



Whole Person Care Pilot Application

Application due July 1, 2016

Section 1: WPC Lead Entity and Participating Entity Information

1.1 Whole Person Care Pilot Lead Entity and Contact Person (STC 117.b.i)

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| Organization Name | Ventura County Health Care Agency |
| Type of Entity (from lead entity description above) | Designated Public Hospital |
| Contact Person | Johnson K. Gill |
| Contact Person Title | Deputy Director, Population Health Management and Clinical Integration |
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1.2 Participating Entities

The Ventura County Health Care Agency’s (VCHCA) Whole Person Care (WPC) pilot, titled the ***Ventura County Whole Person Care Connect Pilot***, focuses on the individual needs of the target population (TP) while bringing together all of the necessary resources to achieve WPC stated goals and positively impacting health outcomes from the patients’ perspective (see Concept Diagram in Attachment A).

The VCHCA is a comprehensive county-operated health system serving a low-income population through its county-wide network of 19 FQHCs, two county-hosted One-Stop homeless centers, 12 California state-licensed clinics, eight mental health clinics, six alcohol and drug clinics, two acute care hospitals (Designated Public Hospitals), seven urgent care facilities, two public health clinics, Emergency Medical Services, Medical Examiner, and the Ventura County Health Care Plan, a county-owned Health Maintenance Organization. VCHCA’s role in the WPC Pilot is as the Lead Entity. In this role as the Lead Entity, the organization will:

1. Be the main communication facilitator
2. Hold, direct, and report on collaborative meetings and Plan-Do-Study-Act (PDSA) quality improvement (QI) processes
3. Develop project infrastructure, including administrative and technology initiatives
4. Provide metric tracking, analysis, and reporting

VCHCA will also operate as the following required organizations: Health Services Agency/Department, Specialty Mental Health Agency/Department, and Public Agency/Department. The Specialty Mental Health and Public Agency operations are described in the required organizations listing that follows in this section. The healthcare services (see attached Workflow Diagram in Attachment B) that VCHCA will provide to project participants include:

1. *WPC Centralized Care Coordination*: A centralized Care Coordination Team (CCT) will connect the new communication and data technology infrastructure and the *Integrated Care Plan* with providers within

the VCHCA, other public entities, and community partners. The CCT will also provide field-based coordination and integration support as required by providers. An administrative Care Coordination Manager leads the CCT, as well as the Engagement Teams and the CHWs. The CCT will include: six (6) Care Managers (1.0 FTE Lead Care Coordination Manager, 2.4 FTE Registered Nurses [RN], 2.4 FTE two Licensed Clinical Social Workers [LCSW]), and 1.2 FTE behavioral health specialists (see Section 1.2.3 below). Field-based care management will be provided by 15.6 FTE Community Health Workers (CHWs) will also be a part of the CCT.

2. *WPC Care Coordination through Outreach*: Two Engagement Teams (based out of two retrofitted mobile health vans) will: facilitate integration of services, coordinate outreach and engagement of participants, determine immediate care needs, provide needed prescriptions, offer enrollment and assessment services, connect services with community-based providers, and ensure that there are no gaps between the Integrated Care Plan and the provision of planned services. The teams will be effective in connecting with participants who predominantly access services outside of the VCHCA. Each Engagement Team will include: 1.0 FTE Care Coordination Manager, 1.0 FTE Nurse Practitioner, and 2.0 FTE Clinic Assistants (MAs).
3. *WPC Care Coordination through Field-Based Care Coordinators*: A part of the CCT, 15.6 FTE CHWs are field-based staff members who have a close understanding of the target population and Ventura County communities, and are culturally/linguistically similar and/or competent with the participants they serve. This trusting relationship will enable them to serve as a liaison, link, and intermediary between health, behavioral health, social services, and community resources to facilitate access to services and improve the quality of service delivery. CHWs will build individual and community capacity by increasing the TP's health knowledge and self-sufficiency through a range of activities such as outreach, community education, informal counseling, social support, and advocacy. Under established protocols, CHWs will:
 - a. Meet participants where care can be the most integrated for that participant (i.e., clinic, One-Stop Center, supportive/transitional housing).
 - b. Administer the *Universal Consent Form*, the *WPC Vulnerability Index* (see Attachment C), and the *WPC Comprehensive Assessment*, which incorporates demographic information, information needed for project enrollment, and social needs such as housing, food, clothing, etc. This information will initiate WPC enrollment, which will be consolidated in the electronic *Integrated Care Plan* platform along with assessments, tests, screening results, and sub-care plans from system-wide WPC care providers.
 - c. Coordinate and facilitate an initial appointment with a primary care provider (PCP) to assess health care, mental health, and substance abuse treatment needs and to serve as the lead for the participant's Patient-Centered Medical Home (PCMH). PCPs will refer participants with behavioral health needs who cannot be cared for within the primary care/behavioral health integrated care clinic to the Ventura County Behavioral Health Department (i.e., above mild-to-moderate mental health conditions).
 - d. Provide troubleshooting, relationship building, system navigation, and crisis intervention.
 - e. Connect participants with services and advocate for them among partners and community resources.
 - f. Assist participants in overcoming barriers to access care plan services, such as transportation, motivation, language, etc.
 - g. Work with Care Managers across systems to synchronize, prioritize, integrate, eliminate duplicative services, and adapt the care plan as indicated.

- h. Contact and work with families and caregivers to support improvement and assist when emergencies arise.
- i. Ensure that care providers are connected through real-time communications about changes in needs or care.

Few activities planned within the WPC pilot duplicate those that are funded through the Medi-Cal Targeted Case Management program, but 5% of the CCT PMPM budget will be discounted to take into account the small overlap (see Section 3.1).

4. *Health Care for the Homeless (HCH) Program:* Since 2002, VCHCA has been operating a HCH program serving area homeless persons. Medical teams provide services at 16 sites, including two One-Stop Centers, in eight cities. Services include primary and preventive health care and assessments, and referrals for mental health, substance abuse, and social services. Linkages include multiple social services, housing supports, and non-medical support services. Historically, the care for these patients has not been centrally coordinated. Through the WPC pilot, an electronic centralized care coordination system that tracks service linkages and communicates in real time with the CCT will eliminate gaps and breakdowns in services. Communication alerts will direct care to the appropriate response level and interventions.
5. *Primary and Preventive Care:* VCHCA has 19 primary care FQHCs and 14 clinics providing both primary and specialty care services, with integrated behavioral health professionals located in many clinics. These clinics provide more than 530,000 outpatient visits annually and are located in nine geographically dispersed communities. They are served by 693 physicians and 87 allied health professionals (inpatient and outpatient). VCHCA also operates a renowned UCLA-affiliated Family Medicine Residency program (ranked #2 nationally).¹ This vast network of venues and providers will be integral in meeting the needs of the TP. With the assistance of the clinic staff and the CCT, the use of a *real-time secure messaging system*, which is part of a secure web-based telemedicine platform, will be a conduit via which TP needs are communicated and addressed with PCPs.
6. *Emergency/Urgent Care:* Ventura County Medical Center (VCMC) is a 180-bed hospital with an additional 43-bed Inpatient Psychiatric Unit. Santa Paula Hospital, also operated by the VCHCA, has 49 beds. Seven urgent care centers provide services that help offset Emergency Department (ED) utilization. Patient engagement and early intervention in a well-coordinated environment is the key to managing participants. Keeping the lines of communication open between the TP and CHWs will be the first line of defense against unnecessary utilization of urgent/emergent services.
7. *Specialty Services:* VCHCA clinics provide 60 specialty services. VCMC also offers high quality specialty services, including Neonatal ICU, Level II Adult Trauma Center, and Palliative Care Program. However, access to many of these specialty services remains a challenge. Improving access to specialty care will continue through PRIME projects 1.2, 1.3, 2.2, and 2.3. The WPC project will utilize the real-time secure messaging system between PCPs and specialty services for the WPC TP, and work with GCHP and specialty services to fast-track care, where necessary.

The VCHCA is not requesting an exemption. The VCHCA is however requesting bonus points for one priority element related to participating organizations: The pilot incorporates more than two participating community partners in the geographic area where the pilot operates (three community partners are included). (Note: Approval was secured from DCHS to remove table format below.)

¹ Doximity, Inc. (2016.) Residency Navigator: Family Medicine. Available at: https://residency.doximity.com/programs?residency_specialty_id=43&sort_by=reputation

Required Organizations: 1. Medi-Cal Managed Care Health Plan

Organization Name: Gold Coast Health Plan

Contact Name and Title: Nancy Wharfield, MD, Associate Chief Medical Officer

Entity Description and Role in WPC: Gold Coast Health Plan (GCHP) is County Organized Health System (COHS) governed by the Ventura County Medi-Cal Managed Care Commission, serving more than 206,000 Medi-Cal beneficiaries living in Ventura County. GCHP's role in WPC efforts will be as a collaborator and to provide data sharing, assistance in the assessment of appropriate technologies, and coordination of care enhancement. GCHP will provide the following data:

1. Utilization and cost of care data for the defined county-wide TP, including:
 - a. Inpatient
 - b. Emergency Department
 - c. Pharmacy
 - d. Diagnosis codes (ICDs)
 - e. Mild to moderate Behavioral Health
2. Risk stratification analytics using the Johns Hopkins ACG tool

GCHP will support WPC technology needs by:

1. Providing guidance around the assessment of technology infrastructure requirements
2. Integrating relevant GCHP data with selected WPC technology
3. Promoting the adoption of electronic information sharing in the provider community which includes medical, behavioral, and county-based services to address social determinants of health outcomes

Finally, GCHP will contribute to WPC coordination of care efforts through Care Manager RNs and Social Worker collaboration with the WPC team in the development and execution of treatment plans for the TP which address all aspects of health outcomes.

Required Organizations: 2. Specialty Mental Health Agency/Department

Organization Name: Ventura County Health Care Agency – Ventura County Behavioral Health Department

Contact Name and Title: Elaine Crandall, Director

Entity Description and Role in WPC: The Ventura County Behavioral Health Department (VCBH) is a service delivery system that provides a full array of services and supports that promote the wellness and recovery of individuals by providing and supporting comprehensive mental health and substance abuse services through its six alcohol and drug clinics; eight mental health clinics for adults, youth and families; residential facilities; and psychiatric facilities, and at various community-based locations. Programs and services are provided both directly and with contracted community partners. VCBH's role in the WPC Pilot is: to serve as a project collaborator, to provide care management of behavioral health services, and to provide integrated substance abuse and mental health services for WPC participants, including the following:

1. *WPC Centralized Care Coordination:* Part of the CCT, 3.6 FTE VCBH Care Managers (see Section 1.2.2 above) will support behavioral health care coordination for participants. These staff will include Licensed Mental Health Professionals (LMFT or LCSW) and Substance Abuse Specialists.
2. *Screening, Triage, Assessment, & Referral (STAR) (Mental Health):* The STAR system coordinates access to services so that consumers receive timely, appropriate, and consistent information, thorough screening, triage, assessments, and/or linkage to appropriate mental health services and supports in an efficient, high quality, culturally sensitive manner countywide.

3. *Adult Mental Health Services, Clinic-Based (Mental Health)*: Provides individual and group therapy, case management, crisis intervention, rehabilitation services, and medication management.
4. *Youth and Family Mental Health Services, Clinic-Based (Mental Health)*: Provides individual and group therapy, case management, crisis intervention, rehabilitation services, parenting support, and medication management.
5. *Adult Intensive (Mental Health)*: Empowering Partners through Integrative Community Services (EPICS) provides comprehensive, intensive, “whatever it takes” services for those consumers with intensive needs who most frequently utilize higher levels of care (inpatient hospitalization and other locked settings, or residential treatment placements), who are at high risk to require those levels of care without intervention, and who have been historically underserved in the mental health system due to a variety of barriers that make access to traditional services challenging.
6. *Adult Assisted Outpatient Treatment Services (Mental Health)*: The AOT services are designed to provide intensive outreach to individuals who may be treatment resistant. In some instances, services may be court-ordered.
7. *Adult and Children Mobile Crisis Response Team (Mental Health)*: Crisis intervention and stabilization services are available 24/7 to individuals who are experiencing an urgent or emergent mental health crisis. Via mobile field response and/or by telephone, the multi-disciplinary Crisis Team provides rapid mental health services that are supportive and strength-based in nature and that assist the individual to remain in the least restrictive level of care possible.
8. *Crisis Residential Treatment (CRT) (Mental Health)*: The licensed 15-bed program serves adults (ages 18-59) throughout the county as an alternative to hospitalization for individuals presenting with sub-acute psychiatric symptoms and possible co-occurring disorders in the least restrictive environment possible, up to 90 days, leading to a reduction in involuntary hospitalizations, incarcerations, and homelessness.
9. *Crisis Stabilization Unit and Short-Term Crisis Residential Program (Mental Health)*: This program provides a missing link in the children’s crisis continuum of care by offering children and their families a safe, supportive, and home-like environment that meets crisis needs in their home community. The goal of the service is to reduce hospitalization and recidivism.
10. *Short-Term Social Rehabilitation (Mental Health)*: Provides adults and transitional-age youth licensed, unlocked residential treatment facility services for up to 18 months.
11. *Mental Health Rehabilitation Center (Mental Health)*: The licensed 16-bed program serves adults who receive rehabilitation services in a locked residential environment with a goal of stepping down into a lower level of care within a 12- to 18-month period (opening late 2016).
12. *Peer Support Specialists & Recovery Coaches (Mental Health)*: This program provides training, advocacy, and direct service for and by peers and family members through several programs. Recovery Coaches, who are individuals with “lived experience,” assist in engaging persons in treatment who have traditionally been un-served and underserved, while helping to ensure that the concepts of empowerment, wellness and recovery are incorporated into services.
13. *Adult and Transitional Age Youth Wellness & Recovery Centers (Mental Health)*: These centers are alternative clinic programs serving adults and transitional-age youth who are recovering from mental illness, and often also substance abuse, who are at risk of homelessness, incarceration, and increasing severity of mental illness or addiction.
14. *Older Adult Full Service Partnership (Mental Health)*: The Older Adult Program provides rich, community-based, mobile, in-home services including psychiatric treatment, case management (i.e., linkage to housing, benefits, health care, and rehabilitation services), skill-building services to decrease functional impairments, individual and group treatment crisis intervention, recovery and wellness

programs, and advocacy and referrals for medical, dental, legal, and benefits support services and community agencies.

15. *Transitional-Age Youth Services (Mental Health)*: Treatment and rehabilitation services are designed and provided for persons ages 18-26. The determination between employment and/or receipt of disability benefits is a focus in seeking to promote self-sufficiency for this age group.
16. *Residential Services (Mental Health)*: Case management is provided to support a client's stability in their home environment and residential treatment programs. Note that WPC funds will only be used for allowable costs that include individual housing transition services and individual housing and tenancy sustaining services in alignment with the CMCS Informational Bulletin. Residential services and room and board are not covered under WPC.
17. *Transformational Liaisons (Mental Health)*: Liaisons assist in navigating a complex system, and providing direction, referrals, and monthly orientation meetings.
18. *Adult Outpatient and Residential Treatment Services (Substance Abuse Services)*: Adult Services provides individual and group counseling, family counseling, community referrals, co-occurring disorders programs for individuals with substance use and a mental health diagnosis, programs for court-mandated individuals, drug testing, confidential treatment services, education and support services, intensive outpatient programs for women and children, residential treatment and detoxification referrals, and crisis intervention.
19. *Driving Under the Influence Programs (Substance Abuse Services)*: A First Offender DUI Program and a Multiple Offender DUI Program are provided for individuals convicted of driving under the influence. The program consists of education sessions, and group and individual counseling.
20. *Other Programs*: VCBH also offers outreach, prevention and early intervention, and education services.

Required Organizations: 3. Public Agency/Department

Organization Name: Ventura County Health Care Agency – Ventura County Public Health Department (VCPH)

Contact Name and Title: Rigoberto Vargas, Director

Entity Description and Role in WPC: VCPH provides a host of services benefiting Ventura County residents, including: two Public Health clinics; community nursing; Emergency Medical Services (EMS); health coverage assistance; health promotion/education; HIV/AIDS center; Maternal Child Adolescent Health programs: Women, Infants and Children (WIC) programs; and smoking cessation classes, among other services. VCPH's role in the WPC Pilot is to serve as a project collaborator, provide care management to participants utilizing services, and to provide participants the following services:

1. *Tobacco Cessation*: VCPH provides "Call it Quits" classes consisting of 1.5 hours smoking cessation sessions that present tools for a successful quit. The program offers group classes, telephone counseling, one-to-one assistance, free Nicotine Replacement Therapy (NRT), and education for family and friends about how to best help the quitter. Since many of the TP are tobacco users, VCPH will conduct tobacco cessation programs for this population.
2. *Ventura One-Stop Center*: Houses center operations and provides eligibility assistance, screening, immunizations, medical/behavioral health assessments, WIC benefits, and referrals. Based on the initial needs assessment of the TP, the services offered through this program will be made available and coordinated through the centralized Care Coordination Team (CCT).

Required Organizations: 4. Public Agency/Department

Organization Name: Ventura County Human Services Agency (VCHSA)

Contact Name and Title: Barry Zimmerman, Director

Entity Description and Role in WPC: The VCHSA provides public services that help protect children and

vulnerable adults, and assists with food, housing, health care, and employment. VCHSA's role in the WPC is to serve as a collaborator and to provide the following services to the target population, as needed:

1. *Homeless Services*: Provides mobile outreach and intensive case management to homeless individuals and families; links individuals and families to homeless prevention, rapid re-housing, and housing support programs; and connects homeless adults and families with children to the county's transitional living centers, as appropriate.
2. *CalFresh*: Helps people with little or no income buy nutritious groceries with an electronic benefit transfer (EBT) card.
3. *CalWORKs*: Assists low-income or unemployed parents with dependent children by providing temporary financial assistance, subsidized child care, and employment-focused services.
4. *Child Welfare Services*: Provides protection and case management for children who are at risk of or have been physically, sexually, or emotionally abused, neglected, or exploited.
5. *Employment Services*: Provides training, recruitment, and job search assistance at centers throughout the county.
6. *General Relief*: Provides eligible adults with short-term assistance, which is considered a loan, for basic living needs such as housing or utility payments.
7. *Health Care Enrollment*: Provides access to Medi-Cal and Affordable Care Act coverage options for qualifying individuals and families.
8. *In-Home Supportive Services (IHSS)*: Assists elderly and disabled individuals to remain safely in their homes by connecting them with providers who help with personal care, housekeeping, shopping, and errands.
9. *Public Administrator/Public Guardian*: Provides bill-paying and income-management support to clients of Ventura County Behavioral Health who receive benefits from Social Security; oversees the care of people, including the elderly and those who are gravely disabled due to mental illness, who are unable to care for themselves.
10. *Veteran Services*: Assists veterans and their dependents, including spouses and children of disabled veterans, with accessing benefits and services; and provides advocacy for those who served in the armed forces.
11. *Youth Services*: Provides Independent Living preparation and extended Foster Care services to youth who are or have been in foster care.
12. *Adult Protective Services*: Responds to allegations of abuse and neglect of dependent adults and seniors; and provides voluntary case management services.

Required Organizations: 5. Public Agency/Department

Organization Name: Ventura County Probation Agency

Contact Name and Title: Mark Varela, Chief Probation Officer

Entity Description and Role in WPC: The Ventura County Probation Agency (Probation) is charged by the courts with the direct supervision of approximately 15,500 adult offenders and 2,500 juvenile offenders on probation, as well as performing two mandated functions: the preparation of sentencing reports for the courts and the operation of the juvenile justice facilities. Probation's role in the WPC Pilot is as a collaborator and to provide data about utilization of services by participants. If a participant becomes institutionalized and in the custody of the Probation Agency, the WPC CCT will work with the Probation team on the appropriate continuum of care. The teams will ensure that the participant receives continued WPC care as established in the Integrated Care Plan upon release. The Probation team will be made aware of a WPC participant coming into their system ahead of time, and the CCT will be made aware that a participant has been institutionalized through the HL7 Admit, Discharge, Transfer (ADT) alert system within the enterprise Care Coordination platform, and vice versa.

Required Organizations: 6. Public Agency/Department

Organization Name: Ventura County Sheriff's Office

Contact Name and Title: Ron Nelson, Commander

Entity Description and Role in WPC: Five of the county's ten incorporated cities contract with the Sheriff's Office to provide police services. These cities, plus the unincorporated areas of the county, make up nearly half of the county's population and 95% of its land area. The services provided by the department range from maintaining the county jail system to providing traditional police services. The department utilizes the Community Oriented Policing and Problem Solving (COPPS) philosophy, promoting proactive problem-solving and police-community partnerships. The department's role in the WPC Pilot is to participate as a collaborative partner; notify the collaborative through the community organization portal concerning any encounter that participants have with the Sheriff's Office; and provide data about the number of arrests, confinements, and causes. The Sheriff's Office will notify the CCT that a participant has been arrested or otherwise involved with the Sheriff's Office through a HL7 ADT alert system within the enterprise Care Coordination platform.

Required Organizations: 7. Public Agency/Department

Organization Name: Area Housing Authority of the County of Ventura

Contact Name and Title: Michael Nigh, Executive Director

Entity Description and Role in WPC: The mission of Area Housing Authority of the County of Ventura is to be a leader providing opportunities and assistance to people in need of affordable housing through development, acquisitions, and partnerships. Through its work with several city-level housing authorities, the Area Housing Authority provides and develops quality affordable housing for eligible low-income residents of Ventura County and establishes strong partnerships necessary for customers to achieve personal goals related to: literacy and education, health and wellness, and job training and employment leading to personal growth and economic self-sufficiency. The organization's role in the WPC pilot is as a collaborative member, care management partner, and to provide the following services:

1. *WPC Housing Support and Transition Services:* The Area Housing Authority and city partners will provide:
 - a. *Individual Housing Transition Services:* Tenancy screening, housing assessment, housing plan development, housing application assistance, resource identification, move-in support, crisis plan development, housing search, transportation assistance, and assistance in establishing the household, such as setting up utilities and arranging for furnishings.
 - b. *Individual Housing and Tenancy Sustaining Services:* Identification/intervention of behaviors that may jeopardize housing status, education, coaching, resolving disputes, advocating, ongoing plan review and training.
2. *Section 8 Program Housing:* Voucher program that pays 30%-40% of housing costs.
3. *Low-Rent Public Housing:* Access to 335 conventional units and 157 units in housing complexes throughout the county, with rents based on adjusted gross income.
4. *Affordable Housing:* Access to 486 units of tax credit financed affordable housing.
5. *Family Self-Sufficiency Program:* A five-year case management program that allows residents to reach economic self-sufficiency for HUD program participants and establish an escrow savings account.
6. *Resident Opportunities and Self-Sufficiency:* Provides coordinators to connect residents with needed services, including: education/lifelong learning, tutoring/homework services, scholarship programs, college applications, career paths, life skills, certification programs, English as a Second Language (ESL), work experience, banking and budgeting, sports programs, and nutrition.

Note that WPC funds will only be used to support individual housing transition services and individual housing and tenancy sustaining services in alignment with the CMCS Informational Bulletin dated June 26, 2015, and will not be used for room and board.

Additional Organizations: 8. Public Agency/Department

Organization Name: Ventura County Transportation Commission

Contact Name and Title: Darren Kettle, Executive Director

Entity Description and Role in WPC: The Ventura County Transportation Commission (VCTC) is a regional transportation planning agency working in close partnership with each of the county's ten cities and the rural unincorporated areas. VCTC's inter-city bus service provides connections between the cities of Ventura County and between neighboring Santa Barbara and Los Angeles counties. The role of VCTC is as a collaborative partner that will provide bus tokens/passes to enable participants to access project resources and alleviate transportation as a barrier to access.

Required Organizations: 9. Community Partner

Organization Name: Project Understanding

Contact Name and Title: Benjamin Unseth, Executive Director

Entity Description and Role in WPC: Project Understanding focuses on ensuring that homeless and at-risk families are housed and fed. The organization's role in the WPC pilot is as a collaborative member and to provide essential assistance programs to participants, including:

1. *Supportive Housing Opportunities In A Residential Environment (SHORE)* – The goal of this program is to assist those who desire to end their homelessness. SHORE at the WAV is Case Management of previously homeless families and individuals in permanent, supportive housing apartments subsidized by Section 8 funds.
2. *Homeless to Home (H2H)*: Field case management services to homeless individuals who desire to change their life situation for the better.
3. *Tender Life Maternity Home*: Provides homeless pregnant women with safe housing and support services that promote self-sufficiency.
4. *Food Pantry*: Provides groceries once a month to families whose budget cannot support the purchase of their own. Donations may include in-kind, non-perishables, fresh vegetables and fruits, and money designated for food.

Required Organizations: 10. Community Partner

Organization Name: FOODShare, Inc.

Contact Name and Title: Susan Haverland, Vice President, Program & Services

Entity Description and Role in WPC: FOOD Share distributes millions of pounds of healthy food every year through its own programs as well as through distributions via partner agencies. The organization's role in the WPC pilot is as a collaborative member and to provide data about resource utilization, care management, and to provide the following services to participants:

1. Assist in applying for CalFresh benefits.
2. Community Market Program distribution of fresh produce free-of-charge via a monthly mobile delivery service throughout the county.
3. FOOD Share and Friends Mobile Pantry provides food for persons in need who lack access to food pantries or other vital services and supports that FOOD Share and its collaborators offer. In addition to food, the Mobile Pantry provides a traveling source of information and links neighborhoods to

nutrition education programs, health services, financial literacy programs, employment/income assistance programs, and housing resources.

Required Organizations: 11. Community Partner

Organization Name: Ventura County St. Vincent de Paul

Contact Name and Title: Sharon Fleur, President, SVdP-OLA Conference

Entity Description and Role in WPC: The Society of St. Vincent de Paul is a faith-based charity that offers tangible assistance to those in need on a person-to-person basis. Assistance includes intervention, consultation, and fiscal support. Nationally, 12 million persons are helped annually by Vincentians in the United States. The organization's role in the WPC pilot is as a collaborative member and to provide essential Ventura County St. Vincent de Paul assistance programs to participants, including:

1. **Community Center Services:** A number of community services are offered to assist low-income families and individuals in meeting basic needs, such as: obtaining housing; employment support; education and training; food, nutrition, and exercise; women and men social issues; free or low-cost legal clinics for immigration and other civil matters; financial literacy and credit counseling; housing resources including a monthly housing fair and information about tenant/owner rights and responsibilities; adult education and employment, including computer labs; small business development; and case management, advice, and other support.
2. **Men's Advancement Program:** Provides males with transitional housing, clothing, living opportunities, and case management services to provide support and direction toward finding more permanent housing. Individuals are assigned to weekly case management sessions, job training, group meetings, and ongoing counseling.
3. **Housing Assistance:** Provides access to shelter, transitional housing, and eviction prevention resources.
4. **Housing Prevention and Intervention:** Provides access to services such as landlord/tenant mediation and emergency rental funds.
5. **Employment and Education Assistance:** Works with local employers and non-profits in Ventura to help the unemployed and people who work part time.
6. **Ventura County Winter Shelters:** Winter shelters are offered in the cities of Ventura and Oxnard, California, from December 1st to March 31st each year.

Other Community Organizations Providing Services: Through Ventura County's vast network of services, the WPC pilot Care Coordination Team will access services based on a participant's unique needs and geographic location in the county to reduce barriers to services. Although the following entities have not yet provide Letters of Participation, the organizations listed below are expected to be a part of the WPC Collaborative and will be instrumental in the project's success and support its goals and strategies. Attachment D lists the many services that will be accessed from countywide resources. (Letters for "Other Community Organizations" not attached nor required, but all "Required Participating Entities'" letters are provided.)

Additional Organizations: 12. Public Agency/Department

Organization Name: Workforce Investment Board/Job and Career Centers

Entity Description and Role in WPC: The vision of the Workforce Investment Board is that Ventura County will have a high-quality, appropriately skilled workforce that is ready and able to support the changing business needs of employers in a dynamic, competitive, global economic environment. The regional workforce strategy is focused on ongoing skills attainment that is supportive of regional growth industry sectors and clusters and enabled by a braided, leveraged workforce system that addresses business-driven demands and worker needs for steady employment. The organization's role in the WPC pilot is as a contributing community partner and to

provide participants job and career support services and training. The county's two American Job and Career Centers provide a direct link to resources that help job seekers choose and pursue careers. The centers offer job listings, career guidance, labor market information, training and education resources, and tools for job preparation. Staff helps job seekers match their skills to available jobs or transition to new careers. Other support services and training are available at no cost and include:

1. Use of computers, printers, and fax machines
2. Help with resumes and interviewing
3. Job listings and employer information
4. Employee recruitments
5. Information on careers and growing occupations
6. On-the-job training and skill certifications
7. Career workshops
8. Assistance with tuition and books
9. Customized training
10. Access to unemployment insurance benefits
11. Online resource access to CalJOBS

Additional Organizations: 13. Community Partner

Organization Name: Ventura County Rescue Mission Alliance

Contact Name and Title: John Saltee, Director

Entity Description and Role in WPC: The Ventura County Rescue Mission Alliance is a faith-based non-profit charity that offers refuge, recovery, and restoration services to the poor and needy in Ventura County. The role of the Rescue Mission is to serve as a contributing community partner and to provide the following services:

1. *Lighthouse for Women and Children:* A transitional living program with 112 beds offers shelter, intervention, substance abuse recovery, case management, education, life skills development, vocational training, employment, and transitional housing.
2. *Men's Emergency Shelter:* An emergency shelter is offered for men who can stay up to 10 consecutive nights.
3. *Men's Recovery Program:* A free, ten-month, residential, Christian-based recovery program is offered that provides biblically-based structure and applied discipline for learning to live while overcoming difficulties. The program provides individual counseling and case management as well as daily classes that include: Christian 12 Steps, anger management, and classes dealing with biblical and spiritual issues.
4. *Meals and clothing assistance.*

Additional Organizations: 14. Community Partner

Organization Name: Ventura County Salvation Army

Entity Description and Role in WPC: Ventura County Salvation Army is a faith-based charity with the goal of doing the most good possible for those in need, with a focus on feeding the hungry, housing the homeless, and changing the lives of individuals and families. The organization's role in the WPC pilot is as a contributing community partner and to provide participants the following services:

1. *Dental Clinic:* Services offered free-of-charge include oral examinations, fillings, simple extractions, and X-rays; dental cleanings are referred to Oxnard College's Dental Hygiene program.
2. *Transitional Living Center:* Short-term housing that also provides case management and supportive services, such as counseling, self-sufficiency education, permanent housing assistance, and information on employment services, job training, and public assistance.

3. *Homeless to Home Program*: A collaborative partnership between The Salvation Army, Project Understanding, and the Turning Point Foundation, the program provides case management that focuses on assisting individuals in obtaining and maintaining a secure income, physical and mental stability, and safe housing. Services include life skills and employment readiness training, assistance with transportation to interviews and work, street outreach, and housing stability services with financial assistance when available.
4. *Winter Homeless Shelter*: Supports the efforts of the West Ventura County winter homeless shelter, providing cots and meals for homeless individuals during the time when the local armory is unavailable.
5. *Safety Net Services*: Provides rent and utility assistance as well as transportation and clothing vouchers.
6. *Food Pantry*: Provides weekly feedings to seniors confined to their homes, sit-down meals to clients during Thanksgiving and Christmas, and more than 200 food baskets per month.

