Whole Person Care Pilot

Application

for

San Joaquin County

Section 1: WPC Lead Entity and Participating Entity Information

1.1 Whole Person Care Pilot Lead Entity and Contact Person

Organization Name	San Joaquin County Health Care Services Agency
Type of Entity (from lead entity description above)	County
Contact Person	Greg Diederich
Contact Person Title	Director
Telephone	209-468-7031
Email Address	GDiederich@sjgh.org
Mailing Address	500 West Hospital Road, Benton Hall East French Camp, CA 95231

1.2 Participating Entities

Required Organizations		Organization Name	Contact Name and Title	Entity Description and Role in WPC
1	Medi-Cal managed care health plan	Health Plan of San Joaquin (HPSJ)	Amy Shin, Chief Executive Officer	Local Initiative Medi-Cal Managed Care Health Plan and primary partner in WPC Pilot, will assist with facilitation, analytics and referral of potential WPC clients
2	Health Services Agency/Department	San Joaquin County Health Care Services Agency (HCSA)	Greg Diederich, Director	County's Health Care Services Agency and Lead Entity for WPC Pilot responsible for WPC administration, reporting and other required deliverables
3	Specialty Mental Health Agency / Department	San Joaquin County Behavioral Health Services (BHS)	James Garrett, Director	County's Specialty Mental Health Plan and a Division within HCSA will provide outreach and services to WPC clients with mental health needs

Required Organizations		Organization Name	Contact Name and Title	Entity Description and Role in WPC
4	Public Agency/ Department (if housing services are provided, must include the public housing authority)	Housing Authority of the County of San Joaquin	Peter Ragsdale, Executive Director	County's Housing Authority who will administer housing activities of the pilot
5	Community Partner #1	Dignity Health St. Joseph's Medical Center	Petra Stanton, Director of Community Health	Largest Hospital in County and integral community partner who along with CMC will support WPC activates in the greater Stockton area
6	Community Partner#2	Community Medical Centers (CMC)	Christine Noguera, Chief Executive Officer	Regional Community Health Center (330 Grantee), along with St. Joseph's Medical Center will support the WPC pilot medical needs and enrollment in the greater Stockton area

Additional Organizations (Optional)	Organization Name	Contact Name and Title	Entity Description and Role in WPC
1. Community Partner#3	San Joaquin Community Health Information Exchange (SJCHIE)	Mark Elson, Executive Director	Locally governed non-profit Health Information Exchange organization serving HPSJ's coverage area will provide centralized data repository, real time coordination capacity and population health analytics
2. Public Agency #2	San Joaquin County Public Health Services (PHS)	Tammy Evans, Director	County Public Health Services and a Division within HCSA, will help build community based care management entity capability and provide nursing support

Additional Organizations (Optional)	Organization Name	Contact Name and Title	Entity Description and Role in WPC
3. Public Agency #3	San Joaquin County Substance Abuse Services (SAS)	Billy Olpin, Deputy Director	County Substance Abuse Services and a Division within HCSA will expand into DMC-ODS and provide ASAM based treatment services to WPC clients
4. Public Agency #4	San Joaquin County Clinics (SJCC)	David Jomaoas, Executive Director	FQHC Look-A-Like clinic system aligned with County's Designated Public Hospital who will support primary care needs in the Stockton and Lathrop areas
5. Medi-Cal managed care health plan #2	Health Net	Abbie Totten, Director, Governmental Programs Policy & Strategic Initiatives	Commercial Medi-Cal Managed Care Health Plan (San Joaquin County is a Two Plan County Model), will join HIE and partner in WPC activities, this will be first large scale collaboration between the County and both health plans
6. Community Partner #4	Central Valley Low Income Housing Corporation (CVLIHC)	Bill Mendelson, Executive Director	Supportive housing program provider and primary contractor for the County's Continuum of Care, will provide tenancy based support and outreach services
7. Public Agency #5	San Joaquin General Hospital (SJGH)	David Culberson, Chief Executive Officer	Designated Public Hospital and along with SJCC will provide primary care, inpatient, specialty and emergency department services to WPC clients and be a primary referral source. Will provide interim community based care management entity services.

Additional Organizations (Optional)	Organization Name	Contact Name and Title	Entity Description and Role in WPC
8. Public Agency #6	Correctional Health Services (CHS)	Stacey Hernandez, Deputy Director	Provides health care services within the County Jail and is a Division within HCSA will enroll clients and provide transitional case management services via 30 day follow-up post release, will coordinate with SAS for an residential substance use treatment needs upon release from custody

1.3 Letters of Participation and Support

Letters of Participation and Support from participating entities and relevant stakeholders in the geographic area are attached as individual PDF's. *Please contact Greg Diederich (209-468-5610) for access to the letters.*

Section 2: General Information and Target Population

2.1 Geographic Area, Community and Target Population Needs

According to California Department of Finance projections San Joaquin County is one of the fastest growing counties in the state and home to approximately 720,000 residents. With over 300,000 residents, Stockton is the largest of the county's four urban areas and is California's 13th most populous city and home to approximately 40% of the county's residents. 42% of the County's population has income below 200% of the FPL with 20% living at or below the poverty level.

There are approximately 280,000 Medi-Cal beneficiaries residing in San Joaquin County, an enrollment increase of over 90,000 over the past three years resulting from both the County's Low Income Health Program and California's implementation of the Affordable Care Act. In spite of this increase in coverage, access to primary care, mental health services and substance use disorder treatment services remains a substantial challenge due to ongoing provider shortages.

Our pilot will initially serve residents living within the Stockton/Lathrop geographic area of the County. It is the Lead Entities desire that prior to the end of the five-year pilot, the interventions and services being performed by the pilot will be expanded to residents of the cities of Lodi, Manteca and Tracy and that after the pilot's demonstration period the entire geographic area of the County of San Joaquin can be served.

The San Joaquin County Health Care Services Agency (HCSA) as the Lead Entity (LE), held a series of one to one and group meetings with representatives of the stakeholder community. These included presentations at the County Homeless Taskforce, the Healthier Communities Coalition, the San Joaquin Community Health Information Exchange board (HIE), the AB109 Community Corrections Partnership, the Mental Health and Substance Abuse Board, and the County Board of Supervisors. LE also meet with the Housing Authority of the County of San Joaquin, Central Valley Low Income Housing, leadership from both Medi-Cal Managed Care Plans, Dignity Health, mental health and substance abuse staff, representatives from both local FQHC clinic systems, and leadership from the County Human Services Agency and San Joaquin General Hospital.

The purpose of our WPC pilot is to test interventions, create a care management infrastructure, and is to better serve individuals who are at high risk and are high utilizers of care. The WPC pilot will examine data from the County Jail, local ED's, the County Behavioral Health Services and the Managed Care Medi-Cal Health Plans. The WPC pilot will identify clients who are hesitant or resistant to engaging in mental health, substance abuse or regular medical care associated with a primary care physician. Case workers assigned will collect data on the most pressing reasons for high utilization, including lack of housing security or transportation. A key element of the WPC pilot will include regular contact with these clients, which builds rapport and provide a framework for voluntary treatment and social supports assistance. Engagement will include providing intensive care management and assistance in the coordination of essential needs such as food, clothing and shelter as well as providing necessary transportation and linkage to community based resources.

WPC goals include:

- To engage clients in voluntary treatment
- To improve client stability
- To improve client self-sufficiency
- To maintain in outpatient treatment
- To move clients to safer and more stable environments
- To provide individualized discharge and safety plans for clients and their family as needed

By accomplishing the above goals, we strive to facilitate additional pathways to mental and physical health services and to create a safer and healthier community.

To be eligible for our pilots WPC program services, clients must meet some of the following requirements: be 18 years of age or older, be eligible for Medi-Cal, have a history of reluctance to traditional mental or physical health treatment, may have a history of multiple living situations and may have a history with law enforcement agencies or justice system involvement (please see section below regarding target populations).

We will have a small client to staff ratios, which means more time to get to know our clients and better understand their individual needs. Clients are engaged in three phases, each is designed to focus on specific needs.

The below client engagements will be in coordination with participating entities, specifically the Medi-Cal Managed Care Health plans:

The beginning phase focuses on rapport building and physiological needs:

- Contact clients at least 2 – 5 times/week
- Linkage to resources pertaining to physiological needs (food banks, insurance eligibility and medical services)
- Assist with appropriate voluntary placement

The middle phase focuses on education, linkage and stabilization as applicable to the individual client

- Teach activities of daily living
- Offer mental health and medication education
- Offer crisis management (e.g. Wellness Recovery Action Plans (WRAP))

The last phase focuses on life skills and linkage to additional resources

- Link clients to socialization resources
- Begin decreasing number of contacts for transition to less intensive care

Referrals will be received via:

- Community/family members
- Both Medi-Cal Managed Care Health Plans
- Correctional Health Services/County Jail
- Emergency Departments
- Primary Care and specialty physicians
- Behavioral Health Services clinicians and program services
- Substance Abuse Services clinicians and program services
- Community Based Organizations

All referrals will be reviewed and approved by Whole Person Care central intake staff.

The Communication plan outlines how the WPC pilot intends to build and strengthen the numerous existing collaborative efforts that already exist in San Joaquin County. The Stakeholder Advisory Committee and Executive Steering Committee will accentuate and enhance collaborative relationships among participating WPC pilot entities and community stakeholders as well as provide learning opportunities for local efforts that exist now which can inform how to extend WPC services beyond the term of this waiver.

The WPC will build sustainable infrastructure based on the SJCHIE that can support communications about populations across the individual delivery systems. The WPC pilot will seek additional partners in the HIE including other counties and will maintain financial self-sustainability after the implementation of additional capacity the WPC pilot will afford.

Additionally the WPC pilot will establish Community Based Care Management Entity infrastructure in the County to support changes in reimbursement methodology post the Medi-Cal 2020 waiver and to allow the two managed care Medi-Cal Health plans who operate in our county to eventually opt into the ACA's Health Homes program. We anticipate that with this infrastructure the two managed care Medi-Cal plans could eventually directly contract with the CB-CME entity and thus help support its long term sustainability based upon the value it will provide to the healthcare community.

