Riverside University HEALTH SYSTEM

Department of Behavioral Health
Department of Public Health
Federally Qualified Health Centers
Medical Center

In partnership with:
Cal State San Bernardino Reentry Initiative
City of Riverside, Mayor's Office
County of Riverside Economic Development Agency
Health to Hope
Inland Empire Health Plan
Housing Authority of the County of Riverside
Molina Healthcare
National Community Renaissance
Path of Life Ministries
Riverside County Board of Supervisors
Riverside County, Chief Executive Officer
Riverside County Department of Public Social Services
Riverside County Probation Department
Riverside County Sheriff's Department

Whole Person Care Pilot Project

Submitted to the California Department of Health Care Services, 2016

Section 1: WPC Lead Entity and Participating Entity Information

The Riverside County Whole Person Care Pilot Project will be led by the Riverside University Health System (RUHS). RUHS is comprised of several key health care agencies that serve Riverside County. These include: the Riverside Regional Medical Center (439-bed Medical Center in Moreno Valley), ten Federally Qualified Health Centers, Behavioral Health department, the Public Health department, several primary clinics and specialty clinics. The combined services of RUHS have been the foundation of health care, community wellness, and medical education in Riverside County for more than 100 years with over 6,000 county employees.

More specifically, the mission of RUHS to "improve the health and well-being of our patients and communities through our dedication to exceptional and compassionate care, education, and research" provides a commitment to delivering exceptional care through an integrated network of skilled and compassionate healthcare professionals who inspire hope, healing and wellness. RUHS is a teaching organization where generations of doctors, nurses, pharmacists, and public, behavioral and allied health professionals have been trained. RUHS provides sensitive and culturally appropriate support for families and individuals facing behavioral health challenges and substance abuse issues, as well as trusted programs aimed at improving the lives and advancing the health of the communities. (County, Designated Public Hospital)

Two important partners in the RUHS Whole Person Care Pilot project (WPC Pilot) are the two Medi-Cal managed care health plans—Inland Empire Health Plan (IEHP) and Molina Healthcare (Molina). Both were partners in the planning and design of the WPC Pilot and have the ability to share data via patient portals. Efforts are also underway to coordinate and integrate care management activities between the Medi-Cal managed care health plans and Riverside County case managers. Additionally, IEHP is leading efforts designed to assist Riverside County in Population Health management and Patient Centered Medical Home projects such as empanelment improvements, identification of high utilizers and collaborative approaches on how to improve access and services, and, best practice implementation for chronic disease states. Both IEHP and Molina agree to participate including all sub-plans of the prime MCP when full delegation of risk has occurred.

The RUHS WPC Pilot has the support of all county departments under RUHS including Behavioral and Public Health.

The **RUHS Department of Behavioral Health (DBH)** will be a participant on the steering committee, will be a direct service provider, and will be engaged in data sharing via the Forward Health electronic population health management program. DBH has developed an exceptional reputation for providing services that involve the latest innovations in clinical practices affecting mental health. A high rate of client satisfaction has added to this reputation. The RUHS Department of Behavioral Health has a dedicated professional team of over 1,500 employees consisting of psychiatrists, clinicians, peer specialists, and paraprofessionals who serve over 54,000 consumers annually. The combination of innovative services and professional staff is reflected in the high rate of client satisfaction.

The RUHS Department of Behavioral Health is strongly committed to cultural competency and accepts and values people from all ethnic, cultural, racial, and linguistic backgrounds. The Department's development and implementation of, cultural competency equip employees to meet the needs of Riverside County's diverse population. The confidentiality of all consumers is strictly adhered to in accordance with Federal regulations. Services are primarily targeted toward individuals on Medi-Cal plus those eligible for other specialized State programs. The RUHS Department of Behavioral Health is comprised of Mental Health Services for all ages, Substance Abuse Prevention and Treatment Services, Detention Behavioral Health Services, and the Public Guardian's Office. (Specialty Mental Health Department)

The **RUHS-Public Health (RUHS-PH)** will be a member of the steering committee, a direct service provider, coordinating with and contributor of data to the Forward Health electronic population health management program. Established in 1926, the RUHS-Public Health (RUHS-PH) is the local, public agency charged with ensuring the health and well-being of county residents and visitors. RUHS-PH administers the county's public health resources with a budget of approximately $80 million and 650 employees. RUHS-PH is functionally divided into various public health programs such as Communicable Disease Control, Nutrition Services, Public Health Nursing, Epidemiology, and Children's Medical Services.

In order to prevent disease and protect and promote the health of County residents, the RUHS-PH works in coordinated fashion with the other members of the Riverside University Health System (Behavioral Health, Medical Center and Care Clinics) while leveraging its strong relationships with other County agencies like Environmental Health, Animal Services, Public Social Services, Office on Aging, Transportation and Land Management and the Emergency Management Department. The RUHS-PH also works closely with numerus community-based organizations, universities, and businesses to ensure that all county residents and visitors have the chance to achieve optimal health.

The **Riverside County Probation Department** will be a participant on the steering committee, will be a direct service provider and will be engaged in data sharing via the Forward Health electronic population health management program. The Probation Department is a progressive criminal justice agency that believes in continuous improvement, searching for, and applying, "best practices," using measurable outcomes to evaluate programs, and making every effort to fulfill the County's mission to make Riverside County a safe and law-abiding community for its citizens. Riverside County Probation is one of the most diversified law enforcement agencies in the county with a budget of $106.3 million and 1,090 sworn and non-sworn allocated permanent and temporary positions. The Riverside County Probation Department has an excellent reputation for working in a collaborative manner with law enforcement, public and private social services agencies, mental health, schools, and other county departments. (Public Department)

In 2011, the Riverside County Probation Department assumed responsibility for supervising specified lower level parolees from the California Department of Corrections and Rehabilitation as a result of the Public Safety Realignment Act (Assembly Bill 109). AB 109 was signed into law on April 4, 2011, and transferred responsibility for supervision to counties in an effort to

reduce the prison population. The Probation Department supervises these offenders and is an integral part of the Community Corrections Partnership Executive Committee (CCPEC). This committee, in conjunction with the court, public defender, district attorney, mental health, local police and the sheriff, is charged with the development of Riverside County's realignment implementation plan. (Public Department)

The **Riverside County Sheriff's Department** will be a participant on the steering committee, will be a direct service provider and will be engaged in data sharing via the Forward Health electronic population health management program. The Riverside County Sheriff's Department is the 2nd-largest Sheriff's Office in California, managing five correctional facilities, Coroner-Public Administrator duties, and providing court services. A staff of over 4,000 dedicated professionals covers this 7,208 square mile expanse of Southern California. The Riverside County Sheriff's Department operates the county's jail system. The Riverside County Jail provides short-term incarceration services for the county, jailing subjects arrested and charged with felony crimes pending their court disposition as well as those convicted of misdemeanor crimes and sentenced to less than one year of incarceration. Services also include transportation of prisoners if necessary related to court appearances, and transferring prisoners between jurisdictions such as other counties, states, or the California Department of Corrections and Rehabilitation. The county's jail system consists of the Robert Presley Detention Center (RPDC) in downtown Riverside, the Southwest Detention Center (SWDC) in French Valley near Murrieta, the Larry Smith Correctional Facility (SCF) in Banning, the Indio Jail, and the Blythe Jail. (Public Department)

The **Riverside County Department of Public Social Services (DPSS)** will be a participant on the steering committee, will be a direct service provider and will participate in data sharing via steering committee reporting. DPSS is comprised of employees who work collectively and in partnership with community-based organizations to serve the needs of the community. The Riverside County Department of Public Social Services (DPSS) provides services and assistance to protect and empower vulnerable people in the community. DPSS provides temporary financial assistance and employment services for families and individuals. DPSS provides programs and services to protect children and adults from abuse and/or neglect. Ensuring health care coverage is important to DPSS. (Public Department)

All of the above county departments are overseen by the elected governing Board of Supervisors. The **Riverside County Board of Supervisors** represents five supervisorial districts. A supervisor is elected from each district every four years. Riverside County is organized as a General Law County under the provision of the California Government Code. And, the Board appoints the **Riverside County Chief Executive Officer** who oversees the general workings of the county budget including the employment of approximately 22,000 personnel. (Public Department governing bodies and oversight)

Inland Empire Health Plan (IEHP) will be a participant on the steering committee, will be a managed Medi-Cal service provider and will be engaged in data sharing via the Forward Health electronic population health management program. IEHP is a not-for-profit, rapidly growing Medi-Cal and Medicare Special Needs Plan health plan in California's San Bernardino

and Riverside Counties. With a provider network of over 4,000 providers and more than 1,200 employees, IEHP currently serves over 1.2 million members who are enrolled in Medi-Cal, Cal MediConnect (Medicare), Medicare DualChoice Special Needs Plan and the Healthy Kids Program. As a result of Healthcare Reform and participation in the California Coordinated Care Initiatives, IEHP is projected to grow to 1.4 million members by 2017. IEHP's annual budget for FY 14/15 is $3.6 billion.

Since 1996, IEHP has developed strong provider relationships, delivered high quality healthcare to its members and transformed Inland Empire care delivery. IEHP was one of the first health plans with a successful health information exchange. IEHP provided startup funds and continues to support the Inland Empire Health Information Exchange (IEHIE). The IEHIE is a leading nonprofit entity that has transformed healthcare across Riverside and San Bernardino Counties through improved health provider coordination, patient care and patient safety. IEHP also helped form the Inland Empire Electronic Health Resource Center (IEEHRC) to assist providers and clinics with EMR selection and implementation. The IEEHRC received its 501 (c) 3 status in 2010—the first Local Extension Center in the nation to be granted such status. IEHP was the first Medi-Cal HMO in the state to earn National Committee for Quality Assurance (NCQA) Accreditation, the nation's leading quality monitoring organization of health plans. IEHP was one of the first health plans in the nation to earn NCQA Accreditation for Disease Management. (Medi-Cal Managed Care Health Plan) Bi-directional data sharing will be accomplished via IT solution data matching between RUHS Forward Health and IEHPs DBMotion population health management solutions and the IEHP Provider Portal.

Molina Healthcare will be a participant on the steering committee, will be a managed Medi-Cal service provider and will participate in data sharing via steering committee reporting. Molina Healthcare is a managed care company founded in 1980. In 2016, Molina Healthcare was ranked 201 in Fortune 500. In 2015, the company's health plans served about 3.5 million people through government-based healthcare programs in fourteen different states. (Medi-Cal Managed Care Health Plan). Bi-directional data sharing will be accomplished via the Molina provider portal.

