Section 1: Whole Person Care Lead Entity and Participating Entity Information

Name of Project: "Cruz To Health Data Connect"

1.1 Whole Person Care Pilot Lead Entity and Contact Person

Organization Name	County of Santa Cruz, Health Services Agency
Type of Entity (from lead entity description above)	County
Contact Person	Giang T. Nguyen
Contact Person Title	Director, Health Services Agency
Telephone	(831) 454-4471
Mailing Address	1080 Emeline Ave., Building D Santa Cruz, CA 95060

1.2 Participating Entities

Required Organizations:

Required Organizations	Organization Name	Contact Name and Title	Entity Description and Role in WPC
1. Medi-Cal Managed Health Plan	Central California Alliance for Health (CCAH)	Alan McKay, Executive Director	Entity Description: The only one Medi-Cal Managed Care health plan as County Organized Health System serving Santa Cruz County. Role in WPC: • Participates in Governance Structure and Communication Process

Required Organizations	Organization Name	Contact Name and Title	Entity Description and Role in WPC
			• Assists in the development, implementation, evaluation and sustainability plan • Provides data necessary for the identification of the target population, project implementation, operation and learning • Participates in routine care coordination meetings when applicable
2. Health Services Agency	Health Services Agency	Giang Nguyen, Director	Entity Description: Oversees health services for the County of Santa Cruz including public health, mental health, substance use disorders, environmental health, and Federally Qualified Health Centers. Role in WPC: • Lead entity • Non-federal share funder • Leads and facilitates the development of the WPC pilot, implementation, evaluation and sustainability plans • Procures and monitors contracted services • Provides overall coordination and monitoring of the project • Coordinates communication with the community and with partnering entities • Facilitates and staffs project governance and oversight structures
3. Specialty/ Mental Health Department	Health Services Agency, Behavioral Health Division	Erik Riera, Behavioral Health Director	Entity Description: Santa Cruz County mental health and substance use disorder safety net provider. Role in WPC: • Non-federal share funder • The WPC project "Cruz to Health Connect" will reside in the Behavioral Health Division of County Health Services Agency • Identification and referral of persons with co-occurring disorders of mental illness, chronic medical conditions such as diabetes mellitus, chronic obstructive pulmonary disorder, obesity, substance use disorders, multiple mental health crisis and/or acute psychiatric

Required Organizations	Organization Name	Contact Name and Title	Entity Description and Role in WPC
			hospitalization and are homeless or at risk of homelessness • Provider of WPC participants • Contract manager for WPC related services • Facilitates and staffs project governance and oversight structures
4. Public Agency/ Department	Santa Cruz County Human Services Department (Social Services)	Ellen Timberlake, Acting Director	Entity Description: Provides eligibility and enrollment into public benefits to help meet the basic needs of individuals and families, ensures the protection of children, elderly and dependent adults. Provides job service assistance and job training to assist job seekers to become self-sufficient. Role in WPC: • Perform eligibility and enrollment into public benefits such as Medi-Cal, CalFresh, and General Assistance • Provides requested outcome data to help support the project. • Participates in Governance Structure and Communication Process
5. Public Agency/ Department	Santa Cruz County Health Services Agency, Clinics Services Division	Amy Peeler, Chief of Clinic Services	Entity Description: Direct service provider as Federally Qualified Health Centers at four different sites throughout the County where primary care, specialty care and integrated behavioral health and dental services as well as housing supports are provided to serve low income and anyone who comes into contact with the centers. One of the clinics is located on the same campus with the Homeless Services Center (HSC) for Santa Cruz County and partnering with the HSC to provide medical services and case management services for its Recuperative Care Center Role in WPC: • Non-federal share funder • Provider of WPC participants who have co-occurring disorders of mental illness, substance use disorders, chronic medical conditions such as diabetes mellitus, chronic obstructive pulmonary disorder, obesity, substance use disorders, multiple

Required Organizations	Organization Name	Contact Name and Title	Entity Description and Role in WPC
			mental health crisis and/or acute psychiatric hospitalization and are homeless or at risk of homelessness. • Facilitates and staffs project governance and oversight structures
6. Public Agency/Department	Santa Cruz County Health Services Agency, Emergency Medical Services	Dr. David Ghillarducci, EMS Medical Director Brenda Brenner, EMS Administrator	Entity Description: Works with partners and providers to provide emergency response to residents of Santa Cruz County Role in WPC: • EMS will benefit from the shared data proposed in the WPC program • Participates in operations workgroups and care coordination meetings
7. Public Agency/ Department	Santa Cruz County, Probation Department	Fernando Giraldo, Probation Chief	Entity Description: An award-wining probation department and a nationwide leader in promoting public safety and productive lives for residents involved at all phases of the criminal justice system. The Department operates as an arm of the local court and is responsible for services required by the Adults and Juvenile Courts, including pretrial assessments, probation, post-trial alternative custody and juvenile detention. Also, is the lead for AB 109 planning, implementation and evaluation Role in WPC: • Refers eligible individuals to WPC program • Participates in care coordination with health care providers for WPC participants on probation • Data sharing • Participates in Operations Workgroup and care coordination meetings • Participates in Governance Structure and Communication Process
8. Safety-Net Hospital	Dominican Hospital	Nan Mickiewicz, M.D. Hospital President	Entity Description: A full service local non-profit hospital providing safety-net hospital services to Santa Cruz County residents Role in WPC:

Required Organizations	Organization Name	Contact Name and Title	Entity Description and Role in WPC
			• Provides emergency and inpatient services to the WPC participants. • Will be an integral part of data sharing, care coordination. • Participates in Governance Structure and Communication Process
9. Safety-Net Hospital	Watsonville Community Hospital	Audra Earle, Hospital CEO	Entity Description: A full service local non-profit hospital providing safety-net hospital services to Santa Cruz County residents Role in WPC: • Provides emergency and inpatient services to the WPC participants. • Will be an integral part of data sharing, care coordination. • Participates in Governance Structure and Communication Process
10. Community Partner	Housing Authority of Santa Cruz County	Jenny Panetta, Executive Director	Entity Description: Provides rental subsidies, manages and develops affordable housing for low income families, seniors and persons with disabilities in Santa Cruz County. Role in WPC: • Partner with the WPC providers to serve WPC participants. • Participates in Governance Structure and Communication Process • Supports the WPC's efforts to link existing housing resources for participants • Identify new housing resources over the course of the WPC project that can be offered to the participants Includes WPC project target population in landlord recruitment and engagement strategies
11. Community Partner	Health Improvement Partnership (HIP)	Elisa Orona, Executive Director	Entity Description: HIP Is a local coalition that brings together organizations involved in health care, all of whom support the mission of expanding access to health care services and improving health outcomes for Santa Cruz County residents. The HIP works with

Required Organizations	Organization Name	Contact Name and Title	Entity Description and Role in WPC
			various local non-profits serving homeless and Medi-Cal residents with housing and care coordination needs (Homeless services Center/Recuperative Care Center, 180/2020, Encompass, Janus of Santa Cruz, Front Street, Inc., Santa Cruz Community Health Centers, Salud Para La Gente, Parajo Valley Shelter Services, etc.). These non-profits are part of the provider network to serve WPC participants WPC Role • Participates in Governance Structure and Communication Process • HIP and the non-profits working with HIP to provide services to WPC participants will participate in Operations workgroups including care management meetings
12. Community Partner	National Alliance for on Mental Illness	Carol Williamson, President, Santa Cruz NAMI Chapter	Entity Description: Is the local chapter of the national mental health non-profit organization dedicated to building better lives for people affected by mental illness. NAMI works in the community to raise awareness and provide support and education that was not previously available to those in need. WPC Role: NAMI will provide family and peer support to WPC participants through family and peer support, engagement, care coordination, data sharing and care management meeting participation.
13. Community Partner	Santa Cruz Health Information Exchange	Bill Beighe, Executive Director	Entity Description: A local Health Information Exchange organization WPC Role: • On-boarding of new WPC participants such as cross sector service providers essential to addressing the underlying causes of poor health outcomes • Provides bi-directional interfaces for participants such as safety net hospital, clinics and behavioral health providers • Notifications and alerts for improved care management and coordination between

Required Organizations	Organization Name	Contact Name and Title	Entity Description and Role in WPC
			hospitals, primary care, behavioral health and social services • Provides care management data system to share care plans across participating organizations, care manager dashboards to track work lists and high priority participants, closed-loop referral management for enhanced transitions of care, event-driven, evidence-based workflows and alerts, simple drill-down pathways to individual participant longitudinal medical records in the HIE clinical data repository • Provides population health analytics and reporting services enabling • Provides dashboards for tracking the status and outcomes of WPC target populations and sub-populations relative to selected quality measures, provides comprehensive reporting capabilities for the WPC program, including custom reports and overlays with open source data as required, data quality improvement through assessment of gaps in data quality; tracking of problems to their sources, interactive implementation of operational, workflow, and technical remediation • Provides analytics and reporting for monitoring and proactively engaging the target population, such as a report refreshed daily showing all individuals discharged from participating hospitals within the past 30 days • Participates in Data and Operations Workgroup

1.3 Erik Riera may be contacted at (831) 454-4767 for access to the letters.

Section 2: General Information and Target Population

2.1 Geographic Area, Community and Target Population Needs

Community Description and Need:

Santa Cruz County has a total area of 607 square miles (1,570 km^2), of which 445 square miles (1,150 km^2) is land and 162 square miles (420 km^2) (27%) is water. As a mix of rural and urban, Santa Cruz is the second-smallest county in California by land area and third-smallest by total area. Of California's counties, only San Francisco is physically smaller.

Santa Cruz County has a population of 262,382 (2015 U.S. Census). The 2015 Santa Cruz County Homeless Census counted 1,964 homeless people in the county, with approximately 69% being unsheltered, 20% were staying in emergency shelter setting, and 21% was staying in a vehicle. The report states, "Unstable living conditions often lead to individuals falling in and out of homelessness. Almost 3 out of 4 homeless individuals reported they had experience homelessness previously and 56% reported they had been homeless for a year or more. Seventeen percent reported the main cause of homelessness as alcohol or drug use, 38% reported having psychiatric or emotional conditions and chronic health problems, 19% reported they were on probation or parole at the time of the homeless count and 32% reported they had spent a night in jail in the last 12 months.

County Behavioral Health staff served approximately 3,500 individuals with serious or persistent mental health disorders and 1,600 individuals with substance use disorders in FY 2015. In 2015, 23.1% of residents were with income below the 200% Federal Poverty Level and 7.4% reported having serious psychological distress during the past year (CHIS 2015).

Santa Cruz County has a long standing challenge of limited affordable housing for the general population, but the issue is exacerbated for individuals with psychiatric disabilities that depend on a social security income of $890 to $1145 (determined according to work history). Current fair market rent for a one bedroom unit for a single adult is $1500 per month in Santa Cruz County. Individuals with co-occurring medical conditions disproportionately remain in locked Institute for Mental Diseases or Mental Health Rehabilitation Centers or Board and Care facilities due to the need for monitoring of mental health and other chronic health conditions.

In addition, individuals with severe mental illness have been shown to have a 25-year shorter life span than the general population. Untreated or undertreated life threatening chronic health conditions such as diabetes, COPD, obesity and hypertension have a direct impact on life expectancy. Individuals who have history of involvement in the criminal justice system have significant physical and behavioral health needs and often lack access to health care and cycle in and out of the criminal justice system, emergency departments and hospitalization.

Project Background and Scope:

Santa Cruz County is seeking to combine several approaches to support individuals with serious, mild or moderate mental illness, homeless or at risk of homelessness and those who might or might not be involved in the criminal justice system (post release from incarceration) to live in the least restrictive setting in the community utilizing a model based on evidence-based housing programs, combined with enhanced support for co-occurring health conditions.

To address the needs of our population we have incorporated four key components in the model:

1. Creating an overarching multidisciplinary team which will include mental health clinicians, primary care clinicians, an occupational therapist, nursing staff, medical assistants, housing outreach/coordinator/navigators, and case managers.
2. Utilizing the Permanent Supported Housing model for participants with co-occurring mental health and health conditions. The housing support team would include in person home-based nursing, case management staff, mental health providers, housing outreach and navigators.
3. Creating an integrated health model that would allow home-based Remote Access Monitoring and care for participants with co-occurring health conditions such as diabetes, obesity, hypertension and Chronic Obstructive Pulmonary Disease (COPD). By providing an electronic Remote Access Monitor devices in the home, the participant could monitor specific psychiatric and other health conditions, linked to a confidential and HIPAA compliant web-based program to communicate with nursing staff monitoring the information from the Remote Access Monitoring device.
4. Including family members and peers trained in Intentional Peer Support (IPS) to provide independent living skills building and support, social engagement and modeling for community integration to the participants living in their homes. The peers will assist with building of natural supports while supporting participants' efforts to recover from co-occurring mental health and health conditions.

The multidisciplinary team will engage in intensive collaboration and communication for project implementation, care coordination and data exchange, and evaluation of the project. Fluid and in-time data exchange among all providers including housing providers will be critical to ensuring the project is successful and sustainable.

A core goal of the proposed program is to reduce avoidable utilization of emergency department, ambulance, and inpatient stays. This goal matches some wider community-wide efforts with such stakeholders as the local hospitals, Medicaid managed care provider, and other safety net clinics working to provide wrap around services. This proposed program will serve to build and strengthen existing efforts in the community as well as providing the resources to improve collaboration across a variety of community resources. Our current engagement and leadership with communitywide projects provide opportunities to share learnings and locally grown potential best practices for future local projects beyond this pilot.

The Community Planning Process:

In the last 15 months, Santa Cruz County Health Services Agency has engaged in a series of community meetings to review our Mental Health Strategic Plan, Public Health Accreditation process and Substance Use Disorders Strategic Plan. Announcements of these meetings were disseminated to all community stakeholders, as well as posted in three local newspapers. Notes from these meetings were kept and most were posted on the County Health Services Agency website. Numerous focus groups included: families, older adults, veterans/veteran advocates, LGBTQ youth, monolingual Spanish speakers, and transition age youth. In addition, the Santa Cruz County Sheriff and the Behavioral Health Court Judge were interviewed as key informants.

Since the release of the Round 2 application in January 2017 for Whole Person Care from DHCS, Santa Cruz has organized and facilitated multiple convening conversations among local interested stakeholders to explore feasibility and plan for program concept and design which has led to a successful completion and submission of the Cruz To Health Connect project application.