2.2 Communication Plan

An Executive Steering Committee (ESC) will be established by the Lead Entity (LE) to serve as the governance body and will be chaired by the LE. The pilot will be organized under the authority of the County Board of Supervisors, and a governance document will be initiated and agreed to by all Participating Entities (PE). The ESC will initially consist of the Director of the Health Care Services Agency (the Lead Entity), the CEO of SJGH, the CEO of HPSJ, the SJCC Executive Director, The Correctional Health Director and the Behavioral Health Director as the pilot will be organized by identifying and enrolling high need, high utilizing Medi-Cal beneficiaries from each of these organizations, assigning intensive case managers, and providing access to supportive resources and assessments. Other ESC members may be added over time and/or the assignment delegated to appropriate staff from the initial ESC participants.

The ESC will hold regular meetings, initially weekly then transitioning to monthly with published agenda and minutes. Operational decisions will be made by consensus. The ESC will make budgetary recommendations to the LE and monitor metrics and set overall policy and operational guidance. The ESC will review progress reports generated by the Participating Entities (PE). The LE will initiate IGT's and manage cash flow and payments per contract or MOU.

As members of the ESC already meet on a regular basis either individually or collectively to solve problems across their operational areas, and are engaged in integrative and collaborative processes and programs there exists a collaborative spirit that is expected to carry over to the WPC pilot.

PE leadership and staff will form an Advisory Board for the ESC. The LE will facilitate the monthly full partnership meetings with a published agenda and minutes. The PE's will provide feedback to the ESC on operational issues and concerns, client needs and identified resources, review metrics, and provide a forum for multi-disciplinary issues, and sharing of best practices. The resource sharing between the PE's will help to ensure clear roles and minimalize duplication of effort. These meetings will be held at a standing date and time in the Community Room located at HPSJ. The main point of contact to coordinate the participating entities will be the WPC Management Analyst.

LE staff will be tasked with communication to employees of the ESC entities, PE's and CBO's and individuals who may act as a referral source for WPC clients. This will include social and

traditional media, grand rounds, staff meetings, community forums and employee newsletters. WPC will set up a profile with the local 211.org to allow for referrals.

Care Managers will keep WPC enrollees informed and will facilitate the creation of patient portals for each to maintain and track critical health information, such as lab tests, and future appointments.

Communication for the WPC will take place on many levels, and take several forms. All meetings will be held on standing dates and times. All program documentation will be securely hosted in the Cloud utilizing Box and primary points of contact at each PE will be automatically notified when new information is posted or documents revised.

2.3 Target Population(s)

In our outreach and engagement with potential Participating Entities (PE) to define specific target population(s), we requested both uniquely identified and population data on high utilizers in each major service area or delivery system to assess the need for potential WPC target populations and the capacity to provide services to. Our collaborative assessment of high utilizers determined the need to establish the following three Whole Person Care target populations and via additional analysis it was determine there may be some overlap of individuals between the three populations:

1. Adult Health Plan of San Joaquin (HPSJ) Medi-Cal Beneficiaries assigned to the San Joaquin County Clinics (an FQHC Look-A-Like clinic system affiliated with San Joaquin General Hospital) who are over utilizers of emergency department services.
2. Adult Medi-Cal beneficiaries who have a mental health and/or substance use disorder.
3. Adult Medi-Cal beneficiaries who are homeless or at risk of homelessness upon discharge from San Joaquin General Hospital, St. Joseph's Medical Center, the County's Psychiatric Health Facility including the Crisis Stabilization Unit, or the County Jail. (This population has often been underserved in many important aspects of healthcare due to their geographic transience and difficulty of contact to assure treatment follow-up. A boots-on-the-ground design of case management within the WPC Behavioral Health Navigation Team of this pilot will, by this design, greatly enhance probability of effective and timely delivery of services to the target population who are homeless. Coordination between the WPC Behavioral Health Navigation Team and the WPC Population Health Team will extend expanded positive outcomes to the entire population served by the pilot including those who are at risk of homelessness.)

As of June 2016 there are 110,891adults enrolled in Medi-Cal managed care through HPSJ in San Joaquin County (SJC) of which a total of 30,595 are assigned to the San Joaquin County Clinics. The San Joaquin General Hospital (SJGH) emergency department served 47,084 patients in calendar 2015 of which 519 had more than five ED visits including 122 individuals who had ten or more ED visits. We anticipate enrolling and being able to provide WPC services to approximately 500 unduplicated Medi-Cal beneficiaries annually by the end of the pilot for the first target population; there will be no enrollment cap established. While efforts will be made to bring the pilot up to full operational capacity as soon as possible, enrollment goals will not likely be met during the ramp-up period of this project and it is projected that the ramp up will be as follows by calendar year: 2017 – 250 enrolled; 2018 – 350 enrolled; 2019 – 450 enrolled; 2020 – 500 enrolled.

Behavioral Health Services served 15,518 consumers in calendar 2015 at an average charge of $4,061 per consumer. The top one hundred consumers had an annual average charge of $78,966. Substance Abuse Services served 3,685 clients in calendar 2015 at an average charge of $3,938. The top one hundred clients had average annual charges of $23,258. The County plans to opt into the Drug Medi-Cal Organized Delivery System waiver by Fall of 2016. We anticipate enrolling and being able to provide WPC services to approximately 400 unduplicated Medi-Cal beneficiaries annually by the end of the pilot for the second target population; there will be no enrollment cap established. While efforts will be made to bring the pilot up to full operational capacity as soon as possible, enrollment goals will not likely be met during the ramp-up period of this project and it is projected that the ramp up will be as follows by calendar year: 2017 – 150 enrolled; 2018 – 250 enrolled; 2019 – 350 enrolled; 2020 – 400 enrolled.

Based upon demographic, intake and discharge information from the Participating Entities who will serve the third target population combined with information from the Health Plan of San Joaquin, the Housing Authority and the Homeless Management Information System it is estimated that in excess of 1,000 Medi-Cal eligible individuals in the County annually are at risk of homelessness when being discharged from the stated facilities. We anticipate enrolling and being able to provide WPC services to approximately 250 unduplicated Medi-Cal beneficiaries annually by the end of the pilot for the third target population; there will be no enrollment cap established. While efforts will be made to bring the pilot up to full operational capacity as soon as possible, enrollment goals will not likely be met during the ramp-up period of this project and it is projected that the ramp up will be as follows by calendar year: 2017 – 100 enrolled; 2018 – 150 enrolled; 2019 – 200 enrolled; 2020 – 250 enrolled.

Certain individuals may qualify under more than one target population though will not be counted more than once for reporting purposes. By the end of the pilot, service capacity should be approximately 1,150 concurrent enrollees. Our pilot will not have an enrollment cap for any of the three target populations, however, we will need to on board and train additional care managers if enrollment surpasses our estimates or as the number of WPC enrollee's increases over the duration of the pilot. Based upon anticipated length services to individuals enrolled in the WPC pilot as well as assumed churn in WPC enrollment due to factors such as dis-enrolling from WPC services, loss of Medi-Cal eligibility, no longer requiring the level of intensive care management being provided under the pilot, moving out of the service area or otherwise no longer meeting criteria for pilot services we estimate that the total unduplicated number of individuals who will be served at some point over the life of the pilot will be approximately 2,130. The Lead Entity understands that WPC reimbursement will not exceed approved annual budget amounts. The Lead Entity understands that Federal Financial Participation cannot be used for individuals who lack Medi-Cal eligibility and to the extent WPC services are provided to such individuals no federal funds will be utilized.

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

3.1 Services, Interventions, and Care Coordination

Based upon demographic, intake and discharge information from participating entities, many individuals who are discharged from local hospitals are likely to have mental health issues and /or substance use disorders. In addition, many discharged individuals will be homeless or are at risk of becoming homeless or have chronic housing instability. It is estimated that in excess of 1,000 Medi-Cal eligible individuals in the County annually are at risk of homelessness when being discharged

from local hospital facilities. These risks are partially associated with the target populations potential unwillingness or inability to continually engage with primary care, mental health or substance abuse treatment. Based upon this unwillingness to engage in community resources, the target population continues to over utilize local emergency and hospital services. The over utilization creates a burden on emergency and hospital services, as the target population continues to rely on these services for primary treatment and care and places enormous risk and cost on both county based and Medi-Cal funded systems.

WPC Behavioral Health Navigation Team (supporting all three target populations)

To improve the overall health outcomes of the target population, the San Joaquin County Whole Person Care Pilot will implement a WPC Behavioral Health Navigation Team dedicated to engaging homeless individuals and those at risk of homelessness throughout the community and to helping them navigate various community services and supports.

Engagement may occur at the time of admission and/or discharge from local hospitals, health facilities and the County Jail—or in response to urgent referrals from a variety of sources throughout the community including the existing Behavioral Health Mobile Crisis Response Teams (MCST).

In additional to previously stated referral processes in section 2.1, the WPC Behavioral Health Navigation Team will seek out individuals who have been identified as high utilizers of medical services and who may be homeless or at risk of being homeless or who may have chronic housing instability and may have two or more chronic health conditions which could include mental health and substance abuse disorders. The primary and overarching identifier of those to be served by the WPC Behavioral Health Navigation Team, beyond housing instability, is their reluctance to accept or participate in mental health or substance abuse treatment and that this reluctance impedes their ability to benefit from available services.

Clients must be at least 18 years of age, Medi-Cal eligible and have a history of reluctance to accept or participate in mental health or substance abuse treatment. This reluctance has created an impact on the community through contact with law enforcement, community disturbances, or excessive utilization of urgent/emergent care services (e.g., medical or psychiatric services, ambulance, 9-1-1 calls, etc.).

The WPC Behavioral Health Navigation Team will also collaborate with MCSTs that conduct on-site mental health assessments, interventions and treatment evaluations for individuals experiencing mental health issues or crisis within the community. This collaboration will help to reduce the potential for unnecessary incarceration due to a mental health crisis and the resultant negative downstream impacts to individuals. The WPC pilot will leverage the existing referral process and protocols that are utilized for the MCSTs and will continue to develop and refine the referral protocols between the WPC pilot's participating entities and community partners.

During service hours, the WPC Behavioral Health Navigation Team will respond to referrals within two hours of receiving them with an on-site in-person response. Once an individual is identified as a member of the WPC pilot program and/or WPC target population, the WPC Behavioral Health Navigation Team will help educate and introduce them to the most appropriate services in a warm and supportive manner.

