Whole Person Care Pilot Application

June 5, 2017

Prepared by:

Santa Clara Valley Health & Hospital System for County of Santa Clara

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Section 1: WPC Lead Entity and Participating Entity Information

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

Organization Name	Santa Clara Valley Health and Hospital System (SCVHHS)
Type of Entity	Designated Public Hospital
Contact Person	Amy Carta
Contact Person Title	Director of Government Affairs, Public Information and Special Projects
Telephone	(408) 885-4551
Email Address	Amy.Carta@hhs.sccgov.org
Mailing Address	2325 Enborg Lane, Suite 220 San Jose, CA 95128

1.2 Participating Entities

Required Organizations	Organization Name	Contact Name and Title	Entity Description and Role in WPC
1. Medi-Cal Managed Care Health Plan	Santa Clara Family Health Plan (SCFHP)	Christine Tomcala, CEO	Currently serves as a Medi-Cal managed care plan for 272,557 enrollees, of which 139,019 are enrolled in the County's safety net clinics. Together, SCFHP and the safety net clinics, including Santa Clara Valley Medical Center, work to improve the health and health outcomes for our members. Many of SCFHP's members fall in to the WPC target populations of high utilizers of multiple systems, transition aged youth and older adults. SCFHP will participate in the development and operation of the WPC Trust Community.
2. Health Services Agency/ Department	Santa Clara Valley Medical Center (SCVMC)	Paul Lorenz, CEO	SCVMC is dedicated to the health of the whole community by providing high quality, cost-effective medical care to all residents of Santa Clara County regardless of their ability to pay through a wide range of inpatient, outpatient and emergency services. SCVMC will participate in care coordination, service provision, and the development and operation of the WPC Trust Community.
3. Specialty Mental Health Agency/ Department	Santa Clara Valley Behavioral Health Services Department (BHSD)	Toni Tullys, Director	BHSD is committed to serving, improving and making a difference in the lives of Santa Clara County residents diagnosed with mental illness and substance use disorders by partnering with clients, families and communities to create culturally competent opportunities for hope, wellness and recovery. BHSD provides an extensive array of services for adults, transitional aged youth and older adults through outpatient services at county sites and contract agencies. Additional services include case management, crisis residential and transitional residential programs, a jail diversion program, client advocacy services, supported housing, shelter programs for the homeless mentally ill, partial hospitalization programs, vocational and educational supports. BHSD will participate

Required Organizations	Organization Name	Contact Name and Title	Entity Description and Role in WPC
			in care coordination, service provision and the development and operation of the WPC Trust Community.
4. Public Agency/ Department	Housing Authority of County of Santa Clara (HACSC)	Katherine Harasz, Executive Director	HACSC assists about 17,000 households through the federal rental housing assistance (Housing Choice Voucher, also known as Section 8) program. HACSC also develops, controls and manages affordable rental housing properties. HACSC programs and properties are targeted to assist low, very low and extremely low-income households. Working together with landlords, housing developers, charities and local governments, HACSC strives to provide housing and support services to as many eligible families as possible. HACSC will assist shared WPC clients to maintain their housing through the provision of support services. HACSC has proposed a special needs direct referral program that would enable County programs to refer clients directly to Section 8 vouchers; this would be a great asset to the WPC pilot and clients. In addition, HACSC will participate in the development and operation of the WPC Trust Community.
5. Community Partner 1	Community Health Partnership (CHP)	Dolores Alvarado, CEO	Community Health Partnership is a consortium organization composed of nonprofit community health centers. CHP advocates for affordable and accessible health services for diverse and multicultural communities regardless of socioeconomic, ethnic, religious, or cultural background, and supports member organizations in achieving these goals. CHP will participate in care coordination, service provision, and the development and operation of the WPC Trust Community.
6. Community Partner 2	Hospital Council, Santa Clara Section	Jo Coffaro, CEO	The Hospital Council is comprised of 12 hospitals, representing over 4,000 licensed beds, in Santa Clara County. The Hospital Council helps members provide high quality health care and improve the health status of the communities they serve. Some Hospital Council

Required Organizations	Organization Name	Contact Name and Title	Entity Description and Role in WPC
			members will participate in care coordination, service provision and the development and operation of the WPC Trust Community.
7. Additional Medi-Cal managed care health plan	Anthem-Blue Cross	Joel Gray, Executive Director	Currently serves as a Medi-Cal managed care plan for 73,886 enrollees in the county. The number of Anthem-Blue Cross members who fall in to the WPC target populations will be determined; Anthem-Blue Cross will participate in the development and operation of the WPC Trust Community.
8. Additional Public Agency	Santa Clara County Public Health Department (SCCPHD)	Dr. Sara Cody, Health Officer and Public Health Director	The Santa Clara County Public Health Department focuses on protecting and improving the health of communities through education, promotion of healthy lifestyles, disease and injury prevention, and the promotion of sound health policy. SCCPHD will participate in the development and operation of the WPC Trust Community.
9. Additional Public Agency	Office of Reentry Services	Javier Aguirre, Director	In order to decrease the number of individuals incarcerated and under probation and parole supervision, the County of Santa Clara is focusing on developing a comprehensive effort that addresses the needs and risks of former offenders. The Office of Reentry Services will participate in care coordination, service provision and the development and operation of the WPC Trust Community.
10. Additional Public Agency	Santa Clara County Social Services Agency (SSA)	Robert Menicocci, Director	SSA is a culturally sensitive and socially responsible public agency providing high quality, professional, financial, and protective services for residents of Santa Clara County. The Department of Employment and Benefits Services (DEBS) is, in part, to provide financial assistance to individuals and families with little or no income. Assistance is provided through a variety of publicly funded programs, including General Assistance (GA), which is a County-funded temporary grant assistance program that helps individuals and couples who have no

Required Organizations	Organization Name	Contact Name and Title	Entity Description and Role in WPC
			other means of adequate support. Department of Family and Children's Services (DFCS) provides services to youth by advancing child and family safety and well-being. DFCS has unique initiatives to improve outcomes for foster youth who have emancipated from the foster care system, ages 18-25. SSA will participate in care coordination, service provision, and the development and operation of the WPC Trust Community.
11. Additional Public Agency	Office of Supportive Housing (OSH)	Ky Le, Director	The Office of Supportive Housing's mission is to increase the supply of housing and supportive housing that is affordable and available to extremely low income and/or special needs households. The OSH supports the County mission of promoting a healthy, safe and prosperous community by ending and preventing homelessness. OSH will participate in care coordination, service provision and the development and operation of the WPC Trust Community.
12. Additional Public Agency	Probation Department	Laura Garnette, Chief Probation Officer	Santa Clara County Probation Department reduces crime and protects the community through prevention, investigation and supervision services and safe custodial care for adults and juveniles. As an integral part of the justice system, the Department is committed to building partnerships with the community and restoring losses to victims of crime and the public through innovative programs that stress offender accountability and development of competency skills. The Probation Department will participate in care coordination, service provision and the development and operation of the WPC Trust Community.
13. Additional Public Agency	Custody Health Services	Maryann Barry, Director	Custody Health Services provides care to over 55,773 inmates annually, of which over 18% have a serious mental illness. Custody Health Services works with the Behavioral Health Services

Required Organizations	Organization Name	Contact Name and Title	Entity Description and Role in WPC
			Department to transition inmates with serious mental illness who have a scheduled release date to providers in the community upon release. Through the WPC pilot, Custody Health Services would work to expand efforts around discharge planning in order to transition more inmates to providers in the community and maintain continuity of care. Custody Health will participate in care coordination, service provision and the development and operation of the WPC Trust Community.
14. Additional Public Agency	Valley Health Plan	Bruce Butler, Chief Executive Officer	Valley Health Plan (VHP) is a Knox-Keene licensed, NCQA Accredited, Health Maintenance Organization (HMO), owned and operated by the County of Santa Clara. VHP has been serving the community for over 30 years and is the only locally based commercial health plan in Santa Clara County. VHP will participate in managing the care coordination and wellness service bundles and the development and operation of the WPC Trust Community.

Required Organizations	Organization Name	Contact Name and Title	Entity Description and Role in WPC
15. Additional Community Partner	Behavioral Health Contractors Association (BHCA)	Elisa Koff-Ginsborg, Executive Director	The Behavioral Health Contractors' Association (BHCA) is a County-wide network of community-based, non-profit organizations providing mental health and substance use prevention, treatment, recovery, and supportive transitional housing services to children, adolescents and adults, under contract with Santa Clara County's Behavioral Health Services Department, which includes mental health, substance use and supportive housing services. BHCA proactively supports the continued development of a mental health and drug and alcohol system that meets the needs of Santa Clara County residents through client centered services that are focused on wellness, prevention and recovery. Services should be accessible, culturally and linguistically competent, cost effective, and able to help people affected by mental illness and substance use to have the same opportunities to fully participate in life as others in our community. BHCA members will participate in care coordination, service provision, and the development and operation of the WPC Trust Community.
16. District Hospital	El Camino Regional Hospital	Tomi Ryba, President and CEO	El Camino Hospital is a nonprofit organization with hospital campuses in Mountain View and Los Gatos, California. El Camino Hospital is an innovative, publicly accountable and locally controlled comprehensive healthcare organization that cares for the sick, relieves suffering and provides quality, cost-competitive services to improve the health and well-being of our community. El Camino Hospital will participate in care coordination, service provision, and the development and operation of the WPC Trust Community.
17. Additional Community Partner	The Health Trust	Frederick J. Ferrer, Chief	The Health Trust provides grants and engages policy and education to provide health services for the Silicon Valley. The Health Trust is an established provider of services to HUMS in Santa Clara County,

Required Organizations	Organization Name	Contact Name and Title	Entity Description and Role in WPC
		Executive Officer	particularly for the 55 and older population. The Health Trust has a long history of providing comprehensive case management for vulnerable populations. They have expertise in working with homeless and high utilizers throughout the community. The Health Trust will serve on the Executive Committee to help guide the WPC pilot. Their expertise is a necessary resource to guide the implementation of services.

1.3 Letters of Participation and Support

Please contact Amy Carta at Amy.Carta@hhs.sccgov.org for access to the letters.

Section 2: General Information and Target Population

2.1 Geographic Area, Community, and Target Population Needs

Santa Clara Valley Health & Hospital Systems (SCVHHS) offers a comprehensive healthcare system that includes a full range of medical and behavioral healthcare services for Medi-Cal beneficiaries and the uninsured. Despite the robust network of public and community-based providers, there remains a group of approximately 10,000 Medi-Cal beneficiaries who are High Utilizers of Multiple Systems (HUMS), characterized by co-occurring medical and behavioral health conditions and more likely to experience health disparities related to social determinants and psychosocial stressors, such as poverty, homelessness and cultural group membership. This combination of complex conditions and psychosocial factors results in 1) service engagement through frequent, unplanned, avoidable use of emergency and acute care services; 2) difficulty engaging in behaviors that promote health and wellness; and 3) experiences that make it difficult to engage in and benefit from planned health care services.

Overview of the SCC WPC Pilot

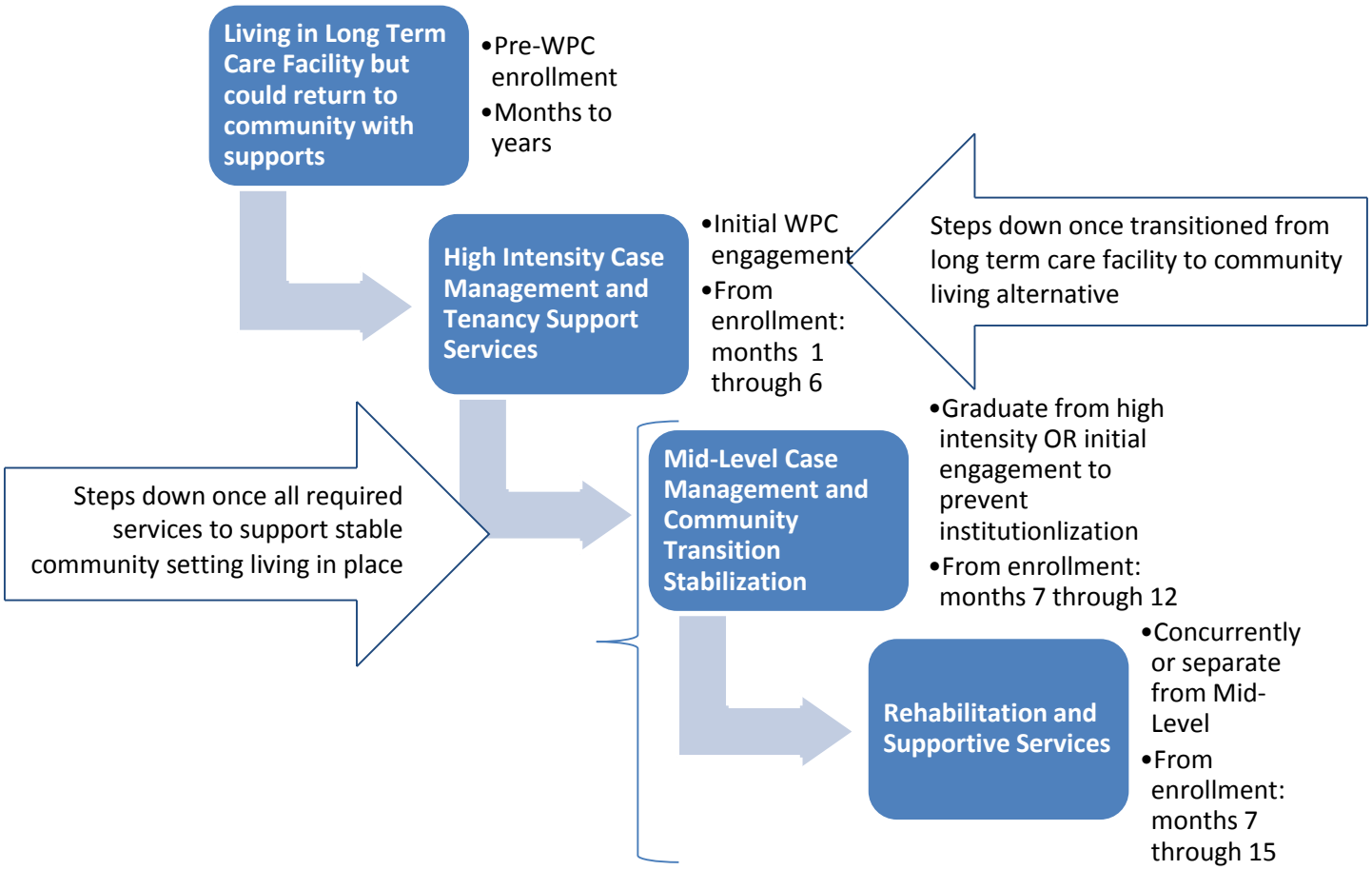
Described in greater detail below, SCVHHS and partners have designed a pilot project that 1) develops new programs to address gaps in the current service system to provide alternatives to and reduce avoidable use of Emergency Department (ED), Emergency Psychiatric Services (EPS) and acute care environments (e.g., hospital and psychiatric inpatient services); 2) provides five bundled service tracks to support WPC participants in engaging with medical and behavioral healthcare as well as addressing barriers to health and wellness, such as homelessness; and 3) builds the data infrastructure necessary to support real-time data sharing across programs and organizations and inform Plan-Do-Study-Act (PDSA) cycles. The pilot will serve all of Santa Clara County, as the target population is generally transient and distributed across the County.

- Emergency and Acute Care Utilization: The HUMS group accesses emergency services, including being post-incarcerated, more frequently than indicated as a result of experiences such as homelessness and substance use. The HUMS group is also more likely to either be discharged back to the streets or admitted to acute care environments without medical necessity because of lack of psychosocial supports, and is also more likely to have longer inpatient stays because of the high frequency of co-occurring medical and psychiatric conditions that make placement in sub-acute settings more challenging. The proposed pilot funds the development of a Sobering Station within the Restoration Center, peer respite, incentivizing providers for additional integrated medical-psychiatric skilled nursing facility (SNF) beds, as well as an expansion of the medical respite program to facilitate placement and participation in sub-acute and intermediate levels of care.

- Care Coordination and Rehabilitation and Peer Support Services: The HUMS group experiences a variety of challenges that make engagement in planned care and health promoting behaviors more difficult, including mental health symptoms, cognitive impairment, substance use, and other psychosocial stressors. The pilot will assess service needs and assign selected participants to a case management program to coordinate care, as well as provide support to address barriers to health and mitigate psychosocial stressors. Short-term interventions will be available for those who could benefit from

intensive case coordination to strengthen their resources and supports. A mid-length case management program will be available to those who could benefit from an extended assessment period to reveal complex needs (e.g., cognitive impairment, trauma, co-occurring disorders), providing a 6-9 month intervention to organize appropriate services and supports. A time-unlimited case management program will be available to those with a high degree of need requiring ongoing supports to improve and maintain health and healthy behaviors. A series of health education, coaching, socialization and promotion activities will be made available to all WPC participants to provide culturally relevant approaches to healing and increase healthy life skills and habits. Additionally, multiple care managers will share a plan.

- Nursing Home Transitions and Diversions Program: A set of the HUMS group encounter significant barriers to discharge and transition from acute and nursing facility settings, thus resulting in extensive, unnecessary and expensive lengths of stay that can range from months to years. This program combines intensive case management and comprehensive tenancy support services that enable stable community transitions in under a year. The program is divided into three levels of care coordination and services: 1) a high intensity case management and tenancy support services bundle where participants may be enrolled an average of three months and up to six months (months 1-6); 2) once the participant has stabilized and is established in an appropriate community living situation, they will graduate to a mid-level case management set of services for up to six months (months 7-12) or they may also engage in this program beginning in this level if they are at-risk of institutionalization; 3) as the participant stabilizes and their needs shift to more supportive services, they can be enrolled in a rehabilitation and supportive (concurrently with or separately from mid-level case management) set of services for up to nine months (months 7-15).



Data Infrastructure: Given the transient nature of the HUMS population and the diversity of environments in which they may seek care, the proposed pilot includes the development of a secure data exchange, based on the Trust Community model, to provide 1) real-time information for service coordinators and healthcare providers to inform shared decision-making, and 2) data to inform continuous program and outcome improvement through the PDSA process.

This model was developed through a collaborative planning process that included entities listed in Section 1, as well as other key partners. SCVHHS held a series of five planning meetings, targeted work sessions and follow-up interviews to iteratively define the vision, population and delivery model. At each work session, planning participants were provided with data about the target population and existing system of care and engaged in a series of facilitated activities to 1) identify the needs and experiences of the target population that make service access, participation and health promotion more difficult; 2) identify the gaps in the system that contribute to avoidable use of emergency and acute care or post-incarceration; and 3) define the vision and program model for the pilot. Follow-up interviews were conducted with planning participants to explore how the emerging model could leverage innovative and evidence-based practices from current high user initiatives as well as apply learnings from previous efforts to serve this population.

Sustainability Plan

The WPC pilot is intended to decrease use of avoidable high cost services and shift care provision to planned service environments including alternatives to acute care, thereby reducing overall expenditures. These savings are projected to exceed the cost of WPC over time such that recuperated costs can be re-invested to promote program sustainability while expanding program reach to those who are at risk of becoming the next group of HUMS, resulting in additional costs savings. This repeated savings cycle is expected to continue for the duration of and following the conclusion of pilot funding and promote the sustainability of WPC. The long-term vision is that the health system will to a greater extent be used for preventive services that are embedded across the community in an upstream fashion that removes barriers to health before onset of disease, achieving our goal of Better Health for All. Moreover, it is anticipated that infrastructure investments (data sharing mechanisms; communications protocols; programmatic policies and procedures, etc.) will be firmly embedded and self-sustaining by the end of the pilot.

2.2 Communication Plan

The pilot will be administered by SCVHHS deploying a collaborative leadership model with participation from all departments, including SCVMC, BHSD, Finance, and VHP; other public agencies such as SSA; and nonprofit organizations such as Medi-Cal managed care plans, contracted providers, and community-based organizations. SCVHHS will provide leadership, coordination and oversight while assigning service delivery to individual departments and contracted providers with demonstrated capacity to serve this population; use data to inform decision-making and PDSA processes; and work collaboratively across systems. The governance structure ensures representation across stakeholders to promote integration and minimize silos.

SCVHHS Director Rene Santiago will have ultimate responsibility for WPC, with supporting oversight provided by the Health and Hospital Committee, Board of Supervisors (BOS), and County Executive. Amy Carta, Special Programs Director, will serve as point of contact for DHCS and stakeholders.

- **Executive Committee (EC)**: Chaired by Mr. Santiago, the EC will set overall strategic and operational direction, meet quarterly to monitor progress and be comprised of executive leadership from WPC participating agencies including SCVMC, BHSD, PH, SSA, VHP, SCFHP, Anthem, and The Health Trust. The Director of System Integration (DSI), who is part of SCVHHS senior executive leadership group, will report progress to this governing body. Discussions will focus on implementation; cost, savings and outcomes data; and policies for improving systems level outcomes. MOUs with participating entities will ensure agreement regarding roles and responsibilities (e.g., sharing data and utilizing care models).

- **Steering Committee (SC)**: Chaired by the DSI, the SC will be include Director-level leadership from participating entities that oversee WPC core functions, including SCVMC,

BHSD, SSA, CHS, Housing Authority, ReEntry, OSH, Probation, SCFHP, Anthem, and VHP. As the primary operational and clinical decision-making body, it will meet monthly, serve in an administrative capacity overseeing various committees and be responsible for project management and implementation, budget oversight, and policy changes. Subcommittees will be convened to address specific challenges in the development of care models and deployment of care interventions. The DSI will keep participating entities abreast of all DHCS requirements and updates using this platform.

- **Community Working Group (CWG)**: There will be quarterly CWG meetings with community-based organizations, direct service providers and stakeholders, including CHP, BHCA, and Hospital Council, to discuss population health outcomes, silo-breaking strategies and methods for improving system integration and maintaining a consumer-centered focus.

- **Consumer Advisory Committee (CAC):** The CAC will meet semi-annually to get direct input from consumers of services.

WPC leadership will coordinate efforts with other County Waiver initiatives (e.g., GPP, PRIME) through participation in the Waiver Integration Team and Waiver Coordination Center (WCC).

Finally, SCVHHS will oversee implementation of a systems-level communication plan to educate stakeholders about efforts associated with all SCVHHS Waiver projects. Spearheaded by the Public Communications Specialist, targeted communications will be directed toward county and community-based stakeholders, elected officials, media, and the public. In addition, the Specialist will create marketing materials that can be used by WPC for beneficiary, provider and stakeholder engagement. The WCC will also hold an annual summit to share progress and gather perspectives from a broad range of community stakeholders, further supporting bidirectional communication.

2.3 Target Population

The WPC target population includes HUMS who are Medi-Cal enrolled, engaging in two or more systems of care and in the top 5% (n=9,869) of utilizers in the population with SCVHHS encounters over the past year. A significant percentage of this group is characterized by co-occurring medical and behavioral health conditions; members are more likely to experience health disparities related to social determinants and psychosocial stressors, such as poverty, homelessness, few social supports, and cultural group membership. Some may also experience cognitive impairment, chronic homelessness or criminal justice system involvement.

The target population was identified primarily through the Center for Population Health Improvement (CPHI), which aggregates data from SCVHHS departments and Valley Health Plan. CPHI developed a statistical point system to identify HUMS that evaluates the number of clinical encounters for each consumer in emergency, inpatient and urgent care systems, assigning points for each type of event. The total number of points for clinical encounters in the past year was then used to rank consumers from highest to lowest use. By assigning more points to emergency

medical and psychiatric encounters, consumers who frequently use these services move higher in the rankings. Points for length of inpatient stays for hospital and inpatient psychiatric care are capped at the 75th percentile so that a consumer who was in and out of the hospital multiple times would accrue more points than a consumer with one long stay. Given that all participating entities' data are not yet included in CPHI's data warehouse, SCVHHS engaged key partners to identify specific sub-groups of the target population who may not be represented in the current methodology. These included 1) a subgroup of individuals with criminal justice involvement who are predominantly being served in the County jails, which would be expanded to include post-incarceration services, and Reentry Resource Center, and 2) a percentage of people receiving general assistance who are also homeless and may be SSI eligible, but lack coordinated care due to challenges related to disability determinations. Preliminary data suggest that the latter group has approximately a 20% overlap with identified HUMS.

The demographic, service utilization and clinical profiles of the target population are presented below.

Demographic Characteristics of Top 5% HUMS (2015)

The HUMS population includes a roughly equal distribution of males and female adults, primarily between the ages of 26-54. They are most likely to be single and to speak English as preferred language. The HUMS group crosses racial and ethnic identities.

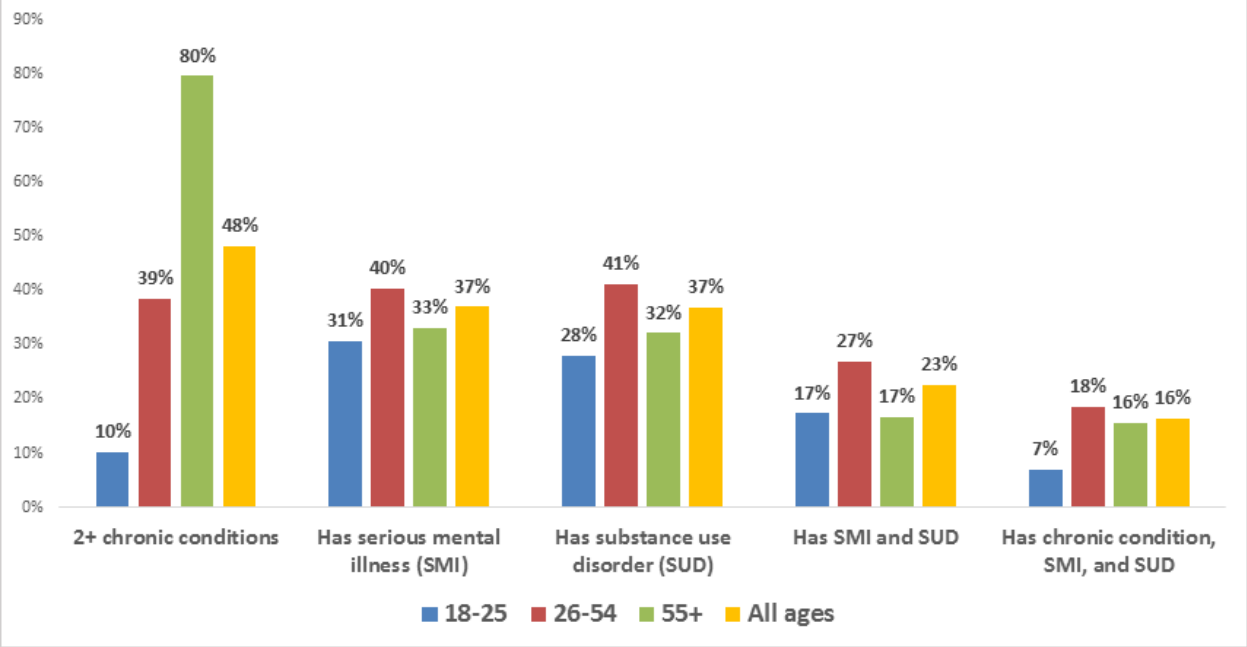
Sex	
Male	53%
Female	47%
Age	
18-25	11%
26-54	58%
55+	31%
Marital Status	
Single	62%
Married/partnered	22%
Divorced/Separated	12%

Preferred Language	
English	79%
Spanish	15%
Asian language	3%
Other/Unknown	3%
Race/Ethnicity	
Hispanic or Latino	45%
White (Non-Hispanic)	32%
Asian/Pacific Islander	12%
Black/African American	9%
Other	2%

Clinical History of Top 5% HUMS (2015)

While the target population is characterized by complex medical and behavioral health conditions, the specific clinical presentation varies by age. A sizeable portion of the target population has multiple chronic medical conditions and mental health/substance use disorders, as shown in Table 1.