Planning with participating entities: Core participants include the County Health Services Agency Leadership Team, Santa Cruz Health Information Exchange Executive Team (comprised of all local hospital

presidents/CEOs, all local non-profit FQHC executive directors, local medical foundation CEOs and medical staff, County Health Services Agency director), local coalition Santa Cruz Health Improvement Partnership who has been the lead in convening discussions and planning with interested non-profit agencies for WPC project.

2.2 Communication Plan

The governance and communication plan for the Project lays the foundation for a collaborative approach to decision making that supports effective project implementation and sustainability and creates an infrastructure that can support communications about the populations across the delivery systems beyond this pilot program.

County Health Services Agency (HSA) will have responsibility and authority for the project and will be the main point of contact for other participating entities.

Central to the success of the program is our project's collaboration with the Santa Cruz County's only Managed Medi-Cal Plan, Central California Alliance for Health (CCAH). HSA's long standing partnership and current coordination on a variety of other projects have set a solid foundation for the work in this initiative. HSA's Director, Giang Nguyen, serves on the CCAH Board of Director's Executive Committee. CCAH will participate in all aspects of the governance structure and communication systems including routine care coordination meetings. In addition, they will assist in the development, implementation, evaluation and sustainability plan. The project relies on CCAH to provide data necessary for the identification of the target population, project implementation, and operation.

Planning and Governance: An infrastructure consisting of an Advisory Council (AC) and Management Committee (MC) will implement decision making and communication strategies to promote integration and minimize silos. Key representatives from partner organizations will meet monthly through Year 2 and then at least quarterly thereafter. Chaired by HSA Behavioral Health and co-chaired by HSA Clinics Division, the AC will be responsible for: further defining and formalizing the shared vision for the project (assessing partner capabilities, infrastructure and system gaps); identifying and resolving challenges that can hinder progress; ensuring that project learnings are captured and articulated; and identifying strategies for long-term sustainability. The County HSA Behavioral Health and Clinic Divisions will work with the AC group (when conflict of interest is not present) in the procurement process to select contractors to deliver project services and to ensure that state requirements are clearly articulated and addressed.

A separate MC will be comprised of individuals responsible for implementation of the vision and plan developed by the AC, and will include representation from each of the key partnering entities. This group will meet at least monthly beginning in the first year of implementation. Separate working groups of the MC will be established to make decisions and communicate around specific project elements such as Clinical Review, Operations including Fiscal/Budget and Data Workgroups.

HSA will convene regularly scheduled monthly meetings of partner representatives to manage the project's operational integrity, problem-solve issues that may arise, share ideas, make collaborative decisions after partners have been consulted and provided feedback, and participate in Plan Do Study Act (PDSA) cycles and evaluation activities toward milestone achievements. The MC will be responsible for generating mid-year and annual reports to be submitted to DHCS.

Transparency and excellent external communication are a focus of the pilot's communication strategy. Information about the project will be disseminated broadly via web postings and updates, press releases and

interviews with local print, radio and television media. Summaries about participation outcomes will be shared with service networks and partner organizations and will leverage the communication infrastructure offered by the Santa Cruz Health Improvement Partnership. At the project level, the Operations and Data Workgroups sharing mechanisms will serve to reduce silos and enhance communication.

2.3 Target Population

Program participants will be up to 1000 adult consumers for the duration of the project. The target population will be comprised of Medi-Cal beneficiaries with the following characteristics: It is anticipated that each year this pilot will see approximately 125 new unduplicated clients for a target of unduplicated clients of 625 over the life of the project.

- Repeated incidents of avoidable emergency use, hospital admissions, or nursing facility placement; and/or
- Two or more chronic conditions; and/or
- Mental Health and/or substance use disorders; and/or
- Currently experiencing homelessness; and/or
- Are at risk of homelessness and require intensive housing supports to live in the community due to their mental illness, substance use disorder and co-occurring health condition; and/or
- Post Incarceration and could include probation or parole status

All participants will have a coordinated and consistent health care team provided by a nationally recognized Patient-Centered Medical Home in an integrated clinic where mental health, substance use disorder, dental, primary and specialty care services as well as housing support services are provided. The proposed program will provide permanent supported housing and an alternative option to more restrictive placements such as locked care and/or board and care. These coordinated services will be provided across the five-year timeline and those participants who drop out for any reason will be replaced with other participants who meet the criteria.

An estimated 16,000 patients of various payer sources are seen in our clinics each year. Of those approximately 71%, or 11,400 have Medi-Cal.

Up to 250 participants covered by Medi-Cal will be served each year, except for PY1. An estimated 50% will be unduplicated each year with a maximum amount of 1000 unduplicated participants by the end of the project.

Estimates broken down by annual target populations (duplication anticipated):

Target Populations	# of Patients served within Target Population (up to)
Repeated incidents of avoidable emergency use, hospital admissions, or nursing facility placement	50
Two or more chronic conditions	130

Target Populations	# of Patients served within Target Population (up to)
Mental health and/or substance use disorders	560
Homeless	60
At risk of homelessness and require intensive housing supports	200

We anticipate that participants will fall into multiple target population groups. The above chart shows that we expect at least 50 of our total participants to be high utilizers of the emergency department, hospital in patient and/or nursing facilities. Up to 130 will have two or more chronic conditions and 560 will have mental health and/or substance use disorders. At least 260 will be homeless or at risk for homelessness.

Currently, Santa Cruz County has identified at least 60% of the PY2 250 capacity that are in other programs that are not meeting the needs of these clients with partial services. We are expecting to be at nearly 100% capacity within 90 days of launch. The WPC pilot will allow services based on their needs to those clients therefore free up the other services that other participants can utilize based on needs and services of other programs. This will prevent duplication of services and better match client and service needs.

The following chart shows how we estimate this population to be stratified over the project years.

Total unduplicated Medi-Cal beneficiaries served considering overlap = up to 1000

Total unduplicated Medi-Cal beneficiaries served by year and target population (all beneficiaries will have a mental health and/or substance abuse disorder).

Target Populations	PY 1	PY 2	PY 3	PY 4	PY 5	Total
Repeated Incidents of avoidable emergency use, hospital admissions, or nursing facility placement	0	12	12	12	14	50
Two or more chronic conditions	0	33	33	33	31	130
Mental health and/or substance use disorders	0	140	140	140	140	560
Homeless	0	15	15	15	15	60
At risk of homelessness and require intensive housing supports	0	50	50	50	50	200
Totals	0	250	250	250	250	1000

Definition/Methodology:

Santa Cruz analyzed the results from a few different methodologies to estimate a population of approximately 500-1,000 individuals who would meet qualifying criteria as "high utilizers" and "high cost". Given challenges related to documenting living situations, it is recognized that the prevalence of individuals experiencing homelessness in the analyses was underestimated.

1. Client identifiable data from the County's Specialty Behavioral Health Services database (Avatar) were merged with the County's Federally Qualified Health Centers database (Epic) that included information on housing status. This analysis identified at least 800 unique adult individuals currently served in the County system whether directly or through contracted providers who were Medi-Cal beneficiaries, had a substance use disorder and/or serious mental illness, and were reported as homeless and not having permanent housing in 2015.

2. The complete claims database from the Santa Cruz Low Income Health Program (LIHP), which the County of Santa Cruz Health Services Agency operated and therefore had available, was analyzed for calendar year 2013. During the year, at the peak of the program, the total cumulative unduplicated enrollees was 2,441, of whom 30% stated they were facing homelessness or at risk of homelessness and at least two-thirds reported having experiences of emotional and psychiatric conditions. During this year, at the peak of emergency room usage, nearly 19% of the clients accessed emergency room services and 9% received inpatient services in hospitals. These clients were treated in the LIHP, some with multiple chronic conditions. The highest prevalence diseases were Hypertension (15.4%), Diabetes (10%), Dyslipidemia (10.9%), Asthma/Chronic Obstructive Pulmonary Disease (COPD) (5.4%) and Cardiac diseases (3.5%).
3. The high-utilizers and high-cost individuals will be identified as:

    a. Having four or more admissions into crisis and acute psychiatric hospitalizations in 12 months/prior year, and/or
    b. Two or more medical hospital admissions within prior 6 months, and/or
    c. Have been in institutional care such as jail, psychiatric inpatient facility, or other locked facility, and/or
    d. Having five or more actively prescribed medications from the following categories: antidepressants, antipsychotics, mood stabilizers, diabetes medications, antihypertensives, cholesterol lowering medications, inhaled corticosteroids and bronchodilators.

Plan for Identification

1. County Behavioral Health and Clinics query their database systems to identify existing adult clients ages 18 and older, Medi-Cal recipients assigned to the County of Santa Cruz who:

    a. Had four or more admissions into crisis and acute psychiatric hospitalizations in 12 months/prior year and/or,
    b. Had two or more hospital admissions within prior 6 months and/or,
    c. Have been in a locked institutions or skilled nursing facility for mental illness and/or,
    d. Having two or more chronic conditions with the following five or more medications that are actively prescribed from the following categories that represent high cost chronic conditions: antidepressants, antipsychotics, mood stabilizers, diabetes medications, antihypertensives, cholesterol lowering medications, inhaled corticosteroids and bronchodilators, seizure medications and anticoagulants and/or,

e. In the recent past (12 months) or currently living in an institutional setting such as Institutes for Mental Disease, Mental Health Rehabilitation Centers, Skilled Nursing facility, or Incarcerated.

The list of clients will then be used to check with the County Human Services Department to confirm Medi-Cal eligibility status.

2. The above data will then be merged with Homeless Management Information System (HMIS) system to identify individuals who are currently homeless or have recently accessed homeless services. The County Homeless Persons Health Project (HPHP) program is the service provider co-located with the Santa Cruz Homeless Services Center and the Recuperative Care Center. The HPHP program has access to homeless and client databases.

3. The County plans to locate and enroll adults who are currently experiencing homelessness using the Electronic Health Records for Clinics and Behavioral Health that have identified homeless participants for the proposed projects. These individuals will be cross matched with health data to ensure they meet all the proposed criteria for admission into the program. In addition, we will be receiving referrals from community programs participating in the proposed project for new individuals who may not yet be connected for services, and they will be screened for housing status as well, and the county will work with those individuals to obtain housing as rapidly as possible utilizing a Housing First model. As the County's Homeless Person's Health Project (HPHP) will be a key provider of these services, they will additionally serve as a referral source as the HPHP is co-located with the County's Homeless Services Center. The County participates in the Statewide Homeless Continuum of Care, and the Homeless Management Information System will also provide data on identifying individuals in need of services who are homeless.

Enrollment Cap

Based on our projection we do anticipate the need to establish an enrollment cap of up to 250 participants per year for the clinical PMPM bundle and 125 per year for the Behavioral Health PMPM Bundle. This enrollment cap may be modified depending on cost savings or underutilization identified in the programs that will allow us to add more participants. Once an enrollment cap is established potential participants will be put on a wait list in order identified, and will be added to the program once a slot opens. In all situations when an enrollment cap is identified we will work with community partners to identify alternative services.

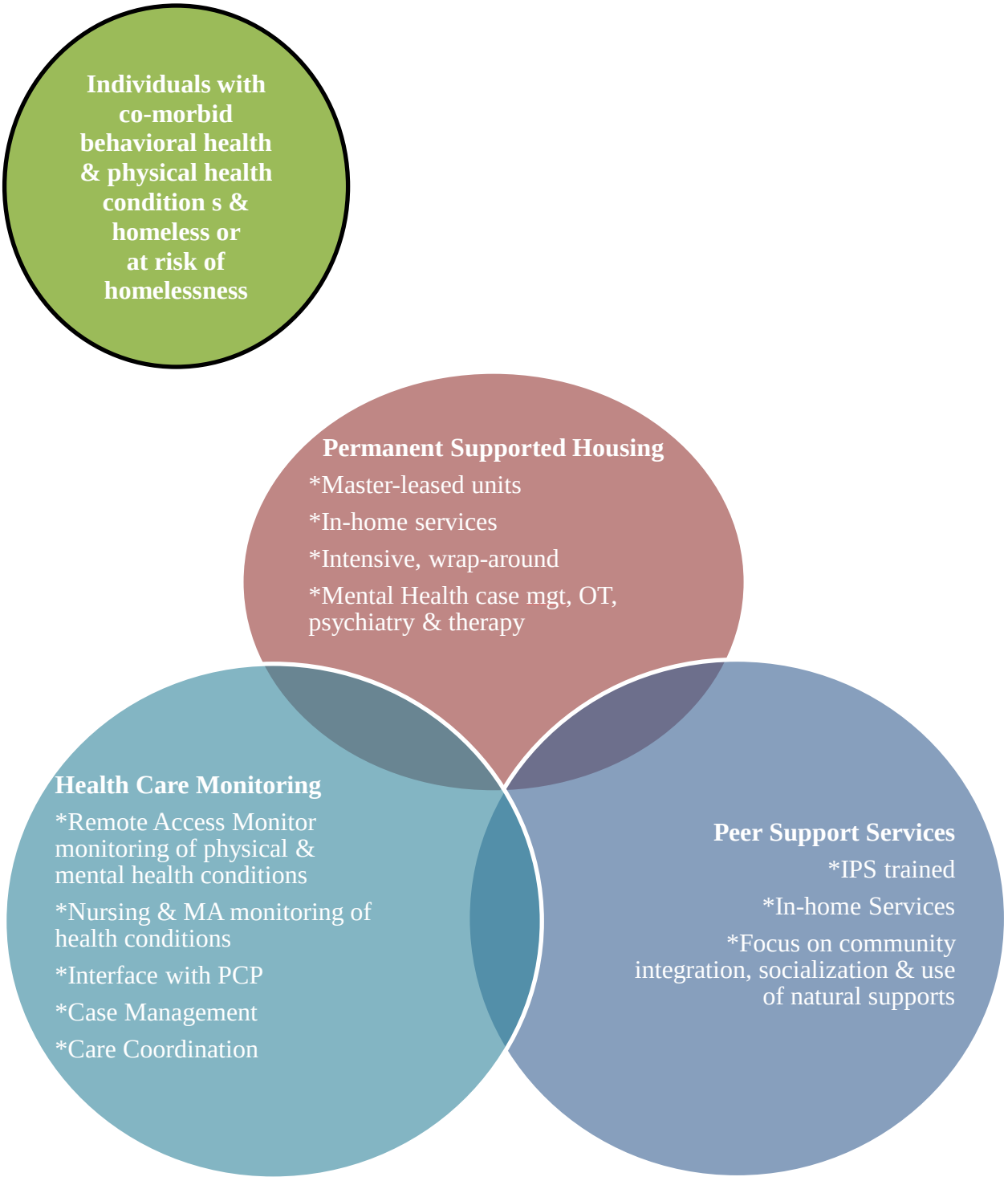
Section 3: Services, Interventions, Care Coordination, and Data Sharing

3.1 Services, Interventions, and Care Coordination

Description of Services to be provided (Not Covered or Reimbursed by Medi-Cal):

The Cruz To Health Connect Project will provide the following primary services: permanent and other supported housing, behavioral health and physical health care treatment and Remote Access Monitoring, and family/peer support services to the one target population described in Section 2.3. These services are not covered by Medi-Cal provider as FQHC requires in person face to face with a physician or nurse practitioner. Monitoring will be completed by nursing staff with general oversight by a physician.

