Whole Person Care Pilot Application

Section 1: WPC Lead Entity and Participating Entity Information

Shasta County Health and Human Services Agency (HHSA) is serving as the lead agency for this application. Dean True, Director of the Adult Services Branch of the Health and Human Services Agency, will serve as the single point of contact for DHCS and is responsible for coordinating and monitoring the WPC Pilot.

1.1 Whole Person Care Pilot Lead Entity and Contact Person

Organization Name	Shasta County Health and Human Services Agency
Type of Entity	County health department
Contact Person	Dean True
Contact Person Title	Director, HHSA-Adult Services Branch
Telephone	(530) 225-5901
Email Address	dtrue@co.shasta.ca.us
Mailing Address	2640 Breslauer Way, Redding, CA 96001.

1.2 Participating Entities

Required Organization			
1. Medi-Cal managed care health plan	Partnership HealthPlan of California (PHC)	Margaret Kisliuk, Director Northern Region	Serve on the WPC Steering Committee, support evaluation of the program through sharing of claims data on identified metrics.
2. Health Services Agency/ Department	Shasta County Health and Human Services Agency (includes Public Health, Mental Health, Alcohol and Drug Services, and Social Services)	Donnell Ewert, Director	Leads design, implementation, administration and evaluation of the WPC pilot. Serve on the WPC Steering Committee. Implements housing case management intervention.
3. Specialty Mental Health Agency / Department	Shasta County HHSA, Adult Services Branch (Mental Health/ Alcohol and Drug Services)	Dean True, Director Adult Services Branch	Leads design, implementation, administration and evaluation of the WPC pilot. Serves on the WPC Steering Committee. Implements

Required Organization	Organization Name	Contact Name and Title	Entity Description and Role in WPC
			housing case management intervention.
4. Public Agency / Department	Shasta County HHSA, Housing Authority	Richard Kuhns	Responsible for Continuum of Care Council and HMIS system oversight. A representative will serve on the WPC Steering Committee.
5. Community Partner 1	Hill Country Health & Wellness Center	Lynn Dorroh, Chief Executive Officer	FQHC and Full Service Partnership provider providing primary care and behavioral health care in Redding. Responsible for implementation of services related to mental health resource center and assisted outpatient treatment. Also responsible for intensive medical case management and comprehensive primary care for assigned Medi-Cal members in the pilot. Serves on the WPC Steering Committee.
6. Community Partner 2	Shasta Community Health Center	Dean Germano, Chief Executive Officer	FQHC providing primary care and healthcare for the homeless services in Redding. Responsible for intensive medical case management and comprehensive primary care for assigned Medi-Cal members in the pilot. Serves on the WPC Steering Committee.
Additional Organizations	**Organization Name**	**Contact Name and Title**	**Entity Description and Role in WPC**

Required Organization	Organization Name	Contact Name and Title	Entity Description and Role in WPC
7. Public Agency	City of Redding	Kurt Starman, City Manager	Providing local funds to support WPC pilot strategies, including development of the Sobering Center.
8. Community Partner	Mercy Medial Center Redding	Jordan Wright, VP of Strategy, Dignity Northstate	Operates one of the hospital emergency departments in Redding. Will support identification and referral of potential WPC pilot participants.
9. Community Partner	Shasta Regional Medical Center	Cyndy Gordon, Chief Executive Officer	Operates one of the hospital emergency departments in Redding. Will support identification and referral of potential WPC pilot participants.
10. Community Partner	Empire Recovery Center	Marjeanne Stone, Executive Director	As a Drug Medi-Cal provider will provide linkages to substance use treatment services for WPC pilot participants. Serves on the WPC Steering Committee.
11. Community Partner	Visions of The Cross	Steve Lucarelli, Executive Director	As a Drug Medi-Cal provider will provide linkages to substance use treatment services for WPC pilot participants. Serves on the WPC Steering Committee.
12. Community Partner	Good News Rescue Mission	Jonathan Anderson, Executive Director	Homeless shelter service provider will inform project activities based on needs of homeless population.
13. Community Partner	United Way of Northern California	Larry Olmstead, Executive Director	Facilitates the Shasta County Prosperity Initiative, an effort to address financial, workforce, housing, and

Required Organization	Organization Name	Contact Name and Title	Entity Description and Role in WPC
			youth development needs of the lowest income residents

1.3 Letter of Participation and Support

Attached with this application are letters of participation or support from the participating pilot entities identified in the table above in Section 1.2.

Section 2 – General Information and Target Population

2.1 Geographic Area, Community and Target Population Needs

Geographic Area

Shasta County, located in northern California, is approximately 230 miles north of San Francisco and 160 miles north of Sacramento. With only 4% of California's population residing north of Sacramento the terrain is vast, with few population centers, and thousands of miles of wilderness. The population of Shasta County is 178,520, half of which (50.9%) lives in the city of Redding with another 11% of residents living along the I-5 corridor in the cities of Anderson and Shasta Lake City. The remaining population is disparately spread throughout unincorporated county. All of Shasta County, with the exception of the city of Redding, meets the definition of either rural or frontier based on population density. Two Medically Underserved Area's (MUA's) comprise the service area, MUA's 00278 and 07334. All areas of the county are designated as a Health Professional Shortage Area (HPSA), except the City of Redding.

The Whole Person Care (WPC) Pilot Program will be implemented in a targeted geographic area in Shasta County, centering on the largest population center in the City of Redding with a total population of 90,725 (U.S. Census, ACS 2010-14).

Community and Target Population Needs

Data sources used to identify and define the target population needs include a behavioral health needs assessment conducted by the Shasta Health Assessment and Redesign Collaborative (SHARC) in 2015 to identify gaps in the health system and other public data. Claims data supplied by Partnership HealthPlan of California (PHC) was used to understand emergency department (ED) utilization trends and related diagnoses.

Shasta County has long experienced high rates of homelessness, however the situation has reached a breaking point in the past few years. A review of community data was recently prepared to better understand the incidence and impact of homelessness. Cal-Fresh enrollment records for the County indicate that as many as 3,000 individuals, or 1.6% of the population

experienced homelessness in 2015. Shasta County's Point In Time (PIT) Count data over time suggests rates of homelessness are increasing, with an approximately 10% increase in homelessness from 2013-2016. The 2016 PIT counted 934 homeless persons in Shasta County. This represents 0.52% of the population, higher than the state rate of 0.29% (U.S. Census, 2015) or the national rate of 0.18% (HUD Annual Homeless Assessment Report to Congress, 2014). Three-quarters of individuals were unsheltered (74%) and about one-third (31%) have a psychiatric or emotional condition (Shasta County and Redding Continuum of Care, 2016).

In Shasta County, it is estimated that 7,333 adults, or 5.25% of the adult population, have serious mental illness (SMI). Approximately 14,000 adults (9.3%) are in need of substance use treatment services. (CA Mental Health and Substance Use System Needs Assessment: February 2012). Death rates in Shasta County resulting from suicide (23.3 per 100,000) and drug-use (26.3 per 100,000) are more than twice that of the state rates of 10.2 and 11.3, respectively (California Department of Public Health, 2016).

Substance use is a critical issue impacting Shasta County and is on the rise. While prescription opiate abuse has been a long-standing issue, heroin use is increasing in Shasta County, particularly among young adults, 18-24. Substance use treatment providers in the county have reported a five-fold increase in Heroin as the primary drug among individuals entering treatment between 2008 and 2013 (CalOMS, 2015). The rise of Heroin use may in part be a result of increased abuse of prescription painkillers. Opiate use has become a priority issue in Shasta County.

Anecdotal data from hospital EDs on use of services by homeless individuals and an analysis of claims data on ED use by Medi-Cal beneficiaries in the first quarter of 2016 illustrate high utilization of the ED by the target population. Given the impact of homelessness or risk of homelessness and these three risk factors – serious mental illness, substance use disorders, and undiagnosed opioid addition – on the community, these were selected as the primary criteria for the WPC pilot target population.

Overview of Whole Person Care Pilot in Shasta County

The Whole Person Care Pilot Program is intended to develop infrastructure, care coordination strategies, services and supports that will better address the needs of high-utilizing Medi-Cal beneficiaries and achieve reduced total cost of care through lowering the number of ED visits and hospital inpatient admissions. The vision for the Shasta County WPC Pilot Program is that each participant:

- Is connected to a patient centered health home
- Has a case management system that supports them in accessing medical and social non-medical services
- Has health needs and chronic conditions that are stabilized through access to medical care
- Has access to substance use treatment services (outpatient and residential) that support their goals

- Has stable housing that supports their behavioral health and physical health through coordination with local housing case managers and housing assistance programs

In Shasta County, the target population includes PHC members who are homeless or at risk of homelessness that have had two or more ED visits or a hospitalization in the last three months. In addition, the target population may have one or more of the following risk factors: a diagnosis of SMI, a diagnosis of Substance Use Disorders (SUD), or an undiagnosed opioid addiction.