Additional Organizations: 15. Community Partner

Organization Name: Not One More

Contact Name and Title: Pat Montoya, President

Entity Description and Role in WPC: Not One More is a non-profit community organization dedicated to providing support to community members and their families who are struggling with addiction within their lives. The organization's role in the WPC pilot is as a contributing community partner and to provide the following services to participants:

1. Help bridge the gap between the cost of rehabilitation and insurance coverage through scholarships and gifts.
2. Assist individuals and families in navigating the insurance, rehabilitation, and services systems.
3. Provide low- or no-cost intervention services.
4. Operate a 24/7 web-based resource center with information about drugs, recovery, and where participants can turn in a time of crisis.
5. Provide an active grief outreach program.

Additional Organizations: 16. Community Partner

Organization Name: Jewish Family Services

Contact Name and Title: Debra Hide, Director

Entity Description and Role in WPC: Jewish Family Services is a faith-based charity with a mission to encourage and support the quality and continuity of individual, family, and community life guided by the ethical and spiritual values of Judaism. The organization's role in the WPC pilot is as a contributing partner and to provide the following services to participants:

1. *Homeless Outreach*: Provides a social worker, operating out of the One-Stop Program, who works with homeless persons on the street to assist them in accessing medical care, shelter, and mental health services.
2. *Clinic Counseling*: Individual, group, couples, and family therapy are provided to people of all ages for clients who are struggling with a variety of issues, including depression, anxiety and trauma.
3. *Rental Assistance for Families*: Provides rental assistance for women and children at risk of becoming homeless, based on need and available funds.
4. *Justice Clinic*: A monthly clinic is offered where an attorney reviews legal paperwork and gives legal advice.
5. *Senior Case Management*: A voluntary service for seniors, giving access to social workers who assess seniors' needs, develop case management plans, and connect seniors with referrals and links to community agencies.

Additional Organizations: 17. Community Partner

Organization Name: Interface Children & Family Services

Contact Name and Title: Erik Sternad, Executive Director

Entity Description and Role in WPC: Interface’s mission is to strengthen children, families, and communities to be safe, healthy, and thriving. To establish a foundation of violence prevention and mental health, Interface offers family strengthening resources, centers and services: family violence intervention through a Family Violence Response Team; Safe Haven Emergency Shelter; Safe Journey Transitional Shelter; women’s support groups; individual, family, and youth mental health assessments, treatment planning, and counseling; youth services, including crisis intervention, case management and after care, family mediation, emancipation information, life skills and youth development activities, and shelter assessment. Interface will provide needed information for care managers and CHWs to access the county resources to address the unique needs of each participant through its 2-1-1 Information and Referral Hotline. This hotline connects more than 20,000 Ventura County callers each year with information about services available to them, including: basic needs resources (i.e., food, clothing, and shelter), physical and mental health resources, domestic violence services, substance abuse services, employment support, rent and utility assistance, senior services, services for persons with disabilities, support for children, youth and families, legal assistance, and much more.

1.3 Letters of Participation and Support

The WPC pilot is a county-wide effort, bringing together the major service providers that can affect health outcomes and service utilization by positively impacting the social determinants of health, health disparities, and access to needed services. Letters of Participation have been provided by all required and optional entities listed in Section 1.2. Letters of Support have also been provided for this needed pilot by influential community physician groups who currently are devoted to providing services to the underserved and are committed to achieving the Triple Aim for the TP through the WPC pilot. These provider groups are listed below and are dispersed among the county’s geographic areas where the TP experiences the greatest needs.

1. Ventura County Continuum of Care Alliance
2. Las Islas Family Medical Group, Oxnard, Miguel Cervantes, MD, Medical Director
3. Magnolia Family Medical Center, Oxnard, Stan Patterson, MD, Medical Director
4. Santa Paula West & Hospital Clinic, Santa Paula, Lisa Solinas, MD, Medical Director
5. West Ventura Medical Clinic, Ventura, Ramsey Ulrich, MD, Medical Director

The pilot contact, Johnson Gill, may be contacted for access to the letters at (805) 677-5110 or johnson.gill@ventura.org.

Section 2: General Information and Target Population

2.1 Geographic Area, Community and Target Population Needs

Geographic Area: Ventura County, the service area, is a large dispersed coastal region northwest of Los Angeles with a population of 850,536 residents² and more than 206,000 Medi-Cal Managed Care

²U.S. Census. QuickFacts, Ventura County, California. Population estimates July 1, 2015. Available at: <https://www.census.gov/quickfacts/table/PST045214/06111>.

beneficiaries.³ It is the 12th most populated of California's 58 counties with ten incorporated cities in 1,843 square miles.

Need for WPC Pilot: In 2015, 1,821 GCHP members had four or more ED visits and/or two or more inpatient admissions. Although this comprised just 0.9% of beneficiaries, they accounted for 9.9% of costs. Twenty-eight percent of these utilizers are homeless, and this group averaged 17.1 encounters in the VCHCA system in 2015 versus an overall average of 5.4 encounters among average beneficiaries. Among VCHCA's highest utilizers in 2015: 27.7% are currently or recently homeless, 40.5% have mental health disorders, 24.4% have substance abuse disorders, and 97.3% have multiple chronic conditions. The 2015 Ventura County Homeless Count identified 1,417 homeless persons in Ventura County during their point-in-time survey.⁴ The 2015 Homeless Count survey identified the following self-reported needs among the homeless population: 31.8% were chronically homeless, 24.3% reported chronic health conditions, and 13.9% reported mental health problems. However, among those who self-reported to be *chronically* homeless, 37% had mental health problems, 52% had a chronic illness, 51% had substance use disorder (SUD), and 36% were released by a correctional facility after a court-ordered sentence in the past year. This sub-population cross-reference clearly indicated that the persons with the greatest needs require services that access multiple social, health, and behavioral health systems.

The social determinants of health exacerbate the health and behavioral health conditions that are generally elevated among the high utilizer population. Thus, focusing only on health/behavioral health care resolutions alone leaves out key causal factors in high utilizers. For many of the individuals with the highest rates of healthcare utilization, lack of stable housing is a primary driver of poor health outcomes and high cost.

Health care, behavioral health care, and social services are fragmented in Ventura County with multiple funding streams, eligibility requirements, and portals for entry. Two county One-Stop Centers have been provided through 330(h) funding (see Section 1.2.2), but care coordination is limited based on assessed needs. The result is that these Ventura County health systems are individually functioning as "silos of excellence," but the experience can feel overwhelming and confusing for a patient interacting with uncoordinated systems, as s/he might receive mixed messages from multiple providers, which may include more than one care manager.

Participating Entities Vision and Structure: The vision of the *Ventura County Whole Person Care Connect* pilot project is to implement a collaborative/integrated approach to the coordination of health, behavioral health, and social services in a holistic, patient-centered manner with the goals of improved health outcomes and more efficient and effective use of resources. The collaborative has been meeting since January 2016 to focus on: 1) developing the project vision based on WPC model best practices gleaned from literature reviews⁵ and attendance at WPC statewide collaborative meetings; 2) identifying the target population through a data-driven collaborative approach; 3) developing a communication plan/model; 4) defining the structure and entities needed for a wraparound model of patient-centered care; 5) aligning health, behavioral health, and social services interests and establishing shared goals and accountability; and 6) collaboratively developing the initial project design plans to respond to the WPC application.

³ Gold Coast Health Plan. Ventura County Medi-Cal Managed Care Commission. Available at: <https://www.goldcoasthealthplan.org/about-us/ventura-county-medi-cal-managed-care-commission.aspx>.

⁴ Ventura County. (2015.) Homeless County and Subpopulation Survey: Final Report. Available at: http://www.cityofventura.net/files/file/VC_Homeless_Count_Survey_2015.pdf.

⁵ Maxwell, 2014.

WPC Pilot General Description: The WPC pilot design is based on best practices and is consistent with recent findings included in WPC studies of successful frameworks that incorporate a focused target population, collaborative leadership, patient-centered care, coordination of services across systems, shared data, and financial flexibility.⁶ The project incorporates these elements in a patient-centered, holistic model, evidence-based care coordination design⁷ with the following components:

- Client support and care management through the WPC Care Coordination Team (CCT) who will work across service providers and multidisciplinary teams
- Enterprise architecture providing technological integration and coordination through a centralized care coordination platform, real-time secure messaging, eReferrals, integrated care plan platform, health registry, and data warehouse to support quality improvements
- Prioritization of access to services based on a Vulnerability Index
- Addressing participants' immediate and ongoing basic needs for shelter and housing supports, transportation, healthy food, clothing, personal items, etc.
- Life skills support/development and self-management education

WPC Pilot Structure: The project structure integrates different organizational service structures into a singular wraparound collaborative structure guided by a Lead Entity and collaborative governance with agreed upon bylaws and protocols. This proposed project will include five structural elements present in successful WPC models: 1) a care coordinator (CHW) who is part of a Care Coordination Team (CCT) overseeing patients' care across settings; 2) a multidisciplinary health/behavioral health care team; 3) care collaborators (community partners); 4) technology to improve provider integration, care coordination, and patient monitoring; and 5) provider incentives (see Attachment E: Organizational Structure).⁸

WPC Pilot Target Population: The target population is drawn from GCHP beneficiaries who are the highest utilizers of ED and inpatient hospital services across Ventura County. For 2015, this population was 1,821 individuals or 0.9% of GCHP's membership. The target population is comprised of 48% White, 45% Hispanic/Latino, and 7% other race/ethnicities.

⁶ Tobey R, Maxwell J, Bateman C, Barron C. (Sept. 2014.) *Opportunities for Whole-Person Care in California*. John Snow, Inc., California Association of Public Hospitals and Health Systems, and the California Health Care Safety Net Institute. Available at: http://www.dhcs.ca.gov/provgovpart/Documents/Waiver%20Renewal/Workforce1_WPC2_JSI.pdf.

⁷ Families USA. (April 2013.) *The Promise of Care Coordination: Transforming Health Care Delivery*. Available at: http://familiesusa.org/sites/default/files/product_documents/Care-Coordination.pdf.

⁸ Choudhury JS, Subramanian S, D'Sa S, Rajamani G. (2013) *Healthcare for Complex Populations: The Power of Whole-Person Care*. Strategy &. Available at: http://www.strategyand.pwc.com/media/file/Strategyand_Healthcare-for-Complex-Populations.pdf.

How the WPC Pilot Addresses Target Population Needs: For the target population, poverty, unstable housing, unemployment, food insecurity, and lack of transportation serve as stressors and structural/social barriers that can cause, exacerbate, and complicate the treatment of health/behavioral health conditions, leading to greatly diminished health status. There is growing agreement that considering social determinants of health concurrently with health and behavioral health conditions is critical to both achieving Triple Aim goals and reducing health disparities in communities.^{9,10} Well-designed, targeted care coordination can improve outcomes for everyone: patients, providers, and payers.¹¹

How the WPC Pilot Reduces Avoidable Utilization: Care coordination across divergent systems has been shown in studies to reduce utilization of inpatient days by up to 25% and ED services by 33%, and increase wellness and prevention visits by 300%.¹² Care coordination, combined with data sharing and real-time communications, will result in participants receiving the right care at the appropriate level of utilization addressing unique needs through facilitated connections with providers trained to address the needs while avoiding duplication of services and providing timely interventions. Improved health outcomes, increased use of preventive services, and access to services to address the social determinants of health will decrease costly overutilization of services. Further, integrated and comprehensive housing support services will facilitate lower utilization of system components due to those key services' influence on health outcomes.¹³

How the WPC Pilot Addresses Current System Problems: Earlier this year, the WPC Collaborative conducted an inventory to understand what care coordination efforts exist and the strength and weaknesses of current systems. While Ventura County has many assets in its systems, partnerships, and current and future initiatives, the collaborative identified some significant system problems that the pilot will overcome or mitigate, including: siloed services, lack of communication between systems, lack of consistent data collected, and multiple, disjointed needs assessments. These gaps will be mitigated through service integration/coordination, communication protocols and technologies, data consolidation through warehousing, and assessments unified to create care plans.

Overarching Vision – Improving Collaboration: The Ventura County WPC Connect project will build upon existing efforts in the community (see Section 3.1) and improve collaboration among participating WPC pilot entities through collaborative leadership, integration (Section 2.2), coordination structures (Section 3.1), and shared data (Section 3.2). Successful collaborative leadership methods¹⁴ will enable participating entities to develop a unified county-level approach to WPC that will successfully align resources, secure commitment from stakeholders, and implement a pilot project that will accomplish proposed performance measures/metrics. Three key components for successful collaborative leadership are integrated into the

⁹ The John D. and Catherine T. MacArthur Foundation Research Network on Socioeconomic Status and Health. (2009.) *Reaching for a Healthier Life: Facts on Socioeconomic Status and Health in the U.S.* Available at:

http://www.macses.ucsf.edu/downloads/Reaching_for_a_Healthier_Life.pdf

¹⁰ RWJF Commission to Build a Healthier America. (2013.) *Overcoming Obstacles to Health in 2013 and Beyond.* Princeton, NJ: The Robert Wood Johnson Foundation. Available at: <http://www.rwjf.org/content/dam/farm/reports/reports/2013/rwjf406474>.

¹¹ U.S. Department of Health and Human Services, Agency for Healthcare Research and Quality. (2015.) *Care Coordination.* Available at: <http://www.ahrq.gov/professionals/prevention-chronic-care/improve/coordination/index.html>.

¹² AHC Media. (2016.) *Case Managers and Decreasing ED Visits.* Available at: <http://www.ahcmedia.com/articles/137698-care-coordination-with-cms-results-in-33-decrease-in-ed-visits>.

¹³ CSH: The Source for Housing Solutions. (July 2014.) *Housing is the Best Medicine: Supportive Housing and the Social Determinants of Health.* Available at: http://www.csh.org/wp-content/uploads/2014/07/SocialDeterminantsofHealth_2014.pdf.

¹⁴ Cantor J, Tobey R, Greenberg E. (November 2015.) *Developing Safety-Net Care Management in California: An Opportunity for Whole-Person Care.* JSI Research and Training Institute, Inc. Available at: http://www.jsi.com/JSIInternet/Inc/Common/download_pub.cfm?id=16370&lid=3.

project: structured coordination, defined roles, and clear understanding of each partner's needs and measures of success.¹⁵

Overarching Vision – Providing Learnings: The VCHCA will participate with statewide learning collaboratives and bi-weekly/months calls among statewide pilot lead entities to share best practices, and share information with other pilot entities as requested. At the pilot's conclusion, learnings will inform local future WPC efforts (see External Communication Plan in Section 2.2).

Overarching Vision – Building Sustainable Infrastructure: Sustainable infrastructure that supports communications across systems will be built by:

- Creating a unified organization using a collaborative leadership approach that fosters relationships and trust among WPC system providers
- Establishing shared data technologies and a data warehouse
- Increasing integration of services for high-risk patients
- Implementing real-time communications protocols and technologies
- Developing a locally defined care coordination model (see Section 3.1)

Pilot Sustainability: This infrastructure and the proposed interventions will be sustained by the initial investment of resources including: 1) VCHCA and DHCS combined funding to establish data systems and technologies for data sharing, reporting, and quality improvement; 2) relationships, collaborations, and agreements that do not require funding to support; and 3) the pilot's integration of services that address the social determinants of health that will lower service utilization resulting in significant cost-savings within all systems. For example, evidence shows that high-cost individuals do not become lower cost over time if they remain homeless.¹⁶ Ensuring that participants are housed can result in a significant reduction in the use of major services, ranging from 28% to 79%.¹⁷ These cost-savings will enable participating entities to fund pilot model components, such as the cost of CHWs and informaticists, as the project moves from the pilot phase to full implementation after waiver funding is terminated.

2.2 Communication Plan

WPC Pilot Communication Process: Communication among the lead entity and participating entities will occur through monthly collaborative meetings; collaborative-wide informational and quality improvement emails; site visits; PSDA activities; monthly data reports about utilization, cost, and metric progress; integrated care plan development; and expansion of technologies, including a centralized care collaboration platform, electronic care plan, eReferrals, real-time secure messaging, HL7 ADT alerts, and real-time dashboards with key indicators for the WPC Connect target population (see Section 3.1). The VCHCA will hold an educational conference upon funding among participating entities that will review all funding requirements and expectations. Communications between the DHCS and VCHCA that define/clarify requirements will be shared at regular collaborative meetings and provided in writing. Written agreements between individual entities and

¹⁵ Cantor, 2015.

¹⁶ Flaming D, Toros H, Burns P. (2015.) *Home Not Found: The Cost of Homelessness in Silicon Valley*. Economic Roundtable, underwritten by Destination: Home and the County of Santa Clara. Available at: http://destinationhomesc.org/wp-content/uploads/2015/05/er_homenotfound_report_6.pdf.

¹⁷ United States Interagency Council on Homelessness. (June 2015.) Opening Doors: Federal Strategic Plan to Prevent and End Homelessness. Available at: http://dev2.usich.gov/resources/uploads/asset_library/USICH_OpeningDoors_Amendment2015_FINAL.pdf.

the lead entity will clearly outline each organization's obligations. The communications infrastructure will be sustained through established communication protocols, data sharing and reporting technologies, bylaws, relationships, and cost-savings from project interventions.

Integration will be promoted by: 1) community-based care coordination (CHWs); 2) web-based, real-time care coordination and care plan platforms; 3) and care coordination administered through a centralized CCT (see Section 3.1). The pilot will minimize silos through a unified vision and goals, increased integrative structures, collaborative bylaws, data sharing technologies and protocols, improved relationships/trust across system providers, regular communications/meetings among participating and lead entities, and alternative financial options for incentives and payments. The key to minimizing silos is a shared platform through integrated enterprise solutions that will create a community care collaborative process driving a virtually integrated delivery network.

Decisions will be made in consultation with the participating entities through collaborative leadership decision-making processes (see Governance Structure below).

Regular meetings will be calendared each project year to facilitate collaborative planning and attendance by participating entities. Leadership team meetings will occur at least biweekly and WPC Collaborative meetings will occur monthly prior to services implementation and the schedule will be adjusted after implementation as indicated, with leadership and collaborative meetings occurring at least monthly. The WPC Administrative Assistant will serve as scribe at each meeting, recording the list of attendees, developing and maintaining agendas, and recording minutes. At least annual stakeholder meetings will be held beginning after Year 2 to report results, challenges, and successes.

Governance Structure: The pilot will be organized through collaborative leadership and systematic coordination among entities. The governance structure: 1) identifies clear roles among the participating entities in providing services and implementing interventions (see Section 1.2), 2) defines financing arrangements (see Section 5), 3) outlines communication protocols and requirements (see above), and 4) sets decision-making authority and practices (see below). WPC partnership bylaws delineate governance, decision-making processes, communication protocols, partner protocols for failing to meet goals, and business structures.

Decision-making authority related to system design and quality improvement will reside with the WPC pilot leadership team, composed of champions/key representatives from each of the participating entities. The leadership team will make decisions by consensus and/or according to bylaw procedures once drafted.

Participating entities will be involved in decision-making through leadership team involvement; entity progress reports outlining barriers, successes, and recommendations for pilot adaptations; input at WPC collaborative and stakeholder meetings and conferences; collaboration processes; PDSA activities for project improvements (see Section 4.2); integrated plan development; and through collaboration via care coordination platforms. Shared decision-making processes will be utilized for project-related decisions (under the constraints of the award) and, as indicated, participant selection and care planning decisions.

Main Point of Contact: The main point of contact to support and coordinate with participating entities will be the WPC Project Director, who will be hired upon approval of the application. Until that time, the main point of contact will be Johnson K. Gill, the VCHCA Deputy Director of Population Health Management and Clinical

Integration.

External Communication Plan: The VCHCA will develop materials (i.e., PowerPoint presentations, pilot study results and analysis documents) based on DHCS annual and final reports to provide annual (post-Year 2) county-wide conferences about WPC, which will be used in other formats and settings (i.e., website pages, participating entity data sharing, statewide WPC conferences, professional conferences). The goals of these efforts will be to improve collaboration and rapport among participating entities, engage stakeholder organizations in joining local WPC efforts, draw input into quality improvement processes, compare results to other pilots, and drive pilot sustainability efforts. These learnings will also provide information crucial to future local efforts, both within the county and as a model for other counties to emulate or understand through “lessons learned.” Beneficiaries will be linked to an assigned CHW who will communicate the project services and information to the participants, and help them navigate WPC services. Providers will be trained in WPC and other project-related topics and provided communications via the project’s enterprise network (see Section 3.1) and with communication between the CHW and provider and/or care manager.

2.3 Target Population(s)

Target Population: The target population is the high-utilizing GCHP beneficiaries with at least four ED visits and/or two inpatient visits (ages 18 and older). For 2015, this high-utilizer population was 1,820 individuals, 1,612 of whom were seen through VCHCA. This is 1.1% of VCHCA’s 147,744 ED/hospital patients in 2015. Once identified, the target population will be stratified for risk using the project’s WPC Vulnerability Index to ensure enrollment prioritization of the highest risk of this population, which is predominantly homeless persons, those at risk of homelessness, and/or persons with SUD or mental illness. It is anticipated that 2,000 total Medi-Cal beneficiaries will be served over the five-year project period, with ongoing enrollment of 800-participant caseload. It is estimated that at 400 participants per year will cycle out of the project due to improvements in outcomes “graduating” the participant out of the project, reduction in overall risk that transitions the participant to Targeted Case Management services, dropped enrollment, re-location, death, etc. It is estimated that 1,612 total Medi-Cal beneficiaries will be eligible for the pilot in the geographic area (based on 2015 totals) in the first project year. Some will not be served because of lack of consent or low overall risk based on the *WPC Vulnerability Index*. Only Medi-Cal beneficiaries will be served by the pilot.

Collaboration with Participating Entities to Identify the Target Population: The target population was identified through a collaborative data approach to identify common patients who frequently access urgent and emergent services at the ED, inpatient hospitals, FQHC and Public Health clinics, urgent care centers, behavioral health clinics, crisis response team, and EMS. The Lead Entity was responsible for designing the data analysis approach, leading collaborators in identifying specific data to be queried, analyzing data to determine commonality across sectors, and determining which of the five possible target populations created the greatest system utilization/cost.

Enrollment Cap: An enrollment cap of a 1,000-participant caseload is anticipated once the pilot is fully implemented. VCHCA will notify DHCS within 90 days of imposing the enrollment cap and will submit to DHCS approval. The rationale for the proposed cap is that project effectiveness will only be achieved if it remains within the maximum caseload of 40 individuals per CHW for complex care models in order to accomplish care goals. A waitlist will be established for eligible participants wishing to be enrolled, and patients will be enrolled and opted in on a rolling basis. The process for establishing and administering the enrollment cap will include: 1) identification for eligibility based on risk stratification, contact by a CHW, and

collecting a signed Universal Consent form; 2) notification of being placed on the wait list, with referral and information on care services available based on assessments within the VCHCA until the candidate can be enrolled in the project; and 3) notification of eligibility for enrollment when a spot is open. Enrollment from wait lists will be based on a combination of risk level and time on the wait list.

Methodology to Identify the Target Population: A collaborative data approach was utilized to identify the target population's use of health care and behavioral health services. Data analysis of GCHP, behavioral health, VCHSA, and HCH records; the 2015 Homeless Count; the VCHCA 2013 Health Care Needs Assessment; collaborative data from community resources regarding homeless and mentally ill service access outside of VCHCA; and Ventura County studies/literature reviews were used in data analysis. The WPC Collaborative and key leaders reviewed the analysis to determine the characteristics and needs of the highest utilizers, from which a target population was determined.

Among the crucial determining factors were the characteristics of the beneficiaries. The high-utilizing GCHP beneficiaries with at least four ED visits and/or two inpatient visits were 1,820 individuals in 2015, 1,554 of whom were seen through VCHCA. Among VCHCA's highest utilizers: 27.7% are currently or recently homeless, 40.5% have mental health disorders, 24.4% have substance abuse disorders, and 97.3% have multiple chronic conditions (see Need above). Among the homeless target population, 56.8% had eight or more physical health encounters and 28.4% had eight or more behavioral health encounters, with 49.0% treated at both health/behavioral health facilities. Among this population, 47.6% had no preventive care visit with either an FQHC or Public Health clinic. These characteristics demonstrated that the high utilization target population has risk factors across all five WPC populations, but persons currently or recently experiencing homelessness are a particularly needy sub-population that shows high incidences of each of the other risk factors.

Data analysis revealed that the high utilizers were often homeless, but other sub-populations (mentally ill, those with SUD, and those with multiple chronic conditions) were also frequently represented among the highest utilizers. High-risk conditions that require care management to optimize outcomes were also present among this population, according to data results: 11.3% had kidney disease, end-stage renal disease; 12.2% had heart disease, heart surgery; and 14.6% had liver disease, cirrhosis. VCHSA data identified the high-levels of social service utilization among the identified target population. Among the target population identified, 49.7% were also in the VCHSA system because they receive CalFresh (food assistance, formerly SNAP) and/or CalWORKS (cash assistance) and/or assistance for the homeless as tracked by the Homeless Management Information System (HMIS); 40% receive at least CalFresh.

It was determined collaboratively by key leaders, therefore, that prioritizing the target population to those most in need of services (highest risk) would most effectively impact the utilization of health, behavioral health, and social service systems. A risk stratification strategy was developed to ensure that not only homeless persons accessed WPC services, but also those in other populations who most often use hospital ED/inpatient services. It is anticipated that homeless beneficiaries will be a large proportion of the proposed target population, since 98.4% of this group is also part of at least one other high-risk sub-population.

Beneficiary Identification: Through the WPC Utilization and Outcomes Monitoring System (UOMS), participants will be identified who access the VCHCA ED four or more times in a year and/or access inpatient services two or more times in a year. Other collaborators will provide queries of their systems to determine high utilizers, which will be cross-referenced with the GCHP data. A Waiver Analytics Team will determine common outliers. Risk stratification will be achieved through predictive analytics based on a risk

algorithm (see Attachment F). Once identified potential participants will be enrolled into the Health Registry, WPC Integrated Care Plan platform, as well as into a specialized platform for WPC community partners to provide alerts to providers and collect data.

Beneficiary Outreach: Any provider who the potential participant accesses will be aware of the patient's eligibility for project inclusion. Providers, care managers, clinical staff, and community partners will be trained about the project and referral protocols. Mobile outreach staff (Engagement Teams and CHWs who provide Fee for Service outreach for persons not yet enrolled) will reach out to those who are identified in a variety of settings, such as clinics, EDs, One-Stops, homeless congregation locations, shelters, transitional housing, etc. The Engagement Teams and CHWs will be trained in motivational interviewing and trauma-informed care to engage the person in motivation to change. The CHWs will outline the project's features and potential benefits. The WPC Universal Consent Form will be signed by the participant. After consent, the CHW will complete the *WPC Comprehensive Assessment*, which will be a tool that determines health, behavioral health, and social needs, and incorporates the Vulnerability Index. The *WPC Vulnerability Index* assessment will prioritize participants for project inclusion. This Vulnerability Index will be a hybrid of assessments from other evidence-based programs,¹⁸ but designed to specifically identify persons who have an increased risk of expensive, frequent service utilization that can be affected by WPC (see Attachment C). The WPC Comprehensive Assessment will be adapted from the National Alliance to End Homelessness Comprehensive Assessment Tool¹⁹ to align with the project's target population. This information will be used as the basis for participant prioritization and integrated care plan development. The Waiver Data Analytics Team will notify the participant's existing providers and pull assessment and care plan information into the *Integrated Care Plan* platform. The CCT will engage these care providers to further develop a consolidated care plan and assess other care providers/managers based on assessed needs. Other community partners' case managers, eligibility staff, and outreach workers will also be trained to engage potential participants to ensure that the WPC CHWs are leveraged by the countywide outreach resources.

¹⁸ O'Connell J. *Vulnerability Index: Prioritizing the Street Homeless Population by Mortality Risk*. Boston Healthcare for the Homeless Program. Available at: <http://www.jedc.org/forms/Vulnerability%20Index.pdf>.

¹⁹ National Alliance to End Homelessness. (2014.) *Comprehensive Assessment Tool*. Available at: <http://www.endhomelessness.org/library/entry/alliance-coordinated-assessment-tool-set>.

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

3.1 Services, Interventions, and Care Coordination

WPC Pilot Services for Beneficiaries: The non-Medi-Cal services that will be provided to the target population are based on: the 2015 homeless count and survey,²⁰ the 2013 VCHCA needs assessment,²¹ evidence-based practices based on the target population needs through literature reviews, county HCH program lessons learned, and experience from collaborative partners serving the target population. All services will be offered to all participants based on assessed needs (see Attachments A and B, the Concept Diagram and Workflow Diagram).

Medical Services: Medical services provided through VCHCA's FQHCs, hospitals, and specialty care providers are Medi-Cal funded (see Section 1.2.2). Services provided by VCHCA through the WPC project include the following:

1. **WPC Centralized Care Coordination:** A centralized Care Coordination Team (CCT) will connect the new communication and data technology infrastructure and the *Integrated Care Plan* with providers within the VCHCA, other public entities, and community partners. The CCT will oversee the day-to-day activity of ensuring the participants are appropriately identified, enrolled, and linked to resources. This centralized staff will have access to a multi-level, interdisciplinary support team of subject matter experts who will advise WPC staff about appropriate resources, services, and interventions, including PCPs, specialists, pharmacists, nurses, behavioral health specialists, housing services representatives, social service representatives, etc. The CCT will also provide field-based coordination and integration support as required by providers. The CCT will include: 6.0 FTE Care Managers (2.4 FTE Registered Nurses [RN] and 3.6 FTE behavioral health specialists (see Section 1.2.3 below). 15.6 FTE Community Health Workers (CHWs) will also be a part of the CCT.
2. **WPC Care Coordination through Outreach:** Two Engagement Teams (based out of retrofitted mobile health vans) will facilitate integration of services, outreach and engagement of participants, determine immediate care needs, provide needed prescriptions, offer enrollment and assessment services, connect services with community-based providers, and ensure that there are no gaps between the Integrated Care Plan and the provision of planned services. The team will be effective in connecting with participants who predominantly access services outside of the VCHCA. The Engagements Team will include: one (1) Care Coordination Manager, one (1) Nurse Practitioner, and two (2) MAs.
3. **WPC Care Coordination through Field-Based Care Coordinators:** CHWs (15.6 FTE), who are part of the CCT, will be field-based staff members who have a close understanding of the target population and Ventura County communities, and are culturally/linguistically similar and/or competent with the participants they serve. This trusting relationship will enable them to serve as a liaison, link, and intermediary between health, behavioral health, social services, and the community resources to facilitate access to services and improve the quality of service delivery. CHWs will build individual and community capacity by increasing health knowledge and self-sufficiency through a range of

²⁰ Colletti J, Herrera S. (April 2015.) *Ventura County 2015 Homeless Count and Subpopulation Survey: Final Report*. Institute for Urban Initiatives. Available at: http://www.cityofventura.net/files/file/VC_Homeless_Count_Survey_2015.pdf.

²¹ Ventura County Health Care Agency. (November 2013.) *Transforming Ventura County Communities: Understanding the Health Status and Needs of Ventura County*. Available at: http://www.vchca.org/docs/public-health/transforming-vc-report_final.pdf?sfvrsn=0.

activities such as outreach, community education, informal counseling, social support, and advocacy. CHWs will administer the WPC Comprehensive Assessment, connect with the CCT to identify needed services, initiate the WPC Integrated Care Plan with the CCT based on the Comprehensive Assessment, link participants with community resources, reduce access barriers, provide in-person ongoing care management and support, and work with system-wide care managers to provide care (see Section 1.2.2).

PCPs/clinical staff, CCT, and CHWs will be trained in complex care patient management, assessing patients' ability to participate in care coordination, WPC components/model, care transitions, cultural competency, and reporting services and outcomes. Participants will have access to a multidisciplinary care team that is unique to each participant, including PCPs, psychiatrists, nurses, specialists, therapists, and behavioral health professionals. The WPC Project Director and Care Managers will integrate existing HCH program, co-located primary care/behavioral health services, PCMH-based care, and One-Stop Center services with the pilot's services to leverage existing resources and optimize pilot funding.

