COUNTY OF MONTEREY
HEALTH DEPARTMENT
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Administration
Behavioral Health
Clinic Services
Emergency Medical Services
Environmental Health/Animal Services
Public Health
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DHCS Whole Person Care Round 2 Application Change Memo
March 1, 2017

Monterey County Health Department (MCHD) proposes the following changes to its Lead Entity WPC Agreement dated October 20, 2016, as its Whole Person Care (WPC) Round 2 Expansion Application.

	PY1	PY2	PY3	PY4	PY5	Totals
Approved in Round 1	$5,366,926	$5,366,926	$5,366,926	$5,366,926	$5,366,926	**$26,346,630**
Requested in Round 2		$1,028,720	$2,057,040	$2,057,040	$2,057,040	**$7,201,040**
Totals	$5,366,926	$6,395,646	$7,423,966	$7,423,966	$7,423,966	**$33,547,670**

Administrative Infrastructure:

MCHD proposes adding three items that support the administrative infrastructure of the WPC Pilot.

- **Assistant Project Manager** to provide additional Pilot oversight and day-to-day staff and activities management based on expansion and quality needs.

  PY2: $68,000 PYs 3-5: $136,000

- **Legal Services** provided by outside counsel (subject matter experts) for agreements in support of our program.

  PY2: $100,000 PYs 3-5: $0

- **Travel expenses** to send five people to in-person Learning Collaborative Meetings in various locations, twice per year. This amount anticipates sometimes driving to meetings, and when needed, air travel to distant locations.

  PYs 2-5: $5,000

Delivery Infrastructure:

MCHD proposes adding delivery infrastructure that supports the proposed Sobering Center services. The item below is for modification of the Sobering Center facilities, and is in addition to the services which are included in Fee for Service.

- **Sobering Center Facility Modification Expenses** for the modification of the facilities, and acquisition of the computers and phone system for the operation of the facility. These costs are requested on PY 2 only as one-time costs.

  PY2: $117,833 PYs 3-5: $0

Incentive Payment:

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

  PY2: $56,000 PYs 3-5: $112,000

Fee for Services:

The core of our WPC Round 2 application expansion are new service activities that align with the WPC purposes of avoiding hospitalization and incarceration, supporting WPC enrollees in housing stability, and targeted outreach to support WPC enrollment.

- **Respite Center**: Development of a new, 6-bed respite center for acute/post-acute, medically fragile WPC enrollees, offering an appropriate level of care post-hospitalization for up to 90 days. The respite center will primarily serve WPC enrollees who are homeless or those with unstable living situations, who are too ill or frail to recover from a physical illness or injury in their usual living environment, but are not ill enough to be in a hospital. This facility will come online at the beginning of PY3, hence, no funds are allocated for PY2. The Respite Center will be staffed and operated by our community partner, Interim, Inc.

  FFS Amount: $165

  PY2: $0 PYs 3-5: $324,998

- **Housing placement services** and supports for up to 20 WPC enrollees annually (10 WPC enrollees in PY2). These services are for WPC enrollees who are living in transitional housing for up to one year and need appropriate coping and living skills required to move into permanent housing. During this time, enrollees will receive peer supports, counseling, skill development training, and other non-Medi-Cal assistance with daily living skills intended to preparing enrollees for discharge to transitional or permanent housing.

  FFS amount $77.28

  PY2: $46,365 PYs 3-5: $92,731

- **Targeted outreach** in the neighborhoods of highest potentially-WPC enrollees. The team will provide pre-enrollment intercept and outreach to engage and build trusting relationships that will lead to WPC enrollment. Engagement activities may include informational sessions regarding stress management, grief and loss, life skills, nutrition, health and healing, job seeking skills, and conflict resolution, among others. The budget for FFS for outreach and referral recognizes the higher level of training and multiple touches needed as our target population is amongst those who are hardest to reach. This activity differs from the Mobile Outreach in our existing contract in that the Mobile Outreach will be in effect throughout the county, whereas the Targeted outreach will specifically operate in a neighborhood that is populated with a concentration of homeless services providers.

  FFS Amount: $288

  PY2: $70,745 PY3: $146,417 PY4: $146,416 PY5: $146,416

- **On-site Housing Sustainability Services** that are proactive and consistent, and crisis intervention to reduce utilization of more expensive services. These services will be provided to enrollees living in permanent house and include crisis intervention, case management, workforce development, computer learning, financial education, health and wellness education for WPC residents with histories of homelessness, mental illness, substance use, co-occurring disorders, and chronic health conditions

  FFS Amount $480.22

  PY2: $0 PYs 3-5: $120,960

- **Sobering Center:** Develop sobering center services for an eight bed, 23-hour stay maximum (Provider: Interim, Inc.) as an alternative for WPC enrollees who otherwise would be booked into county jail. This eight-bed facility will allow WPC enrollees to stay up to 23 hours in a medically-supported environment. Staff will include certified counselors, intake coordinators, and managing staff.

  FFS Amount: $216.65

  PY2: $316,303 PYs 3-5: $632,618

- **Homeless Persons Peer Navigator Program:** homeless or previously homeless persons will provide WPC-enrolled, post-released prisoners and other potential WPC-enrolled homeless persons who live in encampments and who have difficulty trusting and communicating with persons perceived to be in authority. Tasks include initiation and follow up (up to a year per person) using four part-time peer navigators, Peer Navigation training, peer navigator oversight, and interfacing with WPC PHN case managers. Peer Navigators will follow up with the people they are tracking using cell phones that are provided to the WPC-enrollee through another program.

  FFS Amount $40

  PY2: $41,600 PYs 3-5: $83,200

PMPM Bundle:

One additional strategy is added to the PMPM category:

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

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

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

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

Hot Spotting Team will serve 80 WPC-enrollees per month who are the highest utilizers with intensive, multidisciplinary, comprehensive services per month for a total of 480 PMPM units. Hot Spotting clients will be referred from ED and hospitals and will be served for 3 months.

PMPM amount is $413

PY2: $198,240 PY3: $396,479 PY4: $396,479 PY5: $396,480

Revision of WPC enrollment criteria:

When considering our enrollment criteria for the WPC Pilot application, we researched the criteria used by existing programs in other counties and states. After our contract was fully executed, we obtained our safety net hospital's list of 1,000 highest utilizers. We determined that since our research involved counties with utilizer populations much larger than our own, the criteria we identified was severely hindering our enrollment. This easing of enrollment criteria will broaden our pool of potential WPC enrollees.

- **Revision:** Revise enrollment criteria in the following manner: 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 **2** or more of the following characteristics: two or more MHU admissions in the prior year, two or more chronic health diagnoses, two or more ED visits within the prior 12 months, one or more hospital admissions within the prior 12 months, or two or more prescribed medications.

Revision of Approved Metrics

Per DHCS' instructions, approved Universal and Variant Metrics have been changed to reflect at least a five percent change over the prior year where appropriate.