The key services, interventions and care coordination strategies planned as part of the pilot include:

- Screening and enrollment in the WPC Pilot Program (voluntary program) and referral to an intensive medical case management system;
- Development of a hub for behavioral health, assisted outpatient treatment, pre-crisis and social non-medical services for the WPC pilot target population through development of a mental health resource center;
- Mobile Crisis Team that diverts individuals experiencing acute mental health crisis away from the ED and law enforcement and into treatment by providing timely professional intervention in the field;
- Sobering center offers a safe and appropriate place for individuals who are intoxicated as an alternative to ED and/or incarceration in the county jail;
- Intensive medical case managers provide care coordination to connect WPC participants to needed primary care and specialty care, non-medical social services, track referrals, and assist patients in accessing needed care;
- Linkages to residential and outpatient SUD services; and
- Coordinated entry approach to housing services with housing case managers that assist participants in overcoming housing barriers to find and maintain stable housing that will support SUD treatment and medical and behavioral health care goals.

Community Engagement in Planning

There is a long history of community collaboration among health care delivery system partners in Shasta County. In 2006, a 75-member collaborative was established to address the near-collapse of the county's mental health system. Collaboration has continued under health care reform. SHARC has been meeting monthly since 2010 to build a more organized system of healthcare for Shasta County. Membership includes federally qualified health centers, hospitals, Partnership HealthPlan of California, North Valley Medical Association, and the County Health and Human Services Agency. In 2013, SHARC established a strategic plan that identified three strategic priorities (and committees): increasing access to health services, promoting integration of behavioral health, and developing capacity for Health Information Exchange (HIE).

SHARC shifted the focus of the behavioral health integration committee to the Whole Person Care committee. This committee has been the primary vehicle for partner involvement and community engagement in planning for this initiative.

2.2 Communication Plan

Collaborative Leadership
The WPC pilot will be planned and implemented through the Health and Human Services Agency in close collaboration with the Shasta Health Assessment and Redesign Collaborative (SHARC). A Community Development Coordinator within HHSA will be responsible for oversight of the program, with a Case Manager Coordinator being responsible for day-to-day activities of the program. The SHARC Whole Person Care Committee (WPC Committee) will serve as the Steering Committee for the WPC Pilot and will meet monthly to review pilot program progress, address challenges and identify solutions, review evaluation and program improvement data, and ensure timely and effective implementation of the program. In addition, the WPC Committee will routinely assess training needs of the case managers, AOD counselors, and the health care professionals serving the WPC enrollees and plan community-wide training events to build capacity across agencies and health systems.

The current membership of the WPC Committee will be expanded to ensure that all partners are represented. The committee currently includes HHSA, FQHCs, Drug Medi-Cal providers, local elected officials, and the local managed care plan (PHC). The Steering Committee members that may be added include representatives from Mercy Medical Center and Shasta Regional Medical Center, the Continuum of Care (CoC) Council, and the local Housing Authorities.

WPC Steering Committee members will also provide presentations for community partners on the pilot to build community buy-in. The HHSA Community Development Coordinator will coordinate external communications with the local media and community organizations.

Cross Agency Coordination
Shasta County is well positioned to implement the WPC pilot as many of the essential components of the program currently exist in the region, including local attention and action to address homelessness, FQHCs serving the target population, Drug Medi-Cal providers, and an array of social services and community support partners. What is needed is the infrastructure and collaborative leadership to coordinate the services and systems. In order to build the local capacity for cross agency coordination, the WPC pilot will enable Shasta County to create new linkages and referral relationships and share data across systems to better understand and address needs.

Through the WPC pilot, Shasta County will build a hub at the mental health resource center that serves to connect the siloed services and systems. In order to increase collaboration across health, housing, and social service agencies and more effectively utilize community resources to meet the needs of WPC enrollees, the mental health resource center behavioral health clinicians will convene monthly multi-disciplinary clinician and case manager trainings to build capacity for coordination and integrate evidence-based strategies into practice. Mental health resource center led training content may include the American Society of Addiction Medicine (ASAM) criteria and assessment, Milestones of Recovery Scale (MORS), Wellness Recovery Action Planning (WRAP), motivational interviewing, and trauma-informed care. Trainings will

also be an opportunity to network and build relationships across agencies, troubleshoot challenges in accessing resources, coordinate services across systems, and identify resource availability or gaps in the community. WPC case manager meetings may include:

- AOD counselors,
- Mental health resource center staff,
- Intensive medical case managers, and
- Housing case managers.

In addition to these clinical trainings led by the mental health resource center, the WPC Community Development Coordinator will plan and implement additional training opportunities for WPC personnel (from HHSA and participating entities) to build capacity for cross agency coordination, educate staff on data and information sharing policies and procedures, and support data collection, reporting, and PDSA activities. These training opportunities will also be important resources for gaining staff input and understanding how the pilot program is working and designing PDSAs or other continuous quality improvement activities that address key challenges or areas for improvement.

2.3 Target Population(s)

The target population includes adult (age 18-64) PHC members that have two or more Emergency Department visits or a hospitalization in the last three months and are homeless or at risk of homelessness. Priority will be given to individuals who have had four or more ED visits in the past three months. In addition, individuals may have one or more of the following risk factors: diagnosis of SMI, diagnosis of a SUD, or an undiagnosed/ undisclosed opioid addiction. The Shasta County HHSA estimates serving approximately 150 individuals total each year under the pilot program.

SHARC WPC Committee reviewed PHC claims data on individuals who had four or more ED visits in the first quarter of 2016. The dataset included 2,262 individuals representing 12,922 ED visits. The two general hospitals in Redding, Mercy Medical Center and Shasta Regional Medical Center, each reported about 1,000 – 1,100 ED visits per month for this population (represents 1,986 unique Medi-Cal beneficiaries each month). The number of visits ranged from 4-44 ED visits per beneficiary in three months.

Primary diagnosis codes for ED visits were used to segment the population. A total of 622 patients had 1+ ED visits related to a mental health condition, substance use, or pain. Additionally:

- Pain, suicidal ideation or anxiety represented 8 of the top 20 most frequent diagnosis codes for ED visits (9.5% of visits).
- Approximately 167 patients were served in the two EDs through 334 visits for mental health and/or substance use related conditions. Among them, 23% also had visited the ED during the quarter for pain related reasons.

- Approximately 595 patients accounted for 780 visits in the quarter with pain as the primary reason. Among them 9% also had a visit coded with a primary diagnosis related to a mental health condition or alcohol and other drug use related visit.
- Approximately 175 to 215 individuals visit the ED each month for visits related to mental health, substance use, or pain related reasons, which would allow for an opportunity to enroll them in the WPC pilot program.

Understanding the primary criteria for the WPC Pilot of individuals who are homeless or at risk of homelessness that are utilizing the ED is challenging due to a lack of data in medical claims. PHC reviewed data on inpatient admissions and used "Administrative" days as a proxy for days spent locating safe places to discharge patients. PHC found that in 2015 Mercy Medical Center had inpatient claims for 24 individuals with 342 "Administrative" days and Shasta Regional Medical Center had claims for 99 individuals with 155 "Administrative" days. This cohort of 99-123 members likely includes chronically homeless who will be a target for the WPC pilot.

Staff from hospital EDs indicated that patients on 5150 holds, voluntarily walk-in with a mental health crisis, and individuals who are brought in to the ED by family/friends and are intoxicated represent a particular challenge. Individuals are being housed in the ED due to a lack of other options for appropriate placement. Shasta County HHSA clinicians conducted 148 adult crisis evaluations (130 unduplicated adults) at the Mercy Medical ED during the first quarter of 2016 and 231 adult crisis evaluations (203 unduplicated adults) at Shasta Regional. Approximately 69% of those evaluated had a positive toxicology screen.

Utilizing the data described above Shasta County HHSA estimates that a total of 150 adults that meet the eligibility criteria of the target population will be served under the pilot annually. This number is an estimate based on the best available data at this time. This figure has been used as a basis for budgeting services and costs and has been used to set the targets for the metrics.

Shasta County is included in the first cohort of counties under Partnership HealthPlan to implement the 2703 Health Homes for Complex Patients Program. There are a number of questions that remain to be answered about this program including the eligibility criteria for the target population. It is unclear at this time if individuals who are dually eligible for Medi-Cal and Medicare will be served under the 2703 Health Homes program in Shasta County. There is likely overlap between the proposed WPC Pilot target population, many of whom may be dual eligible. In the event there is overlap between the WPC Pilot target population and individuals eligible for the 2703 Health Homes Program, coordination strategies will be developed to ensure that those individuals only receive WPC pilot services that cannot be reimbursed by Medi-Cal under the 2703 Health Homes Program.