VCHCA Public Health Department will provide tobacco cessation classes and access to One-Stop Center services in the city of Ventura (see Section 1.2.4).

Behavioral Services: A host of mental health and substance abuse services will be provided by the *Ventura County Behavioral Health Department* (VCBH) outside of Medi-Cal funding streams (see Section 1.2.3.). In addition, 3.6 FTE VCBH Care Managers who are part of the CCT (see Section 1.2.2 above) will support behavioral health care coordination for participants. The role of the VCBH Care Managers is to integrate behavioral health services with other medical, social, and non-medical services according to the Integrated Care Plan. The centralized behavioral health specialists will: 1) interact with CHWs, patients, physicians, behavioral health professionals, social service providers, and community partners to ensure that behavioral health protective factors are integrated with all aspects of care; 2) track service utilization, health outcomes, and care plan changes; 3) work closely with field-based CHWs to ensure timely behavioral health care; 4) bring all care providers to serve the participant during urgent/emergent behavioral health situations; 5) ensure behavioral health services are accessible in primary care settings; and other services as indicated. At least one Care Manager will be a Licensed Mental Health Professional (LMFT or LCSW) and at least one will be a Substance Abuse Specialist.

Other non-Medi-Cal services include those that are provided through the Mental Health Services Act, Realignment Funds, SAMHSA and other grants, County General Funds, Veteran's Administration, and other sources. SAMHSA grants include Projects for Assistance in Transition from Homelessness (PATH) funding for case management and outreach. Integration with primary care is also provided through a co-located behavioral health professional in some clinics.

Social Services: Social services will address participants' immediate and ongoing basic needs for shelter and housing transition and tenancy services, transportation, healthy food, clothing, and personal items. The role of the use of social services is to stabilize the participant's ability to acquire resources for daily living to improve protective factors that affect health outcomes. The *Human Services Agency* will provide multiple social services through existing community resources, including: CalFresh, CalWORKs, Child Welfare Services, Employment Services, General Relief, Health Care Enrollment, Homeless Services, Transitional Housing, In-Home Supportive Services, Public Guardian, Veteran Services, Youth Services, and Adult Protective Services (see Section 1.2.6). CHWs will connect participants with other existing community resources, as indicated through comprehensive needs assessments, such as:

1. Housing transition and tenancy services/housing (*Housing Authority, St. Vincent De Paul, Rescue Mission Alliance, Salvation Army, Project Understanding*)
2. Food banks/vouchers (*FOOD Share, Rescue Mission Alliance, Salvation Army, Project Understanding*)
3. Clothing (*Rescue Mission Alliance, Salvation Army*)
4. Support groups (*Rescue Mission Alliance, Salvation Army*)

Through the WPC project, the additional services that will be provided will be:

1. *Ventura County Housing Authority* housing transition and tenancy support services (see description below).
2. *Ventura County Transportation Commission* bus vouchers will be provided to participants as needed to maintain health stability and access services according to their care plan, and pilot funded only if not funded through Medi-Cal.

Non-Medical Services: The role of non-medical services is to prepare the participants for project disenrollment in a manner that will ensure stability and success. As participants transition to self-sufficiency, they will take part in life skills and job readiness training. St. Vincent De Paul will provide participants skills training for independent living, including budget management, cooking and nutrition, maintenance of living space, transportation, goal-setting, and personal empowerment. Job readiness training will be provided by two county Workforce Investment Board Job and Career Centers and will include soft skills training (i.e., communication, resume writing, job applications, interviews), job readiness/career development (i.e., construction, office operations, nursing, computer technicians, and maintenance), and job search/placement assistance. The CHWs will assist with housing navigation and accessing life skills training. These services will be provided through existing community resources, and not funded through the WPC project (see Letters of Participation). Non-medical care and ongoing support will be provided by the CHWs, community/partner outreach workers, and family/caregivers, as indicated by the need.

Services Suiting Needs of Beneficiaries: To accomplish WPC (STC 112) goals, best practices will be incorporated into the model. Studies demonstrate that providing stable affordable housing coupled with “high touch” supports that connect people with chronic health challenges to a network of comprehensive primary, behavioral health, and other services can improve health, increase survival rates, foster mental health recovery, and reduce alcohol and drug use among formerly homeless individuals.²² Access to safe, quality, affordable housing – and the supports necessary to maintain that housing – constitute one of the most basic and powerful social determinants of health.²³

At the heart of the pilot design is care coordination through trauma-focused and patient-centered care that is tailored to meet the needs of the individual, taking into account the unique and complex array of social, behavioral, and physical health needs among the target population. Studies demonstrate that patient-centered interventions involving care management and coordination among high-risk homeless persons reduce inpatient admissions by 37% (in one study) and ED visits overall.²⁴

²² Nardone M, Cho R, Moses K. (June 2012.) *Medicaid-Financed Services in Supportive Housing for High-Need Homeless Beneficiaries: The Business Case*. Center for Health Care Strategies, Inc. Available at: http://www.csh.org/wp-content/uploads/2012/06/SH-Medicaid-Bz-Case_Final.pdf.

²³ CSH, 2014.

²⁴ Raven MC, Doran KM, Kostrowski S, Gillespie CC, Elbel BD. *An intervention to improve care and reduce costs for high-risk patients with frequent hospital admissions: a pilot study*. *BMC Health Serv Res*. 2011 Oct 13;11:270. Available at: <http://www.ncbi.nlm.nih.gov/pubmed/21995329>.

Network of Providers: The provider network (participating entities) is listed in the Services section above alongside the services they provide, and is also listed in Section 1.2. A more expansive network of community partners will be accessed by CCT through the county's 2-1-1 community resources directory hotline to connect participants to resources that address each participant's unique needs (see Attachment D).

Housing Services: Linkages to housing services will be determined through initial and ongoing assessments and will be an essential part of the Integrated Care Plan. CHWs will ensure that homeless participants have access to the county's resources of shelters and transitional living facilities for immediate needs, and will utilize motivational interviewing to keep participants off the streets. The care plan and the participant's stratification risk will indicate the need for services. Care Managers will connect participants with transitional housing services to develop a long-term answer to ensure that health outcomes are maximized.

As indicated in the Section 2.1 and described in the CMCS Informational Bulletin,²⁵ housing services will include: individual housing transition services and individual housing and tenancy sustaining services. Housing support services provided by the Area Housing Authority of the County of Ventura and city housing authority partners will include a host of housing supports including: developing housing plans, housing searches, paperwork and legal support, relationship-building with landlords, setting up utilities, etc. Housing authorities will prioritize the project's homeless participants for housing vouchers. *Residential Services (Mental Health):* Case management is provided to support a client's stability in their home environment and residential treatment programs. Note that WPC funds will only be used for allowable costs that include individual housing transition services and individual housing and tenancy sustaining services in alignment with the CMCS Informational Bulletin. Residential services and room and board are not covered under WPC.

Housing services will link participants with a range of options based on the participant's immediate and long-term needs, health, and the timeframe for housing stability, including emergency shelters, treatment/rehab/skilled nursing facilities, transitional housing, rapid re-housing, Section 8 housing vouchers, and veterans' housing support. Linkages between the VCHCA homeless services and housing authorities/services will facilitate housing stability by ensuring participants maintain sheltered residence. Through regular communication of each participant's housing status by the CHW, partners can intervene quickly if there is a change in status.

The Collaborative will evaluate the need and purposes for a housing pool in project year 3. A housing pool will utilize a phased-in approach to assist in ensuring sustainability. The WPC Collaborative will determine the sources, structure, and eligibility priorities of the housing pool during project year 2. It is anticipated that the housing pool will work by collecting funds through a variety of VCHCA and community-based resources (to be decided at a later time by the Collaborative), determining the need and readiness for housing of participants through a standardized assessment. No housing pool administrative or other costs are included in the WPC budget, nor will any WPC funds be used for the housing pool.

Interventions/Strategies to Integrate Services: Innovative and new technologies support project staff in integrating services. Project interventions include:

1. The web-based Integrated Care Plan, that will consolidate assessments, incorporate care plans from diverse system providers, and develop a comprehensive WPC plan.

²⁵ Wachino V. (June 26, 2015.) *Coverage of Housing-Related Activities and Services for Individuals with Disabilities*. CMCS Informational Bulletin. Centers for Medicare & Medicaid Services. Available at: <https://www.medicaid.gov/federal-policy-guidance/downloads/CIB-06-26-2015.pdf>.

2. The web-based *WPC Care Coordination* platform that will maintain the participant repository, care coordination system, data repository, and the project eReferral system, providing real-time communication.
3. A *WPC Community Partner* platform will link outside providers with care coordination while protecting personal health information (PHI).
4. *Real-Time Secure Messaging*, a web-based telemedicine consultation system, will allow PCPs, specialists, CCT, CHWs, mobile van outreach staff, and other VCHCA system providers to securely share health information and discuss patient care (Phase 2).
5. A *data warehouse*, the WPC Utilization and Outcomes Monitoring System (UOMS), will be used to consolidate EHR, behavioral health, VCHSA social services, and health registry data.
6. The *WPC Health Registry*, a population health management tool, enables providers to use data-driven, evidence-based clinical decision making possible. Dashboards will allow providers, CCT, and CHWs to track their participant's needs.
7. CHWs will integrate services through outreach and coordination with participants and system providers.
8. The centralized *Care Coordination Team* will integrate services as defined by the *Integrated Care Plan*.

Prior Experience in Implementing WPC Pilot: VCHCA has experience with projects with similar goals and components, including:

1. EHR platform development in alignment with Meaningful Use Stage 2 requirements and certifications
2. 2015 Health Care Innovation Award project that provides care coordination and infrastructure improvements to the EHR to serve Ventura County residents with COPD
3. PHS 330(h) HCH Program since 2002, with multiple expansions and improvements
4. Expansion to serve all beneficiaries in FQHCs through PHS 330(e) funding
5. Multiple grant-funded SAMHSA programs, including Project for Assistance in Transition from Homelessness (PATH), Mental Health Triage, Drug Court, and other funding.
6. Community Transformation project providing food security, safety, and the emotional and social wellness of residents

Existing Program/Infrastructure to be Leveraged: Participants will have access to a medical home utilizing National Committee for Quality Assurance (NCQA) Patient-Centered Medical Home (PCMH) model practices, with Health Home service integration to be braided with project services when Ventura County's program application round/approval is complete. The HCH program has established a network of health care providers and services that address the unique needs of homeless persons, with linkages to behavioral health services. One-Stop Centers consolidate multiple services in a single location to facilitate WPC system navigation. These existing services are integral to the WPC project's success. The existing EHR system data will provide input to the new technology platforms.

Concurrent initiatives being implemented or expected to be implemented include PRIME projects, FQHC, HCH, and, in future years, Health Homes. The WPC project will be braided with these initiatives to ensure that strategies and services are non-duplicative and leveraged. PRIME's Complex Care project, for example, will bring together a taskforce to implement strategies and data infrastructure, which will be integrated with WPC. All PRIME projects are interdependent with WPC, affecting system-wide changes, integrating care across settings, and coordinating care so that each project can operate optimally.

Engaging and Connecting Individuals to Services: PCPs, clinic staff, and CHWs are/will be trained in motivational interviewing and trauma-informed care to facilitate patient engagement (see Outreach in Section 2.3). CHWs will be adept at developing trust, trained in cultural competence, and be culturally/linguistically appropriate for each participant. As part of primary care assessment, participants will be evaluated for suitability for care management. Connecting participants to services will be accomplished through CHW outreach, CCT and CHW links with appropriate providers who are expert in addressing specific needs, and connectivity through the Care Coordination and Integrated Care Plan platforms.

Improving Health Outcomes: The interventions will improve health outcomes by: 1) linking services that directly affect the social determinants of health with primary and behavioral health services, 2) combining evidence-based care coordination strategies with enterprise technology solutions to ensure real-time communications and improved access to needed services, 3) connecting centralized care coordination management with field-based care coordination to better serve a high-risk population and that can access participants in settings that best suit their needs, and 4) developing infrastructure that will provide ongoing measurement of individual and population health, and input to drive PDSA processes and continuous quality improvement strategies. (See Section 2.1 – How the WPC Pilot Addresses Target Population Needs.)

Decreasing Avoidable Emergency Department/Inpatient Utilization: Care coordination models with key functional elements have proven to decrease both ED and inpatient utilization, while increasing clinic visits.^{26,27,28} Use of telemedicine has been shown to improve coordination of services, provider agreements/knowledge, and access to care, leading to more appropriate use of resources.²⁹ There are several promising studies showing that community health work is an effective tool for reducing health disparities, improving health, and reducing the cost of health care.³⁰

Decreasing Avoidable Utilization of other Systems: One of the key objectives is utilizing the “right care” to address needs, especially those social determinants of health needs that are so impactful on health outcomes. The project will assign provider care managers within each system to specifically address needs in the *Integrated Care Plan*. CHWs will help participants to link the planned services to experts in addressing their needs. This will reduce utilization of other systems by reducing the number of duplicative services, decreasing access to services not suited to meeting a participant’s needs, providing integrated services when applicable at the primary care clinic and One-Stop Centers, and developing a comprehensive set of services with specific providers assigned.

²⁶ Mann, C. (2014.) *Reducing Nonurgent Use of Emergency Departments and Improving Appropriate Care in Appropriate Settings*. Department of Health & Human Services. Centers for Medicare & Medicaid Services. CMCS Informational Bulletin. Available at: <https://www.medicare.gov/Federal-Policy-Guidance/Downloads/CIB-01-16-14.pdf>.

²⁷ Wilder Research. (2014.) *Hospital to Home: Reducing Avoidable Hospital Emergency Department Visits While Improving Stability and Health*. Available at: <https://www.wilder.org/Wilder-Research/Publications/Studies/Hospital%20to%20Home/Reducing%20Avoidable%20Hospital%20Emergency%20Department%20Visits%20While%20Improving%20Housing%20Stability%20and%20Health,%20Full%20Report.pdf>.

²⁸ New England Healthcare Institute. (March 2010.) *A Matter of Urgency: Reducing Emergency Department Overuse*. Available at: http://www.nehi.net/writable/publication_files/file/nehi_ed_overuse_issue_brief_032610final edits.pdf.

²⁹ Hersh WR, Hickam DH, Severance SM, Dana TL, Krages KP, Helfand M. *Telemedicine for the Medicare Population: Update Evidence Report/Technology Assessment No. 131* (Prepared by the Oregon Evidence-based Practice Center under Contract No. 290-02-0024.) AHRQ Publication No. 06-E007. Rockville, MD: Agency for Healthcare Research and Quality. February 2006. Available at: <http://archive.ahrq.gov/downloads/pub/evidence/pdf/telemedup/telemedup.pdf>.

³⁰ Valesky K. (June 2011.) *Community Health Workers in Health Care for the Homeless: A Guide for Administrators*. National Health Care for the Homeless Council. Available at: <http://www.nhchc.org/wp-content/uploads/2011/09/CHWguide.pdf>.

Plan-Do-Study-Act (PDSA) Process: The *Model for Improvement*³¹ will drive system-wide improvement, and PDSA methodology³² will be the basis for testing quality improvement processes and change management. The WPC administrators/management and the Waiver Analytics Team will be consistently monitoring project progress, both in relation specifically to PDSA cycles and through dashboards tracing overall quality indicators. Outlier data and notable trends will indicate opportunities for quality improvement. Needed changes will be identified through root cause analysis, development of change concepts, and Lean processes. Value stream mapping will help to identify the needed change and change concept. Once a targeted change is identified, PDSA processes will test the proposed change to determine if it will be successful, the degree of change expected, and the costs and other impacts associated with the change. Change will be carried out through incremental tests of change, and change modifications through iterative PDSA cycles (see Section 4.2). A Quality Improvement Coordinator will drive PDSA processes, work with leaders to implement and test change, tie VCHCA quality improvement processes and committees in with PDSA processes, use participant feedback to drive improvements, and interact with project staff to optimize the quality of services. PDSA processes will take place at the collaboration and individual systems level (i.e., administrative, field-based, centralized care coordination, mobile engagement, technology, providers) at least monthly to ensure that continuous quality improvement provides excellence in care.

Care Coordination Administration: The WPC pilot will be led by an administrative team that will conduct WPC Collaborative activities and oversee the CCT services. This team will include the Project Director, co-Medical Directors (a PCP and a psychiatrist), Care Coordination Manager, Quality Improvement Coordinator, Informaticist, Database Analyst, and an Administrative Assistant. Care coordination will be administered through a centralized CCT comprised of the WPC Care Managers, CHWs, and Engagement Teams, all led by the Care Coordination Manager. The CCT will oversee the day-to-day activity of ensuring the participants are appropriately identified, enrolled, and linked to resources. This centralized staff will have access to a multi-level, interdisciplinary support team of subject matter experts who will advise WPC staff about appropriate resources, services, and interventions, including PCPs, specialists, pharmacists, nurses, behavioral health specialists, housing services representatives, social service representatives, etc. System providers and/or this support team will assist in developing system-specific care plans that will be consolidated into the Integrated Care Plan that the CHW will utilize in the field. The intent of these service subject matter specialists is to be able to collaborate with external resources and organizations to best meet the participants' needs. The CCT, subject matter experts, and Care Coordination platform will support external/remote access for the CHWs who directly engage with the patients.

Participating entities will be responsible for providing case managers to link participant care with WPC care plans and resources; providing data on utilization, cost, and outcomes; and linking with new collaboration platforms to plan and execute services. Care coordination will be linked with other participating entities through the *WPC Care Collaboration* platform, *eReferral* technologies, *Real-Time Secure Messaging* telemedicine consultation services, access to an *Integrated Care Plan* platform, and communication with assigned CHWs. Care coordination will be seamless to the beneficiary by integrating key care coordination administrative elements:³³ 1) structured coordination with regularly scheduled contacts and co-location of some key services; 2) defined roles and systems that facilitate participants being provided rapid access to partners with appropriate training and expertise when problem situations arise; and 3) understanding how

³¹ Langley GL, Moen R, Nolan KM, Nolan TW, Norman CL, Provost LP. *The Improvement Guide: A Practical Approach to Enhancing Organizational Performance* (2nd edition). San Francisco: Jossey-Bass Publishers; 2009.

³² Institute for Healthcare Improvement. (2016.) *How to Improve: Science of Improvement: Testing Changes*. Available at: <http://www.ihl.org/resources/Pages/HowtoImprove/default.aspx>.

³³ Cantor, 2015.

each partner perceives similar needs. Because it is anticipated that participants will to move along a continuum of health/behavioral health and other social service needs over time, a single lead entity/CHW and single funding stream for WPC services will facilitate more seamless patient care.

Targeted Case Management Program Overlap: Ventura County is currently in the planning stages of implementing Targeted Case Management (Welfare and Institutions Code §14132.44). VCHCA will have a staged approach to build Targeted Case Management. The initial phase will include a revamping of the current referral system to initially begin providing TCM referral and related activities services in 2017. Once the referral system is tested and proven, VCHCA will phase in comprehensive assessment and periodic reassessment, development of a specific care plan, and monitoring and follow-up activities over the following three years. Targeted Case Management in Ventura County will be focused on inpatient services and transitioning individuals to a community setting. Once implemented, there is expected to be very little overlap between Targeting Case Management and the Whole Person Care pilot. The PMPM Care Coordination bundle in the budget, therefore, has been discounted by 5% to take this small degree of overlap into account.

The plan to eliminate duplication of services between the two programs is by integrating alerts into the Health Registry when a potential participant is about to be dually enrolled. Other mechanisms will also be established in the identification and enrollment process, including key questions on the Integrated Assessment form. The lead Care Coordination Manager of the CCT will be responsible for identifying targeted individuals, reviewing the Health Registry to determine if identified potential participants are utilizing Targeted Case Management services prior to enrollment, working with the Targeted Case Management Program Administrator to ensure that all persons at risk are being served by one or the other program as applicable based on their condition in alignment with the specified and divergent eligibility of the target populations to the two programs, and conducting PDSA processes focused on avoiding duplication of services in Whole Person Care and Targeted Case Management programs.

The target population for Targeted Case Management will be medically fragile individuals. These are individuals who are medically fragile, have multiple diagnoses. Such individuals must also be at risk for medical compromise due to one of the following conditions:

- Failure to take advantage of necessary health care services, or
- Non-compliance with their prescribed medical regime, or
- An inability to coordinate multiple medical, social and other services due to the existence of an unstable medical condition in need of stabilization, or
- An inability to understand medical directions because of comprehension barriers, or
- A lack of community support system to assist in appropriate follow-up care at home, or
- Substance abuse, or
- A victim of abuse, neglect or violence; and
- In need of assistance in accessing necessary medical, social, educational, or other services, when comprehensive case management is not being provided elsewhere.

The target population for the Whole Person Care Pilot, however, is the highest utilizers of Ventura County ED, inpatient hospital services who have at least four ED visits and/or two inpatient visits, and are using additional services such as Behavioral Health, Public Health, Social Services, and may be in and out of the justice system due to SUD or mental illness. The identified participants will also have risk factors for readmission. The distinction is different because the targeting mechanism is different. Targeted Case

Management will evaluate participants based on the above conditions, rather than high utilization of multiple systems (HUMS). Although very small percentage of this population may overlap, the Whole Person Care pilot will have electronic alerts built into the enterprise Health Registry to notify the CCT of eligibility in other care systems.

Further, the identification of Whole Person Care participants will be conducted through predictive analytics based on a risk algorithm. Mobile outreach staff (Engagement Teams and CHWs on a Fee For Services basis) will reach out to the identified potential participants in the field in a variety of settings a variety of settings, such as clinics, EDs, One-Stops, homeless congregation locations, shelters, transitional housing, etc. This population needs an intensive comprehensive care management approach with a direct path to medical and behavioral health, housing, and nutrition services, among other social and community services, rather than simple referrals. Behavioral health specialists for both mental health and substance abuse are care managers within the Whole Person Care system itself, rather than referral resources outside the WPC team, where the systems are already impacted and unable to provide the intense care to WPC participants to break the cycle of failed outcomes. The Whole Person Care target population is a group that requires intervention at a neutral location where they are comfortable and at a physical and emotional level through motivational interviewing by an ethnically/linguistically compatible outreach worker. The Targeted Case Management participants, who will not be served by Whole Person Care, will be identified as a result of an inpatient hospital stay and a condition assessment by Registered Nurses, and the identification is based on medical need. These two populations, therefore, have little overlap.

Whole Person Care is focused on care management in an outpatient environment using a “whatever it takes” wraparound approach. It provides a more intensive model of care than Targeted Case Management which will be more limited in scope. A team of care managers, comprised of Registered Nurses, LCSWs or LMFTs, and CHWs, will be assigned to individuals who will work with them on a one-to-one basis to overcome obstacles to utilizing appropriate levels of services, rather than the ED or inpatient services, and will do so in the community setting. They will not have access to Targeted Case Management services, which will be a step below their level of need. Whole Person Care will incorporate mechanisms in the identification and enrollment process, managed by the CCT Lead Care Coordinator, to ensure that those patients identified as eligible for the Whole Person Care pilot do not have the same condition requirements as Targeted Case Management.

One-System Wraparound Care: Participating entities will work together to create one system that provides wrap-around care coordination for participants by building a Care Coordination platform and CCT that will consolidate care under one wraparound system that incorporates all elements of care, including those affecting the social determinants of health. The WPC project incorporates key elements of a highly- functioning wrap-around model, including community partnerships, individualized care planning, access to needed supports and subject matter experts, a collaborative process, fiscal policies and sustainability, and accountability.³⁴

3.2 Data Sharing

Data Sharing Between Entities: Data sharing will occur between entities through a centralized enterprise web-based solution offering real-time notification and communication interfaces that will promote collaboration.

³⁴ Walker JS, Bruns EJ, and The National Wraparound Initiative Advisory Group. (2008). *Phases and Activities of the Wraparound Process: The Resource Guide to Wraparound*. Portland, OR: National Wrap-around Initiative, Research and Training Center for Family Support and Children’s Mental Health. Available at: [http://nwi.pdx.edu/NWI-book/Chapters/Walker-4a.1-\(phases-and-activities\).pdf](http://nwi.pdx.edu/NWI-book/Chapters/Walker-4a.1-(phases-and-activities).pdf).

Participants will sign a Universal Consent Form, allowing their data to be shared among entities for the purpose of care coordination. Data sharing will occur via the following modalities (see the Data Sharing Structure in Attachment G):

1. *Care Coordination Platform:* Member enrollment repository, member data repository, and care coordination system will be shared with all providers across systems in alignment with PHI/PI regulations.
2. *Community Partner Care Coordination Platform:* This platform will link to the Care Coordination platform so that participating entities outside of the VCHCA system can connect to care coordination resources and the CCT.
3. *Integrated Care Plan:* This web-based care plan will include the CHW-administered Comprehensive Assessment Tool, provider assessments and care plans (sub-care plans), Vulnerability Index information, participants' goals and needs, tasks that need to be accomplished, and referrals.
4. *Secure Messaging:* This system will facilitate documented and secure communication to assist with the patients' needs. As necessary, the CHW will use secure messaging to seek clinical advice to assess urgent needs and guidance to direct the patient to proper care and services. This system will be linked to the care coordination platform, which will allow messages to be readily accessed by care team members.

Data sharing development will be overseen by the WPC IT developer, ongoing processes and data quality overseen by the WPC Database Analyst, and data reporting and analysis overseen by the WPC Informaticist.

Data to be Shared: Data shared will be used to evaluate individual as well as population progress, track utilization and cost over time, track universal and variant metric progress, facilitate care coordination, improve the quality of care, and improve access to care. Four major spheres of data will be shared: eligibility, health, behavioral health (including mental health and substance use), and social services (including utilization of county services and community-based social services such as housing). Health and behavioral health outcomes (and other performance and process metrics) will be measured to evaluate the project impact.

In accordance with state and federal law and Exhibit A: HIPAA Business Associate Addendum, only VCHCA departments' staff responsible for participant care (primary care, hospitals, behavioral health, and public health), VCHSA, and contracted health care/behavioral health partners will have access to PHI information. Year 4 and 5 data sharing expansion phases will enable the project to share data with health care networks outside of VCHCA. The DCHS reporting variables, including utilization, cost, and outcomes, will be shared by all systems to the WPC data warehouse (see Section 4.1). Data to be shared (between approved persons and according to regulations) include: participant characteristics/basic information, assessments, care plan information with updated pertinent results and medications, utilization data including cost and units of service, referral information, health outcomes, Data to be shared with community partners include: participant names, referral information, utilization of resource data, and outcome of service, such as a housed participant, involvement in support groups, completion of employment training, etc. In addition, the communication plan will ensure that all participating entities in the collaboration are provided population health information to keep them aware of ongoing project progress (see Section 2.2).

Infrastructure/Data Sharing Evolution: The first phase (Year 2) will launch the operation of Care Coordination and Integrated Care Plan platforms and UOMS. Data sharing within the VCHCA departments will be initiated. Needs assessments for technology development and planning for data sharing among project and collaborative

partners will be developed. During this development process, data sharing will occur through secure email systems and/or through reports distributed at meetings.

The second phase (Year 3) will launch the sub-modules such as integration of management practice guidelines surrounding the identified health issues of the target population; integration of provider task reminders; development of the health registry that taps into the EHR; coordination and refinement of the data query system for data mining and reporting; stratification and predictive modeling; and workflow and notification alerts. Data sharing technologies with project partners will be developed, tested, and launched.

The final phase (Years 4-5) will expand the developed technologies to standardize data sharing among health care systems countywide to enable health care providers and administrators to collect accurate population data. Data sharing protocols and development between the pilot and other health care systems outside of the VCHCA and outside of the pilot (i.e., Clinicas, St. Johns, Community Memorial, Los Robles) that are serving Ventura County beneficiaries will widen the capacity to compile utilization and potential participant information. Determining the cost savings to the system of housing and other social service supports will be crucial in sustainability planning and alternative flexible financing methods.

Tools to Support Data Sharing: Commonly utilized tools across the integrated system will facilitate data sharing by creating a standard by which data can be recorded, reported, and analyzed. These tools include: the EHR; the health registry; the Vulnerability Index; SDOH assessment tool; Office of the National Coordinator (ONC) Direct protocols; HL7 fast healthcare interoperability resources (FHIR); auto-alerts about patient escalations, such as ED or hospital admissions, arrests, or institutionalization; and Care Coordination, and Integrated Care Plan interfaces.

Capacities Currently in Place: Current capacities include the EHR, VCBH Insight data mining platform, limited telemedicine capabilities, and data query resources that currently have no interoperability. Existing gaps include a lack of: data sharing capabilities outside of the VCHCA excepting very limited data that can be acquired through Public Health officer request, coordinated care technologies, data mining and data merging/blending systems, comprehensive telemedicine capabilities, and eReferral capabilities. The project will build the infrastructure needed to enable these capabilities and sustain data sharing after the conclusion of the pilot.

New Development to Support Data Sharing: New development to support data sharing includes: 1) enterprise technologies phased into the data sharing system, including the participant utilization and risk query system, Care Coordination platform, Integrated Care Plan platform, and telemedicine; 2) interfaces and tools to support data sharing; 3) development of the WPC data warehouse (UOMS) including data loading and merging workflows and data quality checks; 4) data architecture, requirements, governance, collection, monitoring, and analysis protocols to support infrastructure development; and 5) role-based application security; and 6) data masking, encryption at rest, and removal of sensitive data if and when non-privileged sharing is necessary.

Timeline/Implementation Plan:

Year 1: Secure contracts with vendors to develop the enterprise data system, collaborative development and agreements pertaining to data sharing protocols.

Year 2: Audit systems to determine data structure needs, develop data governance protocols, develop data technology infrastructure for the Integrated Care Plan and Care Coordination platform (member repository, data repository, interfaces); beta test system; launch pilot data sharing system (3rd quarter); develop the

Outcome and Utilization Monitoring System data warehouse; determine data sharing needs of project partners; plan partner data sharing technology implementation.

Year 3: Develop technology infrastructure, test, and launch eReferral; and develop, test, and launch partner data sharing technologies.

Year 4 and 5: Continue to implement quality improvement processes and adapt systems to be responsive to the project's requirements to provide quality care, collect and share data, and enable provider collaboration; and expand data sharing capabilities to health care providers outside of the VCHCA system.

Building a Sustainable Data Infrastructure: When completed, this data infrastructure will: be sustainable through the initial investment in technology; have a phased implementation that will overcome challenges as development is ongoing; offer safe encrypted data access through secure tunnels to provide comprehensive provider-to-provider connectivity; provide cost savings to the system by lowering expensive avoidable utilization that will enable VCHCA to maintain the ongoing cost of the data sharing system; develop a health registry that will further inform countywide care providers and community partners about target population needs; and develop a data warehouse that will enable data sharing and coordination.

Data Governance: The WPC data governance structure will be a system of decision rights and accountabilities for information-related processes that determine which of the participating entities and their staff can take what actions with what information, and when, under what circumstances, using what methods. Driving this governance is the WPC collaborative decision-making processes, the technology requirements of the new enterprise systems, and PHI/PI, HIPAA, DHCA, and other legal and regulatory requirements. The data governance will be designed to create rules, resolve conflicts, and provide for ongoing activity, as well as ensure that data is safe through data-at-rest and data-in-motion encryption, data file change archiving, limited access to approved users, and other data security measures. The approach will be to audit existing data systems, determine collaborative partners, assess data access needs and system compatibility, and design a data architecture that accounts for regulatory requirements. In addition, the approach will develop protocols for onboarding new data/systems, audit existing systems, and classify systems and data for the degree of governance needed.