Table 1. Co-Occurring Diagnoses for of Top 5% HUMS (2015)



The majority of the target population (69%) has at least one chronic medical condition, including hypertension (42%), Type I and II diabetes (23%), hyperlipidemia (24%), arthritis (18%), asthma (18%), and chronic kidney disease (15%). Many of these conditions are associated with unhealthy lifestyles, inactivity, smoking, and long-term use of psychotropic medication. Approximately 1/3 of the target population experience serious mental illness, predominantly 1) schizophrenia and other psychotic disorders (30%), 2) bipolar and depressive disorders (20%), and 3) anxiety (15%). Of the target population, 36% experience substance use disorders - related to alcohol (21%),

stimulants (22%), marijuana (7%), and opioids (6%). Over 69% of HUMS ages 55 and older have been diagnosed with at least 1 condition associated with increased risk for needing long term supportive services.

Given that the top 5% of consumers accrue more than 50% of annual costs according to CPHI data (average annual per patient cost at SCVHHS: $33,617), this pilot population was chosen due to greatest need as well as potential for optimal benefit and return on investment. This top 5% comprises the total target population over the five-year project period, but, the most intensive modes of service delivery will be focused on the top 1% as this subset presents the gravest need or care coordination and other services as evidenced but an average annual per patient cost at SCVHHS of $63,214.

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

3.1 Services, Interventions, and Care Coordination

The WPC pilot is grounded in a continuum of prevention, health, behavioral health, homeless, and social services, including Medi-Cal funded services. The pilot aims to 1) address gaps in the existing service system resulting in frequent, unplanned and costly use of emergency/acute services across multiple systems for individuals with complex health and psychosocial needs; and 2) provide tiered service coordination to support HUMS engagement in services responding to identified health/psychosocial needs. The pilot will utilize a dynamic, flexible structure to provide an individualized, holistic, trauma-informed approach to meeting the needs of the target population.

Foundational to our model is underlying data infrastructure provided by the WPC Trust Community (WPCTC), a secure data exchange allowing for real-time data sharing and partner coordination. WPCTC will enable providers to access data from distributed systems to support participant identification and coordinate care, as well as pilot-level data to support reporting, measurement and continuous improvement through PDSA cycles.

HUMS will be identified via 1) analysis of existing data, and 2) in clinical settings where HUMS are likely to present. Identified HUMS will be assessed and engaged in the appropriate case coordination program to connect them to appropriate services. The basic model will apply to all participants, but the constellation of services, interventions, and care coordination options are designed to meet the specific needs of transition-aged youth (TAY), adult and older adult subpopulations, then targeted to each individual.

Services

The WPC pilot offers services that address gaps and test innovative approaches to serving the HUMS population. The pilot will 1) invest in development of new services that will become Medi-Cal funded once operational, 2) add new services, and 3) expand/modify existing services to better serve HUMS. Continual assessment of needs and acuity will be conducted to match available services and capacity. Risk stratification of the enrolled population will be implemented to assist in matching available service bundle capacity to enrollees' needs. The WPC pilot will not

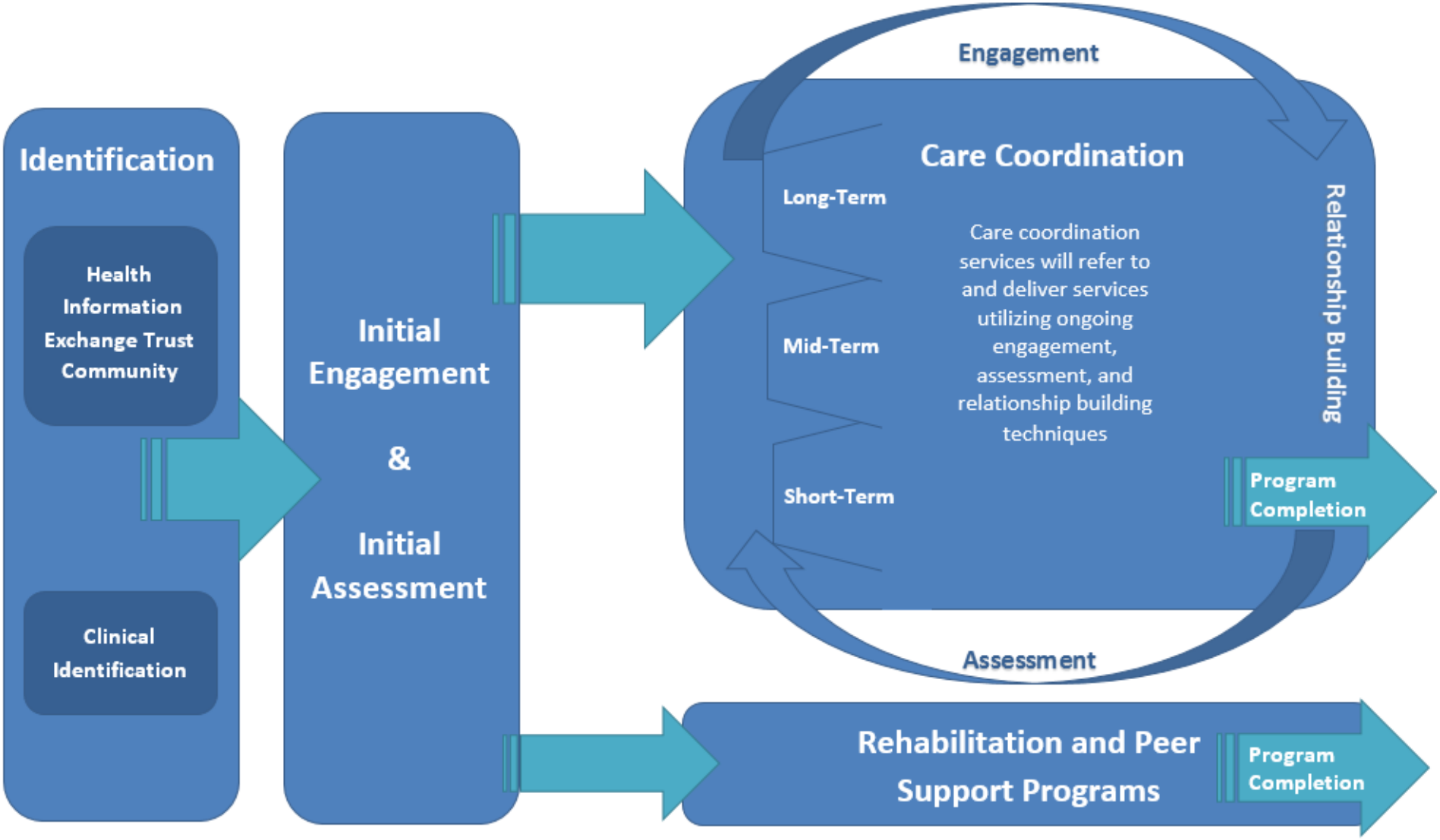
include an enrollment cap. Where new contracts are required to create capacity, RFPs may be utilized.

Table 2. WPC Service Array

Service, Funding Source and Process	WPC Applicability	WPC Day-to-Day Capacity
Sobering Station (within the future Restoration Center)*:* A Sobering Station as a non-medical alternative to ED, EPS, and jail for individuals who are under the influence of alcohol/drugs.	Data indicates high levels of AOD use and homelessness/lack of safe settings for sobering. Sobering Station reduces avoidable use of ED/EPS/jail. Provides alternative options for local law enforcement, walk-ins, and referrals for those not requiring acute medical care.	20 spaces (4-12 hour average length of stay)
Integrated Medical-Psychiatric Skilled Nursing Facility (SNF) *(incentive funding):* Bridges medical and psychiatric services for individuals with concurrent need.	Dedicated unit to address concurrent medical/psychiatric needs that result in avoidable stays in acute environments. Would build upon the existing services that provide either medical or psychiatric services by creating an incentive to add staff to provide both services, concurrently. Integrated Medical Psychiatric SNF services reduce avoidable hospital/psychiatric stays.	PY 3 15 beds PY 4 30 beds PY 5 30 beds
Flexible Housing Pool: Provides affordable housing within the provisions of Section 1903(w), Social Security Act and 42 C.F.R. Part 433, subpart B**.** **In accordance with STC 114(b), housing pool investments in housing units or housing subsidies including payment for room and board will not be eligible for WPC Pilot payments unless otherwise identified in CMS Informational Bulletin, 'Coverage of Housing-Related Activities and Services for Individuals with Disabilities.'**	Many HUMS are in unstable living situations/homeless. Housing search, applications, move-in and other support will be provided to obtain/maintain housing. These services will work in coordination with the WPC pilot but no WPC funds will be used for the housing pool.	NA
Rehabilitation and Peer Support *(funding expands services):* Individual and group services promote health and wellness through peer coaching, mentoring, education and life skills development.	Will improve physical/emotional well-being, increase early detection, reduce preventable system usage; assists individuals to reduce the impact of chronic conditions exacerbated by poor self-care habits by instilling new, healthier habits/skills.	PY 2 625 slots PY 3 1250 slots PY 4 1875 slots PY 5 1875 slots
Medical-Legal Advocacy *(explore funding service expansion):* Legal/advocacy services to resolve justice system involvement that creates	Services could assist HUMS to resolve legal issues resulting from poverty, evictions, homelessness, debt, and criminal behavior that lead to avoidable use of	TBD

Service, Funding Source and Process	WPC Applicability	WPC Day-to-Day Capacity
barriers to housing, benefits and other psychosocial needs.	jails/homelessness, resolving issues before resulting in avoidable costs.	
Medical Respite ***(full funding for non Medi-Cal billable services):*** Post-acute care to monitor homeless patients or those without access to appropriate home care.	For HUMS with health conditions not requiring inpatient care but too serious for discharge. Utilizes peers, counselors and nurses. Reduces avoidable complications/readmissions to acute care by increasing post-discharge supports.	20 beds
Peer Respite ***(full funding):*** Home-like, peer-staffed environment for those experiencing mental health crises. Provides services to manage crises, learn healthier boundaries and develop safety planning.	Provides alternative to inpatient psychiatric treatment when the individual is not a danger to self/others but requires a supportive environment. Utilizes recovery couches and peers. Will reduce avoidable use of EDs, EPS, and inpatient services.	20 beds

Figure 1. WPC Program Model



Funding to Expand Existing Services: Housing and Peer Support

As the majority of HUMS struggle with housing retention, support to develop this set of skills is critical to pilot success. As housing needs for each subpopulation are distinct and require different emphases, programs will feature services tailored to the needs of TAY, adults, long term care and older adult subpopulations.

Peer Support will pervade the model with distinctions for each group. Specialized peer services will assist in engagement, case coordination and service delivery appropriate to subpopulation needs, in order to engage individuals who would not generally participate with professional staff.

Intervention Integration and Care Coordination

Individuals with psychosocial supports and access to planned, regular care have better health outcomes and lower avoidable cost-utilization profiles than those without. Implementing a tiered care coordination system that accounts for diversity of need intensity and length, WPC bridges the gaps in participants' own networks. By adding and expanding existing SCVHHS services to provide a continuous, accessible system of care, WPC reduces avoidable system use barriers to recovery and wellness common to HUMS (e.g., homelessness, long term care, incarceration, poverty). The WPC pilot also seeks to collaborate with existing integration and care programs, such as Waiver programs like the Drug Medi-Cal Waiver. Avoiding duplication of services is integral in the care coordination components.

Table 3. WPC Bundled Programs

Bundled Program Category	Evidence-Based Model Description	Logic and Goals	WPC Applicability	WPC Day-to-Day Capacity	Eligibility Requirements	Care Coordinator* to Participant Ratio	Average Duration of Provision of Services
Short-term Care Coordination[1]	Coordination for medium to high-risk individuals needing short term assistance.	Address needs of patients at significant risk for avoidable complication/ readmission by coordinating proactive transition services.	Reduces incidence/cost of avoidable readmissions and complications by providing coordination focused on establishing needed psychosocial and other supports; coordinates with activities such as the Sobering Station	250 slots	Post-discharge from inpatient stay and/or at-risk for readmission within 30 days; lack of social supports; at-risk for non-adherence to medications	Between 20:1 to 25:1, depending on model	60 days
Mid-term Care Coordination [2]	Time-limited coordination grounded in stages of change	Provide intensive assessment and care coordination to stabilize complex cases, address	Reduces avoidable systems usage through comprehensive assessments that	PY2 570 slots PY 3 585 slots	High HUMS score; multiple diagnoses and utilization of services; in crisis;	Between 10:1 to 20:1, depending on model	4 to 9 months, dependent on need

[1] Roberts, R., Dalton, K., Evans, J., & Wilson, C. (2007). A service model of short-term case management for elderly people at risk of hospital admission. Australian health review: a publication of the Australian Hospital Association., 31(2), 173–83. Retrieved from http://www.ncbi.nlm.nih.gov/pubmed/17470037

[2] Clark, C., Guenther, C., & Mitchell, J. (2016). Case management models in permanent supported housing programs for people with complex behavioral issues who are homeless. Journal of dual diagnosis. 12(2), 185–92. Retrieved from http://www.ncbi.nlm.nih.gov/pubmed/27070841

	and motivational enhancement.	health-related needs, recovery barriers and wellness for transition to independence or long-term coordination.	identify/diagnose health issues and barriers to wellness. Intensive supports contribute to health and psychosocial stability.	PY 4 585 slots PY 5 585 slots	at risk for homelessness or homeless; involved in criminal justice system; graduating from high intensity nursing home transitions care coordination		
Long-term Care Coordination [3,4]	Coordination without time limits for individuals with high needs likely to persist over time.	Intensive coordination for those unlikely to maintain health/recovery and maximal independence in the absence of ongoing intensive services.	Long-term coordination addresses ongoing need to reduce avoidable use of ED, EPS and hospitalization.	750 slots	Mental health disorder; multiple hospitalizations in EPS/ED/BAP; co-occurring substance abuse or medical disorder; without treatment, at risk for deteriorating function in community	Between 10:1 to 20:1, depending on model	12 to 18 months
Rehabilitation and Peer Support Services	Health Promotion and Stabilizing Services, focusing	Ongoing services focusing on rehabilitation, using peer support via	Will improve physical/emotional well-being, increase early detection,	PY 2 625 slots	Willingness and need; those graduating from nursing homes	NA	3 months to 42 months,

[3] Bond, G. R., & Drake, R. E. (2015). The critical ingredients of assertive community treatment. World Psychiatry, 14(2), 240–242. doi:10.1002/wps.20234

[4] Mares, A. S., & Rosenheck, R. A. (2009). Twelve-Month client outcomes and service use in a Multisite project for chronically homelessness adults. The Journal of Behavioral Health Services & Research, 37(2), 167–183. doi:10.1007/s11414-009-9171-5

	on prevention and engagement	coaching, education, mentoring, and life skills development including employment, health navigation, housing assistance and activities of daily living training.	reduce preventable system usage; assists individuals to reduce the impact of chronic conditions exacerbated by poor self-care habits by instilling new, healthier habits/skills	PY 3 1320 slots PY 4 1945 slots PY 5 1945 slots	transitions; can be a concurrent set of services with short, mid or long term care coordination; ends when individual no longer needs the services		dependent on need
Nursing Home Transitions, Diversions and High Intensity Care Coordination[5]	Intensive case management and comprehensive tenancy support services that enable community transitions	Divert from long term care facilities using intensive case management, providing support for obtaining alternative community living, enhanced client assistance, services and goods	Intensive case management and diversion from long term care settings addresses unnecessary hospitalization, improves outcomes and supports individuals' independence	PY 2 53 slots PY 3 76 slots PY 4 76 slots PY 5 76 slots	Long term care individuals who cannot be safely discharged due to multiple conditions, including behavioral health, lack of housing and lack of family supports; ends when successfully placed in community living and graduates to mid-level care coordination	20:1	Average 3 months, but up to 6 months, dependent on need and justification

[5] DHCS Website (2017). California Department of Health Care Services 2016 Innovation Awards, http://www.dhcs.ca.gov/services/Documents/MMCD/2016InnovationAward.pdf

					and/or rehabilitation and peer supports, maintaining continuity of services through consistent care coordinators and/or hot handoffs		

***Care Coordinator roles may be served by a variety of staff, such as Licensed Clinical Social Workers (LCSW), Public Health Nurses (PHN), Peer Counselors, Peer Mentors, Service Counselors, Rehabilitation Counselors, etc.**

Concurrent Enrollment in Services/Care Coordination

WPC pilot participants may be eligible for concurrent enrollment in any of the Services listed in **Table 2**. Additionally, participants may be enrolled in any of the Services plus one (1) of the term-based Care Coordination programs AND Rehabilitation and Peer Support Services; OR may be enrolled in any of the Services plus the Nursing Home Transitions High Intensity, Diversions and Care Coordination, as listed in **Table 3** (i.e., a participant could be enrolled in Peer Respite and Rehabilitation and Peer Support Services AND Short-Term Care Coordination; or Peer Respite AND Rehabilitation and Peer Support Services). A participant may not be enrolled in more than one of any of the Care Coordination programs at a time. A participant may move between the programs, dependent on acuity and need, with the goal of moving enrollees to a lower level of care (i.e. from long-term to mid-term; from Nursing Home Transitions to mid-term care). The Rehabilitation and Peer Support bundle of services may be available concurrently or separate for any participant (except those enrolled Nursing Home Transitions High Intensity). Moving enrollees to lower levels of care and services is based on specific guidelines developed around each program model, with benchmarks and milestones that mark a participant's improved engagement, on-going care by a primary care provider/mental health specialist, and links to appropriate community solutions. No duplication of services or activities will occur as the services and care coordination programs are designed to complement, not overlap, one another. For instance, medical and peer respite services focuses on participant recovery and transitioning back into the community; Rehabilitation and Peer Support services focuses on supports around psychosocial issues like fitness, housing, and employment training; and care coordination programs focuses on intensive case management and referrals for participant's long term success.

Plan-Do-Study-Act

Ongoing Plan-Do-Study-Act evaluation/adaptation process is critical to success. Each intervention will create a delivery plan based on an evidence base and/or best practice model as applicable to the HUMS population. Once implemented, interventions will be evaluated via ongoing data collection and entered into WTCTC for analysis. The analyzed information is then converted into actionable adjustments to delivery and implementation. The appropriate metrics for analysis, methods for data collection and program modification are dependent upon the program target; the PDSA process will be implemented at all levels of the model from the underlying WPCTC, through identification, assessment and engagement, service coordination, and services. Access, utilization and discharge data will be reviewed regularly to make adjustments to service delivery.

Care Coordination Administration

Identification and Engagement/Assessment

The processes of engagement, assessment and coordination are distinct but not purely sequential. The method of identification dictates initial engagement and assessment. HUMS identified through WPCTC data will be engaged through a variety of partner entities; therefore,

there may be a gap between identification and initial engagement/assessment. Conversely, clinically identified HUMS will begin the engagement/assessment process in the clinical setting.

Secure Data Exchange

Through investment in the Epic EHR and development of CPHI, Santa Clara County is able to share and analyze data from within the public healthcare system. The WPC pilot expands upon the current system, engaging key entities including health plans, private hospitals and community providers to enable better coordination and integration of care, providing information for the purposes of:

- Identifying participants;
- Supporting data sharing for intervention;
- Allowing timely follow up by case coordinators; and
- Supporting collaboration amongst providers when participants engage in chaotic care-seeking.

Seamless to the Participant

Existing service systems are well-used by the target population. The WPC pilot will support increased coordination (including multiple care managers) and decrease avoidable systems use. Case coordination will connect participants to existing, expanded and new services efficiently through data entered into the WPCTC by providers. The WPC Care Coordinator will synthesize information to formulate a map of the individual's care, assisting them in navigating systems/components efficiently and effectively. From the perspective of participants, the experience will be a clear set of well-defined roles and services provided by a team of providers, facilitated and managed by the care coordinator.

3.2 Data Sharing

SCVHHS implemented Epic's Electronic Health Record (EHR) system to bring data systems under one umbrella and allow for data standardization and streamlined workflows. With the assistance of CPHI, SCVHHS is working to improve data accessibility and to utilize data to support system changes that will provide Better Health for All. For partner entities outside of SCVHHS, data sharing is limited; processes to support data exchange are non-standardized and typically not repeatable. There is a need to connect systems and better integrate for data exchanged. The County Office of Data Oversight, Management and Evaluation (ODOME) is working to improve the accuracy, consistency and efficiency of cross-system data sharing, and will support efforts to expand WPCTC beyond SCVHHS systems.

SCVHHS intends to facilitate bi-directional data exchange between SCVHHS and WPC partner entities to drive better care for its patients that cross care boundaries. The WPCTC will create a secure data-sharing environment that will unify SCVHHS data with those of WPC participating entities, facilitating data exchange to drive participant identification and care coordination.

SCVHHS will clearly scope data exchange between partners to facilitate the sharing of demographics, claims transactions (pre-adjudicated or adjudicated), HL7 2.x clinical messages for documents and lab results, and Consolidated Clinical Document Architecture (CCDA) summary document exchange. While potential participants may be flagged for outreach and engagement, formal data exchange will be carefully scoped to follow voluntary enrollment, so no data is transferred for patients in an unsolicited manner. Further, WPCTC will use an interface engine to facilitate rules based routing of content and to facilitate message transformation between a source and destination site.

Implementation of the WPCTC will occur over three key phases, detailed in the graphic below:

Phase 1. Planning for Data Sharing will include the following activities:

- Identifying technical and program leads from within SCVHHS and participating entities
- Developing data use agreements (DUAs)
- Defining data sharing priorities in collaboration with participating entities through a WPCTC Planning Committee.
-

Phase 2. Master Data Management Deployment will see the first coordinated data sharing efforts, including:

- Deploying master data management for patient, provider, location and other key master indexes
- Supporting claims feeds from payers for adjudicated or pre-adjudicated claims
- Existing CCDA and HL 7 2.x messages that are exchanged will be integrated into the system.
-

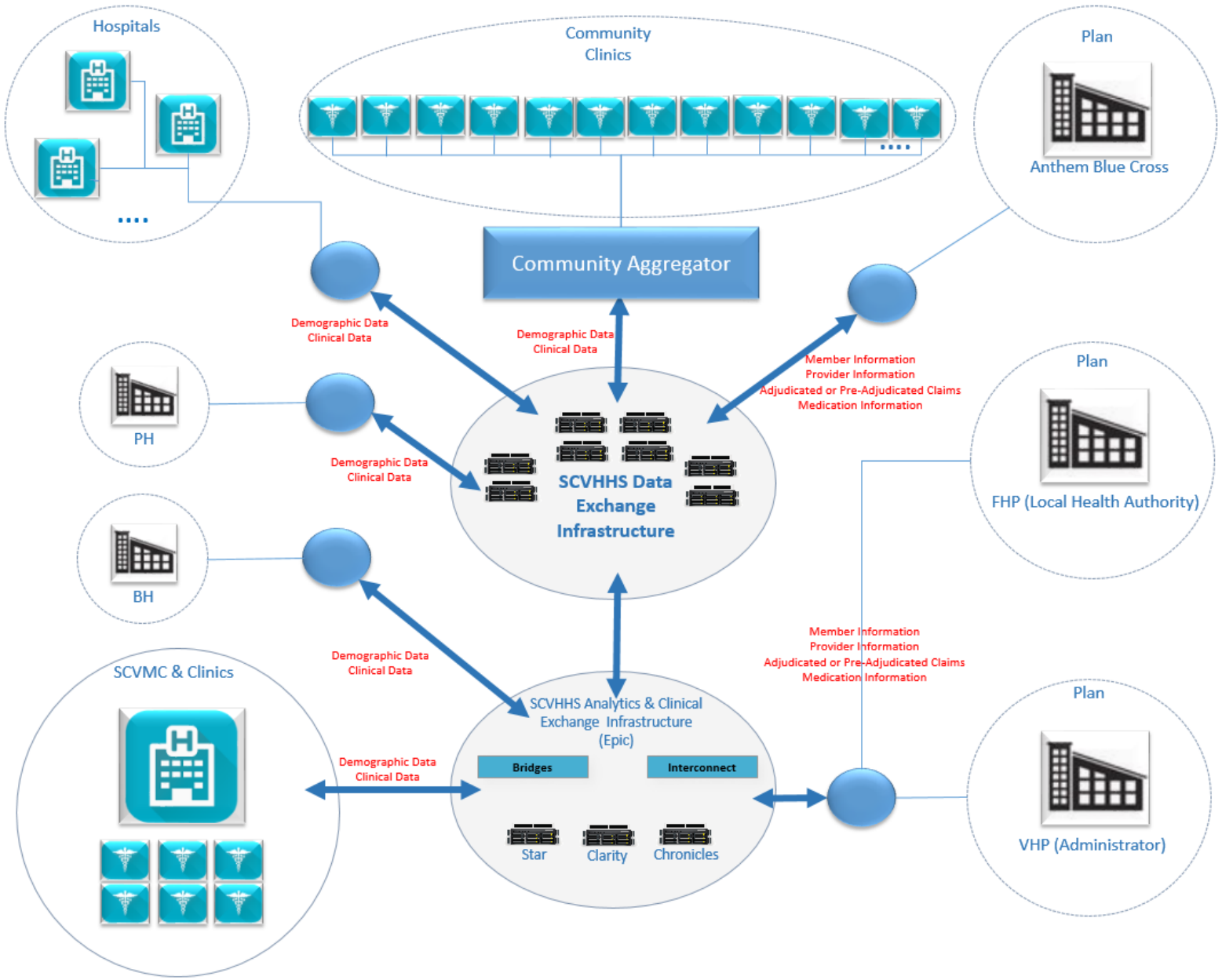
Phase 3. Clinical Data Exchange, will see an expansion of secure data sharing to include:

- The support of clinical data exchange in the form of the HL7 2.x messages from partners for lab, documents and demographic messages
- The support of clinical data exchange in the form of CCDA summary documents for patients on transition events from one system to another
- Support for Fast Healthcare Interoperability Resources (FHIR) based messaging where available
- Terminology management Infrastructure.
-

Anticipated Challenges & Strategies

The effort to build the WPCTC reflects years of experience and lessons learned in business process, data governance and technical architecture. The WPCTC Planning Committee will employ the following strategies to ensure WPCTC success:

1. Engage physicians and other clinical staff in the planning process to ensure that efforts to import external data into the EHR in order to facilitate care coordination do not interfere with clinical workflow.
2. Establish clear data governance from the start to ensure the accuracy of data matching efforts and the appropriateness and legality of the data initiative in a community setting. This effort will standardize terminology and coding systems, as well as standards for data exchange.
3. Address security concerns by facilitating direct exchange of patient data in a treatment context. The exchange will comply with all applicable state and federal laws.
4. Develop a thorough understanding of existing data systems and their capacity to implement message types and support integration profiles.
5. Establish a clear scope of the extent of data exchange and phases of entry for participant entities based on technical and operational readiness and the priority of data to be exchanged.
6. Establish a clear vision and ROI for data sharing that focuses on the potential health impact of participants in an effort to overcome challenges related to current operations, leadership buy-in and resource requirements.
7. Ensure that key aspects of master data management are addressed before exchanging clinical data, to prevent long-term challenges in maintaining the exchange infrastructure. During the first two years of the pilot, the planning process will be invested in developing master patient and provider indices.
8. Ensure investment in a sustainable infrastructure that can be expanded as appropriate beyond the pilot.
9. Each participating entity will be able to participate in bidirectional data exchange and communication with the SCVHHS system that allows the flow of information related to patient care.
10. The entities will play a role ensuring their systems can import and export data from the exchange and take appropriate actions from a care perspective based on this information being made available to them.
11. A proposed connectivity schematic is included on the following page:


Hospitals
Community Clinics
Plan
Anthem Blue Cross
Community Aggregator
Demographic Data
Clinical Data
Demographic Data
Clinical Data
Member Information
Provider Information
Adjudicated or Pre-Adjudicated Claims
Medication Information
PH
Demographic Data
Clinical Data
SCVHHS Data Exchange Infrastructure
Plan
FHP (Local Health Authority)
BH
Demographic Data
Clinical Data
Member Information
Provider Information
Adjudicated or Pre-Adjudicated Claims
Medication Information
SCVMC & Clinics
SCVHHS Analytics & Clinical Exchange Infrastructure (Epic)
Demographic Data
Clinical Data
Bridges
Interconnect
Star
Clarity
Chronicles
Plan
VHP (Administrator)

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

4.1 Performance Measures

SCC's proposed WPC program model brings together diverse entities under a common agenda, shared infrastructure and aligning objectives to implement a varied, mutually reinforcing and coordinated set of services in order to achieve the desired outcomes. Given that this pilot seeks to serve a target population with extremely complex and intertwined needs that can only be addressed when multiple systems work together, our approach to monitoring the universal and variant performance metrics will include measurement of the combined effect of the series of complementary interventions, rather than looking at the outcomes of individual programs separately. This measurement and analytic strategy acknowledges that change can come from the interaction of many strategies that are implemented in a synergistic fashion, and may not be attributable to any single intervention alone. Therefore, the performance measures presented below are proposed to be attributable to the total WPC effort and the interventions that will be implemented by all types of participating entities. As such, the recommended metrics are tied to multiple inputs rather than a single linear effort.

