: **x-2%**	Adult ED Visits: **x-4%**	Adult ED Visits: **x-5%**	Adult ED Visits: **x-7%**
ii Health Outcomes Adult Inpatient Utilization-General Hospital/Acute Care (IPU) (HEDIS)* (measured by aggregated focus population inpatient days)	Adult Inpatient utilization: **x=baseline**	Adult Inpatient utilization: **x-2%**	Adult Inpatient utilization: **x-4%**	Adult Inpatient utilization: **x-5%**	Adult Inpatient utilization: **x-7%**
iii Health Outcomes Follow-up After Hospitalization for Mental Illness (Adults) (FUH) (HEDIS) (measured by the number of discharged clients given a follow up appointment within 7 days and a treatment plan within 30 days)	Adult Follow up After Hospitalization for Mental Illness: **x=baseline**	Adult Follow up After Hospitalization for Mental Illness: **x+2%**	Adult Follow up After Hospitalization for Mental Illness: **x+4%**	Adult Follow up After Hospitalization for Mental Illness: **x+5%**	Adult Follow up After Hospitalization for Mental Illness: **x+7%**
iv Health Outcomes Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (Adults) (IET) (HEDIS) (measured by the number of focus population who have been informed of SUD services and been given an SUD assessment)	Initiation and engagement of AOD for Adults: **x=baseline**	Initiation and engagement of AOD for Adults: **x+2%**	Initiation and engagement of AOD for Adults: **x+4%**	Initiation and engagement of AOD for Adults: **x+5%**	Initiation and engagement of AOD for Adults: **x+7%**

***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, medicalprovider, 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: 84%**	**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: 88%**	**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: 92%**	**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: 96%**
	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:** 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:** Baseline - I event	**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:** Baseline - 2 events	**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:** Baseline-3 events	**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:** Baseline- 4 events

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, 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: **x=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: **x -1%**	**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: **x-2%**	**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: **x-3%**	**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: **x-4%**

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 **PY1:** 65%	**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:** 69%	**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:** 73%	**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:** 75%

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, who had** (HbA1c control <8%) **Denominator:** Members 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:** WPC Pilot participants poorly controlled diabetes (HbA1c ><8%) **Denominator:** WPC Participants with diabetes diagnosis **PY2:** 46%	**Health Outcome:** HbA1c Poor Control <8% across all program years **Target population:** WPC Participants with diabetes diagnosis **Numerator:** WPC Pilot participants poorly controlled diabetes (HbA1c ><8%) **Denominator:** WPC Participants with diabetes diagnosis **PY3:** 44%	**Health Outcome:** HbA1c Poor Control <8% across all program years **Target population:** WPC Participants with diabetes diagnosis **Numerator:** WPC Pilot participants poorly controlled diabetes (HbA1c ><8%) **Denominator:** WPC Participants with diabetes diagnosis **PY4:** 42%	**Health Outcome:** HbA1c Poor Control <8% across all program years **Target population:** WPC Participants with diabetes diagnosis **Numerator:** WPC Pilot participants poorly controlled diabetes (HbA1c ><8%) **Denominator:** WPC Participants with diabetes diagnosis **PY5:** 40%