Anticipated Challenges: Challenges include those associated with privacy concerns, legal concerns, different patient/client identifiers, and non-compatible IT systems. These will be overcome by: 1) enlisting support of the DHCS and California Association of Public Hospitals (CAPH) to work with the network of providers to overcome the barriers associated with concerns of violating privacy and other data sharing regulatory requirements, identifying perceived versus real barriers, and building clarification and consensus; 2) launching a comprehensive audit of each provider's systems to determine common keys and attributes; 3) consulting with legal counsel for each participating entity to ensure data is shared legally and responsibly; 4) designing data sharing systems such as surrogate identification coding or data match algorithms from which various systems with different patient identifiers can access the same patient record or transmit data about the same participant while keeping their own files secure; 5) designing unique platforms for non-compatible systems through a data hub that conforms the data across systems; and 6) developing data quality logic to monitor the potentially evolving formats of incoming data and passing it through data governance protocols (before it potentially merges and disrupts historical formats and records).

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

4.1 Performance Measures

Performance Measures: The performance measures will provide information that determine project progress, inform quality improvement processes, and achieve targeted quality and administrative improvement benchmarks (STC 112e), as follows:

YEAR 1

WPC Pilot:

1. *Short-Term Process Measure:* By 12/31/16, complete contract with enterprise vendor to develop IT infrastructure, as measured by a signed contract.
2. *Long-Term Outcome Measure:* By 12/31/16, finalize measurement of baseline metrics, as measured by baseline metrics reported to DHCS.

Medi-Cal Managed Care Health Plan Gold Coast (GCHP); Health Services Agency, Specialty Mental Health Agency or Department – VCHCA; Public Agency or Department – Ventura County Housing Authority, Sheriff's Office, Probation Department; WPC Community Partners:

1. *Short-Term Process Measure:* By 12/31/16, complete MOUs/contracts to deliver services to participants, as measured by signed documents.
2. *Long-Term Outcome Measure:* By 12/31/16, develop WPC Collaborative policies, procedures, and bylaws, as measured by finalized document approved in minutes.

YEAR 2

WPC Pilot:

1. *Short-Term Process Measure:* By 7/1/17, complete phase 1 infrastructure development, as measured by completed system testing reports.
2. *Short-Term Process Measure:* By 10/1/2017, launch PDSA processes to improve the project as reported by metrics, as measured by PDSA reports.
3. *Long-Term Outcome Measure:* By 12/31/17, the project will be serving a caseload of at least 600 enrolled participants, as measured by UOMS reports.

Gold Coast Health Plan

1. *Short-Term Process Measure:* By 6/1/17, supply required GCHP utilization and cost data to enable the VCHCA and the IT enterprise contractor to develop a reporting system for the WPC project to identify high-utilizing beneficiaries, measure project progress, report metrics, and inform quality improvement processes (PDSA), as measured by completed data system testing reports.

VCHCA/Lead Entity:

1. *Short-Term Process Measure:* By 7/1/2017, hire and train WPC staff, as measured by employment records/contracts.
2. *Short-Term Process Measure:* By 7/1/2017, initiate WPC enrollment and project services, as measured by signed consent forms.
3. *Long-Term Outcome Measure:* By 12/31/17, CHWs will have at least 600 encounters with identified potential participants to conduct enrollment processes, as measured by signed Universal Consent forms.

Public Agencies/Community Partners:

1. *Short-Term Process Measure:* By 6/1/17, the community partners/agencies will work with VCHCA and the IT enterprise contractor to audit data systems, determine data merging requirements, and develop a data sharing platform, as measured by completed system testing reports.
2. *Long-Term Outcome Measure:* By 12/31/17, at least 60% of participants who have been enrolled for three or more months have accessed public/community resources in alignment with the Integrated Care Plan, as measured by UOMS reports.

YEARS 3-5

WPC Pilot:

1. *Short-Term Process Measure:* By 12/31/18, complete phase 2 infrastructure development, as measured by completed system testing reports; by 7/1/20, complete phase 3 infrastructure development, as measured by completed system testing reports.
2. *Short-Term Process Measure:* At least quarterly, conduct PDSA for universal and variant metrics, make improvements based on identified gaps, and document process, as measured by PDSA reports.
3. *Long-Term Outcome Measure:* Serve a project total of 720 participants by 12/31/18, 840 participants by 12/31/19, 960 and by 12/31/20, as measured by UOMS reports.

Gold Coast Health Plan:

1. *Short-Term Process Measure:* At least quarterly, supply required GCHP utilization data to enable WPC staff to measure project progress, conduct quality improvement processes, and report to DHCS, as measured by produced GCHP data reports.
2. *Long-Term Outcome Measure:* By 7/1/20, will promote the integration of utilization data from health care and behavioral health, social services providers outside of the VCHCA system into the data reporting system, as measured by UOMS reports.

VCHCA/Lead Entity:

1. *Short-Term Process Measure:* By 7/1/18, develop a plan to align and integrate PRIME and other VCHCA initiatives with WPC, as documented in the DHCS mid-year report.
2. *Long-Term Outcome Measure:* By 12/31/20, WPC will be launched as a sustained ongoing program of VCHCA, as measured by VCHCA fiscal and clinical outcomes reports that are in line with Population Health Management strategies based on the Triple Aim.

Public Entities/Community Partners:

1. *Short-Term Process Measure:* At least monthly, the community partners/agencies will report utilization and outcome data through the Community Partner platform, as measured by centralized Coordinated Care reports.
2. *Long-Term Outcome Measure:* By the end of each reporting period, at least 80% of participants who have been enrolled for three or more months have accessed public/community resources in alignment with their Integrated Care Plan, as measured by UOMS reports.

Overarching Vision of Performance Measures: The performance measures are designed to ensure that the key project processes and outcomes are identified and benchmarked to determine goal achievement. The performance measures are connected to interventions by including: infrastructure, service, and administrative measures, and measures identified by each participating entity. The performance measures are connected to the target population by measuring processes designed to impact target population needs; outcomes can only be achieved if the target population accesses services among participating entities determined by assessed needs.

Tracking and Documenting WPC Pilot Progress: The UOMS used by the Waiver Analytics Team will assist in

identifying participants, tracking utilization, providing input to PDSA processes, determining health outcomes, and monitoring project performance progress and metrics (see Section 4.2). The WPC Informaticist will track the project progress over time (trending) from data provided by participating entities through monthly UOMS reports. Gold Coast Health Plan, UOMS, PDSA, and Care Coordination reports will inform project monitoring. The WPC Administrative Assistant will prepare monthly performance measure reports to enable tracking by the Project Director. Monthly WPC Project Reports will be derived from multiple data sources and will be used to report to the collaborative and the leadership team at meetings, where performance will be evaluated. VCHCA will submit mid-year and annual reports in alignment with Attachment GG to document progress, identify barriers and challenges, and outline how successes were achieved.

Tracking and Documenting Participating Entity Progress: Participating entities will be required to document service utilization and outcomes through the Community Partner platform, which feeds directly to the Care Coordination platform data registry. Tracking will occur monthly and be included in the WPC Project Reports.

4.1.a Universal Metrics

Health Outcomes Measures

Administrative Measures

WPC Pilot Goals: VCHCA will align the pilot’s universal metric goals with DHCS’s evaluation requirements. Preliminarily, VCHCA proposes the following goals:

Metric i. Health Outcomes Goal i.1: ED visits will maintain baseline measurements in project Year 2, be reduced among enrolled participants by at least 10% from baseline in project Year 3, will be reduced at least 15% from baseline in Year 4, and will be reduced at least 20% from baseline in project Year 5. (Adults and total only. No children in the project.) (Pay for Outcome metric.)

Metric i. Health Outcomes Goal i.2: ED visits will maintain baseline measurements in project Year 2, be reduced among enrolled participants by at least 15% from baseline in project Year 3, will be reduced at least 20% from baseline in Year 4, and will be reduced at least 25% from baseline in project Year 5. (Adults and total only. No children in the project.) (Pay for Outcome metric.)

Metric i. Health Outcomes Goal i.3: ED visits will maintain baseline measurements in project Year 2, be reduced among enrolled participants by at least 20% from baseline in project Year 3, will be reduced at least 25% from baseline in Year 4, and will be reduced at least 30% from baseline in project Year 5. (Adults and total only. No children in the project.) (Pay for Outcome metric.)

Metric i. Health Outcomes Goal i.4: At least quarterly, the ED visit metric will be measured for enrolled participants. A PDSA cycle will be used to make changes and measure ED visit results. (Pay for Reporting metric.)

Metric ii. Health Outcomes Goal ii.1: Inpatient utilization will maintain baseline measurements in project Year 2, be reduced among enrolled participants by at least 10% from baseline in project Year 3, and will be reduced at least 15% from baseline in project Year 4, and will be reduced at least 20% from baseline in project Year 5. (Adults and total only. No children in the project.) (Pay for Outcome metric.)

Metric ii. Health Outcomes Goal ii.2: Inpatient utilization will maintain baseline measurements in project Year 2, be reduced among enrolled participants by at least 15% from baseline in project Year 3, and will be reduced at least 20% from baseline in project Year 4, and will be reduced at least 25% from baseline in project Year 5. (Adults and total only. No children in the project.) (Pay for Outcome metric.)

Metric ii. Health Outcomes Goal ii.3: Inpatient utilization will maintain baseline measurements in project Year 2, be reduced among enrolled participants by at least 20% from baseline in project Year 3, and will be reduced at least 25% from baseline in project Year 4, and will be reduced at least 30% from baseline in project Year 5. (Adults and total only. No children in the project.) (Pay for Outcome metric.)

Metric ii. Health Outcomes Goal ii.4: At least quarterly, number of inpatient encounters and lengths of stay will be measured for those enrolled in the project. PDSA will be used to measure and make changes to improve the inpatient utilization metric. (Pay for Reporting metric.)

Metric iii. Health Outcomes Goal iii: Participants will have a follow-up visit within 30 days of discharge among those who had an ED visit with a primary diagnosis of mental illness. The follow-up visit will be an outpatient visit, intensive outpatient encounter, or partial hospitalization with a primary diagnosis of a mental health disorder and/or to a behavioral health facility. The goal will be to maintain baseline measurements in project Year 2, be improved among enrolled participants by at least 5% from baseline in project Year 3, will be improved by at least 10% from baseline in project Year 4, and will be improved at least 15% from baseline in project Year 5. (Adults and total only. No children in the project.) (Pay for Outcome metric.)

Metric iv. Health Outcomes Goal iv.1: Participants with a new episode of alcohol or other drug (AOD) dependence initiate treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter, or partial hospitalization within 14 days of the diagnosis. The goal will be to maintain baseline measurements in project Year 2, be improved among enrolled participants by at least 5% from baseline in project Year 3, improved by at least 10% from baseline in project Year 4, and will be improved at least 15% baseline in project Year 5. (Adults and total only. No children in the project.) (Pay for Outcome metric.)

Metric iv. Health Outcomes Goal iv.2: Participants with a new episode of alcohol or other drug (AOD) dependence who initiated treatment and who had two or more additional services with a diagnosis of AOD within 30 days of the initiation visit. The goal will be to maintain baseline measurements in project Year 2, be improved among enrolled participants by at least 5% from baseline in project Year 3, be improved at least 10% from baseline in project Year 4, and be improved at least 15% baseline in project Year 5. (Adults and total only. No children in the project.)

Metric v. Health Outcomes Goal v.1: At least 60% of participants will have a comprehensive care plan, accessible by the entire care team, within 30 days of enrollment into the WPC Pilot. (Incentive metric)

Metric v. Health Outcomes Goal v.2: At least 80% of participants will have an updated comprehensive care plan, within 30 days of the participant's anniversary of participation in the pilot (to be conducted annually). (Incentive metric)

Metric v. Health Outcomes Goal v.3: At least quarterly, PDSA will be used to measure and make changes about the comprehensive care plan metric. (Pay for Reporting metric)

Metric vi. Administrative Metric Goal vi.1: No later than July 1, 2017, the Lead Entity will 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 participant case management. (Pay for Reporting metric)

Metric vi. Administrative Metric Goal vi.2: No later than July 1, 2017, the Lead Entity will develop and implement monitoring procedures for oversight of how the policies and procedures for care coordination, case management, and referral policies are operationalized. (Pay for Reporting metric)

Metric vi. Administrative Metric Goal vi.3: At least quarterly, the Lead Entity will review monitoring procedures for care coordination, case management, and referral policies to determine if any needed modifications to the monitoring procedures are needed. (Pay for Reporting metric)

Metric vi. Administrative Metric Goal vi.4: At least semi-annually, PDSA will be used to measure and make changes about the monitoring procedures for care coordination, case management, and referral policies metric. (Pay for Reporting metric)

Metric vi. Administrative Metric Goal vi.5: No later than July 1, 2017, the Lead Entity will develop a method to compile and analyze information and findings from the monitoring procedures for care coordination, case management, and referral policies and procedures; and will develop a process to modify the policies and procedures for care coordination, case management, and referral policies in a streamlined manner and within a reasonable timeframe. (Pay for Reporting metric)

Metric vii. Administrative Metric Goal vii.1: No later than July 1, 2017, the Lead Entity will submit documentation demonstrating the establishment of data and information sharing policies and procedures across the WPC Pilot lead and all participating entities which provide for streamlined participant case management. (Pay for Reporting metric)

Metric vii. Administrative Metric Goal vii.2: No later than July 1, 2017, the Lead Entity will develop and implement monitoring procedures for oversight of how the policies and procedures for data and information sharing are operationalized. (Pay for Reporting metric)

Metric vii. Administrative Metric Goal vii.3: At least quarterly, the Lead Entity will review monitoring procedures for data and information sharing policies and procedures to determine if any needed modifications to the monitoring procedures are needed. (Pay for Reporting metric)

Metric vii. Administrative Metric Goal vii.4: At least semi-annually, PDSA will be used to measure and make changes about the monitoring procedures for the data and information sharing policies and procedures metric. (Pay for Reporting metric)

Metric vii. Administrative Metric Goal vii.5: No later than July 1, 2017, the Lead Entity will develop a method to compile and analyze information and findings from the monitoring procedures for data and information sharing policies and procedures; and will develop a process to update the data and information sharing policies and procedures in a streamlined manner and within a reasonable timeframe. (Pay for Reporting metric)

4.1.a Variant Metrics

The variant metrics were selected in accordance with the WPC Variant Metric Template. Metric goals are designed to provide aggressive benchmarks that will optimize project pilot valuation.

| Variant Metrics | PY 1 | PY 2 | PY 3 | PY 4 | PY 5 |
|--|-------------|-------------------|-----------------|------------------|------------------|
| <i>Administrative Metric:</i> Percentage of CHWs receiving quarterly in-service training based on gaps identified through field work via PDSA improvement cycles. | N/A | 60% | 65% | 70% | 75% |
| <i>Health Outcome Metric. Diabetes:</i> Percentage of patients 18 - 75 years of age with Diabetes (type 1 or type 2) who had Hemoglobin A1c <8.0% during the measurement period. | N/A | Maintain Baseline | +5% of baseline | +10% of baseline | +15% of baseline |
| <i>Depression Remission at Twelve Months:</i> Percentage of adult patients age 18 and older with major depression or dysthymia and an initial PHQ-9 score > 9 who demonstrate remission at twelve months defined as PHQ-9 score less than 5. (NQF 0710) | N/A | Maintain Baseline | +5% of baseline | +10% of baseline | +15% of baseline |
| <i>Adult Major Depression Disorder (MDD): Suicide Risk Assessment:</i> Percentage of patients aged 18 years and older with a diagnosis of major depressive disorder (MDD) with a suicide risk assessment completed during the visit in which a new diagnosis or recurrent episode was identified. (NQF 0104) | N/A | Maintain Baseline | +5% of baseline | +10% of baseline | +15% of baseline |
| <i>Housing – Specific Metric:</i> Percentage of homeless receiving housing services in the project year that referred for housing services. | N/A | 50% | 55% | 60% | 65% |
| <i>Optional Metric:</i> Percentage of participants who have at least six encounters with a CSW during the project year. | N/A | 50% | 55% | 60% | 65% |

4.2 Data Analysis, Reporting and Quality Improvement

Data Collection: Data collection will be consolidated into the Utilization and Outcome Monitoring System (UOMS) data warehouse to determine the effectiveness of service strategies and the impact they have on participants’ health outcomes. This central repository used for data analysis and reporting will derive its data from the CC platform data repository, EHR, and health registry. A standardized data collection procedure and protocols through standardized forms, data variables, and system data entry requirements will be developed to ensure data validity. A separate database will collect project fiscal, staffing, infrastructure development, and other administrative data, such as income/expense statements, project monitoring, PDSA data, etc.

Reporting: Reporting will occur through standardized reports from the CC platform and UOMS data warehouse utilizing dashboards. These reports will inform data analysis processes and the development of the monthly WPC Project Status reports, PDSA reports, DHCS reports, and WPC fiscal reports, among other reports. For the DHCS mid-year and annual reports, the project will report on all Universal and Variant metrics, and describe early trends, potential explanations, and plans to incorporate lessons into a continual cycle of performance

improvement (using a PDSA methodology) during project years 2 and 3. In project years 4 and 5, the project will additionally report on the direction of the changes shown in the health outcomes data, if changes are in the predicted direction, what contributed to the improvement or hindrance, and how interventions will be adapted to improve performance. Collaborative reporting will take place at monthly meetings where WPC Project Status reports will be presented, through email updates, and through quarterly trainings. Project reports will also be used to inform stakeholders and other national pilot project managers through the WPC learnings (see Section 2.2).

Analysis: Analysis will occur on multiple levels to ensure that the project is being implemented as intended and that the quality improvement procedures (PDSA) optimize the quality of care. The WPC Informaticist, with support from the Data Analytics Team, will analyze the data to determine outliers or negative trends, and report the analyses to the Project and Medical Directors and Care Managers. Data analysis will be conducted by: 1) comparing data and to quality improvement goals, metrics, performance goals, and DHCS expectations; 2) examining the underlying causes behind the data collected; 3) comparing results to standardized measures/goals (i.e., HEDIS, Health People 2020); 4) comparing trends by monitoring results over time; 5) collecting additional data as needed; and 6) ensuring that the data is collected consistently, thoroughly, and in alignment with the data collection plan and protocols. Tools will assist in analytics, such as the use of run and control charts to understand variation, *Lean (Six Sigma) processes*³⁵ and tools, and trending charts. VCHCA will work with the independent evaluator to adapt the data analysis design and incorporate any additional data variables that will measure the six evaluation requirements of the pilot program.

Data analysis will also be instrumental in developing the sustainability plan once the five-year pilot project is complete. Much of sustainability funding is expected to come from dramatic cost savings derived from diminished utilization of systems and technology enabled platforms developed for decision support. Estimates of the annual public sector costs of an “average” high-utilizing homeless individual are as high as \$150,000 but vary depending on population criteria and methodology.³⁶ Well over half of these costs are consistently determined to be incurred by health systems.³⁷

Existing and New Data Sources: Existing data sources are the EHRs, VCHCA administrative database (i.e., employment records and clinical/hospital QI), fiscal database, and Gold Coast Health Plan beneficiary outcome and utilization database. New data sources will include the CC platform; Community Partner platform; UOMS; WPC Project Status database (i.e., staff training, infrastructure development status, and collaborative records); and the Health Registry.

Data Capacity Timeline: Data capacity will be developed in year 2, quarters 1 and 2 to enable the project services to launch in the 3rd quarter (see Section 3.2).

Quality Improvement/Change Management Approach: The project will utilize and report PDSA processes and changes, which will not only be used for Universal and Variant metrics, but also to inform quality improvements throughout the project. As indicated in Attachment MM, the pilot will utilize the DHCS

³⁵ Mahalik P. (2016.) *Learning to Think Lean: Six Steps with Review Points*. iSixSigma. Available at: <https://www.isixsigma.com/methodology/lean-methodology/learning-think-lean-six-steps-review-points/>.

³⁶ Cantor, 2015.

³⁷ Culhane DP, Parker WD, Poppe B, et al. (2007.) *Accountability, Cost-Effectiveness, and Program Performance: Progress since 1998*. Available at: <http://aspe.hhs.gov/hsp/homelessness/symposium07/culhane/>.

template's change-management plan, including a mechanism for identifying needed adjustments, a process for carrying out each change, a process for observing and learning from the implemented change(s) and their implications, and a process to determine necessary modifications to the change based on the study results and implement them. National agencies have extensively analyzed change management and quality improvement processes which are effective among Medicaid care collaboratives and providers.³⁸ The *Model for Improvement*³⁹ will be used for change management, which includes setting aims, establishing measures, selecting changes, testing changes, implementing changes, and communicating/disseminating changes. Quality improvement and change will use a team approach both for the collaborative and the pilot staff utilizing PDSA methods.

Identifying Needed Adjustments: The *Model for Improvement* identifies what change is needed by determining intended accomplishments, if the change is an improvement, and which changes will result in improvement. Reports from data collection will be analyzed by the WPC Informaticist, who will report statistical progress and any change in causal factors indicated from the data. *Root Cause Analysis* will assist in planning tests of change. *Change concepts* will be developed and focus on methods of correcting outliers or making other improvements, such as improving work flow, the participant interface with the project, and services, as well as managing time better, error proofing, etc. These concepts will be developed collaboratively through creative thinking techniques, brainstorming, affinity analysis, and evidence-based practice research. *Lean processes* that identify the "value" of potential changes will be utilized, including determining the necessity, cost, purpose of the change, and barriers to change, etc.

Value Stream Mapping will help identify the needed change and change concept, and ensure that the change will add value to the project and close the gap between expectations and the current status. Data to inform needed adjustments will be collected from a variety of sources. For example, the Gold Coast Health Plan HEDIS reports will inform metric improvements and field questions from CHWs will inform training improvements.

Carrying Out Change: The *Model for Improvement* approach includes two key concepts – incremental tests of change and benefits of testing changes before implementation. The PDSA cycle uses the scientific method for action-oriented learning by planning tests, evaluating change, observing the results, and acting on what is learned. Carrying out change involves planning: stating the objective, making predictions, developing a testing plan. This process is followed by carrying out the test and documenting problems and observations. PDSA tests will: be made under various conditions, be based on data over time, and use comparison studies and/or random sampling as applicable.

Observing/Learning from Change: The study of change will occur through the data collection, reporting, and analysis cycle. Data will be compared to predictions and results will be summarized and collaboratively reflected upon by stakeholders to determine if the implemented change was successful or if modifications are required. Linked PDSAs will be used to broaden the test of a change and ensure that special conditions are not missed during the observation phase, as indicated.

³⁸ Griffith K, Moore E, Berger C, Kennedy H, Martinez-Vidal E, Neese-Todd S, Crystal S, Finnerty M. (2014.) *Implementing a State-Level Quality Improvement Collaborative: A Resource Guide From the Medicaid Network for Evidence-Based Treatment (MEDNET)*. U.S. Department of Health and Human Services, Agency for Healthcare Research and Quality. AHRQ Publication No. 14(15)-0064-EF. Available at: <http://www.ahrq.gov/sites/default/files/wysiwyg/professionals/quality-patient-safety/quality-resources/tools/mednetresourceguide/mednetresourcedguide.pdf>.

³⁹ U.S. Department of Health and Human Services, Health Resources and Services Administration. (2016.) *Testing for Improvement*. Available at: <http://www.hrsa.gov/quality/toolbox/methodology/testingforimprovement/part2.html>.

Determining Change Modifications/Implementation: Change modifications will be accomplished through the application of a sequence of iterative PDSA cycles. The use of quantitative data at monthly or more frequent data intervals will inform the progression of cycles. The team will continue linking tests and refining the changes until new/modified strategies are ready for broader implementation. People are more willing to test for a change when they know the change(s) can and will be modified as needed. Linking small tests of change helps an organization to overcome its natural resistance to change and helps promote buy-in from the staff/stakeholders. An improvement tracking tool will be developed (similar to the Institute for Healthcare Improvement's [IHI] Improvement Tracker Tool⁴⁰) to enable the collaborative, staff, and stakeholders to see how each specific change has transformed the project.

4.3 Participant Entity Monitoring

Monitoring Participating Entities: Services and interventions provided by participating entities will be conducted under the parameters of the Letters of Agreement and/or contracts (as appropriate), and WPC bylaws, which will be established during project years 1-2. As the Lead Entity, VCHCA will ensure that participating entities' actions are aligned with the DHCS requirements, applicable state and federal laws, contracts, and the bylaws. The Community Partner platform will collect data about service utilization and outcomes coordination with the Integrated Care Plan entities outside of the VCHCA. This platform will communicate with the UOMS centralized dashboard that will monitor progress of all participating entities on predetermined metrics and goals. This will enable the Waiver Analytics Team, WPC Informaticist, and Project Director to monitor community partner participant services and outcomes in an integrated manner along with data from departments within the VCHCA. Monitoring will also occur through entity reports/presentations at WPC collaborative meetings, site visits, and fiscal reports.

Making Participating Entities Adjustments: In alignment with Attachment HH and the requirements for lead entities, Letters of Agreement/contracts will specify similar requirements for participating entities to hold them equally accountable for the success of the pilot. Participating entities will also work collaboratively with VCHCA in change management surrounding the overall pilot and its individual components utilizing PDSA methods. PDSA will inform any adjustments needed among participating entities (see Section 4.2).

Providing Technical Assistance: If a deficiency is identified by the VCHCA through the entity's progress reports, the status of performance measure accomplishment, or other means, VCHCA will provide technical assistance to the participating entity. Technical assistance will consist of site visits, re-education of pilot requirements, review of Letters of Support/contracts, problem-solving coordination, PDSA methods for quality improvement, data support staff assistance, and other methods as determined by the nature of the problem. DHCS technical assistance will be requested if needed.

Imposing Corrective Action: Ventura County has an extensive history of facilitating collaborative partnerships to benefit the population. VCHCA values these relationships and will make every effort to ensure that partners are aligned with pilot requirements. However, VCHCA will not allow the deficiencies of a participating entity to endanger accomplishment of project goals or effectiveness of services to participants. In alignment with Attachment HH, if the participating entity continues to demonstrate poor performance/deficiencies, a corrective action plan (CAP) will be developed and submitted to DHCS. The CAP will be developed in partnership between the participating entity and the lead entity, with final approval required by both. The CAP will include specific

⁴⁰ Institute for Healthcare Improvement. (2016.) *Improvement Tracker*. Available at: <http://app.ihl.org/Workspace/tracker/>.

milestones and timelines for improvement. The Project Director will examine CAP progress reports prepared by the participating entity to determine if milestones are being reached.

Termination: If substantial progress has not been made in achieving CAP milestones, participating entities will be subject to a reduction in service provision (to be replaced by other entities as applicable) or termination. The decision to terminate a participating entity will only be made with DHCS approval, and all participating entities will be notified. Similar to pilot termination, VCHCA provide a 30-day notice to the participating entity. VCHCA will develop a close-out plan that incorporates similar elements as those discussed in Attachment HH designed to protect beneficiaries from the impact of the termination, such as notification of all pilot participants of changes, pilot benefits, etc.

Section 5: Financing

5.1 Financing Structure

Financing Structure of the WPC Pilot: The VCHCA Finance Department (Lead Entity's department) will assign a Waiver Financial Manager to the WPC project and serve as the project's fiduciary agent, operating in coordination with the Project Director. The department will initiate inter-governmental transfer (IGT) transactions, account for funds received from DHCS, maintain funds, distribute payments among the participating entities, and produce timely reporting on financial transactions, balances, and metrics.

Distribution of Pilot Payments: The pilot will distribute payments to the participating partners using a combined approach of Fee-For-Service (FFS), bundled service payments, pay for reporting and outcomes, and incentives as documented by contracts between the parties. Each partner's requirements will be delineated in MOUs and/or contracts as appropriate, specifying the metrics, objectives, payments, timing, monitoring, reporting, and corrective procedures necessary. The metrics and objectives achieved will be documented with a ledger of payments disbursed and reported to the WPC Leadership Team and to the DHCS.

Financing Arrangements: The agreements between the Lead Entity and the community partners will be structured to accommodate the IGTs and funding flows between the pilot funding and the DHCS. The Leadership Team may authorize distributions under contract to a participating entity in advance of funding received from the DHCS if required, which will be funded using an internal transfer to the WPC pilot fund from the Ventura County General Fund, and repaid upon DHCS funding.

Savings Arrangements: Savings generated through the project may be used to fund expansion activities as determined by the Leadership Team, following the guidelines of DHCS for permissible uses of generated savings, and will be reported to the DHCS as part of the required reporting cycle.

Oversight and Governance: The WPC Collaborative, guided by the Lead Entity, will draft, review, and accept bylaws and procedures during years 1-2. These bylaws will the process for confirming the amounts of IGTs, accepting/certifying the payment requests received from participants, handling/reporting any financing and savings amounts, and matching payment requests from entities against the entities' metrics, goals, and required reporting. The finance section of the bylaws will outline timing and procedures to review income and expense statements, auditing requirements, and other checks and balances in alignment with generally accepted accounting principles (GAAP). Fiscal oversight will be accomplished by the Waiver Financial Manager, CFO, Project Director, and the Collaborative, with specific oversight responsibilities assigned to each.

Payment Timeline: Processes incorporated into the WPC Collaborative's bylaws and procedures will determine the timing of the acceptance, review, and payment of invoices from participants. Shortly after the award, and each year during the pilot's operation, when notified by DHCS or according to scheduled timelines, the Lead Entity will prepare a total annual request amount that specifies budgeted payments for each proposed funded element, including infrastructure, data collection, interventions, and outcomes. The Lead Entity will also include a report on all projected payments

(amounts and timing) during the current period and will prepare an IGT to the upon DHCS notification.

Payment Structure: Each participant's payment structure, whether FFS, PMPM/bundled service payments, pay for reporting/outcomes, incentives, or other arrangements in combination, will be set forth by agreement and accessible to the Finance Department to validate each payment request. Each partner's objectives and metrics will be outlined in MOUs and/or contracts as appropriate.

Payment Process: In alignment with governance requirements, the Finance Department will issue payments either timed with the receipt of funds from DHCS, or paid by invoice in accordance with both procedures and contracts. The Finance Department will coordinate with the Lead Entity and Leadership Team concerning metric certification that must be met prior to the payment being disbursed. Payments for PMPM bundles will be made according to the schedule determined by the collaborative bylaws and procedures, including review of associated requests and reports of metrics being met.

Payment Tracking: The Finance Department will keep segregated accounting of IGTs, funds received from the DHCS, and all funds disbursed to participating entities. Reporting of these amounts and identifying specific payments to entities by reporting period will be part of the annual audits and be made available to the DHCS. The Leadership Team will conduct quarterly reviews, and the Project Director monthly reviews, of payment dispersal.

Payment Infrastructure: The VCHCA Finance Department is well structured currently to act as fiduciary and disburser of funds for the WPC project. Any new capabilities necessary and appropriate to tie metrics/performance goals into the disbursement process will be specified and developed during project Year 1. A Waiver Financial Manager will support accounting and payment tracking.

Ensuring Funding Sufficiency: Funding sufficiency will be ensured by segregated accounting that incorporates the IGT outbound funds, receipts from DHCS, payments to participants, and accumulation of savings. Disbursement prior to the receipt of funds will be done only under circumstances dictated in the collaborative bylaws and procedures, and reviewed prior to disbursement. Budget-versus-actual comparisons will be distributed at least monthly to the Project Director, who will refer any possible over-expenditures to the Leadership Team and initiate corrective action, if necessary.