The diagram below depicts the comprehensive and intensive services which include evidence-based practices and are not covered or reimbursed by Medi-Cal to wrap around the target population. See Section 5.4 (Non-Duplication of Payments and Allowable Use of FFP).



The Cruz To Health Connect Project's multidisciplinary team will consist of staff who will support the individualized behavioral health, other health, and recovery goals for the program participant, utilizing case management interventions, care coordination, Cognitive Behavioral Therapy, Dialectical Behavior Therapy and Motivational Interviewing, Medications and other healthcare supports including health education and health promotion activities, and a new Evidence Practice being adopted in the County called Illness Management and Recovery (IMR). The Occupational Therapist will work with participants to develop functional skills (household

care, budgeting, shopping, cooking, transportation services, life skills education, and groups supporting healthy choices for healthy living, and include medical and social services appointment management) for independent living.
Nursing staff will provide home-based medication compliance and educational support, tailored for each client based on education level health and behavioral health, with focus on health promotion. This service will be provided by RN staff as supportive education and guidance, as this is not done by a licensed provider and not ordered by a medical provider it is not a Medi-Cal billable service Nursing staff will also provide the monitoring of the Remote Access Monitor device, linkages to medical appointments, linkages to psychiatric appointments and provide continuity of care across the domains. The Medical Assistant will work with the Psychiatrist, Primary Care Physician and program participants to coordinate primary care services and provide support to the treatment team and family members. They will act as a primary point of contract for the Physician to utilize to coordinate work around the participant's primary health needs. These services are provides by nursing clinical staff and not a billable Medi-Cal service as they are service oriented and do not meet FQHC requirements for provider level services.

Family members in the community and potentially a member of the multidisciplinary team will be supported through training in a program specially designed for family members in the Evidence Based Practice Cognitive Behavioral Therapy for Psychosis (CBT-P) to provide early identification of issues needing the attention of the treatment team, and tailored supports to the participant from the family member. Family members will also provide a linkage to other supports available through the local NAMI Chapter. Housing outreach/coordinators/navigators will provide intensive outreach, education, transportation, facilitate linkage and referrals and support to participants. Housing service providers will support participants to successfully maintain tenancy once housing is secured by providing education and training to participants and landlords on responsibilities, rights and role of tenants and landlords. The assigned housing coordinator will provide coaching to the participant on how to maintain good working relationships with landlords, assist in resolving any disputes that arise between landlord and participants, and be hands on as needed to maintain tenancy. The housing coordinator will maintain an active relationship with the Connect participants' case manager (probation case manager also, if the participants are involved or at risk to be involved with the Probation Department).

The proposed program also adds Case Managers to the County's Integrated Behavioral Health Program (IBH). The IBH program provides services to individuals who have a mild to moderate mental illness, and/or substance use disorders, as well as other health conditions served by the County operated Federally Qualified Healthcare Clinic (FQHC) who are not eligible for case management services through the Specialty Medi-Cal mental health plan. The IBH program is the largest and most comprehensive IBH program in the County with continued growing demand for services from an increasingly complex population. Although individuals served in this program most often are housed in the community, they nevertheless have complex social and behavioral health needs, but cannot access the critical case management and care coordination services that are needed to support their recovery in the community, and management of their complex health conditions. The case managers will assist IBH clients in referral, linkage and monitoring for supports and services that the individual is receiving. This group of individuals will also be served by the Whole Person Care program and have access to case management services, individual and group therapy services, psychiatry services, and primary care services. Dependent on the complexity and management of their other health conditions, they may also have access to the Remote Access Monitoring system, if they have the demonstrated criteria and have not effectively managed these conditions.

The multidisciplinary team will work very closely with the participants Psychiatrist and Primary Care Physician who will also be participating as members of the treatment team.

The County Health Services Agency has physicians and nurse practitioners on call after hours and on the weekends to respond to patient calls. Those staff will have the ability to log into both the participants Electronic Health Record as well as the secure web portal that contains the health data from the Remote Access Monitoring devices. For participants in a psychiatric crisis, they can be seen at the County designated 5150 Crisis Stabilization Program 24 hours a day, 7 days per week. Participants needing immediate medical attention will be seen at one of the participating safety net hospitals- Dominican or Watsonville Hospital. These options will be reviewed with the program participant prior to enrollment in the program and during their services. In addition, for those participants who have a Remote Access Monitoring device in their home, the device can be programmed to provide emergency instructions to the user to call 911 if they are experiencing a medical emergency or contact the 24-hour crisis line if they need to speak with a mental health clinician.

Finally, the use of Peer Support staff is integral to stabilizing the participant in the housing environment. Peers will provide monitoring of the participant's progress, assistance with community integration and community engagement, modeling for successful management of psychiatric symptoms and linkages to natural supports. Peer Support staff will be trained in the Evidence Based Intentional Peer Support (IPS) model as well as training in health navigator functions through our local health plan and other trainings available online.

All the service providers will participate in coordinated care services with mental health and medical staff to understand the complexities of the mental health and physical health conditions experienced by the participants. Training will be provided to all involved service providers in various psychiatric and physical health conditions, inclusive of understanding symptoms, medication management needs and interventions. Part of this model is an after-hours on-call crisis response system for psychiatric emergencies. Health emergencies after hours will be handled through urgent care sites and the Emergency Medical Services system and are first screened through our on-call providers.

Residential units ongoing rents will be master-leased by contract partner(s) and funded through other local funding, and each unit will be equipped with an automated Remote Access Monitor following County procurement, and potentially other devices such as automated medication dispensing devices and wrist fall monitoring devices that will support the goals and objectives of the project.

Housing navigation and housing searches are not currently a reimbursable service, despite the need and success in having these services provided to the individuals. For WPC participants, funding will be utilized to support these non-reimbursable services to ensure that homeless participants are provided the maximum opportunity to locate and secure safe housing in the community as part of their overall recovery plan.

The multidisciplinary team through the program will provide intensive monitoring and supports to all individuals in their place of residence to ensure community tenure and stability of housing. The different skill sets of members of the team will provide targeted interventions to the individuals in their homes based on need. For example, nursing staff will assist the individuals with health education and use of the Remote Access Monitor devices, as well as case coordination to support health interventions to support the effective addressing of their health conditions.

The peer staff will work with the individuals in their homes to reduce barriers to engagement and accessing services using an evidence based Intentional Peer Support model. Peers will also be trained in the evidence based practice of Illness Management and Recovery, and support IMR skill building activities in the client's residence. Case Management staff will work with the individual in the home and the office to ensure a comprehensive approach to referral, linkage and monitoring of services, and psychiatry and therapy services

will be offered in the office and supported in the home as needed based on the individuals needs identified in the coordinated service plan.

The Remote Access Monitor- monitoring device is capable of monitoring and providing patient education of multiple conditions such as hypertension, Chronic Obstructive Pulmonary Disease (COPD), Congestive Heart Failure (CHF) and diabetes, as well as prompting the participant around education and reminders for medication adherence. The device provides prompts to the participants both visually and by sound to check key health indicators and then provides confidential reports to the nursing staff to monitor. The nurse will be able to respond promptly to indicators such as high blood pressure or blood sugar that might otherwise go unchecked between medical appointments and is not a Medi-Cal billable service. This Remote Access Monitor monitoring device will be key to stability for these participants living independently in the community. These Remote Access Monitoring Devices report data from various input peripherals, report real time data, allows nursing clinical staff to provide daily feedback, help with medication dosing reminders, appointment reminders, patient education that is client specific i.e. medication compliance and effects, health and diagnosis, and program updates. These are services that are needed and not covered as Medi-Cal covered services as FQHC require face to face interactions with a licensed physician or nurse practitioner. Program participants will be individuals connected to services through the County Health Services Agency and/or its contracted providers. The Remote Access Monitors will be ready for immediate dispatch and used as an adjunct to the FQHC structure for data sharing of clinical information without needing to meet the medical justification requirements needed to warrant other telehealth devices. This allows nursing clinical staff the maximum flexibility of services to clients that may use a devices on an as needed basis without a delay of interface to be seen in the FQHC clinic, process through the medical justification for devices, appeals process, ordering delays, access into the clinics, etc. Medical does not cover data transmission or reviewing of data results.

The focus on the use of Remote Access Monitoring stems from research demonstrating that individuals with Severe Mental Illness (SMI) have a higher prevalence rate for many chronic health conditions leading to a 25-year shorter lifespan than the general population. The Remote Access Monitor devices will allow for closer monitoring of these conditions, the participants response to treatment, and incorporate that data into the health record for the treatment team to respond for services not covered by Medi-Cal.

*Risk Factors	Schizophrenia	Bipolar Disorder
Obesity	45-55% prevalence, 1.5 -2X relative risk	26% prevalence
Diabetes	50-80% prevalence, 2-3X relative risk	10% prevalence
Hypertension	18% and over prevalence	15% prevalence

*Bartels, S. (December 20, 2013) Closing the Gap: Implementing Evidence Based Behavioral Health Practices for Older American's., Geisel School of Medicine at Dartmouth Medical School

The proposed Remote Access Monitor devices are HIPAA compliant tablet devices that have health monitoring peripherals connected via Bluetooth technology and record a program participant's vitals and transmit that data to a secure web based portal that the nurse will log into, in order to track health data and determine if the participant needs a recheck or in person follow-up appointment. The peripherals included with the Remote Access Monitor -monitoring system include a scale, blood pressure cuff, and can also include a glucometer and pulse oximeter that are not a billable Medi-Cal service with or without FQCH requirements

The Remote Access Monitor device prompts the participant to take their health readings, and can also be programmed to ask health and mental health related questions, for example, “On a scale of 1 to 5, how did you sleep last night? With 5 being restful sleep more than 6 hours, and 1 being you could not sleep.” The Remote Access Monitor devices also have the capacity to deliver short health promotion videos such as the importance of taking a diuretic for the control of Congestive Heart Failure (CHF) and/or the importance of eating nutritious foods and exercise for the management of diabetes.

The data collected allows for abnormal readings to be quickly flagged and responded to by the treatment team. Many of the products on the market also support a real-time videoconferencing option with the participants, at the request of the participant or treatment provider, this functionality will be explored. During the implementation phase, all videoconferencing calls will be coordinated through the primary care nurse and medical assistant with the individual participant. Data collected is also transmitted to the participants Electronic Health Record and that interface will be developed as part of this project and is not a Medic-Cal billable service.

If a participant has a condition that triggers the Remote Access Monitor (i.e. glucose levels), the nursing staff and medical assistants assigned to these participants will log into a secure web portal and review the participant’s data daily. The web portal will flag any results that are above or below a range programmed for the participation. In addition, the device will prompt the participant for a retest of abnormal results, again based on pre-programmed parameters for the participant. The participant will be instructed via instructions on the device how to contact the on-call physician should a result be in a range that requires immediate medical consultation or calling 911. Those instructions and prompts will be programmed into the Remote Access Monitor devices and reinforced with the participant. Two of the vendors being considered for this product offer devices that can provide a videoconference with the participant- in real time or via a scheduling request.

The Remote Access Monitor devices will be connected to a secure web portal, which clinical staff will log into to verify that the participants have been submitting data and that the data is within the ranges to be expected for that participant. These ranges can be customized based on the specific needs and targets for the participant.

The data from the portal will be transmitted to the two electronic health records utilized by the County: EPIC for the health clinic, and Avatar for the behavioral health services. The County recently adopted Avatar as the sole EHR for all mental health and substance use disorder services for adults with SMI, and children with serious emotional disturbance. All provider organizations can access the client record which supports more effective care coordination and support of the individual in the community. The County is proposing an interface through this project to allow for health and behavioral health data to be transmitted back and forth between the County behavioral health EHR and the Clinics EHR through the Health Information Exchange. This information exchange and review is not a Medical billable service.

Based on the current research, the County anticipates that more careful monitoring of the participant’s mental health and other health conditions, will support better health and mental health outcomes as well as improved community tenure.

As a key component to the integrated and person centered service plan development with the program participant, the multidisciplinary team will work closely with the program participant to identify how long the Remote Access Monitor devices will be in place in their home, and develop key metrics based on the participant, to determine when their condition is stable enough to be able to remove the device and allow the participant to do self-monitoring without the device present. This will be based on the following factors:

1. The stability of the health outcomes being monitored, how close the participant is to achieving the established goals, or in the event that they have achieved the established goal, the length of time they have been stable at that goal level.

2. Input from the participant on the effectiveness and ongoing need of the Remote Access Monitor monitoring device in supporting their positive health outcomes and stability in the community.

3. The frequency of data reporting from the participant-specifically are they not meeting the established benchmarks of at least 75% for a period greater than 30-days and have they not been responsive to coaching in this area.

4. Does the participant refuse to participate in the Remote Access Monitor monitoring or requests the device to be removed and is not responsive to coaching from the team?

It is likely the case with many of the program participants that this could take several years, or for some, the Remote Access Monitor devices may stay in their homes for the duration of the project. If, however, the participant achieves a period of stability that is defined in their treatment plan, then the team will discuss the removal of the Remote Access Monitor monitoring device with the program participant. If the participant requests to have the device remain, for example if they feel it has been a critical component to supporting their positive health and mental health outcomes, then the team will support the device remaining in the participant's residence.

This target population for this WPC pilot are individuals with mild to severe mental illness, co-occurring substance use disorder, and medical condition such as diabetes and/or high blood pressure, or a combination. Most of the clients have been diagnosed with severe mental illness (SMI) and/or substance use disorder will have their services centered within the specialty mental health programs of the County, those consumers with a mild to moderate mental health condition and/or substance use disorder, will have their services centered in the Integrated Behavioral Health Program. All program participants will have primary care services provided by the County operated Federally Qualified Health Center (FQHC).