In addition to the above county entities and managed care providers for Riverside County, the Riverside County Whole Person Care project will include general participation from a number of community partners. They are bulleted below:

- **The City of Riverside Mayor's Office Riverside** will be a participant on the steering committee and will participate in data sharing via steering committee reporting. The City of Riverside Mayor's Office Riverside oversees the county seat and the most populous city in the Inland Empire. Riverside is the 59th most populous city in the United States and 12th most populous city in California. As of the 2010 Census, Riverside had a population of 303,871. The City of Riverside is home to the highest density of new probationers. (Additional Organization)

- **Loma Linda University Health (LLUH)** will be a participant on the steering committee and will participate in data sharing via a shared EPIC electronic patient database. LLUH is a Seventh-day Adventist educational health-sciences institution with more than 4,000

students. Eight schools and the Faculty of Graduate Studies comprise the University organization. More than 55 programs are offered with curricula ranging from certificates of completion and associate in science degrees to doctor of philosophy and professional doctoral degrees. An outgrowth of the original Sanitarium on the hill in 1905, the present 11-story Loma Linda University Medical Center (LLUMC) opened on July 9, 1967.

With the completion of the Loma Linda University Children's Hospital in late 1993, nearly 900 beds are available for patient care, including at Loma Linda University Medical Center East Campus and Loma Linda University Behavioral Medicine Center. Loma Linda University Health Care, a management service organization, supports the many programs and services provided by our 400+ faculty physicians. They also have involvement with several outlying communities, including LLUMC, Murrieta and the Highland Springs Medical Plaza. LLUMC operates some of the largest clinical programs in the United States in areas such as neonatal care and outpatient surgery and is recognized as the international leader in infant heart transplantation and proton treatments for cancer. Each year, the institution admits more than 33,000 Inpatients and serves roughly half a million outpatients. LLUMC is the only level one regional trauma center for Inyo, Mono, Riverside, and San Bernardino counties. In 2012, Loma Linda University Health (LLUH) was created to represent all LLUMC facilities and organization. At LLUH, the commitment to caring for the mind, body and spirit is part of everything they do. They are combining our education, clinical care and research programs to fulfill their mission — "making man whole". (Community Partner)

- **National Community Renaissance (CORE)** will be a participant on the steering committee and will participate in data sharing via steering committee reporting. CORE is one of the nation's largest non-profit affordable housing developers with a 20-year track record in community revitalization. CORE works to transform the economic and social future of communities by building quality, affordable housing combined with best practice social services to improve the self-sufficiency of the residents. CORE work with communities in the most challenged neighborhoods, typically places of crime and blight that the market simply will not address in the foreseeable future. With assets of over $850 million, 10,000 units and over 27,000 residents, CORE supports families and seniors by providing housing communities that are affordable, safe, and of the highest quality. CORE enhances neighborhood stability through long-term management and maintenance, as well as industry-leading services such as senior wellness, preschool and afterschool programs, and family financial training. CORE utilizes funding from the U.S. Departments of Housing and Urban Development, Education, Justice, Health and Human Services and Agriculture. National CORE created the Hope through Housing Foundation (HOPE) in order to provide high-quality services for our residents to improve their lives and their communities. HOPE strives to meet or exceed nationally recognized benchmarks and best practices for its programs. (Community Partner)

- **The California State San Bernardino Reentry Initiative** (CSRI) will be a participant on the steering committee and will participate in data sharing via steering committee reporting. CSRI is a program under California State University San Bernardino,

University Enterprises Corporation. Under contract with the California Department of Corrections and Rehabilitation, CSRI provides comprehensive, wraparound services to over 1,000 parolees per year through three locations in the Inland Empire region of California. In operation for over five years, CSRI has a strong record in reducing recidivism for parolees. (Community Partner)

Finally, below are examples of community providers also participating in the project:

- **Path of Life Ministries** (POL) will be a participant on the steering committee and will participate in data sharing via steering committee reporting. POL is a non-profit organization (501c3) based in the City of Riverside and is committed to serving the greater Riverside homeless population and the poor with the goal to rescue, restore and rebuild lives in our community. Through partnership with the community, Path of Life Ministries is able to accomplish their mission by extending their services with local collaborative partners, other providers and support agencies. Path of Life Ministries focuses on facilitating the stabilization of housing, earned income and personal development for individuals who are homeless or at risk of homelessness. (Community Partner)
- Urban Community Action Projects (UCAP) doing business as **Health to Hope Clinics** will be a participant on the steering committee and will participate in data sharing via steering committee reporting. Health to Hope Clinics (established in 2010) developed from the Path of Life Ministries (POLM) Health in Motion (HIM) initiative. This imitative was a response to Riverside County's public health crises that arose from the economic downturn. In 2009, POLM, in partnership with Riverside Community Health Foundation, implemented HIM staffed by volunteer providers to serve urban homeless residing in the City of Riverside. The model was so successful that POLM subsequently sponsored UCAP's 501 (c) start-up, Health to Hope Clinics. Health to Hope Clinics are Federally Qualified Health Centers (FQHC). Their services include the provision of health services from three fixed sites and through the use of the mobile medical services. (Community Partner)

NOTE: Letters are attached from all public departments, community partners and additional organizations.

1.1 Whole Person Care Pilot Lead Entity and Contact Person

Organization Name	Riverside University Health System – Behavioral Health
Type of Entity	County Behavioral Health Department
Contact Person	Judi Nightingale, DrPH, RN
Contact Person Title	Director, Population Health

Telephone	951 486-6452
Email Address	j.nightingale@RUHealth.org
Mailing Address	2650 Cactus Ave, Moreno Valley, CA 92555

1.2 Participating Entities

After a series of stakeholder and project development meetings, participation in the project has been garnered from many entities. The following represents the engaged and committed partners to this very important and impactful project:

Required Organizations	Organization Name	Contact Name and Title	Entity Description and Role in WPC
1. Medi-Cal managed care health plan	Inland Empire Health Plan (IEHP)	Dr. Brad Gilbert, Chief Executive Officer	Data sharing, external stakeholder group, enrollment assistance
1.a	Molina Healthcare	Maria Lugo, AVP Market Lead	Data sharing, enrollment assistance
2. Specialty Mental Health Agency/Department	Riverside University Health, Behavioral Health	Steven Steinberg, Director	Lead entity, Behavioral health service provision for seriously mentally ill participants, data sharing, housing coordination for people with serious mental illness, care coordination, nurse screening, participant outreach/enrollment, data sharing.
3. Health Services Agency/Department	Riverside University Health	Judi Nightingale, DrPH, RN, Director of Population Health	Federally-Qualified Health Center services, care coordination, nurse screening, participant outreach/enrollment, data sharing
4.a Public Agency/Department	Riverside County Probation	Mark Hake, Chief	Outreach, referrals, co-location, data sharing

	Department		
4.b	Riverside County Sheriff's Department	Stanley Sniff, Sheriff	Outreach, referrals, data sharing
4.c	Riverside County Department of Public Social Services	Sayori Baldwin, Assistant Director	Assistance in enrollment in WIC, Cal Fresh, managed care plan, cash-aid, data sharing
4.d	Riverside County Executive Officer	Jay Orr, County Executive Officer	County Departments Oversight
4.e	Riverside County Board of Supervisors	John Benoit, Chairman	Elected Governing body
5. Community Partner	National Community Renaissance	Steve Pontell, President and Chief Executive Officer	Community partner, data sharing
6. Community Partner	Health to Hope Clinics	Emmanuel Pakrati, Chief Executive Officer	Care management, health and behavioral health services in Blythe, data sharing
Additional Organizations	**Organization Name**	**Contact Name and Title**	**Entity Description and Role in WPC**
7. Community Partner	Cal State San Bernardino Reentry Initiative	Andrea Mitchel, Director Strategic Initiatives and Evaluation	Referrals of dual probation/parole participants, data sharing
8. Government Entity	City of Riverside Mayor's Office Riverside	Rusty Bailey, Mayor	Referrals of prospective participants
9. Community Partner	Path of Life Ministries	Damien O'Farrell, Chief Executive Officer	Community support

10. Community Partner	Loma Linda University Health	Stephen Corbett, M.D., Chief Medical Information Officer	Innovative Wellness Map, data sharing

1.3 Letters of Participation and Support

All of the aforementioned partners to the RUHS Whole Person Care Pilot Project (WPC Pilot) have provided letters of participation and/or support. All letters are attached.

Section 2: General Information and Target Population

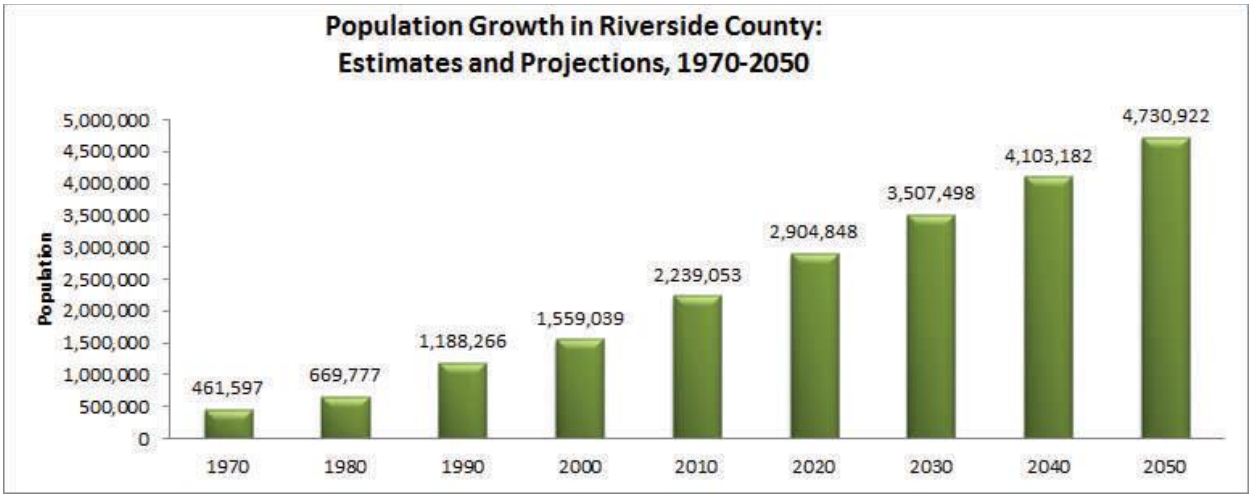
2.1 Geographic Area, Community and Target Population Needs

Spanning over 7,200 square miles and encompassing beautiful fertile river valleys, magnificent mountains, deserts, foothills, and rolling plains, Riverside County is the fourth largest county in California. There is a combination of urban and rural terrain with the eastern part of the county representing the least populated, but growing areas. Sharing borders with Imperial, Orange, San Diego, San Bernardino counties and the State of Arizona, Riverside is as large geographically as the state of New Jersey. Figure 1 reflects a map of Riverside in relationship to neighboring counties. FIGURE 1: Riverside County and neighboring counties

Established in 1893, Riverside has grown from a population of 18,000 to 2.3 million residents making it the fourth largest county in California in population. Within the last decade, Riverside has experienced a 44% increase in population, placing the County in fifth place for population growth in the United States (U.S. Census Bureau, 2011).