Approaching Value-Based Payment Systems: The VCHCA is already in the process of implementing a value-based payment system through a CMS Health Care Innovation Award project focusing on COPD patients. This hybrid payment model uses an innovative design providing a bundled "front end" to CMS/non-CMS payers, while structuring payouts to providers specific/appropriate to the care setting. The pilot's contractual relationships with participating entities will be structured to encourage such designs. By favoring pay for performance over fee-for-service structures, the project will both meet the requirements of the DHCS and will expand the adoption of value-based payment options across the health/behavioral health care systems' programs. Financing and payment approaches will help participants to better prepare for future roll-outs through the project's wrap-around nature that provides better care and greater access. Participants will be taught about the value-based payment systems used, emphasizing the greater access to care provided by such approaches and the broad array of services made available for prevention, assistance, and interventions in the issues faced by

the target population.

5.2 Funding Diagram

Funding Diagram Attached: See Attachment H: Funding Diagram reflecting the flow and disbursement of funds from the DHCS through the Lead Entity's Finance Department with oversight from the WPC Leadership Team.

5.3 Non-Federal Share

Non-Federal Share: Funding for IGT remissions to the DHCS will be derived from the following non-federal entities and sources:

1. County of Ventura government activities including Public Protection, Public Ways and Facilities, Health and Sanitation Services, Public Assistance, and Education.
2. Business-type county entity sources including the Medical Center, Department of Airports, Waterworks Districts – Water and Sewer Divisions, Parks Department, Channel Islands Harbor, the County Health Care Plan, and the Oak View District.
3. Citizens, local businesses, and non-profit organizations will provide substantial direct revenue in the form of taxes, fees, grants, and disbursements.

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

WPC Pilot and VCHCA Services: The funding associated with the WPC pilot will augment the services provided by the VCHCA's two hospitals, 19 FQHC clinics, and broad array of departments serving and caring for Ventura County residents. The model not only connects high-utilizing patients to care-giving solutions, it also connects the many departments, partners, and community resources into a unified, integrated, coordinated system that will deliver high quality care. The model will influence health care provision to high-risk populations, integrating the clinic staff, CCT, and new technology that includes a Care Coordination platform aligned with a platform for community partners meeting PHI/PI requirements, a secure real-time messaging system, a health registry, eReferral, and a data warehouse. This integrated approach to system-wide delivery of needed health care, behavioral health, and social supports will influence the model of service delivery across systems throughout the county. This affect will catapult future endeavors for countywide collaboration and care coordination to unite public and private resources for the benefit of high-risk populations.

Payment Compliance with STC 113: The Lead Entity will ensure that the provisions of STC 113 will be followed assiduously, including: 1) infrastructure to integrate services among local entities that serve the TP; 2) services not otherwise covered or directly reimbursed by Medi-Cal to improve care for the TP, such as housing components; and 3) other strategies to improve integration, reduce avoidable health care services utilization, and improve health outcomes. The collaborative focused on provisions 1-3 during project design planning to ensure that the project's architecture met DHCS's expectations. Provision 2 will guide the Waiver Financial Manager in the tracking and disbursement of payments to the participating entities as they meet performance targets. The Finance Department currently manages the billing and receipt of Medi-Cal-related payments, and is ideally positioned to ensure that the funds for the IGTs associated with the WPC pilot are

appropriately sourced and in compliance with STC 113 and with WPC pilot requirements.

Non-Duplication of Payments: The Finance Department will avoid duplication of payments through its central position as the project fiduciary, its management of all payment activities of the VCHCA, and its full understanding and management of the payments to and receipt of funds from all private, federal, and state funds including Medi-Cal. The Waiver Financial Manager will review records of payments prior to disbursement to ensure that each payment to any participating entity is matched to invoices aligned to funding requirements.

Targeted Case Management Non-Duplication of Services: As indicated in Section 3.1, Targeted Case Management Program Overlap, there are few anticipated activities and interactions of the care coordination teams that would duplicate Medi-Cal's targeted case management (TCM) benefit due to the nature of the specific target population and planned interventions. Specifically, centralized care coordination Care Manager infrastructure, web-based Integrated Care Plan, infrastructure that provides technology-assisted care coordination, and risk stratification methods for identifying participants depart significantly from the encounter-based structure of TCM. In cases when there are encounters between the CHWs and Engagement Teams with the participants, the service would not be eligible for reimbursement under TCM, as the CHWs and outreach staff would not meet the education/experience requirements for TCM case workers or the Nurse Practitioner would be in a supervisory role and would have few, if any, direct contact with clients. 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 peer support, trust-building, motivational interviewing, disease specific 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 transitional housing support services. For these reasons, the budget has accounted for a 5% overlap. Medi-Cal TCM is not currently operating in Ventura County, and its services are in the planning stage. An anticipated launch date is still to be determined.

The plan to eliminate duplication of services between the two programs once Targeted Case Management is launched is by integrating alerts into the Health Registry when a potential participant is about to be dually enrolled. Other mechanisms will also be established in the identification and enrollment process, including key questions on the Integrated Assessment form. The lead Care Coordination Manager of the CCT will be responsible for identifying targeted individuals, reviewing the Health Registry to determine if identified potential participants are utilizing Targeted Case Management services prior to enrollment, working with the Targeted Case Management Program Administrator to ensure that all persons at risk are being served by one or the other program as applicable based on their condition in alignment with the specified and divergent eligibility of the target populations to the two programs, and conducting PDSA processes focused on avoiding duplication of services in Whole Person Care and Targeted Case Management programs.

Federal Financial Participation Limited to Medi-Cal Beneficiaries: Only Medi-Cal beneficiaries will receive direct benefits from the requested through pilot funding. The beneficiary identification and enrollment process ensures that only beneficiaries are identified as potential participants.

5.5 Funding Request

Please see the attached Budget Narrative in the file labeled VCHCA WPC Budget Narrative.

Section 6: Attestation

The original attestation has been removed. This attestation is superseded by the revised attestation included in the agreement.

Attachments Table of Contents

Attachment A: Concept Diagram

Attachment B: Workflow Diagram

Attachment C: WPC Vulnerability Index

Attachment D: Ventura County Services Accessible by WPC Participants

Attachment E: Organizational Structure

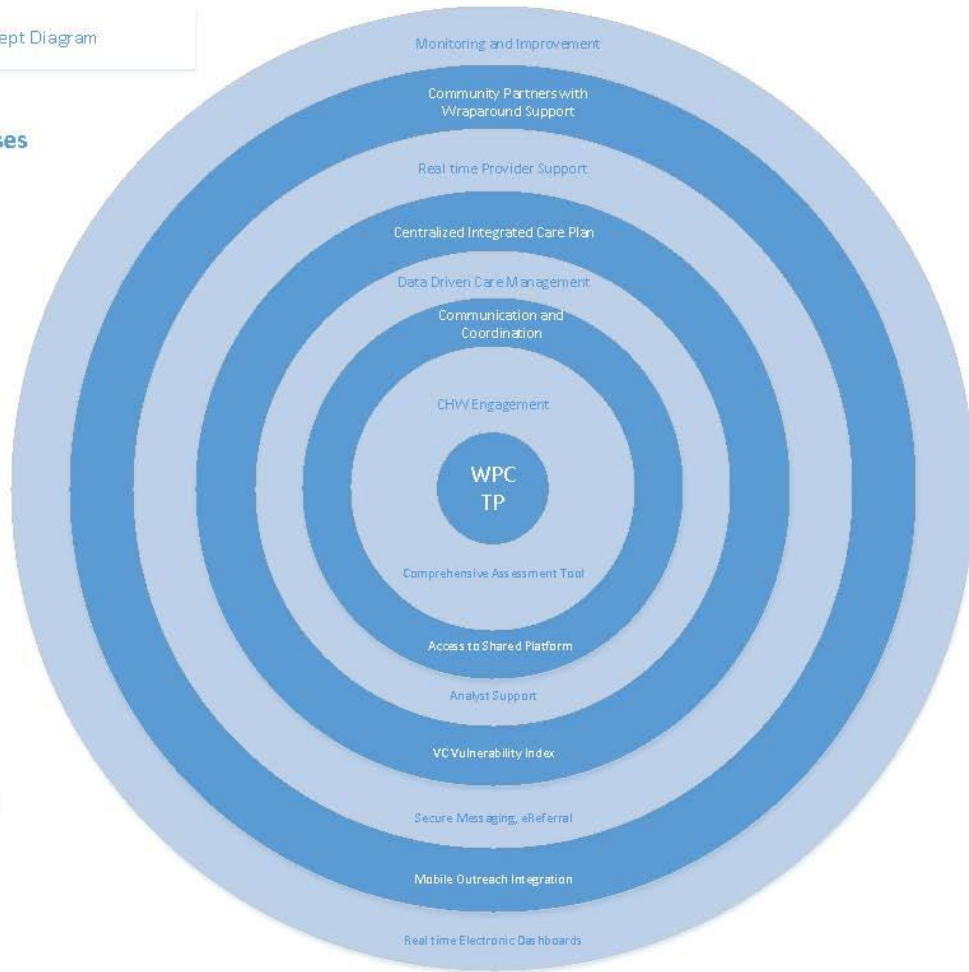
Attachment F: Identification and Enrollment Diagram

Attachment G: Data Sharing Structure

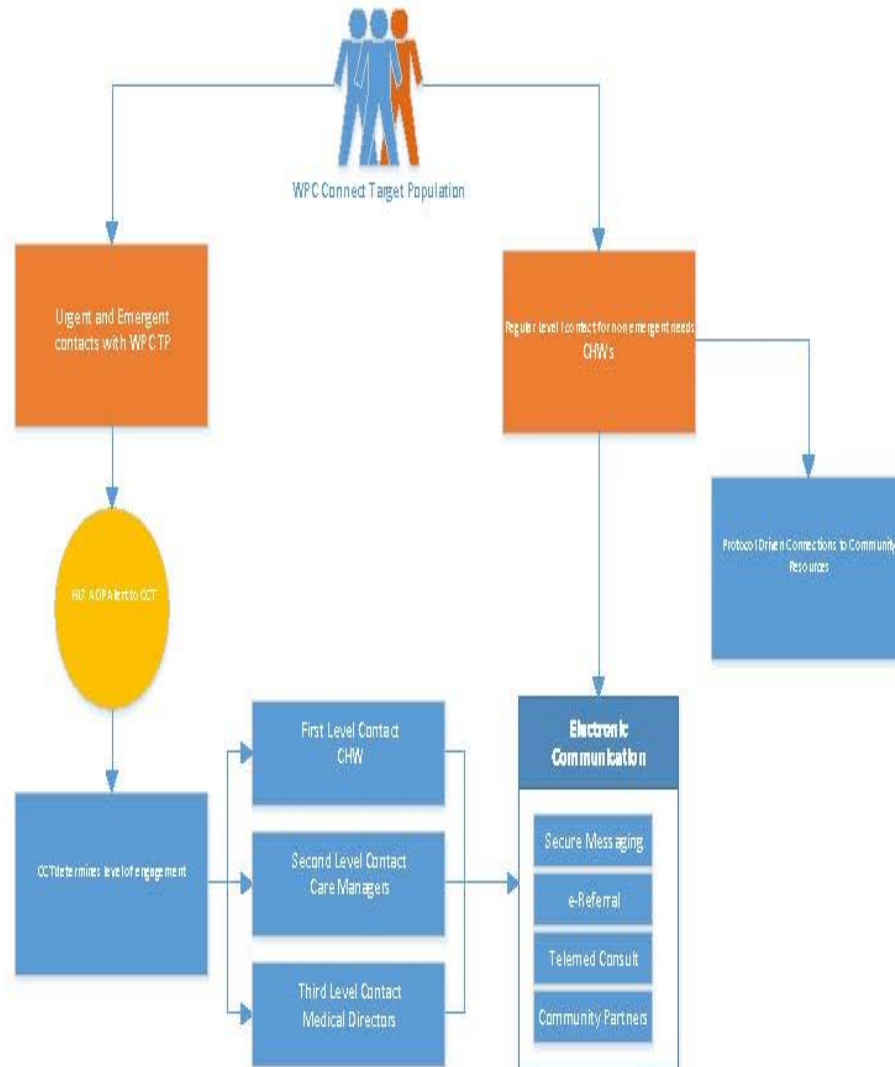
Attachment H: Funding Diagram

Processes

Tools



Attachment B: VCHCA WPC Connect Workflow



Attachment C: Ventura County Whole Person Care Vulnerability Index

VCM

Vulnerability will be scored based on risk factors that place individuals at heightened risk for poor health outcomes. These factors will be weighted to stratify risk for priority in project enrollment among identified high utilizers.

3 points: Condition with significant threat to life or public health

1. Kidney disease / End Stage Renal Disease or Dialysis
2. Heart disease, Heart Surgery, Heart Failure
3. Liver disease or Cirrhosis
4. Cancer
5. HIV/ AIDS

2 points: Major condition with increased potential for harm

1. Homelessness
2. Age 60+
3. Physical mobility problems/Joint Disorders
4. Legally blind or deaf
5. Diabetes
6. Hepatitis C
7. COPD
8. Stroke

1 point: Health concern requiring management

1. 3 or more ER visits and/ or admissions in 3 months
2. Tuberculosis
3. Asthma
4. Mental health diagnosis
5. Substance abuse
6. Trimorbidity (health, mental health, substance abuse)
7. Hypertension

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| <p>Thousand Oaks - Lutheran Social Services 80 E. Hillcrest Dr #101..... 497-6207</p> <p>MEALS (also see Food) Simi Valley - Samaritan Center (call for info) 280 Royal Ave..... 579-9186</p> <p>Thousand Oaks - Lutheran Social Services 80 E. Hillcrest Dr #101 (call for info)..... 497-6207</p> <p>MEDICAL • Health Care for the Homeless..... 652-6694</p> <p>Countywide • Children's Medical/Dental Services..... 652-5960 • WIC (women, infants, children)..... 1-800-413-2611</p> <p>Moopark • Family Care Center - 35 W. Los Angeles Ave. 529-6264</p> <p>Simi Valley • Public Health Department 650 E. Los Angeles Ave..... 579-3675 • Sierra Vista Family Care Center 127 E. Los Angeles Ave..... 582-4000 • Free Clinic of Simi Valley - 2050 Tago St. (Tuesdays, 9 a.m. - 1 p.m.)..... 522-3733 • Simi Valley Hospital - 2975 Sycamore Dr..... 955-0000</p> <p>Thousand Oaks • Conejo Valley Family Medical Group 125 W. Thousand Oaks Blvd. #300..... 481-9100 • Los Robles Hospital - 215 W. Janss Rd..... 497-2727 • Westminster Free Clinic - at the United Methodist Church - 1000 E. Janss Rd. (Wednesdays, 4 - 9 p.m.)..... 241-8366</p> <p>MENTAL HEALTH Countywide • Adult Crisis Team - 24 hour..... 1-866-998-2243 • Mental Health Liaison..... 981-4227 • Bilingual Mental Health Liaison..... 981-3331 • NAMI (support / advocacy)..... 641-2426 • RISE Team / CO Line..... 981-4233 • STAR (Access to Mental Health Services)..... 1-866-998-2243</p> <p>Simi Valley • Ventura County Behavioral Health Clinic 1227 E. Los Angeles Ave. - (also sees Moorpark)..... 582-4075</p> <p>Thousand Oaks • Conejo Behavioral Health Clinic 72 Moody Ct..... 777-3500</p> | <p>SENIOR CITIZENS SERVICES • 24-hour Helpline..... dial 211 • Adult Protective Services (abuse/neglect)..... 654-3200 • Area Agency on Aging 646 County Square Dr. #100, Ventura..... 477-7300 • Mental Health, Older Adult Services..... 777-3500 • Ombudsman Services (nursing homes)..... 656-1586 • Senior Nutrition (meal site info)..... 477-7300</p> <p>SHELTERS Domestic Violence Shelters • Coalition for Family Harmony..... 656-1111 Spanish Hotline..... 1-800-300-2181 • Interface Children & Family Services..... 1-800-339-9597</p> <p>Year-round Shelters There are no year-round shelters in the Simi-Conejo area • Lighthouse - (women & children) Oxnard..... 385-7200 • Rescue Mission - (men only) 234 E. 6th St., Oxnard..... 487-1234 • Turning Point Foundation - Our Place Shelter (mentally ill) 538 E. Thompson Blvd., Ventura..... 652-2551</p> <p>Winter Shelters • Simi Valley - P.A.D.S. (November - April) - call for information 579-9186 • Thousand Oaks - Conejo Valley Winter Shelter (December - March) - call for information..... 497-6207</p> <p>SHOWERS/TOILETS • Rescue Mission - 234 E. 6th St., Oxnard..... 487-1234 • Samaritan Center - 280 Royal Ave., Simi Valley Monday - Thursday, 9 a.m. - noon..... 579-9186 • Lutheran Social Services (Monday - Friday, 9 a.m. - noon) 80 E. Hillcrest Dr. #101, Thousand Oaks..... 497-6207</p> <p>TRANSITIONAL HOUSING • RAIN Transitional Living Center (families & singles) Camarillo - Applications call..... 382-7925 • Sarah's House (Maternity Home)..... 581-1510 • Tender Life (Maternity Home)..... 653-7471 • Veteran Transitional Housing (Ventura)..... 652-0000 x102</p> <p>VETERANS' SERVICES • County of Ventura Veteran Services 5740 Rakston St. #300, Ventura..... 477-5155 • Department of Veterans Affairs - Outpatient Clinic Veterans Center - Counseling Services Monday - Friday, 8 a.m. - 4:30 p.m. 4400 Calle Real, Santa Barbara..... (805) 683-1491</p> | <p>• Disabled Veterans Outreach (EDO)..... 582-8763 • Oxnard VA Outpatient Clinic 2000 Outlet Dr. Dr. #225, Oxnard..... 604-6960 • Ventura Vet Center (Counseling) 790 E. Santa Clara St. #1000..... 585-1860 • Veteran's Home of Ventura..... 659-7502 • Veteran Transitional Housing (Ventura)..... 652-0000 x102</p> <p>YOUTH SERVICES • Interface Youth Crisis Line / Shelter..... 469-5882 • Interface Youth Services Drop-In Center Monday - Friday, 2 - 6 p.m. 260 W. 4th St., Oxnard..... 469-5882 • Independent Living Program (former Foster Youth) • Pacific Clinics, Transition Age Youth (TAY Tunnel) 141 W. 5th St., #D, Oxnard..... 240-2538 • Teen Runaway Helpline..... 1-800-RUN-RUN • Transitions (VC Behavioral Health)..... 1-866-998-2243</p> |
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**Resources
for Homeless People
Eastern
Ventura
County**

Moorpark • Simi Valley
Thousand Oaks

Most of the agencies listed can offer only limited, temporary services, dependent on available funds. Refer to the Western Ventura County Resources brochure for resources available in other regions of the County.



County of Ventura
This brochure was prepared by
County of Ventura • Human Services Agency
Homeless Services Program
(805) 385-1800
www.vchsa.org

This information current as of
May 2016

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| <p>ALCOHOL & DRUG SERVICES • 24-hour Helpline..... dial 211 • County Alcohol/Drug Line..... 981-8200 • Alcoholics Anonymous - Countywide Info..... 389-1444 • Alonon..... 495-0270 • Simi Valley Center - 3150 Los Angeles Ave..... 575-1724 • Khepera House (men) Treatment..... 653-2596 • Lighthouse Recovery (Oxnard)..... 385-7200 • Palmer Drug/Alcohol Abuse Program..... 482-1265 • Prodigies (women/children)..... 382-6296 • Rescue Mission (men) - 234 E. 6th St., Oxnard..... 487-1234 • Salvation Army - Caroga Park/ARC..... (818) 983-6121 • Teen Challenge..... 648-3295 • Victory Outreach..... 388-4182</p> <p>BENEFITS • Human Services Agency (CalWORKS, General Relief, CalFresh (Food Stamps), Medi-Cal) Simi Valley - 2900 N. Madera Rd..... 584-4842 Moopark - 6128 Spring Rd. #301..... 523-5444</p> <p>Thousand Oaks 80 E. Hillcrest Dr. #200..... 449-7320 • Social Security - Countywide Registration..... 1-800-772-1213 T.O. Office - 322 E. Thousand Oaks Blvd..... 1-888-367-4807 • Unemployment Benefits Claims English..... 1-800-300-5616 Spanish..... 1-800-326-8937</p> <p>BUS • ADA/Dial-A-Ride..... 983-6464 • Camarillo Area Transit..... 988-4228 • Gold Coast Transit - Countywide Transportation Information..... 1-800-438-1112 • Greyhound Bus..... 1-800-231-2222 • Simi Valley Transit..... 583-6456</p> <p>CAMPGROUNDS • County Park Information..... 654-3951 • State Park Info..... 968-1033 / 1-800-444-7275</p> <p>Camping Fillmore - Kenny Grove - 823 N. Oak..... 524-0750 Santa Paula - Shekelle Park - 8080 Modetote Rd. 654-3951 • Short-Term Camping (14 days maximum) Moopark - Oak Park - 901 Quamesa..... 654-3951 Oxnard - McGrath St Beach - 2211 Harbor Blvd Ventura - Emma Wood - Rincon Parkway, Hwy 1..... 654-8444</p> | <p>Faria Beach - 4350 W. PCH..... 654-3951 Hibson Park - 5218 W. Pacific Coast Hwy..... 654-3951 Lake Castles - 13111 Santa Ana Rd..... 649-2233 Ventura Beach Resort - 800 W. Main St..... 643-9137</p> <p>CHILDREN'S SERVICES • Children's Crisis Team..... 1-866-431-2478 • Child Development Resources (CDR) (childcare, Head Start) Camarillo..... 485-7878 • Children & Family Services (abuse, adoption, foster care)..... 582-8062 • Children's Medical Services..... 652-5960 • County Schools Homeless Education Project..... 437-1526 • School on Wheels (tutoring/supplies)..... 1-800-923-1100</p> <p>CITIZENSHIP/IMMIGRATION • El Concello Del Condado 301 S. "C" St., Oxnard..... 486-9777 x232</p> <p>CLOTHES • Catholic Charities - 612 Spring Rd., Moorpark (Monday - Thursday, 9 a.m. - noon)..... 529-0720 • Lutheran Social Services..... 80 Hillcrest Dr #101, Thousand Oaks..... 497-6207 • Samaritan Center - 280 Royal Ave., Simi Valley (Monday - Thursday, 7 - 11 a.m.)..... 579-9186</p> <p>DENTAL • Children - referrals from CHDP..... 981-5291 • Clinicas Del Camino Real (fee for services) Oxnard - 650 Meta St..... 487-5351 Ventura - 200 S. Wells Rd..... 659-0560 • Free Clinic of Simi Valley (call for appt.)..... 522-3733 • Salvation Army Free Clinic - Oxnard (call for appointment)..... 483-9235</p> <p>DISABLED PERSONS • Department of Vocational Rehabilitation 1701 Pacific Ave #120, Oxnard..... 385-2400 • Independent Living Resource Center..... 656-5993 • Tri-Counties Regional Center 1900 Los Angeles Ave., Simi Valley..... 522-8030</p> <p>DOMESTIC VIOLENCE • Adult Abuse & Neglect..... 654-3200 • Child Abuse & Neglect..... 654-3200 • Coalition for Family Harmony..... 656-1111 • Interface Children & Family Services..... 1-800-636-6738</p> | <p>DROP-IN SERVICES • One-Stop Centers - Conejo Valley Family Medical Group - 125 W. Thousand Oaks Blvd, Thousand Oaks (Monday 9 a.m. - noon) - Sierra Vista Family Medical Clinic - 1227 E. LA Ave, Simi Valley (Monday 2 - 5 p.m.) • Samaritan Center - 280 Royal Ave, Simi Valley - showers, clothing, mail, messages, job coach (Monday - Thursday, 9 a.m. - noon)..... 579-9186</p> <p>EMPLOYMENT/JOB TRAINING • California Conservation Corps (18-25 years)..... 278-2787 • Catholic Charities - 612 Spring Rd #101, Moorpark 529-0720 • East County Job & Career Center 2900 N. Madera Rd, Simi Valley..... 955-2282 • Goodwill Industries - 130 Lombard, Oxnard..... 581-0130 • Job Corps (18-24 yrs.)..... 1-800-733-5627 • Lutheran Social Services Re-employment Program 80 E. Hillcrest Dr #101, Thousand Oaks call for appointment..... 497-6207 • Moorpark Community Service Center 6128 Spring Rd #301..... 523-5444 • Thousand Oaks Community Service Center 80 E. Hillcrest Dr #200..... 374-9006 • Unemployment Benefit Claims English..... 1-800-300-5616 Spanish..... 1-800-326-8937</p> <p>FOOD (also see Meals) • FOOD Share - countywide food pantry (call for referral in your area)..... 983-7100</p> <p>Moopark • Catholic Charities - 612 Spring Rd #101..... 529-0720 (Mon - Thurs 9 am - 1:30 pm, Sat 9 am - 1 pm)</p> <p>Simi Valley • Salvation Army - 1407 E. Los Angeles Ave #P (Monday - Thursday, 10 am - 2 pm)..... 527-1070</p> <p>Thousand Oaks • Lutheran Social Services - 80 E. Hillcrest Dr #101..... 497-6207 • Marra Conejo Valley Food Bank - 3020 Crescent Way (Tues 11 am - 4 pm, Fri 10 am - 4 pm, Sat 10 am - 1 pm) 497-4959</p> | <p>• Cabrillo Economic Development Corporation (affordable housing)..... 659-3791 • Housing Rights Center..... 1-800-477-5977 • Catholic Charities - 612 Spring Rd #101, Moorpark • HSA Homeless Services Program..... 385-1880 • NHRP Homeless Prevention & Rental Deposit..... 385-8505 • Lutheran Social Services 80 E. Hillcrest Dr. #101, TO..... 497-6207 • Many Mansions / Housing Central (Mon. - Thurs.) 1425 E. Thousand Oaks Blvd, TO..... 497-0344 • Mental Health Housing / STAR..... 1-866-998-2243 • Salvation Army 1407 E. Los Angeles Ave #P, Simi Valley..... 527-1070 • Samaritan Center - 280 Royal Ave., Simi Valley (mornings Mon. - Thurs.)..... 579-9186 • St. Vincent de Paul..... 487-1558</p> <p>INFORMATION AND REFERRAL Dial 211 for info 24 hours/7 days/week about Community Resources near you • Area Agency on Aging (seniors)..... 477-7300 • County of Ventura..... 1-800-660-5474 • Homeless Services Program Info..... 385-1800</p> <p>LAUNDRY • Lutheran Social Services - 80 E. Hillcrest Dr #101, Thousand Oaks (Mon. - Fri. mornings)..... 497-6207 • Samaritan Center - 280 Royal Ave., Simi Valley - (Monday - Thursday, 7 a.m. - 11 a.m.)</p> <p>LEGAL SERVICES • Conejo Free Clinic - 80 E. Hillcrest Dr. #211, TO (call for information)..... 497-3575 • Self Help Legal Access Center - 800 S. Victoria Ave, Ventura (Courtroom 1st floor)..... 654-3962 • Simi Free Clinic - 2050 Tago St, Simi Valley (by appointment only)..... 522-3733</p> <p>Countywide • California Rural Legal Assistance 138 S. "A" St., Oxnard..... 483-8083 • Gray Law (60 yrs+)..... 658-2266 • 290 Maple Court #128, Ventura..... 658-2266 • Housing Rights Center..... 1-800-477-5977</p> <p>MAIL/MESSAGES Moopark - Catholic Charities 612 Spring Rd #101..... 529-0720 Simi Valley - Samaritan Center - 280 Royal Ave. (mornings)..... 579-9186</p> |
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County of Ventura • Human Services Agency • Homeless Services Program • (805) 385-1800