In terms of target outcomes, there is a triple aim for the WPC effort: 1) enhance participants' engagement in and experience of healthcare and service delivery; 2) reduce avoidable healthcare costs at the systems level; and 3) improve participants' health related quality of life. The proposed monitoring approach will examine data for all participants who are enrolled in WPC programming across all health domains as well as the degree to which new services succeed in filling gaps and meeting beneficiary needs across the larger system. We are also particularly interested in learning what is needed for the various program components to maximize return on investment, produce cost savings that are evidenced in conjunction with improved health related quality of life for participants and eventually be able to pay for themselves. Reducing unnecessary medical and psychiatric hospitalizations through care diversion to less intensive services is expected to result in the most significant cost savings since inpatient stays are among the most expensive of interventions. Ultimately, we want to know if we are comprehensively addressing the multi-faceted needs of the target population in a manner that does not overburden the service delivery system, addresses social determinants of health and root causes of illness, and promotes health equity.

We forecasted evidence-based benchmark goals for each of the universal and variant performance metrics for the duration of the pilot period. We set targets that are aspirational yet feasible to achieve during the short pilot period, and, moreover believe that satisfaction of these goals will make a significant difference in the lives of program participants. The annual benchmark targets will allow for monitoring of both short-term process and ongoing outcome measures as well as provide indicators that will inform the development of PDSA cycles. Each participating entity will collect and report service provision and participant outcome data pertaining to performance metrics and other pertinent indicators (e.g., quantitative and qualitative case and claims data; social determinants of health) into the WPCTC to support care

coordination, service delivery, and local monitoring efforts on a quarterly basis (**Table 4**). Given that the WPC population is expected to change each year as participants come in and out of the system, the overall unit of analysis will remain at the systems level.

Table 4. Data Collection from Participating Entity Types

Participating Entities	Service Utilization	Outcomes	Population Demographics	Bi-Directional Data Sharing	Other Indicators
Santa Clara Valley Medical Center	X	X	X	X	
Santa Clara Valley Behavioral Health Services Department	X	X	X	X	
Santa Clara County Housing Authority	X	X	X	X	
Santa Clara County Public Health Department			X	X	Population health data
Social Services Agency			X	X (As appropriate)	Benefits enrollment figures
Managed Care Health Plans	X	X	X	X	Service claims
Community Partners	X	X	X	X (As appropriate)	
Criminal Justice Partners		X	X	X (As appropriate)	Outcomes (e.g., recidivism)
Community Hospital Partners	X		X	X	

4.1.a Universal Metrics

We will report on progress made on each of the following universal performance metrics towards achievement of annual benchmark goals as described in Table 5. Our target population does not include children under the age of 18; all metrics apply to adults only.

- ✓ Health Outcomes Measures
- ✓ Administrative Measures

<table>
<tr><th>PROGRAM YEAR</th><th colspan="4">COHORTS*</th></tr>
<tr><td>Baseline</td><td>High Utilizer Data as of 1/1/2017</td><td colspan="3"></td></tr>
<tr><td>PY2</td><td></td><td>C17</td><td rowspan="2">C17 + C18</td><td rowspan="3">C17 + C18 + C19</td><td rowspan="4">C17 + C18 + C19 + C20</td></tr>
<tr><td>PY3</td><td colspan="2"></td></tr>
<tr><td>PY4</td><td colspan="3"></td></tr>
<tr><td>PY5</td><td colspan="4"></td></tr>
</table>

*Each cohort includes enrollees for that year, for example, C17 = enrollees into the WPC pilot during PY2/2017 calendar year; any attrition, death, long term incarceration, move out of area, patient refusal to participate, or loss to follow-up would be removed from the cohort. Cohorts will be formed for all WPC enrollees by calendar year: those who enroll in 2017 would become part of cohort 2017 (C17) and so on. For each cohort enrolled, eligibility will be based on utilization for the calendar year prior to enrollment and the utilization scored according to our High Utilizers of Multiple Systems schema. The schema is based on a point system which assigns points to each clinical event per patient in the past 365 days, based on data from electronic health records. Three points are assigned for emergency department (ED) or psychiatric (EP) visits; 1 point for each day in an inpatient medical (IM) or psychiatric (IP) stay (capped at the 75th percentile of length of stay), and 1 point for each urgent care visit. Patients would also be eligible from other systems if they meet any of the following utilization thresholds: having three or more emergency department visits in the calendar year prior to enrollment; one or more inpatient hospitalizations or hospitalizations for mental illness; and/or any emergency or inpatient utilization related to a substance use disorder. Patients from other systems would also be eligible if ever homeless or by clinician referral. Eligibility will also be limited to patients ages 18 to 64 on January 1 of the enrollment year and those who do not have dementia. Once patients are determined to be eligible, we will enroll patients based on the capacity of each of the services, interventions, and care coordination programs included for the cohort year, which will yield a mix of patients with more and less intensive care coordination and service needs.

Table 5. Universal Metrics

	YEAR 1	YEAR 2 (C17)	YEAR 3 (C17 + C18)	YEAR 4 (C17 + C18 + C19)	YEAR 5 (C17 + C18 + C19 + C20)
Health Outcomes for WPC Pilot					
Ambulatory Care – Emergency Department Visits (HEDIS)	Baseline data to be compiled upon application approval	Maintain baseline	Of those enrolled, reduce ED utilization by 4%, relative from year 2	Of those enrolled, reduce ED utilization by 6%, relative from year 3	Of those enrolled, reduce ED utilization by 8%, relative from year 4
Inpatient Utilization – General Hospital/ Acute Care (IPU) (HEDIS)	Baseline data to be compiled upon application approval	Maintain baseline	Of those enrolled, reduce inpatient utilization by 10%, relative from year 2	Of those enrolled, reduce inpatient utilization by 15%, relative from Year 3	Of those enrolled, reduce inpatient utilization by 20%, relative from year 4
Follow-up After Hospitalization for Mental Illness (FUH) (HEDIS)	Baseline data to be compiled upon application approval	Maintain baseline	Of those enrolled, 5% absolute increase of consumers who have a minimum of four outpatients visits after discharge from hospital from year 2	Of those enrolled, 5% absolute increase of consumers who have a minimum of four outpatients visits after discharge from hospital from year 3	Of those enrolled, 5% absolute increase of consumers who have a minimum of four outpatients visits after discharge from hospital from year 4

4.1.b Variant Metrics

In accordance with the proposed WPC interventions and the identified needs and characteristics of the target population and based on the existing literature, we have selected the following variant performance metrics and corresponding annual benchmark goals

Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET) (HEDIS)	Baseline data to be compiled upon application approval	Maintain baseline	Of those enrolled, 10% relative increase in the number of referrals to treatment by providers from year 2	Of those enrolled, 10% relative increase in the number of referrals to treatment by providers from year 3	Of those enrolled, 10% relative increase in the number of referrals to treatment by providers from year 4
ADMINISTRATIVE: WPC lead organization will ensure completion of the following deliverables by each of the participating entities.					
Comprehensive care plans that are accessible by entire care team within 30 days of: **1) WPC enrollment, and** **2) annual anniversary of WPC enrollment**	Baseline data to be compiled upon application approval	Maintain baseline	*For new enrollees*: 20% absolute increase of consumers who are receiving care coordination services have comprehensive care plan from year 2 *For existing participants on annual basis*: 50% absolute increase of consumers who have been receiving care coordination services have an updated	*For new enrollees*: 15% absolute increase of consumers who are receiving care coordination services have comprehensive care plan from year 3 *For existing participants on annual basis*: 15% absolute increase of consumers who have been receiving care coordination	*For new enrollees*: 10% absolute increase of consumers who are receiving care coordination services have comprehensive care plan from year 4 *For existing participants on annual basis*: 15% absolute increase of consumers who have been receiving care coordination

			comprehensive care plan from year 2	services have an updated comprehensive care plan from year 3	services have an updated comprehensive care plan from year 4
Care coordination, case management, and referral infrastructure	Preparation and submission of application	Development of: • Care coordination documentation • Referral policies and procedures for WPC lead and participating entities • Communication structures • Monitoring and oversight procedures (with regular review) • Method for compiling and analyzing monitoring findings	Development of: • Access and updates to beneficiary information for all participating entities • Process for modifying policies and procedures	PDSA to refine care coordination, case management and referral infrastructure	PDSA to refine care coordination, case management and referral infrastructure
Data and information sharing infrastructure	Preparation and submission of application	Development of: • Policies and procedures for WPC lead and participating entities • Monitoring and oversight	Development of: • Access and updates to beneficiary information for all participating entities • Process for modifying	PDSA to refine data and information sharing infrastructure	PDSA to refine data and information sharing infrastructure

		procedures (with regular review) • Method for compiling and analyzing monitoring findings	policies and procedures		

pending DHCS approval (see **Table 6**). We believe that this set of indicators, in conjunction with the universal metrics presented above, are closely aligned with the overarching process, infrastructure, and outcome objectives of the WPC pilot and will enable us to effectively monitor progress towards achievement. Many of these metrics are currently being assessed by participating entities. As the WPC Pilot learns more via the PDSA cycles, these variant metrics will be reviewed and potentially modified to ensure applicability and assure the metrics are measuring the intended outcomes.

Table 6. Variant Metrics

Metric ID:	***Variant Metric 1***	***Variant Metric 2***	***Variant Metric 3***	***Variant Metric 4***	***Variant Metric 5***
Target Population:	All	All target populations across all program years	PHQ-9/depression	SMI population	Homeless/at-risk for homelessness
Measure Type:	Administrative: Beneficiary Enrollment and Assessment in WPC Pilot Program	Health Outcomes: 30 day All Cause Readmissions	Health Outcomes: Required for Pilots using PHQ-9	Health Outcomes: Required for Pilots w/SMI Target Population	Housing: Supportive Housing
Description:	New participants enrolled and patient assessments completed within 60 days	30 day All Cause Readmissions	NQF 0710: Depression Remission at 12 Months	NQF 0104: Suicide Risk Assessment:	Percent of homeless referred for supportive housing who receive supportive housing
Benchmark:	PY 1: Not Applicable PY 2: 1250 PY 3: 2500 PY 4: 2500 PY 5: 3750	PY 1: Report Baseline Data PY 2: Maintain Baseline PY 3: 5% decrease PY 4: 5% decrease PY 5: 5% decrease	PY 1: Report Baseline Data PY 2: Maintain Baseline PY 3: 5% increase PY 4: 5% increase PY 5: 5% increase	PY 1: Report Baseline Data PY 2: Maintain Baseline PY 3: 5% increase PY 4: 5% increase PY 5: 5% increase	PY 1: Report Baseline Data PY 2: Maintain Baseline PY 3: 5% increase PY 4: 5% increase PY 5: 10% increase
Numerator:	Newly enrolled participants with patient assessments completed within 60 days	Count of 30-day readmission	Adults who achieved remission at twelve months as demonstrated by a twelve month (+/- 30 days) PHQ-9 score of less than five	Patients who had suicide risk assessment completed at each visit	Number of participants referred for supportive housing who receive supportive housing
Denominator:	Number of newly enrolled participants	Count of index hospital stay (HIS)	Adults age 18 and older with a diagnosis of major depression or dysthymia and an initial PHQ-9 score greater than nine during an outpatient encounter	All patients aged 18 years and older with a new diagnosis or recurrent episode of Major Depressive Disorder	Number of participants referred for supportive housing

4.2 Data Analysis, Reporting, and Quality Improvement

Data Analysis

In accordance with DHCS reporting requirements, each participating entity will collect and report service provision and participant outcome data pertaining to performance metrics and other pertinent indicators (e.g., quantitative and qualitative case and claims data) into the WPCTC to support care coordination, service delivery and monitoring efforts. CPHI will oversee data aggregation and analysis efforts, develop the necessary IT infrastructure and facilitate development of governance practices and data use agreements to support seamless, real-time data sharing in Year 2. **Table 7** outlines data sources. The WPCTC data warehouse will be HIPAA and 42CFR compliant. Data analysis will assess costs savings and ROI as well as support effective service provision and sustainability planning. As more data are aggregated and the WPCTC becomes fully operational, the analytics will be refined to become predictive of who is likely to become a HUMS. It is anticipated that collection of data related to social determinants of health will improve the system's predictive capacities and in turn the array of outreach services and interventions offered as WPC evolves.

Table 7. Existing and New Trust Community Data Sources

Current Data Sources	Planned Data Sources
SCVMC Hospital, Inpatient, Urgent Care	Emergency Medical Services (EMS)
SCVMC Ambulatory Care	Custody Health
Behavioral Health Services Department	Pharmacy
Office of Supportive Housing	Social Services Agency
Valley Health Plan (VHP) Claims	Community Clinics and Community Based Organizations
	Criminal Justice (CJIC)
	Managed Care Health Plans
	Community Hospitals

Reporting

SCVHHS views the reporting cycle as a tool for performance accountability. SCVHHS will complete mid-year and annual reports in alignment with DHCS requirements, including required data to measure progress towards the objectives specified in the WPC Special Terms and Conditions. The Year 1 report will include baseline data that will be used as a comparison for future years. We will provide information on the number of enrolled participants; type and volume of medical, non-medical, emergency department, and inpatient services utilized; and total amount of funds spent. We will also provide a narrative description of successes, challenges and barriers associated with implementation activities and interventions during the reporting period. We will report on universal and variant metrics, reviewing evidenced trends, directionality of changes, and potential interpretations of data in the context of overall impact. We will discuss how metrics have been operationalized, and how activities and processes have been completed. Reports will

discuss outcome measures related to implementation including care coordination across entities; beneficiary demographics, clinical profiles and service utilization; housing stability; access to social services; and reductions in avoidable use of emergency and inpatient services. The report appendices will contain agendas from meetings among participating entities and stakeholders. We will also report the results of all CQI and PDSA efforts. We will participate in the DHCS-conducted mid-point and final statewide evaluations and accommodate data requests. We will also connect the evaluator to appropriate staff and stakeholders from participating entities for primary and secondary data collection as needed.

Quality Improvement

We will promote CQI through strategic application of PDSA to ensure that WPC is making ongoing refinements that promote achievement of objectives. As part of this effort, we will implement targeted PDSA cycles for each performance metric as needed to support advancement of annual benchmark goals. PDSA will be used to document change and assess the success of newly implemented and innovative programmatic components before scaling WPC interventions. PDSA cycles will assess which elements should be maintained in the WPC model and support refinements to service plans, benchmark goals and financing structures.

Data-driven CQI processes will be facilitated throughout pilot implementation via PDSA cycles that are led by the Quality Improvement (QI) Manager in conjunction with cross-system leadership and key stakeholders. The QI Manager will convene workgroups representing appropriate participating entities to administer the PDSA cycles, which will be managed according to targeted plans with realistic, actionable and measurable objectives and timelines that are collaboratively developed and regularly monitored by the Manager. PDSA cycles will range in duration and intensity depending on the degree of change. Small changes in outreach and engagement mechanisms could be measured in a short period of time while larger changes in system function might last over a year. Even more complex PDSA plans may go through several cycles before specific activities are fully developed. Concurrent change management efforts will be managed by the WPC team, who will develop a communications strategy to disseminate PDSA results, program updates, and lessons learned to participating entities and stakeholders; engage them in the change process; offer technical assistance; and garner buy-in.

To develop the initial PDSA cycles, WPC staff, leadership, and key stakeholders will consider the following types of questions:

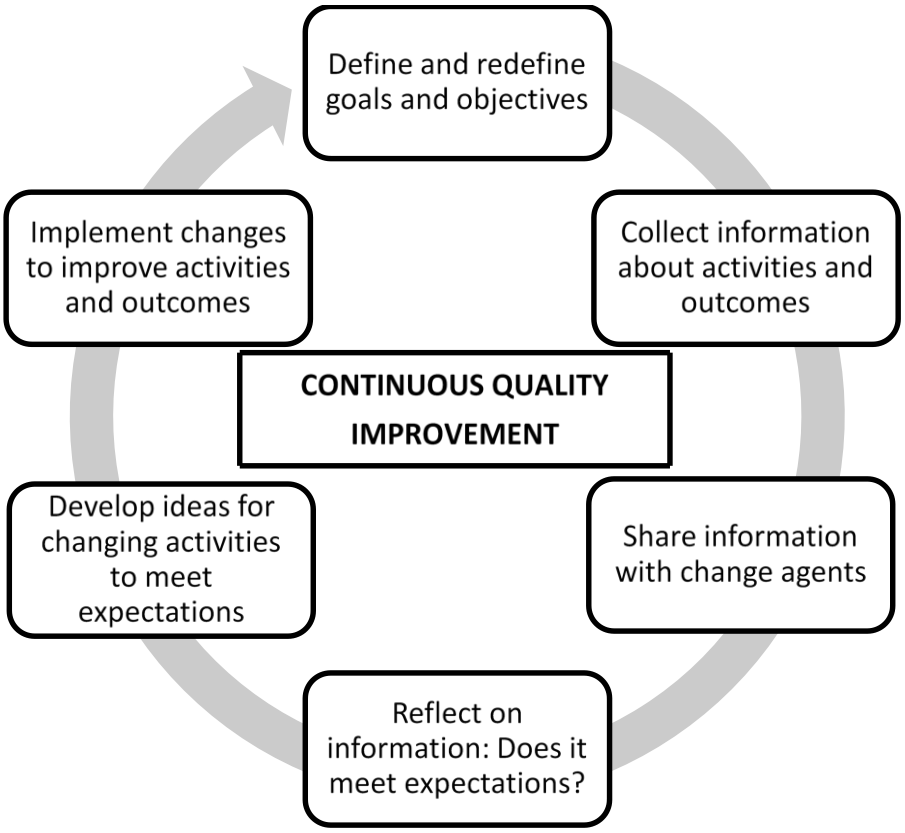
- To what extent is WPC achieving programmatic access, utilization, and outcome milestones?
- Is WPC implementation and subsequent pace of enrollment happening according to plan and in a culturally responsive manner? Are there disparities in who is being served?
- To what extent are full systems integration and interagency collaboration being achieved?
- To what extent is WPC changing utilization patterns?
- What level of service dosage, frequency, and intensity is being evidenced?
- Which services are being used by the greatest number of participants?
- What are WPC participants' experiences of care?

- What are the barriers to implementation or participation by specific demographic groups?
- What practice changes will result in improvements?
- What are the criteria for a change to be considered a marked improvement?

The WPCTC will collect robust data on access, utilization and outcomes to assess the success of program elements. The rapid WPC implementation timeline necessitates that data on program implementation, cost savings and client outcomes be up to date and readily available. As such, data dashboards will be developed to provide aggregate real-time information so that any program modifications can be made expeditiously. Based on the results of ongoing monitoring efforts and quantitative and qualitative analysis, WPC will identify opportunities for PDSA and implement a process for enacting changes; observe and learn from changes and their implications; and determine to how to scale implementation in a manner that incorporates learnings. Analytic findings that are not in the expected direction will trigger the need for PDSA.

Figure 2 illustrates this cycle on the following page:

Figure 2: CQI Cycle



4.3 Participant Entity Monitoring

SCVHHS understands the value of performance monitoring as the basis for programmatic fine-tuning, reorientation, future planning, and accountability. We believe that participant entities must be engaged as partners to reach desired outcomes under a common commitment to improving lives. A pilot offers a venue in which challenges signify an opportunity for learning; as such, the goal of WPC monitoring efforts will be to treat issues that surface as an opportunity for PDSA and quality improvement and only resort to punitive measures as a last resort. To ensure future applicability, we will also monitor WPC efforts in a manner that is consistent with existing Medi-Cal program monitoring practices. Learnings will be discussed at Executive and Steering Committee meetings to inform CQI.

Following establishment of individual MOUs that explicitly detail expectations, roles/functions, responsibilities, performance measures, and resources to the pilot, we will ask participating entities to develop implementation plans to guide ongoing management actions. To monitor fulfillment of these plans, participating entities will be asked to submit quarterly reports that detail service delivery activities, enrollment figures, data collection, progress made towards performance metrics, as well any challenges and support needs that have arisen. Reports will include process and outcome measure data as well as deliverables (e.g., policies and procedures that are developed as part of WPC). Monitoring efforts will support modifications to implementation plans based on analysis of lessons learned.

Technical assistance will be made available to support achievement of pilot goals through a variety of modalities such as webinars, continuing medical education seminars, and individual meetings as needed. In addition, WPC will sponsor a learning community for program leadership and direct service providers to create opportunities for sharing lessons learned, facilitators of success, and challenges in meeting the wide-ranging needs of the WPC population. These quarterly meetings will provide venues for training and technical assistance in line with system integration and workforce development objectives.

We will establish mechanisms for resolution of issues that surface during regular reviews with MOUs used as the basis for inspection. Audits will be undertaken periodically to examine use of resources; reliability of financial and other information provided; compliance with regulations, rules and established policies and procedures; effectiveness of risk management; and adequacy of organizational structures, systems, and processes. In the event of non-compliance, corrective action plans that detail specific actions to be taken to come into compliance within a specified timeline will be imposed to re-align activities and resources to WPC pilot objectives. These plans will be monitored closely; sustained inability to meet requirements and desired outcomes will result in contract termination and discontinuance of funding. SCVHHS will serve as a partner in organizational change first, and as an auditor second; thus, technical assistance will be offered at every step of this process, ideally prior to formal corrective action.

Section 5: Financing

5.1 Financing Structure

The proposed WPC pilot financing model 1) invests in data and service delivery infrastructure, and 2) provides services and interventions that are not eligible for Medi-Cal reimbursement but are needed in order to best serve the target population. The financial and program model is grounded in the premise that the WPC investments will 1) reduce the use of avoidable emergency and acute care services, and 2) increase the use of alternative and planned care environments. This financial model aims to reduce use of the most costly services when not clinically indicated or medically necessary, thereby reducing the occurrence of administrative hospital and inpatient days and providing revenue for medically necessary sub-acute and alternative care delivery. It is also responsive to the health and psychosocial needs of the target population, reducing the likelihood that WPC participants will experience or perceive the need for the same level of emergency and/or acute services.

An Application Fund entitled "Whole Person Care Application Fund," which will have a unique General Ledger account number, will be used to administer this effort. Each organization providing local match funds will contribute their non-federal share to this fund, which will be transmitted to DHCS via Intergovernmental Transfer (IGT). Once SCVHHS receives the WPC payment from DHCS via IGT, the identified funds will be distributed to each of the participating public agencies via an internal transfer, according to the agreed upon budget and reconciled expenses incurred. Additionally, SCVHHS will distribute WPC funds for services delivered using agreed-upon bundled Per Member Per Month (PMPM) case rates or other payment mechanisms to their contracted non-profit and community-based agencies providing service.

SCVHHS plans to distribute payments to individual budget units via internal transfer within 30 days of receipt of funds from DHCS. The payments receipts and payment disbursement tracking will be done through the SAP system and the unique General Ledger account number. Payments made to contracted program and service providers (e.g., community-based organizations) will be made on a monthly basis, based on agreed upon contract terms and in advance of DHCS payment (e.g., actual expenses incurred or actual members served with bundled PMPM), so that providers do not experience delays in payment and/or cash flow difficulties.

There are no new financial systems or changes to the existing financial systems needed to support SCVHHS' participation in the WPC pilot. Incorporating the WPC budget into the County's budget requires legislative file considered, it must undergo review by the County Office of Budget and Financial Analysis, as well as the County Executive's Office. Each would require SCVHHS to have identified and justified the matching funds and expenditures.