The WPC Behavioral Health Navigation Team will assist in enrolling individuals into WPC services and will offer non-Medi-Cal reimbursable services to help individuals navigate services

such as transportation, meals, information, and other supports to stabilize at-risk individuals in medically necessary housing and to access non-urgent medical care as needed, using motivational interviewing skills, “enthusiastic engagement” and continual encouragement in working with individuals at high-risk of homelessness.

Interventions by the WPC Behavioral Health Navigation Team will address some of the largest barriers to receiving crisis services as the team is able to provide sufficient and immediate support in natural environments to eliminate or reduce the need for law enforcement involvement or repeated hospitalizations or inappropriate utilization of urgent/emergent level of care services and will be a critical component within the County’s pending implementation of the Stepping Up Initiative which seeks to reduce the prevalence of individuals with mental illness in jails.

Once clients are voluntarily enrolled into WPC services and fully engaged they will be connected to Medi-Cal primary care, mental health and/or substance abuse services or other appropriate community supports as individually determined. The WPC Behavioral Health Navigation team will maintain engagement and support for individuals by providing weekly face-to-face contacts for the first three months.

The WPC Behavioral Health Navigation Team will also focus on helping individuals address non-clinical barriers to care such as lack of transportation or unstable housing, while developing strong linkages with community resources as needed. Additionally, the WPC Behavioral Health Navigation Team will link individuals to post-crisis follow-up and stabilization to prevent the recurrence of a crisis.

If an individual fails to follow through on appointments or services, WPC Behavioral Health Navigation Team members will work to re-engage them into services. The team will provide wrap around services including, but not limited to, outreach, engagement, peer support, screening, assessment, referral and linkage to continuing services.

The WPC Behavioral Health Navigation Team will also provide on-going support to high-risk individuals, including intensive services such as outreach and engagement that require meeting clients where they are, whether in the community or in a hospital setting. Team members will remain active with WPC participants throughout the participants’ involvement in the pilot to ensure a continuity of services.

Participants’ status, in relation to the identified reasons for participation, will be regularly assessed, with a formal evaluation every 6 months. When participant has demonstrated 3 months of stability, resolution of initial areas of concern, and utilization of appropriate community resources, a transition out of WPC services, to independent utilization of community resources will be initiated with full collaboration of staff and participant.

Performance Outcomes for the <u>WPC Behavioral Health Navigation Team</u>:

1. Reduce the number of annual psychiatric hospitalizations among the WPC enrollees by 5% for each program year.
    - Yr. 1: Establish baseline
    - Yr. 2: 5% reduction from baseline
    - Yr.3: 10% reduction from baseline
    - Yr. 4: 15% reduction from baseline
    - Yr. 5: 20% reduction from baseline

2. Decrease the number of reported annual emergency room visits by 5% for each program year.
    - Yr. 1: Establish baseline
    - Yr. 2: 5% reduction from baseline
    - Yr.3: 10% reduction from baseline
    - Yr. 4: 15% reduction from baseline
    - Yr. 5: 20% reduction from baseline

3. Decrease the number of reported annual hospitalizations for issues related to substance use or mental illness by 5% for each program year.
    - Yr. 1: Establish baseline
    - Yr. 2: 5% reduction from baseline
    - Yr.3: 10% reduction from baseline
    - Yr. 4: 15% reduction from baseline
    - Yr. 5: 20% reduction from baseline

Population Health Team (supporting all three target populations)

In coordination with the WPC Behavioral Health Navigation Team the Population Health Team will provide each enrolled client will have an individualized care plan based upon a standardized assessment of his or her medical, behavioral health, and key social needs, such as shelter and this care plan would be shared across agencies. Each client will be assigned a single dedicated care coordinator within the team and potentially based in the agency that is most appropriate for that individual's needs who may be a behavioral health provider located in supportive housing for the chronically homeless, or a nurse case manager at a primary care site. This function will initially be based out of San Joaquin General Hospital but could eventually be transitioned to the Community Based Care Management Entity once such is fully developed via the pilot. Establishing consistency and trust with one care coordinator will be critical and this care coordinator will also serve as the point of contact for all agencies providing services to the individual client.

Connecting the target populations to continuous care, seamlessly from hospital admission and discharge to an outpatient setting, will significantly improve their physical and mental health outcomes overall. In addition, creating a system for follow-up to this hard to engage population will decrease the likelihood that the WPC target population will be inappropriately hospitalized or incarcerated. As these individual are typically hesitant or reluctant to participate in continuing services, these early interventions during hospital admission and stay will help address some of the largest barriers for individuals to receiving services that address their physical and behavioral health needs. Overall, it is anticipated that the WPC pilot program will increase the capacity of local emergency and hospital services to provide care, as they will be able to focus on those who they can appropriately serve. After patients are identified via referral or other means as meeting criteria and potentially benefiting from the care coordination services of the Population Health Team staff will attempt to engage and enroll into this optional program and patients will remain under the teams care management until they no longer desire such services or when upon periodic case review it is determined the patient can successfully be transitioned into less intensive care management services.

Additionally, the WPC pilot will implement a County Flexible Housing pool with segregated non WPC funding from compliant sources (County/City general fund, not for profit hospital community benefit funding, private grants and donations) to assist with the housing needs of our WPC target populations. The various WPC pilot teams will provide outreach and tenancy support services to Medi-Cal beneficiaries at risk of homelessness who have a medical need for respite care or

transitional housing. The Housing Pool and tenancy supports are provided through the San Joaquin County Housing Authority (SJCHA). The WPC Teams will work in conjunction with the SJCHA in locating appropriate housing for the WPC individuals. It is anticipated that the SJCHA will provide rental assistance through housing vouchers to WPC individuals when necessary.

San Joaquin County has two active Targeted Case Management (TCM) claiming units and the services and interventions included in this Whole Person Care pilot application are not duplicative or otherwise provided currently within the County. The County's Human Services Agency (welfare department) provides TCM to Individuals at Risk of Institutionalization under their Linkages program whose purpose is to help clients live in their own homes rather than in long term care or nursing facilities. The County's Public Health Department provides TCM to Individuals with Communicable Disease and case manages all TB clients within San Joaquin County. Prior to FY 2011-2012, San Joaquin General Hospital provided TCM to Medically Fragile Individuals receiving outpatient dialysis treatment. At this time there are no active TCM claiming units within San Joaquin County providing services to Medically Fragile Individuals and staff has confirmed that this target population has not been listed in our annual LGA Participation requests for the past several years though for some reason this TCM population is still listed in the State Plan Amendment. Comprehensive case management is currently not being provided to Medically Fragile Individuals within San Joaquin County. Additional narrative regarding non-duplication of payments or services and allowable use of Federal Financial Participation and Targeted Case Management is included at the end of section 5.4.

3.2 Data Sharing

This section describes San Joaquin County's approach to data sharing to meet WPC goals. It begins with a description of our overall approach to use and build on existing infrastructure, followed by specific considerations for our two target populations.

San Joaquin Community Health Information Exchange (SJCHIE)

San Joaquin County has robust data sharing today through a Health Information Exchange (HIE) organization, the San Joaquin Community Health Information Exchange (SJCHIE). SJCHIE's active membership is primarily in San Joaquin County. Its founding members are the San Joaquin County Health Care Services Agency, San Joaquin County Behavioral Health Services, San Joaquin General Hospital and County Clinics, Community Medical Centers, and the Health Plan of San Joaquin. Each of these organizations contributes data into the HIE. SJCHIE is a sustainable organization through the annual fees paid by its members with a long-term time horizon for meeting its members evolving data sharing needs beyond the term of the WPC pilot.

In support of the County's WPC pilot and related population health programs, additional participants will onboard to SJCHIE over the next 1-3 years including St. Joseph's Medical Center, Health Net, American Medical Response (AMR), the County Jail, and other County and non-profit social services providers supporting WPC populations both within and outside of San Joaquin County. Stakeholders in the Stockton area were recently awarded a grant for the California Accountable Communities for Health Initiative (CACHI), with SJCHIE providing the data infrastructure for the program to support improved care delivery and outcomes for individuals impacted by trauma. SJCHIE is also in contracting with Stanislaus County's Health

Services Agency and Behavioral Health and Recovery Services, and a group of stakeholders in Merced County recently decided to join SJCHIE pending final negotiations.

With the participation of SJ County Behavioral Health Services, SJCHIE is at the forefront of integrating mental and physical health information, as the first community HIE in the state receiving patient data from a county behavioral health services agency. This accomplishment was made possible through the dedication of San Joaquin County leadership and detailed attention to the development and implementation of an appropriate framework addressing policy, workflow, and technical issues. This existing behavioral health data-sharing will enable SJCHIE to support the rapid implementation of key aspects of the proposed WPC program.

As a California non-profit 501c3 corporation, SJCHIE is governed by a Board of Directors comprised by senior leadership from each of the founding member organizations. With this level of executive engagement and oversight, SJCHIE is well positioned to meet community needs and foster collaboration across organizations.

SJCHIE is a member of the California Association of Health Information Exchanges (CAHIE) and a participant in the California Trusted Exchange Network (CTEN). SJCHIE's Executive Director, Mark Elson, PhD, serves on the California Interoperability Committee (CIC) and is active in other CAHIE groups including the CAHIE Sensitive Information Workgroup.

Priority real-time interfaces for provider organizations are ADT (demographics, encounters, diagnoses, allergies, and problems), ORU (lab results), RDE (medications), and VXU (immunizations). Health plans submit eligibility, medical claims (including encounters), and pharmacy claims files through a file upload process on a weekly or monthly basis. County Behavioral Health Services submits a subset of these data types for mental health conditions but not substance use treatment (demographics, encounters, diagnoses, medications, allergies, and lab results). SJCHIE has Minimum Data Requirements aligned with national standards that all data contributors must meet to ensure data quality and reliability. Users' access shared information based on their user level (e.g. a doctor or NP has full access to their patients' information unless the patient has opted out of data sharing, whereas other members of a care team have access to a much more limited data set).

SJCHIE maintains a robust policy framework to facilitate the private and secure sharing and use of protected health information (PHI) that meets or exceeds legal requirements and industry best practices. Key components of our approach include role-based access controls, restrictions on access to sensitive information, encryption of data, auditing and testing, and breach notification procedures. Participants' Notice of Privacy Practices must inform patients that their health information will be exchanged with other health care organizations to facilitate the coordination of care, and patients must be given the right to opt out of data exchange through SJCHIE. At SJ County Behavioral Health Services, clients provide affirmative consent upfront prior to their information being shared.