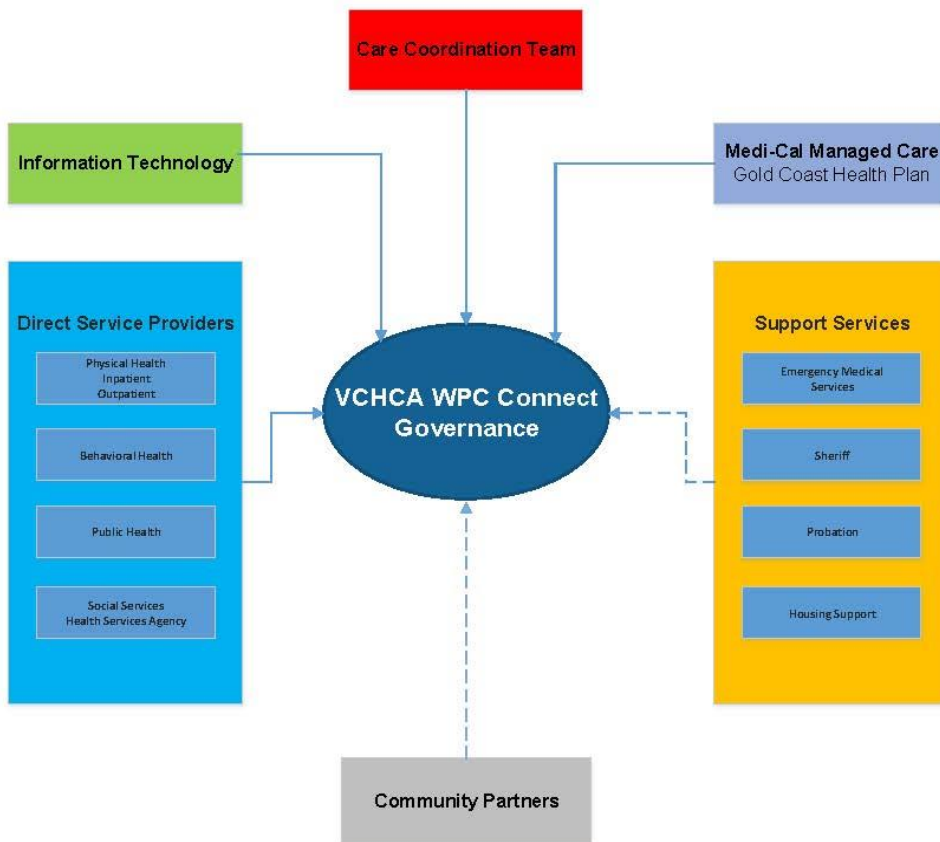
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| <p>• Self Help Legal Access Center Ventura 805 S. Victoria Ave. (Courthouse, 1st fl.) 654-3062</p> <p>MAIL/MESSAGES Oxnard • Catholic Charities - 402 N. 7th St. 486-2000 • Community Action Program of Ventura County 621 Richmond 436-4000</p> <p>Ventura • Catholic Charities - 303 N. Ventura Ave. 643-4694 • Turning Point Foundation (mentally ill) 536 E. Thompson Blvd. 652-2151</p> <p>MEALS (also see Food) Oxnard • Catholic Charities - sandwiches - 402 N. 7th St. Lyons Park - 9th & 7th St. - Sat & Sun: 8:30 a.m. - 1 p.m. • Rescue Mission - 6th & Meta - Dinner 5:30 - 6 p.m. Mon - Fri 11 - 11:30 a.m. - Sat & Sun 12 - 12:30 p.m.</p> <p>Santa Paula • Many Meals - 121 Davis St. - Wed. 5 - 6 p.m.</p> <p>Ventura • Family to Family - 305 N. Ventura Ave. Mon, Wed, Fri 11:30am - 12:30pm - Sat, Sun 8 - 9am</p> <p>MEDICAL • Health Care for the Homeless 652-6694</p> <p>Countywide • Children's Medical/Dental Services 652-5960 • Ventura County Medical Center (VCMC) 2726 Loma Vista Rd, Ventura 652-6000 • WIC (women, infants, children) 1-800-433-2611</p> <p>Oxnard • Clinica del Camino Real - 650 Meta St. 487-5351 • Las Flores Women's Center 2300 S. "C" St. #B 385-9142 • Las Isles Medical Clinic 325 W. Channel Islands Blvd. 240-7000 • Public Health Clinic - 2502 S. "C" St. 305-8632 • Salvation Army - 622 W. Woolley Rd. - free clinic Monday & Thursday 483-9235</p> <p>Santa Paula • Public Health Clinic - 620 W. Harward 993-5525 • Santa Paula Hospital - 825 N. 100th St. 933-8600</p> <p>Ventura • Clinica del Camino Real - (dental & medical) 200 S. Wells Rd. 647-6322 • Public Health Clinic - 3147 Loma Vista Rd. 1-888-285-5012</p> <p>MENTAL HEALTH • Crisis Team - 24 hours 1-866-998-2243 • Rise Team / OD line 981-4233 • Mental Health Liaison 981-4227 • Bilingual Liaison 981-3333</p> | <p>• NAME (support / advocacy) 5253 Versago Way PK, Camarillo 641-2425</p> <p>• STAR (Access to Mental Health Svcs.) 1-866-998-2243</p> <p>• Turning Point Foundation New Vision Center 1065 E. Main, Ventura 652-0596 4238 Telegraph Rd, Ventura 477-5700 1511 Williams Drive, Oxnard 981-4200 2500 S. "C" St. #C, Oxnard 385-9420 333 W. Harward Blvd, Santa Paula 933-8480</p> <p>SENIOR CITIZENS SERVICES • 24-hour Helpline 654-1211 • Adult Protective Services (abuse/neglect) 654-2000 • Area Agency on Aging 646 County Square Dr #100, Ventura 477-7300 • Mental Health, Older Adult Services 777-3300 • Ombudsman Services (nursing homes) 656-1986 • Senior Nutrition (meal site information) 477-7300</p> <p>SHELTERS Domestic Violence Shelters: • Coalition for Family Harmony 656-1111 Spanish Hotline 1-800-300-2181</p> <p>Year-Round Shelters • Rescue Mission - (men only) 234 E. 6th St, Oxnard/483-1234 Turning Point Foundation - Our Place Shelter (mentally ill) 538 E. Thompson Blvd, Ventura 652-2151 • Lighthouse - (women & children) 385-7200 • Women's Shelter/Kingdom Center, Oxnard 487-3445</p> <p>Winter Shelters (December - March) • Ojai Valley Family Shelter - for info 204-7094 • West County Winter Shelter - for info 385-1800</p> <p>SHOWERS/TOILETS • Community Action Program of Ventura County 621 Richmond, Oxnard 436-4000 • Our Place Shelter (mentally ill) 538 E. Thompson Blvd, Ventura 652-2151 • Rescue Mission - 234 E. 6th St, Oxnard 487-1234</p> <p>TRANSITIONAL HOUSING • City Center - 837 E. Thompson Blvd, Ventura 628-9035 • Kingdom Center (Goldilocks House) 1450 Rose Ave, Oxnard 487-3445 • Lighthouse Family Center, Oxnard 385-7200 • Lutheran Social Services, LLC 426-6287 • RAIN Transitional Living Ctr, Camarillo - (families & singles) 389-3308 Call for an application 385-7505 • Salvation Army (Transitional single women) Ventura 648-4977 • Tender Life Maternity Home 653-7474</p> | <p>• Turning Point Countywide Supported Housing - Wishes House (Oxnard) 652-0596 River Haven (Ventura) 652-2151 • Veterans Transitional Housing (Ventura) 652-0000x102</p> <p>VETERANS SERVICES • County of Ventura Veterans Services 5740 Rainbow Street, #340, Ventura 477-5155 • Department of Veterans Affairs - Outpatient Clinic Veterans Center - Counseling Svcs Mon-Fri 8 am - 4:30 pm 4400 Calle Real, Santa Barbara (805) 683-1491 • Disabled Veterans Outreach (EDO) 635 S. Ventura Rd, Oxnard 382-8626 • Oxnard VA Outpatient Clinic 2000 Outlet Center Dr #225, Oxnard 604-6960 • Ventura Vet Center (Counseling) 790 E. Santa Clara St. #1000 985-1860 • Veterans Home of Ventura 652-0000 10800 Telephone Rd, Ventura 659-7502 • Veterans Transitional Housing (Ventura) 652-0000 x102</p> <p>YOUTH SERVICES • Interface Youth Crisis Line / Shelter 469-5882 • Independent Living Prog (Former Foster Youth) 454-3245 • Interface Youth Svcs Drop-In Center - Mon-Fri 2 - 6 p.m. 360 W 4th St, Oxnard 469-5882 • Pacific Clinics, Transition Aged Youth (TAY Tunnel) 141 W 5th St #D, Oxnard 240-2538 • Teen Runaway Helpline 1-800-RUN-AWAY • Transitions (VA Behavioral Health) 1-866-998-2243</p> <p style="font-size: small;">Most of the agencies listed can offer only limited, temporary assistance, depending on available funds. Refer to the Eastern Ventura County Resource directory for resources available in other regions of the County.</p> <p style="text-align: center;">  COUNTY OF VENTURA This brochure was prepared by: County of Ventura - Human Services Agency Human Services Program (805) 385-1800 www.vchsa.org </p> <p style="text-align: right;">This information current as of May 2016</p> |
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| <p>ALCOHOL & DRUG SERVICES • 24-hour Helpline dial 211 • County Alcohol / Drug Line 981-6200 • Alcoholics Anonymous - countywide information 389-1444 Español (Spanish) 988-8329 • Alanon 495-6276 • Oxnard Center - 1911 Williams Dr 981-9206 • Ventura Center - 24 E. Main St. 652-6919 • Absepa House - 338 N. Ventura Ave, Via 653-2596 • Lighthouse Recovery 385-7200 • New Start for Moms - 1911 Williams St, Oxn 981-9250 • Palmer Drug/Alcohol Abuse Program 482-1265 • Prosteph (teen/youth) 382-6296 • Rescue Mission (men) - 234 E. 6th St, Oxn 487-1234 • Teen Challenge 646-1295 • Victory Outreach 988-4102</p> <p>BENEFITS • Human Services Agency (CalWORKS, General Relief, CalFresh [Food Stamps], Medi-Cal) 1400 Vanguard Dr, Oxnard 385-9363 Santa Paula - 725 E. Main 933-8300 Fillmore - 833 Ventura St, #200 524-8666</p> <p>Ventura & Ojai 4651 Metcalf Rd #100, Ventura 658-4100</p> <p>Social Security - registration 1-800-772-1213 Oxnard - 2000 Outlet Center Dr #250 Ventura - 6477 Telephone Rd #1 Monday - Friday 9 a.m. - 3:30 p.m.</p> <p>• Unemployment Benefits Claims English 1-800-300-5636 Spanish 1-800-444-7275</p> <p>BUS • ADA / Dial-a-Ride 583-6464 • Gold Coast Transit - countywide transportation information 1-800-638-1112 • Camarillo Area Transit 988-4228 • Groundbus - 201 E. 4th St, Oxnard 487-2707 Information 1-800-231-2222 • Gold Coast Transit Oxnard 487-4222 Ventura 643-3158</p> <p>CAMP GROUNDS • County Park Information 654-3951 • State Park Information 1-800-444-7275/968-1013</p> <p>Camping • Fillmore - Korry Grove - 823 N. Oak 524-6750 • Ojai - Lake Castles - 11311 Santa Ana Rd. 649-2333 Santa Paula - Stevie Park 8080 Hildebrand Rd. 654-3951</p> | <p>• Short-Term Camping (14 days maximum) Ojai - Camp Comfort - 11969 N. Creek Rd. 654-3951 Oxnard - McGrath State Beach, 2211 Harbor Blvd Ventura • Emma Wood - Rincon Parkway, Hwy 1 654-8444 • Faria Beach - 4350 W. PCH 654-3951 • Hobson Park - 5216 W. PCH 654-3951 • Lake Castles - 11311 Santa Ana Rd. 649-2333 • Ventura Beach Resort - 800 W. Main St 647-9137</p> <p>CHILDREN'S SERVICES • Children's Crisis Team 1-866-431-2478 • Child Development Resources (CDR) (childcare, Head Start, Preschool) 465-7078 • Children & Family Services (abuse/neglect, adoption, foster care) 654-3200 • Children's Medical Services 981-5381 • Children's Mental Health (access line) 1-800-671-0887 • County Schools Homeless Education Project 431-1536 • School on Wheels (showering/supplies) 1-800-923-1100</p> <p>CITIZENSHIP/IMMIGRATION • El Corcillo Del Condado - 301 S. "C" St, Oxn 486-9777 x232</p> <p>DENTAL • Children - referrals from CHDP 981-5291 • Clinica Del Camino Real (see for services) 487-5351 • Oxnard - 650 Meta St. 487-5351 • Ventura - 200 S. Wells Rd. 659-6560 • Oxnard Dental Group 778-9499 • Salvation Army Free Clinic - 622 W. Woolley Rd, Oxnard (call for appointment) 483-9235</p> <p>DISABLED PERSONS • Department of Vocational Rehabilitation 1701 Pacific Ave #120, Oxnard 385-2400 • Independent Living Resource Center 1802 Eastman Ave #112, Ventura 659-5993 • Tri-Counties Regional Center 4611 E. Gonzales Rd #190, Oxnard 485-3177</p> <p>DOMESTIC VIOLENCE • Adult Abuse & Neglect 654-3200 • Child Abuse & Neglect 654-3200 • Coalition for Family Harmony 656-1111 • Interface Children & Family Services 1-800-636-6738</p> <p>DROP-IN SERVICES • Community Action Program of Ventura County 621 Richmond, Oxnard 436-4000 • Community Assistance Program - 108 Fox St, Ojai 640-3320 • One Stop Centers 652-6111 Oxn - CAP: 621 Richmond Ave. (Wed 8:30-11:30) Via - Public Health Auditorium, 3147 Loma Vista (Tue/0-1)</p> | <p>EMPLOYMENT/JOB TRAINING • California Conservation Corps (18-25 yrs.) 278-2787 • Goodwills (Native Americans) 1445 Donker St #18, Ventura 659-8352 • Center for Employment Training (CET) - 761 S. "C" St, Oxnard 487-9821 • Community Action Agency - 621 Richmond, Oxnard 436-4000 • Employment Development Department (EDD) 1400 Vanguard Drive, Oxnard 382-8610 • Employee Assistance & Placement 600 N. Ventura Ave, Ventura (M-F 9-11 a.m.) 648-5888 • Fillmore Community Service Center - 828 W. Ventura St. Fillmore 933-8900 • Goodwill Industries - 130 Lombard St, Oxnard 981-0130 • Job Corps (18-24 yrs.) 1-800-733-5627 • Labor Finders - 3411 Telegraph Rd, Ventura 650-4964 • Labor Ready - 711 St. Marys Dr, Oxnard 988-4650 • 1963 E. Main St, Ventura 477-0418 • Santa Clara Valley Job & Career Center 725 E. Main St, Santa Paula 933-8300 • Unemployment Benefits Claims - English 1-800-300-5616 Spanish 1-800-326-8937 • Ventura Job & Career Center - 4651 Telephone Rd. 654-3434 • Oxnard Job & Career Center - 1400 Vanguard Dr. 204-5100 • Workforce Development Board (WDB) 1400 Vanguard Dr, Oxnard 204-5100</p> <p>FOOD (also see Meals) • FOOD Share - countywide food pantry info 983-7100 Ojai 640-3320 • Community Assistance Program - 108 Fox St 640-3320</p> <p>Oxnard • Catholic Charities - 402 N. 7th St. 486-2900 • Community Action of Ventura Co - 621 Richmond 436-4000 • Salvation Army (call first) - 622 W. Woolley Rd. 483-9235 • St. John's Outreach - 535 Cooper Rd. (pre-registered) 968-2651 Santa Paula • Community Assistance of Santa Paula (CASP) 133 N. Mill St. (Monday) 525-8890 • Spirit of Santa Paula (Call first) 340-5025</p> <p>Ventura • Catholic Charities - 303 N. Ventura Ave 643-4694</p> <p>HOMELESS & HOUSING SERVICES • Catholic Charities - 303 N. Ventura Ave, Ventura 643-4694 402 N. 7th St, Oxnard 486-2900 • Cabrillo Economic Development Corporation (affordable housing) 659-3791 • Community Action Program 621 Richmond, Oxnard 436-4000 • Housing Rights Center 1-800-477-5977 • HSA Homeless Services Program 385-1800 • I99P Homeless Prevention & Rental Deposit 385-8585</p> |
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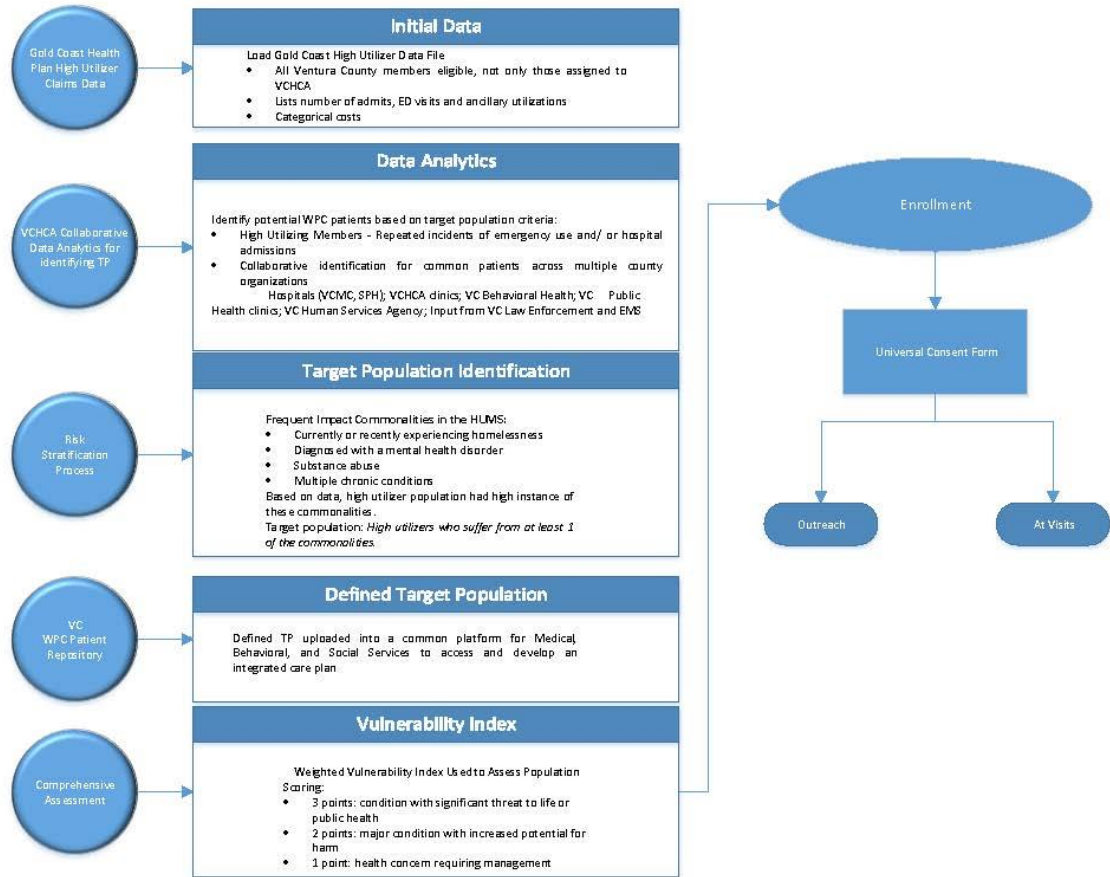
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| <p>• Many Mansions - Housing Central 497-0344 • Project Understanding 652-1236 • St. Vincent de Paul 754-2009 • The Salvation Army, Safe Sleep Ventura 648-2099 • Turning Point Foundation (mentally ill) 538 E. Thompson Blvd, Ventura 652-2151</p> <p>HOUSING AUTHORITIES (No emergency housing provided) • Housing Rights Center 1-800-477-5977 • Area Housing Authority (Ojai & unincorporated areas) 1400 W. Hillcrest Dr, Newbury Park 800-800-2123 or 1-800-800-2123 • Oxnard Housing Authority - 1470 Colonia Rd. Public Housing 385-8097 Section 8 1-800-800-2123 • Port Huemene Housing Authority 986-6551 250 W. Ventura Rd. 385-8097 • Santa Paula Housing Authority 525-3339 • Ventura Housing Authority Public Housing - 995 Riverside St 648-5008 Section 8 - 11122 Snapdragon St, #100 647-5990</p> <p>INFORMATION AND REFERRAL Dial 211 for info 24 hours/7 days/week about Community Resources near you • Area Agency on Aging (seniors) 477-7300 • County of Ventura 1-800-660-5474 • Homeless Services Program Info 385-1800</p> <p>LAUNDRY • Community Action Program of Ventura County 621 Richmond, Oxnard 436-4000 • Community Assistance Program 108 Fox St, Ojai (805) 640-3320 • Laundry of Love Vc Mission Plaza - 110 N. Olive - 1st Tues 5:30 - 8 p.m. Quik Wash - 9298 Telephone Rd. - 2nd Tues 5 - 7 p.m. 2011 E. Thompson Blvd. - 3rd Tues 5:30 - 8 p.m. • Turning Point Foundation (mentally ill) 536 E. Thompson Blvd, Ventura 652-2151</p> <p>LEGAL SERVICES • California Bar Assoc. Legal Clinic - (family law/tenant/ landlord/bankruptcy) - Mon - Fri 459-7599 • California Rural Legal Assistance 338 S. "A" St, Oxn 483-8883 • Gray Law (60 yrs+) 659-2566 • 299 Maple Ct #108, Ventura 659-2566 • Housing Rights Center 1-800-477-5977 • Jewish Family Services 3915 E. Main St, Ventura 641-6565</p> |
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County of Ventura • Human Services Agency • Homeless Services Program • (805) 385-1800

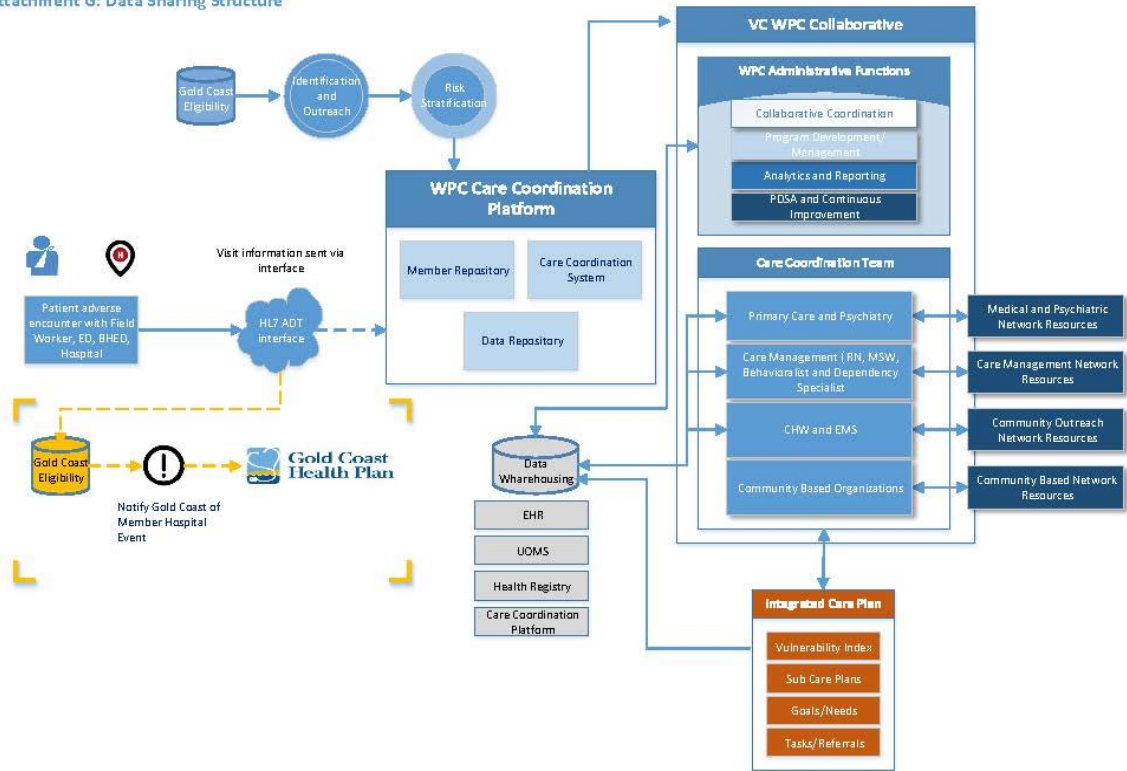
Attachment E: Organizational Structure



Attachment F VC WPC Identification and Enrollment Process



Attachment G: Data Sharing Structure



Attachment G: Data Sharing Structure

The figure is a flow chart that has two entry points and shows connections between activities, resources, and data warehousing. Here the flow chart steps and linkages are represented as lists.

The flow chart has two different starting points, presented here as separate lists with numbered links. When a step has more than one possible next step or linkage, they are listed beneath it.

Entry Point A.

1. Gold Coast Eligibility
2. Information and Outreach
3. Risk Stratification, with an arrow leading down to
 - a. Whole Person Care Platform box. Inside the box are three small boxes:
 - i. Member Repository
 - ii. Care Coordination
 - iii. Data Repository
4. An arrow from the Whole Person Care Coordination Platform leads upward to the top of a set of nested and linked lists entitled "Ventura County Whole Person Care Collaborative." Connections between activities, resources, and systems are shown with nested information boxes, and arrows. The Ventura County Whole Person Care Collaborative Box contains two information sets:
 - a. Whole Person Care Administration Functions includes:
 - i. Collaborative coordination
 - ii. Administration and Management
 - iii. Analytics and Reporting
 - iv. Plan-Do-Study-Act and Continuous Improvement
 - b. Care Coordination Team contains four primary care activities, that are linked to relevant data tools and community resources.
 - i. Primary Care and Psychiatry.
 1. A two-way arrow links this to Data Wharehousing.
 2. A two-way arrow links this to Medical and Psychiatric Network Resources.
 - ii. Care Management (Registered Nurse, Social Worker, Behavioralist, Dependency Specialist)
 1. A two-way arrow links this to Data Warehousing.
 2. A two-way arrow links this to Care Management Network Resources.
 - iii. Community Health Worker, Emergency Medical Services
 1. A two-way arrow links this to Data Wharehousing.
 2. A two-way arrow links this to Community Outreach Network Resources.
 - iv. Community Based Organizations
 1. A two-way arrow links this to Community Based Network Resources.
5. A two-way arrow leads from the Ventura County Whole Person Care Collaborative box to another list at the lower left:
 - a. A cylindrical form holds the words Data Warehousing at the top. It is followed by four boxes:
 - i. Electronic Health Record
 - ii. Utilization and Outcomes Monitoring System

- iii. Health Registry
- iv. Care Coordination Platform

6. A two-way arrow connects the Ventura County Whole Person Care Collaborative box to an Integrated Care Plan list at the bottom that includes:
- a. Vulnerability Index
 - b. Sub-care Plans
 - c. Goals/Needs
 - d. Tasks/Referrals

A one-way arrow leads from this list box to the Data Warehousing cylinder to its left.

Entry Point B.

1. Patient Adverse Encounter with Field Worker, Emergency Department, Behavioral Health Emergency Department, Hospital.
2. HL7 ADT Interface is in a cloud-shaped form. Above it are the words "Visit Information sent via interface." Below it a broken line leads downward to three icons:
 - a. Gold Coast Eligibility
 - b. Notify Gold Coast of Member Hospital Event
 - c. Gold Coast Health Plan.
3. An arrow connects HL7ADT to the
 - a. Whole Person Care Platform box. Inside the box are three small boxes:
 - i. Member Repository
 - ii. Care Coordination
 - iii. Data Repository
4. An arrow from the Whole Person Care Coordination Platform leads upward to the top of a set of nested and linked lists entitled "Ventura County Whole Person Care Collaborative." Connections between activities, resources, and systems are shown with nested information boxes, and arrows. The Ventura County Whole Person Care Collaborative Box contains two information sets:
 - a. Whole Person Care Administration Functions includes:
 - i. Collaborative coordination
 - ii. Administration and Management
 - iii. Analytics and Reporting
 - iv. Plan-Do-Study-Act and Continuous Improvement
 - b. Care Coordination Team contains four primary care activities, each of which is linked to data tools and community resources. All are linked to the care plan activities list.
 - i. Primary Care and Psychiatry.
 1. A two-way arrow links this to Data Warehousing.
 2. A two-way arrow links this to Medical and Psychiatric Network Resources.
 - ii. Care Management (Registered Nurse, Social Worker, Behavioralist, Dependency Specialist)
 3. A two-way arrow links this to Data Wharehousing.
 4. A two-way arrow links this to Care Management Network Resources.
 - iii. Community Health Worker, Emergency Medical Services
 3. A two-way arrow links this to Data Wharehousing.
 4. A two-way arrow links this to Community Outreach Network Resources.

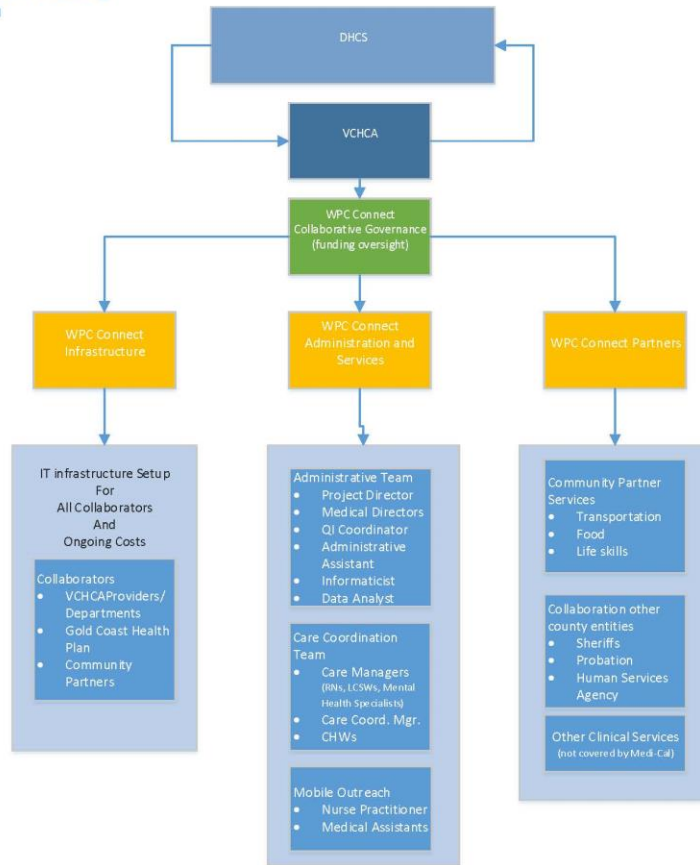
iv. Community Based Organizations

2. A two-way arrow links this to Community Based Network Resources.

5. A two-way arrow leads from the Ventura County Whole Person Care Collaborative box to another list at the lower left:
- b. A cylindrical form holds the words Data Warehousing at the top. It is followed by four boxes:
 - i. Electronic Health Record
 - ii. Utilization and Outcomes Monitoring System
 - iii. Health Registry
 - iv. Care Coordination Platform
6. A two-way arrow connects the Ventura County Whole Person Care Collaborative box to an Integrated Care Plan list at the bottom that includes:
- a. Vulnerability Index
 - b. Sub-care Plans
 - c. Goals/Needs
 - d. Tasks/Referrals

A one-way arrow leads from this list box to the Data Warehousing cylinder to its left.

VCHCA WPC Connect – Funding Diagram



5.5 Funding Request — Budget Narrative

Overall Considerations:

No Unallowable Payments: None of the budget years for this pilot include costs for services reimbursable with Medi-Cal or other federal funding resources.

Enrollment: In Year 2, the first phase of the technology infrastructure will be functioning, and participants will be enrolled to meet the project goal of 800 participants total by month 5. Waiting lists will be started (with DHCS approval) of potential participants as the target enrollment is met. During Years 3-5, it is expected that attrition will reduce the number of participants, which will need to be replaced by new participants from the waiting list. The attrition rate is anticipated to be approximately 400 participants per year, consisting primarily of participant reassessment and project “graduation” due to improvements in risk factors and health outcomes, and a reduction in risk factors that would transition them into the Targeted Case Management program. Other reasons for this attrition will also be dropouts, participant mortality, or inability to continue due to other factors such as institutionalization or departure from the area.

Year 1

This budget year activities are application submission, developing and reporting the required baseline data, developing infrastructure requirements, and further planning for implementation launch. Later years are addressed in detail below.

Year 2

| Administrative Infrastructure | | | |
|--|----------------------------|------------------|----------------------------|
| <i>Item</i> | <i>Max Amount Per Unit</i> | <i>Max Units</i> | <i>Max WPC Fund Amount</i> |
| Program Director | 164,835 | 1.00 | 164,835 |
| Informaticist | 127,178 | 1.60 | 203,485 |
| Database Analyst | 100,850 | 1.60 | 161,360 |
| Administrative Assistant | 70,069 | 1.00 | 70,069 |
| Medical Director (Primary Care) | 224,300 | 0.50 | 112,150 |
| Behavioral Health Director (Psychiatric) | 441,697 | 0.50 | 220,849 |
| WPC Financial Manager | 167,388 | 1.00 | 167,388 |
| QI Coordinator | 124,398 | 1.00 | 124,398 |
| Legal Counsel | 140 | 120.00 | 16,800 |
| Office supplies, per person | 300 | 48.00 | 14,400 |
| Mobile Van | 50,000 | 3.00 | 150,000 |
| Medical Van Conversion | 15,000 | 3.00 | 45,000 |
| Cubicles | 5,000 | 25.00 | 125,000 |
| Cellphones - Administrative | 700 | 6.00 | 4,200 |
| Cellphone - Care Coordination Team | 700 | 41.00 | 28,700 |
| Desktop Computers, Administrative | 1,165 | 12.00 | 13,980 |

| | | | |
|--|------------|-------|---------|
| Desktop Computers, Care Coordination Staff | 1,165 | 9.00 | 10,485 |
| Laptop Computers, CHWs, Mobile Team, Van | 1,250 | 41.00 | 51,250 |
| Printers, Network Server | 6,000 | 2.00 | 12,000 |
| Indirect Rate at 5% | 18,635,750 | 0.05 | 931,788 |

Administrative Infrastructure

Program Director: The Program Director (tbd) will be the main point of contact to support and coordinate with participating entities. The Program Director will lead the VCHCA service delivery and administrative teams, conduct WPC Collaborative activities, oversee technology infrastructure development, monitor project progress to metrics and performance measure, liaison with stakeholders, and facilitate system integration across providers. The annual salary is \$164,835 including fringe benefits at 1.0 FTE in each of Years 2 through 5.

Informaticist: The Informaticist is responsible for monitoring system performance, tracking metrics/performance goals, analyzing data, determining outliers, and reporting to the Project Director and QI Coordinator concerning project successes and areas in need of quality improvement. The annual salary is \$127,178 x 1.6 FTE = \$203,485 including fringe benefits at 1.0 FTE for Years 2 through 5.

Database Analyst: The Database Analyst (tbd) is responsible for maintaining the validity and security of the project databases, ensuring HIPAA compliance, providing reliable verifiable quality data, and incorporating data from all participating entities. The annual salary is \$100,850 x 1.6 FTE = \$161,360 including fringe benefits in each of Years 2 through 5.