	Health Outcome: Control blood pressure across all program years **Target population:** WPC participants with hypertension diagnosis **Numerator:** Within the denominator, whose BP was adequately controlled during the measurement year based on the following criteria: • Member 18-59 year of age whose BP was <140/90 mm Hg. • Members 60-85 years of age with a diagnosis of diabetes whose BP was <140/90 mm Hg. • Members 60-85 years of age without a diagnosis of diabetes whose BP was <150/90 mm **Denominator** Members 18-85 years of age who had a diagnosis of hypertension (HTN) **PY1: 50%**	**Health Outcome:** Control blood pressure across all program years **Target population:** WPC participants with hypertension diagnosis **Numerator:** Within the denominator, whose BP was adequately controlled during the measurement year based on the following criteria: • Member 18-59 year of age whose BP was <140/90 mm Hg. • Members 60-85 years of age with a diagnosis of diabetes whose BP was <140/90 mm Hg. • Members 60-85 years of age without a diagnosis of diabetes whose BP was <150/90 mm **Denominator** Members 18-85 years of age who had a diagnosis of hypertension (HTN) **PY2: 54%**	**Health Outcome:** Control blood pressure across all program years **Target population:** WPC participants with hypertension diagnosis **Numerator:** Within the denominator, whose BP was adequately controlled during the measurement year based on the following criteria: • Member 18-59 year of age whose BP was <140/90 mm Hg. • Members 60-85 years of age with a diagnosis of diabetes whose BP was <140/90 mm Hg. • Members 60-85 years of age without a diagnosis of diabetes whose BP was <150/90 mm **Denominator** Members 18-85 years of age who had a diagnosis of hypertension (HTN) **PY3: 56%**	**Health Outcome:** Control blood pressure across all program years **Target population:** WPC participants with hypertension diagnosis **Numerator:** Within the denominator, whose BP was adequately controlled during the measurement year based on the following criteria: • Member 18-59 year of age whose BP was <140/90 mm Hg. • Members 60-85 years of age with a diagnosis of diabetes whose BP was <140/90 mm Hg. • Members 60-85 years of age without a diagnosis of diabetes whose BP was <150/90 mm **Denominator** Members 18-85 years of age who had a diagnosis of hypertension (HTN) **PY4: 58%**	**Health Outcome:** Control blood pressure across all program years **Target population:** WPC participants with hypertension diagnosis **Numerator:** Within the denominator, whose BP was adequately controlled during the measurement year based on the following criteria: • Member 18-59 year of age whose BP was <140/90 mm Hg. • Members 60-85 years of age with a diagnosis of diabetes whose BP was <140/90 mm Hg. • Members 60-85 years of age without a diagnosis of diabetes whose BP was <150/90 mm **Denominator** Members 18-85 years of age who had a diagnosis of hypertension (HTN) **PY5: 60%**

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

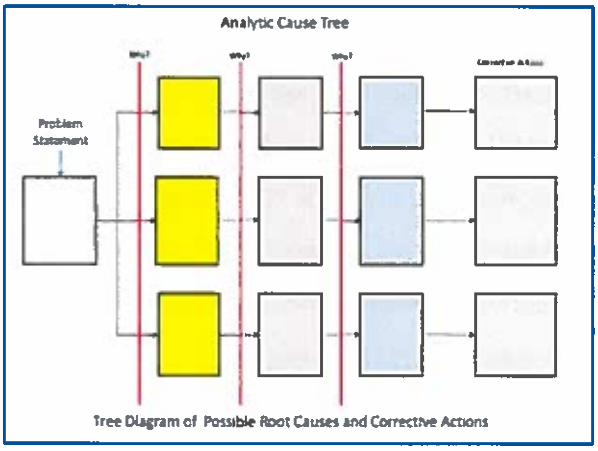
Ongoing data collection, reporting, and analysis of the WPC Pilot's interventions, strategies, participant health outcomes, and return on investment will be accomplished using existing and new data sources. Initial partnership work has included identification of current universal and potential variant 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