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

3.1 Services, Interventions and Care Coordination

The Shasta County WPC Pilot Program has identified a target population of members who are homeless or at risk of homelessness that are high utilizers of the ED and have one or more risk factors. In collaboration with the SHARC WPC Committee, Shasta County HHSA has designed services, interventions and care coordination strategies as part of the pilot program to better integrate and coordinate care according to the needs of this population as described below.

Medical Services

Preliminary screening for potential entry in the WPC Pilot Program will begin in the two hospital EDs. This will ensure a focus on high utilizers as the primary target for enrollment of the target population in the program. The personnel responsible for outreach in the WPC Pilot Program will be HHSA mental health clinicians that are currently co-located in the EDs to perform assessments on individuals who are on a 5150 or 1799 hold. A work flow will be established so that the clinician can assess and discuss the pilot program with individuals identified as a potential fit for the pilot. Enrollment will be voluntary. Potential WPC participants will be referred to an intensive medical case manager for further assessment and enrollment as appropriate. In PY 3-5 additional settings will also conduct screening and referral of the eligible population, including the mental health resource center, Good News Rescue Mission, Hope Van, sobering center, medical respite center, and other community provider entities that serve the population.

Shasta County FQHCs are moving towards a model of intensive outpatient care management to better engage patients with complex medical and social non-medical needs in their plan of care and coordinate care to improve health outcomes and reduce ED visits and inpatient admissions. Shasta County is part of the first cohort of counties scheduled to implement the 2703 Health Homes for Complex Patients Program that is currently planned to begin January 2017. Given the number of questions that remain regarding the target population for both programs, coordination strategies will be developed during PY 2 to ensure that there will be no duplication of medical case management and other services that may be reimbursed by Medi-Cal under the 2703 Health Homes Program.

Shasta County HHSA will conduct a procurement process to contract for intensive medical case management services under the WPC pilot program. Two of the largest FQHC providers in the county, Shasta Community Health Center and Hill Country Health and Wellness Center, have been actively involved in the planning of this application and have informed development of the medical case management intervention. When an individual is identified at one of the entry points as eligible for enrollment in the WPC pilot program, they will be referred to an intensive case manager. The intensive case manager will provide care coordination and case management services to connect patients to needed primary care and specialty care, make referrals for non-medical social service needs, track referrals, and assist patients in accessing needed care.

Behavioral Health Services

Three key strategies and interventions will provide behavioral health services for the target population, including:

Mental Health Resource Center: The mental health resource center will serve as a hub for behavioral health services for the WPC pilot target population, and will serve as an alternative to the ED for individuals experiencing less severe mental health crises. Some of the behavioral health clinical services offered will be directly reimbursed by Medi-Cal for the target population. Any services that are Medi-Cal covered services will not be funded by the WPC Pilot Program. The WPC case management coordinator will support WPC pilot participants in accessing medical, behavioral, and social non-medical services according to identified needs. The WPC case management coordinator will work in collaboration with the medical case managers and housing case managers to coordinate roles and responsibilities, collaboratively plan shared action plans, and ensure no duplication of services for each WPC participant. Licensed clinicians will be available to evaluate and assess a member's immediate needs upon drop-in to the center or by referral from the ED. As members are stabilized, they will have access to many services on site, including substance use disorder group and individual treatment, through co-located SUD treatment providers, groups that address needs associated with anxiety, depression, and pain management. A warm line staffed by individuals with lived experience will be established and outreach staff will be present in the community to work closely with case managers and other partner organizations. A peer-staffed resource center and peer support program will be developed to enhance the wrap around supports offered to the target population. Hill Country Health and Wellness Center will operate the mental health resource center under a contract with Shasta County HHSA. The facility that will house the center is in a separate location from the primary care clinic this organization operates. The Mental Health Resource Center will also operate the Assisted Outpatient Treatment program.

Assisted Outpatient Treatment (AOT): Assisted Outpatient Treatment (AOT) allows certain individuals to be court ordered to participate in outpatient mental health treatment while living in the community. AOT was initially proposed in the early 1980's by families of individuals with the most serious mental illnesses as a way to help. Because individuals with disorders, like schizophrenia, don't recognize they are ill ("Anosognosia"), and see no need to be in treatment, they often decompensate resulting in suicide, homelessness, or incarceration. The criteria to place someone in AOT are easier to meet than the "imminent dangerousness" standard often required for inpatient commitment. AOT allows someone to be ordered into treatment "to prevent a relapse, or deterioration, which would likely result in serious harm to the patient or others." The AOT program consists of two major components:

- Outreach and engagement, and
- Direct mental health treatment services within the evidenced based model of Assertive Community Treatment (ACT).

Outreach and engagement activities are not Medi-Cal reimbursable, and consist primarily of discussion and education with individuals and/or their families about what mental health services are available, and how these can benefit those with serious mental illness. Such contacts and engagement often must occur many times before an individual feels comfortable in taking the next step toward recovery. It is anticipated that approximately 40% of the work in the AOT program will consist of outreach and engagement activities. Individuals willing to actively engage in treatment, or those who are court ordered to participate, will be enrolled in

ongoing AOT/ACT mental health services. Many of these services are eligible for reimbursement under Medi-Cal Specialty Mental Health Services including: rehabilitation activities (skill building and education), medication support with psychiatrist and nurses, limited case management, and individual/group therapy sessions. No WPC funds will be utilized to support Medi-Cal covered services.

Mobile Crisis Team (MCT): The MCT will serve as an entry point for WPC Target population individuals who are experiencing an urgent/immediate mental health or substance use crisis situation in the community. There will be 3 teams, each consisting of one clinician and one case manager. At least one MCT will be available to respond to the field/community at large from 6:00 am in the morning until 12:30 am at night, seven days a week. Calls to the MCT for assistance and/or service may be initiated by law enforcement, concerned community members (family, friends, etc), or by the individual themselves. Teams consisting of 2 professionals will allow the MCT to provide services directly to homes, apartments, and businesses without need for law enforcement. In those situations where the referral comes from someone other than law enforcement, and the MCT assesses a serious safety concern, the MCT will notify law enforcement and request 'ride along' assistance and initial contact. Law enforcement will make initial contact, and perform a short 'standby' service until the MCT communicates an 'all clear'. In those situations where the individual is either a 5150 (and refusing intervention), or is significantly demonstrating intoxication, law enforcement will detain and escort to an emergency room or sobering center.

Sobering Center: The critical overcrowding of the EDs in Redding is impacted due to housing of intoxicated individuals who require time to sober up before a psychiatric assessment can be conducted. Shasta County HHSA and our community partners seek to establish a Sobering Center that offers a safe and appropriate place for individuals who are intoxicated as an alternative to the emergency department and are not in need of further mental health evaluation. The Sobering Center will be developed under WPC pilot and services will be available to support the WPC target population. Shasta County HHSA will develop a request for proposal to identify a contractor to operate the Sobering Center. While the center itself will not require certification, qualified entities must demonstrate/be certified Drug Medi-Cal or other alcohol/drug treatment providers with experience working with the WPC pilot target population.

Linkages to Substance Use Disorder Treatment Services: Analysis of the target population for the WPC pilot underscores the importance of connecting these individuals to residential and outpatient substance use disorder (SUD) treatment services. SUD treatment providers will play a key role in the services delivered to WPC pilot program participants. Through the WPC pilot, enhanced referral relationships will be established to ensure coordination between the HHSA ED-based clinicians, three Drug Medi-Cal (DMC) treatment providers, primary care medical homes, housing case management services, and the mental health resource center. Intensive medical case managers will use motivational interviewing in conjunction with DMC providers to encourage patients with SUD disorders to enroll in an appropriate level of SUD treatment. In addition, motivational interviewing will be used to

engage patients in the sobering center to encourage them to seek treatment in a detoxification center currently operated by one of the local DMC providers. The FQHCs will continue to expand their outpatient SUD services to provide an integrated setting for individuals with SUDs who also are enrolled in their primary care services. The WPC Steering Committee offers key opportunities to address SUD treatment related issues community-wide. All three Drug Medi-Cal providers participate (Empire Recovery, Right Roads, Visions of the Cross) and can raise and address challenges and identify collective solutions.

Coordinated Entry and Housing Services

The Shasta County and Redding Continuum of Care is developing a strategic plan for expansion of housing services. This effort presented an opportunity to integrate evidence-based solutions to address homelessness in Shasta County. The two local housing authorities, local non-profits, Shasta County HHSA, the WPC Steering Committee and the CoC are working to align strategies in this strategic plan and the housing services and supports offered through the WPC pilot in order to leverage and more effectively coordinate housing services. The WPC Pilot Program offers an opportunity to enhance the existing Continuum of Care (CoC) coordination in order to provide the necessary infrastructure to develop a County-wide Coordinated Entry system for Homeless services that currently is lacking, but is critical to the success of the WPC Pilot program. Specific activities of the CoC will include convening of local housing service providers to better coordinate services, sharing information about the WPC pilot program to enhance community buy-in and referrals, building relationships and trust across housing agencies in the county, evaluating coordinated entry tools and identifying those that will work best in Shasta County, collecting and reporting program data to support the project, and informing selection, implementation and training on the HMIS system.