Figure 2 reflects the anticipated population growth in Riverside County from 1970 to 2050.

FIGURE 2: Anticipated population growth in Riverside County



In terms of socio-economic status, Riverside continues to suffer economic challenges. In September 2013, the U.S. Census Bureau ranked the Inland Empire first in poverty rates among the nation's 25 largest metropolitan areas. This low economic ranking of the San Bernardino-Ontario-Riverside metro area even surpassed such urban areas as Detroit and Philadelphia.

By 2020, Riverside County population will be primarily comprised of Hispanics and Whites (46% and 40%, respectively). About 50% of Riverside County residents 18-24 years old have a high school education or less. Fewer (4.4%) residents 18-24 years have a bachelor's degree or higher, compared to those in California (7.8%) and in the U.S. (9.2%). Between 2000 and 2010, rates of unemployment in Riverside County have exceeded the rates for California and the US (except in years 2002, 2003, and 2004).

In 2014, there were 12,348 individuals on the total Riverside County Probation Department (Probation Department) caseload. This number is lower than the previous nine years. With the implementation of AB 109, Probation Department states that the number of probationers has increased.

In 2014, Riverside partnered with California Forward (Cal Forward) on the Justice System Change Initiative. In 2015, Cal Forward developed a Jail Utilization report to Riverside County. The report identified the following significant findings:

- More than half of the petitions filed were for technical, not for committing new crimes/new criminal violations
- Half of the probation violations were for drug offenses, and 32% were for property crime
- The most common term of probation violation was failing to report to Probation Department officials followed by failing to have a residence approved by the Probation Department.

Based on this information, the following areas were identified by Probation staff for system improvement:

- Reduce probation failures resulting in jail by increasing probation success through better engagement of probationers.
- Reduce formally filed technical violations by increasing the document used of intermediate sanctions.

Understanding that drug use and addiction are significant drivers to probation violations and an impediment to successful probation engagement, develop new methods to treat and engage with substance users and abusers. Due to urgent actions needed regarding the Plata v. Brown and the Public Safety Realignment Act, RUHS began to study characteristics of individuals being released from incarceration. Some of these results are below:

- Between 8% and 82% of the homeless populations studied reported having been previously incarcerated (Metraux and Culhane, 2006).

- A large number of new probationers have HIV or AIDS or other illnesses such as hepatitis B, hepatitis C, and tuberculosis (National GAINS Center 1999; Roberts, Kennedy, and Hammett 2002).

- Ex-prisoners also have high rates of substance abuse and mental illness (Beck and Maruschak 2001). Estimates of the substance abuse problems of new probationers, which derive from numbers gathered for the incarcerated population, range from 55 to 84 percent (Hughes, Wilson, and Beck 2001; Mumola 1999).

- According to the Bureau of Justice Statistics, an estimated 16% of adult prisoners report having either a mental disorder or an overnight stay in a psychiatric facility (Ditton, 1999).

- Much like people who spend time in jail, individuals who are under community supervision tend to be low-income men who are uninsured, despite having extensive health care needs, including mental illnesses and/or substance use disorders (Regenstein, 2014).

While not tracking an individual's previous incarceration, RUHS understands that the cost of an emergency department (ED) visit for a non-urgent condition is two to five times greater than the cost of receiving care in a primary care setting for the same condition. A housing and care management program for homeless adults reduced emergency department use by 24% (National Quality Forum, 2009).

RUHS convened a group of stakeholders that are now represented as partners in the WPC Pilot to discuss a plan to:

- Increase integration among stakeholders;

- Develop an infrastructure that will ensure local collaboration among stakeholders in the WPC Pilot over the long term;
- Increase coordination and appropriate access to care for probationers;
- Reduce inappropriate emergency and inpatient utilization;
- Improve data collection and sharing among partners to support ongoing case management, monitoring, and strategic program improvements in a sustainable fashion;
- Achieve targeted quality and administrative improvement benchmarks;
- Increase access to or utilization of housing or other non-medical supportive services; and,
- Improve health outcomes for the WPC population.

After eight group meetings and well over thirty individual meetings, the RUHS WPC Pilot program design was created. Through a collaborative approach to engagement of inmates before release, co-location of Nurses in Probation Department offices, effective evaluation of comprehensive needs, appropriate physical and behavioral health treatment/linkages and complex care management, the RUHS WPC Pilot program will successfully address the needs of probationers and achieve the intended outcomes.

With cost savings in avoidable utilization of ED visits, recidivism back to jail/prison and engagement in preventive care activities, the RUHS WPC will build sustainable infrastructure that can support communications about the populations across the delivery systems beyond the term of the pilot.

2.2 Communication Plan

The purpose of the external communication plan is to ensure that RUHS, the lead entity of the RUHS WPC Pilot project, provides relevant, accurate, and consistent project information to providers, beneficiaries, project stakeholders and other appropriate audiences.

The WPC pilot, proposed herein, will employ a rigorous and efficient process for inter-agency communication. The lead agency, RUHS, will designate a point person (or team) who will act as the communication clearinghouse (CCH) for all WPC-related inter-agency communication. Information to be shared with participating entities will run through this CCH, which will also track responses and follow-up items, as necessary. An on-line project website will be developed with the help of a utility such as Microsoft SharePoint, which will warehouse digital project materials, track versions of developing documents, and allow secure and robust collaboration on WPC-related work product. This digital warehouse (DWH) will allow creative input from all involved entities and stakeholders.

The WPC leadership team to encourage collaboration and integration between participating entities will leverage the CCH and DWH. Regular meetings (quarterly or more frequently) will allow for team-based approaches to challenges and will institutionalize the practice of performance review and forthright communication. By bringing together the heads of the various participating divisions of each entity, silos that can traditionally form in multi-agency projects like this will be minimized. These decision makers will be able to confront areas of concern and address them collaboratively.

Regular and transparent engagement with our stakeholders is a fundamental aspect of maintaining open communication leading to positive results for the RUHS WPC Pilot. RUHS believes that the sustainability of the WPC Pilot is dependent on stakeholder relationships and that sound, structured stakeholder relationships serve to strengthen the resilience of the collaborative.

The RUHS WPC Pilot stakeholder group will meet on a monthly basis during the first year of implementation. A representative of each participating entity will be required to attend the regularly scheduled meetings. After the implementation year, meetings may shift to quarterly, depending upon the engagement during the subsequent years.

Understanding that group decision making is a type of participatory process in which multiple individuals acting collectively, analyze problems or situations, consider and evaluate alternative courses of action, and select from among the alternatives a solution or solutions, decisions will be made with each member of the stakeholder group being equal in weight. The development of the process for group decision-making is important and will be addressed by the entire group.

RUHS has a full team of marketing and communications professions that will develop an external communications plan that will be used to communicate with providers, beneficiaries and stakeholders. Upon award, the RUHS Marketing and Communications Department will meet with the stakeholders to craft a communications plan that address the needs of all stakeholders.

2.3 Target Population(s) Identify the target population(s) that will be served by the WPC pilot

The RUHS WPC Pilot is targeting individuals with the following characteristics:

- New probationers;
- Probationers who are on probation for at least one full year;
- Probationers who, are at-risk of, or experiencing homelessness;
- Probationers who have a behavioral health diagnosis; and,
- Probationers who have a physical health diagnosis.

The Probation Department anticipates the RUHS WPC Pilot will screen and link approximately 7,800 probationers to be enrolled in Medi-Cal per year, totaling approximately 38,000 over the course of the pilot. Probationers will be offered screening at their first probation visit. Physical screenings performed by health care professionals will include blood pressure check, blood tests (Hemoglobin A1C, Hepatitis, HIV) and a TB test. Other written screening information collected includes health information and behavioral health information. Acceptance of the screening by the probationer enrolls them into the WPC pilot. They will be free to decline or accept screening without consequence.

Riverside University Health Systems hopes to be able to identify early stage disease processes as a result of this pilot. By doing so, RUHS can provide earlier care that is less burdensome to the

individual as well as reducing costs to the system. Assisting individuals to access care in a clinic setting, early in an illness, reduces the burden of care currently placed on the Emergency Department. The goal is to enroll every probationer found to have a need for behavioral, physical, social or housing needs, into the appropriate program. RUHS does not yet know the number of those who will follow through with accessing services to which they are referred although our goal is 100% of those referred. If the numbers of individuals accessing services exceeds the projected number, RUHS will hire additional personnel.

The Director of the Behavioral Health, in partnership with the Director of Population Health, met with the Riverside County Sheriff's and Probation Departments to discuss the Cal Forward report and the needs as set forth by the Plata v. Brown and the Public Safety Realignment Act. The target population was identified by RUHS after discussions with the following departments of Riverside County:

- Detention Health Services
- Sheriff
- Probation
- RUHS Public Health
- RUHS Medical Center
- Community Care Clinics
- Behavioral Health
- DPSS

After a thorough discussion between all parties, this target population was chosen for the following reasons:

- There is minimal preventive care being performed while individuals are incarcerated-acute issues are addressed while incarcerated;
- New probationers with undiagnosed chronic physical health conditions;
- New probationers with undiagnosed behavioral health issues, including some with serious mental illness (SMI);
- New probationers use the ED for primary health care needs;
- Most individuals are at-risk of being homeless or experiencing homelessness;
- Most individuals need assistance to obtain social services such as Medi-Cal and food programs.
- Better coordination among Riverside County Departments in the care of new probationers would be beneficial;
- Streamlining of services and role clarification amongst Riverside County Departments is needed;
- There are gaps in services provided to new probationers;
- There is a need for a high quality, brief, assessment tool to assess for physical health, behavioral health, trauma-experience, housing and supportive needs of new probationers;
- There is a need for coordination in supporting the well-being of new probationers; and,

- There will be a substantial cost-savings and improvement in the quality of life for Riverside County residents in a successful program identifying needs and coordinating the care of new probationers.

RUHS Population Health did further research to determine:

- According to one alarming statistic, one in five people leaving prison will soon be homeless (National Alliance to End Homelessness, 2013).
- Obtaining housing is complicated by several factors, including the scarcity of affordable and available housing, legal barriers, discrimination against ex-offenders, and strict eligibility requirements for federally subsidized housing (The Council of State Governments, What Works in Reentry).
- In a 1996 HUD study, of those homeless, 49% of adults have reported that over their lifetimes, they have spent five or more days in a city or county jail, where 18% of those experienced incarceration in a state or federal prison (Burt et al., 1999).
- A large number of new probationers have HIV or AIDS or other illnesses such as hepatitis B, hepatitis C, and tuberculosis (National GAINS Center 1999; Roberts, Kennedy, and Hammett 2002).
- Although national numbers on the prevalence of HIV among new probationers are not tabulated, the National Commission on Correctional Health Care (NCCHC) estimated that between 13.1 to 19.3 percent of inmates with HIV were released from prisons and jails in 1996 (2002).
- Ex-prisoners also have high rates of substance abuse and mental illness (Beck and Maruschak 2001). Estimates of the substance abuse problems of new probationers, which derive from numbers gathered for the incarcerated population, range from 55 to 84 percent (Hughes, Wilson, and Beck 2001; Mumola 1999).
- According to the Bureau of Justice Statistics, an estimated 16% of adult prisoners report having either a mental disorder or an overnight stay in a psychiatric facility (Ditton, 1999.)