HIE Population 1: At-Risk WPC Target Population(s)

San Joaquin County and its participating WPC partners and contractors will use SJCHIE services for the treatment, care management, coordination and monitoring of specific at-risk populations to

include: Adult Medi-Cal beneficiaries with a mental health and/or substance use disorder, or at risk of homelessness upon discharge from participating WPC partners, or otherwise targeted for interventions by SJGH programs. There is significant overlap between these cohorts.

Existing SJCHIE services supporting the WPC pilot to address the needs of this population are:

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

While some of these existing services may require enhancements to meet the specific needs of the WPC program, they provide an initial baseline of functionality for the WPC pilot for existing SJCHIE participants.

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

- A care management platform enabling:
    - Shared care plans across participating organizations;
    - Care manager dashboards to track worklists and high-priority patients;
    - Closed-loop referrals management for enhanced transitions of care;
    - Event-driven, evidence-based workflows and alerts;
    - Simple drill-down pathways to individual patient longitudinal medical records in the HIE clinical data repository;
    - Communication channels for patient engagement and patient-centered care.
- Population health analytics and reporting services enabling:
    - Dashboards for tracking the status and outcomes of WPC target populations and sub-populations relative to selected quality measures;
    - Comprehensive reporting capabilities for the WPC program, including custom reports and overlays with open source data as required;
    - Data quality improvement through assessment of gaps in data quality; tracking of problems to their sources; iterative implementation of operational, workflow, and technical remediation.

HIE Population 2: WPC-eligible Medi-Cal Managed Care Members in County

The second population of focus for this WPC pilot is the broader cohort of WPC-eligible Medi-Cal managed care members in the County served by the County's two Medi-Cal managed care

plans: HPSJ and Health Net. SJCHIE will provide the data sharing, care management, and population health analytics infrastructure to support a community-based care management entity. This will enable the Medi-Cal health plans to opt into services authorized under the Affordable Care Act's Health Homes program, while also supporting the County's establishment of a WPC sustainable housing pool.

SJCHIE already collects data from HPSJ and participating provider organizations on HPSJ members, and plans to do the same with Health Net pending contract negotiations. Both health plans see value in supporting care management with near-real-time clinical information through SJCHIE.

No additional services for Population 2 beyond those described above for Population 1 will be required, but it will require scaling-up of infrastructure and user training in the community.

SJCHIE WPC Implementation Milestones tied to Incentive Payments:

PY2:

- Implement HIE interfaces from new participating provider organizations
    - ADT interface (demographics, problem list, allergies, encounters, diagnoses)
    - ORU interface (lab results)
    - RDE interface (medications)
- Implement an HIE interface from a new participating payer organizations
    - Eligibility data
    - Encounter claims data
    - Medications claims data
- Train and onboard additional clinical users to improve treatment of WPC populations
    - Identification of user cohorts, HIE training, activation of user accounts
    - Implement Workflows for Data Access/Sharing in Support of WPC QI Interventions
    - Implement Privacy and Security policies and procedures specific to WPC QI Interventions
- HIE platform upgrade
    - Migrate HIE data to enhanced vendor platform
- Implement basic analytics and reporting tools and integrate with HIE data repository

PY3:

- Implement HIE interfaces from new participating provider organizations
    - ADT interface (demographics, problem list, allergies, encounters, diagnoses)
    - ORU interface (lab results)
    - RDE interface (medications)
- Implement an HIE interfaces from new participating payer organizations
    - Eligibility data
    - Encounter claims data
    - Medications claims data
- Train and onboard additional clinical users to improve treatment of WPC populations
    - Identification of user cohorts, HIE training, activation of user accounts
    - Implement Workflows for Data Access/Sharing in Support of WPC QI Interventions
    - Implement Privacy and Security policies and procedures specific to WPC QI Interventions
- Implement additional analytics and reporting tools that integrate with HIE data repository
- Implement basic care management tools and integrate with HIE data repository
    - Define user cohorts and workflows
    - User training and activation of user accounts
    - Use of tools across all partnering WPC organizations in support of program initiatives
- Implement basic population heath analytics and reporting tools and integrate with HIE data repository
    - Define users and workflows
    - User training and activation of user accounts
- Implement data quality management
    - Implement systems to monitor and improve data quality

PY4:

- Implement HIE interfaces from new participating provider organizations
    - ADT interface (demographics, problem list, allergies, encounters, diagnoses)
    - ORU interface (lab results)

    - RDE interface (medications)
- Train and onboard additional clinical users to improve treatment of WPC populations
    - Identification of user cohorts, HIE training, activation of user accounts
    - Implement Workflows for Data Access/Sharing in Support of WPC QI Interventions
    - Implement Privacy and Security policies and procedures specific to WPC QI Interventions
- Enhance data quality management
    - Expand systems to monitor and improve data quality
- Implement additional care management tools that integrate with HIE data repository
    - Define user cohorts and workflows
    - User training and activation of user accounts
    - Use of tools across all partnering WPC organizations in support of program initiatives
- Implement additional population health analytics and reporting tools that integrate with HIE data repository
    - Define users and workflows
    - User training and activation of user accounts
    - Use of tools (e.g. dashboards) across all partnering WPC organizations in support of program initiatives
- Enable reporting on WPC measures and near-real-time monitoring of performance on these measures

PY5:

- Train and onboard additional clinical users to improve treatment of WPC populations
    - Identification of user cohorts, HIE training, activation of user accounts
    - Implement Workflows for Data Access/Sharing in Support of WPC QI Interventions
    - Implement Privacy and Security policies and procedures specific to WPC QI Interventions
- Complete build out care management tools that integrate with HIE data repository and provide real time access to all teams
    - Define user cohorts and workflows
    - User training and activation of user accounts

- Use of tools across all partnering WPC organizations in support of program initiatives

- Complete build out of analytics and reporting tools that integrate with HIE data repository
  - Define users and workflows
  - User training and activation of user accounts
  - Use of tools (e.g. dashboards) across all partnering WPC organizations in support of program initiatives

- Enhance reporting on WPC measures and near-real-time monitoring of performance on these measures

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

4.1 Performance Measures

The overarching vision of the San Joaquin County Whole Person Care Pilot is to more efficiently and effectively coordinate the physical health, behavioral health and social service systems within the County in a patient-centered manner with the goal of improving the health and well-being of Medi-Cal beneficiaries and enable partnerships to target the highest-risk and most vulnerable patients. We seek to build and sustain relationships and infrastructure to share data between system and to eventually coordinate care in real time and be able to evaluate progress in improving individual and population health. Additionally, we seek to establish community based care management entity capacity in the County that will position our delivery systems for potential changes in reimbursement methodology post the Medi-Cal 2020 demonstration waiver and allow our two Medi-Cal Managed Care Health Plans to re-consider opting into the Affordable Care Act's Health Home Program. We hope that by building and sustaining partnerships and integrating technology we will not only improve health outcomes but will also decrease per member costs in the Medi-Cal population.

Additionally, our pilot will implement a County Flexible Housing pool with segregated non WPC funding from compliant sources (County/City general fund, not for profit hospital community benefit funding, private grants and donations) to assist with the housing needs of our WPC target populations. We are not anticipating redirecting any potential WPC PMPM saving into this housing pool. The WPC pilot will provide outreach and tenancy support services to Medi-Cal beneficiaries at risk of homelessness who have a medical need for respite care or transitional housing.

The Health Information Exchange will be the central data repository for healthcare information, including behavioral health and care management notes and will build toward real time care management capabilities. The HIE will expand regionally into other Counties and of note will have Health Net, the commercial Medi-Cal Managed Care Plan in both San Joaquin and Stanislaus Counties join the HIE and be a participating entity in our WPC pilot.

Performance Measures by type of Participating Entity:

Medi-Cal Managed Care Health Plan: Increase Health Plan of San Joaquin's NCQA HEDIS scores in San Joaquin County to 15.5 by June 2017 and by an additional 0.5 points annually thereafter during the WPC pilot.

Health Services Agency: As the Lead Entity submit all bi-annual reporting complete and on time as well as all other requirements outlined in the state terms and conditions. By the end of the pilot have a viable Community Base Care Management Entity capacity available to the Managed Care Medi-Cal Health Plans serving our County. This measure will be met at 100% in each WPC program year.

Specialty Mental Health Department: Opt into the Drug Medi-Cal Organized Delivery System pilot prior to May 2017. For Community Adult Treatment Clinical Services, from the June 2016 quarterly baseline decrease by an average two days per WPC program year the time from first request to first clinical assessment until maintained under average days' target policy.

Public Agency (Housing Authority): Provide 20 rental assistance vouchers to WPC pilot enrollees in calendar 2017 and increase by 20 additional voucher per each WPC program year of the pilot.

Community Partner (Health Information Exchange): Onboard at least four additional partners (hospitals, county health systems, community medical centers, health plans) over the life of the pilot and implement the Care Management and Data Analytics Reporting capabilities of the HIE per the schedule outline in section 4.2 below. At minimum a new partner will join the HIE in calendar year (2017-2020) until the four additional partners anticipated have joined.

WPC Pilot: Assure total enrollment of Medi-Cal beneficiaries into WPC services reach the following minimums by WPC program year (combination of all populations): 300 in 2017, 600 in 2018, 900 in 2019 and 1,200 in 2020 or until a minimum number of 1,600 clients are actively enrolled after which an annual increase of at least 10% will be met in each subsequent reporting year. Provide intensive care management to all enrolled clients and via required PDSA cycles improve processes that lead to population health improvements, increased system capacities and decreased per member costs.

San Joaquin General Hospital/San Joaquin County Clinics: Send data to SJCHIE; NQF0710 Depression screening measures are to be administered in accordance with established national or local benchmarking targets; timely follow-up after hospital discharge will be maintained at a performance standard of 90% or higher.

4.1.a Universal Metrics

Health Outcomes Measures (all measures are for Adults Medi-Cal beneficiaries only):

Ambulatory Care – Emergency Department Visits: Decrease the percentage of adult Medi-Cal beneficiaries who utilize the San Joaquin General Hospital Emergency Department more than once per year from the calendar year 2016 baseline by at least one percentage point in each WPC program year (2017-2020).

Inpatient Utilization – Adult Inpatient Utilization - General Hospital/Acute Care: Decrease the Hospital-wide unplanned 30-day readmission rate at San Joaquin General Hospital from the baseline percentage (estimated at 16.3% as of FY 13/14) by at least half a percentage points in each

WPC program year (2017-2020) or until a minimum of one percentage point below the National Rate (estimated at 15.2%).