The strategic plan promotes Coordinated Entry as a key strategy for Shasta County. Coordinated Entry creates a centralized system for effectively prioritizing and matching people to the resources they need to regain housing or never become homeless in the first place. The planned coordinated entry approach will utilize one consolidated assessment tool that measures housing and health care, behavioral health and other needs across all provider entities included in the pilot. Through the coordinated entry approach WPC participants will be referred to housing case managers trained to assist participants in finding and maintaining stable housing. Under the WPC pilot the housing case managers would build collaborative relationships with the county agencies, Drug Medi-Cal providers and the intensive medical case managers serving WPC enrollees to ensure an efficient referral process and coordinate housing supports with the mental health and substance use treatment services and patient-centered health homes services. WPC pilot funding will be used to enhance the case management services offered to individuals, such as contracting with a local non-profit to employ a volunteer coordinator who will recruit and train volunteers as case manager extenders to make regular contact with individuals housed through the project. Collaboration between agencies will help to prioritize housing vouchers for WPC enrollees to ensure rapid re-housing of participants or help prevent homelessness before that occurs. A more comprehensive Homeless Management Information System (HMIS) computer software product will be implemented among service

providers to better collect and share data about homeless individuals and case management services.

Other Social Non-Medical Services
In addition to housing services, other social non-medical services will be integrated into the services and interventions to support the WPC pilot participants. The mental health resource center will be the primary hub for coordinating these services, which may include enrollment in CalFresh, General Assistance and other public benefit programs, employment skills training, parenting classes, and other services as identified.

3.2 Data Sharing

The WPC Pilot program will employ three primary sources of data on program participants to coordinate services, monitor progress and assess performance and outcomes on identified metrics. These sources include health plan claims data provided by Partnership HealthPlan of California (PHC), electronic health records maintained by HHSA and FQHCs for primary care and behavioral health services and outcomes, program reports from case managers and other pilot partners, and HMIS.

PHC currently provides select providers in their primary care network with information on the highest cost members through their Intensive Outpatient Care Management program. Under the WPC pilot, similar strategies to identify members that are eligible for enrollment in the pilot will be explored. Bi-directional data sharing will include:

- Partnership HealthPlan will provide lists of WPC pilot potentially eligible health plan members to FQHCs for outreach.
- FQHCs will send PHC information on WPC pilot participant for formal enrollment into WPC pilot program.
- FQHCs will track services provided to WPC pilot participants in an excel workbook (modeled after practice under the IOPCM program). Program reports will be prepared and shared with Shasta County HHSA and PHC.

PHC will also support measurement on the universal and variant metrics described in this application for the population of WPC pilot enrolled participants. HHSA will request claims data for WPC enrolled participants for identified pilot metrics for inclusion in WPC pilot program reports in accordance with requirements outlined in the STC and program reporting guidelines.

The two hospital partners will also be involved in bi-directional data sharing activities. Through collaborative data sharing activities between the hospitals, the managed care plan and the FQHCs, information on ED visits, hospital admissions and hospital discharges will be provided to FQHCs for WPC participants in a timely manner. This will assist medical case managers in their work with WPC participants to plan and achieve shared goals.

Any data sharing activities related to Personal Health Information/Personal Information (PHI/PI), mental health or substance use disorder services information, between HHSA,

Partnership HealthPlan, and participating network providers will comply with all applicable state and federal law. Required patient consent to share information across provider entities will be obtained as appropriate to support data sharing activities.

The Shasta County HHSA Adult Services Branch operates the specialty mental health plan. Cerner is the electronic health record used for services provided through the County specialty mental health clinics. As permitted by all relevant state and federal law protecting privacy, information on individuals served through county-operated specialty mental health services may be shared with the mental health resource center in order to coordinate the plan of care across service sites and teams.

The mental health resource center, which will be operated by Hill Country Health & Wellness Center, will use Centricity Practice Management Solutions, their electronic health record, to track patient activity and services. Additional data system capabilities will be needed to track resource center activities and outcomes. Identification and implementation of the system will be completed during Program Year 2 of the WPC Pilot. Shasta Community Health Center utilizes NextGen as their electronic health record and will be the primary source of clinical data on WPC participants that are assigned members. In addition to data in the health center EHR systems, Shasta County is part of a 12-county Health Information Exchange (HIE) operated by SacValley MedShare. The HIE is in early stages but will be a focus for the WPC pilot in building capacity across health systems and providers to coordinate and integrate care.

The Redding Area Homelessness Coalition Project worked with HomeBase to document the costs and impact of homelessness in Shasta County. The study finds that Shasta County's financial cost for responding to homelessness is $34.2 million annually. The Coalition is establishing a strategic plan to respond to homelessness in Shasta County. A priority outlined in the plan is to "Implement a community-wide system for data collection and performance measurement". The WPC pilot provides the opportunity to ensure coordination of the HMIS system with the health and other social non-medical services that will be required to adequately respond to the needs of homeless individuals. Shasta County will implement an expanded HMIS, with greater participation across the County. The housing case managers will be active users of the system along with other homeless service providers. In addition, the WPC pilot staff will explore extending access as appropriate for the mental health resource center case management coordinator and clinical staff to support the continuum of services provided to WPC pilot participants.

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

4.1 Performance Measures

Shasta County HHSA has established performance measures that utilize both qualitative and quantitative data to monitor implementation of the pilot and achievement of pilot goals. The

performance measures outline the impact of the WPC pilot interventions and services for the target population on related health outcomes and health care utilization. Variant metrics selected are currently reported under PHC Quality Improvement Program (QIP) or HEDIS reporting and therefore have gone through extensive clinical review in the region. Responsibility for collecting process and outcome data is shared among the lead entity, the Shasta County Health and Human Services Agency (HHSA), and participating community partners. Shasta County HHSA will adapt existing data collection tools and protocols for measuring performance over the five-year pilot period.

Shasta County HHSA will hire two primary personnel to provide administrative management of the pilot. The Community Development Coordinator and data analyst (Senior Agency Staff Services Analyst) will be responsible for day-to-day monitoring and management of all pilot contractors, activities, and reporting. HHSA will be responsible for collecting and aggregating pilot data related to the universal and variant metrics identified below and reporting of pilot program data to DHCS. The HHSA pilot staff members will also lead PDSA activities in collaboration with pilot partner entities to support achievement of pilot targets.

HHSA WPC Pilot staff will work with Partnership HealthPlan of California (PHC) to review claims data to support ongoing assessment of pilot program performance and reporting on identified universal and variant metrics. HHSA staff will also work with the two FQHCs to collect clinical and patient encounter data from electronic medical records to support performance measurement and report.

The Shasta County WPC Pilot includes a housing component and as such a variant metric related to housing has been identified to assess performance. HHSA staff will work with the Continuum of Care (CoC) collaborative and relevant partner entities with responsibility for the HMIS as well as with housing case managers to develop data collection and reporting processes that are aligned with the identified metric.

4.1.a Universal Metrics

Please check the boxes below to acknowledge that all WPC pilots must track and report the following universal metrics. Please list the WPC pilot goal for each metric.

- ☑ Health Outcomes Measures
- ☑ Administrative Measures

<u>Health Outcomes Measures</u>

1. Ambulatory Care – Emergency Department Visits [Adults] (HEDIS).
   Pilot Goal: Reduce emergency department visits for the WPC target population by 10% per year.

2. Inpatient Utilization – General Hospital/Acute Care [Adults] (HEDIS).
   Pilot Goal: Reduce inpatient Utilization for the WPC target population by 10% per year.

3. Follow-up After Hospitalization for Mental Illness [Adult] (HEDIS).

Pilot Goal: Increase follow-up within 7 days post-discharge for Mental Illness [Adults] for the WPC target population by 5% per year.

4. Initiation and engagement of alcohol and other drug dependence treatment [Adults] (HEDIS).
   Pilot Goal: Increase initiation and engagement of AOD dependence treatment for WPC target population by 3% per year.

Administrative Measures

1. Proportion of participating beneficiaries with a comprehensive care plan, accessible by the entire care team within 30 days of enrollment in WPC pilot.
   Pilot Goals:
   a) Achieve 75% of participating beneficiaries with a comprehensive care plan within 30 days of enrollment in the pilot.
   b) Achieve 50% of participating beneficiaries with a comprehensive care plan within 30 days of the beneficiary's anniversary of participation in the pilot (to be conducted annually).