This target population have chronic conditions that are related and interconnected with their lack of ability to establish and/or maintain housing. Santa Cruz County assists with a master-lease by a contract provider. Independently rented units, or family-owned or rented unit on behalf of their consumer family member may participate to obtain the Supported Housing component. Housing costs will be co-funded by MHSA funding and the utilization of Housing Authority Section 8, Housing Authority Shelter Plus Care vouchers or Housing and Urban Development (HUD) Veterans Affairs Supported Housing (VASH) vouchers for veterans.

In addition to traditional funding supports through HUD, such as Section 8, Shelter Plus Care and HUD VASH vouchers, each participant will receive a comprehensive needs assessment inclusive of mental health needs, medical issues and challenges, functional assessment by an Occupational Therapist and a social integration assessment. A comprehensive treatment and care plan will be developed to address the needs for each domain.

Why Services are Well-Suited to Meet the Needs of Target Population

The Cruz to Health model proposed for Santa Cruz County's WPC initiative takes an Evidence-Based Practice model of Permanent Supported Housing and enhances the model with two key elements, intensive health care needs monitoring using the use of Remote Access Monitor home monitoring devices, and peer support

services. The integration of peers into a supported housing services with expertise in Intentional Peer Support, a promising practice model, allows for a trauma-informed service delivery paradigm that focuses on building community-oriented supports, and works toward mobilizing participants to look at alternatives to "treatment as usual" in a traditional system. In addition, peers and family members, who are also a critical component to the multidisciplinary team, can engage and outreach program participants in a very different manner than a traditional clinician. Some of the individuals proposed to be served by the project will be individuals who have traditionally been difficult to engage in health and behavioral health services. The peer and family component of the team will be used to engage these individuals and their family members, who are central to the success of the project, but often not focused on enough as a key partner for the team.

The County anticipates success with this project based on the research that has been done with similar projects across the country, although not to the expansive degree the County is proposing with this project by combining Remote Access Monitor, with coordinated behavioral health and primary care, supported housing inclusive of a peer and family partner approach on a multidisciplinary team, and partnership with a large network of social service providers in the community.

The success of mobile technology aids for home health management has been highly successful in reducing medical hospitalizations nationwide. In an article in "Modern Healthcare" by Joseph Conn in January 2014, the utilization of home-health monitoring within the Veterans Administration was reviewed. According to the article, a study by the VA in 2008 of more than 144,000 veterans participated in electronic home-health monitoring in fiscal year 2013. The results demonstrated a 19% reduction in readmissions and a 25% reduction in bed days. In addition, the School of Medicine from Dartmouth College studied the use of a remote telemedicine disease management device by 100 individuals with serious mental illness and a co-occurring health condition such as COPD, diabetes and hypertension. The results demonstrated a sharp reduction in fasting glucose level. Initially 63% of the individuals had a fasting glucose of over 130. After six months of using the Remote Access Monitor device, 2/3 of the individuals had a fasting glucose less than 120. Also, both routine and urgent medical visits for individuals with diabetes dropped due to the stability of the patients. The consistent element in these outcomes was the use of the Remote Access Monitor device in the home and the linkage to the nursing staff to monitor the reports for areas of concern, followed by prompt intervention.

Isolation in the community and significant health conditions frequently lead to the decompensation of psychiatric symptoms in the community. Providing a proactive approach to address both concerns and complimented with a full range of mental health services, we are confident this model will allow participants to live independently in the community.

3.2 Data Sharing

Santa Cruz County has robust data sharing today through the Santa Cruz Health Information Exchange (SCHIE). SCHIE is a sustainable organization supported by the annual fees paid by its members with a long-term time horizon for meeting its members evolving data sharing needs beyond the term of the WPC pilot. SCHIE is governed by a Board of Directors comprised by senior leadership from each of the founding member organizations. With this level of executive engagement and oversight, SCHIE is well positioned to meet community needs and foster collaboration across organizations. The cost of the format, data, services, integration and support have an annual cost of $400,000 per year and will be prorated for PY2. This access of data is to encourage sharing data across various agencies and departments for better case management of the chronic conditions as described in the target population on page 12 and the detailed characteristics on page 15. There is not an additional computer module, software, or other program to purchase or lease.

Priority real-time interfaces for provider organizations are ADT (demographics, encounters, diagnoses, allergies, and problems), ORU (lab results), RDE (medications), and VXU (immunizations). The Central Coast Alliance for Health, which serves as the local Medi-Cal health plan, submits eligibility and pharmacy claims files through a file upload process on a weekly or monthly basis. The local health plan is a key partner in the WPC project, and will provide the initial baseline data to identify participants in the WPC project, and ongoing health data for those participants to establish the metrics needed for the determination of health-related outcomes scores for each of the participants. As a key partner, the local health plan will also play a key role in the governance of the project, and in providing technical assistance in promoting best practice models to achieve the health outcomes proposed for the project.

Santa Cruz County and its participating WPC partners and contractors will use SCHIE services for the treatment, care management, coordination and monitoring of specific at-risk populations to include: Adult Medi-Cal beneficiaries with a mental health and/or substance use disorder, or at risk of homelessness upon discharge from participating WPC partners, or otherwise targeted for interventions by Santa Cruz County programs.

Existing SCHIE services supporting, coordinating, and benefiting the WPC pilot to address the needs of this population are:

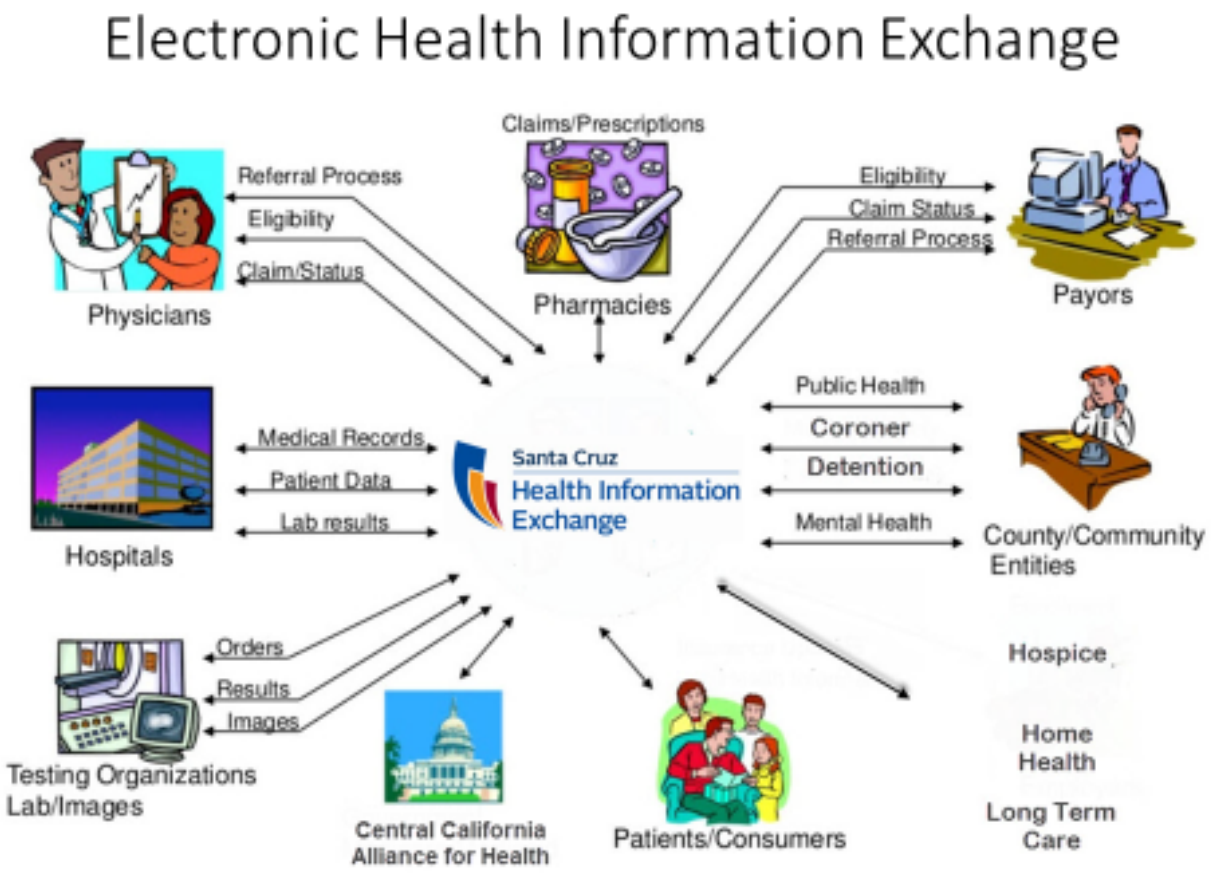
- Data sharing for improved clinical treatment via access to an HIE portal with community- level longitudinal health information on participating WPC individuals;
- Notifications and alerts for improved care management and coordination between hospitals, primary care, behavioral health, and social services;
- Directly aide WPC clients with coordination of care, improved outcomes, and sustainability of the improved outcomes;
- Integration of clinical and claims information to fill gaps in information (e.g. medications claims inform clinicians on which prescriptions have been filled), key data will be provided by the Central California Alliance for Health;
- Analytics and reporting for monitoring and proactively engaging the target population, such as a report refreshed daily showing all individuals discharged from participating hospitals within the past 30 days;
- Identity and consent-management services;
- HIE Patient Portal.

Additional participants will be on-boarded in years 2-3 of the WPC pilot, and additional services to be developed by SCHIE for all WPC pilot participants are:

- On-boarding of new WPC participants such as cross sector service providers essential to addressing the underlying causes of poor health outcomes;
- Provide bi-directional interfaces for participants such as safety net hospital, clinics, the local health plan – the Central California Alliance for Health and behavioral health providers;
- Notifications and alerts for improved care management and coordination between hospitals, primary care, the local health plan, behavioral health and social services;
- Provide care management data system to share care plans across participating organizations, including the local health plan – the Central California Alliance for Health, care manager dashboards to track work lists and high priority participants, closed-loop referral management for enhanced transitions of care, event-driven, evidence-based workflows and alerts, simple drill-down pathways to individual participant longitudinal medical records in the HIE clinical data repository;

- Provide population health analytics and reporting services dashboards for tracking the status and outcomes of WPC target populations and sub-populations relative to selected quality measures, provides comprehensive reporting capabilities for the WPC program, including custom reports and overlays with open source data as required, data quality improvement through assessment of gaps in data quality; tracking of problems to their sources, interactive implementation of operational, workflow, and technical remediation;
- Provide analytics and reporting for monitoring and proactively engaging the target population and the detailed characteristics on page 15, such as a report refreshed daily showing all individuals discharged from participating hospitals within the past 30 days.

SCHIE eConnection Diagram



Privacy Protocols: The County Health Services Agency (HSA) and partners will determine the minimum information necessary to be shared to effectively accomplish data sharing tasks. Since information will include protected health information, including substance abuse and mental health information, HSA as the lead entity will ensure that the data sharing protocols comply with all applicable state and federal laws. At this time, HSA has developed and is in compliance with robust policies and procedures around privacy and security in place, providing a solid foundation for any additional data sharing policies and procedures to ensure both compliance with state and federal laws as well as success of the project.

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

4.1 Performance Measure

4.1.a Universal Metrics:

Check the boxes below to acknowledge that all WPC pilots must track and report the following universal metrics:

- ✓ Health Outcomes Measures
- ✓ Administrative Measures

Metrics	PY 1	PY 2	PY 3	PY 4	PY 5
I. Health Outcomes Ambulatory Care – Adult ED Visits *HEDIS)* (measured by aggregated focus population visits)	Adult ED Visits: Establish baseline	Adult ED Visits: Maintain baseline	Adult ED Visits: PY2 with 5% decrease	Adult ED Visits: PY3 with 5% decrease	Adult ED Visits: PY4 with 5% decrease
ii. Health Outcomes Adult Inpatient Utilization – General Hospital/Acute Care (IPU) (HEDIS)* (measured by aggregated focus population inpatient days)	Adult Inpatient utilization: Establish baseline	Adult Inpatient utilization: Maintain baseline	Adult Inpatient utilization: PY2 with 5% decrease	Adult Inpatient utilization: PY3 with 5% decrease	Adult Inpatient utilization: PY4 with 5% decrease
iii. Health Outcomes Follow-up After Hospitalization for Mental Illness (Adults) (/FUH) (HEDIS) measured by the number of discharged	Adult Follow UP After Hospitalization for Mental Illness: Establish baseline	Adult Follow UP After Hospitalization for Mental Illness: Maintain baseline	Adult Follow UP After Hospitalization for Mental Illness: PY2 plus 5% increase	Adult Follow UP After Hospitalization for Mental Illness: PY3 plus 5% increase	Adult Follow UP After Hospitalization for Mental Illness: PY4 plus 5% increase

Metrics	PY 1	PY 2	PY 3	PY 4	PY 5
clients given a follow up appointment within 7 days and a treatment plan within 30 days)					
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: Establish baseline	Initiation and Engagement of AOD for Adults: Maintain baseline	Initiation and Engagement of AOD for Adults: PY2 plus 5% increase	Initiation and Engagement of AOD for Adults: PY3 plus 5% increase	Initiation and Engagement of AOD for Adults: PY4 plus 5% increase

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

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	1) Enrollment into WPC Pilot: Establish baseline 2) Beneficiary's anniversary of participation in the Pilot: Establish baseline	1) Enrollment into WPC Pilot: Maintain Baseline 2) Beneficiary's anniversary of participation in the Pilot: Maintain baseline	1) Enrollment into WPC Pilot: PY 3 100% 2) Beneficiary's anniversary of participation in the Pilot: Baseline plus 5% increase	1) Enrollment into WPC Pilot: PY 4 100% 2) Beneficiary's anniversary of participation in the Pilot: Baseline plus 10% increase	1) Enrollment into WPC Pilot: PY 5 100% 2) Beneficiary's anniversary of participation in the Pilot: Baseline plus 15% increase

in the Pilot (to be conducted annually)*					
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 PY 1 PY1 Establish Baseline PY1 Establish Baseline	Number of WPC high utilizers who receive at least 12 months of coordinated case management: Maintain Baseline Beneficiaries with a comprehensive care plan: PY2 Maintain Baseline	Number of WPC high utilizers who receive at least 12 months of coordinated case management: Baseline plus 50% Beneficiaries with a comprehensive care plan: PY3 Baseline Plus 10%	Number of WPC high utilizers who receive at least 12 months of coordinated case management: Baseline plus 60% Beneficiaries with a comprehensive care plan: PY4 Baseline plus 20%	Number of WPC high utilizers who receive at least 12 months of coordinated case management: Baseline plus 70% Beneficiaries with a comprehensive care plan: PY5 Baseline plus 30%

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

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. ** c. Compile and analyze information and findings from the monitoring procedures set forth in iv.1b.	Upon completion of all documents establishing care coordination, case management and referral policies and procedures, PDSA will be utilized annually The completed documents establishing care coordination, case management & referral policies and procedures, findings will be compiled & analyzed semi-annually, and a PDSA will be utilized semi-annually to modify such as needed	PDSA will utilized semi-annually findings will be compiled and analyzed semi-annually, and a PDSA will be utilized semi-annually to modify as needed.	PDSA will utilized semi-annually findings will be compiled and analyzed semi-annually, and a PDSA will be utilized semi-annually to modify as needed.	PDSA will utilized semi-annually findings will be compiled and analyzed semi-annually, and a PDSA will be utilized semi-annually to modify as needed.	PDSA will utilized semi-annually findings will be compiled and analyzed semi-annually, and a PDSA will be utilized semi-annually to modify as needed.