Administrative Assistant: The WPC Administrative Assistant (tbd) will prepare monthly WPC Project Status reports to enable tracking by the Project Director, serve as scribe at each Collaborative meeting, maintain WPC records, and assist the Program Director in maintaining effective communications with the WPC Collaborative, partners, and staff. The annual salary is \$70,069 including fringe benefits at 1.0 FTE in each of Years 2 through 5.

Medical Director (Primary Care): The PCP Medical Director will work with Care Coordination staff/teams to design and maintain project services and interventions that are aligned with clinical care standards, resolve issues that arise, direct care coordination for participants that present with unusual circumstances, integrate medical care with other needed services to ensure the administration of a holistic and patient-centered model of care, and maintain a high quality of primary care for project participants. The annual salary is \$224,300 including fringe benefits for each of Years 2 through 5 at 0.5 FTE for an annual cost of \$112,150.

Behavioral Health Director (Psychiatrist): The Psychiatrist Medical Director is the behavioral health counterpart to the PCP Medical Director. The Psychiatrist Medical Director will work with Care Coordination staff/teams to design and implement project services and interventions that are aligned with clinical care standards, direct care coordination for participants that present with unusual psychiatric circumstances, integrate behavioral health care with other needed services to ensure the administration of a holistic and patient-centered model of care, and maintain a high quality of behavioral health care for project participants. The annual salary is \$441,697 including fringe benefits for each of Years 2 through 5 at 0.5 FTE for an annual cost of \$220,849.

WPC Financial Manager: The WPC Financial Manager will ensure that the flow of funds are directed as proposed, ensure all accounting principles are upheld on the project, and meet all DCHS requirements from fiscal management and reporting. The annual salary is \$167,388 including fringe benefits at 1.0 FTE in each of Years 2 through 5, for an annual cost of \$167,388.

QI Coordinator: The Quality Improvement Coordinator will direct quality improvement processes using the Model for Improvement, orchestrate and direct the reporting of PDSA processes and changes, monitor improvements made, conduct iterative PDSA cycles, and work with staff, partners, and the collaborative to facilitate PDSA testing and changes. As indicated in Attachment MM, the QI Coordinator will utilize the DHCS template's change-management plan, including a mechanism for identifying needed adjustments, a process for carrying out each change, a process for observing and learning from the implemented change(s) and their implications, and a process to determine necessary modifications to the change based on the study results and implement them. The annual salary is \$124,398 including fringe benefits at 1.0 FTE in each of Years 2 through 5.

Legal Counsel: The Legal Counsel will develop and review contracts between the Lead Entity and the participants, develop the release documents and similar legal documents and advise on compliance with all regulatory agencies and legal jurisdictions that could impact the project. The compensation is \$140 per hour including fringe benefits, with an expected usage of ten hours per month and an annual cost of \$16,800 in each of years 2 through 5 with an FTE of approximately 0.06.

Non-Staff Expenses

Office supplies, per person: Each member of the project team has been allocated \$300 in office supplies, a number derived from internal studies conducted at VCHCA over a period of years. The total cost of office supplies in Year 2 is \$300 per person x 41 persons = \$14,400.

Mobile Health Vans: These three cargo vans, when retrofitted to support two examination rooms, will facilitate integration of services, outreach, and engagement of participants, determining immediate care needs, provide needed prescriptions, offer enrollment and assessment services, connect services with community-based providers, and ensure that there are no gaps between the Integrated Care Plan and the provision of planned services. The teams using these vans will be effective in connecting with the highest risk participants who are homeless, do not show up to appointments, do not abide by the care plan or physician instructions, and/or who access services outside of the VCHCA. The cost of the vehicles is derived from a review of prices for an appropriately configured, high-roofline, extended-wheelbase cargo van from local sources. The total cost for the vehicle is three cargo vans at \$50,000 = \$150,000 in Year 2.

Medical Van Conversion: The conversion is required to change three empty cargo vans into mobile health units with two interior spaces suitable to examinations, with some additional seating and storage. The cost will be 3 x \$15,000 conversion (estimated) for a total cost of \$45,000 in Year 2.

Cubicles: These modular office cubicles include the desk, storage, walls, and chair necessary to make the empty office space into one suitable for the data-intensive work. Space provided by these 19 cubicles will support the work of the administrative staff, Care Managers, and field/mobile staff when they are in-office. This Year 2 cost is \$5,000 per cubicle installed x 25 cubicles = \$125,000.

Cellphones – Administration: Administrative staff will have a cellphone that set up for secure, encrypted data communications. These devices are \$1,800 each and include a full set of office accessories and software for accessing administrative functions. This Year 2 cost is \$700 per cellphone x 6 cellphones = \$4,200.

Cellphones – Care Coordination Teams: Each care coordination staff member across the three teams requires a cell phone to enable them to connect with the CCT, each other, providers, and community resources to align care with the Integrated Care Plan. Year 2 cost is 41 cellphones x \$1,250 per cellphone = \$36,250.

Desktop Computers, Administration/Care Managers: A standard desktop computer, monitor, and mouse will be needed by the 12 administrative staff and Care Managers access the central databases to conduct and monitor project activities and facilitate participant care. The total cost for Year 2 is 12 desktop computers x \$1,165 per computer = \$13,980.

Desktop Computers, Field Staff: There will be six standard desktop computer configurations that will be used by CHWs when they are in the WPC offices to facilitate participant care coordination. This cost will be 9 computers x \$1,165 per computer = \$10,485 for Year 2.

Laptop Computers, CHWs and Mobile Team: Laptops are required for the 16 CHWs, six Engagement Team staff members, and seven care coordination staff to allow them to connect with the Integrated Care Plan, enrollment system, and web-based system resources. This total cost is 41 laptops x \$1,250 per laptop = \$51,250 in Year 2.

Printers, Network Server: These heavy-duty professional grade printers will serve the printing, scanning, faxing, and administrative needs the WPC staff. These printers will cover printing needs at the main WPC offices. Total costs are 2 printers x \$6,000 per printer = \$12,000 in Year 2.

Indirect Rate at 5%: The indirect rate is 5% of direct costs. The total indirect cost for Year 2 is the direct charges of \$18,635,750 x 5% “de minimus” indirect rate = \$931,788.

Delivery Infrastructure

| Delivery Infrastructure | | | |
|---------------------------------------|----------------------------|------------------|----------------------------|
| <i>Item</i> | <i>Max Amount Per Unit</i> | <i>Max Units</i> | <i>Max WPC Fund Amount</i> |
| Centralized Enterprise Infrastructure | 671,000 | 1 | 671,000 |
| Centralized Enterprise Contract | 25,000 | 9 | 225,000 |
| IT Development | 596,464 | 1 | 596,464 |
| WPC Connect Infrastructure | 200,000 | 1 | 200,000 |
| WPC Connect Contract | 25,000 | 9 | 225,000 |
| Health Registry | 129,500 | 1 | 129,500 |
| Health Registry Contract | 2,250 | 8 | 18,000 |

Enterprise WPC Infrastructure: This vendor provided technology will build the data sharing and project

monitoring/reporting infrastructure, as illustrated in Attachment G. It is a web-based solution offering real-time notification and communication interfaces that will promote collaboration. The Phase I cost in Year 2 includes site licenses, training, interfacing, and customization to adapt it to system infrastructure needs. This total cost is \$671,000 in Year 2.

Enterprise WPC Contract: The ongoing maintenance and operation of the enterprise infrastructure will be provided by the vendor at a monthly contract of \$25,000 per month x 9 months in Year 2 = \$225,000.

IT Development: The IT Developer team (tbd) will direct new technology data requirement development, plan for the architecture design, audit vendor systems, develop governance rules, develop EHR interfaces, and liaison with the vendor for implementation. The IT Developer team will train staff about system implementation and operation, train WPC Collaborative members about data sharing, and address any problems that arise from this process. The total projected cost for the Year 2 development contract is \$596,464.

WPC Connect Infrastructure: This one-time cost to provide infrastructure technology and integrate it with current systems will enable communication across systems to facilitate VCHCA and community partner communications, telemedicine, and information sharing. This cost is expected to be \$200,000 in Year 2.

WPC Connect Contract: This is a monthly license for the communication infrastructure that allows access to the databases and reports across the collaborative partners, CCT, and field personnel. The total cost in Year 2 is 1 license at \$25,000 per month x 9 months = \$225,000.

Health Registry: This system is a crucial support element for the technology infrastructure to enable effective care coordination. This population health management tool enables providers to use data-driven, evidence-based clinical decision making. Dashboards will allow providers, CCT, and CHWs to track their participant’s needs. The total cost of the Health Registry in Year 2 is 1 site-wide license at \$129,500 = \$129,500.

Health Registry Contract: The maintenance and support fee for the Health Registry is calculated at \$2,250 per month x 8 months = \$18,000 in Year 2.

Incentive Payments

| Incentive Payments | | | |
|---|----------------------------|------------------|----------------------------|
| <i>Item</i> | <i>Max Amount Per Unit</i> | <i>Max Units</i> | <i>Max WPC Fund Amount</i> |
| Housing support services | 175 | 2,264 | 396,200 |
| At least 60% of patients will have care plan within 30 days | 500 | 480 | 240,000 |
| At least 50% follow-up after MD ED visit | 500 | 400 | 200,000 |
| Meeting attendance expense coverage | 100 | 280 | 28,000 |

Housing Support Services: During Y2, the project will provided incentive payments to the Area Housing Authority (a public housing entity) for its services in assisting and educating homeless participants with the goal of housing. To achieve this incentive payment, the Housing Authority will provide Individual Housing Transition Services, including tenancy screening, housing assessment, housing plan development, housing application

assistance, resource identification, move-in support, crisis plan development, housing search, transportation assistance, and assistance in establishing the household, such as setting up utilities and arranging for furnishings. The Area Housing Authority will also provide participants with Individual Housing and Tenancy Sustaining Services, including identification/intervention of behaviors that may jeopardize housing status, education, coaching, resolving disputes, advocating, ongoing plan review and training. This total cost is 2,264 incentive payments of \$175 = \$396,200 in Year 2.

Care Plan Incentives: The primary care providers will receive a \$100 incentive payment for developing and making available a comprehensive care plan for newly recruited participants within 30 days of their enrollment in the Pilot system, and the lead entity will receive a \$400 incentive. The goal is to accomplish this for 60% of the participants, totaling 800 participants 60% x \$500 = \$240,000 in Years 2-5.

Mental Health ED visit followed-up within 30 days: In support of Universal Metric iii.1, this incentive is paid to the behavioral health clinicians for achieving this follow up (after an Emergency Department visit with a Mental Health related diagnosis) in the allotted time. The anticipated payouts will be for 400 participants (50% of participants) x a \$100 incentive payout, and the lead entity will receive a \$400 incentive = \$200,000 in Years 2-5.

Meeting attendance for Collaborative partners: To support the representatives of participating entities, a stipend of \$100 per month will be provided to attend monthly meetings. The total cost is \$100 per month x 14 meetings x 20 partners = \$28,000 in Year 2, and \$100 per month x 12 meetings x 20 partners = \$24,000 in Years 3-5.

Fee for Services

| FFS Services | | | |
|--------------------------|----------------------------|------------------|----------------------------|
| <u>Item</u> | <u>Max Amount Per Unit</u> | <u>Max Units</u> | <u>Max WPC Fund Amount</u> |
| Mobile Outreach Services | 168.94 | 1,600 | 270,304 |

Mobile Outreach Services: Mobile outreach services are those that identify and connect with non-participants who may be eligible for project services. Mobile outreach services, provided by the Engagement Team and CSWs, will support community outreach to identify persons who have been targeted by the risk stratification technology system (or are otherwise eligible based on assessment), introduce project services, get consent, develop initial assessments, attend to urgent needs, and connect them with a Field-Based Care Coordination CSW. In Year 2, these services will support project start-up and ensure that the full caseload is engaged in project services in month 5. These services are calculated at \$168.94 for each engagement of the engagement and mobile outreach team (6 staff) x 1,600 engagements = \$270,304.

Bundled PMPM Services

| PMPM Bundle | | | |
|--------------------------------------|-------------|--------------------------|----------------------------|
| <u>Item</u> | <u>PMPM</u> | <u>Max Member Months</u> | <u>Max WPC Fund Amount</u> |
| Field-based Care Coordination Bundle | 229.65 | 6,400 | 1,469,768 |
| Care Coordination Bundle | 297.28 | 6,080 | 1,769,653 |

| | | | |
|-------------------|--------|-------|---------|
| Engagement Bundle | 300.55 | 2,560 | 854,513 |
|-------------------|--------|-------|---------|

Services Provided Within Bundles: WPC Connect has three teams providing PMPM bundled services. The numbers above represent their anticipated delivery of their respective services.

Medical Services: Health care related care management services are provided in each of the three bundles as CHWs facilitate field-based access to primary and specialty care services in the Field-based Care Coordination Bundle; Care Managers ensure that medical health care is integrated in a holistic, wraparound model with other needed services and community resources in the Care Coordination Bundle; and mobile teams access hard-to-reach individuals who do not access health care as needed on a regular basis to determine their immediate need for services and facilitate rapid access to clinic-based care. No Medi-Cal funded services are provided by any of the PMPM bundles.

Behavioral Health Services: Although access regular, urgent, and emergent to behavioral health services is facilitated in the Field Based Care Coordination and Engagement Bundle, behavioral health specialists are embedded in the Care Coordination bundle, with the role of interacting with CHWs, patients, physicians, behavioral health professionals, social service providers, and community partners to ensure that behavioral health protective factors are integrated with all aspects of care; 2) tracking service utilization, behavioral health outcomes, and care plan changes; 3) working closely with field-based CHWs to ensure timely behavioral health care; 4) bringing all care providers to serve the participant during urgent/emergent behavioral health situations; 5) ensuring behavioral health services are accessible in primary care settings; and other services as indicated. At least one Care Manager will be a Licensed Mental Health Professional (LMFT or LCSW) and at least one will be a Substance Abuse Specialist.

Social Services: Direct social services are provided through the Care Coordination Bundle through Ventura County Transportation Commission bus vouchers to assist participants as needed to access needed services according to their care plan. Bus vouchers will be provided for transportation not fundable through Medi-Cal. Housing transition and support services will be provided through incentives to the Ventura County Housing Authority.

Non-Medical Services: Although there are no direct non-medical services funded through the pilot, the CHWs and Care Managers within the Field-based Care Coordination and Care Coordination bundles will be facilitating access to life skills, job readiness, and job search/placement assistance.

Participant Eligibility, Duration, Discontinuation: The eligibility for the Field-Based Care Coordination and the Care Coordination bundles is the same as eligibility for the program: the high-utilizing GCHP beneficiaries with at least four ED visits and/or two inpatient visits (ages 18 and older). Risk stratification will then evaluate these candidates for risk according to the Vulnerability Index, which includes the presence of multiple diseases, mental illness, substance abuse, and homelessness. Those at highest risk are prioritized for enrollment. As a result, the Field-Based Care Coordinators (CHWs) maintain a maximum caseload of 40 participants. Through the centralized Care Coordination bundle, six Care Managers service 600 participants, averaging 100 participants per Care Manager. The two Engagement Teams are expected to access 40% of participants. The each of the two Engagement Team Care Managers will see 240 participants at least four times a year and link services with the other centralized Care Managers and CHWs.

All bundled services are complementary, meaning taken together, they form the continuum of services required to manage Whole Person Care for the pilot’s highly fragile target population. For example, the

eligibility for services for the Field-Based Care Coordination bundle and the Care Coordination bundle would be admittance to or termination from the pilot. These services work together to form comprehensive care coordination as the field-based CHWs' services are designed to support participants and aid access to and utilization of services. The centralized Care Managers' services, supported by the care coordination technology infrastructure, are designed to plan, implement, track, and follow-up on care; modify care plans based on changes to the participants' conditions; and liaison with care providers to ensure a comprehensive continuum of Whole Person Care. The combination of the two bundle of services, therefore, fund the project design components needed for all participants. Eligibility for the Engagement Bundle will be based on elevated risk. Those participants who are homeless and/or not accessing services at primary care and behavioral health clinics would receive engagement services. This will be determined by housing status (i.e., not sheltered), the number of missed appointments, and use of the ED, urgent care, or inpatient care. Participants have the potential to receive services from all three bundles at the same time, but at minimum all participants will receive services from the Field-Based Care Coordination and the Care Coordination bundle during the same time frame. There is no duplication of services between these three bundles as each have a specific purpose and perform specific tasks and activities that the other bundled staff members do not perform. The services also do not duplicate services eligible under the Targeted Case Management Program.

The duration of services will vary based on risk stratification of each participant. The project includes monthly review of care plans based on risk and annual complete care plan assessments. The factors that qualified the participant for the project will also be used to "graduate" participants from project participation. Participants who have had no ED visits and/or inpatient stays over the course of a year; demonstrate health improvements in alignment with project metrics; and consistently keep appointments will qualify them to be evaluated for project termination and transitional services to the Patient-Centered Medical Home to continue care. It is anticipated that 400 participants will graduate, be transferred to other care programs, such as Target Case Management, or otherwise discontinue services over the course of each project year. Due to the anticipated acuity of the participants' health and the severity of the mental health and substance abuse issues, it is expected that average duration of services will be approximately two years. The model places enrollment eligibility priority on the persons who are the most highly at risk for ED or inpatient stays. The participants are expected to have complex care needs on multiple levels that they will need to overcome during their enrollment. Discontinuation for Engagement Team Services will occur when the elevated risk is stabilized, i.e., keeping regular appointments, maintaining shelter, and abiding by provider instructions. Since the project's enrollment cap maintains the project caseload at 800 participants, the duration of services does not affect the per member per month calculations.

Field-based Care Coordination Bundle: This team consists of a Care Coordination Manager and 20.8 FTE CHWs who will administer the WPC Comprehensive Assessment, connect with the CCT to identify needed services, link participants with community resources, provide support for access, and work with system-wide care managers. They are anticipated to reach 6,400 participant/months at a PMPM cost of \$229.65, making the total cost \$1,469,768 in Year 2.

The following table shows the breakout of how the PMPM cost was developed. This spreadsheet is also attached as a separate document.

| Field-based Care Coordination Bundle | Qty | Rate | Rate Description | Units Y2 | Units Y3-Y5 | Unit Description | Annual Cost per Unit | Total, Y2 | Total, Y3-Y5 |
|---|--------------------------|-------------|-----------------------------------|-----------------|--------------------|------------------------------------|-----------------------------|--------------------|---------------------|
| Staff | | | | | | | | | |
| Care Coordination Manager | 173.333 | \$77.57 | hours per month x per hour rate | 8 | 12 | | \$13,445 | \$107,564 | \$161,345 |
| CHWs | 3,603.999 | \$34.43 | Hours per mo. (20.8 FTE p) x rate | 8 | 12 | Month x 20.8 FTE persons | \$124,086 | \$992,685 | \$1,489,028 |
| | | | | | | | | | |
| Infrastructure | | | | | | | | | |
| Rent (partial, 25% of 576 sq ft) | 144.00 | \$2.10 | Rent (25%) x cost per square foot | 8 | 12 | Months | \$302 | \$2,419 | \$3,629 |
| Wireless Contract - Cellphones | 22.00 | \$150.00 | Contracts x cost per month | 8 | 12 | Cellphones - Admin | \$3,300 | \$26,400 | \$39,600 |
| Wireless Contract Laptops | 22.00 | \$150.00 | Cellphones - Mobile Team | 8 | 12 | Cellphones - Mobile Team | \$3,300 | \$26,400 | \$39,600 |
| Care Coordinator Training (50%) | 0.50 | \$10,500.00 | Training per session, 4 per | 6 | 4 | 2 per Q Y2, 1 per Q later | \$5,250 | \$31,500 | \$21,000 |
| Travel for CHWs | 65,000 | \$0.54 | Miles, all CHWs per month | 8 | 12 | Months of travel 100 miles per day | \$35,100 | \$280,800 | \$421,200 |
| Conference travel cost | 1 | \$1,000.00 | Per trip quarterly | 2 | 4 | Quarterly expenses | \$1,000 | \$2,000 | \$4,000 |
| | | | | | | | | | |
| | Portion in Bundle | | | | | Total | | \$1,469,768 | \$2,179,402 |

This breakout addresses the differences between Y2, when there is eight months of direct services and Y3 through Y5 which are expected to have an attrition rate of 20% (or 120 of the 600 participants replaced per year).

The Care Coordinator shows a monthly hours figure and a rate per hour. This is multiplied by 8 months to achieve a total of \$107,564 for Year 2, and \$161,345 in later years.

The CHWs are calculated in the same manner, with the quantity being the number of hours that 15.6 FTE CHWs will work per month. This produces \$992,685 for the partial Year 2 and \$1,489,028 for Years 3-5.

Rent: The 576 sq. ft. office rent is partially allocated to this team (25%, or 144 sq. ft.) and multiplied by \$2.10 per sq. ft. for one month's rent. This is then multiplied by 8 months for Year 2 and 12 for subsequent years producing annual totals of \$2,419 and \$3,629 respectively.

Wireless Contracts – Cellphones/Laptops are the monthly service contracts for secure cellphone and laptop service with Internet hotspots, calculated at 22 cell phones x \$150 x 8 months = \$26,400 in Year 2 and \$39,600 in Years 3-5.

Care Coordinator Training is also being allocated 50% to this team. The full-day training sessions in subsequent years will be conducted once per quarter, but during this start-up phase will have three per quarter. At a training session day cost of \$10,500, this team is allocated half of the Year 2 cost or \$31,500 and half of the four annual sessions of subsequent years or \$21,000 for Years 3-5.

Travel for CHWs is based on 100 miles per day x 20.8 CHW x \$0.54 cents per mile federal rate for 2016. This results in 65,000 miles per month x \$0.54 per mile = \$35,100 per month. In Year 2, eight months of this travel will apply totaling \$280,800 then 12 months in subsequent Years 3-5 totaling \$421,200.

Conference travel cost is allocated to each team to attend WPC conferences and meetings. A total of one person-trips per quarter x \$1,000 estimated cost per person for the Care Coordination Manager. With two quarters in Year 2 and four in Years 3-5, the totals will work out to be \$2,000 and \$4,000 respectively.

| | Portion in Bundle | | | Y2 | Y3-Y5 | Total | | \$1,469,768 | \$2,179,402 |
|----------------------|-------------------|-------|--|-------|-------|----------------------|--|-------------|-------------|
| | Y2 | Y3-Y5 | | | | | | Y2 | Y3-Y5 |
| Member Months | 100% | 100% | | 6,400 | 9,600 | Member Months | | \$229.65 | \$227.02 |

Determining PMPM Cost: The Portion section in the lower part of the table (visible above) identifies what portion of the participant base that the team is expected to reach per month. This is multiplied against the total member months available (which are 6,400 for Year 2 and 9,600 for subsequent years). The result is used to divide the costs for Year 2 and Years 3-5 to produce the PMPM cost for this team. In this instance, the total cost of \$1,469,768 in Year 2 x 6,400 member months x 100% = \$229.65 for Year 2. For the later years, \$2,179,402 x 9,600 member months x 100% produces a PMPM of \$227.02 in Years 3-5. (Rounding due to spreadsheet calculations.)

Care Coordination Bundle: This team is expected to reach 4,800 member months at a PMPM cost of \$291.06 producing a cost of \$1,769,653 for Year 2.

| Care Coordination Bundle | Qty | Rate | Rate Description | Units Y2 | Units Y3-Y5 | Unit Description | Annual Cost per Unit | Total, Y2 | Total, Y3-Y5 |
|---------------------------|---------|---------|---------------------------------|----------|-------------|------------------|----------------------|-----------|--------------|
| Staff | | | | | | | | | |
| Care Coordination Manager | 173.333 | \$77.57 | hours per month x per hour rate | 8 | 12 | | \$13,445 | \$107,564 | \$161,345 |
| Care Manager (LCSW/MA) | 554.666 | \$58.94 | hours x per hour | 8 | 12 | | \$32,692 | \$261,536 | \$392,304 |

| | | | | | | | | | |
|----------------------------------|--------------------------|--------------|---------------------------------|-----------|--------------|------------------------------|------------------|--------------------|--------------------|
| Care Manager (RN) | 554.666 | \$58.94 | hours x per hour (2 persons) | 8 | 12 | | \$32,692 | \$261,536 | \$392,304 |
| Care Manager (LMFT) | 277.333 | \$58.94 | hours x per hour (1 persons) | 8 | 12 | | \$16,346 | \$130,768 | \$196,152 |
| | | | | | | | | | |
| Infrastructure | | | | | | | | | |
| Rent (partial, 50% of 576 sq ft) | 288 | \$2.10 | Allocated footage x cost per sf | 8 | 12 | Months | \$605 | \$ 4,838 | \$7,258 |
| Wireless Contract - Cellphones | 10 | \$150.00 | Contracts x cost per month | 8 | 12 | Cellphones - Admin | \$1,500 | \$12,000 | \$18,000 |
| Wireless Contract Laptops | 10 | \$150.00 | Contracts x cost per month | 8 | 12 | Cellphones - Mobile Team | \$1,500 | \$12,000 | \$18,000 |
| Care Coordinator Training (25%) | 0.25 | \$ 10,500.00 | Training, per session, 4 per | 6 | 4 | 2 per Q Y2, 1 per Q later | \$2,625 | \$15,750 | \$10,500 |
| Conferences travel cost | 10 | \$ 1,000.00 | Per trip quarterly | 2 | 4 | Quarterly expenses | \$10,000 | \$20,000 | \$40,000 |
| Enhanced Care Coordination | 4,800 | \$ 27.00 | 80% of population | 8 | 12 | Bus Tokens, food vouchers | \$129,600 | \$1,036,800 | \$1,555,200 |
| | | | | | | Subtotal | \$241,005 | \$1,862,792 | \$2,791,063 |
| | | | | | | Less 5% TCM Allowance | | \$(93,140) | \$(139,553) |
| | Portion in Bundle | | | | | Total | | \$1,769,653 | \$2,651,510 |
| | Y2 | Y3-Y5 | | Y2 | Y3-Y5 | | | Y2 | Y3-Y5 |
| Member Months | 95% | 95% | | 6,400 | 9,600 | Member Months | | \$291.06 | \$290.74 |

Care Coordination Bundle Table: This table is broken out the same way as the Field-based Care Coordination Team table just discussed. The primary differences are the number of staff, and the allocation of 50% of the rent, due to the team’s centralized “in-office” base, and 25% of the training costs to this team.

Determining PMPM Cost: The Portion section in the lower part of the table identifies what portion of the participant base that the team is expected to reach per month. This is multiplied against the total member months available (which are 6,400 for Year 2 and 9,600 for subsequent years). The result is used to divide the costs and produce the PMPM cost for this team. In this instance, the total cost is \$1,769,653/6,400 participant months x 95% = \$291.06 PMPM for Year 2, and \$2,651,510/9,600 participant months x 95% = \$290.74 PMPM cost in Years 3-5. Totals in this bundle are affected by a small overlap with the Targeted Case Management Program, resulting in a reduction in total request funding. (Rounding due to spreadsheet calculations.)

Engagement Bundle

| <i>Engagement Bundle</i> | <i>Qty</i> | <i>Rate</i> | <i>Rate Description</i> | <i>Units Y2</i> | <i>Units Y3-Y5</i> | <i>Unit Description</i> | <i>Annual Cost per Unit</i> | <i>Total, Y2</i> | <i>Total, Y3-Y5</i> |
|----------------------------------|--------------------------|--------------|---------------------------------|-----------------|--------------------|---------------------------|-----------------------------|------------------|---------------------|
| Staff | | | | | | | | | |
| Care Coordination Manager | 519.999 | \$77.57 | hours per month x per hour rate | 8 | 12 | | \$40,336 | \$322,691 | \$484,036 |
| Nurse Practitioner (for mobile) | 519.999 | \$77.57 | hours per month x per hour rate | 8 | 12 | | \$40,336 | \$322,691 | \$484,036 |
| Clinic Assistant (MA) | 519.999 | \$27.61 | per month x per hour | 8 | 12 | | \$14,357 | \$114,857 | \$172,286 |
| | | | | | | | | | |
| Infrastructure | | | | | | | | | |
| Rent (partial, 25% of 576 sq ft) | 144.00 | \$2.10 | Allocated footage x cost per sf | 8 | 12 | Months | \$302 | \$2,419 | \$3,629 |
| Mobile van maintenance | 3 | \$2,104.38 | Cost per mo. @ 0.54 cents | 8 | 12 | Months of service | \$6,313 | \$50,505 | \$75,758 |
| Wireless Contract - Cellphones | 9 | \$150.00 | Contracts x cost per month | 8 | 12 | Months of service | \$1,350 | \$10,800 | \$16,200 |
| Wireless Contract Laptops | 9 | \$150.00 | Contracts x cost per month | 8 | 12 | Months of service | \$1,350 | \$10,800 | \$16,200 |
| Care Coordinator Training (25%) | 0.25 | \$10,500.00 | Training, per session, 4 per | 6 | 4 | 2 per Q Y2, 1 per Q later | \$2,625 | \$15,750 | \$10,500 |
| Collaborative travel cost | 2 | \$1,000.00 | Per trip quarterly | 2 | 4 | Quarterly expenses | \$2,000 | \$4,000 | \$8,000 |
| | | | | | | | | | |
| | Portion in Bundle | | | | | Total | | \$854,513 | \$1,270,644 |
| | Y2 | Y3-Y5 | | Y2 | Y3-Y5 | | | Y2 | Y3-Y5 |
| Member Months | 40% | 40% | | 6,400 | 9,600 | Member Months | | \$333.79 | \$330.90 |

Engagement Bundle Table: This table is broken out the same way as the previous two. The Engagement Teams have relatively small staff, but incurs costs for the operation of the vehicles. Only 25% of the rent and training costs are allocated to this team.

Determining PMPM Cost: The Portion section in the lower part of the table identifies what portion of the participant base those teams are expected to reach per month. This is multiplied against the total member

months available (which are 6,400 for Year 2 and 9,600 for subsequent years). The result is used to divide the costs for Year 2 and Years 3-5 to produce the PMPM cost for this team. In this instance, the Engagement Teams are expected to reach 2,560 participant-months during Year 2 (6,400 x 40%). The cost using the breakout table is \$854,513/6,400 participant months x 40% = PMPM cost of \$333.79 for Year 2. For later years, Engagement Teams are expected to reach 3,840 participant-months during Year 2 (9,600 x 40%). The cost using the breakout table is \$1,270,644/9,600 participant months x 40% = PMPM cost of \$330.90. (Rounding due to spreadsheet calculations.)

Pay for Reporting

In the Pay for Reporting category for Year 2 are a number of milestones connected to demonstrating capabilities of the developing system. All Pay for Reporting will be paid to the Lead Entity which is responsible for reporting project progress. Pay for Reporting incentives will only be requested in Year 2.

| Pay For Reporting | | |
|--|--|----------------------------|
| <i>Item</i> | <i>Incentive Payment for Achievement</i> | <i>Max WPC Fund Amount</i> |
| UM i.4: The ED visit metric will be measured for enrolled participants at least quarterly. | 250,000 | 250,000 |
| UM ii.4: The number of inpatient encounters and lengths of stay will be measured for those enrolled in the project at least quarterly. | 250,000 | 250,000 |
| UM v3: PDSA will be used to measure and make changes about the comprehensive care plan metric at least quarterly. | 250,000 | 250,000 |
| Establishment of care coordination, case mgmt, referral policies | 250,000 | 250,000 |
| Implement oversight of care coordination, case mgmt, referral policies | 250,000 | 250,000 |
| Quarterly review of care coordination, case mgmt, referral policies | 250,000 | 250,000 |
| Semi-annual PDSA review of care coordination, case mgmt, referral policies | 250,000 | 250,000 |
| Compile, analyze PDSA results and modify policies for care coordination, case management, referral policies as indicated | 250,000 | 250,000 |
| Establish data/information sharing policies and procedures | 250,000 | 250,000 |
| Establish monitoring procedures for data/information sharing | 250,000 | 250,000 |
| Quarterly review of data/information sharing policies | 250,000 | 250,000 |
| Semi-annual PDSA review of data/information sharing policies | 250,000 | 250,000 |

| | | |
|---|---------|---------|
| Compile, analyze PDSA results and modify policies for data/information sharing as indicated | 250,000 | 250,000 |
| Record and report housing authority follow-ups | 250,000 | 250,000 |
| At least 500 encounters, signed consent forms | 250,000 | 250,000 |

Metric i. Health Outcomes Goal i.4: Measuring and PDSA process of ED visits: The achievement of this item in accordance with timelines will be reported to DCHS for an incentive payment of \$250,000 paid to the lead entity.