2. Care coordination, case management, and referral infrastructure.
   Pilot Goals:
   a) Submit documentation demonstrating the establishment of care coordination, case management and referral policies and procedures across the WPC Pilot lead and all participating entities, which provide for streamlined beneficiary case management by June 30, 2017.
   b) Establish an oversight process to review compliance across the WPC Pilot lead and all participating entities with the policies and procedures by June 30, 2017.
   c) Establish a method to compile and analyze information and findings from the monitoring procedures and a process to update policies and procedures by December 31, 2017.
3. Data and information sharing infrastructure.
   Pilot Goals:
   a) Submit documentation demonstrating the establishment of data and information sharing policies and procedures across the WPC Pilot lead and 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, by December 31, 2017.
   b) Establish monitoring procedures for oversight of how the WPC Pilot lead and all participating entities are operationalizing policies and procedures for data and information sharing – including 1) a process for regular review to determine any needed modifications, and 2) utilization of PDSA with measurement and testing necessary changes a minimum of semi-annually – by December 31, 2017.
   c) Establish a method to compile and analyze information and findings from the data and information sharing monitoring procedures, and a process to update the data and

information sharing policies and procedures in a streamlined manner and within a reasonable timeframe in accordance with PDSA findings by December 31, 2017.

4.1.b Variant Metrics

Variant Metric	Numerator	Denominator	PY 1 Baseline	PY2	PY 3	PY 4	PY 5
Variant Metric 1 Administrative: Average number of monthly contacts by WPC pilot case manager per WPC Participant.	Total number of contacts per month	Total number of WPC participants	1	Up to 300% improvement over PY1	Up to 15% improvement over PY2	Up to 10% improvement over PY3	Up to 5% improvement over PY4
Variant Metric 2: Comprehensive diabetes care: HbA1c Poor Control <8%	Within the denominator, who had HbA1c control (<8.0%)	Members 18–75 years of age with diabetes (type 1 and type 2)	47.1%	Maintain baseline	Up to 5% improvement over PY2	Up to 5% improvement over PY3	Up to 5% improvement over PY4
Variant Metric 3: Depression Remission at 12 Months (NQF 0710)	Adults who achieved remission at twelve months as demonstrated by a twelve month (+/- 30 days) PHQ-9 score of less than five	Adults age 18 and older with a diagnosis of major depression or dysthymia and an initial PHQ-9 score greater than nine during an outpatient encounter	15%	Maintain baseline	Up to 5% improvement over PY2	Up to 5% improvement over PY3	Up to 5% improvement over PY4
Variant Metric 4: NQF: 0104 Suicide Risk Assessment	Patients who had suicide risk assessment completed at each visit	All patients aged 18 years and older with a new diagnosis or recurrent episode of Major Depressive Disorder	0%	Maintain baseline	Up to 5% improvement over PY2	Up to 5% improvement over PY3	Up to 5% improvement over PY4
Variant Metric 5: Housing: Permanent Housing	Number of participants in housing over 6 months	Number of participants in housing for at least 6 months	5%	Up to 5% improvement over PY1	Up to 10% improvement over PY2	Up to 15% improvement over PY3	Up to 15% improvement over PY4

4.2 Data Analysis, Reporting and Quality Improvement

Shasta County HHSA staff will develop and document data collection, reporting and analysis procedures for the WPC Pilot interventions, strategies, and participant health outcomes. To the extent possible, analysis of return on investment for the WPC Pilot will be analyzed using Partnership HealthPlan claims data and other data as identified under the pilot.

Program data related to interventions will be collected through the following sources:

- Intensive Medical Case Managers – will be required to report on all WPC Pilot activities including contacts with WPC enrolled participants, engagement in outreach activities, and related outcomes for WPC participants.
- Housing Case Managers – will be required to report on all WPC Pilot activities including contacts with WPC enrolled participants, engagement in outreach activities, and related outcomes for WPC participants.
- Mental Health Resource Center – will be required to submit data on WPC participants served and utilization of behavioral health services.
- Sobering Center – will be required to report utilization data on number of unduplicated individuals served and length of stay.

Initially, WPC Pilot data will be collected through standardized reporting templates (excel spreadsheet) developed by the HHSA Data Analyst. The reporting templates will be designed to collect data related to the metrics identified above and additional data required for pilot budget management. These processes are currently utilized to manage contractors, including Full Service Partnership (FSP) contractors. Dashboards on services provided will be produced and analyzed to monitor performance, assess gaps and evaluate impact on outcomes.

HHSA will explore during PY 2 opportunities to procure a data system that can support collection of relevant WPC pilot data across services, interventions and existing data systems (e.g. CalOMS, HMIS, EHR/HIE). This may include purchasing licenses for a software solution that can be implemented across agencies.

A Utilization Review Committee will be convened to review and inform data analysis and ongoing monitoring of performance. This committee will inform WPC pilot PDSA activities developed under the pilot to address areas for improvement. The managed care plan, Partnership HealthPlan, as well as other required project partners will participate in PDSA activities. The Utilization Review (UR) Team will review data collected from across the provider entities involved the pilot. These meetings will convene staff across all WPC pilot provider entities, including the FQHCs, Housing case managers, Hospitals, and the health plan. The Community Development Coordinator and Data Analyst (ASSA) will convene meetings monthly during PY 1 and 2 with the option to move these meetings to quarterly in PY 3- 5 once systems are established.

4.3 Participant Entity Monitoring

Shasta County HHSA is the lead entity for the WPC Pilot and will be responsible for monitoring of all contracted provider entities. The Community Development Coordinator will conduct

oversight and monitoring of all contractors in accordance with Shasta County contracting policies and procedures. A clear scope of work with all deliverables, timelines and specification of services will be developed for each contractor. The Community Development Coordinator will meet with contracted entities on a routine basis (at least annually) to assess performance, provide technical assistance when a contractor is not meeting the identified terms of the contract, and to impose corrective action if required. Shasta County maintains the right to terminate any contracted entity that is not able to meet the terms of correction actions or the agreed upon scope of work.

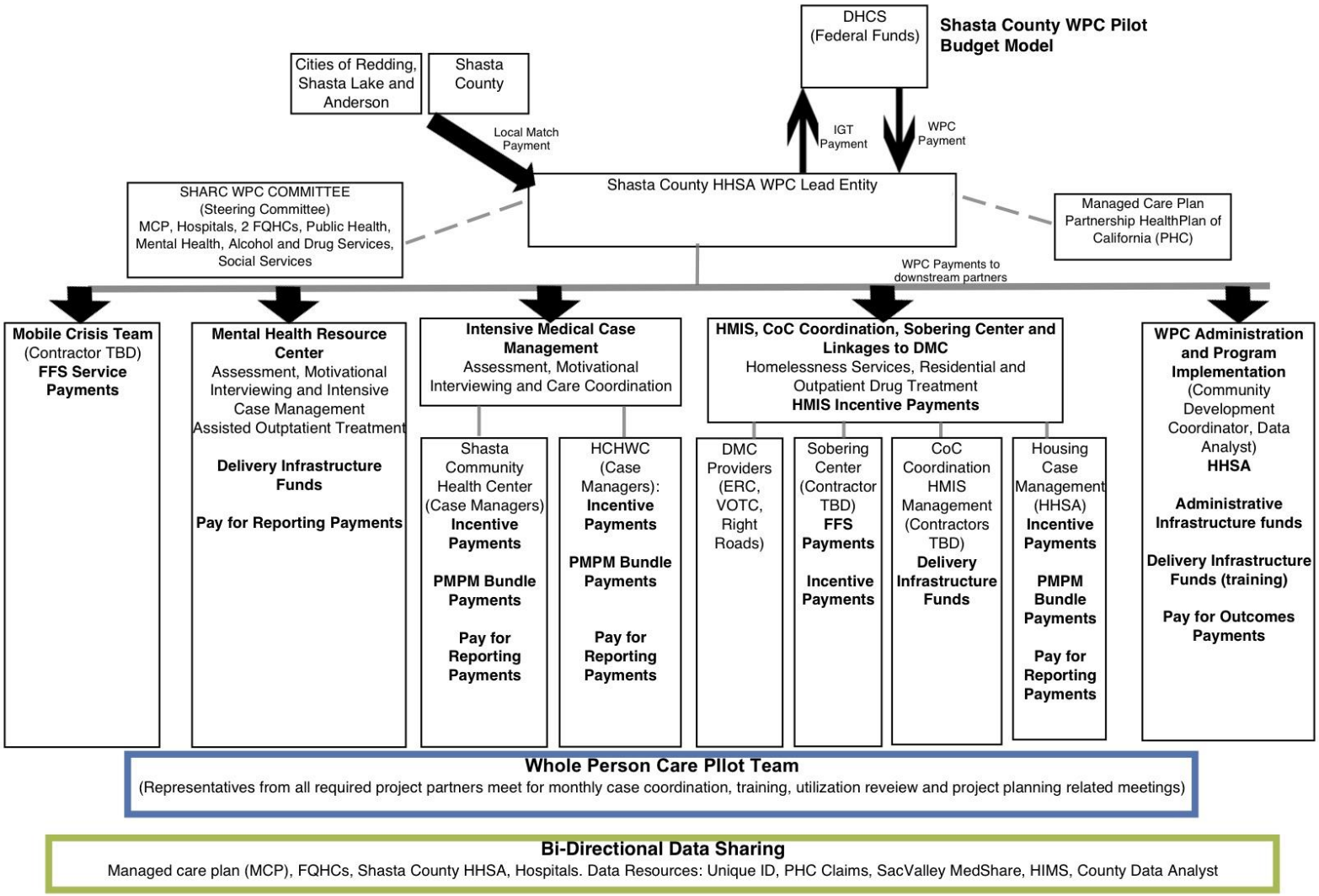
Section 5: Financing

5.1 Financing Structure

Local funds for the WPC pilot will originate with the County of Shasta and the cities of Redding, Anderson, and Shasta Lake. Agreements between the County of Shasta and the three cities will be needed to transfer the city funds to the county for the pilot. The County of Shasta will conduct the procurement processes for contractors, and will develop contracts with the successful applicants. Shasta County HHSA will transfer funds through the IGT process and receive the matched funds as part of the WPC payment, as illustrated in the budget model.