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

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 PY 1 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

4.1.b Variant Metrics:

Variant Metric	PY 1	PY 2	PY 3	PY 4	PY 5
Health outcomes metrics across all five program years *Reporting Partners: Hospitals, mental health providers, medical providers and comprehensive case managers.*	Health Outcomes: Timely case management enrollment Target population: All WPC Pilot Participants Numerator: Follow up medical, mental health and SUD appointments no later than 30 days from date of release from jail or discharge from hospital Denominator: All WPC Pilot Participants PY 1: Establish Baseline	Health Outcomes: Timely case management enrollment Target population: All WPC Pilot Participants Numerator: Follow up medical, mental health and SUD appointments no later than 30 days from date of release from jail or discharge from hospital Denominator: All WPC Pilot Participants PY 2: Maintain Baseline	Health Outcomes: Timely case management enrollment Target population: All WPC Pilot Participants Numerator: Follow up medical, mental health and SUD appointments no later than 30 days from date of release from jail or discharge from hospital Denominator: All WPC Pilot Participants PY 3: Baseline plus 5%	Health Outcomes: Timely case management enrollment Target population: All WPC Pilot Participants Numerator: Follow up medical, mental health and SUD appointments no later than 30 days from date of release from jail or discharge from hospital Denominator: All WPC Pilot Participants PY 4: Baseline plus 10%	Health Outcomes: Timely case management enrollment Target population: All WPC Pilot Participants Numerator: Follow up medical, mental health and SUD appointments no later than 30 days from date of release from jail or discharge from hospital Denominator: All WPC Pilot Participants PY 5: Baseline plus 15%
	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)	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)	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) PY 3: Baseline minus 5% Decrease	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)	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)

Variant Metric	PY 1	PY 2	PY 3	PY 4	PY 5
	PY 1: Establish Baseline	PY 2: Maintain Baseline		PY 4: Baseline minus 10% Decrease	PY 5: Baseline minus 15% Decrease

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 Denominator: All WPC Pilot participants PY 1: Fully define the scope of comprehensive case management, provider roles, and management systems. Establish Baseline	Health Outcomes: Coordinated case management Target Population: All WPC Pilot Participants Denominator: All WPC Pilot participants PY 2: Fully define the scope of comprehensive case management, provider roles, and management systems. Maintain Baseline	Health Outcomes: Coordinated case management Target Population: All WPC Pilot Participants Denominator: All WPC Pilot participants PY 3: 250 Numerator: WPC participants receive at least 12 months of coordinated case management. 250 WPC participants have a comprehensive care plan PY 3 = Baseline plus 5% Increase	Health Outcomes: Coordinated case management Target Population: All WPC Pilot Participants Denominator: All WPC Pilot participants PY 4: 250 Numerator: WPC participants receive at least 12 months of coordinated case management. 250 WPC participants have a comprehensive care plan PY 4 = Baseline plus 10% Increase	Health Outcomes: Coordinated case management Target Population: All WPC Pilot Participants Denominator: All WPC Pilot participants PY 5: 250 Numerator: WPC participants receive at least 12 months of coordinated case management. 250 WPC participants have a comprehensive care plan PY 5 = Baseline plus 15% Increase
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	Health Outcomes: Hospital coordination Target Population: All WPC Pilot Participants Numerator: All WPC Pilot Participants Denominator: All WPC Pilot Participants PY2: Medication list provided on discharge: 5% Timely documentation	Health Outcomes: Hospital coordination Target Population: All WPC Pilot Participants Numerator: All WPC Pilot Participants Denominator: All WPC Pilot Participants PY3: Medication list provided on discharge: 10% Timely documentation	Health Outcomes: Hospital coordination Target Population: All WPC Pilot Participants Numerator: All WPC Pilot Participants Denominator: All WPC Pilot Participants PY4: Medication list provided on discharge: 15% Timely documentation	Health Outcomes: Hospital coordination Target Population: All WPC Pilot Participants Numerator: All WPC Pilot Participants Denominator: All WPC Pilot Participants PY5: Medication list provided on discharge: 20%

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 Denominator: All WPC Pilot participants PY 1: Fully define the scope of comprehensive case management, provider roles, and management systems. Establish Baseline	Health Outcomes: Coordinated case management Target Population: All WPC Pilot Participants Denominator: All WPC Pilot participants PY 2: Fully define the scope of comprehensive case management, provider roles, and management systems. Maintain Baseline	Health Outcomes: Coordinated case management Target Population: All WPC Pilot Participants Denominator: All WPC Pilot participants PY 3: 250 Numerator: WPC participants receive at least 12 months of coordinated case management. 250 WPC participants have a comprehensive care plan PY 3 = Baseline plus 5% Increase	Health Outcomes: Coordinated case management Target Population: All WPC Pilot Participants Denominator: All WPC Pilot participants PY 4: 250 Numerator: WPC participants receive at least 12 months of coordinated case management. 250 WPC participants have a comprehensive care plan PY 4 = Baseline plus 10% Increase	Health Outcomes: Coordinated case management Target Population: All WPC Pilot Participants Denominator: All WPC Pilot participants PY 5: 250 Numerator: WPC participants receive at least 12 months of coordinated case management. 250 WPC participants have a comprehensive care plan PY 5 = Baseline plus 15% Increase
	provided on discharge: 0% Timely documentation transition to clinics/PCP: 0% MHU: re-hospitalization within 30 days Establish baseline	transition to clinics/PCP: 5% MHU: re-hospitalization within 30 days Maintain baseline	transition to clinics/PCP: 10% MHU: re-hospitalization within 30 days PY2 minus 5% decrease	transition to clinics/PCP: 15% MHU: re-hospitalization within 30 days PY3 minus 5% decrease	Timely documentation transition to clinics/PCP: 20% MHU: re-hospitalization within 30 days PY4 minus 5% decrease

Health Outcome Metric – Depression and SMI Reporting Partners: Medical clinics and mental health services providers	Health Outcomes: Required for Pilots using PHQ-9 Target Population: WPC participants with depression diagnosis Numerator: Adults who achieved remission at 12 months as demonstrated by a 12 month (+/- 30days) PHQ-9 score of less than five Denominator: Adults age 18 & older with a diagnosis of major depression or dysthymia and an initial PHQ-9 score greater than 9 during an outpatient encounter PY 1 Establish Baseline	Health Outcomes: Required for Pilots using PHQ-9 Target Population: WPC participants with depression diagnosis Numerator: Adults who achieved remission at 12 months as demonstrated by a 12 month (+/- 30days) PHQ-9 score of less than five Denominator: Adults age 18 & older with a diagnosis of major depression or dysthymia and an initial PHQ-9 score greater than 9 during an outpatient encounter PY 2 Maintain baseline	Health Outcomes: Required for Pilots using PHQ-9 Target Population: WPC participants with depression diagnosis Numerator: Adults who achieved remission at 12 months as demonstrated by a 12 month (+/- 30days) PHQ-9 score of less than five Denominator: Adults age 18 & older with a diagnosis of major depression or dysthymia and an initial PHQ-9 score greater than 9 during an outpatient encounter PY 3 PY 2 minus 5% decrease	Health Outcomes: Required for Pilots using PHQ-9 Target Population: WPC participants with depression diagnosis Numerator: Adults who achieved remission at 12 months as demonstrated by a 12 month (+/- 30days) PHQ-9 score of less than five Denominator: Adults age 18 & older with a diagnosis of major depression or dysthymia and an initial PHQ-9 score greater than 9 during an outpatient encounter PY 4 PY 3 minus 5% decrease	Health Outcomes: Required for Pilots using PHQ-9 Target Population: WPC participants with depression diagnosis Numerator: Adults who achieved remission at 12 months as demonstrated by a 12 month (+/- 30days) PHQ-9 score of less than five Denominator: Adults age 18 & older with a diagnosis of major depression or dysthymia and an initial PHQ-9 score greater than 9 during an outpatient encounter PY 5 PY 4 minus 5% decrease

	Health Outcomes: 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 yrs & older with a new diagnosis or recurrent episode of Major Depressive Disorder PY 1: Establish Baseline	Health Outcomes: 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 yrs & older with a new diagnosis or recurrent episode of Major Depressive Disorder PY 2: Maintain Baseline	Health Outcomes: 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 yrs & older with a new diagnosis or recurrent episode of Major Depressive Disorder PY 3: PY 2 plus 5%	Health Outcomes: 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 yrs & older with a new diagnosis or recurrent episode of Major Depressive Disorder PY 4: PY 3 plus 5%	Health Outcomes: 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 yrs & older with a new diagnosis or recurrent episode of Major Depressive Disorder PY 5: PY 4 plus 5%
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 2) PY 1 Establish baseline	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 2) PY 2 Maintain Baseline	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 2) PY 3 PY 2 plus	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 2) PY 4 PY 3 plus	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 2) PY 5 PY 4 plus

			5% increase	5% increase	5% increase
	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: Members 18-59 yrs. of age whose BP was <140/90 mm Hg. Members 60-85 yrs. of age with a diagnosis of diabetes whose BP was <140/90 mm Members 60-85 yrs. 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) PY 1 Establish baseline	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: Members 18-59 yrs. of age whose BP was <140/90 mm Hg. Members 60-85 yrs. of age with a diagnosis of diabetes whose BP was <140/90 mm Members 60-85 yrs. 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) PY 2 Maintain baseline	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: Members 18-59 yrs. of age whose BP was <140/90 mm Hg. Members 60-85 yrs. of age with a diagnosis of diabetes whose BP was <140/90 mm Members 60-85 yrs. 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) PY 3 PY 2 plus 5% increase	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: Members 18-59 yrs. of age whose BP was <140/90 mm Hg. Members 60-85 yrs. of age with a diagnosis of diabetes whose BP was <140/90 mm Members 60-85 yrs. 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) PY 4 PY 3 plus 5% increase	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: Members 18-59 yrs. of age whose BP was <140/90 mm Hg. Members 60-85 yrs. of age with a diagnosis of diabetes whose BP was <140/90 mm Members 60-85 yrs. 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) PY 5 PY 4 plus 5% increase

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 PY 1: Tobacco Assessment and Counseling: Alcohol & Drug Misuse (SBIRT): Establish baseline	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 PY 1: Tobacco Assessment and Counseling: Alcohol & Drug Misuse (SBIRT): Maintain baseline	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 PY 1: Tobacco Assessment and Counseling: Alcohol & Drug Misuse (SBIRT): PY 2 plus 5%	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 PY 1: Tobacco Assessment and Counseling: Alcohol & Drug Misuse (SBIRT): PY 3 plus 5%	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 PY 1: Tobacco Assessment and Counseling: Alcohol & Drug Misuse (SBIRT): PY 4 plus 5%

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. PY 1 Establish 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. PY 2 Maintain 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. PY 3 PY 2 plus 10%	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 PY 4 PY 3 plus 10%	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. PY 5 PY 4 plus 10%
Housing-Specific Metric: Develop 60 permanent supportive rental housing units for focus for chronic homelessness in Santa Cruz 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 PY 1 Establish 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 PY 2 Secure financing; design 60 units for permanent/supportive 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 PY 3 Renovation of Existing housing 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 PY 4 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 PY 5 Ongoing case management at

Variant Metric	PY 1	PY 2	PY 3	PY 4	PY 5
					the housing site with 70% retention rate

4.2 Data Analysis, Reporting and Quality Improvement

Overview: As stated in Section 3.2 (Data Sharing), Santa Cruz County has considerable existing capacity and infrastructure in the area of data collection, tracking and sharing. However, each health and social services data system has functioned in silos and does not have interoperability capacity to exchange and share patient data in a meaningful way.

Measuring the universal and variant metrics delineated in the requested WPC project will require outcome data sharing from the HMIS for housing data, Probation Department data, County Health and Behavioral Health electronic health record systems, hospital emergency room and inpatient data, inpatient acute psychiatric data from contracted Telecare Corporation, and the Homeless Services Center's Recuperative Care Center. Data from these sources will be used to collect, track and report on project participant outcomes, specifically around the service interventions and strategies and participant health outcomes. Data will be collected to track progress in delivering short-term process measures. These data sources will also be used to perform return on investment evaluations and incentive payments for qualified providers. New data sources will also need to be established to ensure data collection, reporting and analysis of the project's interventions, strategies, participant health outcomes are accurately obtained. All data will be integrated within required reports and shared with DHCS and local stakeholders.

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

The contracted services provider(s) will designate a responsible staff person for collecting, tracking and reporting upon short-term process and administrative measures such as relating to number of participants engaged and their characteristics, as well as the types and units of services provided. Data will be collected on an ongoing basis and will be compiled by the contractor in a monthly report, due by the 10th of the month following the reporting period. The contracted services provider(s) will participate as a member of the WPC Management Committee.