Follow-up After Hospitalization for Mental Illness: Increase the percentage of adult Medi-Cal beneficiaries managed by San Joaquin County Behavioral Health Services who were hospitalized for treatment of selected mental health disorders (HEDIS FUH-A tabled codes) who received follow-up after hospitalization (outpatient visit, an intensive outpatient encounter or partial hospitalization with a mental health practitioner) within 7 days of discharge from the calendar 2016 baseline by at least one percentage point in each WPC program year (2017-2020).

Initiation and Engagement of Alcohol and Other Drug Dependence Treatment: Increase the percentage of adult Medi-Cal beneficiaries managed by San Joaquin County Substance Abuse Services that initiate AOD treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization within 14 days of diagnosis from the calendar 2016 baseline by at least two percentage points in each WPC program year (2017-2020) AND increase the percentage of these individual who initiated treatment and who had two or more additional services with a diagnosis of AOD within 30 days of the initial visit from the calendar 2016 baseline by at least one percentage point in each WPC program year (2016-2017).

Administrative Measures:

Comprehensive Care Plan: 80% of participating beneficiaries will have a comprehensive care plan, accessible by the entire care team, within 30 days of enrollment into the WPC Pilot and 50% of participating beneficiaries will have an updated comprehensive care plan, accessible by the entire care team, within 30 days of the beneficiary's annual anniversary of participation in the WPC pilot. Both percentages will increase by at least two percentage points in each WPC program year (2017-2020) from the above initial target percentages.

Care Coordination, Case Management, and Referral Infrastructure: Lead Entity will submit documentation to DHCS demonstrating the establishment of care coordination, case management, and referral policies and procedures across the entire WPC Pilot to all participating entities which provide for streamlined beneficiary case management within a timeline approved by the State and the policies and procedures will be submitted to the State for review and approval. All participating entities will have access to and be provided with timely access and updates to beneficiary information for care coordination and case management purposes. The policies and procedures shall establish a communication structure for participating beneficiaries and the number of participating entities for purposes of the Pilot as points of contact for beneficiaries shall be minimalized. Monitoring procedures for oversight of how the policies and procedures, as required by state terms and conditions, will be operationalized – including a regular review to determine any needed modifications via utilization of PDSA with measurement and necessary changes at minimum semi-annually. A method to compile and analyze information and findings from the monitoring procedures set forth the state terms and conditions and a process to modify the policies and procedures set forth in the state terms and conditions will be performed in a streamlined manner and within a reasonable timeframe. This measure will be meet at the 100% performance level in each WPC reporting year.

Data and Information Sharing Infrastructure: Lead Entity will submit documentation demonstrating the establishment of data and information sharing policies and procedures across the WPC Pilot to all participating entities that provide for streamlined beneficiary care coordination, case management, monitoring, and strategic improvements, to the extent permitted by applicable state and federal law. Upon completion, and within a timeline approved by the State, the policies and procedures will be submitted to the State for review and approval. The Lead Entity will serve as the central data and information sharing entity across all participating entities and will assure that all participating entities have access to and be provided with timely access and updates to necessary beneficiary data and information to the extent permitted by applicable state and federal law for streamlined beneficiary care coordination,

case management, monitoring, and strategic improvements. Lead Entity will assure implementation of monitoring procedures for oversight of how the policies and procedures set forth in the state terms and conditions are operationalized – including a regular review to determine any needed modifications via utilization of PDSA with measurement and necessary changes at minimum of semi-annually. A method to compile and analyze information and findings from the monitoring procedures set forth in state terms and conditions and a process to update as appropriate the policies and procedures set forth in state terms and conditions will be performed in a streamlined manner and within a reasonable timeframe in accordance with PDSA. <u>This measure will be meet at the 100% performance level in each WPC reporting year.</u>

4.1.b Variant Metrics

	PY 1	PY 2	PY 3	PY 4	PY 5
Administrative Metric #1	Number of unique individuals who had updated information pushed into the SJCHIE in the given PY. PGY 1 will be baseline data reporting only and reflect calendar year 2016.	Number of unique individuals who had updated information pushed into the SJCHIE in the given PY. Up to 15% increase over the prior year's performance	Number of unique individuals who had updated information pushed into the SJCHIE in the given PY. Up to 15% increase over the prior year's performance	Number of unique individuals who had updated information pushed into the SJCHIE in the given PY. Up to 15% increase over the prior year's performance	Number of unique individuals who had updated information pushed into the SJCHIE in the given PY. Up to 15% increase over the prior year's performance
Health Outcome Metric Comprehensive Diabetes Care: HbA1c Poor Control (<8%)	Percentage of WPC enrolled adults (18-75 years of age) diagnosed with diabetes (type 1 and type 2) who had HbA1c control (<8.0%). Baseline reporting will be based on County FQHC data for their adult Medi-Cal members.	Percentage of WPC enrolled adults (18-75 years of age) diagnosed with diabetes (type 1 and type 2) who had HbA1c control (<8.0%). Pilot will maintain baseline.	Percentage of WPC enrolled adults (18-75 years of age) diagnosed with diabetes (type 1 and type 2) who had HbA1c control (<8.0%). Up to 15% increase over the prior year's performance	Percentage of WPC enrolled adults (18-75 years of age) diagnosed with diabetes (type 1 and type 2) who had HbA1c control (<8.0%). Up to 15% increase over the prior year's performance	Percentage of WPC enrolled adults (18-75 years of age) diagnosed with diabetes (type 1 and type 2) who had HbA1c control (<8.0%). Up to 15% increase over the prior year's performance
Health Outcome Metric Depression Remission at Twelve Months (NQF 0710)	Percentage of WPC enrolled adults age 18 and older with a diagnosis of major depression or dysthymia and an initial (index) PHQ-9 score greater than nine during an outpatient encounter who achieved remission at twelve months as demonstrated by a	Percentage of WPC enrolled adults age 18 and older with a diagnosis of major depression or dysthymia and an initial (index) PHQ-9 score greater than nine during an outpatient encounter who achieved remission at twelve months as demonstrated by a	Percentage of WPC enrolled adults age 18 and older with a diagnosis of major depression or dysthymia and an initial (index) PHQ-9 score greater than nine during an outpatient encounter who achieved remission at twelve months as demonstrated by a	Percentage of WPC enrolled adults age 18 and older with a diagnosis of major depression or dysthymia and an initial (index) PHQ-9 score greater than nine during an outpatient encounter who achieved remission at twelve months as demonstrated by a	Percentage of WPC enrolled adults age 18 and older with a diagnosis of major depression or dysthymia and an initial (index) PHQ-9 score greater than nine during an outpatient encounter who achieved remission at twelve months as demonstrated by a

	twelve month (+/- 30 days) PHQ-9 score of less than five. Baseline reporting will be based on County FQHC data (as available) for their adult Medi-Cal members for calendar 2016.	twelve month (+/- 30 days) PHQ-9 score of less than five. Pilot will maintain baseline.	twelve month (+/- 30 days) PHQ-9 score of less than five. Up to 15 percent increase over the prior Program Year's performance.	twelve month (+/- 30 days) PHQ-9 score of less than five. Up to 15 percent increase over the prior Program Year's performance.	twelve month (+/- 30 days) PHQ-9 score of less than five. Up to 15 percent increase over the prior Program Year's performance.
Health Outcomes: Required for Pilots w/SMI Target Populations Suicide Risk Assessment (NQF 0104)	Percentage of WPC enrollees aged 18 years and older with a new diagnosis or recurrent episode of major depressive disorder (MDD) who had a suicide risk assessment completed at each visit. Baseline reporting will be based on County FQHC data (as available) for their adult Medi-Cal members for calendar 2016.	Percentage of WPC enrollees aged 18 years and older with a new diagnosis or recurrent episode of major depressive disorder (MDD) who had a suicide risk assessment completed at each visit. Pilot will maintain baseline.	Percentage of WPC enrollees aged 18 years and older with a new diagnosis or recurrent episode of major depressive disorder (MDD) who had a suicide risk assessment completed at each visit. Up to 15% increase over the prior year's performance.	Percentage of WPC enrollees aged 18 years and older with a new diagnosis or recurrent episode of major depressive disorder (MDD) who had a suicide risk assessment completed at each visit. Up to 15% increase over the prior year's performance.	Percentage of WPC enrollees aged 18 years and older with a new diagnosis or recurrent episode of major depressive disorder (MDD) who had a suicide risk assessment completed at each visit. Up to 15% increase over the prior year's performance.
Housing-Specific Metric: Housing Services	Percent of WPC enrollees referred for housing services that receive housing services in program year. Baseline data will be number of adult County FQHC Medi-Cal clients who were referred to housing services that received housing services in calendar 2016.	Percent of WPC enrollees referred for housing services that receive housing services in program year. Maintain baseline.	Percent of WPC enrollees referred for housing services that receive housing services in program year. Up to 15% increase over the prior year's performance.	Percent of WPC enrollees referred for housing services that receive housing services in program year. Up to 15% increase over the prior year's performance .	Percent of WPC enrollees referred for housing services that receive housing services in program year. Up to 15% increase over the prior year's performance

4.2 Data Analysis, Reporting and Quality Improvement

The Lead Entity (LE), Executive Steering Committee (ESC) and Participating Entities (PE) are all committed to a data driven process. This assures transparency and drives process improvement. All metrics will be evaluated monthly and used to develop a dashboard. The progress reports and dashboards will be widely shared and posted to the cloud. Currently identified data sources include reporting from HPSJ, SJGH, SJCC, BHS, Correctional Health, and County Jail. Case managers will

report on client outcomes including services utilized since enrollment in the WPC, interventions and service provided. The case manager will report on interventions, successful and otherwise. The cost of the new interventions, which might include assignment to a primary care physician and enrollment into a substance abuse program, and including case management, will be calculated and compared to the base year. The difference could be viewed as savings.