Unfortunately, there is little data regarding the post-custody physical health, behavioral health, housing and supportive service needs and resulting outcomes of new probationers. Through screening, the RUHS WPC Pilot seeks to identify baseline occurrence for these issues as well as others and to measure the impact of a coordinated complex care management model.

RUSH anticipates that all WPC Pilot participants will be eligible Medi-Cal beneficiaries.

The RUHS WPC Pilot will not cap enrollment for any year of the project.

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

3.1 Services, Interventions, and Care Coordination

The RUHS WPC Pilot is committed to providing safe and quality care to the underserved and vulnerable probationer population which is easy to access, centered around the probationers, coordinated across all care domains and engages community resources thereby both raising the quality of care and reducing healthcare expenditures and generating savings via accessing services in the right place at the right time

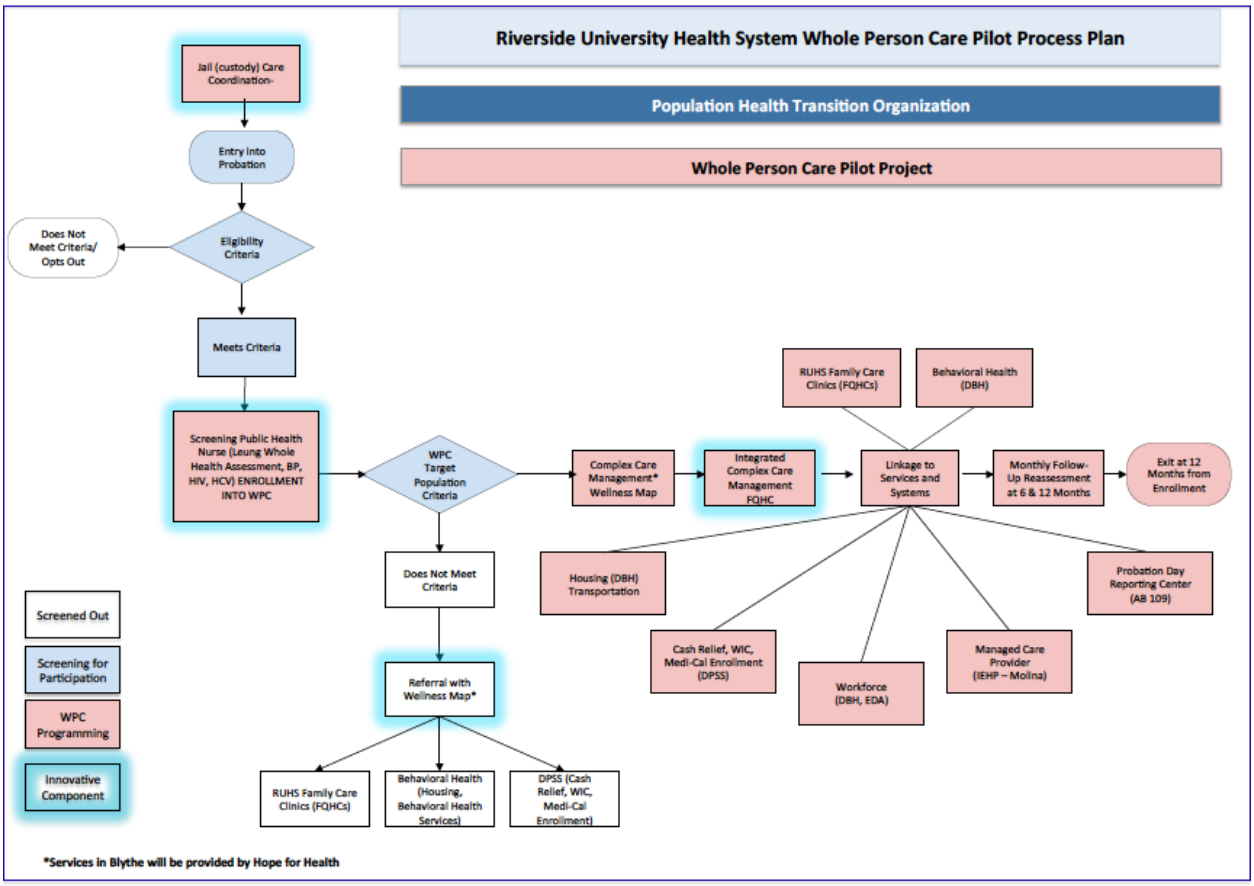
After months of careful planning, the RUSH WPC Pilot stakeholder team determined that no one, singular department/agency could address the continuum of care and the complex needs of new probationers. The RUHS WPC Pilot team sought to **increase integration** among county agencies, health plans, providers, and other entities within Riverside County to address the needs of these high-risk, high-utilizing beneficiaries and develop an infrastructure to ensure local collaboration among the entities participating in the RUHS WPC Pilot over the long term. The RUHS WPC Pilot team was developed in an effort to best utilize existing resources and coordinate them to meet the expansive needs of new probationers.

Through the dialogue portion of the RUHS WPC Pilot planning process, it was discovered that there was no singular entity responsible for **increasing coordination and appropriate access to care** for the probationer population. Utilizing Nurses to screen this population and RN Complex Care Coordinators and/or clinical therapists located at the RUHS FQHCs and DBH clinics, the RUHS WPC Pilot team, under the leadership of RUHS Population Health, will act as the organization responsible for increasing access and coordination to care for the probationer population.

Understanding that data access is a critical component of increasing coordination and appropriate access to care, RUHS has plans in place to integrate electronic health record components from both of the local Medi-Cal managed care health plan (MCP) into the Forward Health (FH) product. Both MCPs report Healthcare Effectiveness Data and Information Set (HEDIS) results in multiple domains and for multiple measures.

Figure 3 reflects the process flow for the RUHS WPC Pilot project.

FIGURE 3: RUHS WPC Pilot Process Flow



New probationers must report to their local Probation Department Office within 48 hours. A Nurse will be housed at each Probation Department Office. The Nurse will coordinate the screening and referral process for the individual including greeting, screening, and checking records for past services in the EHR.

The Nurse will enroll the probationer into the screening part of the WPC and evaluate the probationer for eligibility for RUHS WPC Pilot's Complex Care Case Management (CCCM). The probationer will be screened for the following:

- Length of time on probation-minimum 12 months
- At-risk of, or experiencing, homelessness;
- Social needs
- Medi-Cal eligibility
- Behavioral health needs; and,
- Physical health needs.

The Nurse will use a new Whole Person Care Health Score evaluation tool. The Whole Person Care Health Score evaluation tool is designed to assess for level of acuity in each of the broad

categories of: physical health, emotional health, resource utilization, socioeconomics, ownership, criminogenic needs, and nutrition/lifestyle. While there are numerous tools used to evaluate each of these individual categories (e.g. COMPAS for criminogenic needs, Vulnerability Index-Service Prioritization and Decision Assistance Tool (VI-SPDAT) for risk of homelessness, Adverse Childhood Experience (ACE), etc.), use of these individualized assessments would result in hours of assessments. The Nurse will screen rather than assess. Further assessments may be completed, in individual departments (DBH, FQHCs, etc), upon referral for additional care. Utilizing evidence-based assessments, Geoffrey Leung M.D., RUHS, Family Medicine Chair created a brief (35 questions), innovative survey that provides a snapshot of probationer needs in a very short amount of time. The Whole Person Care Health Score evaluation tool will be utilized in conjunction with EHR and claims data at 6 months and one year to determine plan progress.

The Nurse will also perform the following assessments:

- Blood pressure
- HbA1c
- HIV
- Hepatitis
- Tuberculosis

Based on screening results, the Nurse will coordinate "warm hand offs" to the appropriate department(s) to provide follow up. These departments include DPSS for access to Medi-Cal, Cal Fresh, Welfare service, etc; DBH for services related to serious mental illness and housing for those with mental illness; FQHC clinics for all identified medical and mild/moderate mental illness; Office on Aging for those who qualify for their services; and into the community for additional housing support.

The "warm hand offs" from one agency to another for the individuals needing services will occur via the Nurse. The Nurse will provide information directly to the referent agency. Each of the departments, above, have Care Managers who will provide personalized assistance that is specific to the resources being accessed in the individual department. The goal of the Nurse is to have specific appointments made and paper work completed prior to the probationer exiting this visit with the Nurse. After the first encounter with the Nurse, and upon accessing services from the departments as outlined above, the probationer will be care managed within the department from which they are receiving services. There will be Care Managers, within the FQHCs, to provide services for those with complex care needs.

Upon the request of the probationer, the Probation Officer will be a part of the team approach to insuring the individuals' care is accomplished and communicate with the Care Manager. The nurse will seek to solve any issues related to access to care as identified by either the Probation Officer or the individual. If the probationer is able to access services without complication, the nurse's role will be complete.

Each probationer will also receive a personalized Wellness Map. The Wellness Map is an innovative technology-based tool that provides the recipient with local resources (either online or via a hard copy) to address their health and social service needs. Personalized to their location, the map will assist the probationer in accessing physical and behavioral health care, housing support, and other supportive services.

The Nurse will schedule all needed follow up appointments at the nearest RUHS FQHC, DPSS office, and or DBH location. Absent of Blythe, each Probation Department Office is within easy access via public transportation to these services. While Blythe receives fewer than two probationers per week, the RUHS WPC Pilot team felt it was important to include services to new probationers in the community of Blythe. RUHS contacted Health to Hope—a nonprofit organization providing services via a FQHC in the Coachella Valley. At Health to Hope, patients receive care from providers experienced in meeting medically complex needs, as well as behavioral health issues. During the intake, assessment and treatment process, the behavioral health, social, and physical health needs of each patient are identified. The clinicians recognize the opportunity that primary care provides to heal the present issue and address the other issues through a model of care that integrates primary care, behavioral health care, and case management services. This is one option of a provider in the Blythe area.