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

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

Variant Measure	Data Collection Plan
Health Outcomes: Timely case management enrollment	Data collected by hospitals, mental health providers, medical providers and comprehensive case managers.
Health Outcomes: Coordinated case management	Data collected by County HSA BH and Clinics Divisions on a monthly basis and also via their contracted service providers
Health Outcomes: Hospital coordination	Data collected by hospital providers (ED and in-patient on an ongoing basis and entered/shared via the Care Management Tool.
Health Outcome Metric – Depression and SMI	Data collected by County HSA Clinics and BH services providers including contractors
Health Outcome: 1) HbA1c Control 2) Blood Pressure Control	Data collected by County HSA Clinics and BH services providers including contractors
Health Outcome: Substance abuse prevention	Data collected by County HSA Clinics and BH services providers including contractors
Housing Services for homeless/at-risk homeless participants	Data collected by County HSA Clinics and BH services providers including contractors and housing providers

Plan Do Study Act: HSA will use the PDSA model to improve the interventions and services over the life of the pilot. Through agreement with WPC partners HSA has established a set of outcome measures for the pilot as well as a desired target or change expected. PDSA is woven into the fabric of HSA departments and staff continually uses data to inform processes and to ensure data driven decision making with the programs.

County HSA BH and Clinics systems also have robust Quality Management units in which annual goals are developed in multiple areas including that services are client centered; services are safe; services are effective; services are efficient and accessible; services are equitable; and services are timely. These goals are then evaluated in the development of future goals to ensure a continuous improvement model. In addition, two Performance Improvement Projects are conducted annually, based on BH's extensive data, to ensure the

ongoing quality improvement of services and programs. The pilot will draw from subject matter experts, such as these teams, for their expertise as needed.

Sustainability Planning: Project reports that will include analysis of data regarding client outcomes and return on investment will be carefully reviewed by the AC and the information will be used to inform the WPC Pilot sustainability Plan.

4.3 Participant Entity Monitoring

HSA will be conducting regular ongoing monitoring of the WPC partners throughout the course of the project. HSA will monitor partner performance measures outlined in section 4 as well as all Universal and Variant measures using the PDSA process outlined in section 4.2. The WPC AC will meet regularly and part of each meeting will include reviewing partner performance measures and Universal and Variant metrics. For concerns regarding partner performance measures outlined in section 4, HSA will meet privately with partners to understand the issue and brainstorm solutions. If solutions cannot be generated or overcome, HSA will elevate the concern to the AC for discussion. Most of the monitoring will be performed on the contracted provider(s) operating the SIT's. HSA will use the Project Coordinator and Data Analyst to support provider(s) monitoring activities.

HSA will analyze data across the WPC Teams and compare performance among providers of the same service. HSA will use data to understand if there is an issue with a particular intervention or provider. Again, if performance concerns arise, HSA will meet privately with the provider(s) to understand the circumstances and make necessary corrections. For low performing providers/s, HSA will provide needed support in the form of technical assistance to make the necessary corrections. It is the hope that through discussions and the receipt of technical assistance that the provider(s) will improve performance and that it is sustained over time. However, if the provider(s) do not demonstrate improved performance a course of corrective action may be taken. This process may include a Corrective Action Notice requiring a response within a specified period of time, increased monitoring of the contractor, and if issues of underperformance continues, it could ultimately result in contract termination.

We acknowledge that a critical element to the project'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 team members of case managers, and housing navigators. The County Health Services Agency will ensure the WPC's Program Director to be responsible for overseeing the success of this component.

Section 5: Financing

5.1 Financing Structure

Overview: The County of Santa Cruz Health Services Agency (HSA) is the lead governmental agency for the local program. Financing for the program will primarily be for the support of the service delivery and development of IT infrastructure in order to gather data, analyze, and provide better coordinated service delivery.

Funding Flow: HSA will be providing the non-federal share of the Intergovernmental Transfer (IGT) Process. The financing used for the non-federal share of the IGT process will be through tax and fee collections received by the County either directly or indirectly from the State primarily through realignment of State General Funds. The County will follow the wire transfer provisions to the State to transfer the non-federal share of the IGT to the State. Upon the State leveraging those funds with federal funds, HSA will monitor and track the transfer of funds back to the County to finance the program. These funds will be specifically set aside into an interest bearing trust fund for the sole purpose of financing this program. HSA will then distribute funds from the trust fund to cover the cost of services based on contractual arrangements identified below.

The fiscal oversight of the program will be maintained by HSA which will include all accounting, financial reporting, oversight of the IGT payment process, payment distribution to community providers, and internal cost allocations. HSA's fiscal unit has a well-developed fiscal control structure and works in conjunction with the County's Auditor Controller's Office. All transactions are maintained utilizing Generally Accepted Accounting Principles and/or Governmental Accounting Standard Board guidance. The County utilizes a very comprehensive accounting system and software to track and monitor all fiscal and accounting transactions within the organization. These general ledger transactions are reviewed internally by both HSA staff and the County's Auditor Controller's office. In addition, the financials are audited on an annual basis by an external audit team and our organization complies with the single audit act for review of federally funded programs.

Oversight of Payment Distribution: Oversight of the payment distribution process will be completed by HSA with additional oversight by the County's Auditor Controller's Office.

Oversight of Payments to Community Partners Providing Services: For services provided by a community partner a contractual agreement will be established delineating the scope of services to be provided. The reimbursement methods, rates, timeline of payments, and other standard County purchasing provisions will also be incorporated into the contractual relationships in addition to privacy provisions. The reimbursement provisions will be through a Per Member Per Month (PMPM) distribution. Reimbursements will be done through a warrant payment. All payments will be recorded into the County's accounting system and recorded in the general ledger separately using a specific program code that will delineate these payments as part of this program.

Oversight of Payments for Internal Services and Other Governmental Units: For services provided internally and through other governmental units. Reimbursement will be based on a combination of actual costs and PMPM rate distributions. For the oversight of the financial services and administrative services, reimbursement will be based on actual costs. All costs for these activities will be maintained using either a time study and/or actual costs to provide services. For the direct services provided to participants, reimbursement will be done utilizing a PMPM methodology and reimbursed based on the number of participants seen or that could have seen during the month. Payments will be completed through journal entry transfers. All of these transactions

will be maintained and recorded in the general ledger separately using a specific program code that will delineate these payments as part of this program.

Oversight of Payments for Program Oversight and Monitoring: For reimbursement for coordinated program oversight through the Health Improvement Partnership. The program will reimburse for services based on agreed upon deliverables and activities. These deliverables and activities will be delineated into the scope of work established through a contractual arrangement. Reimbursements will be done through a warrant payment. All payments will be recorded into the County's accounting system and recorded in the general ledger separately using a specific program code that will delineate these payments as part of this program.

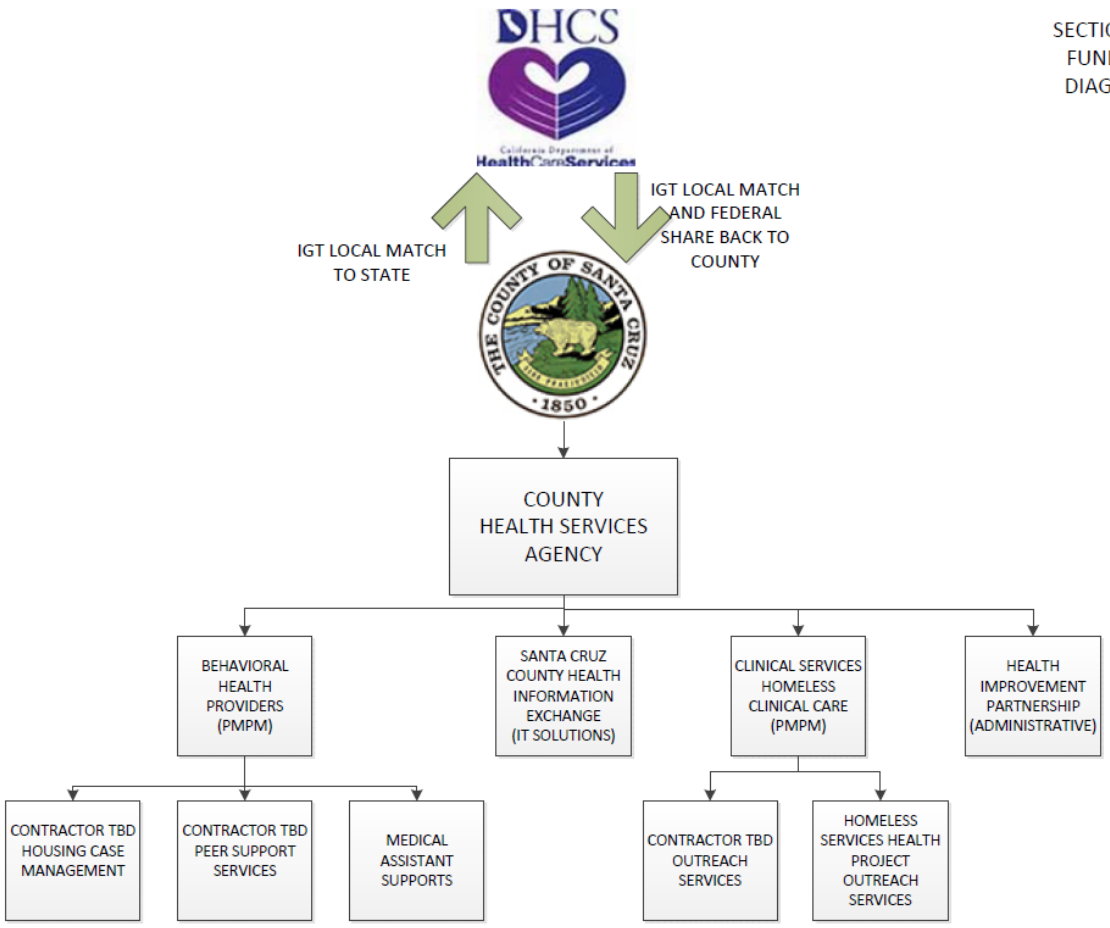
Oversight of Payments for IT Infrastructure: For reimbursements provided to the Santa Cruz County Health Information Organization for the development of IT Infrastructure to gather data, report on data, and to assist in coordinated services. The Program will reimburse for services based on agreed upon deliverables and activities. These deliverables and activities will be delineated into the scope of work established through a contractual arrangement. Reimbursements will be done through a warrant payment. All payments will be recorded into the County's accounting system and recorded in the general ledger separately using a specific program code that will delineate these payments as part of this program.

For all PMPM distributions either through community partners or other governmental units HSA will require a monthly report identifying the number of program participants that received or could have received services from the entity

Timeliness of Payment Distribution: Pursuant to the County of Santa Cruz purchasing guidelines all payments will be made to providers who are reimbursed on a fee for services model and/or PMPM model and will be reimbursed within 30 days upon receipt of an acceptable invoice. The specific terms and outlay of an acceptable invoice will be determined with the providers prior to implementation.

Sufficient Funding: To ensure there is sufficient funding a master grid and budget unit will be created to track all contractual agreements and their spending utilization. Each contractual agreement will have a contract maximum and internal program costs will have a budgetary maximum. In total, the spending authority will be limited to the maximum of the annual program State approved amounts. A dedicated staff will also be assigned to oversee and monitor the budget of the program and the tracking of the expenditures.

5.2 Funding Diagram



5.3 Non-Federal Share

Non-Federal Share: The Non-Federal Share of the project will be fully funded by HSA in a combination of County General Funds, Mental Health Services Act, Health and Mental Health Realignment funds.

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

Participants who have been identified to be Medi-Cal beneficiaries will be highlighted in electronic data systems, thereby ensuring that federal participation is only for Medi-Cal beneficiaries.

The clear 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 participant's 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 most instances of the cases, the encounters between participants 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, or would be in a supervisory role and would have few, if

any, direct contact with participants. Further, the scope of care support and coordination activities available through the program is intended to be more robust than available through Medi-Cal TCM. The program team will engage in activities such as peer support, trust-building, motivational support, disease specific education, and general reinforcement of health concepts, which are distinct from and outside the TCM benefits. The program will also provide direct social and other services that would not be recognized as TCM, such as benefit advocacy and tenancy support.

For these reasons, we have concluded that the clear majority of the program activities will not duplicate services available through Medi-Cal TCM or through reimbursement of FQHC eligible staff and services. Our program case managers will receive training and periodic reminders on the differences between TCM, eligible FQHC, and WPC criteria. Eligible FQHC encounters and staff will not be claimed for this WPC program. Whole Person Care funding will also not be used for Target Case Management reimbursement. The TCM population will be checked against the WPC population to ensure no duplication.

Payments will comply with STC 113 in that they will support infrastructure approved in the program application to promote highly integrated service delivery and contracted coordination and integration services not otherwise reimbursed by Medicaid.

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

The participants will also have access to housing support eligible for program funding, as well as rent subsidies and other housing funds not eligible for FFP. HSA has a robust accounting system that is led by a Certified Internal Auditor with strong processes and controls already in place to enable oversight and separate tracking of these funds. WPC will be the payer of last resort.

5.5 Funding Request:

Santa Cruz County is requesting annual budgets of $2,611,542 for program years 1 and 2, and $5,223,084 for years 3, 4, and 5, for a 5-Year total budget of $20,892,336. Please see the attached for the Budget Summary and Top Sheet.

Program Year 1:

Application Approval	$1,958,656
Submission of Baseline Data	$ 652,886
TOTAL:	$2,611,542

There are no participants that will be served during this Program Year.

Program Year 2:

Administrative Infrastructure	$ 336,414
Delivery Infrastructure	$ 431,550
Incentive Payments	$ 160,500
FFS Services	$ 141,750
PMPM Bundle	$ 1,218,136
Pay for Reporting	$ 323,192

Pay for Outcomes	$ 0
TOTAL:	$2,611,542

It is anticipated that up to 250 participants will be served by the WPC Pilot Program during this start-up year. These participants were calculated based on the number anticipated to be served by the hospitals, behavioral health, and community clinics.

Program Year 3:

Administrative Infrastructure	$ 499,962
Delivery Infrastructure	$ 621,600
Incentive Payments	$ 328,500
FFS Services	$ 283,500
PMPM Bundle	$2,436,249
Pay for Reporting	$ 700,000
Pay for Outcomes	$ 353,273
TOTAL:	$5,223,084

It is anticipated that up to 250 participants will be served by the WPC Pilot Program during program year 3. These participants were calculated based on the number anticipated to be served by the hospitals, behavioral health, and community clinics.

Program Year 4:

Administrative Infrastructure	$ 499,962
Delivery Infrastructure	$ 621,600
Incentive Payments	$ 328,500
FFS Services	$ 283,500
PMPM Bundle	$ 2,436,249
Pay for Reporting	$ 700,000
Pay for Outcomes	$ 353,273
TOTAL:	$5,223,084

It is anticipated that up to 250 participants will be served by the WPC Pilot Program during program year 4. These participants were calculated based on the number anticipated to be served by the hospitals, behavioral health, and community clinics.