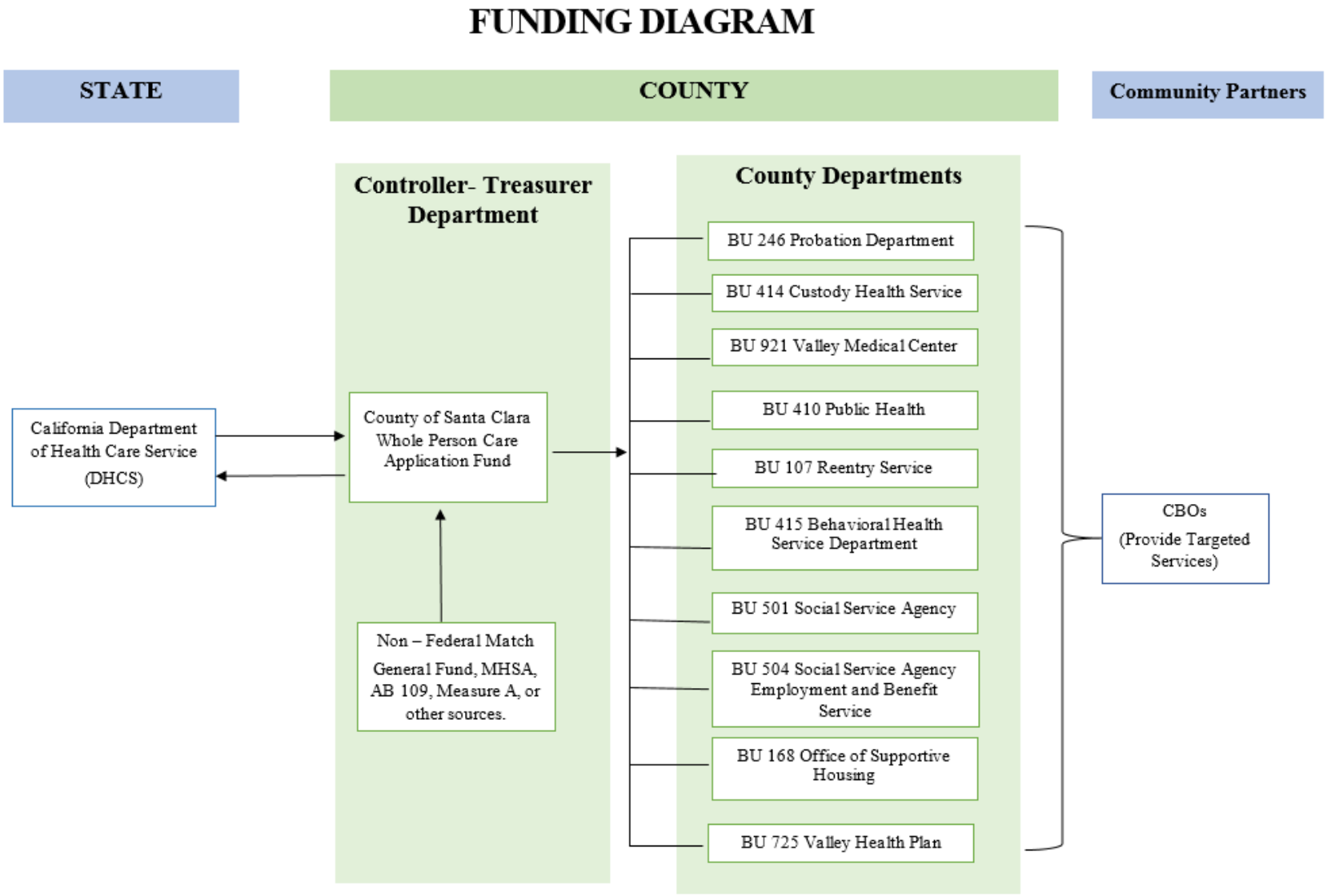
Assuming the Whole Person Care application is approved, SCVHHS will seek a budget modification from the Board of Supervisors to support the Whole Person Care program such that there is sufficient appropriation for all expenditures. Doing so will create the necessity for regular

reporting to the Board of Supervisors, participating in the usual County financial processes, and completing an independent audit as part of the County Comprehensive Annual Financial Report (CAFR) process. Financial oversight and governance will be conducted by the WPC Executive and Steering Committees, which will have access to annual financial reports that document investments, allocations and savings generated, in addition to the standard financial oversight provided by the County Board of Supervisors.

If there are savings gained from the PMPM estimated rates when compared to actual expenses of service delivery, the rates will be adjusted in subsequent years. Overall health system savings gained from this project will be re-invested in the healthcare system to ensure that services can be made available to those who could benefit, as well as promote the sustainability of WPC investments upon completion of the pilot project. Should the estimated PMPM rates prove insufficient or should the needs of the enrollees differ from our assumptions, SCVHHS would propose modifications to the budget and services. Such proposals would stay within the allocation and use PDSA to inform the proposed changes. Flexibility in the program is crucial as we learn more about the needs of the enrollees and how the new models and service bundles interact.

The Whole Person Care financing and payment approach prepare the entities for value based payment approaches in the future by establishing Performance Metrics. During the pilot project, deliverables payments will be based on the achievement of administrative metrics as well as the reporting of service utilization and health outcomes, as specified in Section 4. As the pilot progresses and PDSA cycles inform program modifications that improve the pilot's performance, SCVHHS anticipates that participating entities will be adequately prepared for value based payments derived from the identified performance metrics.

5.2 Funding Diagram



5.3 Non Federal Share

The following entities will provide portions of the non-federal share to the lead entity to be used for payments under the pilot:

- Santa Clara Valley Medical Center
- Santa Clara Behavioral Health Services Department
- Santa Clara County Public Health Department
- Office of Reentry Services
- Santa Clara County Social Services Agency
- Custody Health Services
- Probation Department
- Valley Health Plan (VHP)
- Office of Supportive Housing

5.4 Non-Duplication of Payments and Allowable Use of FFP

SCVHHS' WPC pilot project will fund 1) investments in data and service delivery infrastructure, and 2) services and interventions that are not eligible for Medi-Cal reimbursement in order to best serve the target population.

No Medi-Cal eligible services are included in the WPC pilot project budget or planned WPC services and interventions. Specific services and interventions, as proposed in Section 3, are bundled into PMPM or bed day rates, and are specifically targeted to filling the service and case/care coordination needs of the target population that are not Medi-Cal reimbursable and result in high utilization of multiple systems and poor health outcomes. The program and financial models ensure that all Medi-Cal eligible services to this target population may continue according to existing regulations and practices while the proposed WPC services, which are not Medi-Cal eligible, are included in the bundled service rates. While the PMPM and service bundle rates were estimated using projected expenses, the WPC pilot will not reimburse providers based on certified public expenditures; instead, SCVHHS will reimburse provider organizations for deliverables, including number of bed days provided or number of beneficiaries receiving bundled service packages.

As described in Section 5.1, all WPC funds will be maintained in the "Whole Person Care Application Fund," which will have a unique General Ledger account number. Each organization providing local match funds will contribute their non-federal share to this fund, which will be transmitted to DHCS via Intergovernmental Transfer (IGT). SCVHHS will verify the source of local match dollars from contributing public agencies to ensure that transferred funds qualify for federal financial participation pursuant to 42 C.F.R. part 433 subpart B, and are not derived from impermissible sources. We also will certify this upon IGT to DHCS. SCVHHS will also only request payment for approved deliverables, as described in this application and as documented in annual progress reports. SCVHHS will not apply payments as reimbursement for health care services otherwise reimbursable under the Medi-Cal program or recognized under these STCs or

state plan. Additionally, the payments will not be used to offset certified public expenditures, disallowed administrative or Managed Care Plan (MCP) activities, or supplant provider payments.

In accordance with STC 114(b), housing pool investments in housing units or housing subsidies including payment for room and board will not be eligible for WPC Pilot payments unless otherwise identified in CMS Informational Bulletin, 'Coverage of Housing-Related Activities and Services for Individuals with Disabilities.'

The activities and interactions of the care coordination teams will not duplicate Medi-Cal's targeted case management ("TCM") benefit. Specifically, more extensive health education, telehealth communication with participants and their providers, and supporting transportation and language services departs significantly from the encounter-based structure of TCM, and in the vast majority of cases the encounters between care management teams and patients/clients/members would not be eligible for reimbursement under TCM, as the workers either would not meet the education or experience requirements for TCM case workers or the team members 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 pilot short term care management teams will engage in activities such as peer counseling, socialization skills development, ensuring proper patient medications and utilization, 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 tenancy supports and employment training sessions. For these reasons, we have concluded that the vast majority of WPC Pilot activities will not duplicate services available through Medi-Cal TCM. Coordination will occur between the TCM program and WPC pilot and assurances will be made that services are not duplicated, including continuing the TCM program practice of time studies and closely tracking both population groups so that the WPC pilot provides services beyond the TCM benefit. Adjustments have been made to budgets to ensure duplication of services are not proposed.

The proposed WPC pilot only includes services for currently enrolled and eligible Medi-Cal beneficiaries. Upon identification of potential WPC participants, SCVHHS or partner will verify Medi-Cal eligibility and status. No person will be enrolled in WPC who is not enrolled in Medi-Cal. If a Medi-Cal eligible individual is identified but has not yet enrolled in Medi-Cal, SCVHHS and partner agencies will support the individual to enroll in Medi-Cal prior to WPC service enrollment, outside of WPC program costs.

5.5 Funding Request

Budget Narrative

Budget Summary

Santa Clara County Health and Hospital System (SCVHHS) is proposing a WPC Pilot with a total 5-year program budget based on an annual budget of $52,136,363 for Program Years 3 - 5, including the expansion request. For each program year 3 - 5, SCVHHS will match the $26,068,182 provided through the Whole Person Care (WPC) Pilots Program with $26,068,182 in non-Federal funding through an IGT set-up for this purpose. Program Year 2's total budget request is $48,639,711, which includes an expansion request (referenced as PY 2 – Ltd) that is a six- month period from July through December 2017. Program Year 1 does not include any expansion request, totaling $45,143,059.

A description of each program year follows:

- **Program Year 1 Budget Allocation:** Two activities are required of SCVHHS to receive the $45,143,059 allocation:
  - An approved WPC Pilot application, valued at 75% of the budget, or $33,857,294; and
  - Submission of Baseline Data, valued at 25% of the budget, or $11,285,765.
- **Program Year 2 Budget Allocation:** In PY2, activities and accomplishments fall into the following seven categories:
  - Building the Administrative Infrastructure required to operate the pilot, valued at $5,678,908;
  - Building the Delivery Infrastructure required to operate the pilot, valued at $20,332,380, which includes PY 2 $18,519,228 plus PY 2 – Ltd $1,813,152;
  - Dissemination of Incentive Payments to Partner Entities that are integral to the Trust Community early adoption, and downstream incentives that support providers' and entities' quality participation that are integral to the Pilot's success, valued at $8,384,785;
  - Fee for Service (FFS) offerings valued at $450,410;
  - Delivery of five service bundles consisting of four care coordination bundles and one Rehabilitation and Peer Support services bundle, valued at $11,642,180, which includes PY 2 $10,409,091 plus PY 2 – Ltd $1,233,089;
  - Pay for Reporting utilized as incentives to develop multidisciplinary Triage Teams to assess, screen and identify WPC participants, valued at $2,051,048; and
  - Pay for Outcome metric achievement, valued at $100,000.

- **Program Year 3 Budget Allocation:** In PY3, activities and accomplishments fall into the following seven categories:
  - Continuing to examine and refine the Administrative Infrastructure required to operate the pilot, valued at $7,362,730;

- Continuing to examine and refine the Delivery Infrastructure required to operate the pilot, valued at $3,681,413;
- Downstream provider incentives for accepting Med-Psych enrollees in SNF beds, and downstream incentives that support providers' and entities' quality participation that are integral to the Pilot's success , valued at $5,121,450;
- Fee for Service (FFS) offerings valued at $7,897,278;
- Delivery of five service bundles consisting of four care coordination bundles and one Rehabilitation and Peer Support services bundle, valued at $25,433,160;
- Pay for Reporting utilized as incentives to develop multidisciplinary Triage Teams to assess, screen and identify WPC participants, valued at $2,540,332; and
- Pay for Outcome metric achievement, valued at $100,000.

- **Program Year 4 Budget Allocation:** In PY4, activities and accomplishments fall into the following seven categories:
  - Continuing to examine and refine the Administrative Infrastructure required to operate the pilot, valued at $7,107,541;
  - Continuing to examine and refine the Delivery Infrastructure required to operate the pilot, valued at $3,324,825;
  - Downstream provider incentives for accepting Med-Psych enrollees in SNF beds, and downstream incentives that support providers' and entities' quality participation that are integral to the Pilot's success , valued at $5,074,747;
  - Fee for Service (FFS) offerings valued at $7,897,278;
  - Delivery of five service bundles consisting of four care coordination bundles and one Rehabilitation and Peer Support services bundle, valued at $26,462,104;
  - Pay for Reporting utilized as incentives to develop multidisciplinary Triage Teams to assess, screen and identify WPC participants, valued at $2,169,869; and
  - Pay for Outcome metric achievement, valued at $100,000.

- **Program Year 5 Budget Allocation:** In PY5, activities and accomplishments fall into the following seven categories:
  - Continuing to examine and refine the Administrative Infrastructure required to operate the pilot, valued at $7,107,541;
  - Continuing to examine and refine the Delivery Infrastructure required to operate the pilot, valued at $3,324,824;
  - Downstream provider incentives for accepting Med-Psych enrollees in SNF beds, and downstream incentives that support providers' and entities' quality participation that are integral to the Pilot's success , valued at $5,074,747;
  - Fee for Service (FFS) offerings valued at $7,897,278;
  - Delivery of five service bundles consisting of four care coordination bundles and one Rehabilitation and Peer Support services bundle, valued at $26,462,104;
  - Pay for Reporting utilized as incentives to develop multidisciplinary Triage Teams to assess, screen and identify WPC participants, valued at $2,169,869; and

- Pay for Outcome metric achievement, valued at $100,000.

A. Administrative Infrastructure

1. Core Program Development and Support

		PY 2		PY 3 - PY 5	
Category	***Per Month Cost with 5% administrative fee***	***Max Months***	***Start-up Costs***	***Max Months***	***Annual Cost***
Facility Lease	$ 25,200	6	$151,200	12	$302,400
Facility Maintenance	$ 1,260	7	$ 8,820	12	$ 15,120
Office Equipment	$ 788	7	$ 5,513	12	$ 9,450
Utilities	$ 8,243	7	$ 57,698	12	$ 98,910
Telephone/Communications	$ 788	7	$ 5,513	12	$ 9,450
Equipment Lease	$ 394	7	$ 2,756	12	$ 4,725
Office Supplies	$ 1,103	7	$ 7,718	12	$ 13,230
Program/Activity Supplies	$ 2,100	7	$ 14,700	12	$ 25,200
Security Service	$ 15,330	12	$ 183,960	12	$ 183,960

All core development and support include a 5% indirect rate to represent fully loaded rates. Costs expected to begin in April 2017 in PY2, for a 0.6 FTE, as a start-up period.

a) Facility Lease: $25,200 per month for 6 months in PY 2 totaling $151,200 and an annual total of $302,400 in PY 3-5, for a program total of $1,058,400, for a portion of an existing facilities in which WPC administrative staff will be housed.
b) Facility Maintenance: $1,260 per month for 7 months in PY 2 totaling $8,820 and an annual total of $15,120 in PY 3-5, and a program total of $54,180 for a portion of the facility maintenance expenses related to the building in which the WPC Administration team will be housed.
c) Office Equipment: $788 per month for 7 months in PY 2 totaling $ $5,513 and an annual total of $9,450 in PY 3-5, and a program total of $33,863 to acquire hospital-grade office equipment for the WPC Administration team.
d) Utilities: $8,243 per month for 7 months in PY 2 totaling $57,698 and an annual total of $98,910 in PY 3-5, and a program total of $354,428 distributed on a monthly basis across multiple utilities as follows:
    - Water $3600;
    - PG&E $2400;
    - Garbage $1200;
    - Medical Waste Disposal $650

e) Telephone/Communications: $788 per month for 7 months in PY 2 totaling $5,513 and an annual total of $9,450 in PY 3-5, and a program total of $33,863 distributed on a monthly basis across two carriers as follows:
   - Internet/Cable: $600;
   - VoIP: $150

f) Equipment Lease: $394 per month for 7 months in PY 2 totaling $2,756 and an annual total of $4,725 in PY 3-5, and a program total of $16,931 for leases related to copiers/printers and fax machines for the WPC Administration team.

g) Office Supplies: $1,103 per month for 7 months in PY 2 totaling $7,718 and an annual total of $13,230 in PY 3-5 and a program total of $47,408 for administrative office supplies including paper, pens, notepads, desk supplies, ink cartridges, etc.

h) Program/Activity Supplies: $2,100 per month for 7 months in PY 2 totaling $14,700 and an annual total of $25,200 in PY 3-5 and a program total of $90,300 for programmatic and other group materials, journals, art supplies, etc.

i) Security Service: $15,330 per month for an annual total of $183,960 in PY 2-5, and a program total of $735,840 as a portion of the security contract for the facility in which the WPC programs are housed.

2. IT Infrastructure

Item	*Max Amount Per Unit*	*Max Units*	*Max WPC Fund Amount*
VHP-System Modification	525,000	1.0	525,000

a) VHP System Modification: $500,000 plus a 5% indirect rate for a total of $525,000 in PY 2 only for systems modification for all non-configured systems to expand existing Rehabilitation and Peer Support and case management programs and provide technical assistance related to care management teams. VHP will provide the contract administration and oversight of the services related to, required to operationalize the PMPM service bundles.

3. Staffing (FTEs, Salaries, Employee Benefits, Average Per Person Cost)

Staffing is included for both WPC Pilot Implementation, as well as to support WPC integration and coordination between BHSD and SSA. SCVHHS acknowledges that the WPC program, as designed, requires a higher level of administration than would be necessary for a single program or service. The SCVHHS WPC program represents a systems change initiative that will serve thousands of individuals over the course of the pilot, requiring significant collaboration across multiple existing departments and agencies, as well as an investment in data and administrative infrastructure to support the level of change required. In addition, the WPC program will likely increase the number of clients receiving

ongoing behavioral health services provided by County and contract providers, necessitating a significant investment in related administration and QI activities.

SCVHHS intends to use WPC waiver funds to establish a new model of care to serve HUMS, one that will ultimately be extended beyond the HUMS population at the conclusion of the pilot. SCVHHS operates a unique integrated health care system, one that is moving to have one standard level of care, where access to services designed and operated with a whole person lens. While there are places where specific services are needed to fill gaps and reduce hospitalization, there is a much larger need to create the administrative infrastructure to connect existing services at the delivery level to ensure appropriate workflows and communication within internal as well as contracted providers, as well for larger system management and planning, which includes oversight, coordination, and the technology to support these activities. The additional Waiver Coordination Center and QI resources will ensure the success of this systems change.

Several of these positions will ensure appropriate scaling capacity for the Behavioral Health Services Department (BHSD) to participate in WPC. Most of the target population is already being served within the Santa Clara Valley Medical Center (SCVMC) constellation of services, albeit often with less coordination of care between medical and behavioral health with social services. Based on existing data, where the WPC target population is receiving behavioral health services, they are seen in emergency or acute psychiatric settings or within the jail population, which the WPC pilot would help to change the patterns so that those enrolled would prevent re-incarceration. The WPC program is designed to shift the population into outpatient community settings, thus significantly increasing the total number of people receiving ongoing high-intensity case management services from BHSD.

Staffing Salary Table

			PY 2		PY 3 - PY 5	
Personnel	***Annual Salary***	***Fully Loaded Salary = Salary + 40% Benefits + 5% indirect***	***FTEs***	***Start-up Cost***	***FTEs***	***Annual Cost***
Behavioral Health Quality Director	$ 250,000	$ 367,500	0.6	$ 220,500	1.0	$ 367,500
Sr. Health Care Program Manager	$ 177,306	$ 260,640	1.2	$ 312,768	2.0	$ 521,280
Office Specialist III	$ 92,754	$ 136,348	0.6	$ 81,809	1.0	$ 136,348
Quality Improvement Coordinator I	$ 202,655	$297,903	1.2	$357,483	2.0	$595,806
Sr. Health Care Program Analyst	$153,492	$225,633	0.6	$135,380	1.0	$225,633
Director for Service Integration	$251,862	$370,237	1.0	$370,237	1.0	$370,237
Quality Improvement Coordinator I	$202,655	$297,903	1.0	$297,903	1.0	$297,903
QI Manager/WPC	$244,056	$358,762	1.0	$358,762	1.0	$358,762
Public Communication Specialist	$122,752	$180,445	1.0	$180,445	1.0	$180,445
Medical Director	$301,455	$443,139	0.60	$265,883	1.0	$443,139
Project Manager	$121,133	$178,066	0.60	$106,839	1.0	$178,066
Sr. Health Care Analyst	$113,651	$167,067	1.20	$200,480	2.0	$334,134
Epic Sr. Report Writer	$130,794	$192,267	0.60	$115,360	1.0	$192,267
VHP - Sr. BI Tech Consultant	$216.25/hour	2080 hours/year		$449,800		$449,800
Total Staffing				**$3,453,651**		**$4,651,320**

All staff salaries are listed as salary plus 40% benefits, plus 5% indirect rate to represent fully loaded rates. New positions will be hired by April 2017 in PY2, for a 0.6 FTE, as a start-up period. Existing positions will be 1 FTE for PY2.

Full Time Staffing

a) Behavioral Health Quality Director: $250,000 annual salary totaling $367,500 fully loaded. 0.6 FTE in PY 2 start-up and 1 FTE in PY 3-5, for a program total of $1,323,000, to oversee the BHSD portion of the WPC Pilot, incentivizing integrated Medical-Psychiatric SNF for providers and coordination with the Drug Medi-Cal waiver; working with contract agencies and coordinating services; developing policies, procedures, and workflows as services are established; and report writing. This role will be responsible for cementing the connection between Behavioral Health and WPC and connecting primary care health and other services with BHSD and spend 100% of effort on WPC.

b) Sr. Health Care Program Managers*:* $177,306 annual salary totaling $260,640 fully loaded. 1.6 FTE in PY 2 start-up and 2 FTE in PY 3-5, for a program total of $1,876,607, to support BHSD/WPC integration, including incentivizing integrated Medical-Psychiatric SNF for providers and coordination with the Drug Medi-Cal waiver; working with contract agencies and coordinating services; developing policies, procedures, and workflows as services are established; and report writing. These positions will ensure the level of administrative leadership required for the influx of clients into the case management programs, as well as playing a primary role in managing the necessary PDSA cycles to achieve system objectives and spend 100% of effort on WPC.

c) Office Specialist III: $92,754 annual salary totaling $136,348 fully loaded. 0.6 FTE in PY 2 start-up and 1 FTE in PY 3-5, for a program total of $490,854, to provide executive support to the Behavioral Health Quality Director and BHSD team.

d) Quality Improvement (QI) Coordinator I*:* $202,655 annual salary totaling $297,903 fully loaded. 1.2 FTE in PY 2 start-up and 2 FTE in PY 3-5, for a program total of $2,144,901, to coordinate and oversee QI policies and standards; these resources will work within BHSD to oversee the quality of services in relation to Behavioral Health, their contractors/providers and reports.

e) Sr. Health Care Program Analyst: One FTE $153,492 annual salary totaling $225,633 fully loaded. 0.6 FTE in PY 2 start-up and 1 FTE in PY 3-5, for a program total of $812,280, to support analysis and reporting related to BHSD and WPC operations to support DHCS and other pilot reporting requirements.

f) Director of System Integration: One FTE at $251,862 annual salary totaling $370,237 fully loaded in PY 2-5, for a program total of $1,480,949 to oversee the enterprise-wide activities associated with WPC; oversee the Waiver Coordination Center; reports to Director of SCVHHS and will spend 100% of effort on WPC.

g) Quality Improvement (QI) Coordinator I: One FTE at $202,655 annual salary totaling $297,903 fully loaded in PY 2-5, for a program total of $ $1,191,611, who will serve as part of the Waiver Coordination Center, working to coordinate and oversee QI policies and standards for all aspects of the WPC pilot and to support PDSA efforts.

h) Quality Improvement (QI) Manager/WPC: One FTE at $244,056 annual salary totaling $358,762 fully-loaded in PY 2-5, for a program total of $1,435,049, who will serve as part of the Waiver Coordination Center, to oversee QI operations, including all PDSA efforts in WPC, and staff assigned to WPC pilot.

i) Public Communication Specialist: One FTE at $122,752 annual salary totaling $180,445 fully-loaded in PY 2-5, for a program total of $721,782, who will serve as part of the Waiver Coordination Center, to support internal and external communications, writing stories to update public and staff, develop/disseminate marketing materials, support PDSA process, help write briefs and other materials for elected officials, media, and other stakeholders.

j) Medical Director: $301,455 annual salary totaling $443,139 fully-loaded. 0.6 FTE in PY 2 start-up and 1 FTE in PY 3-5, for a program total of $1,595,300, to oversee the medical models of care coordination for WPC, and who will serve as part of the Waiver Coordination Center. The Medical Director will provide the medical direction and

leadership required for the development of new workflows to facilitate system change. The delineation between medical and behavioral health will not always be clear, and may at times present conflict. For example, the population is characterized by high incidences of cardiovascular and metabolic problems; however, psychiatric medications frequently result in weight gain and diabetes. This conflict between symptoms and medications will need to be mediated across medical and behavioral health providers. The Medical Director will provide oversight and consultation, and will set policy and standards of practice for participating WPC providers. The Medical Director position is expected to focus 50% of their time on WPC administrative and development work for the first year, and 50% of time on system utilization review of WPC services. By the end of the project (in 2020) the administrative time could potentially decrease to 20% of their time. The remaining hours would be spent on system utilization and value review, for WPC services. No clinical, billable hours are expected from this position. 100% efforts goes towards WPC activities.

k) Project Manager*:* $121,133 annual salary totaling $178,066 fully-loaded. 0.6 FTE in PY 2 start-up and 1 FTE in PY 3-5, for a program total of $641,036, located within SCVHHS Finance to develop policies, procedures and oversee contracts related to the Medical-Psychiatrist SNF incentive project.

l) Sr. Health Care Analyst: $113,651 annual salary totaling $167,067 fully-loaded. 1.2 FTE in PY 2 start-up and 2 FTE in PY 3-5, for a program total of $1,202,882, located within SCVHHS Finance to compile and compute WPC finances for reporting. Will be proficient in gathering and sorting data from multiple sources including HealthLink, Unicare, and PHIS, and conduct required financial analyses.

m) Epic Sr. Report Writer: One FTE at $130,794 annual salary totaling $192,267 fully-loaded. 0.6 FTE in PY 2 start-up and 1 FTE in PY 3-5, for a program total of $692,162, to pull data from Epic and compile, validate and create reports on the outcomes/metrics as required by DHCS and WPC pilot operations; 100% effort is for WPC activities.

Consultants

n) VHP Sr. Business Information Technology Consultant: 2,080 hours of consultant time at $216.25 per hour in PY 2-5, for an annual cost of $449,800 and a program total of $1,799,200. The consultant will work from VHP and dedicated to work with the Center for Population Health Innovations and the Waiver Coordination Center on WPC to assist in the evaluation of the program and ensuring proper data and reports from VHP.

4. Program Governance

	PY 2	PY 3	PY 4	PY 5
Rehabilitation and Peer Support and Case Management Program Administration	$1,054,608	$1,841,192	$1,586,003	$1,586,003

a) VHP Rehabilitation and Peer Support and Care Coordination Program Administration: Funds allocated across PY 2-5, as noted above, for a program total of $6,067,806, to expand existing Rehabilitation and Peer Support and care coordination programs, contract administration, oversight monitoring of contractors, and provide technical assistance and workforce development support related to coordination of WPC care management teams.

5. Training

Item	Max Amount Per Unit	Max Units	Max WPC Fund Amount
Clinical/Professional staff (CME-eligible training)	630	44.1	27,783
Coordination/management	131,250	1.0	131,250

a) Clinical/Professional staff training: $27,783 annually in PY 2-5 to provide 44 units of CME-eligible training at a rate of $600, plus 5% indirect rate, per training; total program cost is $111,132.
b) Workforce Coordination/management: $131,250 annually in PY 2-5 to host a quarterly conference at a rate of $31,250, plus 5% indirect rate, for all expenses related to securing a venue, refreshments, materials, and publicity. Conferences will provide an opportunity for training and technical assistance in line with the Pilot's system integration and workforce development objectives; for a total program cost of $525,000.