Metric i. Health Outcomes Goal i.4: Measuring and PDSA process of inpatient utilization: The achievement of this item in accordance with timelines will be reported to DCHS for an incentive payment of \$250,000 paid to the lead entity.

Metric v. Health Outcomes Goal v.3: Measuring and PDSA process of comprehensive care plan process: The achievement of this item in accordance with timelines will be reported to DCHS for an incentive payment of \$250,000 paid to the lead entity.

Metric vi. Administrative Metric Goal vi.1: Establishment of care coordination, care management, and referral policies: The achievement of this item in accordance with timelines will be reported to DCHS for an incentive payment of \$250,000 paid to the lead entity.

Metric vi. Administrative Metric Goal vi.2: Implement oversight of care coordination, care management, and referral: The achievement of this item in accordance with timelines will be reported to DCHS for an incentive payment of \$250,000 paid to the lead entity.

Metric vi. Administrative Metric Goal vi.3: Quarterly review of care coordination, care management, and referral policies: The achievement of this item in accordance with timelines will be reported to DCHS for an incentive payment of \$250,000 paid to the lead entity.

Metric vi. Administrative Metric Goal vi.4: Semi-annual PDSA review of care coordination, care management, and referral policies: The achievement of this item in accordance with timelines will be reported to DCHS for an incentive payment of \$250,000 paid to the lead entity.

Metric vi. Administrative Metric Goal vi.5: Demonstrate compiling and analysis of care coordination, care management, and referral data and the Quality Improvement process: The achievement of this item in accordance with timelines will be reported to DCHS for an incentive payment of \$250,000 paid to the lead entity.

Metric vii. Administrative Metric Goal vii.1: Establish data and information sharing policies and procedures: The achievement of this item in accordance with timelines will be reported to DCHS for an incentive payment of \$250,000 paid to the lead entity.

Metric vii. Administrative Metric Goal vii.2: Establish monitoring procedures for data and information sharing: The achievement of this item in accordance with timelines will be reported to DCHS for an incentive

payment of \$250,000 paid to the lead entity.

Metric vii. Administrative Metric Goal vii.3: Quarterly review of data and information sharing policies: The achievement of this item in accordance with timelines will be reported to DCHS for an incentive payment of \$250,000 paid to the lead entity. The total amount paid will be based on the accomplishment of each deliverable on a quarterly basis at 4 quarters x \$75,000.

Metric vii. Administrative Metric Goal vii.3: Semi-annual PDSA review of data and information sharing policies: The achievement of this item in accordance with timelines will be reported to DCHS for an incentive payment of \$250,000 paid to the lead entity. The total amount paid will be based on the accomplishment of each review deliverable on a semi-annual basis at 2 per year x \$125,000.

Metric vii. Administrative Metric Goal vii.5: Demonstrate compiling and analysis of above and QI processes: The achievement of this item in accordance with timelines will be reported to DCHS for an incentive payment of \$250,000 paid to the lead entity. This incentive will be triggered if at least 1,500 of the 1,698 anticipated encounters, types of services, and results with the Area Housing Authority are recorded and reported.

Housing authority's record for follow-ups: The achievement of this item in accordance with timelines will be reported to DCHS for an incentive payment of \$250,000 paid to the lead entity. This incentive will be triggered if at least 2,000 of the 2,264 anticipated encounters, types of services, and results with the Area Housing Authority are recorded and reported.

At least 500 encounters as ascertained by signed consent forms: The status of this will be reported out and there is an incentive payment associated with this item of \$250,000. The recording and reporting of a signed Universal Consent form will trigger this incentive, calculated at \$312.50 x 800 participants = \$250,000.

Pay for Outcomes Achievement

Universal Metrics: The Pay for Outcomes has four Universal Metrics and two Variant Metrics in Year 2:

| Pay for Outcomes | | |
|--|--|----------------------------|
| <i>Item</i> | <i>Incentive Payment for Achievement</i> | <i>Max WPC Fund Amount</i> |
| U. Metric i: ED visits - maintain baseline | 750,000 | 750,000 |
| U. Metric ii: Inpatient utilization - maintain baseline | 750,000 | 750,000 |
| U. Metric iii: Follow-up within 30 day post ED MH visit - maintain baseline | 500,000 | 500,000 |
| U. Metric iv.1: New AOD events treated within 14 days - maintain baseline | 500,000 | 500,000 |
| U. Metric iv.2: New AOD events get treatment and at least 2 services within 30 days. Maintain baseline | 500,000 | 500,000 |

| | | |
|---|---------|---------|
| Variant M1: Percentage of participants that have at least six encounters with a CSW during the project year. At least 60% of participants. | 500,000 | 500,000 |
| Variant M2: Percentage of patients 18 - 75 years of age with Diabetes (type 1 or type 2) who had Hemoglobin A1c <8.0% during the measurement period. At least maintain baseline. | 500,000 | 500,000 |
| Variant M3: Percentage of adult patients age 18 and older with major depression or dysthymia and an initial PHQ-9 score > 9 who demonstrate remission at twelve months defined as PHQ-9 score less than 5. (NQF 0710). At least maintain baseline. | 500,000 | 500,000 |
| Variant M4: Percentage of patients aged 18 years and older with a diagnosis of major depressive disorder (MDD) with a suicide risk assessment completed during the visit in which a new diagnosis or recurrent episode was identified. (NQF 0104) At least maintain baseline. | 500,000 | 500,000 |
| Variant M5: Percentage of homeless receiving housing services in the project year that referred for housing services. At least 50%. | 450,000 | 450,000 |
| Optional Variant M6: Percentage of participants who have at least six encounters with a CSW during the project year. At least 50%. | 450,000 | 450,000 |

- **Metric i. Health Outcomes Goal i.1:** ED visits will maintain baseline measurements in project Year 2, be reduced among enrolled participants by at least 10% from baseline in project Year 3, will be reduced at least 15% from baseline in Year 4, and will be reduced at least 20% from baseline in project Year 5. This incentive of \$750,000 will be triggered by maintaining or any reduction in baseline ED visits in Year 2.
- **Metric i. Health Outcomes Goal i.2:** ED visits will maintain baseline measurements in project Year 2, be reduced among enrolled participants by at least 15% from baseline in project Year 3, will be reduced at least 20% from baseline in Year 4, and will be reduced at least 25% from baseline in project Year 5. This incentive of \$750,000 will be triggered by maintaining or any reduction in baseline ED visits in Year 2.
- **Metric i. Health Outcomes Goal i.3:** ED visits will maintain baseline measurements in project Year 2, be reduced among enrolled participants by at least 20% from baseline in project Year 3, will be reduced at least 25% from baseline in Year 4, and will be reduced at least 30% from baseline in project Year 5. This incentive of \$500,000 will be triggered by maintaining or any reduction in baseline ED visits in Year 2.
- **Metric ii. Health Outcomes Goal ii.1:** Inpatient utilization will maintain baseline measurements in project Year 2, be reduced among enrolled participants by at least 10% from baseline in project Year 3, and will be reduced at least 15% from baseline in project Year 4, and will be reduced at

least 20% from baseline in project Year 5. This incentive of \$500,000 will be triggered by maintaining or any reduction in baseline for inpatient utilization in Year 2.

- **Metric ii. Health Outcomes Goal ii.2:** Inpatient utilization will maintain baseline measurements in project Year 2, be reduced among enrolled participants by at least 15% from baseline in project Year 3, and will be reduced at least 20% from baseline in project Year 4, and will be reduced at least 25% from baseline in project Year 5. This incentive \$500,000 will be triggered by maintaining or any reduction in baseline for inpatient utilization in Year 2.
- **Metric ii. Health Outcomes Goal ii.3:** Inpatient utilization will maintain baseline measurements in project Year 2, be reduced among enrolled participants by at least 20% from baseline in project Year 3, and will be reduced at least 25% from baseline in project Year 4, and will be reduced at least 30% from baseline in project Year 5. This incentive \$500,000 will be triggered by maintaining or any reduction in baseline for inpatient utilization in Year 2.
- **Metric iii. Health Outcomes Goal iii:** Participants will have a follow-up visit within 30 days of discharge among those who had an ED visit with a primary diagnosis of mental illness. The follow-up visit will be an outpatient visit, intensive outpatient encounter, or partial hospitalization with a primary diagnosis of a mental health disorder and/or to a behavioral health facility. The goal will be to maintain baseline measurements in project Year 2, be improved among enrolled participants by at least 5% from baseline in project Year 3, be improved at least 10% from baseline in project Year 4, and be improved at least 15% from baseline in project Year 5. This incentive of \$500,000 will be triggered by maintaining or any improvement in baseline for follow-up after mental health ED visits within 14 days in Year 2.
- **Metric iv. Health Outcomes Goal iv.1:** Participants with a new episode of alcohol or other drug (AOD) dependence initiate treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter, or partial hospitalization within 14 days of the diagnosis. The goal will be to maintain baseline measurements in project Year 2, be improved among enrolled participants by at least 5% from baseline in project Year 3, improved by at least 10% from baseline in project Year 4, and will be improved at least 15% baseline in project Year 5. This incentive of \$500,000 will be triggered by maintaining or any improvement in baseline for treatment for AOD within 14 days in Year 2.
- **Metric iv. Health Outcomes Goal iv.2:** Participants with a new episode of alcohol or other drug (AOD) dependence who initiated treatment and who had two or more additional services with a diagnosis of AOD within 30 days of the initiation visit. The goal will be to maintain baseline measurements in project Year 2, be improved among enrolled participants by at least 5% from baseline in project Year 3, be improved at least 10% from baseline in project Year 4, and be improved at least 15% baseline in project Year 5. This incentive of \$500,000 will be triggered by maintaining or any improvement in baseline for treatment for AOD within 14 days in Year 2.

Variant Metrics:

- **Variant Metric M1:** Percentage of CHWs receiving quarterly in-service training based on gaps identified through field work via PDSA improvement cycles. This incentive will be triggered if at least 60% of CHWs attend quarterly trainings in Year 2, at least 65% in Year 3, at least 70% in Year 4, and at least 75% in Year 5.
- **Variant Metric M2:** Percentage of patients 18 - 75 years of age with Diabetes (type 1 or type 2) who had Hemoglobin A1c <8.0% during the measurement period. This incentive will be triggered if participants maintain or there is any improvement in baseline Hemoglobin A1c in Year 2, at least 5% improvement from baseline in Year 3, at least 10% improvement from baseline in Year 4,

and at least 15% improvement from baseline in Year 5.

- **Variant Metric M3:** Percentage of adult patients age 18 and older with major depression or dysthymia and an initial PHQ-9 score > 9 who demonstrate remission at twelve months defined as PHQ-9 score less than 5. This incentive will be triggered if participants maintain or there is any improvement in baseline PHQ-9 > 9 in Year 2, at least 5% improvement from baseline in Year 3, at least 10% improvement from baseline in Year 4, and at least 15% improvement from baseline in Year 5.
- **Variant Metric M4:** Percentage of patients aged 18 years and older with a diagnosis of major depressive disorder (MDD) with a suicide risk assessment completed during the visit in which a new diagnosis or recurrent episode was identified. This incentive will be triggered if participants maintain or there is any improvement in baseline suicide risk assessments administered in Year 2, at least 5% improvement from baseline in Year 3, at least 10% improvement from baseline in Year 4, and at least 15% improvement from baseline in Year 5.
- **Variant Metric M5:** Percentage of homeless receiving housing services in the project year that referred for housing services. This incentive will be triggered if at least 50% of referred homeless receive housing services in Year 2, at least 55% in Year 3, at least 60% in Year 4, and at least 65% in Year 5.
- **Variant Metric M6:** Percentage of participants who have at least six encounters with a CSW during the project year. This incentive will be triggered if at least 50% of referred homeless receive housing services in Year 2, at least 55% in Year 3, at least 60% in Year 4, and at least 65% in Year 5.

The discussion of Years 3 through 5 that follows in the next section will focus on the differences from Year 2.

Years 3, 4, and 5

Administrative Infrastructure

| Administrative Infrastructure | | | |
|--|----------------------------|------------------|----------------------------|
| <i>Item</i> | <i>Max Amount Per Unit</i> | <i>Max Units</i> | <i>Max WPC Fund Amount</i> |
| Program Director | 164,835 | 1.00 | 164,835 |
| Informaticist | 127,178 | 1.60 | 203,485 |
| Database Analyst | 100,580 | 1.60 | 160,928 |
| Administrative Assistant | 70,069 | 1.00 | 70,069 |
| Medical Director (Primary Care) | 224,300 | 0.50 | 112,150 |
| Behavioral Health Director (Psychiatric) | 441,697 | 0.50 | 220,849 |
| WPC Financial Manager | 167,388 | 1.00 | 167,388 |
| QI Coordinator | 124,398 | 1.00 | 124,398 |
| Legal Counsel | 140 | 120.00 | 16,800 |
| Office Supplies, per person | 300 | 41.00 | 12,300 |
| Indirect Rate at 5% | 18,635,750 | 0.05 | 931,788 |

The staff calculations are all the same as Year 2. But of the non-staff expenses, only the office supplies remain. Other expenses are absorbed into the PMPM bundles as discussed above or are one-time expenses. This remains true for Years 4 and 5 as well.

Delivery Infrastructure Year 3

| Delivery Infrastructure | | | |
|---------------------------------------|----------------------------|------------------|----------------------------|
| <i>Item</i> | <i>Max Amount Per Unit</i> | <i>Max Units</i> | <i>Max WPC Fund Amount</i> |
| Centralized Enterprise Infrastructure | 297,950 | 1 | 297,950 |
| Centralized Enterprise Contract | 25,000 | 12 | 300,000 |
| IT Development | 611,215 | 1 | 611,215 |
| WPC Connect Contract | 25,000 | 12 | 300,000 |
| Health Registry Contract | 2,250 | 12 | 27,000 |

The Centralized Enterprise Infrastructure will provide vendor work, hardware, and software development to launch the Integrated Care Plan, data sharing, and other technology to support care management. The Centralized Enterprise Contract and WPC Connect Contract, both billed by the month, will be calculated at 12 months x \$5,000 per month in Years 3-5. IT Development will be needed to integrate the Enterprise system with current technologies, define architecture, work with partnering entities to develop data sharing technologies, and develop data and reporting systems.

Years 4-5

| Delivery Infrastructure | | | |
|---------------------------------|----------------------------|------------------|----------------------------|
| <i>Item</i> | <i>Max Amount Per Unit</i> | <i>Max Units</i> | <i>Max WPC Fund Amount</i> |
| Centralized Enterprise Contract | 25,000 | 12 | 300,000 |
| IT Development | 309,165 | 1 | 309,165 |
| WPC Connect Contract | 25,000 | 12 | 300,000 |
| Health Registry Contract | 2,250 | 12 | 27,000 |

The Centralized Enterprise Infrastructure costs are concluded in Year 2, but IT Development continues through Phase II implementation to provide more advanced integrative capabilities to the data sharing and tracking are added, eReferral, and other improvements as discussed more fully in the application narrative. It is also anticipated that much of the PDSA processes will drive technology improvements to optimize the support of care management. In Year 3, the Phase II IT Development cost is \$602,050 in Year 3, then drops to \$300,000 in Years 4-5 to maintain ongoing connectivity, integration, trouble shooting, and training within the system, and to initiate any additional needed changes identified through PDSA processes.

Incentive Payments

| Incentive Payments | | | |
|--|----------------------------|------------------|----------------------------|
| <i>Item</i> | <i>Max Amount Per Unit</i> | <i>Max Units</i> | <i>Max WPC Fund Amount</i> |
| Housing support services | 150 | 5,194 | 779,100 |
| At least 60% of patients will have care plan within 30 days | 500 | 478 | 239,000 |
| At least 80% of patients will have updated care plan within 30 days of anniversary | 625 | 640 | 400,000 |
| At least 50% follow-up after MD ED visit | 500 | 400 | 200,000 |
| Meeting attendance expense coverage | 100 | 240 | 24,000 |

In Year 3-5, the incentives support a larger and complete patient population for the full year, totaling \$1,642,100. The incentive categories remain the same, with the exception of the addition of Universal Metric v.2, which is that at least 80% of participants will have an updated comprehensive care plan, within 30 days of the participant's anniversary of participation in the pilot.

Fee-for-Service

| FFS Services | | | |
|--------------------------|----------------------------|------------------|----------------------------|
| <i>Item</i> | <i>Max Amount Per Unit</i> | <i>Max Units</i> | <i>Max WPC Fund Amount</i> |
| Mobile Outreach Services | 168.94 | 1,200 | 202,728 |

Mobile Outreach Services: Mobile outreach services, provided by the Engagement Team and CSWs, will

continue to support community outreach to identify persons who have been targeted by the risk stratification technology system (or are otherwise eligible based on assessment), introduce project services, get consent, develop initial assessments, attend to urgent needs, and connect them with a Field-Based Care Coordination CSW. In Years 3-5, however, these services will be provided to fewer persons because in Year 2, the count is elevated to support filling the caseload by month 5. These services are calculated at \$168.94 for each engagement of the mobile outreach team (6 staff) x 1,200 engagements = \$202,728.

PMPM Bundled Services

| PMPM Bundle | | | |
|--------------------------------------|-------------|--------------------------|----------------------------|
| <i>Item</i> | <i>PMPM</i> | <i>Max Member Months</i> | <i>Max WPC Fund Amount</i> |
| Field-based Care Coordination Bundle | 227.02 | 9,600 | 2,179,402 |
| Care Coordination Bundle | 290.74 | 9,120 | 2,651,510 |
| Engagement Bundle | 330.90 | 3,840 | 1,270,644 |

These bundles are in the same categories described earlier, but reflect an increase in the number of member months because of the larger patient base being served, with 9,600 patient months versus 6,400 patient months. The combined total for the three PMPM bundles is \$6,101,556, which remains fixed at this level for Years 3 through 5.

Pay for Reporting

Year 3-5

| Pay For Reporting | | |
|--|--|----------------------------|
| <i>Item</i> | <i>Incentive Payment for Achievement</i> | <i>Max WPC Fund Amount</i> |
| UM i.4: The ED visit metric will be measured for enrolled participants at least quarterly. | 250,000 | 250,000 |
| UM ii.4: The number of inpatient encounters and lengths of stay will be measured for those enrolled in the project at least quarterly. | 250,000 | 250,000 |
| UM v3: PDSA will be used to measure and make changes about the comprehensive care plan metric at least quarterly. | 250,000 | 250,000 |
| Quarterly review of care coordination, case mgmt, referral policies | 250,000 | 250,000 |
| Semi-annual PDSA review of care coordination, case mgmt, referral policies | 250,000 | 250,000 |
| Establish data/information sharing policies and procedures | 250,000 | 250,000 |
| Quarterly review of data/information sharing policies | 250,000 | 250,000 |

| | | |
|--|---------|---------|
| Semi-annual PDSA review of data/information sharing policies | 250,000 | 250,000 |
| Record and report housing authority follow-ups | 250,000 | 250,000 |
| At least 500 encounters, signed consent forms | 250,000 | 250,000 |

After Year 2 when policies have been established, then PDSA processes, and quarterly and semi-annual reviews remain to ensure that the quality of the services provided are maintained at the highest level. The one-time Pay for Reporting metrics that are omitted in Years 3-5 include Metrics vi.1, vi.2, vi.5, vii.1, vii.,2, and vii.5. All Pay for Reporting Metrics are proposed for \$250,000, and triggered by achievement of the metric as indicated in Year 2.

Pay for Outcomes

Year 3

| Pay for Outcomes | | |
|--|--|----------------------------|
| <i>Item</i> | <i>Incentive Payment for Achievement</i> | <i>Max WPC Fund Amount</i> |
| U. Metric i1: ED visits: At least 10% increase from baseline | 250,000 | 250,000 |
| U. Metric i2: ED visits: At least 15% increase from baseline | 300,000 | 300,000 |
| U. Metric i3: ED visits: At least 20% increase from baseline. | 375,000 | 375,000 |
| U. Metric ii1: Inpatient utilization: At least 10% increase from baseline. | 250,000 | 250,000 |
| U. Metric ii2: Inpatient utilization: At least 15% increase from baseline. | 300,000 | 300,000 |
| U. Metric ii3: Inpatient utilization: At least 20% increase from baseline. | 375,000 | 375,000 |
| U. Metric iii: Follow-up within 30 day post ED MH visit: At least 5% increase from baseline. | 450,000 | 450,000 |
| U. Metric iv.1: New AOD events treated within 14 days: At least 5% increase from baseline. | 350,000 | 350,000 |
| U. Metric iv.2: New AOD events get treatment and at least 2 services within 30 days. At least 5% increase from baseline. | 350,000 | 350,000 |
| Variant M1: Percentage of participants that have at least six encounters with a CSW during the project year. At least 65% of participants. | 350,000 | 350,000 |
| Variant M2: Percentage of patients 18 - 75 years of age with Diabetes (type 1 or type 2) who had Hemoglobin A1c <8.0% during the measurement period. At least 5% increase from baseline. | 450,000 | 450,000 |

| | | |
|---|---------|---------|
| Variant M3: Percentage of adult patients age 18 and older with major depression or dysthymia and an initial PHQ-9 score > 9 who demonstrate remission at twelve months defined as PHQ-9 score less than 5. (NQF 0710). At least 5% increase from baseline. | 450,000 | 450,000 |
| Variant M4: Percentage of patients aged 18 years and older with a diagnosis of major depressive disorder (MDD) with a suicide risk assessment completed during the visit in which a new diagnosis or recurrent episode was identified. (NQF 0104) At least 5% increase from baseline. | 450,000 | 450,000 |
| Variant M5: Percentage of homeless receiving housing services in the project year that referred for housing services. At least 55%. | 350,000 | 350,000 |
| Optional Variant M6: Percentage of participants who have at least six encounters with a CSW during the project year. At least 55%. | 350,000 | 350,000 |

Years 4

| Pay for Outcomes | | |
|---|--|----------------------------|
| <i>Item</i> | <i>Incentive Payment for Achievement</i> | <i>Max WPC Fund Amount</i> |
| U. Metric i1: ED visits: At least 15% increase from baseline. | 250,000 | 250,000 |
| U. Metric i2: ED visits: At least 20% increase from baseline. | 300,000 | 300,000 |
| U. Metric i3: ED visits: At least 25% increase from baseline. | 350,000 | 350,000 |
| U. Metric ii1: Inpatient utilization: At least 15% increase from baseline. | 250,000 | 250,000 |
| U. Metric ii2: Inpatient utilization: At least 20% increase from baseline. | 350,000 | 350,000 |
| U. Metric ii3: Inpatient utilization: At least 25% increase from baseline. | 350,000 | 350,000 |
| U. Metric iii: Follow-up within 30 day post ED MH visit: At least 10% increase from baseline. | 550,000 | 750,000 |
| U. Metric iv.1: New AOD events treated within 14 days: At least 10% increase from baseline. | 350,000 | 350,000 |
| U. Metric iv.2: New AOD events get treatment and at least 2 services within 30 days. At least 10% increase from baseline. | 350,000 | 350,000 |

| | | |
|--|---------|---------|
| Variant M1: Percentage of participants that have at least six encounters with a CSW during the project year. At least 70% of participants. | 350,000 | 350,000 |
| Variant M2: Percentage of patients 18 - 75 years of age with Diabetes (type 1 or type 2) who had Hemoglobin A1c <8.0% during the measurement period. At least 10% increase from baseline. | 550,000 | 550,000 |
| Variant M3: Percentage of adult patients age 18 and older with major depression or dysthymia and an initial PHQ-9 score > 9 who demonstrate remission at twelve months defined as PHQ-9 score less than 5. (NQF 0710). At least 10% increase from baseline. | 550,000 | 550,000 |
| Variant M4: Percentage of patients aged 18 years and older with a diagnosis of major depressive disorder (MDD) with a suicide risk assessment completed during the visit in which a new diagnosis or recurrent episode was identified. (NQF 0104) At least 10% increase from baseline. | 550,000 | 550,000 |
| Variant M5: Percentage of homeless receiving housing services in the project year that referred for housing services. At least 60%. | 350,000 | 350,000 |
| Optional Variant M6: Percentage of participants who have at least six encounters with a CSW during the project year. At least 60%. | 350,000 | 350,000 |

Year 5

| Pay for Outcomes | | |
|---|--|----------------------------|
| <u>Item</u> | <u>Incentive Payment for Achievement</u> | <u>Max WPC Fund Amount</u> |
| U. Metric i1: ED visits: At least 20% increase from baseline | 250,000 | 250,000 |
| U. Metric i2: ED visits: At least 25% increase from baseline | 300,000 | 300,000 |
| U. Metric i3: ED visits: At least 30% increase from baseline | 350,000 | 350,000 |
| U. Metric ii1: Inpatient utilization: At least 20% increase from baseline | 250,000 | 250,000 |
| U. Metric ii2: Inpatient utilization: At least 25% increase from baseline | 350,000 | 350,000 |
| U. Metric ii3: Inpatient utilization: At least 30% increase from baseline | 350,000 | 350,000 |

| | | |
|--|---------|---------|
| U. Metric iii: Follow-up within 30 day post ED MH visit: At least 15% increase from baseline. | 550,000 | 750,000 |
| U. Metric iv: New AOD events treated within 14 days: At least 15% increase from baseline. | 350,000 | 350,000 |
| U. Metric iv.2: New AOD events get treatment and at least 2 services within 30 days. At least 15% increase from baseline. | 350,000 | 350,000 |
| Variant M1: Percentage of participants that have at least six encounters with a CSW during the project year. At least 70% of participants. | 350,000 | 350,000 |
| Variant M2: Percentage of patients 18 - 75 years of age with Diabetes (type 1 or type 2) who had Hemoglobin A1c <8.0% during the measurement period. At least 15% increase from baseline. | 550,000 | 550,000 |
| Variant M3: Percentage of adult patients age 18 and older with major depression or dysthymia and an initial PHQ-9 score > 9 who demonstrate remission at twelve months defined as PHQ-9 score less than 5. (NQF 0710). At least 15% increase from baseline. | 550,000 | 550,000 |
| Variant M4: Percentage of patients aged 18 years and older with a diagnosis of major depressive disorder (MDD) with a suicide risk assessment completed during the visit in which a new diagnosis or recurrent episode was identified. (NQF 0104) At least 15% increase from baseline. | 550,000 | 550,000 |
| Variant M5: Percentage of homeless receiving housing services in the project year that referred for housing services. At least 65%. | 350,000 | 350,000 |
| Optional Variant M6: Percentage of participants who have at least six encounters with a CSW during the project year. At least 65%. | 350,000 | 350,000 |

The Pay for Outcomes section has changed in Year 3 because additional metrics have been added that pertain to the participant completing one year utilizing project services or were performance improvements year-over-year. The complete list of these metrics along with the corresponding year-to-year calculations follow.

The Pay for Outcomes has the same 11 Universal Metrics and six Variant Metrics in Years 3-5 is listed and describe in Year 2. The differences are the progressive increase in percentages to achieve incentive payments. For most Pay for Outcomes categories, the goal for improvements over baseline measures is at least 5% improvements in Year 3, at least 10% in Year 4, and a least 15% in Year 5. The differences between these metrics are those that are defined according to baseline and those that are defined by a starting percentage in Year 2, including Variant Metrics 1, 5, and 6. All metrics, however, increase in the achievement level by 5% per year.

The first two Universal Metrics i. and ii. are tiered and cumulative, meaning that there are three levels that can be reached to earn incentives. In the case of the proposed incentives for ED visits for example, if VCHCA only achieved a 10% reduction Year 3, then it would receive \$250,000 in incentives for that metric. If, however, VCHCA achieved a 20% or greater reduction in Year 3, then it would receive the total of all three sub-metrics (10%, 15%, and 20%) or \$925,000.

WPC Budget Template: Summary and Top Sheet

WPC Applicant Name: Ventura County Health Care Agency

| | Federal Funds <small>(Not to exceed 90M)</small> | IGT | Total Funds |
|---------------------------------------|--|------------|--------------------|
| Annual Budget Amount Requested | 9,783,769 | 9,783,769 | 19,567,538 |

| PY 1 Budget Allocation (Note PY 1 Allocation is predetermined) | |
|---|------------|
| PY 1 Total Budget | 19,567,538 |
| <i>Approved Application (75%)</i> | 14,675,654 |
| <i>Submission of Baseline Data (25%)</i> | 4,891,885 |
| PY 1 Total Check | OK |

| PY 2 Budget Allocation | |
|--------------------------------------|------------|
| PY 2 Total Budget | 19,567,538 |
| <i>Administrative Infrastructure</i> | 2,431,569 |
| <i>Delivery Infrastructure</i> | 2,045,520 |
| <i>Incentive Payments</i> | 655,150 |
| <i>FFS Services</i> | 202,728 |
| <i>PMPM Bundle</i> | 3,132,571 |
| <i>Pay For Reporting</i> | 4,500,000 |
| <i>Pay for Outcomes</i> | 6,600,000 |
| PY 2 Total Check | OK |

| PY 3 Budget Allocation | |
|--------------------------------------|------------|
| PY 3 Total Budget | 19,567,538 |
| <i>Administrative Infrastructure</i> | 2,092,386 |
| <i>Delivery Infrastructure</i> | 1,527,000 |
| <i>Incentive Payments</i> | 1,239,750 |
| <i>FFS Services</i> | 152,046 |
| <i>PMPM Bundle</i> | 4,656,356 |
| <i>Pay For Reporting</i> | 3,000,000 |
| <i>Pay for Outcomes</i> | 6,900,000 |
| PY 3 Total Check | OK |

| PY 4 Budget Allocation | |
|--------------------------------------|------------|
| PY 4 Total Budget | 19,567,538 |
| <i>Administrative Infrastructure</i> | 2,092,386 |
| <i>Delivery Infrastructure</i> | 927,000 |

| | |
|---------------------------|-----------|
| <i>Incentive Payments</i> | 1,239,750 |
| <i>FFS Services</i> | 152,046 |
| <i>PMPM Bundle</i> | 4,656,356 |
| <i>Pay For Reporting</i> | 3,000,000 |
| <i>Pay for Outcomes</i> | 7,500,000 |
| PY 4 Total Check | OK |

PY 5 Budget Allocation

| | |
|--------------------------------------|------------|
| PY 5 Total Budget | 19,567,538 |
| <i>Administrative Infrastructure</i> | 2,092,386 |
| <i>Delivery Infrastructure</i> | 927,000 |
| <i>Incentive Payments</i> | 1,239,750 |
| <i>FFS Services</i> | 152,046 |
| <i>PMPM Bundle</i> | 4,656,356 |
| <i>Pay For Reporting</i> | 3,000,000 |
| <i>Pay for Outcomes</i> | 7,500,000 |
| PY 5 Total Check | OK |