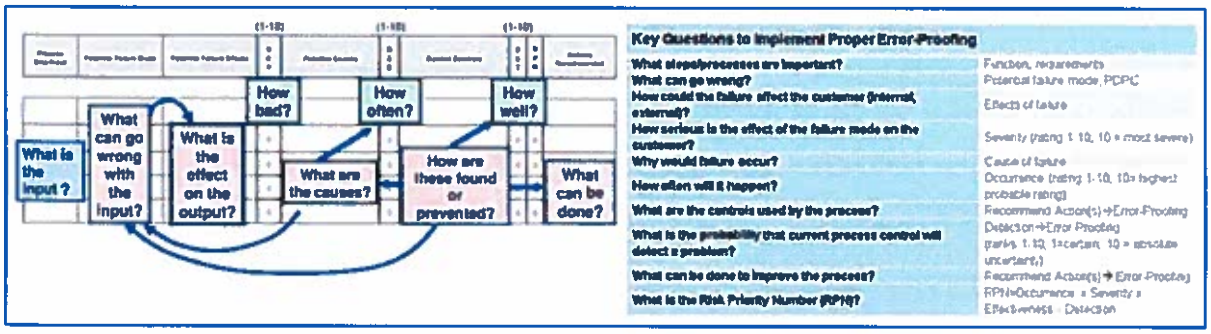
Initially, Epidemiologists will develop an analytic approach, including the program questions and fields to track from the various data sets from the participating partners. Algorithms will be developed using the partner's datasets and used to query them to track individuals in each system who match 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 Services 2.0 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 (right), 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 PCDA 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 5 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 an quarterly bases, 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.

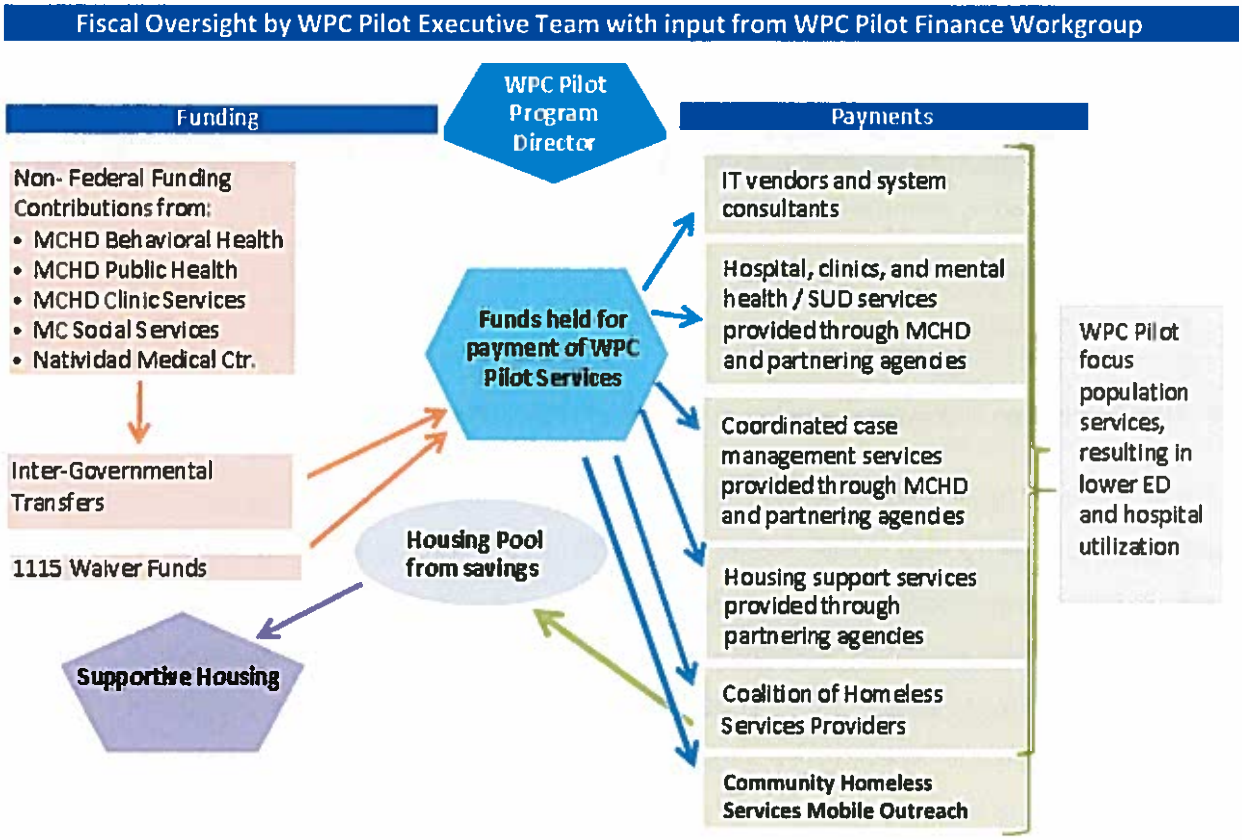
The case management system (CMS) will enable the program coordinators to access information across multiple data systems for individuals that are enrolled in the pilot program. The CMS will enable participating agencies and program coordinators to query, input data, and track the services provides and 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
Housing Pool from savings
Supportive Housing
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
Community Homeless Services Mobile Outreach
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)	IGT	Total Funds
Annual Budget Amount Requested	2,683,463	2,683,463	5,366,926
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	5,366,926		
Administrative Infrastructure	990,150		
Delivery Infrastructure	941,000		
Incentive Payments	1,200,000		
FFS Services	32,500		
PMPM Bundle	793,251		
Pay For Reporting	1,010,025		
Pay for Outomes	400,000		
PY 2 Total Check	OK		
PY 3 Budget Allocation			
PY 3 Total Budget	5,366,926		
Administrative Infrastructure	237,956		
Delivery Infrastructure	805,160		
Incentive Payments	1,200,000		
FFS Services	125,000		
PMPM Bundle	1,741,500		
Pay For Reporting	857,310		
Pay for Outomes	400,000		
PY 3 Total Check	OK		
PY 4 Budget Allocation			
PY 4 Total Budget	5,366,926		
Administrative Infrastructure	237,956		
Delivery Infrastructure	896,336		
Incentive Payments	1,200,000		
FFS Services	125,000		
PMPM Bundle	1,741,500		
Pay For Reporting	766,134		
Pay for Outomes	400,000		
PY 4 Total Check	OK		
PY 5 Budget Allocation			
PY 5 Total Budget	5,366,926		
Administrative Infrastructure	237,956		
Delivery Infrastructure	896,336		
Incentive Payments	1,200,000		
FFS Services	125,000		
PMPM Bundle	1,741,500		
Pay For Reporting	766,134		
Pay for Outomes	400,000		
PY 5 Total Check	OK		