6. Marketing and Materials

Item	Max Amount Per Unit	Max Units	Max WPC Fund Amount
Marketing Materials	26,250	1.0	26,250

a) Marketing Materials: $25,000, plus 5% indirect rate, annually in PY 2-5, for a program cost of $105,000 to develop and print a range of marketing materials including:
    - A participant outreach 1-pager to inform potential participants about program benefits. While printed materials are not the only or primary outreach method, this brochure will be produced in a highly visual format that can be distributed in a clinical or other service setting and will be distributed to partner entities such as SSA, Reentry Resource Center, Probation, hospitals, and targeted clinics and will include contact information for enrollment.

- A provider education 1-pager that can be distributed to clinical staff so that they are informed and can appropriately refer potential participants; will include a website and email address for more information. Distribution will include SSA, Reentry Resource Center, Probation, hospitals, and targeted clinics.
- A briefing packet for hospital, health plan, and clinic leadership including heads of ambulatory care and care coordination to drive awareness of the WPC pilot; will include tear sheets on care coordination, the Trust Community, and new services.

Administrative Infrastructure costs will be attributed to the following deliverables in the proportions provided:

Year	**Deliverable 14: Care Coordination Infrastructure (40%)**	**Deliverable 15: Data and information sharing infrastructure (60%)**
PY 2	$2,271,563	$3,407,345
PY3	$2,945,092	$4,417,638
PY4	$2,843,016	$4,264,525
PY5	$2,843,016	$4,264,525

(refer to **Section H, Deliverables Summary**, for additional details)

Deliverable 14: SCVHHS will develop, build and maintain the Care Coordination infrastructure necessary to support the WPC Pilot.

- PY2 activities will include development of 1) Care coordination documentation; 2) Referral policies and procedures for WPC lead and participating entities; 3) Communication structures related to care coordination; 4) Monitoring and oversight procedures and related regular review process definition; 5) Method for compiling and analyzing monitoring findings.
- PY3 activity will include achieving access to beneficiary information for key participating entities.
- PY4 activities will include achieving write capabilities to beneficiary information for key participating entities; and implementing a PDSA within SCVHHS to refine care coordination, case management, and referral infrastructure.
- PY5 activity will consist of expanding the PDSA to refine care coordination, case management, and referral infrastructure to include Participating Entities.

Deliverable 15: SCVHHS will develop, build and maintain the data and information infrastructure necessary to support the WPC Trust Community (WPCTC).

- PY2 activities will include development of: 1) Policies and procedures for WPC lead and participating entities; 2) Monitoring and oversight procedures and related regular review process definition; and 3) Method for compiling and analyzing monitoring findings.
- PY3 activities will include: 1) Achieving access and updates to beneficiary information for all participating entities; 2) Development of a process for modifying policies and procedures.
- PY4 activity will consist of implementing a PDSA to refine care coordination, case management, and referral infrastructure for initial subset of providers.
- PY5 activity will consist of expanding the PDSA to refine care coordination, case management, and referral infrastructure for additional providers.

B. Delivery Infrastructure

Delivery infrastructure costs consist of the WPC Trust Community across the four program years and startup costs to stand-up new services for WPC participants. Startup costs are estimated to take six months, during PY 2 and/or PY 3. These startup and development activities are critical to ensuring the creation and success of ongoing services for the WPC participants to develop the infrastructure necessary. Once the delivery infrastructure for the services (excluding Trust Community) are developed by PY 3, services will be billed either as FFS or PMPM.

Year	WPCTC	S/T Care Start up	M/T Care Start up	L/T Care Start up	Peer Respite Start up	Medical Respite Start up
PY 2	$12,750,001	$915,522	$ 1,192,778	$ 2,024,491	$647,649	$988,787
PY3	$3,681,413	/	/	/	/	/
PY4	$3,324,825	/	/	/	/	/
PY5	$3,324,824	/	/	/	/	/

1. WPC Trust Community:

The WPCTC is integral to the overall mission of the WPC pilot, providing both the infrastructure and support for population and participant identification, data sharing, and reporting across the pilot period and beyond. The WPCTC will function as a secure exchange such that 100% of staffing and software investments will be dedicated to data collection, analysis, and reporting related to WPC pilot participants. The following components make up the WPCTC investment:

a) **Server Side Software and Services** totaling $5,925,950 across PY 2-5, including:
   - Electronic Master Patient Index software to be used for matching patients across multiple systems, a one-time investment of $525,950 in PY 2.
     - Health Information Service Provider (HISP)/Health Information Exchange (HIE) Platform: This software is required to receive and process clinical, claims and demographic data centrally.

- Electronic Master Patient Index: This software is required to centrally match patients that come from different systems.
- Interface Engine (Used to route Electronic transactions): This software is needed to translate data to a common standard that will be used to route clinical, demographic and claims transactions between systems involved in the exchange.

- Professional Services required to implement the Electronic Master Patient Index and connect clients to the Electronic master patient index, including 1) Installing server-based software components; 2) Loading demographic data for each client and building out interfaces to the Electronic Master Patient Index; and 3) Installing server side software and configure each client when they connect to the server.

  This investment is factored at $125/hour, with 230 hours per site with Enterprise Master Person Index (EMPI), and 450 hours for HISP/HIE, with 40 sites total. The total estimated is $3,400,000 spread across PY 2-3 as follows:

  - It is estimated that 90% of the work will take place in PY 2 for a total of $3,060,000.
  - The remaining work will be in PY 3 in the amount of $340,000.
- Maintenance Fees, a recurring cost of $500,000 each year for PY 2-5, for a total program cost of $2,000,000. Fees will consist of a service-based cost for the following software items based on industry standard cost models for these types of software; $0.25 for the EMPI and Interface Engine per patient and $0.75 for the HISP/HIE on a per patient basis. This will be paid to a HIE/HISP vendor on a yearly basis based on volumes of transactions processed through the system.

b) **Server Side Hardware** a one-time cost totaling $350,000 in PY 2 required as the EMPI has its own minimum hardware requirements to install software. Investment includes:
   - Centralized Test Server for EMPI: Test Servers for EMPI software installation. These servers will be used for testing, for a total PY 2 cost of $100,000.
   - Centralized Production Server for EMPI: Production Servers for EMPI installation. These servers will be used for a production environment, for a total PY 2 cost of $250,000.
c) **Client Side Software and Services** totaling $5,600,000 across PY 2-5, including:
   - Software License Cost for the software used to connect clients to the EMPI and HIE that is sold by the EMR systems that will be connecting to the HIE. This software will enable SCVHHS to access data from the client systems that will be connecting to the HIE and EMPI. A one-time cost of

$800,000 for the EMPI software and $1,200,000 for the HIE software for $2,000,000 total in PY 2.

- Professional Services: Client side services costs to connect each of the 40 sites to the MPI and HISP/HIE and implement the initial deployment. These services will be used to connect the client software that exports data from each client site to the HIE and configure those systems to export clinical, claims and demographic data. A one-time cost of $400,000 for the EMPI and $1,600,000 for the HIE in PY 2, for a total of $2,000,000, factored at $125/hour, representing 16,000 hours of effort (approximately 400 hours per site).
- Maintenance Fees: An ongoing maintenance cost for the client side software to be paid to the EMR vendors that will be connecting to the HIE to maintain their software. These services are required to maintain the interfaces that export clinical, claims and demographic data from each connecting client site to the HIE. A recurring project cost of $640,000 in PY2, decreasing to $320,000 in PY 3-5, for a total project cost of $1,600,000.

d) **Client Side Hardware** totaling $940,973 in PY 2 only, which consist of servers that host the software that will export data from each of the client sites that will be connecting to the HIE. These investments include:
   - Test Servers for the interface software sold by the EMR vendor to be installed on, at a cost of $540,973 in PY 2.
   - Production Servers for the interface software sold by the EMR vendor to be installed on, at a cost of $400,000.

e) **Office Supplies** totaling $5,606 across the WPCTC project for administrative supplies including paper, pens, notepads, desk supplies, and ink cartridges, costing $1,499 in PY 2 and PY5, and $1,108 in PY 3 and $1,500 in PY 4.

f) **Staffing** for WPCTC will include a total of 13 FTEs for each project year at a fully loaded cost of $2,345,000 per year, totaling $9,380,000 across PY 2-5. Staffing includes:
   - One FTE Interoperability Manager at a fully loaded salary of $245,000 who will provide strategic and managerial oversight to the WPCTC.
   - Two FTE Interoperability Techs at a fully loaded salary of $175,000 each who will support day to day WPCTC operations.
   - 10 FTEs Client Side FTE Sponsorship who will be assigned 0.25 time at each of the 40 implementation sites within the WPC pilot and who will provide technical assistance for WPCTC implementation and operations.

	PY 2	PY 3	PY 4	PY 5
Trust Community Annual Costs	$12,112,501	$3,497,343	$3,158,584	$3,158,583
Trust Community Annual Costs **including 5% administrative Fee**	$12,750,001	$3,681,413	$3,324,825	$3,324,824

2. *Short-term Care Coordination start-up:*

Part of the overall approach to care coordination, providing coordination for medium to high-risk individuals needing short term assistance to avoid complication/readmission. This program is intended to reduce the incidence/cost of avoidable readmissions and complications by providing coordination focused on establishing needed psychosocial and other supports. The total **six month startup only cost** is $915,522 in PY 2 to develop the administrative infrastructure to deliver the Short-term Care Management models and conduct activities related to program start-up including initial salaries for seven interdisciplinary teams consisting of two months (.25 FTE) of 25 staff to ramp-up services for a total salary of $622,804, with 40% benefits ($249,122), and a 5% indirect rate ($43,596).

PERSONNEL			
Personnel	***FTEs***	***Annual Salary***	***Year 2 startup salary .25 FTE (2 months)***
Public Health Nurse II	3	$127,543	$95,657
Public Health Assistant	1	$54,871	$13,718
Public Health Nurse II	2	$115,864	$57,932
Public Health Manager I	1	$167,955	$41,989
Medical Social Worker	1	$152,793	$38,198
Social Media/Internet Communication Specialist	0.25	$78,289	$4,893
Peer Counselors	6	$53,556	$80,334
Pharmacist	2	$163,405	$81,703
Technician	1	$65,555	$16,389
Hospitalist	0.5	$250,000	$31,250
Physician	0.5	$250,000	$31,250
Pharmacist	2	$163,405	$81,703
Technician	1	$65,555	$16,389
Assistant	3	$41,867	$31,400
Benefits	Rate	40%	$249,122
			$871,925
INDIRECT			
Indirect Expenses	5%		$43,596
			year 2 startup
Total Expenses			**$915,522**

3. *Mid-term Care Coordination start-up:*

Part of the overall approach to care coordination, providing time-limited coordination grounded in stages of change and motivational enhancement to address the needs of patients at significant risk for avoidable complication/readmission by coordinating proactive transition services. This program is intended to reduce the incidence/cost of avoidable readmissions and complications by providing coordination focused on establishing needed psychosocial and other supports. The total **six month startup only cost** is based on four targeted case coordination teams for a total of $1,192,778 in PY 2 to

conduct activities related to program start up including $659,128 in personnel for an interdisciplinary team consisting of six months of 47 staff at .25 FTE with 40% benefits ($263,651), and $223,826 for operational costs including office set up ($213,120), recruitment and re-employment expenses ($4,706), staff development and training ($6,000), and a 5% indirect rate ($56,799).

PERSONNEL				
Personnel		***Total FTEs(4 teams)***	***Annual Salary***	***Year 2 startup salary .25 FTE (2 months)***
Project Oversight		1	$85,000	$10,625
Program Manager		4	$85,000	$42,500
Psychiatrist		4	$ 320,000	$160,000
Hospitalist		1	$ 250,000	$31,250
Physician		1	$ 250,000	$31,250
Psychologist		4	$ 115,000	$57,500
LCSW		12	$85,000	$127,500
PHN		8	$ 115,000	$115,000
Peer Counselors		8	$53,556	$53,556
Social Media/Internet Communication Specialist		0.25	$78,289	$2,447
Financial Analyst		4	$55,000	$27,500
Benefits	Rate	40%		$263,651
Total Personnel				**$912,154**
OPERATIONS				
Category	***Rate***	***Quantity***		***Start-up Cost***
Office				
Furniture/Fixtures	$ 37,000	4 teams		$148,000
Computers	$ 16,280	4 teams		$65,120
Staffing				
Recruitment/Preemployment Expenses	$127	37		$4,706
Staff Development and Training				$6,000
Total Operations				**$223,826**
INDIRECT				
Indirect Expenses				$56,799
				Year 2 startup
Total Expenses				**$1,192,778**

4. Long-term Care Coordination start-up:

Part of the overall approach to care coordination, providing intensive coordination without time limits for those unlikely to maintain health/recovery and maximal independence in the absence of ongoing intensive services. Long-term coordination addresses ongoing need to reduce avoidable use of ED, EPS, and hospitalization. The total **six month startup only cost** is based on seven targeted care coordination teams for a total of $2,024,491 in PY 2 to include costs related to program start up including interdisciplinary teams staffing ($1,255,989) for 74 staff at .25 FTE or 2 months; with 40% benefits ($502,396); operational costs ($169,702) made up of office set-up ($135,450), supplies ($4,200), recruitment and staff development ($23,325), Insurance ($6,727), and a 5% indirect rate ($96,404). Staffing will allow for leadership to accomplish program development and hiring, and training for staff prior to initiating services.

PERSONNEL				
Personnel		***Total FTEs(7 teams)***	***Annual Salary***	***Year 2 startup salary .25 FTE (2 months)***
Team Leader		7	$85,000	$148,750
Psychiatrist		1.4	$320,000	$112,000
Clinician		7	$115,000	$201,250
Social Media/Internet Communication Specialist		0.25	$78,289	$4,893
Nurse		7	$115,000	$201,250
AOD Counselor		7	$45,760	$80,080
Service Coordinators		28	$45,760	$320,320
Peer Counselors		14	$53,556	$187,446
Benefits		Rate	40%	$502,396
Total Staffing				**$1,758,385**

OPERATIONS				
Category	***Rate***	***Quantity***	***Teams***	***Start-up Cost***
Office				
Office Lease	$1,200	2 months	7 teams	$16,800
Office Equipment	$1,000	70		$70,000
Computers	$440	70		$30,800
Utilities	$150	2 months	7 teams	$2,100
Telephone/Communications	$750	2 months	7 teams	$10,500
Equipment Lease	$375	2 months	7 teams	$5,250
Supplies				
Office Supplies	$600	12	7 teams	$4,200
Staffing				
Recruitment/Preemployment Expenses	$241	72 background checks	12	$17,325
Staff Development and Training				$6,000
Other				
Insurance	$961		7 teams	$6,727

TOTAL OPERATIONS				**$169,702**
INDIRECT				
Category		***Rate***		
Indirect Expenses		5%		$96,404
				Year 2 Startup
Total Expenses				$2,024,491

5. *Peer respite startup:*

Intended to provide a home-like, peer-staffed environment for those experiencing mental health crises, where participants can learn healthier boundaries and develop safety planning. This six month startup investment provides an alternative to inpatient psychiatric treatment when the individual is not a danger to self/others but requires a supportive environment, and is designed to reduce avoidable use of EDs, EPS, and inpatient services. The total **six month startup only cost** of $647,649 in PY 2 will develop 20 new beds, support initial staffing of 16 from .08 FTE to .5 FTE ($124,089); with 40% benefits ($49,635); operational costs ($443,085), including facility siting and related set up ($394,050); acquisition of office, program, and other necessary supplies ($8,550); transportation costs including vehicle lease, registration and insurance ($3,960); janitorial service ($18,000); recruitment and staff development ($6,825), and insurance ($11,700); and a 5% indirect rate ($30,840).

PERSONNEL				
Personnel	***FTEs***	***Annual Salary***	***Year 2 Start-up FTE***	***Year 2 Start-up Costs***
Program Director	1	$65,000	0.25	$16,250
Clinical Consultant	0.1	$85,000	0.08	$680
Recovery Coaches	14	$41,600	0.08	$46,592
Project Manager	1	$121,133	0.50	$60,567
Relief Staff	***# of Hours***	***Hourly Rate***		
Recovery Coaches	2240	$18.00		
Benefits	Rate	40%		$49,635
Total Staffing				**$173,724**
OPERATIONS				
Category	***Rate***	***Quantity***		
Facility				
Facility Maintenance				$129,600
Facility Lease				$240,000
Utilities	$2,950	6 months		$17,700
Telephone/Communications	$750	6 months		$4,500
Equipment Lease	$375	6 months		$2,250
Supplies				
Office Supplies	$400	3 months		$1,200
Program/Activity Supplies	$450	3 months		$1,350
Medical Supplies	$650			$6,000
Transportation				
Vehicle Lease	$330	3 months		$990
Operations	$450	3 months		$1,350
Insurance	$540	3 months		$1,620
Contract Services				

Janitorial Service	$6,000	12		$18,000
Staffing				
Recruitment/Preemployment Expenses	$52	16 background checks		$825
Staff Development and Training				$6,000
Other				
Insurance	$1,950	6 months		$11,700
TOTAL OPERATIONS				**$443,085**
INDIRECT				
Indirect Expenses	5%			$30,840
TOTAL EXPENSES				Year 2 Start-up
Total Expenses				$647,649

6. *Medical Respite start up:*

The medical respite center combines the features of a transitional/shelter service with limited medical services; this addition to the constellation of services in Santa Clara County is intended to reduce hospitalization for HUMS who are homeless and lack appropriate step-down options, providing a lower level of care than a SNF but more medical support than a traditional shelter. Provides post-acute care to monitor homeless patients or those without access to appropriate home care, intended for HUMS with health conditions not requiring inpatient care but too serious for discharge in order to reduce avoidable complications/readmissions to acute care by increasing post-discharge supports. The Health Center Manager, Assistant Nurse Manager and RN Coordinator position duties are not Medi-Cal billable. The Health Center Manager would provide operational and administrative oversight for the Medical Respite Center. The Assistant Nurse Manager would provide clinic oversight. The RN Coordinator would conduct staff training and program coordination. The Program Manager, Project Manager, physician, psychologist, RN, Medical Assistant and driver positions would perform administrative duties and spend time in team meetings, focusing on the patient's needs; these services are not Medi-Cal billable. The shift leads, case managers and counselors/peers would focus their duties on non-Medi-Cal billable services, such as the administrative analysis, team meetings and non-medical service coordination. The total **six month startup only cost** of $988,787 in PY 2 will develop 20 additional beds, to support initial staffing at .01 FTE to .25 FTE, totaling $92,890 including both fully loaded and salary-only staff; benefits for fully loaded staff at 33% ($4,187); operational costs ($844,625), including facility siting and related set up

($803,550); acquisition of office, program, and other necessary supplies ($6,550); recruitment and staff development ($4,825), and insurance ($11,700); and a 5% indirect rate ($47,085).

PERSONNEL				
Medical Staff	***FTEs***	***Annual Salary***	***Year 2 Start-up FTE***	***Year 2 Start-up Cost***
HCM	0.1	$ 293,951	0.02	$ 588
ANM	0.2	$ 293,952	0.02	$ 1,176
RN Coordinator	0.2	$ 293,953	0.02	$ 1,176
Physician	0.3	$ 293,954	0.01	$ 882
Psychologist	0.5	$ 177,236	0.01	$ 886
RN	2	$ 222,995	0.01	$ 4,460
Medical Assistant	0.2	$ 97,769	0.01	$ 196
Medical Social Worker	1.5	$ 152,793	0.01	$ 2,292
Mobile Outreach Driver	0.2	$ 103,331	0.01	$ 1,033
Shelter/Respite Staff		****Salary only***		
Program Manager	1	$ 49,920	0.02	$ 9,984
Shift Leads	2.8	$ 41,600	0.08	$ 3,328
Case Manager(s)	1	$ 41,600	0.08	$ 3,328
Counselors/Peers	12.6	$ 37,440	0.08	$ 2,995
Project Manager	1	$ 121,133	0.05	$ 60,567
Benefits	Rate	33%		$ 4,187
Total Staffing				**$ 97,077**

OPERATIONS				
Category	***Rate***	***Quantity***		***Start-up Cost***
Facility				
Facility Lease				$ 648,000
Facility Maintenance				$ 129,600
Office Equipment	$ 250	6 months		$ 1,500
Utilities	$ 2,950	6 months		$ 17,700
Telephone/Communications	$ 750	6 months		$ 4,500
Equipment Lease	$ 375	6 months		$ 2,250
Supplies				
Office Supplies	$ 400	3 months		$ 1,200
Program/Activity Supplies	$ 450	3 months		$ 1,350

Medical Supplies	$ 650	3 months		$ 4,000
Contract Services				
Janitorial Service	$ 6,000	3 months		$ 18,000
Staffing				
Recruitment/Preemployment Expenses	$ 52	16 background checks		$ 825
Staff Development and Training				$ 4,000
Other				
Insurance	$ 1,950	6 months		$ 11,700
TOTAL OPERATIONS				**$ 844,625**
ADMINISTRATIVE				
Category	***Rate***			
Administrative Expenses	5%			$ 47,085
TOTAL EXPENSES				Year 2 Start-up
Total Expenses				$ 988,787

7. *Sobering Station Infrastructure (within the Restoration Center):*

A 20 recliner chair Sobering Station, as part of the existing plans for a future Restoration Center, will be developed during the six-month startup in PY 2 – Ltd budget year. Services will begin in limited capacity at the beginning of the Pilot Expansion PY 2 (July 1, 2017) – Ltd budget year with 5 recliner chair spaces in a temporary location while concurrent facility siting for the permanent Sobering Station occurs. The Restoration Center is part of the larger SCVHHS initiative in development to provide a comprehensive and seamless system of medical and behavioral healthcare services to support the whole person as an alternative care setting for acutely intoxicated individuals. The Restoration Center will be co-located with the Mental Health Urgent Care Clinic, adjacent to the Santa Clara Valley Medical Center (SCVMC) and its ED, and will be in proximity to a Detoxification Center and long-term residential substance use treatment facility. The Sobering Station is one component of what will become the Restoration Center and the only element of the Restoration Center in the WPC funding request. All funding requests in this application for the Sobering Station have taken into account prorated costs for the overhead, space and facilities that may be shared within the Restoration Center. The Sobering Station is estimated to occupy 33% of the shared building.

Sobering Station Need

Estimating the anticipated demand for sobering station services may be challenging because: 1) data across EMS, EDs, EPS, and jail systems are not currently centrally stored; and 2) understanding who could potentially be diverted from an emergency or jail setting requires treatment protocols not yet developed. However, it is possible to estimate from previous studies and utilization rates the pool of potential consumers. Data indicates high levels of AOD use and homelessness/lack of safe settings for sobering among the target HUMS population.

We anticipate that the Sobering Station will annually provide 14,600 episodes of care to approximately 3,650 unique individuals. Of these 3,650 individuals, we estimate that 53% (1,934) will come to the Sobering Station as a jail diversion and avoid being booked into the jail and that the other 47% (1,715) will come directly from the community in lieu of ED/EPS. There may be a small percentage of individuals who come to the Sobering Station who require more medical monitoring than the Sobering Station can provide and may be sent to the ED for medical clearance prior to admittance.

In 2011, a preliminary EMS study on Ambulance Transport to Emergency Departments found that approximately 2,720 patients who presented with alcohol-related intoxication or other primarily-alcohol related effects (without drug, trauma, illness or other confounding factors) were transported via 911 EMS ambulance each year to hospital EDs throughout Santa Clara County. SCVHHS estimates approximately 60% of these individuals, 1,632 individuals, could be diverted to a Sobering Station**.** An analysis conducted in 2012, using clinical data and ICD-9 codes, found that 1,120 individuals who would otherwise be transported to an ED, could be transported directly from the field using a treat and release protocol and non-emergency transportation. When taken together, this suggests that *1,376 unique individuals* could be diverted from EMS/ED services to the Sobering Station.

Based upon data collected from 2013-2016 on the Santa Clara Valley Medical Center (SCVMC) Emergency Department, SCVHHS estimates that every year 2,920 patients in the SCVMC ED present with acute alcohol intoxication without medical issues. SCVHHS estimates approximately 60% of these individuals could be diverted to a Sobering Station, or *1,752 consumers annually.*

Based upon data collected from 2013-2016 on Emergency Psychiatric Services, SCVHHS estimates that every year 652 patients in the EPS present with acute alcohol or drug intoxication and that all *652 individuals* could be diverted to the Sobering Station**.**

A review of 2016 Santa Clara County Sheriff's Department's booking numbers conservatively estimates that approximately 1,800 individuals are brought to the jail each month for reasons-related to alcohol intoxication. The County further estimates that approximately 20% of these individuals do not require medical attention or have charges that would require incarceration and could be diverted to a Sobering Station, resulting in 360 consumers per month or *4,320 individuals* annually.

This suggests that there are **8,160 unique individuals** who could be diverted to a Sobering Station, as described in Table 2 below.

Table 1. Estimated Number

Origin of Eligible Consumers	Diverted Consumers
Ambulance Transport to Emergency Departments	1,376
Valley Medical Center Emergency Department	1,752
Emergency Psychiatric Services	652
Police/Sheriff	4,380
Total	**8,160**

This estimate combines data sources that may be duplicative and overestimate the number of persons to be served. Specifically, there may be some overlap between the individuals transported via EMS to any ED within the County with the group that was seen at the SCVMC ED; this may overestimate need. However, the ambulance transport, SCVMC ED, and police/sheriff data only include alcohol intoxication; this may underestimate need by excluding people experiencing drug or other substance intoxication.

Findings from other sobering centers includes data from the San Francisco Sobering Center, which was established in 2003 and is a 12-bed facility providing short-term (4-12 hour) sobering services. During the 2015-16 fiscal year, the San Francisco Sobering Center served 1,216 unique individuals in 3,883 encounters, equating to an average of approximately three encounters per individual. From FY 2010-14, the average cost per stay at the Sobering Center was $274, compared to $518 to $741 for an ED visit.

Rationale for Sobering Station Services

Clinical protocols are in development between the Behavioral Health Department, Emergency Department and Emergency Medical Services as a cross-departmental effort. The EMS protocol for treat and release in the field would allow EMS to provide a "field medical clearance" so that the person could go to the sobering station via non-medical transport that can include van outreach services staffed by Sobering Station personnel to accompany clients to engage in services. The protocol, under development, considers the patient's medical history, level of intoxication, substances ingested, and range of vital signs, and applies lessons learned from similar protocols currently being implemented in Orange and Alameda Counties.

The Sobering Station staff include an interdisciplinary team that includes medical, nursing, and non-licensed staff. This model is based on lessons learned from sobering stations in Seattle and Portland as well as San Diego, San Francisco, and Alameda Counties. The

nursing staff play a critical role in medical triage upon admission to determine appropriateness and safety of referral as well as provide ongoing monitoring for people whose condition may change while sobering and facilitate their transport to a medical setting.