Program Year 5:

Administrative Infrastructure	$ 499,962
Delivery Infrastructure	$ 621,600
Incentive Payments	$ 328,500
FFS Services	$ 283,500
PMPM Bundle	$ 2,436,249
Pay for Reporting	$ 700,000
Pay for Outcomes	$ 353,273
TOTAL:	$5,223,084

It is anticipated that up to 250 members will be served by the WPC Pilot Program during program year 5. These members were calculated based on the number anticipated to be served by the hospitals, behavioral health, and community clinics.

Budget Narrative

Administrative Infrastructure

Administrative Infrastructure payments are only budgeted for program year 2 through 5. The administrative infrastructure makeup of the program consists of 3.5 full time equivalent (FTE). The staffing compliment, roles, and annual costs for the program are identified as follows: These positions are prorated for program year 2.

STAFFING

County of Santa Cruz - Program Director (1.00 FTE) -Responsible for oversight and implementation of pilot project; contract oversight; receives direction from Pilot Executive Team. This position will be responsible for the coordination of the selection of participants into the program, coordination of all trainings for staff related to this program, direct coordination with State on reporting requirements, work with safe prescribing coalition for opioid dependency of this population, work and establish relationships with hospitals and emergency medical services, Social Services, Criminal Justice system, Managed Care Health Plan, housing providers, and other providers involving in the care of the participants. This position will be integral in developing trust amongst the community and participants of the pilot and in addition, provide program guidance to all direct service staff. Annual cost of position fully loaded is $143,447 with CalPERS benefits weight of 53% for all positions.
County of Santa Cruz - Program Support (0.50 FTE) -Reports to the Program Director; day to day coordination of WPC Pilot services; staff's governance structure and workgroups; aids in the contract development and oversight of operations. Annual cost of position fully loaded is $92,067 budget for this position is at half time.
County of Santa Cruz - Fiscal Manager (1.0 FTE) - Responsible for the budget of the program, fiscal transactions and monitoring of the program and review; expenditure and revenue tracking; accounts payable; fiscal reporting; IGT process tracking; and fiscal contract compliance. Annual cost of position fully loaded is $113,064
County of Santa Cruz - Quality Control/ & Improvement Manager (1.0 FTE) - Responsible for data analysis; reporting of evaluation metrics; compilation of statistics and analysis of collected data; and Continuous Quality Assurance and Improvement aspect of this program. Manages and coordinates organization-wide efforts to ensure that performance management (PM) and quality improvement (QI) programs are developed and managed using a data-driven focus that sets priorities for improvements aligned to ongoing strategic imperatives. Develops and communicates the strategic vision, scope and mission of the whole person care pilot. Also, assures that organization-wide PMQI initiatives and PDSA's are focused and aligned on improving operational and program efficiencies and effectiveness; participates in organizational strategic planning and provides leadership for PM and QI policy development; provides leadership and coordination for improving the whole person care pilot and evaluating the impact that systems improvements have on the participants and system; and researches and develops PM and QI training programs that focus on enabling the staff and community to achieve improvements. Annual cost of position fully loaded is $144,809

SERVICES AND SUPPLIES

To support the staffing of the administrative infrastructure in program year 2, the program is budgeting for the purchase of the following one-time items:

Computer purchases: for 4 staff at approximately $1,000 each plus individual printers at approximately $200 each.

Vehicle Purchase: To purchase a hybrid vehicle for use for the program staff and direct service providers for program activities. Cost of the vehicle is identified as $30,000. Maintenance and ongoing operational costs are also included estimated at $2,500 per year. All vehicle utilization will be for direct participant services to assist with client coordination, MA's, OT's, and LVN's going to home visits, staff to attending care coordination, attending Primary Care Provider appointments and/or specialty medical appointments as advocates, attending administrative training- related to WPC client benefits, and set up and troubleshooting checks with clients and Remote Access Monitoring Devices. This will be a dedicated vehicle for WPC activities and the sole purpose for use and utilization for WPC clients and/or staff activities.

Initial Office Equipment: To retrofit current County owned space for use by administrative program staff. Cost of retro-fit and purchase of equipment is identified as $23,600 and the sole purpose for use and utilization for WPC clients and/or staff activities.

Ongoing costs of the administrative infrastructure and included in program years 2 through 5 are the following:

Network Charges: These are charges incurred to support the computers and printers with network access and maintenance of the county services and IT shared utilities.

General Office Supplies: Budgeted at $1,000 per person per year for a total annual budget of $3,500 and the sole purpose for use and utilization for WPC clients and/or staff activities.
Travel and Training: Budgeted at $2,400 per training per year for a total annual budget of $9,600. This is to cover all mandated and non-mandated training and travel expenses related to the program such as

i. Health Navigator training for peers and case managers
ii. Illness Management and Recovery (IMR) training for all housing team members
iii. Intentional Peer Support (IPS) training for peers
iv. County trainings required of new such as HIPAA training, safety and de-escalation training, Avatar and Epic Trainings

Indirect Costs: Included in the budget for this category is a 5% indirect rate based on total costs of the administrative infrastructure.

Delivery Infrastructure

Delivery Infrastructure payments are only budgeted for program years 2 through 5. The delivery infrastructure makeup consists of developing and supporting a County-wide health information and sharing system, purchasing of health monitoring devices and associated fees. A detail of these budgeted expenditures is identified as follows:

Information and Sharing Data System: To develop a county-wide data sharing system to aide in the care coordination, collaboration, and tracking among the partners within the WPC community. The budget includes a service level agreement with the Santa Cruz Health Information Exchange for the development and maintenance of the data sharing and reporting platform. This service level agreement includes the maintenance of the platform, support and development of interfaces, administration of the sharing agreements, support for data collection and development of reporting tools. The annual cost of the service level agreement is identified at $400,000 for the Santa Cruz Health Information Exchange as an annual cost

Health Monitoring Devices: Included in the budget is the purchase of 125 health monitoring devices for program year 2 and the purchase of 20 health monitoring devices for program years 3, 4 and 5 for replacement of damaged and/or lost devices. The Remote Access Monitoring Devices will be utilized by multiple clients and transferred based on need, understanding, compliance, utilization and adaptability of the clients. This will be based on the care team as every client will not use the device the entire program. The goal is to have this be a transition to personal health independence. The purchase cost of the health monitoring devices is identified as $1,000 each for a total annual budget of $125,000 in Program year 2 and $20,000 in Program years 3, 4, and 5. Also included in program years 3, 4, and 5 are the cost of having the devices connected to the cellular networks and monitoring fees. The cost is projected at $70 per month per device for an annual total of $105.000.

Remote Access Monitor Integration Fees: Remote Access Monitor Integration fees are identified to connect the health monitoring devices to the data sharing platforms for monitoring the results of the monitoring activity. The budget includes the cost of three integration connections. The cost of the connections is identified as $20,000 each for an annual budgeted amount of $60,000.

Telecommunication devices: These are to fund the annual purchase of 10 telecommunication devices to be used by field staff to monitor and communicate with program staff and participants of the program. The cost of these devices is budgeted at $700 each for an annual budget of $7,000.

Indirect Rate: Included in the budget for this category is a 5% indirect rate based on total costs of the delivery infrastructure.

Incentive Payments

Incentive payments are only budgeted for program years 2 through 5. Incentive Payments are designed to increase and incentivize program participants and community partners to achieve specific goals and objectives.

Primary Care Clinic Follow-up: Payment of Incentive is for scheduling and holding scheduled spaces follow up urgent appointments within 7 days of recent acute 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 Services will meet measure for up to 360 occurrences per year. Payment trigger: The Health Services Agency Clinics Division will receive $300 per program participant scheduled within 7

days post discharge or release. Biannual payments will be made. Total annual payments through this incentive shall not exceed $108,000. Rate of biannual incentive may be changed based on overall utilization of the overall incentive. This will used to guarantee one full hour of provider service openings per week consisting of two 30 minute appointment slots.

Behavioral Health Clinic Follow-up: Payment for reduction in mental health unit readmission rates within 7 days; urgent follow up care improves health outcomes, provides necessary resources, and supports for ongoing mental health treatment and therapy. Behavioral Health will meet this measure for up to 360 occurrences per year. Payment trigger: The Health Services Agency Behavioral Health Services will receive $300 per program participant scheduled for, and successful participation in, an urgent follow-up appointment within 7 days post discharge or release. Biannual payments will be made. Total annual payments through this incentive shall not exceed $108,000. Rate of biannual incentive may be changed based on overall utilization of the overall incentive. Behavioral Health follow-up appointments are based on national best practice models, including Project RED (Re-engineered discharges) which have demonstrated that rapid follow-up with a patient following hospitalization improves clinical outcomes and reduces the likelihood of readmissions for the same medical or psychiatric condition. Current research has also demonstrated the need for rapid follow-up post psychiatric hospitalization as this is often the most vulnerable time for patients in terms of high risk factors. These incentives are provided to support timely follow-up but also important data submission and communication between providers to ensure that patients are seamlessly transitioned across provider groups. This will used to guarantee one full hour of provider service openings per week consisting of two 30 minute appointment slots.

Incentives for Utilization of Health Monitoring Device: Payment to the case management organization will be made for each participant who maintains compliance with completing the requirements of utilizing the home health devices. Organizations will be asked to work with participants to ensure daily utilization of the home health devices.
Payment trigger: The primary organization shall receive up to $25 per month for participant's compliance with the utilization of the health monitoring devices compliance standard of 75% or greater. In addition, organizations shall receive up to $50 per month for a compliance standard of 85% or greater.

Payments will be paid monthly 30 days after verification of compliance of the previous month. Budget is done estimating 100% compliance. Total annual payments through this incentive shall not exceed $112,500. Rate of monthly incentive may be changed based on overall utilization of the overall incentive.

Fee for Service/One Time Costs

Fee for Service payments are only budgeted for program years 2 through 5. Payment will be made based on actual costs incurred for the services performed. An invoice shall be received and approved by the County from a contract provider for payment. In addition, the contract agency will also be charged with aiding clients with one-time housing transition costs which will include security deposit, first/last month's rent and utilities set-up charges. It is anticipated that approximately half of the individuals will require this one-time assistance. This budget amount is projected at $4,500 per participant which is determined as $1,500 for first month's rent, $1,500 for last month's rent, and $1,500 for security deposit. With a potential annual cost of $270,000. It is also the intention of the program to help up to 60 clients with utility set-up cost which will be paid from this amount

based on actual cost. An indirect rate will also be added to recover costs associated with processing of invoices and other indirect costs, this is calculated at 5%. The total for this non billable service and WPC as payer of last resort could is $283,500 per year.

PMPM Bundle Payments

PMPM bundle payments are only budgeted for program years 2 through 5. The budget includes two PMPM bundles, one for contracted clinical services and one for contracted behavioral health services. They are identified as follows:

Behavioral Health Bundle: For behavioral health services a contracted Intensive Support team with a ratio of 1 staff to 20 clients for all services and will be contracted to assist participants with their goal to live successfully in the community, to manage their own medications and be engaged with meaningful daily activities that may include work or school. The support team will consist of 2.5 FTE Mental Health Care Coordinators that will collaborate to coordinate care in the capacity of case managers with the clinical health case managers as this is not a direct care position, 2.0 FTE Licensed Nurse and/or LVN/LPT, and 1.0 FTE Occupational Therapist (OT) with an annualized cost estimate of $551,346. There are no peer support staff in this bundle. Pursuant to the governmental purchasing rules and guidelines contractor selection will be completed through a competitive request for proposal and final selection of contractor.

Nursing staff will provide home-based medication compliance and educational support, tailored for each client based on education level, health and behavioral health, with focus on health promotion. This service will be provided by RN staff as supportive education and guidance, as this is not done by a licensed provider and not ordered by a medical provider it is not a Medi-Cal billable service and not a duplication of services.

Nursing staff will also provide the monitoring of the Remote Access Monitor device, linkages to medical appointments, linkages to psychiatric appointments and provide continuity of care across the domains. The Medical Assistant will work with the Psychiatrist, Primary Care Physician and program participants to coordinate primary care services and provide support to the treatment team and family members. They will act as a primary point of contract for the Physician to utilize to coordinate work around the participant's primary health needs. These services are provides by nursing clinical staff and not a billable Medi-Cal service as they are service oriented and do not meet FQHC requirements for provider level services.

The Occupational Therapist will work with participants to develop functional skills (household care, budgeting, shopping, cooking, transportation services, life skills education, and groups supporting healthy choices for healthy living, and include medical and social services appointment management) for independent living.

For clients that are on probation or connected to the legal system, which is projected at approximately 25% of the annual population, behavioral health will contract to support the cost of a probation officer that will be assisting the multidisciplinary treatment team in providing oversight to the individual participants who are receiving case management services.

A monthly case load of 63 clients is projected for the Probation officer for the life of the pilot. According to the American Probation and Parole Association, the recommended adult case load standard for individuals to be served by a probation department are identified as 20 to 1 for an intensive population and 50 to 1 for moderate to high risk population. In addition, supporting those participants who are on probation and mental health probation through the behavioral health court. Cost of a full-time Probation Officer is identified as $125,838. The bundle also includes a budget of $6,200 for services and supplies associated with each position.

This new position will provide a full-time probation officer to actively supervise cases that would otherwise be unsupervised or on banked caseloads. These populations often exhibit chronic, low-level offending in areas such as local ordinance violations, misdemeanor or property felonies. Due to limited resources and staffing, the Probation Department actively supervises only moderate-to-high risk specialized caseloads, such as sex offenders, domestic violence, mental health, gang intensive, and AB109 cases. Cases that do not fall under these categories are either minimally supervised, or banked which means they do not receive active case management services.

The new whole person care probation officer will identify cases currently unsupervised who are low risk to public safety/high need, and will provide supervision and case management services in collaboration with the whole person care team. These cases will receive wraparound service focused on housing coordination, SUD and mental health treatment, health care enrollment, employment, education, family support, attend collaboration of care management meetings, meeting with nursing, behavioral health staff and medical staff as needed and other unmet assessed treatment needs.
The new position will allow probation to dedicate a 1.0 FTE to the project and case manage cases that would, in absence of the grant funding, would go unsupervised despite being assessed as needing services. The DPO position also supports the goal of the department to implement the recommendations found in the new Blue Print for Shared Safety developed by Californians for Safety and Justice. These recommendations present a vision for addressing public health and criminal justice issues through collaboration and community engagement to break the cycle of harm and lead to more positive, lasting outcomes across multiple domains

The target population of this bundle will include up to 125 members per month and will run through the life of the WPC program. This bundled rate also includes indirect costs factored in at 5%.