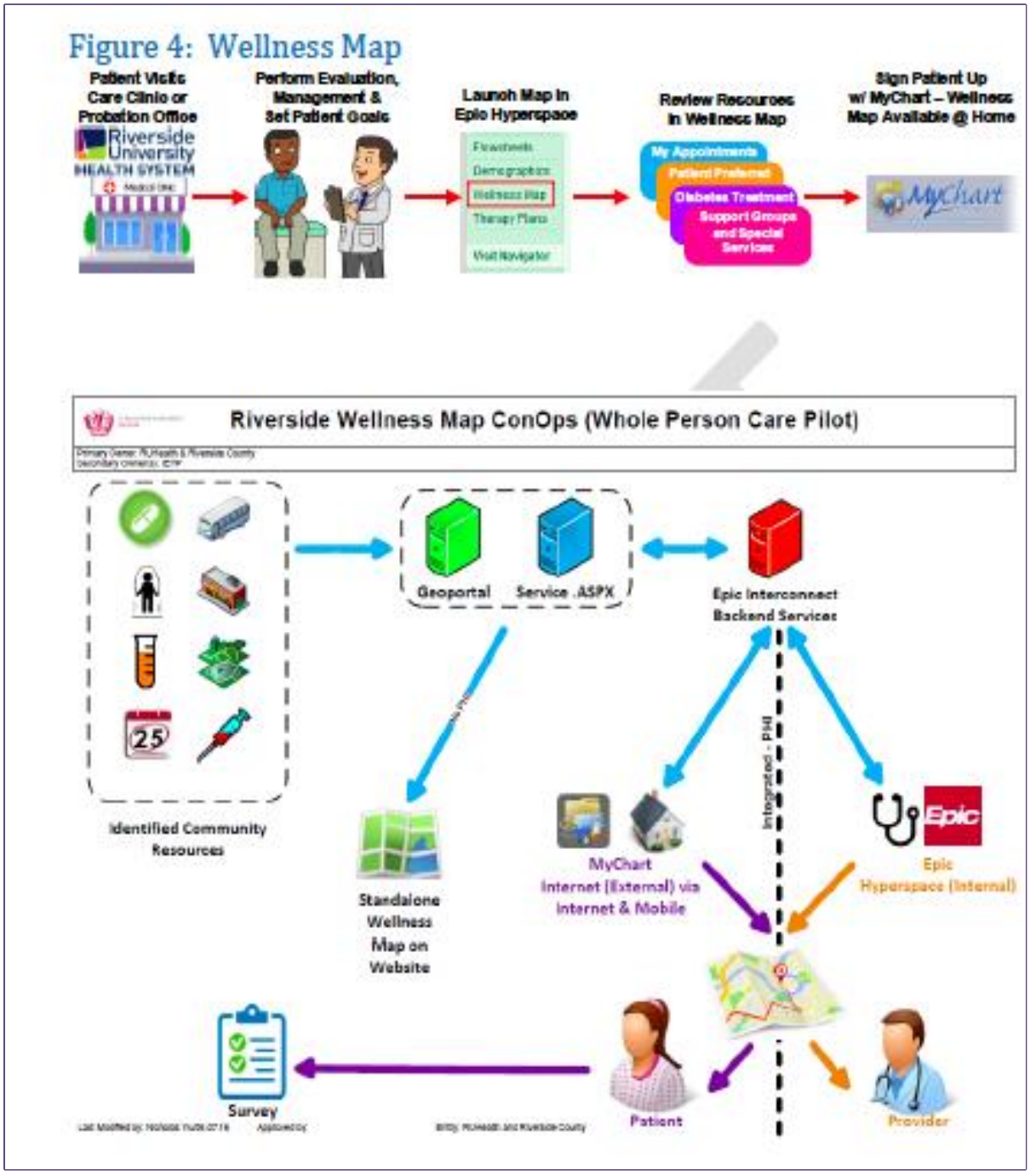
Understanding the need for carefully managing the expansive needs of new probationers, the RUHS WPC Pilot project will incorporate PRIME CCM techniques. There will be an equal number of RN Complex Care Case Managers, clinical therapists and care coordinators at each of the FQHC clinics. An RN Complex Care Case Manager or a Complex Care Clinical therapist will be assigned to each FQHC. The role of the RN Complex Care Case Managers will be to facilitate care of the Complex Care needs probationers between primary care, behavioral health and additional supportive services/enabling resources and coordinating providers.

RUHS WPC Pilot has been designed to support the mission of early recognition and treatment of disease, enhancing the quality of patient management and patient satisfaction. Continuity of care and cost effectiveness will be accomplished through the integration and functions of case management. The CCCM program provides intensive, personalized case management services and goal-setting for probationers who are at risk of homelessness, and have complex medical, behavioral and social service needs. This group requires a wide variety of resources to manage health and improve quality of life. Services will be provided in a collaborative process that will assess, plan, implement, coordinate, monitor and evaluate the options and services required to meet an individual's needs.

The RUHS WPC Pilot's Complex Care Case Management (CCCM) program will utilize the Epic EHR system and the Forward Health Population Health Management EHR system. Forward Health's application Population Manager will aggregate the disparate data sources in order to report and track progress on WPC pilot participants.

After presenting at the FQHC probationers will receive a customized Wellness Map. The LLUH Wellness Map integrates with the electronic health record (EHR) and can provide specific resources based on diagnosis, demographics, questions answered, gender, and other pertinent

information. See Figure 4 for high-level workflow. In addition, IEHP will share claims data with LLUH to create key performance indicators (KPIs).



There are ten RUHS FQHC Community Care Clinics. Through partial funding from IEHP, each FQHC is integrating behavioral health services through the Behavioral Health Integrated Complex Care Initiative. This will enable FQHCs to provide integrated behavioral and physical

health services in the primary care setting. In addition to the primary care and behavioral health care services provided at the FQHC, the CCCMs will link probationers to partners to assist with social service needs.

Understanding the importance of safe and stable housing, the RUHS WPC Pilot will create a housing bundle which will include a contract with DBH to perform the critical task of housing navigation for probationers diagnosed with a serious mental illness. DBH will work with the probationer to assist with housing needs and will determine their choice of housing. Some individuals may be desirous, and are in need of, supportive housing while others may seek to live independently. While the WPC prohibits rental subsidies, the RUHS WPC Pilot housing bundle will include financial assistance for non-rental support. Specifically, this money will be used to provide monies to landlords for up to a triple security deposit. Landlords are typically wary of offering housing to new probationers. The goal is to incentivize landlords to allow this population to obtain housing. The RUHS WPC Pilot is allocating over $900,000 for housing approved housing assistance. For people who do not meet the WPC Pilot project criteria, referrals to other community providers such as Path of Life Ministries, the Housing Authority and National CORE will be made.

As part of the assessment, the Nurse will link probationers to other supportive services such as employment development, assistance with enrollment into Medi-Cal, application for CalFresh, WIC, and cash-aid through partnerships with the DPSS. Probationers will also receive additional necessary services through the CCCM at the FQHC and within the DBH clinics, for complex care management assistance, as needed.

A Care Management bundle will provide care management to all probationers with a severe mental illness (SMI) who also have at least 5 other health diagnoses. This population is consistent with the population being care managed within the Complex Care (CC) part of the PRIME portion of the 2020 waiver. To determine the Prime CC population, a data query examined the percentage of patients using 50% of the total dollars spent on services provided by RUHS (DBH, MC and clinics). This data was then cross referenced with IEHP data. The total cost of services within these departments was 1.4 billion dollars. A subsequent report determined that 2.3% of the population utilized half of the RUHS resources ($700 million). Within this 2.3%, RUHS further narrowed the population by including those with a BH diagnosis and 5 other health diagnoses. The WPC will require SMI to qualify which the CC criteria will not. These patients are those in the most need of care management services.

The RUHS WPC Pilot administrative team will ensure the use of the Plan-Do-Study-Act (PSDA) process on a regular basis. PDSAs will be incorporated during the stakeholder meetings.

3.2 Data Sharing

The RUHS WPC Pilot stakeholder group understands the importance of, and is committed to, the collection, sharing and analysis of data. Thanks to a substantial financial investment from IEHP, RUHS will soon be “going live” with Epic and Forward Health, PopulationManager®,a powerful health analytics and data visualization platform. PopulationManager® focuses on

patient-level, point-of-care quality improvement support and aggregation of measures within a single health care provider organization.

While not all participating WPC partners are utilizing the Epic data management system, Forward Health has the ability to pull data from disparate electronic record systems. IEHP and Molina Healthcare will be providing member use information to the RUHS WPC Pilot. The RUHS WPC Pilot administrative team will have the capability to navigate the various data platforms to access participant data.

Approximately two years ago, RUHS, Riverside County and Loma Linda University Health entered into a formal agreement for a Clinically Integrated Network (CIN). The CIN is a result of the leadership of two large public county Medi-Cal/Medicare health plans. Components of the CIN include regional medical centers, primary care clinic systems, FQHCs, and a large academic medical center. It further includes the largest FQHC Look Alike in the region to transform clinical practices in the Inland Empire. Lastly, the CIN addresses the health and funding disparities in the region.

The initial meeting of the CIN took place in October 2014. Representatives of all organizations soon signed a formal commitment to the CIN. The RUHS WPC Pilot will utilize the CIN structure to review and analyze clinical and financial measures, examine areas of partner success, discuss replicating success at all clinics and learn about practice transformation best practices to increase patient safety, make the region healthier, move towards better coordination with post-hospital care and improve clinical quality.

RUHS surveyed all partners to determine their current system for data collection as well as the potential for data sharing. While it was expected that there would be extensive barriers to overcome in the sharing of data, the signed commitment to the CIN and the use of Forward Health, PopulationManager® has resulted in the ability to share data.

The RUHS WPC Pilot will ensure compliance with all applicable state and federal laws when sharing data containing Personal Health Information/Personal Information (PHI/PI), mental health or substance abuse disorder information. Forward Health's cloud based solution will allow to easily deploy Population Manager to all WPC Pilot participating agencies without location restrictions. Role based security permissions are administered at both the interface and database level providing granular security capabilities that limit access to PHI/PI.

All communication to and from Population Manager is encrypted using the most stringent industry standard data encryption protocols. In addition to the encryption on the user interface all data transferred between Forward Health and RUHS is transferred using the encrypted secure file transfer protocol (sFTP). To assure the highest level of data security and privacy Forward Health has recently completed a successful SOC 2, Type II audit. The Service Organization Control (SOC) 2 type II audit measured Forward Health's description of security and privacy controls but also included rigorous testing of the controls over the most recent six month period. All data access and querying is aggressively audited and reportable through Population Manager.

In addition to the use of Epic and Forward Health, PopulationManager®, the RUHS WPC Pilot will work with IEHP to utilize their Member data. IEHP will provide in-kind initial population-level measurement reports to the RUHS WPC Pilot and comparison reports to document member utilization changes and health outcomes. IEHP will support consulting engagements through fund matching, managing partnering clinic consultant activities and provide additional technical assistance and ongoing support as needed. The RUHS WPC Pilot will use IEHP data and results to improve core clinical and operational quality measures. Generated data will be used to monitor and communicate practice performance, improve primary and specialty care delivery coordination and improve patient outcomes.