Payments to contractors will be in the form of (1) infrastructure payments based on cost, (2) fee-for-service payments, (3) Incentive payments, (4) PMPM bundled payments, and (5) Pay for Reporting. Payments will be made on a quarterly schedule based on invoices and reported deliverables. Payments will be tracked through the county's accounting system, and the capped compensation amounts in the contracts will assure that sufficient funds are available for the entire project. The county will use several local funding streams for local match, and will use revenue from year one of the pilot for cash flow until the federal match is reimbursed after PY2.

We will experiment with bundled or PMPM payment arrangements for intensive medical case management and housing case management. An important component of project management and oversight will be assisting case management teams with measuring the efficacy and cost effectiveness of various services and the impact of these services in reducing health care costs.


DHCS
(Federal Funds)
Shasta County WPC Pilot
Budget Model
Cities of Redding, Shasta Lake and Anderson
Shasta County
Local Match Payment
IGT Payment
WPC Payment
SHARC WPC COMMITTEE
(Steering Committee)
MCP, Hospitals, 2 FQHCs, Public Health, Mental Health, Alcohol and Drug Services, Social Services
Shasta County HHSA WPC Lead Entity
Managed Care Plan
Partnership HealthPlan of California (PHC)
WPC Payments to downstream partners
Mobile Crisis Team
(Contractor TBD)
FFS Service Payments
Mental Health Resource Center
Assessment, Motivational Interviewing and Intensive Case Management
Assisted Outptatient Treatment
Delivery Infrastructure Funds
Pay for Reporting Payments
Intensive Medical Case Management
Assessment, Motivational Interviewing and Care Coordination
Shasta Community Health Center (Case Managers)
Incentive Payments
PMPM Bundle Payments
Pay for Reporting Payments
HCHWC (Case Managers):
Incentive Payments
PMPM Bundle Payments
Pay for Reporting Payments
HMIS, CoC Coordination, Sobering Center and Linkages to DMC
Homelessness Services, Residential and Outpatient Drug Treatment
HMIS Incentive Payments
DMC Providers (ERC, VOTC, Right Roads)
Sobering Center (Contractor TBD)
FFS Payments
Incentive Payments
CoC Coordination HMIS Management (Contractors TBD)
Delivery Infrastructure Funds
Housing Case Management (HHSA)
Incentive Payments
PMPM Bundle Payments
Pay for Reporting Payments
WPC Administration and Program Implementation
(Community Development Coordinator, Data Analyst)
HHSA
Administrative Infrastructure funds
Delivery Infrastructure Funds (training)
Pay for Outcomes Payments
Whole Person Care Pllot Team
(Representatives from all required project partners meet for monthly case coordination, training, utilization reveiew and project planning related meetings)
Bi-Directional Data Sharing
Managed care plan (MCP), FQHCs, Shasta County HHSA, Hospitals. Data Resources: Unique ID, PHC Claims, SacValley MedShare, HIMS, County Data Analyst

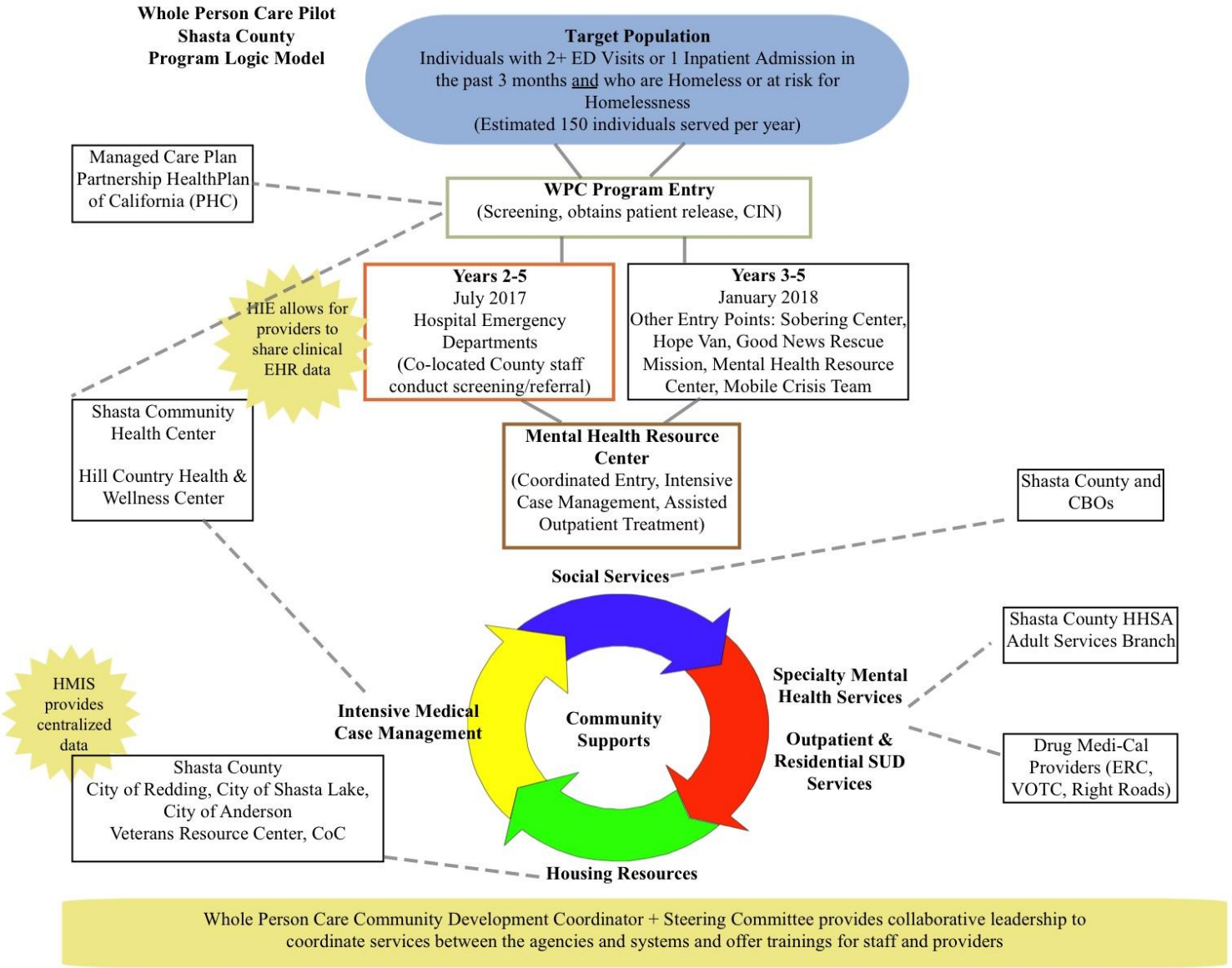
EXPLANATION FOR ACCESSIBILITY:
This diagram shows how the Whole Person Care pilot will be funded.

Shasta County HHSA is the WPC Lead Entity, with WPC payment coming from DHCS (federal funds) and IGT payment going from the lead entity to DHCS. Local matches come from Cities of Redding, Shasta Lake and Anderson, and Shasta County.

WPC payments go to downstream partners in five categories, including:
1. Mobile Crisis Team (Contractor TBD) - paid by FFS service payments
2. Mental Health Resource Center (assessment, motivational interviewing and intensive case management, assisted outpatient treatment) - paid by delivery infrastructure funds and pay for reporting payments
3. Intensive Medical Case Management (assessment, motivational interviewing and care coordination), which would be done by Shasta Community Health Center and HCHWC (case managers) - paid by incentive payments, PMPM bundle payments, pay for reporting payments
4. HMIS, CoC Coordination, Sobering Center and Linkages to DMC (homelessness services, residential and outpatient drug treatment) - paid by HMIC incentive payments. This work would be done by DMC providers (ERC, VOTC, Right Roads), Sobering Center (Contractor TBD) which would be paid by FFS payments and incentive payments, CoC Coordination HMIS Management (contractors TBD) which would be paid by delivery infrastructure funds), and Housing Case Management (HHSA), which would be paid by incentive payments, PMPM bundle payments, and pay for reporting payments.
5. WPC Administration and Program Implementation (community development coordinator, data analyst) - this would be done by HHSA and paid by administrative infrastructure funds, delivery infrastructure funds (training), and pay for outcomes payments.