WPC Budget Narrative PY1

WPC Budget Narrative	
WPC Applicant Name:	**Monterey County Health Department**
Program Year 1	
Approved Application (75%)	4,025,194
Submission of Baseline Data (25%)	1,341,731
PY 1 Total Budget	**5,366,926**

WPC Budget Narrative PY2

WPC Budget Narrative WPC Applicant Name: Monterey County Health Department PY 2 Budget Total			5,366,926
Administrative Infrastructure			
Staff	**Annual**	**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
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 Adminstrative costs.**	145,000	1.50	217,500
Public Health Epidemiologist II (1.0 FTE) – responsible for data anlaysis; reporting of evaluation metrics	125,000	0.50	62,500
Sub-total			**818,500**

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
Training Curriula 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			124,500
Indirect Costs (5% of total Administrative Cost	943,000	0.05	47,150
TOTAL ADMINISTRATIVE INFRASTRUCTURE			**990,150**

Delivery Infrastructure			
	Annual	**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 Assessement 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
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 start up year; therefore 50% of this item is included in Infrastructure and the remaining 50% is included in PMPM. It is anticpated there will be salary savings due to start up 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 start up year; therefore 50% of this item is included in Infrastructure and the remaining 50% is included in PMPM. It is anticpated there will be savings due to start up period, therefore PY 2 is lower than PYs 3-5. Additionally, wil 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			**941,000**
Incentive Payments			
	Annual	**Unit**	**Total**
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
TOTAL INCENTIVE PAYMENTS			**1,200,000**