Care coordination staff will meet with individuals at the Sobering Station towards the end of their stay to determine needs and next steps, which may include enrollment in care coordination bundles of services. Given the likely urgency of care needs, we expect that the care coordinators will support individuals to connect with the next service provider upon discharge. This is a critical linkage to care and services that will support HUMS towards recovery and wellness. This will, at minimum, include the care coordinator making contact with the receiving service provider to schedule an appointment and provide any background information as well as supporting the individual to address any barriers to making the next appointment (i.e. reminder phone call, transportation). In many instances, we expect that the care coordinator will also physically support the person to get to the next service, such as walking the person across the street to the substance use treatment facility or across the medical campus to the mental health clinic.

The total **six-month startup cost** of $1,346,240 PY 2 - Ltd will fund implementing 20 recliner-chair spaces in the Sobering Station. Startup activities will consist of

- Facility siting ($898,370);
    - Facility Lease for 4,500 square foot facility (33% of the Restoration Center) at $3.00/sq ft (per existing county standards for facilities) for 3 months (3 x 4,500 x $3.00 = $40,500). The 4,500 square foot facility will consist of approximately 60% or 2,700 square foot for sobriety services and 40% or about 1,800 square foot for administrative and office space.
    - One-time Leasehold Improvements, including facility development and preparations, such as carpet, paint, ceiling tiles, plumbing, lights, movement of walls, etc. for launch of the Sobering Station is estimated at $362,870.
    - One-time office equipment purchasing to include acquisition of hospital grade office equipment, such as recliner chairs with warranty, task chairs, privacy screens, side tables, work stations, and miscellaneous office equipment during start-up is estimated at $250,000
    - One-time use items Recuperative Supplies stock, including, for example: for single-use consumable items including gloves, anti-nausea resources, fluids, first-aid supplies, antiseptic gel/wipes, masks, thermometer sleeves, laundry detergent, personal hygiene kits, vomit bags, biohazard bags, gowns, paper, pens, notepads, file folders, and paper towels to be purchased during start-up phase from July through September in PY 2 – Ltd and is estimated at $67,979.
    - One-time Recuperative Equipment expenses for durable items including vital signs monitors, IV pumps for hydration therapy, stethoscopes, blood

pressure cuffs, digital thermometers, pulseoximeters, defibrillator/AED, weight scales, dressing trays, medical waste bins, and various office equipment for direct WPC services to be purchased during start-up phase from July through September in PY 2 – Ltd and is estimated at $175,200.

All one-time costs are not included in any other section of the Sobering Station budget.

- Two months of supplies and utilities ($9,850) and contracts ($41,200) such as janitorial and security (shown at a prorated amount for the size of the unit); staff recruitment and hiring activities ($7,609); insurance ($3,900) and initial salaries, which includes 2 to 4 months' salary for program leadership to conduct program development and hiring, and 1-2 months for remaining staff to complete training and preparations prior to delivering services.

  Medical Director: During the start-up phase, the Medical Director will work with the ED and EMS Directors to develop the eligibility and screening criteria for admission to the sobering station as well as the patient assessment protocols. On an ongoing basis, the Medical Director will provide oversight and supervision to the sobering station to ensure that the sobering services are safe and effective.

  RN*:* The RN will provide oversight to the patient screening and assessment services and supervise the nursing staff. The RN will also provide direct services for screening, assessment, and monitoring while on shift.

  LVN/LPTs: The nursing staff will provide screening and assessment services to patients upon arrival to the sobering station as well as ongoing supervision during a patient's stay at the sobering station. Nursing staff will also provide basic counseling to individuals, in partnership with the recovery coaches.

  Recovery Coaches*:* The recovery coaches will support the sobering station milieu using social rehabilitation techniques as part of the recuperative care. This includes recovery coaching and basic substance abuse counseling with the goal of supporting each individual to recognize a need for additional recovery services and facilitate their acceptance of ongoing substance abuse services. The recovery coaches/peer support workers will actively connect clients to care coordinators as part of the linkage to care and may provide transportation through the sobering station's van service.

  Program Manager*:* The program manager will provide oversight and supervision to the daily operations of the sobering station, in partnership with the Medical Director and RN. This includes supervision of the recovery coaches, managing all aspects of the sobering station operations, and communication with referring parties to ensure that the community of professional and natural supports likely to come into contact with a high user of multiple systems/WPC consumer are aware of the sobering station services and how to refer and/or access services.

  Staffing totals for start-up is estimated at $243,397 in salary; plus benefits for fully loaded staff at 40% ($93,759); and a 5% indirect rate ($64,107).

PERSONNEL				
Personnel	***FTEs***	***Annual Salary***	***PY 2 Months of salary***	***PY 2 Start-up cost***
Medical Director	0.1	$ 301,455	2	$ 5,024
RN	4.2	$ 115,000	2	$ 80,500
LVN/LPT	4.2	$ 66,000	2	$ 46,200
Recovery Coaches/Peer Support Workers	16.8	$ 53,556	1	$ 74,978
Health Care Program Manager II	0.76	$ 109,320	4	$ 27,694
Benefits full time only	Rate	40%		$ 93,759
Total Staffing				**$ 328,156**

OPERATIONS				
Category	***Rate***	***Quantity***	***PY 2 Start Up (services begin in PY 3)***	
Facility			**Months**	**Cost**
Facility Lease	$ 3.00	4500 sq ft	3	$ 40,500
One-time costs for "fit up" of sobering station - leasehold improvements				$ 357,741
One-time costs for "fit up" of sobering station - office equipment				$ 250,000
One-time costs for "fit up" of sobering station - stocking recuperative supplies: consumables				$ 175,200
One-time costs for "fit up" of sobering station - recuperative supplies: durable equipment				$ 67,979
Utilities (water $100, gas $450, garbage $300, electricity $1500)	$ 2,350		2	$ 4,700
Telephone/Communications	$ 750		2	$ 1,500
Equipment Lease	$ 375		2	$ 750
Supplies				
Office Supplies	$ 400		2	$ 800
Program/Activity Supplies	$ 450		2	$ 900
Hygiene Supplies/Personal Items	$ 600		2	$ 1,200
Contract Services				
Janitorial Service	$ 6,000		2	$ 12,000

Security Service	$ 14,600		2	$ 29,200
Staffing				
Recruitment/Preemployment Expenses	$ 62		26	$ 1,609
Staff Development and Training	$ 3,000		2	$ 6,000
Other				
Insurance	$ 1,950		2	$ 3,900
Total Operations				**$ 953,979**
INDIRECT RATE				
Category	***Rate***		***PY 2 Start-up Base***	***PY 2 Start-up Indirect Cost***
Indirect Costs	5%		$ 1,282,135	$ 64,107
				PY 2 Start-up
Total for Sobering Station				$ 1,346,240

8. Nursing Home Transitions, Diversions and Care Coordination Program start up:

A 2016 Santa Clara County Facilities Gap Analysis highlighted data showing that 10-20% of long-term care (LTC) residents could live independently in the community with appropriate medical and social services supports. These HUMS are at risk of or experiencing long term care placement due to a combination of barriers including lack of housing, inadequate income, family support and/or challenging behaviors. This group experiences multiple chronic conditions - including medical, mental health, cognitive, and substance use issues - and is more likely to be hospitalized in acute inpatient settings and subsequently placed in nursing facility placements because of issues related to housing, accessibility, and other support needs. More appropriate community based alternatives for these patients would support better outcomes and lower costs.

The Nursing Home Transitions, Diversions and Care Coordination Program set of services is designed to combine tenancy support services with intensive care management services to assist clients in transitioning back into the community or to assist clients who are already in the community to stay there. Participants of this program will be a group of HUMS whose acute inpatient and LTC high costs could be avoided and whose outcomes can improve with supported community integration. Through strong county and community-based partnerships, along with options for community living alternatives such as Residential Care Homes for the Elderly (RCFE's), the program is uniquely suited to transition or divert this population of difficult to place individuals back into the community.

Care coordination across the program with the same core team and/or individual is key to the success of community living transitions – the core team meets regularly to develop a shared, multi-disciplinary Community Living Plan that the participant follows through the program. Services are provided to enrolled participants primarily Monday through Friday.

The Nursing Home Transitions (NHT) program consists of three potential bundles of services earned through PMPM of enrolled participants for each bundle and are defined and criteria are as follows:

Nursing Home Transitions, Diversions and Care Coordination Program start up:

High Intensity Care Management

The criteria for the High Intensity Care Management PMPM bundle includes Medi-Cal enrolled individuals who are living in a long term care facility or acute hospital stay, but could transition back to the community with supports. These are individuals who without the appropriate level of support could not be safely discharged due to multiple conditions, including behavioral health, lack of housing and lack of family supports. In order to graduate out to a lower level service, individuals would be successfully placed in community living and/or their condition would be stabilized, which allows movement to mid-term care coordination. The anticipated time for most clients in this bundle is an average of three months, but with a range of no less than one month and no more than six months. The ratio of clients to each care coordinator/manager to client ratio is 20:1. The direct care staff serving WPC enrollees in this bundle include clinical and care manager staff that make up the Core Group who work collaboratively and comprehensively with participants. The Core Group will meet biweekly to share the Community Living Plan for each enrollee and develop a multi-disciplinary approach to their care and transitions. The care coordinators/managers (MSW and LCSW staff) conduct frequent home visits, identify and fulfill needs in the Community Living Plan, and connect with providers and social supports. They would focus their work on establishing tenancy supports to achieve community transitions. The clinical staff (RNs and occupational therapist staff) are part of the Core Group that contribute to the decisions and actions to be taken on each Community Living Plan and ensures they are in the best clinical interest of the clients in order to successfully transition to community or alternative living. The PMPM rate requested is $2,076.70. In PY 2 - Ltd, 318 member months are anticipated over the six month period. In PY 3 – 5, 912 member months are anticipated for each year. These services are not covered by Medi-Cal because the direct service would be provided by staff not billable through Medi-Cal.

Mid-term Care Coordination

The criteria for the Mid-term Care Coordination PMPM bundle includes Medi-Cal enrolled individuals who have successfully transitioned back into a community or alternative living setting from a long term care facility or acute hospital stay OR who currently lives in the community and is at-risk for institutionalization. In order to graduate out to a lower level service, individuals would have all required services to support stable community setting living in place. The anticipated time for most clients in this bundle is an average of five months, but with a range of no less than one month and no more than six months. The ratio of clients to each care coordinator/manager to client ratio is 20:1. The direct care staff serving WPC enrollees in

this bundle include clinical, behavioral, care manager and peer counselor staff that make up the Core Group who work collaboratively and comprehensively with participants. This Core Group will meet to update the Community Living Plan for each enrollee and continue a multi-disciplinary approach to their on-going stabilization and care. The care coordinators/managers (LCSW and Peer Counselor staff) conduct bi-weekly home visits. The clinical and behavioral staff are part of the Core Group and provide continued support for enrollee's success in the community. The PMPM rate requested is $1,363.54. In PY 2 - Ltd, 420 member months are anticipated over the six-month period. In PY 3 – 5, 1,020 member months are anticipated for each year. These services are not covered by Medi-Cal because the direct service would be provided by staff not billable through Medi-Cal.

Rehabilitation and Peer Support Services

The criteria for the Rehabilitation and Peer Support Services PMPM bundle includes Medi-Cal enrolled individuals who have successfully graduated from the mid-term care coordination services and are transitioning into independence OR are who currently enrolled in mid-term care coordination and would benefit from additional peer focused services to support their ability to stay housed in the community. In order to graduate from this service bundle, enrollees would show stabilization in their activities of daily living in the community. The anticipated time for most clients in this bundle is an average of seven months, but with a range of no less than one month and no more than nine months. This PMPM does not have care coordinators, but instead utilizes peer support workers and rehabilitation counselors to provide the necessary supports to move enrollees towards great independence. The direct care staff serving WPC enrollees in this bundle include peer support workers and rehabilitation counselors, in consultation with clinical staff to work collaboratively and comprehensively with participants. The staff may support enrollees with engaging in activities of daily living and helping develop self-determining problem solving skills. The PMPM rate requested is $137.19. In PY 3 – 5, 840 member months are anticipated for each year. These services are not covered by Medi-Cal because peer workers at this level are not reimbursable

Nursing Home Transitions Program – process of transitioning across bundles of service

High Intensity Care Management
Months 1 – 6 (avg. 4-6 month duration)

$2,076.70 PMPM
Reach: 90 unduplicated/year

Care Manager Activities

- Care manager conducts intensive assessment
- Care Manager and Client create a Community Living Plan
- Coordinates delivery of community based services, including housing
- Purchases interim goods and services to fill gaps in community living plan
- Collaborates with Primary Care Provider, stakeholders and service providers
- Ensures access to medications, medical care, DME and support services
- Facilitates benefits changes from institutional to community living

May enter program at high intensity (currently institutionalized) or mid-term (at-risk for institutionalization)

Mid-term Care Coordination
Months 7 – 12 (avg. 4-6 month duration)

$1,363.54 PMPM
Reach: 110 unduplicated/year

Care Manager Activities

- Care Manager problem solves gaps in care coordination
- Assess for unmet needs
- Facilitates transition of community living skills
- Ensures client engagement in meaningful activities
- Provides bi-weekly to monthly home visits
- Reviews Community Living Plan with client on monthly basis
- Provides updates to Core Group
- Continues to provide emotional support
- Provides crisis intervention if needed

Rehabilitation and Peer Support Services
Months 7 – 15 (avg. 6- 9 month duration)

$137.19 PMPM
Reach: 110 unduplicated/year

Care Manager Activities

- Determine ability to maintain independent living without care management
- Facilitate transfer of care responsibilities to long-term care management
- Resolve unmet Community Living Plan goals
- Coordinate services to assist in development community living skills and enhance ADL's and IADL's
- Engage client in health and wellness support services
- Encourage independent problem solving skills

Participants may receive Mid-Term Care Coordination and Rehabilitation and Peer Support bundles of services concurrently or separately, depending on need

The Tenancy Support Services could include:

- Purchase of Goods and Services - goods and services necessary to avoid unnecessary institutionalization. Services may include items such as short-term coverage (e.g. purchasing homecare during transition period when IHHS will not cover), accessibility / one time set-up costs for home modifications, home set-up, and equipment.
- Tenancy Acquisition – acquiring tenancy options to transition/divert clients into the most appropriate level of community living with support services. WPC funds would support seeking, securing and working to establish tenancy, but will not include any funds for room and board. Strategies include securing corporate- or master-leased units of scattered-site community supportive housing for people transitioning out of homelessness or institutionalization. Scattered-site supportive housing programs create opportunities for rapid re-housing and community integration through unit identification, master leasing, rent subsidy administration, accessibility modifications, tenant-landlord liaison services, and ongoing housing retention services.

The total **three month startup cost** of $466,912 in PY 2 - Ltd will support getting to full implementation of the High Intensity Care Coordination Bundle and preparing the slots for services for the step-down levels that will concurrently begin in PY 2 – Ltd (July – December 2017). Costs for startup will support IT consultants and software/hardware purchases to prepare for data sharing and technology requirements ($294,672), initial purchase of services and goods in preparation of participants ($150,000) and a 5% indirect rate ($22,240). See detailed budget below.

OPERATIONS			
Category			***Py 2 Start-up cost (1st 3 months)***
Purchase of Service			$ 150,000
Professional Services (IT Consultants)			$ 75,000
Software and Hardware			$ 219,672
Total Operations			**$ 444,672**
INDIRECT RATE			
Indirect Costs	5%		$ 22,240
			PY 2 Start-up
Total Expenses			$ 466,912

Deliverables associated with the delivery infrastructure include:

PY	D1: WPCTC 1	D2: WPCTC 2	D3.a.: Medical Respite Start Up	D4.a.: Peer Respite Start up	D5.a.: S/T Care Start up	D6.a.: M/T Care Start up	D7.a.: L/T Care Start up
PY 2	$6,375,001	$6,375,001	$988,787	$647,649	$915,522	$1,192,778	$2,024,491
PY 3	$1,840,707	$1,840,707	N/A	N/A	N/A	N/A	N/A
PY 4	$1,662,413	$1,662,413	N/A	N/A	N/A	N/A	N/A
PY 5	$1,662,412	$1,662,412	N/A	N/A	N/A	N/A	N/A

Year	D17.a.: Restoration Center Sobering Station Start up	D18.a.: Nursing Home Transitions, Diversions and Care Coordination Start up
PY 2 - Ltd	$1,346,240	$467,000
PY 3	N/A	N/A
PY 4	N/A	N/A
PY 5	N/A	N/A

Deliverable 1. WPCTC 1: SCVHHS will conduct activities related building the WPCTC as follows:

- PY2 activity will consist of finalizing DUAs among partner entities.
- PY3 activity will consist of deploying master data management for patient, provider, location and other key master indexes.
- PY4 activity will consist of achieving support for clinical data exchange in the form of HL7 2.x messages from an initial subset of partners.
- PY5 activity will consist of achieving support for clinical data exchange in the form of HL7 2.x messages from additional partners.

Deliverable 2. WPCTC 2: SCVHHS will conduct activities related building the WPCTC as follows:

- PY2 activity will consist of engaging stakeholders including clinical staff in defining workflows to be observed in data sharing.
- PY3 activity will consist of integrating existing CCDA and HL 7 2.x messages and business processes improvement.
- PY4 activity will consist of achieving support for clinical data exchange in the form of C-CDA summary documents and business processes improvement for initial subset of partners.

- PY5 activity will consist of achieving support for clinical data exchange in the form of CCDA summary documents and business processes improvement for additional partners.

Deliverable 3.a. Medical Respite Start Up: SCVHHS will conduct activities in PY 2 for six months to conduct activities related to program start up including facility siting; acquisition of necessary equipment, supplies and contracts such as insurance, janitorial, laundry and security; and staff recruitment and hiring. Once the Medical Respite begins services, costs will be accounted through FFS (see FFS services below).

Deliverable 4.a. Peer Respite Start Up: SCVHHS will conduct activities in PY 2 related to program start up including facility siting; acquisition of necessary equipment, supplies, and contracts; and staff recruitment, hiring and initial salary. Once the Peer Respite begins services, costs will be accounted through FFS (see FFS services below).

Deliverable 5.a. Short-term Care Start Up: SCVHHS will conduct activities in PY 2 related to program start up including staff recruitment and hiring; initial salaries and training; and operational set up.

Deliverable 6.a. Mid-term Care Start Up: SCVHHS will conduct activities in PY 2 related to program start up including facility siting and preparation; staff recruitment and hiring; initial salaries and training; and operational set up.

Deliverable 7.a. Long-term Care Start Up: SCVHHS will conduct activities in PY 2 related to program start up including facility siting and preparation; staff recruitment and hiring; initial salaries and training; and operational set up.

Deliverable 17.a. Restoration Center Sobering Station Start Up: SCVHHS will conduct activities in PY 2 - Ltd related to program start up including facility siting; acquisition of necessary equipment, supplies, and contracts; and staff recruitment, hiring and initial salary. Once the Restoration Center Sobering Station begins services, costs will be accounted through FFS (see FFS services below).

Deliverable 18.a. Nursing Home Transitions, Diversions and Care Coordination Start Up: SCVHHS will conduct activities in PY 2 - Ltd related to program start up including operational set up; data sharing infrastructure; program supplies.

C. Incentive Payments

1. *WPC Trust Community Adoption Incentive*

Year	**Deliverable 8: WPC Trust Community Adoption Incentive**
PY 2	$4,000,000
PY 3	/
PY 4	/
PY 5	/

Deliverable 8: This PY 2-only incentive is designed to encourage early adoption of the Trust Community connection for participating entities. WPCTC is a critical component of the SCVHHS WPC Pilot, supporting target population and individual participant identification; engagement, and service coordination; reporting and evaluation of pilot activities and outcomes. At the same time, there are significant barriers to organization adoption, including fears around security and competitive advantage, lack of uniform buy-in, and organizational inertia. This incentive is intended to provide participating entities with the necessary stimulus to establish organizational buy-in and facilitate identification of appropriate resources to participate in implementation. Entities will be incentivized to be early adopters through developing an agreement to share data within the WPC Trust Community and developing an implementation plan. Participating entities eligible for this incentive include all listed participating entities in **Section 1.2** (BHSD, PHD, SSA, OSH, Re-Entry Services, CHP, BHCA, etc.) and any clinical and provider sites that may participate in WPC from CHP and BHCA membership organizations.

Payment will be triggered for each participating entity when the following two deliverables are provided to the lead entity:

1. Signed Data Use Agreement (DUA) between the participating entity the lead entity that establishes an agreement to interface and exchange data through the WPC Trust Community.
2. Development of an implementation plan that includes designing methods for compiling and analyzing participation, services, and outcomes.

Early adopters into the WPC Trust Community will be rewarded with a higher percentage of the incentive payment available. Estimates are that 40 total entities will participate in the WPCTC. The formula for determining payments are outline in the table below based on the 40 entity estimate:

Tiers and Deadlines	**Payments**
Tier 1: Six months from beginning of WPC (June 30, 2017) *(up to first 10 entities)*	Max 45% of the total incentive = $1,800,000 • 4.5% of the total incentive per entity = $180,000
Tier 2: Nine months from beginning of WPC (September 30, 2017) *(up to next 10 entities)*	Max 25% of the total incentive = $1,000,000 • 2.5% of the total incentive per entity = $100,000
Tier 3: 12 months from beginning of WPC (December 30, 2017) *(remaining entities)*	Min 30% the total incentive = $1,200,000 • 1.5% of the total incentive per entity = $60,000

2. Integrated Medical-Psychiatric Skilled Nursing Facility (SNF) Provider Incentive Payments

Year	**Deliverable 10: Integrated Medical-Psychiatric Skilled Nursing Facility (SNF) Provider Incentive Payments**
PY 3	$736,665
PY 4	$1,605,270
PY 5	$1,605,270

Deliverable 10: A critical unmet need in the community is a SNF unit designated for our participants with concurrent medical and psychiatric needs (Med-Psych SNF). These patients are challenging to place in the community as there are no designated facilities equipped to address their holistic needs. Although Medi-Cal pays for SNF, the complexity of this population requires enhanced reimbursement to entice SNFs to accept these patients. For example, there is an aging population with co-morbidities such as brain injury along with end-stage disease. Many of these patients have behavioral issues which complicate placement. Medi-Cal includes rates for medical or psychiatric SNF days; however, providers in Santa Clara County will not accept patients with concurrent medical and psychiatric or behavioral needs. Given the dearth of such beds in Santa Clara County, funding to incentivize development of capacity is necessary.

This project would create an incentive for providers to develop the additional services/hire clinicians or providers for this integrated service which would fill a severe service gap that currently leaves many patients unable to be discharged from hospital stays. These complex and combined medical/psychiatric/behavioral needs result in avoidable stays in acute environments as placements are not available. The integrated Medical-Psychiatric SNF is integral to the pilot objective of reducing avoidable hospital/psychiatric stays. This Med-Psych SNF will have a 49% behavioral health designation and is an identified need within Santa Clara County. These incentives will support Santa Clara County to improve the trajectory and array of integrated services by creating this alternative to hospitalization for those with significant behavioral health and medical needs.

The WPC pilot will create an incentive for providers to increase the capacity and accept these high needs participants. The incentive will be used to develop the additional services/hire clinicians or providers for this integrated service which would fill a severe service gap that currently leaves many patients unable to be discharged from hospital stays. The incentive payment is structured as a $146.60 per bed day rate, which is a 50% incentive increase on-top of the highest Medi-Cal SNF bed day rate in Santa Clara County ($293.20).

Payment is triggered upon a participating provider accepting a Med-Psych WPC pilot enrollee and counted for each bed day, for a maximum payment of $736,665 in PY 3 (15 beds for 11 months, in consideration of ramping up period in PY 3 = 15 x 335 x $146.60); $1,605,270 annually in PY 4 and PY 5 (30 beds for 12 months = 30 x 365 x $146.60); a total program

incentive of $3,947,205 will be eligible. The lead entity will provide the downstream incentive for each day of that enrollees' stay at the provider SNF.

3. Social Services Referral Integration

Year	**Deliverable 12: Social Services Referral Integration**
PY 2	$2,484,785
PY 3	$2,484,785
PY 4	$2,027,131
PY 5	$2,027,131

Deliverable 12: Social Services Referral Integration is an Incentive Payment deliverable, with potential payments outlined above for each PY that will be made available to SCVHHS and Social Services Agency (SSA) as incentive payments. This deliverable incentives the integration and coordination between SCVHHS and SSA to provide the critical component of meeting WPC participants' psycho-social needs through timely and appropriate referrals. SSA provides General Assistance via temporary assistance to indigent adults with the sole purpose of financially supporting access to food, shelter and other basic needs, which SCVHHS recognizes as a critical ingredient to a person's overall health and ability to participate in their own wellness and recovery. Part of the services SSA offers includes formal hand offs to SSI and SCVHHS services, such as behavioral health. Proper assessment will help get clients in either SSI or other longer term services, depending on their actual behavioral and physical needs. The work completed by the WPC multidisciplinary teams situated in SSA will provide in-depth triage not currently done and will expedite the process to screen for and identify WPC participants for enrollment and streamline the referral process for SSI and SCVHHS services that currently take over a year. These "Triage Teams" will support WPC participants to obtain the array of services they qualify for and need to improve and maintain their overall health and wellbeing. Payments are incentives for reduced time from first encounter at SSA to appropriate referrals for services to more rapidly address WPC participants' needs.