IEHP requires clinicians and practices to utilize appropriate code sets including the HIPAA Compliant 837 Version 5010. Records are identified by a unique Claim Reference Number. IEHP has established HIPAA-complaint processes to receive industry standard encounter feeds from all contracted providers (i.e., 837-P, 837-I file formats). IEHP also receives lab results via standard transaction data sets (HL-7) from contracted labs which many IECPT partners utilize (i.e., LabCorp, Quest, BioData, ARMC). Any data that is stored solely in the EMR or medical record will need to be collected via chart review.

IEHP's bi-directional data exchange capabilities with participating clinicians/practices allows partners to make informed and effective resource allocation decisions. IEHP hosts a secure web portal for contracted providers, which serves as the main Provider data sharing method. IEHP regularly posts care rosters and other patient-level data for Providers on the portal. Project-level data will be gathered and analyzed to determine successes, failures, and best practices in order to replicate the efforts across the region.

RUHS has begun work on a system wide data governance initiative that will build on existing policy. Current RUHS data integrity and validation policies require that all data reports go through a multi-point approval process. An administrative committee will be formed for the WPC pilot with purview over data validation. Questions regarding data validity are initially filtered through the RUHS-IS project manager and the WPC executive stakeholder who have responsibility for confirming the accuracy of the data in conjunction with the submitting entity. Ambiguity will be settled by the data validation administrative committee.

While RUHS has not yet implemented Epic and Forward Health, PopulationManager®, implementation is imminent. By Fall, 2016 RUHS will have implemented Epic and Forward Health, PopulationManager®.

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

4.1 Performance Measures

The RUHS Whole Person Care Pilot project personnel will identify, track, and measure numbers of screening and referral of new probationers. Nurses will screen probationers at the first

probation visit (approximately 48 hours post release), for social service, behavioral health, housing and physical health needs. The Nurse in Probation will be the gate keeper for tracking referrals into other departments including DBH and the FQHCs. The Complex Care WPC probationer population will be "owned" by the care management team within the FQHCs. The care management team, within the FQHCs, will act as the lead entity for all care management activities and will ensure coordination of care and access to needed services.

The Nurses will refer probationers to Riverside County Department of Public Social Services (DPSS) personnel to assist probationers sign up for Medi-Cal and to access other services they are eligible for (ie: WIC, Cal Fresh, etc). DPSS will track and measure numbers of individuals referred to them and will also track how many are assisted in provision of services and which services they received. Inland Empire Health Plan (IEHP) and Molina will also track numbers of individuals signed up for Medi-Cal services via this referral pathway.

The Nurses will make referrals to Department of Behavioral Health (DBH) for probationers who screen positive for risk of depression, substance and/or alcohol use, serious mental illness needs and housing assistance due to a serious mental illness. DBH staff will track: the number of referrals, the type of referrals (shelter and/or housing), and the length of time they are able to maintain permanent housing.

The Nurse will make referrals for people's housing needs not associated with a mental health diagnosis to the community partners. The community partners/providers will track metrics on referrals and numbers of individuals provided with shelter and/or housing and the length of time they are able to maintain permanent housing.

The Nurse will also refer probationers to Riverside County FQHC clinics for all identified medical needs including positive screens for HIV, TB, Hep C, HgA1C, and hypertension as well as any additional needs identified in the written screening process. The Nurse will refer the probationer to DPSS to be signed up for Medi-Cal. Working in concert with Molina and IEHP, the probationer will select a physician close to their place of residence (via the managed Medi-Cal web portal or phone). If the probationer requires assistance with this process, managed Medi-Cal providers, probation personnel and/or the Nurse will assist.

The Riverside County Sherriff's Department and Riverside County Department of Probation will track probationer numbers who are re-incarcerated as well as those who are not compliant in keeping probation appointments. The goal is to reduce the number of probationers who are re-incarcerated due to early linkages to social services, housing, behavioral health and medical care.

RUHS will also track the numbers of probationers who have avoidable Emergency Department (ED) visits (at both the medical and psychiatric emergency departments) and how many avoidable hospitalizations occur. The goal is to reduce use of the ED as a site for primary care access via early identification of disease, or disease risk, and proactive access to m/cal and medical, social, housing and behavioral health services.

RUHS has purchased a Population Health electronic management system intended to capture data from multiple disparate electronic health records and databases. RUHS Information

Services is currently working on ensuring all metrics related to WPC needs will be built into reports that can be reviewed by both individual departments and the WPC committee as a whole. Trends will be carefully assessed.

This is a new program. No current data exists to measure any of these outcomes. For this reason, the first year of this study will be focused on gathering data to see what our current state is. Baseline year data will be collected via the Forward Health population health tool recently purchased by RUHS. RUHS anticipates that through early linkage to Medi-Cal, early assessment of risk factors and identification of disease, housing and social service needs, probationers will be more likely to be successful on probation.

The WPC committee hopes that the numbers of probationers inappropriately accessing services from the ED will be reduced. We will establish a baseline number of probationers inappropriately accessing primary care services from the ED during PY 1 and use this number as our baseline from which to improve. This will be our performance metric.

4.1.a Universal Metrics

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

☒**Health Outcomes Measures**

☒**Administrative Measures**

4.1.b Variant Metrics

Required variant metrics will be as follows in the excel document.

After a survey was completed by all partners, the RUHS WPC Pilot partners also agreed upon the following administrative and health outcomes. These may be duplicative of what is required to be gathered within the variant metrics.

Administrative Outcome Metrics	Year 1	Year 2	Year 3	Year 4	Year 5
Data Sharing- implementation of EPIC electronic documentation and Forward Health (FH) will execute this (both are being launched prior to the beginning of this WPC pilot)	Establish methodology	Universal for participating departments	Universal for participating departments	Universal for participating departments	Universal for participating departments
Universal Care Coordination-When EPIC and FH are in place; there will be a specific universal care coordination tool to provide necessary data. The actual structure and flow of communication will need further design work.	Establish methodology	Universal for participating departments	Universal for participating departments	Universal for participating departments	Universal for participating departments
Total participants screened (all probationers at-risk and expected to remain in probation for at least 12 months) **Performance metric**	Establish Baseline	Maintain baseline	Increase of 5% over baseline	Increase 5% over PY 3	Increase 5% over PY 4
Total enrolled into WPC every month (those with both a physical and a behavioral health problem needing a referral and will remain in probation for at least 12 months.	Establish Baseline	Maintenance of baseline metric	Increase of 5% over baseline	Increase 5% over PY 3	Increase 5% over PY 4
Participants screened who are referred to follow up for the following:	Establish Baseline	Maintenance of baseline metric	Increase of 5% over baseline metric	Increase 5% over PY 3 metric	Increase 5% over PY 4 Metric
• **alcohol and other drug use/abuse.**					
• **physical health needs**					
• **social services**					
• **behavioral health needs.**					
• **housing services.**					
• **HIV**					

• high blood pressure					
• HgbA1C					
• Hepatitis C					
• tuberculosis					
• other referrals					
Medi-Cal Enrollment-(all probationers will be screened for Medi-Cal enrollment and enrolled if appropriate)	Establish baseline	Maintenance of baseline metric	Increase of 5% over baseline	Increase 5% over PY 3	Increase 5% over PY 4
Department Integration Meetings-All participating departments will meet monthly and then quarterly to determine administrative modifications and data collection analytics.					
Health Outcome Metrics	**Year 1**	**Year 2**	**Year 3**	**Year 4**	**Year 5**
Decrease avoidable admission to psychiatric and primary care hospitals.	Establish baseline.	Decrease by 5% over baseline year	Decrease by 5% over year 2	Decrease by 5% over year 3	Decrease by 5% over year 4
Decrease avoidable emergency department usage for both physical and behavioral health primary care needs.	Establish baseline.	Decrease by 5% over baseline year	Decrease by 5% over year 2	Decrease by 5% over year 3	Decrease by 5% over year 4
Adult Major Depression Disorder (MDD): Suicide Risk Assessment **(Defined as: Percentage of patients aged 18 years and older with a diagnosis of major depressive disorder (MDD) with a suicide risk assessment completed during the visit in which a new diagnosis or recurrent episode was identified). This would be done, in the clinic setting, when probationers are referred. This will not be done by the Nurse, as a screening activity**	100%-in clinic setting-upon referral. Not to be done by Nurse in probation.	Clinic metric	Clinic metric	Clinic metric	Clinic metric
Antidepressant Medication Management **(Defined as: Percentage of adults 18 years of age and older with a diagnosis of major depression, who were newly treated with antidepressant medication and remained on an antidepressant**	Establish baseline.	Clinic metric	Clinic metric	Clinic metric	Clinic metric

medication treatment). This data component will be gathered in the FQHC and DBH clinics.					
Housing - Defined as: **1) Percentage of participants, adults 18 years of age older, homeless who acquired housing**	Establish baseline.	Maintenance or improvement of baseline metric	Increase of 5% over baseline	Increase 5% over PY 3	Increase 5% over PY 4
2) Percentage of participants who acquired housing, successfully maintained housing 6 months or longer.	Establish baseline.	Maintenance or improvement of baseline metric	Increase of 5% over baseline	Increase 5% over PY 3	Increase 5% over PY 4
3) % of probationers referred for alcohol and other drug use/abuse who kept appointment	Establish baseline.	Maintenance or improvement of baseline metric	Increase of 5% over baseline	Increase 5% over PY 3	Increase 5% over PY 4
4) % of probationers referred for physical health needs (including HIV, BP, HgA1C, Hepatitis or TB), who kept appointment.	Establish baseline.	Maintenance or improvement of baseline metric.	Increase of 5% over baseline	Increase 5% over PY 3	Increase 5% over PY 4
5) % of probationers referred to services for behavioral health needs who kept appointment.	Establish baseline.	Maintenance or improvement of baseline metric	Increase of 5% over baseline	Increase 5% over PY 3	Increase 5% over PY 4
6) % of probationers referred to services for housing who kept appointment	Establish baseline.	Maintenance or improvement of baseline metric	Increase of 5% over baseline	Increase 5% over PY 3	Increase 5% over PY 4

4.2 Data Analysis, Reporting and Quality Improvement

Data will be collected monthly and will be reported to the RUHS Director of Population Health or designee. Analysis of data will occur in a monthly meeting which will include all Community and County stakeholders involved in the RUHS WPC Pilot. Results of data will be compared to goals in short-term process measures and ongoing outcome measures. A PDSA review will be in place to make changes to processes or data collection as needed to reach the goals of the RUHS WPC Pilot.

Health outcomes will be assessed through tracking of departmental data and will be align with HEDIS and OSHPD measures, PRIME outcomes, specific RUHS WPC Pilot measures and all other required and optional quality improvement measures being currently utilized. The Forward Health (FH) Population Health management tool will assist in gathering and compiling data from all participating departments. Until FH is fully implemented (expected to go live prior to the RUHS WPC Pilot approval date but may not include all stakeholders immediately), each department will ensure they are able to gather and produce reports needed for the RUHS WPC Pilot. This data analysis, reporting, and quality improvement will all be done in the context of

the Plan, Do, Study, Act methodology as outlined by the CA Department of Health Care Services.