The Whole Person Care Pilot Team includes representatives from all required project partners who will meet for monthly case coordination, training, utilization review and project planning related meetings.

Bi-Directional Data Sharing will be done by the Managed Care Plan (MCP), FQHCs, Shasta County HHSA and hospitals. Data resources will include Unique ID, PHC claims, SacValley MedShare, HIMS and County Data Analyst.


Whole Person Care Pilot
Shasta County
Program Logic Model
Target Population
Individuals with 2+ ED Visits or 1 Inpatient Admission in the past 3 months and who are Homeless or at risk for Homelessness
(Estimated 150 individuals served per year)
Managed Care Plan
Partnership HealthPlan of California (PHC)
WPC Program Entry
(Screening, obtains patient release, CIN)
HIE allows for providers to share clinical EHR data
Years 2-5
July 2017
Hospital Emergency Departments
(Co-located County staff conduct screening/referral)
Years 3-5
January 2018
Other Entry Points: Sobering Center, Hope Van, Good News Rescue Mission, Mental Health Resource Center, Mobile Crisis Team
Shasta Community Health Center
Hill Country Health & Wellness Center
Mental Health Resource Center
(Coordinated Entry, Intensive Case Management, Assisted Outpatient Treatment)
Shasta County and CBOs
Social Services
Shasta County HHSA Adult Services Branch
Specialty Mental Health Services
HMIS provides centralized data
Intensive Medical Case Management
Community Supports
Outpatient & Residential SUD Services
Drug Medi-Cal Providers (ERC, VOTC, Right Roads)
Shasta County
City of Redding, City of Shasta Lake, City of Anderson
Veterans Resource Center, CoC
Housing Resources
Whole Person Care Community Development Coordinator + Steering Committee provides collaborative leadership to coordinate services between the agencies and systems and offer trainings for staff and providers

This flow chart shows how the target population will receive services through the Whole Person Care Pilot.

The target population is individuals with 2+ ED visits or 1 inpatient admission in the past three months, and who are homeless or at risk for homelessness (estimated 150 individuals served per year).

The person enters the WPC program and has a screening, signs a patient release and CIN. This step includes the Managed Care Plan Partnership HealthPlan of California (PHC) and Shasta Community Health Center and/or Hill Country Health and Wellness Center; HIE allows for providers to share clinical EHR data.

For years 2-5 (starting July 2017), individuals enter through hospital emergency departments (co-located county staff conduct screening/referral).
For years 3-5 (starting January 2018) , entry points also include the sobering center, Hope Van, Good News Rescue Mission, Mental Health Resource Center and Mobile Crisis Team.

For all participants, the Mental Health Resource Center will provide coordinated entry, itnensive case management, and assisted outpatient treatment.

The circle of community supports includes social services (Shasta County and CBOs), specialty mental heatlh servcies (Shasta County HHSA - Adult Services Branch), outpatient and residential SUD services (drug Medi-Cal providers - ERC, VOTC, and Right Roads), housing resources (Shasta County, city of Redding, city of Shasta Lake, city of Anderson, Veterans Resource Center and CoC, with HMIS providing centralized data), and intensive medical case management (Shasta Community Health Center and Hill Country Health and Wellness Center.

The Whole Person Care Community Development Coordinator and steering committee will provide collaborative leadership to coordinate services between the agencies and systems and offer trainings for staff and providers.

5.3 Non-Federal Share

The following entities will provide the non-federal share to Shasta County HHSA to be used for payments under the WPC pilot.

1. Shasta County Health and Human Services Agency
2. City of Redding
3. Shasta County Housing Authority
4. City of Anderson
5. City of Shasta Lake

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

WPC Pilot payments shall support 1) infrastructure to integrate services among local entities that serve the target population; 2) services not otherwise covered or directly reimbursed by Medi-Cal to improve care for the target population such as housing components; and 3) other strategies to improve integration, reduce unnecessary utilization of health care services, and improve health outcomes.

Broadly speaking, the local funds and the federal WPC pilot match will be used to fund the projects described in this proposal. There will be some non-Medi-Cal clients served, and some services provided through the projects will be billable to Medi-Cal. HHSA and its contractors will track which enrolled individuals are enrolled in the WPC pilot to determine which are enrolled in Medi-Cal. Only the services rendered to Medi-Cal beneficiaries will be claimed for federal match through the WPC pilot. Only services that are not Medi-Cal billable will be claimed for federal match through the WPC pilot.

The vast majority of the activities and interactions of the care coordination teams will not duplicate Medi-Cal's tareted case management (TCM) benefit. Specifically, the medical case management and housing case management services and interventions depart significantly from the encounter-based structure of TCM, and in the vast majority of cases the counters between medical case management and housing case management teams and WPC participants would not be eligible for reimbursement under TCM. Shasta County Health and Human Services Agency does claim for Targeted Case Management (TCM), however the work is focused on families at risk of entering the child welfare system, and is conducted by a local non-profit called the Child Abuse Prevention Coordinating Council (CAPCC). CAPCC provides TCM services for parents of children three to five years of age who are enrolled in select state preschools. The vast majority of this population is quite distinct from the target population of the WPC Pilot, homeless adults with a mental illness or a substance use disorder. Any homeless families who are encountered by the CAPCC staff will be referred to the Family Stabilization program in CalWORKs, and not to the WPC Pilot. Moreover, the scope of care support and coordination activities available through WPC is intended to be more robust than available through Medi-Cal TCM. WPC teams will engage in activities such as relationship building, peer support, motivational supports, disease specific education, wellness education, and general reinforcement of health concepts, which are distinct from and outside the TCM benefit. WPC

will also provide direct social and other services that would not be recognized as TCM, such as benefits advocacy, housing transition services, and enhanced care coordination. For these reasons we have concluded that the vast majority of WPC Pilot activities will not duplicate services available through Medi-Cal TCM. However, in response to concerns of duplication of payment, we have applied a TCM budget adjustment to the medical case management to reduce our request for WPC funds. The TCM budget adjustment can be found in the corresponding service description.

5.5 Funding Request

In addition to this narrative, please see the attached WPC Pilot Application – Budget Summary document and the budget detail narrative documentation.

Funding from Shasta County's WPC pilot program is separated into the following main categories: Administrative Infrastructure, Delivery Infrastructure, Incentive Payments, PMPM Bundles, Pay for Reporting and Pay for Outcomes. Shasta County is requesting a total of $3,898,678 per year for 5 years of the pilot program.

The funding requests for each year by budget categories are as follows:

- Program Year 1 – the requested budget amount of $3,880,710 is for the submission of the application ($2,910,553) and the required baseline data ($970,178).
- Program Years 2 - 5 – the requested budget amount of $3,880,710 is for the initial year of implementation and delivery of services under the WPC pilot program. It is anticipated the pilot will serve a total of 150 WPC participants.

Budget Category	Year 2	Year 3	Year 4	Year 5
Administrative Infrastructure	290,000	290,000	290,000	290,000
Delivery Infrastructure	2,177,291	1,518,529	1,518,529	1,518,529
Incentive Payments	55,250	55,250	55,250	55,250
FFS Services	646,088	646,088	646,088	646,088
PMPM Bundle	658,761	1,317,523	1,317,523	1,317,523
Pay for Reporting	37,800	37,800	37,800	37,800
Pay for Outcomes	15,520	15,520	15,520	15,520
Totals	$3,880,710	$3,880,710	$3,880,710	$3,880,710

The following activities are attributable to the identified budget categories:

1. **Administrative Infrastructure** includes HHSA personnel required for the day-to-day implementation, monitoring and evaluation of the WPC pilot program. The personnel included in administrative infrastructure will be responsible for data collection and program reporting, management of contract partners, management of program budgets and fiscal administration, and data analysis and PDSA activities. This category also includes costs for licensing software for HHSA personnel and partner entities to collect and analyze program

data and support reporting on pilot program metrics. Additional detail on the cost breakdown is included in the attached budget detail narrative.

2. **Delivery Infrastructure** includes funding for the mental health resource center, coordination of the Continuum of Care (CoC) for Redding and Shasta County, licensing of a new Homeless Management Information System (HMIS), and training for WPC pilot staff and partners to build capacity for cross agency coordination, educate staff on data and information sharing policies and procedures, and support data collection, reporting, and PDSA activities. Additional detail on the cost breakdown is included in the attached budget detail narrative. In PY2 50% of the costs for medical case management teams and housing case management teams are included in the delivery infrastructure line to allow for time spent developing the programs and establishing data sharing agreements across agencies.