WPC Budget Narrative PY2

FFS Services - N/A			
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 start up year; therefore 50% of this item is included in Infrastructure and the remaining 50% is included in PMPM. It is anticpated there will be savings due to start up 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 particpants to care coordination system as requested by Core Case Management Team).			
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	61	532.78	**32,500**
PMPM Bundle			
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 start up year, therefore 50% of this item is included in Infrastructure and the remaining 50% is included in PMPM. It is anticpated there will be salary savings due to start up period.	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**	565,000	0.05	28,250
Total for Complex Care Management Team			**593,251**
Member months (6 months)	**100**	**600**	**988.75**

WPC Budget Narrative PY2

Pay for Reporting	Annual	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 halth 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 participants will have comprehensive diabetes 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

WPC Budget Narrative PY2

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 documentatoin 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
hospitalizatin 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**
Pay for Outcomes			
	Annual	**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**

WPC Budget Narrative PY3

WPC Budget Narrative			
WPC Applicant Name: Monterey County Health Department			
PY 3 Budget Total			5,366,926
Administrative Infrastructure			
Staff	**Annual**	**Unit**	**Total**
Public Health Epidemiologist II - responsible for data anlaysis; reporting of evaluation metrics	125,000	0.50	62,500
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			222,500
Services/Supplies/Indirect Costs			
Data Processing and Telecommunications Support	2,500	1.50	3,750
General office supplies, printing, educational materials	250	1.50	375
Indirect Costs (5% of total Admin Costs)	226,625	0.05	11,331
Sub-total			15,456
TOTAL ADMINISTRATIVE INFRASTRUCTURE			237,956
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

WPC Budget Narrative PY3

Incentive Payments	Annual Cost/Unit	Unit	Total
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	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
TOTAL INCENTIVE PAYMENTS			1,200,000

WPC Budget Narrative PY3

FFS Services - N/A			
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 start up year; therefore 50% of this item is included in Infrastructure and the remaining 50% is included in PMPM. It is anticpated there will be savings due to start up period, therefore PY 2 is lower than PYs 3-5. Additionally, wil 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 particpants 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

PMPM Bundle			
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			
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 Mngmt Team)	1,130,000	0.05	56,500
Total for Complex Care Management Team			**1,186,500**
Member months (12 months)	**110**	**1320**	**898.864**
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
Total for Case Management-Housing Support			**555,000**
Member months (12 months)	**110**	**1320**	**420.45**
TOTAL PMPM			**1,741,500**

WP C Budget Narrative PY3

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**	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 halth 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**	60,000	1	60,000
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
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	117,310	1	117,310
Reporting Health Outcome Metric: WPC participants will have comprehensive diabetes care: HbA1c poor control > 9.0%. **Payment trigger: Measure will be met for 50% or less of patients enrolled in WPC pilot. 50% of**			
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

WPC Budget Narrative PY3

Health Outcome Metric-Hospital. Timely documentatoin 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-hospitalizatin 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**

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**

WPC Budget Narrative PY4

WPC Budget Narrative			
WPC Applicant Name: Monterey County Health Department			
PY 4 Budget Total			**5,366,926**
Administrative Infrastructure			
Staff	**Annual**	**Unit**	**Total**
Public Health Epidemiologist II - responsible for data anlaysis; reporting of evaluation metrics	125,000	0.50	62,500
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			222,500
Services/Supplies/Indirect Costs			
Data Processing and Telecommunications Support	2,500	1.50	3,750
General office supplies, printing, educational materials	250	1.50	375
Indirect Costs (5% of total Admin Costs)	226,625	0.05	11,331
Sub-total			15,456
TOTAL ADMINISTRATIVE INFRASTRUCTURE			**237,956**
Delivery Infrastructure			
	Annual	**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	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**
Incentive Payments			
	Annual	**Unit**	**Total**
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
TOTAL INCENTIVE PAYMENTS			**1,200,000**