The LE and ESC have the responsibility of performing oversight of WPC activities to ensure full compliance with best practices and evidence based methods, and to make recommendations for improvement and monitor corrective actions. All WPC participants (PE, Contractors and care management team members) will follow a Plan-Do-Study-Act (PDSA) process and use a tool to plan and document progress with tests of change conducted as part of performance improvement projects (PIPs). Using the established goals, scope, timing, milestones, and team roles and responsibilities for the WPC pilot, the process below will be completed by the project leader/manager/coordinator with review and input by the project team:

1. What are we trying to accomplish (aim)?

State your aim that will improve resident health outcomes and quality of care

2. How will we know that change is an improvement (measures)?

Describe the measureable outcome(s) you want to see

3. What change can we make that will result in an improvement?

Define the processes currently in place; use process mapping or flow charting

Identify opportunities for improvement that exist (Perform Root Cause Analysis with Performance Improvement Projects).

- Points where breakdowns occur
- “Work-a-rounds” that have been developed
- Variation that occurs
- Duplicate or unnecessary steps

Decide what you will change in the process; determine your intervention based on your analysis

- Identify better ways to do things that address the root causes of the problem
- Learn what has worked at other organizations (copy)
- Review the best available evidence for what works (literature, studies, experts, guidelines)
- Remember that solution doesn’t have to be perfect the first time

The LE and ESC have the responsibility of performing oversight of WPC activities to ensure full compliance with best practices and evidence based methods, and to make recommendations for improvement and monitor corrective actions. As part of the contracting process the LE will review

submitted written policies, procedures and descriptions for the WPC activities. This will be followed by an on-site review is scheduled as necessary.

Upon completion of the review, the findings will be reported to LE and ESC in a written summary.

The contractor or WPC unit will be provided written notice of any deficiencies, required to correct said deficiencies within 30 days and provide documentation of such correction, including a Plan-Do-Study-Act process. Collaboratively with the ESC, the LE evaluates the contractor's ability to perform the activities. The LE reviews, on an annual basis, coordination of care policies for consistency with DHCS contractual obligations of the WPC pilot. Any substantive revisions to contractor's policies are to be submitted to the LE within 30 days of the date changes were made. A written summary of the review's findings will be presented to LE administration. Contractor will be provided written notice of any deficiencies, required to correct said deficiencies within 30 days, and provide documentation of such changes.

Data Analysis and Reporting:

Section 3.2 describes our use of the San Joaquin Community Health Information Exchange (SJCHIE) for data sharing, care management, and data analysis and reporting. SJCHIE will function as the data steward and service provider for shared infrastructure in support of analysis and reporting for our WPC pilot.

While SJCHIE has basic reporting functionality today, it is limited in nature, reports must be created by SJCHIE's vendor (Inland Empire Health Information Exchange) in a labor-intensive process, and the user interface leaves room for improvement. Hence, SJCHIE will work with IEHIE and its technology partners to (a) enhance current systems with WPC-specific reports as an interim solution, and then (b) implement a more sophisticated and user-friendly population health analytics platform to inform quality improvement and change management interventions with our targeted populations, and to report outcomes to DHCS on WPC pilot metrics.

4.3 Participant Entity Monitoring

The Lead Entity (LE) in conjunction with the Executive Steering Committee (ESC) shall develop a monitoring plan for all Participating Entities (PE), and determine the design and features of a dashboard to monitor all metrics. A standing report on metrics will be on each monthly agenda. A Plan-Do-Study-Act (PDSA) cycle will be established for major project components, and training on the PDSA cycle will be provided to all WPC PE, contractors, and care management team members.

The LE and ESC have the responsibility of performing oversight of all WPC activities to ensure full compliance with relevant State Terms and Conditions as well as with best practices and evidence based methods, and to make recommendations for improvement and monitor corrective actions. As part of the contracting process the LE will review deliverables and descriptions of the WPC activities. This may be followed by an on-site review if deemed necessary.

All PE, as well as partners on the ESC will report on a monthly basis metrics determined as assigned by the LE based on services to be provided. These metrics will form a dashboard which will be distributed at monthly meetings and posted in the cloud. The dashboard will provide for transparency in evaluating performance. Any contracted entity providing services to the WPC will have a defined scope of services with required deliverables and reporting requirements. Contractors who are unable to meet the requirements will be provided a performance improvement plan, and in general be given 30-60-90 days to correct based on the deficiency and the cause. Assistance can be provided either from ESC staff or

other contractors who are meeting and exceeding their deliverables. This may include: direct observation, interviews with key utilization staff to ascertain level of expertise and verify processes, and document review to ascertain that documentation is thorough and appropriate.

Payments for services may be withheld. If they cannot meet the terms of their agreement, the contractor will be terminated.

Section 5: Financing

5.1 Financing Structure

The WPC pilot will be financed via the compliant use of eligible Mental Health Services Act funds that are included as part of an approved MHSA annual plan as well as the use of existing San Joaquin General Hospitals Enterprise Funds.

The Lead Entity will request approval for and the establishment of a separate budget fund from the County's Auditor-Controller to support and isolate all financial records for purposes of accounting the WPC pilot. The funds identified for the non-federal share of the WPC pilot shall be deposited and held in this WPC Fund until an official request is received for processing the first Intergovernmental Transfer (IGT). From the official State request, the Lead Entity shall initiate and process the transfer of funds according to the specifications provided, within 7 days. Upon receipt of payment from the State, funds shall be deposited to the WPC pilot fund. This deposit will provide a source of funding to support ongoing, approved and eligible WPC pilot activities.

Each participating entity will be reimbursed based upon a direct or bundled payment structure at the point of submitting a valid claim for reimbursement. The claims will provide a summary sheet with required information (Requestor's Name and Address, Unique Claim #, Date of Claim and Amount of Claim). Detailed and appropriate supporting documentation should be included with the summary claim sheet; this information will be maintained in the participating entity's master file for future audit and recordkeeping requirements. Claims for payment will either be submitted monthly or quarterly depending upon the contract or MOU. To ensure timely payment, claims should be submitted to the Lead Entity within 30 days after the close of each calendar month or quarter as appropriate. Upon review and approval of each submitted claim, payment will be distributed from the WPC Fund to the participating or contracted entities.

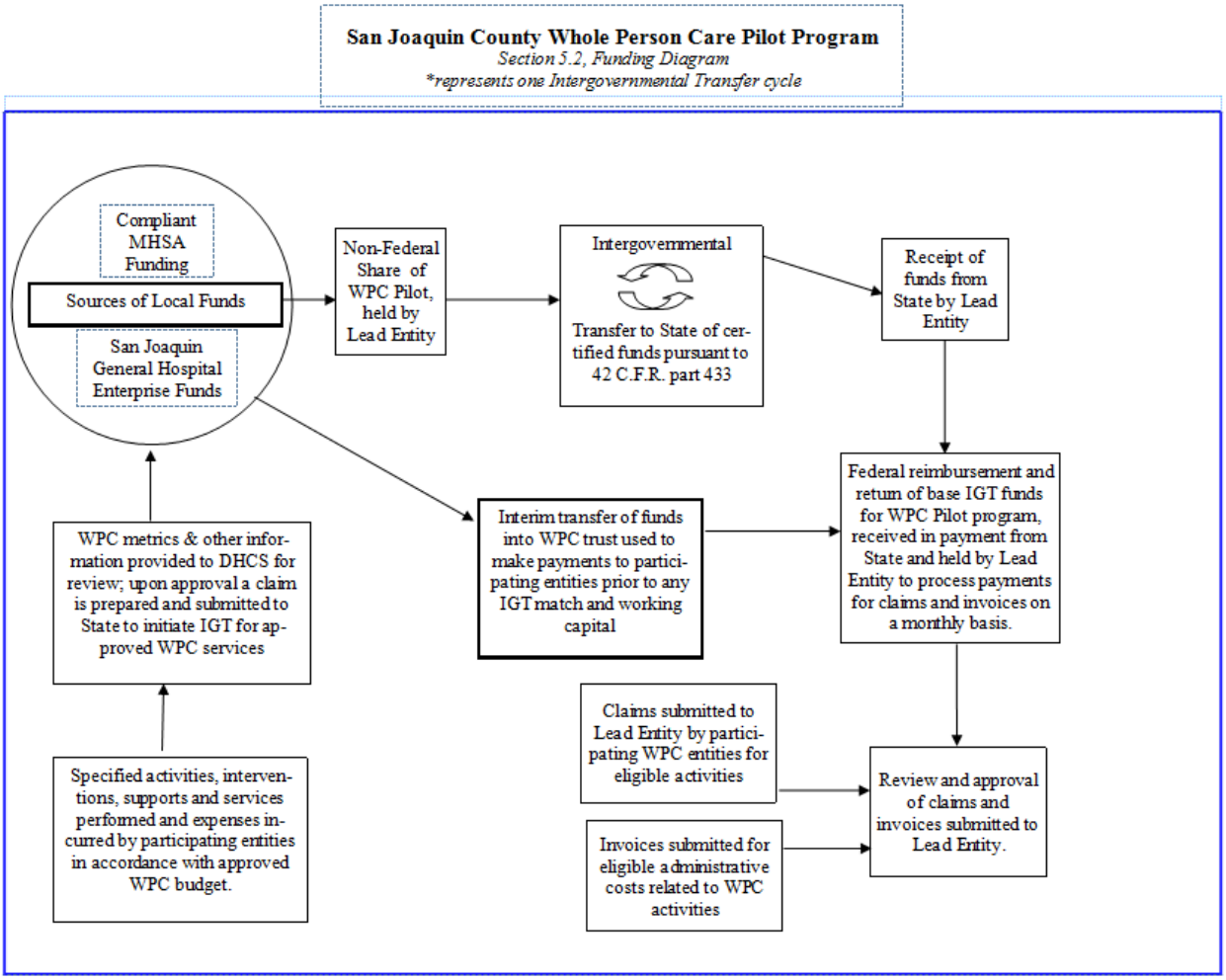
Overhead costs related to the implementation and operation of the WPC pilot program can be requested for reimbursement by submitting a detailed invoice with valid, supporting documentation to the Lead Entity for review and approval. Claims for overhead reimbursements are limited to the amounts established in the WPC pilot budget and will follow the same submission and payment schedule outlined above for WPC Claims.

The Lead Entity is subject to the fiscal oversight of the San Joaquin County Auditor-Controller's Office and complies with all established rules, regulations, policies and procedures. All transactions impacting the WPC Fund and pilot program will be captured and recorded in San Joaquin County's financial management system; detailed reporting and financial statements can be generated to support, maintain and validate all WPC fiscal transactions. The Lead Entity will be responsible for a monthly reconciliation of the WPC trust fund to monitor, track and confirm all fiscal activity and transactions related to the WPC pilot program.