3. **Incentive Payments** include the following:
    - HMIS incentive to input a homeless person's intake information into the Homeless Management Information System (HMIS). Estimate a total of 150 WPC participants per year and $10 per HMIS entry. This activity will be conducted by CoC Coordinator and HHSA housing case managers. The incentive payments will be split as follows: 100 for CoC and 50 for housing case management based on completion of HMIS data entries.
    - Sobering Center incentive for each WPC enrolled participant in the sobering center who enters detox program and stays at least 72 hours. Estimate that of WPC participants served by sobering center 50 will enter detox annually.
    - Housing Support Volunteers incentive will be paid to HHSA Housing Support Volunteer Program for each 100 home visits to WPC enrolled participants completed per volunteer. Estimate 5,000 home visits per year.
    - Housing case management incentive for each WPC enrolled participant who stays in permanent housing for at least 6 consecutive months. Estimate 50 per year; 75% of incentive paid to housing case management and 25% to intensive medical case management.
    - Reduced ED utilization incentive for each WPC enrolled participant who has <2 emergency department visits for 6 consecutive months. Estimate 50 per year; 75% of incentive paid to intensive medical case management and 25% to housing case management.

4. **Fee-for-Service Payments** include two services that are part of the WPC pilot program, the Sobering Center, and the Mobile Crisis Team.
    - The **Sobering Center** will be operated by a contractor and will offer an alternative to emergency department visits for WPC participants with substance use disorders who are intoxicated in the community. The sobering center is estimated to provide 650 encounters for WPC pilot participants per year. Payments are $250 per encounter for a WPC enrolled participant based on estimated cost. Additional cost detail is included in the attached budget detail narrative.

- The **Mobile Crisis Team (MCT)** will include 3 teams, each consisting of one clinician and one case manager. At least one MCT will be available to respond to the field/community at large from 6:00 am in the morning until 12:30 am at night, seven days a week. The MCT FFS rate will be $134.33 based on projected cost and estimated face-to-face contacts with WPC enrolled participants of 300 per month or 3,600 annually. Additional detail on the cost breakdown is included in the attached budget detail narrative.

5. **PMPM Bundle Payments** include two services that are part of the WPC pilot program, the Intensive Medical Case Management and Housing Case Management. WPC participants are eligible to receive services from more than one service bundle (i.e., medical and housing case management) and/or FFS service as there is no duplication of services across these distinct service lines. Participants will receive services according to the eligibility criteria established for each distinct type of service as described in the Budget Narrative.
    - **Intensive Medical Case Management** will be provided to WPC enrolled participants (not eligible for 2703 Health Home). A clinician case manager and patient navigator team will be developed to support the target population. Bundled services will include a comprehensive assessment, patient-centered care plan, care coordination, nursing support for management of chronic conditions, home visits, coordination with housing case manager, coordination with mental health resource center and substance use providers, and medication monitoring support. These teams will be operated out of Shasta Community Health Center and Hill Country Health & Wellness Center (Redding primary care clinic site). Costs are budgeted for the sub-set of 100 WPC enrolled participants that are estimated to be served through intensive medical case management with an estimated 1,000 member months annually. PMPM Bundle is valued at $595.00. Additional detail on the cost breakdown is included in the attached budget detail narrative.
    - **Housing Case Management** will be provided to WPC enrolled participants that are homeless or at risk of homelessness. A team of social workers will provide case management and housing support services to assist individuals find stable housing. Social workers and volunteer peer support specialists will conduct home visits to assess barriers to maintaining housing and address identified needs. Peer support will encourage participation in substance use treatment, mental health resource center wellness programs, and other community programs to promote recovery and maintain housing. Costs are budgeted for the sub-set of 100 WPC enrolled participants that are estimated to be served through housing case management with an estimate of 885 member months annually. PMPM Bundle is valued at $816.41. Additional detail on cost breakdown is included in the attached budget detail narrative.
    - **Targeted Case Management** The vast majority of the activities and interactions of the care coordination teams will no duplicate Medi-Cal's targeted case management (TCM) benefit. Specifically, the medical case management and housing case management services and interventions depart significantly from the encounter-

based structure of TCM, and in the vast majority of cases the counters between medical case management and housing case management teams and WPC participants would not be eligible for reimbursement under TCM. Shasta County Health and Human Services Agency does claim for Targeted Case Management (TCM), however the work is focused on families at risk of entering the child welfare system, and is conducted by a local non-profit called the Child Abuse Prevention Coordinating Council (CAPCC). CAPCC provides TCM services for parents of children three to five years of age who are enrolled in select state preschools. The vast majority of this population is quite distinct from the target population of the WPC Pilot, homeless adults with a mental illness or a substance use disorder. Any homeless families who are encountered by the CAPCC staff will be referred to the Family Stabilization program in CalWORKs, and not to the WPC Pilot. Moreover, the scope of care support and coordination activities available through WPC is intended to be more robust than available through Medi-Cal TCM. WPC teams will engage in activities such as relationship building, peer support, motivational supports, disease specific education, wellness education, and general reinforcement of health concepts, which are distinct from and outside the TCM benefit. WPC will also provide direct social and other services that would not be recognized as TCM, such as benefits advocacy, housing transition services, and enhanced care coordination. For these reasons we have concluded that the vast majority of WPC Pilot activities will not duplicate services available through Medi-Cal TCM. However, in response to concerns of duplication of payment, we have applied a TCM budget adjustment to the medical case management to reduce our request for WPC funds. The TCM budget adjustment can be found in the corresponding service description.

6. **Pay for Metric Reporting** includes payments to support time spent on collecting and reporting the data required under the WPC pilot program. The following pay for reporting metrics are included:
    - FQHC reporting of clinical encounter data, case management services data, and other data collection related to WPC pilot enrolled participants required for WPC Pilot monthly reporting for participating entities. Also includes time for preparation of semi-annual progress reports.
    - Housing case management program reporting includes case management services data, home visits, peer support services, and other data collection related to WPC pilot enrolled participants required for WPC pilot monthly reporting. Also includes time for preparation of semi-annual progress reports.
    - Housing volunteer program pay for reporting includes 4 hours per month for data collection and reporting on volunteer peer home visits and other support services for WPC pilot enrolled participants and time to prepare 2 semi-annual reports.
    - Mental health resource center pay for reporting includes 8 hours per month for data collection on touches and outreach encounters with WPC participants (demographic information, types of services offered, participation in wellness programs, etc.) and reporting. Also includes time to prepare 2 semi-annual reports.

7. **Pay for Metric Outcome Achievement** includes payments for achievement of one outcome measure. The measure selected is Increase follow-up within 7 days post-discharge for Mental Illness [Adults] for the WPC target population. The pilot goal is to increase follow-up by 5% per year. In PY2 the metric payment is based on maintaining baseline established through reporting in PY1. For PY 3 the estimated target is 50%; PY 4 the target is 55%; and in PY 5 the target is 60%.

Section 6: Attestations and Certification

6.1 Attestation

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

WPC Budget Template: Summary and Top Sheet

WPC Applicant Name:	Shasta County Health and Human Services Agency

	Federal Funds *(Not to exceed 90M)*	IGT	Total Funds
Annual Budget Amount Requested	1,940,355	1,940,355	3,880,710

PY 1 Budget Allocation (Note PY 1 Allocation is predetermined)	
PY 1 Total Budget	3,880,710
Approved Application (75%)	2,910,533
Submission of Baseline Data (25%)	970,178
PY 1 Total Check	OK

PY 2 Budget Allocation	
PY 2 Total Budget	3,880,710
Administrative Infrastructure	290,000
Delivery Infrastructure	2,177,291
Incentive Payments	55,250
FFS Services	646,088
PMPM Bundle	658,761
Pay For Reporting	37,800
Pay for Outomes	15,520
PY 2 Total Check	OK

PY 3 Budget Allocation	
PY 3 Total Budget	3,880,710
Administrative Infrastructure	290,000
Delivery Infrastructure	1,518,529
Incentive Payments	55,250
FFS Services	646,088
PMPM Bundle	1,317,523
Pay For Reporting	37,800
Pay for Outomes	15,520
PY 3 Total Check	OK

PY 4 Budget Allocation	
PY 4 Total Budget	3,880,710
Administrative Infrastructure	290,000
Delivery Infrastructure	1,518,529
Incentive Payments	55,250
FFS Services	646,088
PMPM Bundle	1,317,523
Pay For Reporting	37,800
Pay for Outomes	15,520
PY 4 Total Check	OK

PY 5 Budget Allocation	
PY 5 Total Budget	3,880,710
Administrative Infrastructure	290,000
Delivery Infrastructure	1,518,529
Incentive Payments	55,250
FFS Services	646,088
PMPM Bundle	1,317,523
Pay For Reporting	37,800
Pay for Outomes	15,520
PY 5 Total Check	OK