As there is insufficient data to provide current state on those probationers who receive care for behavioral, physical and social needs currently, the concrete returns on investment for this project will be demonstrated during year 2. Most notably, until all stakeholders have approved a definition of recidivism, it will be difficult to determine the recidivism rate. The RUHS WPC Pilot will determine the baseline for "bookings" into jail. While this does not necessarily accurately reflect new crimes and/or convictions, it does provide a number from which to compare to show progress.

Other studies have demonstrated that the societal impact of former inmate homelessness, unemployment, and unnecessary medical usages are significant. The average cost of homelessness per person per year is over $34,000. Incarceration per inmate per year averages around $31,000. The average emergency room visit averages $1,233 and average hospitalization exceeds $12,000.

Without early identification and adequate referrals and support, former inmates suffering from mental illness and/or physical ailments are substantial contributors to these costs. According to the California Legislative Analyst's Office, it costs an average of about $47,000 per year to incarcerate an inmate in prison in California. Over two-thirds of these costs are for security and inmate health care. Since 2000-01, the average annual cost has increased by about $19,500. This includes an increase of $8,300 for inmate health care and $7,100 for security.

Therefore, return on investment is expected to be demonstrated due to early assessment, identification of risk and proactive referral linkages for assistance in social, behavioral and physical care needs. The goal is to ensure provision of services in the right setting and in a coordinated care managed method. This approach should reduce the use of the ED, and following hospitalization for both mental and physical needs. Also, the goal is to identify and assist with social needs in order to improve access to food and shelter. Thus, the number of people re-entering into jail in order to obtain food and shelter will be diminished.

4.3 Participant Entity Monitoring

RUHS will be the lead for the RUHS WPC Pilot. The Director of Population Health, or designee, will receive information from all county and community participants on a monthly basis. A committee comprised of a representative from all county and community participants will review the data. The RUHS Chief Integration Officer will direct and assist departmental IT personnel in proactive data collection and reporting to meet the requirements of the WPC project.

If a participating entity does not demonstrate compliance with the expectations set forth in the RUHS WPC Pilot, a review for discovery of barriers will be implemented. This will include a request for remediation as applicable to the situation. If there is a repeated inability to

demonstrate compliance, the committee will review and make recommendations for improvement and/or termination of participation.

During the first 6 months of the first year of the RUHS WPC Pilot, the committee will meet monthly. Based on outcomes and committee vote, after the first 6 months, the committee will continue to meet monthly or will move to meeting quarterly. At each meeting, the committee will request data summary from each participant and will discuss and provide recommendations as needed.

Section 5: Financing

5.1 Financing Structure

Program Funding Overview

Riverside County's Whole Person Care pilot proposal has a yearly $7 million budget, and targets a high-risk population needing behavioral and physical health intervention. The county's funding responsibility for the match is $3.5 million; which will be funded using a combination of Mental Health Services Act funds, and Non-Federal Hospital Enterprise Funds. All County departments as well as the Executive Office and Board of Supervisors are supportive of this program.

A new fund will be established to track and manage the inflow and outflow of payments and revenue. This fund will be under the control of the pilot manager as approved by the county's Board of Supervisors. The new WPC Pilot Project fund will have a Board-approved budget in an amount equal to the project budget.

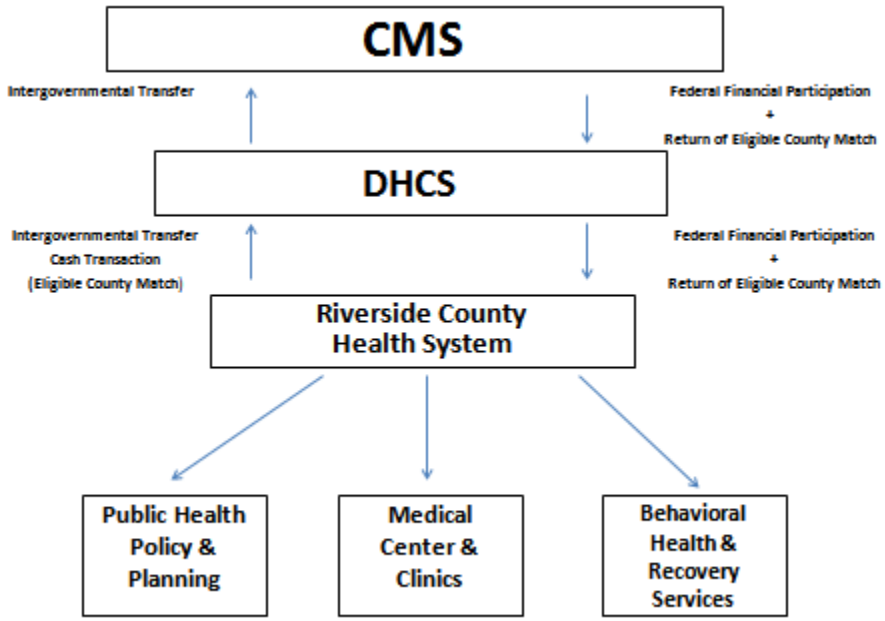
Administrative staff will be assigned to and directly paid from this fund. Program staff providing screening and other direct participant support will be assigned to participating county departments, particularly Behavioral Health and Public Health. These county departments will be reimbursed for the personnel costs associated with this program.

County staff, hired or reassigned to this program will perform all necessary tasks. Data sharing with participating partners is an important component of this project, so this cost is included.

Initiating and maintaining ongoing medical or behavioral care is an integral and essential element of this program. In order to achieve this goal, WPC Pilot staff will take the steps necessary to confirm existing medical insurance coverage for all participants. Failing this, staff will help participants apply for new coverage. The target population is typically uninsured, and qualifies for Medi-Cal. The cost of direct patient care – clinic visits, medication, or hospitalization – will be billed to medical insurance. No direct patient care costs will be charged to the WPC.

5.2 Program Funding Diagram

Figure 5 reflects the flow of requested funds from DHCS to RUHS and other participating entitle



Riverside University Health System Eligible County Match is $3.5 million; which will be funded using a combination of Mental Health Services Act funds and Non-Federal Hospital Enterprise Funds. RUHS will carry out an Intergovernmental Transfer (IGT) to DHCS. DHCS will complete an (IGT) to CMS. CMS will combine the Eligible County Match and the Federal Match for a total of $7 million and transfer to funds to DHCS. DHCS which will then forward the Federal Financial Participation and Return of Eligible County Match to Riverside County Health System.

5.3 Non-Federal Share

Riverside County is committed to whole person care and in improving the quality of life for the residents of the county. The county's funding responsibility for the match is $3.5 million; which will be funded using a combination of Mental Health Services Act funds and Non-Federal Hospital Enterprise Funds.

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

The RUHS WPC Pilot is designed to provide coordinated complex care management to new probationers. All participants will be current Medi-Cal beneficiaries or will be enrolled into Medi-Cal at enrollment into the RUHS WPC Pilot and will meet the terms set forth in STC 111. Participants will be identified as high-risk, high-utilizing Medi-Cal beneficiaries who

frequently access urgent and emergency services, across multiple systems. The RUHS WPC Pilot will ensure that alternative care models currently available through existing resources shall be available to all individuals identified as meeting the criteria as set forth in STC 111. RUHS will ensure compliance with STC 113 by listing all Universal and Variant metrics that the collaborative plans to meet for each program year. RUHS WPC Pilot is familiar with the terms set forth in STC 114 and will ensure compliance and adherence. Riverside County is approved for targeted case management (TCM) for five California State Plan target populations including children under the age of 21, medically fragile individuals, individuals at risk of institutionalization, individuals in jeopardy of negative health or Psycho-Social outcomes, and individuals with a communicable disease.

The vast majority of the activities and interactions of the WPC care coordination teams will not duplicate Medi-Cal's TCM benefit. Specifically, care management in DBH, the FQHC clinics, DPSS and the housing authority departs significantly from the encounter-based structure of TCM. Additionally, to protect against potential overlap, Riverside will compare client level data, capturing any potential overlap in services and ensuring that clients are appropriately covered by pre-existing programs and that WPC is the payor of last resort.

Moreover, the scope of care support and coordination activities available through WPC is intended to be more robust than available through TCM. WPC teams will engage in activities such as comprehensive screening, peer support, trust-building, motivational supports, disease specific education, and general reinforcement of health concepts, as well as introducing clients to Wellness Mapping, which are distinct from and outside the TCM benefit. WPC will also provide direct social and other services that would not be recognized as TCM, such as in-depth case management which will guide clients through Medi-Cal enrollment, and tenancy support. For these reasons, we have concluded that the vast majority of WPC Pilot activities will not duplicate services available through Medi-Cal TCM.

However, in response to concerns of duplication of payment, Riverside County has calculated a 9% reduction in the WPC screening/outreach FFS rate, or $200k in total, to offset potential financial overlap in any county program that utilizes TCM. This figure was calculated based on a percentage of the county's TCM claims where the possibility of overlap may occur

5.5 Funding Request

a.BudgetModel

Riverside University HEALTH SYSTEM

Whole Person Care Pilot Project

Riverside University Health System
Whole Person Care Pilot Budget

Administrative Infrastructure				Year 2	Year 3	Year 4	Year 5
Position	FTE	Salary & Benefits	Total Salary & Benefits	TOTAL	TOTAL	TOTAL	TOTAL
Director	0.25	63,000	$ 63,000	$ 64,056	$ 64,056	$ 64,056	$ 64,056
Administrative Services Manager I	1	154,000	$ 154,000	$ 156,580	$ 156,580	$ 156,580	$ 156,580
Indirect Expenditures 5%			$ 10,850	$ 11,032	$ 11,032	$ 11,032	$ 11,032
Total Administrative Infrastructure				$ 231,668	$ 231,668	$ 231,668	$ 231,668

Delivery Infrastructure			Year 2	Year 3	Year 4	Year 5
Item	Qty	Cost	TOTAL	TOTAL	TOTAL	TOTAL
Notebook computers	23	$ 1,500	$ -	$ -	$ -	$ -
Cell	23	$ 960	$ -	$ -	$ -	$ -
LLUH Wellness Mapping	1	$ 325,200	$ 289,200	$ 289,200	$ 289,200	$ 289,200
Health to Hope Mileage	5200	$ 0.54	$ -	$ -	$ -	$ -
Total Delivery Infrastructure			$ 289,200	$ 289,200	$ 289,200	$ 289,200