Social Services Referral Integration - Incentive Payments				
Outcome	**Outcome 1**	**Outcome 2**	**Outcome 3**	**Outcome 4**
Valuation PY 2 & PY 3	$621,196	$621,196	$621,196	$621,196
Valuation PY 4 & PY 5	$506,783	$506,783	$506,783	$506,783
Measure Type:	Behavioral Health (BH): referral to assessment	Behavioral Health (BH): referral time	Behavioral Health (BH): assessment	Behavioral Health (BH): Referral to BH services
Description:	Percent of formal hand-offs to BH Assessments	Time (in days) from formal hand off to BH assessment	Percent of BH assessments completed	Percent of new Medi-Cal GA WPC clients with BH treatment plan
Benchmarks:	PY 1: Report Baseline Data PY 2: Development of formal hand-off procedure PY 3: 1% increase PY 4: 1% increase PY 5: 1% increase	PY 1: Report Baseline Data PY 2: Implementation of formal hand-offs PY 3: 1% decrease PY 4: 1% decrease PY 5: 1% decrease	PY 1: Report Baseline Data PY 2: Implementation of BH assessments PY 3: 1% increase PY 4: 1% increase PY 5: 1% increase	PY 1: Report Baseline Data PY 2: Implementation of BH treatment plans for Medi-Cal GA WPC clients PY 3: 1% increase PY 4: 1% increase PY 5: 1% increase
Numerator:	Number of new Medi-Cal General Assistance (GA) WPC Clients to receive formal hand-offs for to BH Assessments	Time (in days) from formal hand off to BH assessment for Medi-Cal GA WPC clients	Number of new Medi-Cal GA WPC clients completing BH assessment	Number of new Medi-Cal GA WPC clients with BH treatment plan
Denominator:	Number of new Medi-Cal General Assistance (GA) WPC Clients		Number of new Medi-Cal GA WPC Clients to receive referral for to BH Assessments	Number of new Medi-Cal GA WPC clients referred to BH services

This deliverable involves proportional payments triggered by achieving the described benchmarks, to the following table:

Benchmark	**Payment**
PY2: Implementation of referrals and hand-offs begin *each outcome measured and paid respectively to the change achieved*	• $621,196 per respective outcome
PY3: 1% decrease (Outcome 2) and 1% increase (Outcomes 1, 3, 4)	• 1% change = $621,196 per respective outcome (100% payment) • 0.75% change = $465,897 (75%)

Benchmark	Payment
each outcome measured and paid respectively to the change achieved	• 0.5% change = $310,598 • 0.25% change = $155,299
PY4: 1% decrease (Outcome 2) and 1% increase (Outcomes 1, 3, 4) *each outcome measured and paid respectively to the change achieved*	• 1% change = $506,783 per respective outcome (100% payment) • 0.75% change = $380,087 (75%) • 0.5% change = $253,391 (50%) • 0.25% change = $126,696 (25%)
PY5: 1% decrease (Outcome 2) and 1% increase (Outcomes 1, 3, 4) *each outcome measured and paid respectively to the change achieved*	• 1% change = $506,783 per respective outcome (100% payment) • 0.75% change = $380,087 (75%) • 0.5% change = $253,391 (50%) • 0.25% change = $126,696 (25%)

4. Drug and Alcohol Screening

Year	**Deliverable 13: Drug and Alcohol Screening**
PY 2	$1,900,000
PY 3	$1,900,000
PY 4	$1,442,346
PY 5	$1,442,346

Deliverable 13: Drug and Alcohol Screening is an Incentive Payment Achievement deliverable with potential payments outlined above for each PY that will be made available to downstream providers as incentive payments. This deliverable establishes Drug and Alcohol screening benchmarks based on the proportional payments for the pay for metric outcome achievements in the belief that additional screening will expand the HUMS population beyond SCVHHS and help to continuously identify vulnerable patients. By further expanding the providers doing the screening and entering the data into the Trust Community, SCVHHS will develop a better picture of the population and their needs, allowing us to better serve them. This screening tool is a proxy for the implementation of additional tools. In addition, this incentive functions to encourage additional partner providers and the use of additional tools to meet WPC goals. Payments are incentives for connecting services to the patients that allow us to provider better services.

Drug and Alcohol Screening - Incentive Payments				
Outcome	**Outcome 1**	**Outcome 2**	**Outcome 3**	**Outcome 4**
Valuation PY 2 & PY 3	$475,000	$475,000	$475,000	$475,000
Valuation PY 4 & PY 5	$360,587	$360,587	$360,587	$360,587
Measure Type:	Health Outcome: Drug and Alcohol	Drug and Alcohol: Referral to intervention	Drug and Alcohol: Interventions	Drug and Alcohol: Referral to Substance Abuse Treatment
Description:	SBIRT: Drug and Alcohol Screening	Percent of referrals to Substance Abuse intervention with Behavioral Health Specialists who received screening	Percent of Substance Abuse interventions completed by Behavioral Health Specialists who were referred	Percent of referrals to Substance Abuse Treatment who received intervention
Benchmarks:	PY 1: Report Baseline Data PY 2: Implementation of SBIRT screening PY 3: 1% increase PY 4: 1% increase PY 5: 1% increase	PY 1: Report Baseline Data PY 2: Implementation of referrals to substance abuse intervention PY 3: 1% increase PY 4: 1% increase PY 5: 1% increase	PY 1: Report Baseline Data PY 2: Implementation of substance abuse intervention PY 3: 1% increase PY 4: 1% increase PY 5: 1% increase	PY 1: Report Baseline Data PY 2: Implementation of referrals to substance abuse treatment PY 3: 1% increase PY 4: 1% increase PY 5: 1% increase
Numerator:	Number of participants who had drug and alcohol screening (SBIRT) completed	Number of referrals to Substance Abuse intervention with Behavioral Health Specialists who received screening	Number of Substance Abuse interventions completed by Behavioral Health Specialists who were referred	Number of referrals made to Substance Abuse Treatment who received intervention
Denominator:	Number of participants enrolled	Number of participants who had drug and alcohol screening (SBIRT) completed	Number of referrals to Substance Abuse intervention with Behavioral Health Specialists who received screening	Number of Substance Abuse interventions completed by Behavioral Health Specialists who were referred

This deliverable involves proportional payments to the lead entity, SCVHHS, triggered by achieving the described benchmarks, to the following table:

Benchmark for Payment to SCVHHS	**Payment to SCVHHS**
PY2: Implementation of referrals and hand-offs begin	• $475,000 per respective outcome

Benchmark for Payment to SCVHHS	Payment to SCVHHS
PY3: 5% increase (Outcomes 1 – 4) *each outcome measured and paid respectively to the change achieved*	• 1% change = $475,000 per respective outcome (100% payment) • 0.75% change = $356,250 (75%) • 0.5% change = $237,500 (50%) • 0.25% change = $118,750 (25%)
PY4: 5% increase (Outcomes 1 – 4) *each outcome measured and paid respectively to the change achieved*	• 1% change = $360,587 per respective outcome (100% payment) • 0.75% change = $270,440 (75%) • 0.5% change = $180,293 (50%) • 0.25% change = $90,147 (25%)
PY5: 5% increase (Outcomes 1 – 4) *each outcome measured and paid respectively to the change achieved*	• 1% change = $360,587 per respective outcome (100% payment) • 0.75% change = $270,440 (75%) • 0.5% change = $180,293 (50%) • 0.25% change = $90,147 (25%)

Payments will made to downstream providers as incentive payments based on their proportional contribution to outcomes accomplished in the WPC pilot each year. Eligible Provider Entities will include participating SCVMC Clinics and Community Health Partnership Clinics.

Benchmark for Downstream Payments to Provider Entities	Payment to Provider Entities
Percent contribution outcome change *Example: 1,000 screenings completed in WPC pilot, a clinic contributes 50 screenings or 5% of total screenings*	Percent contribution to the total screenings x total incentive payment received by lead entity *Example: 5% of $475,000 incentive payment earned by SCVHHS, or $23,750*

D. FFS Services

The SCVHHS WPC Pilot includes three sets of discrete services that are to be reimbursed on a per encounter basis: Peer Respite Services, Medical Respite Services and Sobering Station Services within the future Restoration Center. The unit of reimbursement for Peer and Medical Respite will be a bed day rate; the Sobering Station Services will be a per encounter rate. Medi-Cal does not provide Peer Respite, Medical Respite or Sobering Station services; thus these will be funded as part of the WPC pilot.

1. **Peer Respite Services:** Intended to provide a home-like, peer-staffed environment for those experiencing mental health crises, where participants can learn healthier boundaries and develop safety planning. This investment provides an alternative to inpatient psychiatric treatment when the individual is not a danger to self/others but

requires a supportive environment, and is designed to reduce avoidable use of EDs, EPS, and inpatient services. Twenty beds will be operated through the WPC pilot. Ongoing costs includes a bed day rate of $213.56, which includes a 5% indirect rate. The program startup will occur in PY 2, and services will be initiated in PY 3 with an annual cost in PY 3-5 of $1,558,996 (20 beds x 365 days x $213.56) and $4,676,987 over the life of the pilot.

2. **Medical Respite Services:** Provides post-acute care to monitor homeless patients or those without access to appropriate home care, intended for HUMS with health conditions not requiring inpatient care but too serious for discharge in order to reduce avoidable complications/readmissions to acute care by increasing post-discharge supports. *The bed day rate requested in the WPC pilot will not include Medi-Cal billable services.* Ongoing costs includes a bed day rate of $376.02, which includes a 5% indirect rate. The program startup will occur in PY 2, and services will be initiated in PY 3 with an annual cost in PY 3-5 of $2,744,978 (20 beds x 365 days x $376.02) and $8,234,934 over the life of the pilot.

3. **Sobering Station Services:** The Sobering Station will be embedded within the future Restoration Center, a voluntary, multi-service center intended to provide an array of non-acute services for adults with drug and/or alcohol intoxication and/or co-occurring mental health challenges. The Restoration Center will be a multi-service center and will include a Sobering Station, providing linkages to care and connect with WPC care coordination services, particularly short-term care coordination. The Sobering Station is one component of a broader array of behavioral and medical healthcare services. The future Restoration Center is being developed in conjunction with ongoing Behavioral Health Services Department (BHSD) and Santa Clara Valley Medical Center (SCVMC) activities that leverages the Drug Medi-Cal Waiver and other sources of funds. *This WPC FFS funding request addresses the Sobering Station services for HUMS only.* Estimates are that the Sobering Station will make up 33% of the Restoration Center's facilities. The combination of the Restoration Center Sobering Station and other bundles of services adds the "missing pieces" that should allow HUMS to more easily access available services, and provide the complete set of linkages and services needed by the population.

   Given the high prevalence of substance use disorders (SUDs) amongst the HUMS group, this group accesses emergency services, including jail, for substance use and intoxication more frequently than other consumers. The HUMS group is also more likely to then either be discharged back to the streets or admitted to acute care environments without medical necessity because of lack of psychosocial supports.

   The Sobering Station will

   1) Provide an alternative to reduce the avoidable use of Emergency Medical Services (EMS), Emergency Department (ED), Emergency Psychiatric Services (EPS), and incarceration of acutely intoxicated adults;
   2) Provide safe, short-term (4-12 hours) sobering services for consumers, and;

3) Provide critical linkages to care and connect care coordination (aka "hot handoff") to support consumers' engagement with the appropriate medical and behavioral healthcare resources as well as address barriers to health and wellness.

Sobering Station Capacity

Estimating the number of persons to be served in the sobering station requires several assumptions about average length of stay, vacancy rates, and recidivism. SCVHHS expects that:

1) Capacity: The Sobering Station will have the capacity to serve up to *20 individuals* at any given time.

2) Hours of Operation: The Sobering Station will remain *open 24 hours a day, 7 days a week, 365 days a year*.

3) Average Length of Stay: The Sobering Station will provide short-term (4-12 hour) services. SCVHHS estimates the average length of stay will be approximately *10 hours*. Most consumers will likely require at least eight or more hours to receive medical screening and admittance, become sober and recover, identify care coordination needs, and receive a warm hand-off to the appropriate services.

4) Vacancy Rate: It is unlikely that all the Sobering Station spaces will be at 100% capacity at all times. Rather, there will be periods of vacancy when consumers discharge and others haven't yet been admitted. To account for the natural fluctuation in capacity, SCVHHS estimates that spaces may be unoccupied for an average of 4 hours per day, equivalent to a *vacancy rate of 16.7%.* During high volume hours, it is likely all spaces will be full and the vacancy length will be brief. However, during low volume hours, there may be some unoccupied spaces and the vacancy time may be longer.

5) Recidivism: SCVHHS estimates that consumers will visit the Sobering Station an average of *four times per year*, as has been shown in sobering centers in other jurisdictions, such as in San Francisco County.

Based on these assumptions, SCVHHS anticipates that the Sobering Station would provide approximately 14,600 episodes of care to approximately 3,650 unique individuals. During the 4-12 hour episode of care, participants will receive monitoring and care services for acute intoxication. Upon arrival, consumers will receive medical screening to assess whether the Sobering Station is appropriate or if the consumer needs a higher level of care (e.g., ED, EPS,). Vitals will then be taken periodically (every 2-4 hours) during the consumers' stay. The Sobering Station is non-medical; therefore, if at any point a consumer appears to have an emerging need for more acute medical or psychiatric services, staff will support consumers to get to the SCVMC Urgent Care Clinic, ED, or EPS by the most appropriate means necessary. In addition to linkage to care, care and monitoring services, the Sobering Station will also include recuperative supports such as laundry machines and donated clothes for consumers requiring fresh clothing; clean linens and blankets for each client to use on the recliner-chair; bathrooms, showers and towels for consumers wishing to wash off and clean up; as

well as anti-nausea resources, warm drinks, and oral rehydration to help consumers recover.

The Sobering Station will be located within the future Restoration Center and all budget requests assume the Sobering Station makes up 33% of the Restoration Center with prorated amounts. The prorated standard operating costs, as estimated by facilities management, for a unit of this estimated size are requested, including utilities at $2,350/month (includes Water $100; Electricity $1,500; Natural Gas $450; Garbage $300), monthly lease of the Sobering Station's space, maintenance and building security. Estimates for the Sobering Station size is about 4,500 square feet with about 60% or 2,700 square feet for sobriety services (recliner chairs, client bathrooms/showers, laundry area, private areas for meeting with care coordination and peer recovery staff with clients) and about 40% or 1,800 square feet for administrative and office areas.

Building security estimates have been prorated to include WPC costs for the Sobering Station unit, only, and are based on requiring one security guard, 24 hours a day, 7 days a week. Security services will be contract or county staff who will monitor the facility and ensure the safety of Sobering Station clients and staff. Contract laundry service monthly expenses are required for replenishing the rapid turnover of all linens, towels, pillowcases, patient gowns and blankets to be used on each recliner-chair with each client encounter. An in-house laundry machine and dryer will be utilized for clients needing to launder any soiled clothes to feel refreshed upon discharge. Janitorial services are required 24 hours a day, 7 days a week. Janitorial staff will empty waste bins, clean-up spills, and facility space throughout operation. Consumables such as soap and toiletries are also a needed for the Sobering Station. Recuperative support related supplies that are considered one-time use consumables, such as gloves, anti-nausea resources, fluids, first-aid supplies, antiseptic wipes, masks, thermometer sleeves, gowns, paper towels, etc. will be restocked on a regular basis, with the cost being built into the monthly expense.

Lease of a van for the Recovery Coaches/Peer Support Workers to outreach and engage with potential Sobering Station clients is requested. These staff would utilize the van to reach clients in the community once identified as needing Sobering Station services and can accompany them to the Sobering Station to enroll in services to support their sobriety and recuperation. Vehicle leasing and insurance expenses to cover the staff and transport of clients are requested on a monthly basis.

Staffing enforces a non-medical model that includes a multi-disciplinary team 24/7 of 1 RN, 1 LVN and 4 Recovery Coaches/Peer Support Workers that is based on evidence informed models used in other jurisdictions. This team will provide medical triage, recuperative support, checking of vitals, rehydration therapy, assist with personal needs, peer counseling and support, van outreach and accompanying transportation

as needed, link clients to care coordinators or other services and overall provide a comprehensive set of supports to put the client towards recovery.

Sobering Stations services will begin on July 1, 2017 in a temporary location with 5 recliner chairs. Concurrently, the permanent Sobering Station facility will be developed for full service delivery with 20 spaces by January 1, 2018, as described in the Delivery Infrastructure.

The FFS rate requested in the WPC pilot will not include Medi-Cal billable services provided as components of other areas of the Restoration Center. Ongoing costs includes a FFS rate of $246.12 which includes a 5% indirect rate. Program services will be initiated in PY 2 - Ltd for 6 months in limited capacity at a cost of $450,410 (5 spaces x 2 episodes of care per day x 183 days x $246.12). In PY 3-5 the annual cost is anticipated at $3,593,304 (20 spaces x 2 episodes of care per day x 365 days x $246.12) and $11,230,322 over the life of the pilot. See detailed budget on next page.

PERSONNEL					
Personnel	***Annual Salary***	***PY 3 - 5 FTEs***	***PY 3 - 5 Annual Cost***	***PY 2 FTEs (July-December)***	***PY 2 Cost (July-December)***
Medical Director	$ 301,455	0.10	$ 30,146	0.09	$ 13,565
RN	$ 115,000	4.20	$ 483,000	1.30	$ 74,750
LVN/LPT	$ 66,000	4.20	$ 277,200	1.00	$ 33,000
Recovery Coaches/Peer Support Workers	$ 53,556	16.80	$ 899,741	4.00	$ 107,112
Health Care Program Manager II	$ 109,320	1.00	$ 109,320	0.24	$ 13,118
Relief Staff	***# of Hours***	***Hourly Rate***	***Annual Cost***		
RN	672	$ 100	$ 67,200		
LVN/LPT	672	$ 80	$ 53,760		
Recovery Coaches	2688	$ 18	$ 48,384		
Benefits full time only	Rate	40%	$ 719,763		$ 96,618
Total Staffing			**$ 2,688,513**		**$ 338,164**

OPERATIONS					
Category	***Rate***	***PY 3 - 5 Quantity***	***PY 3 -5 Annual Cost***	***PY 2 Quantity***	***PY 2 Cost (July- December)***
Facility					
Facility Lease	$ 3.00	4500 x 12 months	$ 162,000	6 months @ 25%	$ 20,250
Facility Maintenance	$ 600	12	$ 7,200	6 months @ 25%	$ 900
Office Equipment	$ 250	12	$ 3,000		
Utilities (water $100, gas $450, garbage $300, electricity $1500)	$ 2,350	12	$ 28,200	6 months @ 25%	$ 3,525
Telephone/Communications	$ 750	12	$ 9,000	6 months @ 25%	$ 1,125
Equipment Lease	$ 375	12	$ 4,500	6 months @ 25%	$ 563
Supplies					
Office Supplies	$ 400	12	$ 4,800	6 months @ 25%	$ 600

Program/Activity Supplies	$ 450	12	$ 5,400	6 months @ 25%	$ 675
Recuperative Consumable Supplies (gloves, gowns, fluids, first-aid supplies, etc.)	$ 8,290	12	$ 99,480	6 months @ 25%	$ 12,435
Hygeine Supplies/Personal Items	$ 600	12	$ 7,200	6 months @ 25%	$ 900
Client Assistance	$ 600	12	$ 7,200	6 months @ 25%	$ 900
Contract Services					
Janitorial Service	$ 6,000	12	$ 72,000	6 months @ 25%	$ 9,000
Laundry Service	$ 4,088	12	$ 49,056	6 months @ 25%	$ 6,132
Security Service	$ 14,600	12	$ 175,200	6 months @ 25%	$ 21,900
Staffing					
Recruitment/Pre employment Expenses	$ 62	5	$ 309	5 items @ 25%	$ 93
Staff Development and Training	$ 366	26	$ 9,516	26 staff @ 25%	$ 549
Other					
Client Transportation to Sobering Station	$ 5,325	12	$ 63,900	6 months @ 25%	$ 7,988
Vehicle Insurance	$ 200	12	$ 2,400	6 months @ 25%	$ 300
Insurance	$ 1,950	12	$ 23,400	6 months @ 25%	$ 2,925
Total Operations			**$ 733,761**		**$ 90,759**
Indirect Rate					
Category	***Rate***	***Base***	***Annual Indirect Cost***	***PY 2 Base***	***PY 2 Indirect Cost (July - December)***

Indirect costs	5%	$ 3,422,274	$ 171,030	$ 428,923	$ 21,488
			PY 3 - 5 Total		**PY 2 Total**
Total for Sobering Station			$ 3,593,304		$ 450,410
Per episode of care rate for FFS		20 chairs x 2 episodes of care x 365 days	$ 246.12	5 beds x 2 episodes of care x 183 days	$ 246.12

Deliverables associated with delivery of Peer Respite, Medical Respite and Sobering Station services will be paid on a Fee for Service (FFS) basis, on a bed day/encounter rate.

Year	**Deliverable 3.b.: Medical Respite Services**	**Deliverable 4.b.: Peer Respite Services**	**Deliverable 17.b.: Restoration Center Sobering Station Services**
PY 2	/	/	$450,410
PY3	$2,744,978	$1,558,996	$3,593,304
PY4	$2,744,978	$1,558,996	$3,593,304
PY5	$2,744,978	$1,558,996	$3,593,304

E. Bundled PMPM Services

The SCVHHS WPC Pilot includes five sets of bundled services, three related to term-based care coordination, one focused on Rehabilitation and Peer Support Services and one focused on Nursing Home Transitions, Diversions and Care Coordination. The term-based Care Coordination Programs and Rehabilitation and Peer Support Service Teams will be developed and implemented in PY 2 with services commencing within the same year. The Nursing Home Transitions, Diversions and Care Coordination will be developed in first three months of PY 2 – Ltd and commence in the last three months of the program year. The capacity per month through the four care coordination programs will remain stable PY 2-5. The Rehabilitation and Peer Support Service Teams will increase capacity per month each year from PY 2-5. PMPM's were calculated based on estimated care coordinator ratios and per month capacity. It is expected that care coordinators will be able to accept 10-12 new enrollees each month as enrollees move through different levels of programs and services, end participation, or become loss to follow-up.

PY2 PMPM Bundle			
Item	*PMPM*	*Max Member Months*	*Max WPC Fund Amount*
Rehabilitation and Peer Support	$ 137.19	3,750	$ 514,472
Short Term Care Management	$ 1,220.70	1,500	$ 1,831,043
Mid Term Care Management	$ 1,363.54	3,420	$ 4,663,307
Long Term Care Management	$ 882.88	4,500	$ 3,972,968
Nursing Home Transitions	$ 2,076.70	318	$ 660,390
PY3 PMPM Bundle			
Item	*PMPM*	*Max Member Months*	*Max WPC Fund Amount*
Rehabilitation and Peer Support	$ 137.19	15,840	$ 2,173,102
Short Term Care Management	$ 1,220.70	3,000	$ 3,848,121
Mid Term Care Management	$ 1,363.54	7,020	$ 9,572,051
Long Term Care Management	$ 882.88	9,000	$ 7,945,936
Nursing Home Transitions	$ 2,076.70	912	$ 1,893,950
PY4 PMPM Bundle			
Item	*PMPM*	*Max Member Months*	*Max WPC Fund Amount*
Rehabilitation and Peer Support	$ 137.19	23,340	$ 3,202,046
Short Term Care Management	$ 1,220.70	3,000	$ 3,848,121
Mid Term Care Management	$ 1,363.54	7,020	$ 9,572,051
Long Term Care Management	$ 882.88	9,000	$ 7,945,936
Nursing Home Transitions	$ 2,076.70	912	$ 1,893,950
PY5 PMPM Bundle			
Item	*PMPM*	*Max Member Months*	*Max WPC Fund Amount*
Rehabilitation and Peer Support	$ 137.19	23,340	$ 3,202,046
Short Term Care Management	$ 1,220.70	3,000	$ 3,848,121
Mid Term Care Management	$ 1,363.54	7,020	$ 9,572,051
Long Term Care Management	$ 882.88	9,000	$ 7,945,936
Nursing Home Transitions	$ 2,076.70	912	$ 1,893,950

1. *Care Coordination Service Bundles:*

Targeted care coordination is the cornerstone of the SCVHHS pilot. Due to the broad range of psychosocial services and participating entities, it makes most sense to offer these services in a bundle. While each care management level is unique, all feature sufficient administrative leadership and support to drive expansion, as well as a dedicated multidisciplinary team led by a care coordinator and supported by medical and other expert staff in order to ensure ongoing engagement in services and recovery. Individuals with psychosocial supports and access to planned, regular care have better health outcomes and lower avoidable cost-utilization profiles than those without. Implementing

a tiered care coordination system that accounts for diversity of need intensity and length, WPC bridges the gaps in participants' own networks. By adding and expanding existing services to provide a continuous, accessible system of care, WPC reduces avoidable system use barriers to recovery and wellness common to HUMS (e.g., homelessness, incarceration, poverty).

a. Short Term Care Coordination:

This set of care coordination services is intended to provide coordination for medium to high-risk individuals needing short term assistance. The expenses associated with this bundle are premised on the provision of seven unique teams, at a cost of $3,848,121 once fully built out and operational in PY 3-5. In PY 2, services will be provided just half the year at a total cost of $1,831,043. The short-term care coordination teams will serve 250 participants on a day to day capacity, with the anticipation of accepting 10-12 new enrollees each month as enrollees complete, transition or drop-out. The PMPM case rate for these services is $1,220.70 in PY 2 and $1,282.71 in PY 3 – PY 5, which is based on the total cost of services each year divided by the annualized number of people served (250) monthly.

Services in this bundle include: extensive health education, telehealth communication with participants and their providers, and supporting transportation and language services, tenancy supports, peer counseling and patient medication counseling. Peer counseling is critical for patient engagement – the variety of services offered will depend on the needs of the patients. These short term care management teams will spend significant effort supporting clients and their providers to ensure proper services are provide, based on their unique needs. This is unique from the encounter-based structure of TCM and more robust in depth. Coordination will occur between the TCM program and WPC pilot and assurances will be made that services are not duplicated, including continuing the TCM program practice of time studies and closely tracking both population groups so that the WPC pilot provides services beyond the TCM benefit.

The Short Term Care Coordination bundle includes the following expenses:

i. Personnel costs totaling $1,245,608 in the first six months of service in PY 2, and $2,491,215 in PY 3-5, plus 40% benefits ($498,243 PY 2 and $996,486 PY 3-5). This model will operate out of SCVMC Hospital, expanding to other hospitals and clinics over the pilot period.
    1. The Short-Term Care Management component will be supervised by 1 Public Health Manager who will develop and oversee 7 teams. The 7 teams would share 5 Public Health Nurses to identify those individuals who could benefit most from case management services; attend weekly primary care case management meetings with clinic/hospital staff to consult on progress; conduct home assessment of the patient's

medical, functional, cognitive, affective, psychosocial, nutritional and environmental status, as well as identify community health barriers, engage enrollees; provide in-home, phone and in-clinic follow-up with to continue to promote self-efficacy. There would be 5 clinical staff to analyze the medical and care records, making recommendations for the 250 enrollees at any given time. One Medical Social Worker and 1 Public Health Assistant will support the PH Nurses and enrollees by collaborating with the care team to further their understanding of significant social and emotional factors underlying the patient's health issues; conducting medical-bio-social assessment of the patient (MSW) and providing assistance with transportation and language services; clarifying professional instructions to individuals and families; and providing para-professional counseling on health care related problems (PHA).

2. The Short-Term Care Coordination Team includes Pharmacists, Pharmacy Technicians and Pharmacy Assistants comprising the Pharmacy Discharge Service. The Pharmacy Discharge Service provides medication reconciliation, expedited dispensing of medications, in-depth discharge counseling, medication calendars, and follow-up phone calls for patients discharged from hospitals. None of these services are Medi-Cal billable, thus 100% of the Pharmacy Discharge Service will be for WPC.

ii. Operations: Operational costs for PY 3-5 will consist of facility expenses ($117,000 annually) including lease, maintenance, and communications; office, programmatic and other supplies, transportation and a client assistance fund to pay for incidental expenses that could help stabilize the participant ($33,750); ongoing recruitment and staff development to address staff turnover, as well as comprehensive training for teams ($11,894); local travel for 24 staff to support the transportation needs of participants ($3,000); and insurance to cover the facility and operations ($11,532).

iii. All program costs will be subject to an annual 5% indirect rate $87,193 in PY 2 and $183,244 in PY 3-5.