PMPM Bundle			
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 Mngmt Team)	1,130,000	0.05	56,500
Total for Complex Care Management Team			**1,186,500**
Member months (12 months)	**140**	1680	**706.250**
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 Service Providers for placement. Costs include: staffing costs,			
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,	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
Total for Case Management-Housing Supports			**555,000**
Member months (12 months)	**140**	**1680**	**330.357**
TOTAL PMPM			**1,741,500**

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.**	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 halth 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.**	50,000	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 participants will have comprehensive diabetes 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

WPC Budget Narrative PY4

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 documentatoin 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-hospitalizatin 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**

WPC Budget Narrative PY4

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**	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**	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**

WPC Budget Narrative PY5

WPC Budget Narrative			
WPC Applicant Name: Monterey County Health Department			
PY 5 Budget Total			**5,366,926**
Administrative Infrastructure			
Staff	**Annual**	**Unit**	**Total**
Public Health Epidemiologist II – responsible for data anlaysis; reporting of evaluation metrics	125,000	0.50	62,500
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			222,500
Services/Supplies/Indirect Costs			
Data Processing and Telecommunications Support	2,500	1.50	3,750
General office supplies, printing, educational materials	250	1.50	375
Indirect Costs (5% of total Admin Costs)	226,625	0.05	11,331
Sub-total			15,456
TOTAL ADMINISTRATIVE INFRASTRUCTURE			**237,956**
Delivery Infrastructure			
	Annual	**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 Assessement 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**

WPC Budget Narrative PY5

Incentive Payments	Annual	Unit	Total
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
TOTAL INCENTIVE PAYMENTS			**1,200,000**
FFS Services – N/A			
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 start up 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 start up 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**

PMPM Bundle			
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			
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/Indirects			
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 Mngmt Team)	1,130,000	0.05	56,500
Total for Complex Care Management Team			**1,186,500**
Member months (12 months)	**150**	**1800**	**659.17**
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 Service Providers for placement. Costs include: staffing costs, operational			
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
Total for Case Management-Housing Supports			**555,000**
Member months (12 months)	**150**	**1800**	**308.333**
TOTAL PMPM			**1,741,500**

WPC Budget Narrative PY5

Pay for Reporting	Annual	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**	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 halth 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.**	50,000	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 participants will have comprehensive diabetes 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

WPC Budget Narrative PY5

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 documentatoin 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-hospitalizatin 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
Pay for Outcomes	**Annual**	**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**

MONTEREY COUNTY
DEPARTMENT OF HEALTH Elsa Jimenez, Director of Health
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 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,

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

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

COALITION OF HOMELESS SERVICES PROVIDERS

220 12th Street, Marina, CA 93933 | P: (831) 883-3080 | F: (831) 883-3085 | Email: chspmonterey@aol.com | www.CHSPMontereyCounty.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

Franciscan Workers of Junipero Serra
PO Box 2027, Salinas, CA 93902
www.dorothysplace.org
ph 831.757.3838
fx 831.757.2173

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 601 Monterey, CA 93942
831-241-6154
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

June 21, 2016

CENTRAL OFFICE:
123 RICO ST.
SALINAS CA 93907
831-775-5000
831-649-1541
FAX 831-424-9153
TDD 831-754-2951

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 encourage quality affordable housing and related services to eligible residents of Monterey County.

INCORPORATED Post Office Box 3222 • Monterey, CA 93942 • (831) 649-4522 • fax (831) 647-9136 • www.interiminc.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 provider 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

Executive Director

A non-profit organization dedicated to the self-sufficiency of people who have mental illness

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
Building 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
PO 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

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
KRISTI MARKEY - 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

2616 1st Avenue, Marina, CA 93933 • (831) 883-7570 • district4@co.monterey.ca.us