Participants will we be added to the bundle if they meet the target population identified below and if the bundle is not at capacity. Triggers out of the bundle include relocation out of the area, death, loss of Medi-Cal eligibility and/or successful graduation of program requirements and goals. Santa Cruz County has initiated a wait list therefore services will begin on July 1, 2017 and anticipate reaching full capacity within 90-120 days.

All WPC participants will have a coordinated and consistent health care team provided by a nationally recognized Patient-Centered Medical Home in an integrated clinic where mental health, substance use disorder, dental, primary and specialty care services as well as housing support services are provided. The proposed program will provide permanent supported housing and an alternative option to more restrictive placements such as locked care and/or

board and care. These coordinated services will be provided across the five-year timeline and those participants who drop out for any reason will be replaced with other participants who meet the criteria. Any potential TCM overlap has been account for and a 5% adjust has been made as a line item dedication in the budget.

The total cost of the positions includes salaries, health insurance, employment related taxes, retirement contributions, and worker's compensation when applicable.

POSITION TITLE / COST TYPE	Cost	Times	Annual Cost
Intensive Support Team	551,346	1.00	551,346
Probation Officer	125,838	1.00	125,838
Services and Supplies	6,200	6.50	40,300
Indirect Costs	35,874		35,874
TOTAL COST			**753,358**
Avg monthly @ 125 Participants			125
Total Member Months			1,500
Total PMPM			**502.24**

Clinical Health Services Bundle: Contracted clinical health services the service delivery with a ratio of 30 clients to 1 staff member, will include 2.00 FTE Medical Assistants for assisting with the home medical devices with participants of the program. Annualized cost per FTE equates to $90,924. In addition to aide in the oversight of the health data reported from the home health devices, clinic services will be dedicating 1.00 FTE, Medical oversight which will be completed through a combination of Physician, Mid-Level, and nursing support to review the health data and highlight any significant factors needing potential clinical follow-up and referral. This service is a non-billable service. Projected annual cost of non-billable Medi-Cal WPC nursing and medical oversight is identified at $194,665. In addition, 4.00 FTE case managers and a Supervisor will be assigned to case manage and to coordinate with collaboration between behavioral health, housing, medical providers, psychiatric providers and parole/probation. Cost of the positions are identified as $565,516. The bundle will also include the costs for a 1.00 FTE Project Manager and a 0.50 FTE Program Support to aide in the operations of the pilot and data and clinical coordination of IT infrastructure needed between the different data systems. In addition, included in the budget is $6,200 per position for services and supplies associated with the effective discharge of their duties. There are no peer support staff in this bundle. Pursuant to the governmental purchasing rules and guidelines contractor selection will be completed through a competitive request for proposal and final selection of contractor.

WPC Participants will we be added to the bundle if they meet the target population identified in the narrative bundle and if the bundle is not at capacity. Triggers out of the bundle include relocation out of area, death, loss of Medi-Cal eligibility and/or successful graduation of program requirements and goals.

This Clinic bundle will serve on average 210 WPC participants monthly with an estimated up to 250 unduplicated WPC participants annually. This bundled rate also includes indirect costs factored in at 5%. The total cost of the positions includes salaries, health insurance, employment related taxes, retirement contributions, and worker's compensation when applicable.

POSITION TITLE / COST TYPE	Cost	Times	Annual Cost
Medical Oversight	194,665	1.00	194,665
Medical Assistants	90,924	2.00	181,848
Case Manager Supervisor	132,712	1.00	132,712
Case Manager / Care Coordinator	108,201	4.00	432,804
Project Management and Support	200,584	1.00	200,584
Services and Supplies	6,200	9.70	60,140
Indirect Costs	60,138		60,138
TOTAL COST			**1,262,891**
Avg monthly @ 210 Participants			210
Total Member Months			2,520
Total PMPM			**501.15**

Intensive Housing Support Bundle. Services include contracting with a community partner for outreach services to aide in care coordination of the participants and to educate landlords for housing supports. Projected annual budget for these services are projected at $215,250 annually which include peer support within the bundle. This bundled rate includes 5% indirect administrative costs of a total of $20,000. Total for this Contracted Housing Support Service is $215,250. The services provided in this bundle are provided by a contracted provider and are not County of Santa Cruz employees. Peer Support Services are utilized in this bundle.

Contracted Housing supports are available to WPC only individuals that are homeless or near homeless based on a two level model:

Level I: Intensive Housing Supports are provided for the first 3-6 months of tenancy at a high level of frequency (up to 2X daily) for individuals who are homeless or presenting and will be serviced by this level for poor housing readiness skills, and have a poor history of community tenure or ability to remain in housing such as multiple evictions, frequent tenant and community complaints regarding the individual, or acuity level of mental illness and/or substance use. Once individuals have maintained stability in their housing for at least 1 month, they will be stepped down. Total inclusive flat rate cost for Level 1 is $125,000 per year for completed services listed. There will not be additional charges with the transition of clients in and/or out of this level of service. All participants that need housing will automatically be enrolled into level 1 before being transitioned to level 2.

Level II: Intermediate Housing Support Bundle Intermediate housing supports services will have contacts up to 2 times weekly. We project that at any point in time, approximately 25 of the individuals will be in Level I and 100 will be in Level II. In addition, for Housing Supports we will contract for Peer Support Services at a ratio of 1.00 FTE peer support specialist per 33 participants in the program. The cost of a contracted Peer Support specialist averages about $40,000 on an annual basis. The target population of this bundle will include up to 100 members per month and will run through the life of the WPC program. Total inclusive cost for Level 1 is $204,750 per year for completed services listed. There will not be additional charges with the transition of clients in and/or out of this level of service.

WPC Participants will we be added to the bundle if they meet the target population identified in the narrative bundle and if the bundle is not at capacity. Participants will transition from level 1 to level 2 based on need and acuity as defined in the specific bundle. Triggers out of the bundle include relocation out of the area, death, loss of Medi-Cal eligibility and/or successful graduation of program requirements and goals. There is a currently a waiting list of clients and anticipate that maximum capacity should be reached within 90-120 days.
Services are separated from Level 1 to Level 2 as by the table below.

Services	Level I (and frequency)	Level II (and frequency)
Peer Support Services	X 2 times daily until there is 1-month of stability for the participant	X 2 times weekly, Step up to Level I if there is a decline in the clients psychiatric status
Remote Access Monitoring	X daily	X daily
Rental Deposits	X At the time of initial housing acquisition	Only if the client loses their housing
Housing Search and Acquisition	X At the time the client becomes homeless	Only if the client becomes homeless
Health education and promotion	X As needed based on the clients other health conditions	X As needed based on the clients other health conditions

Intensive Housing Support Level I			
COST TYPE	**Cost**	**FTE**	**Annual Cost**
Housing Coordinator	62,500	2.00	125,000
Peer Support Staff	40,000	2.00	80,000
Indirect Costs	10,250		10,250
Total Budget			215,250
Total # of Member months			300
PMPM Rate for Bundle			718

Moderate Housing Support: Level 2			
COST TYPE	**Cost**	**FTE**	**Annual Cost**
Housing Coordinator	62,500	1.20	75,000
Peer Support Staff	40,000	3.00	120,000
Indirect Costs	9,750		9,750
Total Budget			204,750
Total # of Member months			1,200
PMPM Rate for Bundle			171

Pay for Reporting

Pay for reporting payments to the County and participating organizations in the project are only budgeted for program years 2 through 5. The budget includes 14 incentives for reporting for each of the program years. The information will be tracked by each participating organization and reported to the County and maintained by the County. These incentive payments for each report will be paid at a value of $50,000, for a total annual cost not to exceed $700,000. A detail of the reports is identified as follows:

Reporting Number of ED Visits -active monitoring of avoidable ED visits will help target care coordination services to appropriate participants to link to primary care medical home thus increasing appropriate use of ED. Payment trigger: Weekly reporting of ED visits by participating hospital.
Reporting Number Inpatient Utilization -active monitoring of avoidable inpatient days will help target care coordination services to appropriate participants 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.
Reporting Follow up after hospitalization for mental illness -active monitoring of mental health unit days and linking participants to outpatient mental health services will increase avoidable mental health unit days. Payment trigger: Weekly reporting of follow up after hospitalization for mental illness.

Reporting Number of ED Visits -active monitoring of avoidable ED visits will help target care coordination services to appropriate participants to link to primary care medical home thus increasing appropriate use of ED. Payment trigger: Weekly reporting of ED visits by participating hospital.
Reporting Number of participants who are informed of SUD services -initiation and engagement and completion of assessment of participants needing substance use disorder treatment services will increase likelihood of road to recovery. Payment trigger: Weekly reporting of SUD assessments completed.
Reporting Number of participants enrolled into WPC and number with comprehensive care plan within 30 days of enrollment. Payment trigger: Monthly reporting of participants and development of comprehensive care plan.
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.
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 participants enrolled in WPC pilot.
Reporting Percentage of Avoidable Hospitalizations -active monitoring of avoidable hospitalization visits will help target care coordination services to appropriate participants to link to primary care medical home. Payment trigger: Weekly reporting of inpatient stays by participating hospital over the program year will trigger the incentive payment.
Health Outcome Metric-Hospital. Medication list provided at discharge. Payment trigger: Measure will be met for 50% or more of participants enrolled in WPC pilot.
Health Outcome Metric-Hospital. Timely documentation transition to clinics/PCP. Payment trigger: Measure will be met for 5% or more of participants enrolled in WPC pilot.
Health Outcome Metric-Hospital. Depression remission at 12 months. Payment trigger: Measure will be met for baseline minus 5% or more of participants enrolled in WPC pilot.
Health Outcome Metric-Hospital. MHU re-hospitalization within 30 days. Payment trigger: Measure will be met for baseline minus 5% or more of participants enrolled in WPC pilot.
Health Outcome Metric: Participants with controlled hypertension. Payment trigger: Measure will be met for 50% or more of participants enrolled in WPC pilot.

Reporting Number of ED Visits -active monitoring of avoidable ED visits will help target care coordination services to appropriate participants to link to primary care medical home thus increasing appropriate use of ED. Payment trigger: Weekly reporting of ED visits by participating hospital.
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 to be made annually.

Pay for Outcomes

Pay for Outcome payments to the County and participating organizations in the project are only budgeted for program years 2 through 5. The budget includes five incentives for outcome based payments for each of the program years for a total annual cost not to exceed $353,273. For program year 2 the incentives will be further pro-rated. For program years 3-5 incentive metrics (per section 4.1 starting on page 34) will be analyzed and benchmarks will be adjusted to force continued improvement as needed. These incentives payments for each outcome are detailed below:

Health outcomes: An outcome incentive of $75,000 per year shall be paid upon successful outcome for 80% or greater for a routine follow up after the initial urgent appointment that occurred with 7days of the patient's recent discharge from mental health, medical, and SUD appointment within 10 days post hospitalization appointment that improves compliance with discharge planning. Follow-up is defined as an in person visit at the Clinic or with a Behavioral Health Provider. Payment trigger: Measure will be met for participants enrolled in WPC pilot.
Health Outcome Metric: An outcome incentive of $75,000 per year shall be paid upon successful outcome for compliance with 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; compliance will reduce avoidable ED visits, mental health unit stays and improve health outcomes. Payment trigger: Tool will be used with 60% of participants enrolled in WPC pilot.
Health Outcome Metric: An outcome incentive of $75,000 per year shall be paid upon successful outcome if greater than 75% of WPC participants receive tobacco assessment and counseling. Payment trigger: Measure will be met for 90% or more of participants enrolled in WPC pilot.
Health Outcome Metric: An outcome incentive of $75,000 per year shall be paid upon successful outcome if WPC participants receive 12 months of coordinated case management. Payment trigger: Measure will be met for 25% or more of participants enrolled in WPC pilot.
Health Outcome Metric: An outcome incentive of $53,273 per year shall be paid upon successful outcome if WPC participants have a comprehensive care plan. Payment trigger: Measure will be met for 50% or more of participants enrolled in WPC pilot.

Second Round WPC Budget Template, New Applicant: Summary and Top Sheet

New WPC Applicant Name:	*County of Santa Cruz*

	Federal Funds *(Not to exceed 90M)*	**IGT**	**Total Funds**
PY 1 Annual Budget Amount Requested	1,305,771	1,305,771	2,611,542
PY 2 Annual Budget Amount Requested	1,305,771	1,305,771	2,611,542
PYs 3-5 Annual Budget Amount Requested	2,611,542	2,611,542	5,223,084
Total WPC Pilot	10446176	10446176	20,892,352

Second Round PY 1 Budget Allocation (Note PY 1 Allocation is predetermined)	
PY 1 Total Budget	2,611,542
Approved Application (75%)	1,958,656
Submission of Baseline Data (25%)	652,886
PY 1 Total Check	OK
Does PY 1 Total = 50% of PY 3 Total?	Yes

Second Round PY 2 Budget Allocation	
PY 2 Total Budget	2,611,542
Administrative Infrastructure	336,414
Delivery Infrastructure	431,550
Incentive Payments	160,500
FFS Services	141,750
PMPM Bundle	1,218,136
Pay For Reporting	323,192
Pay for Outcomes	0
PY 2 Total Check	OK
Does PY 2 Total = 50% of PY 3 Total?	Yes

Second Round PY 3 Budget Allocation	
PY 3 Total Budget	5,223,084
Administrative Infrastructure	499,962
Delivery Infrastructure	621,600
Incentive Payments	328,500
FFS Services	283,500
PMPM Bundle	2,436,249
Pay For Reporting	700,000
Pay for Outcomes	353,273
PY 3 Total Check	OK

Second Round PY 4 Budget Allocation	
PY 4 Total Budget	5,223,084
Administrative Infrastructure	499,962
Delivery Infrastructure	621,600
Incentive Payments	328,500
FFS Services	283,500
PMPM Bundle	2,436,249
Pay For Reporting	700,000
Pay for Outcomes	353,273
PY 4 Total Check	OK

Second Round PY 5 Budget Allocation	
PY 5 Total Budget	5,223,084
Administrative Infrastructure	499,962
Delivery Infrastructure	621,600
Incentive Payments	328,500
FFS Services	283,500
PMPM Bundle	2,436,249
Pay For Reporting	700,000
Pay for Outcomes	353,273
PY 5 Total Check	OK