Total payments issued for claims shall not exceed the total amount received in local match and Federal reimbursement; a minimum balance will be maintained in the WPC Fund to facilitate the operations of the Pilot. Additional local match funds will be deposited into the WPC Fund as required to provide additional non-Federal share for the bi-annual IGT's.

Participation in the WPC pilot program will help participants be better prepared for value based payment approaches in the future by allowing an opportunity for early experimentation of processes and practices amongst the WPC pilot participants that effectively determine how to maximize coordination, provision and continuity of care.

5.2 Funding Diagram



5.3 Non-Federal Share

San Joaquin County Behavioral Health Services and San Joaquin General Hospital (a designated Public Hospital) will provide the non-federal share to the San Joaquin County Health Care Services Agency who acting as the Lead Entity for the Whole Person Care pilot will request the County's Auditor-Controller to facilitate required Intergovernmental transfers.

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

Funding sources to be used for the non-federal share of the WPC pilot program include eligible Mental Health Services Act (MHSA) funds and general purpose enterprise revenue held by San Joaquin General Hospital (SJGH), a designated Public Hospital. Efforts under MHSA include providing prevention and early intervention services and community services and support as part of statewide goals established to promote recovery and wellness. Via a stakeholder process, San Joaquin County will update their annual MHSA plan to incorporate components of the WPC pilot program which will further support working towards the established MHSA plan goals. SJGH receives County general funds to support operations; these funds are discretionary and are used to achieve various goals while enhancing care and health outcomes for the community it serves. Both of these funding sources provide a platform for San Joaquin County's WPC pilot program to reach the identified target populations.

Our WPC Pilot will assure that payments issued will be subject to the limitations established by the California Medi-Cal 2020 Demonstration Special Terms and Conditions (STC) 132 and 133.

The primary goals of all participating entities under San Joaquin County's WPC pilot program are to:

> Develop and support infrastructure to integrate services among local entities that serve the target populations via the expansion of interfaces into the SJCHIE from partners who predominantly serve Medi-Cal populations; the expansion into real time care management and population health analytics of the HIE; and the establishment of a community based care management entity infrastructure in the County to support changes in reimbursement methodology post the Medi-Cal 2020 waiver and to allow the two managed care Medi-Cal Health plans who operate in our county to eventually opt into the ACA's Health Homes program; and
>
> Only Medi-Cal beneficiaries will be enrolled into the pilot and Federal financial participation will only be utilized for services provided to Medi-Cal beneficiaries. San Joaquin County's WPC pilot program will ensure compliance by tracking and verifying claims for reimbursement against the database maintained with identified and enrolled WPC pilot participants. As Medi-Cal beneficiary's opt-in or out of the WPC pilot program, appropriate indicators will be added to designate those eligible to receive WPC services; and
>
> Innovatively and efficiently seek to provide services not otherwise covered or directly reimbursed by Medi-Cal to improve total care for the target populations; and seek alternative strategies to improve integration, reduce unnecessary utilization of health care services and improve health outcomes. Each participating entity has determined what specific WPC deliverables can be achieved and what strategies should be implemented to accomplish these goals. Claims submitted for payment by participating entities shall provide details related to billable activities (see section 5.1, Financing Structure). The supporting documents provided with reimbursement claims will be reviewed and approved for payment upon verification that the activities comply with STC 113.

Additionally, any direct housing supports will use only funds segregated into a to be established sustainable county housing pool which will be funded with appropriate and complaint alternative sources.

Additional Targeted Case Management Notes for both the FFS and PMPM funded activities:

The vast majority of the activities and interactions of the care coordination teams will not duplicate Medi-Cal's targeted case management (TCM) or Mental Health Services (MHS) benefits. Specifically, the WPC Behavioral Health Navigation Team services will depart significantly from the encounter-based structure of TCM and from the eligibility requirements for

MHS, and in the vast majority of cases the encounters between the WPC Behavioral Health Navigation Team and clients would not be eligible for reimbursement under MHS, as the clients would not have yet received a formal mental health assessment or been authorized to receive MHS services. Once a WPC client is engaged, assessed and authorized for MHS services, their services will transition to a different funding source.

Moreover, the scope of care support and coordination activities available through WPC is intended to be more robust than available through Medi-Cal TCM and MHS. WPC teams will engage in activities such as: street outreach for clients who have not yet been authorized for MHS and those with substance use disorder issues; incentives to initiate engagement; peer support; trust-building; motivational supports; mental health and substance abuse education, general reinforcement of health concepts; assistance in locating shelter; linkages to mental health crisis services and substance abuse services as needed; information about resources for housing, food and clothing; reengagement/enrollment of clients that are incarcerated or in an IMD facility for continuity of care coordination to outpatient settings immediately prior to their being released (no direct treatment services will be provided via WPC pilot funding to clients who are incarcerated or in an IMD facility); continuing connection to clients for continuity of care that are currently residing in inpatient hospitals and skilled nursing facilities; and, collaboration with other county and community-based agencies. These are distinct from and outside the TCM and MHS benefits. For these reasons, we have concluded that the vast majority of WPC Pilot activities will not duplicate services available through Medi-Cal TCM or MHS.

WPC Behavioral Health Navigation Team services will be provided in non- typical community settings such as streets, under bridges, parks, behind dumpsters, and in tent cities. Attempts to contact individuals will be made several time each week to gain trust and rapport with the goal of securely engaging them in mental health and/or substance abuse services.

The Population Health team services will assist patient navigation through the various health system including managing transitions following hospitalizations to post-acute care settings, managing referrals to specialists and other ancillary services, managing medication refills/adherence/safety, managing ED utilization and facilitating access to lower-cost care settings when appropriate, remote monitoring of clinical data (sensors, wearables), liaising with primary care team members to coordinate care, connecting patients with community-based services and with care provided by other agencies, removing barriers to access, including scheduling/transportation/language issues.

5.5 Funding Request

San Joaquin County's Whole Person Care pilot program is requesting a total of $17,500,000 for the term of the demonstration project. Specifically, Budget Year 1 includes a request for $3,500,000 – with the required local match to be supplied by the Lead Entity for successfully submitting the WPC application and providing required baseline data. Budget Years 2-5 each include an annual request of $3,500,000 – for a total of $14,000,000. Details related to each activity and/or deliverable for which funding is requested, are provided in this narrative document as well as in the Excel based WPC Budget Template, which is included in our application submission. Each annual budget includes activities under the following components with minimum and maximum amounts per component where applicable. Specific details related to each budget year and component are provided in the WPC Budget Template.

- **Infrastructure Development: $1,187,828 (PY2); $1,786,198 (PY3); $1,646,198 (PY4); $982,798 (PY5)**

    - Administrative Infrastructure: $582,324 (PY2-5)

This includes programmatic support required in planning, implementing and operating the WPC pilot program. Costs include:

Item	**Amount**	**Description**
1.0 FTE Department Applications Analyst III	$159,163	This position will work to support and implement information technology interfacing required for the WPC project.
1.0 FTE Management Analyst II	$139,784	This position will provide data analysis and reporting as well as provide coordination and administrative support for the WPC project.
0.32 FTE Accountant I/I	$35,004	This position will be assigned to monitoring, tracking and providing accurate and timely financial reporting related to the WPC project.
1.0 FTE Public Health Nurse	$141,231	This position will be assigned to clients with high risk obstetrical needs and will provide necessary support and coordination of care.
1.0 FTE Registered Nurse	$92,142	This position will be assigned to Community Health Education Outreach which will seek to identify and enroll eligible Medi-Cal beneficiaries in the WPC project.
Community Health Education and Outreach Events	$15,000	This operational cost will support materials, supplies, travel and other fees associated with activities and events to reach the target population(s) and eligible WPC pilot beneficiaries.

    - Incentive Payments for Downstream Providers: $605,504 (PY2); $1,203,874 (PY3); $1,063,874 (PY4); $400,474 (PY5)

These costs are comprised of payments made to downstream providers and contractors for achievement of specific operational and quality deliverables that are critical for the

pilot's overall success including build out of delivery infrastructure by SJCHIE. The amounts listed below are maximums to be requested, per project period, based upon the provider's performance and achievement of specific deliverable(s). Incentive amounts to El Concilio will be a direct pass through to that entity; Incentive amounts related to Clinic Patient Services for Patient Navigation will be fully passed through to our two partner FQHC's based upon a to be established MOU's with the Lead Entity; Incentive Payments to the HIE will be based upon a to be established MOU with the Lead Entity but it is assume that pass-through will be limited to actual hard costs related to the HIE's acquisition and support of new technologies and services, direct expenses incurred by the HIE and technical staff of interfacing partners, waived implementation and first year subscription fees by newly joined interfacing partners, and funds used to train end user staff. It is anticipated that the incentive payments will be approximate to the sum of these hard cost though timing is uncertain. Any balance of funds will be retained by the Lead Entity to support other patient facing activities of the WPC project as appropriate and approved by the pilots executive committee which may include support to partner entities performing services to our target populations who are not directly associated with either the PMPM or FFS bundles.

Item	**Amount**	**Description**
Health Information Exchange	$410,030 (PY2); $1,008,400 (PY3); $868,400 (PY4); $205,000 (PY5)	These annual incentive payments will be issued by the Lead Entity upon SJCHIE successfully executing various deliverables related to implementing Health Information Exchange technology including: interface development; end user access and functional use by local healthcare providers organizations, health plans, and additional county's; implementing the care management infrastructure and care management capabilities for identified WPC target populations; providing analytics and reporting infrastructure related to the WPC target populations per the timeframes listed at the end of section 3.2 within this application. Shifts in each annual incentive payments are reflective of the workload and correspond with the level of intensity, hard costs and expectations from SJCHIE and their participating entities. This item has been moved from Delivery Infrastructure to Incentive Payments in the current application revision.
El Concilio for Patient	$167,667 (PY2-5)	This incentive payment will be issued to the provider upon their successful facilitation with assisting monolingual

Item	Amount	Description
Advocate/Navigator		patients through necessary administrative processes such as application completion, linkage to services, documentation submission, etc. and their reporting the number of referrals to and linking of eligible Medi-Cal beneficiaries to the WPC pilot program and when the pilot successfully meets total WPC enrollment goals in the given program year (at least 200 enrolled by the end of PY2, 500 at end of PY3, 800 by end of PY4 and 1,000 by end of PY5).
Clinic Patient Services for Patient Navigation (both partnering FQHC's)	$27,807 (PY2-5)	This incentive payment will be issued to the provider upon successfully reporting enrollment information of eligible Medi-Cal beneficiaries into the WPC pilot program to the Lead Entity. This service provides a front-line interaction with patients as they enter the health system; assessment and referral to the WPC program will be performed as beneficiaries are identified.