Screening/Outreach				Year 2	Year 3	Year 4	Year 5
Position	FTE	Salary & Benefits	Total Salary & Benefits	TOTAL	TOTAL	TOTAL	TOTAL
RN V	10.6	$ 147,970	$ 1,568,478	$ 1,594,759	$ 1,594,759	$ 1,594,759	$ 1,594,759
OA III	1	$ 71,183	$ 71,183	$ 72,376	$ 72,376	$ 72,376	$ 72,376
Assist. Nurse Manager	1	$ 158,775	$ 158,775	$ 161,435	$ 161,435	$ 161,435	$ 161,435
Lab/Medical Costs			$ 281,316	$ 286,030	$ 286,030	$ 286,030	$ 286,030
Indirect Expenditures 5%			$ 89,922	$ 91,429	$ 91,429	$ 91,429	$ 91,429
Total Screening/Outreach				$ 2,206,029	$ 2,206,029	$ 2,206,029	$ 2,206,029
Possible TCM Duplication				$ (200,000)	$ (200,000)	$ (200,000)	$ (200,000)
Number of Services				8,400	8,400	8,400	8,400
Screening/Outreach Fee For Service Rate				**$ 239**	**$ 239**	**$ 239**	**$ 239**

Care Management				Year 2	Year 3	Year 4	Year 5
Position	FTE	Salary & Benefits	Total Salary & Benefits	Total	Total	Total	Total
RN V	9.6	$ 147,970	$ 1,420,508	$ 1,444,310	$ 1,444,310	$ 1,444,310	$ 1,444,310
OA III	1	$ 71,183	$ 71,183	$ 72,376	$ 72,376	$ 72,376	$ 72,376
Assist. Nurse Manager	1	$ 158,775	$ 158,775	$ 161,435	$ 161,435	$ 161,435	$ 161,435
Indirect Expenditures 5%			$ 82,523	$ 83,906	$ 83,906	$ 83,906	$ 83,906
Total Care Management				$ 1,762,028	$ 1,762,028	$ 1,762,028	$ 1,762,028
Number of Members				420	420	420	420
Number of Member Months				5,040	5,040	5,040	5,040
Care Management Per Member Per Month Rate				**$ 350**	**$ 350**	**$ 350**	**$ 350**

Housing Navigation & Supports				Year 2	Year 3	Year 4	Year 5
Item	Positions	Salary & Benefits	Total Salary & Benefits	Total	Total	Total	Total
Behavioral Health Specialist II	9	$ 80,878.00	$ 727,902	$ 740,099	$ 740,099	$ 740,099	$ 740,099
Community Services Assistant	3	$ 68,285.00	$ 204,855	$ 208,288	$ 208,288	$ 208,288	$ 208,288
Direct Housing Supports Security Deposits/Application Fees			$ 564,900	$ 574,365	$ 574,365	$ 574,365	$ 574,365
Indirect Expenditures 5%			$ 64,640	$ 65,723	$ 65,723	$ 65,723	$ 65,723
Total Care Management				$ 1,588,475	$ 1,588,475	$ 1,588,475	$ 1,588,475
Number of Members				282	282	282	282
Number of Member Months				3,389	3,389	3,389	3,389
Housing Navigation & Supports Per Member Per Month Rate				**$ 469**	**$ 469**	**$ 469**	**$ 469**

Incentive Payments			Year 2	Year 3	Year 4	Year 5
Item	Qty	Cost	TOTAL	TOTAL	TOTAL	TOTAL
Pay for Outcomes	1	$ 500,000	$ 500,000	$ 500,000	$ 500,000	$ 500,000
Pay for Reporting - Emergency Department	1	$ 150,000	$ 150,000	$ 150,000	$ 150,000	$ 150,000
Pay for Reporting - Outpatient Services	1	$ 150,000	$ 150,000	$ 150,000	$ 150,000	$ 150,000
Pay for Reporting - Housing Services	1	$ 200,000	$ 200,000	$ 200,000	$ 200,000	$ 200,000
Pay for Reporting - Avoided Hospitalizations Impact	1	$ 200,000	$ 200,000	$ 200,000	$ 200,000	$ 200,000
Total Incentive Payments			$ 1,200,000	$ 1,200,000	$ 1,200,000	$ 1,200,000

Grand Total Whole Person Care Pilot Budget	**$ 7,077,399**	**$ 7,077,399**	**$ 7,077,399**	**$ 7,077,399**

b. Budget Narrative

RUHS is requesting $7 million per year for the five year project, totaling $35 million to screen up to 42,000 probationers who are at risk of being homeless, with physical health and behavioral health issues who are high utilizers of emergency departments instead of primary care services. Below by budget category is additional information to explain the budget model including a description of the funds requested and how they will support the pilot.

Administrative Infrastructure – RUHS is requesting approximately $232k annually to cover the actual time and expenditures of the 1.25 FTE of staff who will oversee the Whole Person Care Pilot. These positions will provide the necessary programmatic supports, program development, program governance, training, assist in ongoing data collection, and other necessary administrative functions for the pilot.

Delivery Infrastructure – RUHS is requesting $289k annually to cover the actual expenditures associated with delivery infrastructure. As detailed in the budget model, RUHS is requesting notebook computers and cell phones for the 23 positions providing screening and care management services under the Whole Person Care Pilot at a combined cost of $56k. RUHS is also requesting $325k for a Wellness Mapping program. The Wellness Mapping program is an innovative technology-based tool that provides the recipient with local resources (either online or via a hard copy) to address their health and social service needs. Personalized to their location, the map will assist the probationer in accessing physical and behavioral health care, housing support, and other supportive services.

Screening/Outreach Services – RUHS is requesting Fee For Service reimbursement of $239 per screening up to a maximum reimbursement amount of $2.2m annually to cover the actual expenditures associated with new screening/outreach services to the eligible population. These figures reflect the 9% rate reduction for possible TCM payment duplication discussed later in the paragraph, prior to this reduction the proposed rate was $263. This figure was calculated assuming an estimated population of 8,400 potential probationers receives up to a two hour complete behavioral health and physical healthcare screening. If the full 8,400 probationers are screened, RUHS estimates a need for eleven Nurse V FTEs, one Assistant Nurse Manager for supervision, and one Office Assistant III to provide clerical support. This is based on the assumption that each Nurse can provide approximately 800 screenings per year. These figures also include 5% to cover operating costs related to the positions. Budget in this area will be adjusted if different disciplines are utilized for the Nurses as the project moves forward. Riverside County will offset possible TCM payment duplication by implementing a 9% rate reduction or $200K reduction per year in screening/outreach services.

Care Management Services – RUHS is requesting Per Member Per Month reimbursement of $350 per member per month up to a maximum reimbursement amount of $1.8m annually to cover the actual expenditures associated with new care management services to the eligible population. This figure was calculated assuming an estimated 5% of the screened population is identified as meeting the whole person care pilot criteria. If the full 420 probationers are care managed each month, RUHS estimates a need for ten Registered Nurse V FTEs, one Assistant Nurse Manager for supervision, and one Office Assistant III to provide clerical support. This is

based on the assumption that each Nurse can manage the complex care of approximately 44 probationers. These figures also include 5% to cover operating costs related to the positions.

Housing Navigation and Support Services – RUHS is requesting Per Member Per Month reimbursement of $469 per member per month up to a maximum reimbursement amount of $1.6m annually to cover the actual expenditures associated with assisting approximately 282 of the eligible care management population with housing navigation and supportive services. This figure was calculated assuming an estimated 282 clients require a personalized housing assessment plan, assistance touring potential housing, meeting with landlords, completing applications, negotiating rental agreements, completing reasonable accommodation letters, providing security deposits and helping establish the client into their housing arrangement. These figures include an estimated $2k per client to cover application fees and security deposits for the whole person care clients. Staffing required to provide this assistance includes nine Behavioral Health Specialist IIs, and three Community Services Assistants.

Incentive Payments – RUHS is requesting up to a total of $1.2m for five incentive payments related to Pay for Outcomes and Pay for Reporting. RUHS is requesting a $500k incentive payment for meeting the outcome goal of decreasing avoidable emergency department usage for both physical and behavioral health primary care needs by 5% from the baseline year. RUHS is requesting a $150k incentive payment for reporting on emergency department visits, a $150k incentive payment for reporting on outpatient services, a $200k incentive payment for reporting on housing navigation and supports, and a $200k incentive payment for reporting on avoided hospitalization impacts by partner agencies.

Section 6: Attestations and Certification

6.1 Attestation

This attestation is superseded by the revised attestation included in the agreement.

WHOLE PERSON CARE MONTHLY PHN SCREENING REPORT

(Due the 5th Working Day of Each Month)

Month: Month **Year:** 2016

PHN: First Last **Probation Location:** Location

I. SUMMARY OF REFERRALS

ALL NEW REFERRALS		PROBATION OFFICE VISITS INITIAL			TEST PERFORMED			WARM HAND OFF			PRODUCTIVITY		
Received	Waiting to be Seen	Released	Reported In	Assessed	TB	A1C	Other	Clinic Referral	Mental Health Referral	Other Referral	New Referrals	Assessments	Referred
											0	0	0

II. WORK SCHEDULE

Time Out of Office:

Time Serving Other Probation Office:

III. COMMENTS:

WPC Budget Template: Summary and Top

WPC Applicant Name:	Riverside University Health System

	Federal Funds *(Not to exceed 90M)*	**IGT**	**Total Funds**
Annual Budget Amount Requested	3,538,700	3,538,700	7,077,399

PY 1 Budget Allocation (Note PY 1 Allocation is predetermined)	
PY 1 Total Budget	7,077,399
Approved Application (75%)	5,308,049
Submission of Baseline Data (25%)	1,769,350
PY 1 Total Check	OK

PY 2 Budget Allocation	
PY 2 Total Budget	7,077,399
Administrative Infrastructure	231,668
Delivery Infrastructure	289,200
Incentive Payments	0
FFS Services	2,006,029
PMPM Bundle	3,350,502
Pay For Reporting	700,000
Pay for Outomes	500,000
PY 2 Total Check	OK

PY 3 Budget Allocation	
PY 3 Total Budget	7,077,399
Administrative Infrastructure	231,668
Delivery Infrastructure	289,200
Incentive Payments	0
FFS Services	2,006,029
PMPM Bundle	3,350,502
Pay For Reporting	700,000
Pay for Outomes	500,000
PY 3 Total Check	OK

PY 4 Budget Allocation	
PY 4 Total Budget	7,077,399
Administrative Infrastructure	231,668
Delivery Infrastructure	289,200
Incentive Payments	0
FFS Services	2,006,029
PMPM Bundle	3,350,502
Pay For Reporting	700,000
Pay for Outomes	500,000
PY 4 Total Check	OK

PY 5 Budget Allocation	
PY 5 Total Budget	7,077,399
Administrative Infrastructure	231,668
Delivery Infrastructure	289,200
Incentive Payments	0
FFS Services	2,006,029
PMPM Bundle	3,350,502
Pay For Reporting	700,000
Pay for Outomes	500,000
PY 5 Total Check	OK