- **Services and Interventions: $1,110,066 (PY2); $1,686,081 (PY3); $1,822,457 (PY4); $2,404,232 (PY5)**
    - Discrete Services: $298,000 (PY2-5)

Respite Care: $225,000 (PY2-5)

Services provided under the WPC pilot to eligible Medi-Cal beneficiaries include medically necessary respite care. The fee included in this budget will support respite care for individuals, primarily those who are homeless or those with unstable living situations, who are too ill or frail to recover from a physical illness or injury in their usual living environment but are not ill enough to be in a hospital. The estimated total cost per year is $225,000 with a projected 5,000 respite days to be utilized; the calculated rate per unit to be reimbursed under the WPC pilot program is $45.

Care Coordination: $73,000 (PY2-5)

This cost of a Mental Health Specialist II (1.0 FTE) position will provide case management, individual and group counseling, crisis management and discharge planning for WPC pilot beneficiaries that are being released from a local facility. The estimated cost per year is $73,000 with a projected 1,300 clients to be served per year [650 total estimated

participants in the target populations with an anticipated 2 encounters per enrollee]; the calculated rate per unit to be reimbursed under the WPC pilot program is $56.15.

- FFS Services-WPC Behavioral Health Navigation Team: $570,468 (PY2); $904,885 (PY3); $799,663 (PY4); $1,139,840 (PY5)

This team will provide wrap around services to include outreach engagement, peer support, screening, referral and linkage to continuing services for the WPC project.

Details related this calculated FFS rate are included in the table below:

Item	**Units**	**Annual Cost per Unit**	**Total**
Mental Health Clinician I/II	1.0	$140,327	$140,327
Mental Health Outreach Worker	2.0	$67,000	$134,000
Mental Health Specialist II	2.0	$99,087	$198,174
Substance Abuse Counselor II	3.0	$78,337	$235,011
Chief Mental Health Clinician	0.5	$153,006	$76,503
Office Assistant Specialist	1.0	$87,034	$87,034
General Operating Expenses (phones, office supplies, transportation, etc.		$45,000	$45,000
Total			**$1,139,840**
FFS Rate – Hourly	**$137 per hour**	**8,320** (total hours provided to vary per year)	**$1,139,840 FFS**

- Bundled Per-Member-Per-Month Services

Population Health Team: $241,605 (PY2); $483,196 (PY3); $724,794 (PY4); $966,392 (PY5)

Certain services provided under our WPC pilot to eligible Medi-Cal beneficiaries or enrolled WPC clients will include a comprehensive care management system initially

based at San Joaquin General Hospital. Services and activities will be provided by a newly created population health unit and include more than one service/activity that will be offered to the target population for a set value per PMPM bundled service deliverable. Interpretation services to be provided to WPC pilot beneficiaries who communicate in a language other than English are included as Enhanced Care Coordination services. The purpose is to ensure accurate and complete information is shared and received while interacting with the clients. This is not the same interpretation that current clinic staff provide for Medi-Cal patients during routine primary care, specialty care or other medical visits. Interpretive services will be provided by trained staff for WPC pilot beneficiaries to facilitate various aspects for effective WPC. Staff may interpret in person, telephone or tele-video.

Additionally, Enhanced Care Coordination costs will support a community-based organization's activities related to providing necessary transportation for WPC pilot beneficiaries, including to and from medical/ counseling appointments or other supportive services.

These services will eventually be transitioned to the community based care management entity once such can be functionally established. Total member months consist of an estimated 500 enrollees (maximum after full implementation/ramp-up) under this target population x 12 months = 6,000.

Details related to this calculated bundle are included in the table below:

Item	**Units**	**Annual cost per Unit**	**Total**
Staff			
Staff Nurse III-Ambulatory	1.0	$126,402	$126,402
Staff Nurse IV-Ambulatory	1.0	$134,696	$134,696
Licensed Vocational Nurse	1.0	$88,100	$88,100
Outpatient Clinic Assistant	3.0	$59,552	$178,657
Office Supervisor	1.0	$66,707	$66,707
Office Worker	2.0	$35,644	$106,931
Interpretive Services staff (Enhanced Care	Various	$28,834	$28,834

Item	**Units**	**Annual cost per Unit**	**Total**
Coordination)			
El Concilio for Transportation (Enhanced Care Coordination)	1.0	$161,577	$161,577
Infrastructure			
Office Admin Supplies	1.0	$14,019	$14,019
Other Minor Equipment	1.0	$17,500	$17,500
Other Non-Medical Supplies	1.0	$15,000	$15,000
Rental Lease Equipment	1.0	$10,000	$10,000
Telephone	1.0	$5,000	$5,000
Educational Materials	1.0	$1,000	$1,000
Outside Training	1.0	$15,000	$15,000
Staff Travel	1.0	$1,000	$1,000
Total			**$966,420** *Minimum level utilizes lower staffing and operating supplies for a total of $241,605 during ramp-up*
Member Months	**125 - 500** (estimated enrollees; range due to ramp-up)	**1,500 - 6,000** (total member months per year; range due to ramp-up)	**$161.07 PMPM**

- **Reporting and Quality: $1,202,106 (PY2); $27,721 (PY3); $31,345 (PY4); $112,970 (PY5)** (Please note that higher amounts are presented in PY2 as a result of ramping-up services).

    - Pay for Metric Reporting: $901,580 (PY2); $20,791 (PY3); $23,509 (PY4); $84,728 (PY5)

Costs reflected in this category support collecting and reporting on the pilots Variant Metrics. SJC's WPC pilot program proposes to report on and achieve the goal listed in: Variant Metrics #1, the quantity of unique individuals with updated data within the San Joaquin Community Health Information Exchange (SJCHIE), with a pay for reporting payment indicated in the respective Project Year of the detailed budget document - for successfully providing and achieving this metric. The report will require the number of patients for whom data was shared with SJCHIE. Implementation and utilization of the SJCHIE will allow comprehensive coordination of care and access to critical information by various qualified providers related to each patient or client. This will prevent duplication of services and a more informed assessment and diagnosis. Additionally, SJC intends to report on and achieve the targeted goals listed for Variant Metric #2 related to comprehensive diabetes control. A payment is attached to this reporting metric upon successfully providing the percentage individuals with diabetes in the WPC pilot program who have an HbA1c under 8.0%. The County's 2016 Community Health Needs Assessment identified diabetes as the top health concern as the prevalence is estimated at 10.4%, compared to a statewide rate of 8.1% (Centers of Disease Control and Prevention, 2012). The WPC population is at high risk for diabetes due to lack of regular health care and use of alcohol and other drugs. The WPC Pilot will engage individuals into regular health care and behavioral health treatment to regain control over diabetes. Finally, SJC proposes to report the number of clients enrolled in the WPC pilot with a PHQ-9 score of more than 9 and related percentage rates (NQF 0710). The payment will be issued for this metric upon successfully reporting the number of WPC enrollees with a PHQ-9 score in accordance to the established performance benchmarks for national or local targets. Evaluating and monitoring client's mental health as a measurable component will allow for an overall assessment of the population's mental wellbeing and provides a mechanism to gauge progress towards programmatic improvements.

    - Pay for Outcomes $300,527 (PY2); $6,930 (PY3); $7,836 (PY4); $28,243 (PY5)

Incentive payments will be issued based upon meeting the established goals. SJC's WPC pilot program proposes to provide timely follow-up with individuals who have been discharged from hospitalization. Following-up on high-risk patients increases the likelihood of continued preventive care and consequently, reduced inpatient utilization. Initiating contact with these patients will include confirmation of upcoming appointments, coordination of necessary services and assistance in coordinating or obtaining enabling services. Annual incentive payments are included in the budget to be distributed upon reporting a rate of 90% or higher related to follow-up with individuals after hospitalization.

San Joaquin County's Whole Person Care pilot program budgets do not include costs for services that are reimbursable by Medi-Cal or other federal funding resources. All

activities, costs and reimbursements are tracked and monitored via a unique fund value – which has been established and assigned solely for the purpose of the Whole Person Care pilot program. Funding will only be expensed for services provided to Medi-Cal eligible individuals.

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WPC Budget Template: Summary and Top Sheet

WPC Applicant Name:	San Joaquin County

	Federal Funds *(Not to exceed 90M)*	IGT	Total Funds
Annual Budget Amount Requested	1,750,000	1,750,000	3,500,000

PY 1 Budget Allocation (Note PY 1 Allocation is predetermined)	
PY 1 Total Budget	3,500,000
Approved Application (75%)	2,625,000
Submission of Baseline Data (25%)	875,000
PY 1 Total Check	OK

PY 2 Budget Allocation	
PY 2 Total Budget	3,500,000
Administrative Infrastructure	582,324
Delivery Infrastructure	0
Incentive Payments	605,504
FFS Services	868,463
PMPM Bundle	241,605
Pay For Reporting	901,580
Pay for Outcomes	300,525
PY 2 Total Check	OK

PY 3 Budget Allocation	
PY 3 Total Budget	3,500,000
Administrative Infrastructure	582,324
Delivery Infrastructure	0
Incentive Payments	1,203,874
FFS Services	1,202,880
PMPM Bundle	483,210
Pay For Reporting	20,784
Pay for Outcomes	6,928
PY 3 Total Check	OK

PY 4 Budget Allocation	
PY 4 Total Budget	3,500,000
Administrative Infrastructure	582,324
Delivery Infrastructure	0
Incentive Payments	1,063,874
FFS Services	1,097,664
PMPM Bundle	724,815
Pay For Reporting	23,493
Pay for Outcomes	7,830
PY 4 Total Check	OK

PY 5 Budget Allocation	
PY 5 Total Budget	3,500,000
Administrative Infrastructure	582,324
Delivery Infrastructure	0
Incentive Payments	400,474
FFS Services	1,437,835
PMPM Bundle	966,420
Pay For Reporting	84,711
Pay for Outcomes	28,236
PY 5 Total Check	OK

End of worksheet