PERSONNEL				
Personnel	***FTEs***	***Annual Salary***	***Annual Cost years 3-5***	***Year 2 second half 6 months***
Public Health Nurse II	3	$ 127,543	$382,629	$191,315
Public Health Assistant	1	$ 54,871	$54,871	$27,436
Public Health Nurse II	2	$ 115,864	$231,728	$115,864
Public Health Manager I	1	$ 167,955	$167,955	$83,978
Medical Social Worker	1	$ 152,793	$152,793	$76,397
Social Media/Internet Communication Specialist	0.25	$ 78,289	$19,572	$9,786
Peer Counselors	6	$ 53,556	$321,336	$160,668
Pharmacist	2	$ 163,405	$326,810	$163,405
Technician	1	$ 65,555	$65,555	$32,778
Hospitalist	0.5	$ 250,000	$125,000	$62,500
Physician	0.5	$ 250,000	$125,000	$62,500
Pharmacist	2	$ 163,405	$326,810	$163,405
Technician	1	$ 65,555	$65,555	$32,778
Assistant	3	$ 41,867	$125,601	$62,801
Benefits	Rate	40%	$996,486	$498,243
Total Option 1			**$3,487,701**	**$1,743,851**

OPERATIONS				
Category	***Rate***	***Quantity***	***Annual Cost***	
Office				
Office Lease	$ 1,200	12	$14,400	
Utilities	$ 1,000	70	$70,000	
Telephone/Communications	$ 440	70	$30,800	
Equipment Lease	$ 150	12	$1,800	
Supplies				
Office Supplies	$ 400	12	$4,800	
Program/Activity Supplies	$ 450	12	$5,400	
Hygeine Supplies/Personal Items	$ 400	12	$4,800	
Client Assistance	$ 25	250	$6,250	
Transportation Vouchers	$ 50	250	$12,500	
Staffing				

Recruitment/Preemployment Expenses	$ 127	12	$1,526	
Staff Development and Training	$ 864	12	$10,368	
Other				
Local Travel	$ 125	24	$3,000	
Insurance	$ 961	12	$11,532	
TOTAL OPERATIONS			$177,176	
INDIRECT				
Indirect Expenses	5%		$183,244	$87,193
			Year 3 - 5 Annual cost	**Year 2 (6 month implement)**
TOTAL EXPENSES				
Total Expenses			$3,848,121	$1,831,043
PMPM			$1,283	$1,221
			250 members per month for 12 months = 3000 member months	250 members per month for 6 months = 1500 member months

PERSONNEL				
Personnel	***FTEs***	***Annual Salary***	***Annual Cost years 3-5***	***Year 2 second half 6 months***
Public Health Nurse II	3	$ 127,543	$ 382,629	$ 191,315
Public Health Assistant	1	$ 54,871	$ 54,871	$ 27,436
Public Health Nurse II	2	$ 115,864	$ 231,728	$ 115,864
Public Health Manager I	1	$ 167,955	$ 167,955	$ 83,978
Medical Social Worker	1	$ 152,793	$ 152,793	$ 76,397
Social Media/Internet Communication	0.25	$ 78,289	$ 19,572	$ 9,786
Peer Counselors	6	$ 53,556	$ 321,336	$ 160,668
Pharmacist	2	$ 163,405	$ 326,810	$ 163,405
Technician	1	$ 65,555	$ 65,555	$ 32,778
Hospitalist	0.5	$ 250,000	$ 125,000	$ 62,500
Physician	0.5	$ 250,000	$ 125,000	$ 62,500
Pharmacist	2	$ 163,405	$ 326,810	$ 163,405
Technician	1	$ 65,555	$ 65,555	$ 32,778
Assistant	3	$ 41,867	$ 125,601	$ 62,801
	24.3			
Benefits	Rate	40%	$ 996,486	$ 498,243
Total Option 1			**$ 3,487,701**	**$ 1,743,851**

OPERATIONS				
Category	***Rate***	***Quantity***	***Annual Cost***	
Office				
Office Lease	$ 1,200.00	12	$ 14,400.00	
Utilities	$ 1,000.00	70	$ 70,000.00	
Telephone/Communications	$ 440.00	70	$ 30,800.00	
Equipment Lease	$ 150.00	12	$ 1,800.00	
Supplies				
Office Supplies	$ 400	12	$ 4,800.00	
Program/Activity Supplies	$ 450	12	$ 5,400.00	
Enhanced Care Coordination	$ 400	12	$ 4,800.00	
Client Assistance	$ 25	250	$ 6,250.00	
Transportation Vouchers	$ 50	250	$ 12,500.00	
Staffing				
Recruitment/Preemployment Expense	$ 127	12	$ 1,526.25	
Staff Development and Training	$ 864	12	$ 10,368.00	
Other				
Local Travel	$ 125	24	$ 3,000.00	
Insurance	$ 961	12	$ 11,532.00	
TOTAL OPERATIONS			$ 177,176.25	

ADMINISTRATIVE				
Administrative Expenses	5%		$ 183,244	$ 87,193
			Year 3 - 5 Annual cost	**year 2 (6 month implement)**
TOTAL EXPENSES			$ 3,848,121	$ 1,831,043
PMPM			$ 1,282.71	$ 1,220.70
			250 members per month for 12 months = 3000 member months	250 members per month for 6 months = 1500 member months

b. Mid Term Care Coordination:

This set of care coordination services is intended to provide time-limited coordination grounded in stages of change and motivational enhancement coordination for medium to high-risk individuals needing short term assistance. The expenses associated with this bundle total $9,572,051 once fully built out and operational in PY 3-5. In PY 2, services will be provided just half the year at a total cost of $4,633,307 for 570 participants on average each month. Five teams will be utilized for WPC. The mid-term care coordination teams will serve 585 participants on a day to day capacity beginning in PY 3, with the anticipation of accepting 10-12 new enrollees each month as enrollees complete, transition or drop-out. The PMPM case rate for these services is $1,363.54, which is based on the total cost of services ($9,572,051) divided by the annualized number of people served (585) monthly. This bundle includes the following expenses:

i. Personnel costs for 54 FTEs to create five multidisciplinary teams sharing unified management, totaling $2,995,744 for six months of services in PY 2 and $6,137,810 in PY 3-5, plus 40% benefits ($1,198,298 PY 2 and $2,450,023 PY 3-5).
    1. The Mid-Term Care Coordination Teams are comprised of the positions listed below; there will be 4 teams to serve 500 enrollees. The Program Oversight position would supervise and provide direction to 4 of the teams; the hospitalist and physician would provide inpatient and outpatient review, consultation and analytics for all 500 enrollees. Each team would have a Program Manager to lead the team's work and coordinate on-boarding and transitions to another level of care for Mid-Term enrollees. In addition, each team would have 1 psychiatrist, 1 psychologist, 3 LCSWs, 2 PH Nurses, 2 Peer Counselors, and 1 Financial Analyst. The Peer Counselors would attend peer recovery meetings with clients, go to medical and/or behavioral health appointments to support them, as well as sharing personal experiences related to system navigation and/or health and wellness activities. The licensed staff assist enrollees in many ways that are not Medi-Cal billable, for example, in situations when clients are unable to use public transportation or personal means for traveling to important appointments (e.g., to access medical, behavioral health or social services) and transports clients to these appointments. A 5th team will consist of care coordinators and a core group of multidisciplinary staff to serve 70 enrollees from PY 2 – Ltd each month on average and 85 enrollees each month on average in PY 3 – 5 as part of the second level of Nursing Home Transitions program, once members have graduated from the high intensity services.

ii. Operations: Operational costs will consist of facility expenses ($59,400 in PY 2, $118,800 in PY 3-5 annually) including lease, maintenance, and communications; office, programmatic and other supplies, transportation and a client assistance fund to pay for incidental expenses that could help stabilize the participant ($113,200 in PY 2, $260,400 in PY 3-5 annually); ongoing recruitment and staff development to address staff turnover, as well as comprehensive training for teams ($23,789 in PY 2, $47,577 in PY 3-5 annually); local travel for 37 staff to support the transportation needs of participants $27,750 in PY 2, $55,500 in PY 3-5 annually); and insurance to cover the facility and operations $23,064 in PY 2, $46,128 in PY 3-5 annually);

iii. All program costs will be subject to an annual 5% indirect rate $222,062 in PY 2 and $455,812 in PY 3-5.

PERSONNEL					
Personnel		***Total FTEs(4 teams)***	***Annual Salary***	***Year 2 second half 6 months***	***Annual Cost years 3-5***
Project Oversight		1	$ 85,000	$ 42,500	$ 85,000
Program Manager		4	$ 85,000	$ 170,000	$ 340,000
Psychiatrist		4	$ 320,000	$ 640,000	$ 1,280,000
Hospitalist		1	$ 250,000	$ 125,000	$ 250,000
Physician		1	$ 250,000	$ 125,000	$ 250,000
Psychologist		4	$ 115,000	$ 230,000	$ 460,000
LCSW		12	$ 85,000	$ 510,000	$ 1,020,000
PHN		8	$ 115,000	$ 460,000	$ 920,000
Peer Counselors		8	$ 53,556	$ 214,224	$ 428,448
Social Media/Internet Communication Specialist		0.25	$ 78,289	$ 9,786	$ 19,572
Financial Analyst		4	$ 55,000	$ 110,000	$ 220,000
Additional Staffing for Nursing Transitions Program					
Hospitalist		0.9	$ 250,000	$ 112,500	$ 225,000
Psychologist		1	$ 115,000	$ 65,678	$ 277,678
LCSW		3	$ 85,000	$ 127,500	$ 255,000
Peer Counselors		2	$ 53,556	$ 53,556	$ 107,112
Benefits	Rate	40%		$ 1,198,298	$ 2,450,024
Total Personnel				**$ 4,194,042**	**$ 8,587,834**
OPERATIONS					
Office	***Rate***	***Quantity***			***Annual Cost***
Office Lease	$ 1,200	12		$ 28,800	$ 57,600
Utilities	$ 150	12		$ 3,600	$ 7,200
Telephone/Communications	$ 750	12		$ 18,000	$ 36,000
Equipment Lease	$ 375	12		$ 9,000	$ 18,000
Supplies					
Office Supplies	$ 150	12		$ 3,600	$ 7,200
Program/Activity Supplies	$ 400	12		$ 9,600	$ 19,200
Client Assistance	$ 50	500 up to 570		$ 50,000	$ 117,000
Transportation Vouchers	$ 50	500		$ 50,000	$ 117,000
Staffing					

Recruitment/Preemployment Expenses	$ 127	12		$ 3,053	$ 6,105
Staff Development and Training	$ 864	12		$ 20,736	$ 41,472
Other					
Insurance	$ 961	12		$ 23,064	$ 46,128
Local Travel	$ 125	37 staff, 12 months		$ 27,750	$ 55,500
TOTAL OPERATIONS				$ 247,203	$ 528,405
INDIRECT RATE					
Category		***Rate***	***Base***		***Annual Cost***
Indirect Costs	5%			$ 222,062	$ 455,812
				Year 2 (6 month implement)	**Year 3-5 Annual Cost**
TOTAL EXPENSES				$ 4,663,307	$ 9,572,051
PMPM				$ 1,363.54	$ 1,363.54
				570 members per month for 6 months = 3420 member months	585 members per month for 12 months = 7020 member months

c. Long Term Care Coordination:

This set of care coordination services provides coordination without time limits for individuals with high needs that are likely to persist over time, Intensive coordination will focus on maintaining engagement and focus on health/recovery needs and establishing/maintaining a level of independence. The expenses associated with this bundle are premised on the provision of seven unique teams, at a cost of $7,945,936 once fully built out and operational in PY 3-5. In PY 2, services will be provided just half the year at a total cost of $3,972,968. The PMPM case rate for these services is $882.88, which is based on the total cost of services ($7,945,936) divided by the annualized number of people served (750) monthly. This bundle includes the following expenses:

i. Personnel costs for 73 FTEs, of whom just over 17 FTEs are clinically trained, totaling $2,511,978 for six months of services in PY 2 and $5,023,956 in PY 3-5, plus 40% benefits ($1,004,791 PY 2 and $2,009,583 PY 3-5).

   The Long-Term Care component of the WPC pilot will have 7 teams to serve 750 clients. The 7 teams will share 1.4 psychiatrist, 1 hospitalist and 2 physician who will provide the recommendations regarding the enrollees care plan/needs. Each team will have 1 team leader to oversee the team's work and assist in the patient on-boarding and transition. The other team members include 1 nurse, 1 Alcohol/Substance Use counselor, 4 service coordinators, 2 peer

counselors and 2.2 clinical staff to provide the individualized care needs and assistance in socialization. The licensed staff assist enrollees in many ways that are not Medi-Cal billable, for example, in situations when clients are unable to use public transportation or personal means for traveling to important appointments (e.g., to access medical, behavioral health or social services) and transports clients to these appointments

ii. Operations: Operational costs will consist of facility expenses ($103,950 in PY 2, $207,900 in PY 3-5 annually) including lease, maintenance, and communications; office, programmatic and other supplies, transportation and a client assistance fund to pay for incidental expenses that could help stabilize the participant ($60,600 in PY 2, $121,200 in PY 3-5 annually); ongoing recruitment and staff development to address staff turnover, as well as comprehensive training for teams ($9,598 in PY 2, $19,196 in PY 3-5 annually); local travel for 70 staff to support the transportation needs of participants $52,500 in PY 2, $105,000 in PY 3-5 annually); and insurance to cover the facility and operations $40,362 in PY 2, $80,724 in PY 3-5 annually);

iii. All program costs will be subject to an annual 5% indirect rate $189,189 in PY 2 and $378,378 in PY 3-5.

PERSONNEL				
Personnel	***Total FTEs (7 Teams)***	***Annual Salary***	***Annual Cost***	***Year 2 (6 month implement)***
Team Leader	7	$ 85,000	$ 595,000	$ 297,500
Psychiatrist	1.4	$ 320,000	$ 448,000	$ 224,000
Clinician	7	$ 115,000	$ 805,000	$ 402,500
Social Media/Internet Communication Specialist	0.25	$ 78,289	$ 19,572	$ 9,786
Nurse	7	$ 115,000	$ 805,000	$ 402,500
AOD Counselor	7	$ 45,760	$ 320,320	$ 160,160
Service Coordinators	28	$ 45,760	$ 1,281,280	$ 640,640
Peer Counselors	14	$ 53,556	$ 749,784	$ 374,892
Benefits	Rate	40%	$ 2,009,583	$ 1,004,791
Total Staffing			**$ 7,033,539**	**$ 3,516,769**
OPERATIONS				
Category	***Rate***	***Quantity***	***Annual Cost***	
Office				
Office Lease	$ 1,200	12	$ 100,800	$ 50,400
Utilities	$ 150	12	$ 12,600	$ 6,300
Telephone/Communications	$ 750	12	$ 63,000	$ 31,500
Equipment Lease	$ 375	12	$ 31,500	$ 15,750
Supplies				
Office Supplies	$ 150	12	$ 12,600	$ 6,300
Program/Activity Supplies	$ 400	12	$ 33,600	$ 16,800
Client Assistance	$ 50	750	$ 37,500	$ 18,750
Transportation Vouchers	$ 50	750	$ 37,500	$ 18,750
Staffing				
Recruitment/Preemployment Expenses	$ 241	12	$ 2,888	$ 1,444
Staff Development and Training	$ 1,359	12	$ 16,308	$ 8,154
Other				
Insurance	$ 961	12	$ 80,724	$ 40,362
Local Travel	$ 125	70 staff, 12 months	$ 105,000	$ 52,500

TOTAL OPERATIONS			$ 534,020	$ 267,010
INDIRECT				
Indirect Expenses	5%		$ 378,378	$ 189,189
			Years 3-5 Annual Cost	**Year 2 (6 month implement)**
TOTAL EXPENSES			$ 7,945,936	$ 3,972,968
			$ 882.88	$ 882.88
			750 members per month for 12 months = 9000 member months	750 members per month for 6 months = 4500 member months

d. Rehabilitation and Peer Support Teams:

Ongoing services that promote health and wellness through coaching, education, and life skills development and empowering WPC participants to improve their whole lives. These services will improve physical/emotional well-being, and provide a pathway to increase early detection and reduce preventable system usage; and will assists individuals to reduce the impact of chronic conditions exacerbated by poor self-care habits, instilling new, healthier habits/skills. Peer support and mentoring services are critical to engaging the target populations and helping WPC enrollees stay engaged. Services would vary depending on the needs of the enrollees, but might include outreach to encourage completing the WPC consent form, coaching on socialization skills, transportation coaching, emotional support, and mentoring.

Enrollees would become eligible for Rehabilitation and Peer Support services through the initial assessment and identification of the individual's needs. For example, those enrollees who are unemployed would be identified as benefitting from employment coaching; others might benefit from emotional support from peer mentors and counselors. The duration of services would depend on the enrollee's complement of needs. Employment coaching would cease when the enrollee completed secured employment. Depending on the enrollees needs, they could be enrolled only in Rehabilitation and Peer Support services, or Rehabilitation and Peer Support services and a care coordination bundle. The acuity levels of enrollees benefitting from Rehabilitation and Peer Support services will span the range from low-level to high-level. Those enrollees with high acuity needs may benefit from self-care training or socialization skills, in addition to intensive care coordination provided by the Long-term Care Coordination staff.

A set of 70 enrollees in PY 3 - 5 in this bundle would be part of the Nursing Home Transitions (NHT) program as part of the step down from the high intensity or mid-term care coordination bundles. Individuals would be enrolled in this bundles of services based on need and assessments that show that the services would support their ability to stay housed in the community with some modest support.

Some participants will receive these services while enrolled in the NHT mid-term car coordination as part of their transition, while others will graduate into this lower level of care as they successfully transition into independence. These enrollees may benefit from support with developing independence with activities of daily living and helping develop self-determining problem solving skills.

Services delivered will increase each year from an initial day to day capacity of 625 enrollees in the second half of PY 2, 1,320 enrollees in PY 3, to 1,945 in PY 4-5. The PMPM case rate for these services is $137.19, which is based on the total cost of services ($3,202,046) divided by the annualized number of people served (1,945) monthly, at the highest capacity. The expenses associated with this bundle are premised on a diverse team including health coaches and peer mentors, supported by health education specialists at a cost of $514,472 in PY 2, $2,173,102 in PY 3, $3,202,046 in PY 4, and $3,202,046 in PY 5, including the following expenses:

i. Personnel costs: The personnel costs are $338,985 in PY 2, $1,429,923 in PY 3, $2,144,884 in PY 4-5, plus benefits at 40% of $135,594 in PY 2, $571,969 in PY 3 and $857,954 PY 4-5.
ii. Operations: Operational costs are adjusted to increase with program expansion. Key categories include office, programmatic and enhanced care coordination costs, as well as a client assistance fund to pay for incidental expenses that could help stabilize the participant; ongoing recruitment and staff development; and insurance to cover the facility and operations.
iii. All program costs will be subject to an annual 5% indirect rate $24,499 in PY 2, $107,833 in PY 3 and $104,217 in PY 4-5.

PERSONNEL						
Personnel	***FTEs***	***Salary***	***Year 2 (625)***	***Year 3 (1250)***	***Year 4 (1875)***	***Year 5 (1875)***
Program Manager	1	$ 121,133	$ 30,283	$ 121,133	$ 181,700	$ 181,700
Wellness Coordinators	2	$ 52,500	$ 26,250	$ 105,000	$ 157,500	$ 157,500
Health Education Specialists	3	$ 42,000	$ 31,500	$ 126,000	$ 189,000	$ 189,000
Health Coaches	2	$ 42,000	$ 21,000	$ 84,000	$ 126,000	$ 126,000
Peer Support Workers	6	$ 53,556	$ 80,334	$ 321,336	$ 482,004	$ 482,004
Mental Health Community Workers	3	$ 56,160	$ 42,120	$ 168,480	$ 252,720	$ 252,720
Rehabilitation Counselors	4	$ 83,699	$ 83,699	$ 334,796	$ 502,194	$ 502,194
Clinical Dietician	0.5	$ 86,245	$ 10,781	$ 43,123	$ 64,684	$ 64,684
Social Media/Internet Communication Specialist	0.25	$ 78,289	$ 4,893	$ 19,572	$ 29,358	$ 29,358
Expressive Therapist	0.5	$ 65,000	$ 8,125	$ 32,500	$ 48,750	$ 48,750
Fitness/Yoga Instructor	0	$ 42,000	$ -	$ -	$ -	$ -
Additional Staffing for Nursing Transitions Program						
Peer Support Workers	0.6	$ 53,556		$ 32,134	$ 48,200	$ 48,200
Rehabilitation Counselors	0.5	$ 83,699		$ 41,850	$ 62,774	$ 62,774
Benefits	Rate	40%	$ 135,594	$ 571,969	$ 857,954	$ 857,954
Total Staffing			**$ 474,579**	**$ 2,001,892**	**$ 3,002,838**	**$ 3,002,838**
OPERATIONS						
Category	***Rate***	***Quantity***		***Annual Cost***	***Annual Cost***	***Annual Cost***
Supplies						
Office Supplies	$ 400	12	$ 1,200	$ 4,800	$ 7,200	$ 7,200

Program/Activity Supplies	$ 450	12	$ 1,350	$ 5,400	$ 8,100	$ 8,100
Hygiene Supplies/Personal Items	$ 400	12	$ 1,200	$ 4,800	$ 7,200	$ 7,200
Client Assistance	$ 25	1250	$ 7,813	$ 33,000	$ 49,500	$ 49,500
Staffing						
Recruitment/Preemployment Expenses	$ 41	12	$ 124	$ 495	$ 743	$ 743
Staff Development and Training	$ 276	12	$ 828	$ 3,312	$ 4,968	$ 4,968
Other						
Insurance	$ 960	12	$ 2,880	$ 11,520	$ 17,280	$ 17,280
TOTAL OPERATIONS			$ 15,394	$ 63,327	$ 94,991	$ 94,991
INDIRECT RATE						
Indirect Costs	5%		$ 24,499	$ 107,883	$ 104,217	$ 104,217
			Year 2 Annual	**Year 3 Annual**	**Year 4 Annual**	**Year 5 Annual**
TOTAL EXPENSES			$ 514,472	$ 2,173,102	$ 3,202,046	$ 3,202,046
PMPM			$ 137.19	$ 137.19	$ 137.19	$ 137.19
			625 members per month for 6 months = 3,750 member months	1320 members per month for 12 months = 15,840 member months	1945 members per month for 6 months = 23,340 member months	1945 members per month for 6 months = 23,340 member months

e. Nursing Home Transitions High Intensity Care Coordination:

This bundled service is designed to combine community living alternatives with intensive care management services to assist clients in transitioning back into the community or to assist clients who are already in the community to stay there. Clients enrolled in this high intensity care coordination may either be residing in long term or acute care facility, such as skilled nursing facility or hospital, or be at imminent risk of institutionalization. The care management service proposed is considered intensive / transitional care management. Members are typically enrolled in the high intensity bundle of services for an average of 3 months, up to 6 months, experiencing assessment, planning, care coordination, and tenancy support services to transition the member into a community living situation. The intention is not for the service to be long term, but to help long-term care

residents and those not requiring acute hospitalization the ability to reside in the community. The WPC funds requested will not pay for any housing directly, but will pay for services to help seek alternative housing options, goods and services that support participants'' ability to live in the community, and provide in-home supports and care coordination. These set of services will work in conjunction with Medi-Cal and other Waiver related funding, but will not overlap or duplicate such services.

In PY 2 - Ltd, services will be provided for six months (July through December) at a total cost of $660,390 for 318 member months, in which this ramp up period serves an average of 53 participants each month. In PY 3 – PY 5, the annual cost for these services is $1,893,950. The PMPM case rate for these services is $2,076.70, which is based on the total cost of services ($1,893,950) divided by the annualized number of people served (912 member months), which serves an average of 76 participants each month at full implementation. Upon completion of this bundle of service, members may step-down to either Mid-term care coordination or both Mid-term care coordination and Rehabilitation and Peer support bundles. It is expected that each year, approximately 90 unduplicated individuals each year will transition through this service bundle and step down to the mid-term care coordination bundle. The high intensity bundle includes the following expenses:

i. Personnel costs for 8 FTEs totaling $307,063 for six months of services in PY 2 - Ltd and $553,325, in PY 3-5, plus 40% benefits ($122,825 PY 2 and $221,330 PY 3-5).
   The clinical and care manager staff make up the core group that work comprehensively with participants of this program. The core group meets biweekly to share the Community Living Plan for each enrollee and develop a multi-disciplinary approach to their care and transitions to the community. The care managers' activities include home visits, helping identify and purchase goods and services that fill gaps in the community living plan, connecting with providers, social supports, and supporting community living activities. The clinical staff and core group provide support and assessment of the participant throughout the high intensity service months (up to 6 months). The care coordinator continues on serving the participant as they step-down through transitioned services to maintain continuity. All referrals, whether for self or by someone else, will be received by IOA Connect (an intake and referral department and initial entry point to all NHT programs and services.) The IOA Connect Intake Specialist will screen prospective clients for CLC eligibility. Additional staff are required for administration of care coordination services including contracts, entering data and assuring quality of care.
ii. Operations: Operational costs will consist of facility expenses ($53,500 in PY 2, $62,400 in PY 3-5 annually) including lease, maintenance, and communications; equipment ($0 in PY 2 - Ltd, $4,800 in PY 3-5

annually); IT consultants and software/hardware to maintain data sharing technology participant ($32,817 in PY 2 – Ltd, $70,000 in PY 3-5 annually); purchase of services to pay for goods and services (i.e., medical durable devices, adult day services, transportation, etc.) and expenses that could help stabilize the participant ($5,966 in PY 2 - Ltd, $150,000 in PY 3-5 annually); ongoing recruitment and staff development to address staff turnover, as well as comprehensive training for teams ($2,500 in PY 2 - Ltd, $3,000 in PY 3-5 annually); local travel for 8 staff to support home visits and transportation for participant appointments ($15,000 in PY 2 – Ltd and PY 3-5 annually); Residential Care Home for the Elderly (RCFE) service payments to provide the services for caring for participants in residential care ($43,963 in PY 2 - Ltd, $524,753 in PY 3-5 annually); and tenancy support services subcontracts to help secure tenancy options using scattered-site, master-lease or community living for rapid-rehousing and community integration through unit identification, which does not include rent ($45,309 in PY 2 - Ltd, $193,154 in PY 3-5 annually);

iii. All program costs will be subject to an annual 5% indirect rate $31,447 in PY 2 and $90,188 in PY 3-5.

PERSONNEL					
Personnel	***Annual Salary***	***FTEs PY 3 -5***	***PY 3-5 annual***	***FTEs PY2***	***Py 2 Start-up cost (July-Dec 2017)***
VP Community Living Svcs	$ 150,000	0.1	$ 15,000	0.1	$ 15,000
Regional Director	$ 105,000	0.3	$ 31,500	0.2	$ 21,000
Clinical Supervisor (LCSW)	$ 84,000	0.4	$ 33,600	0.3	$ 25,200
Director of Clinical Development (LCSW)	$ 90,000	0.2	$ 18,000	0.1	$ 9,000
Program Coordinator	$ 51,000	0.4	$ 20,400	0.3	$ 15,300
Care Managers (MSW's)	$ 87,703	1	$ 87,703	0.5	$ 43,852
Senior Care Manager (MSW's)	$ 96,940	2	$ 193,881	0.5	$ 48,470
Registered Nurse	$ 142,478	0.4	$ 56,991	0.4	$ 56,991
Occupational Therapist	$ 85,000	0.4	$ 34,000	0.4	$ 34,000
Biller	$ 60,000	0.1	$ 6,000	0.1	$ 6,000
IOA Connect	$ 48,000	1	$ 48,000	0.5	$ 24,000
Director of Operations	$ 110,000	0.075	$ 8,250	0.075	$ 8,250
Benefits full time only	40%	Rate	$ 221,330		$ 122,825.20
Total Staffing			$ 774,655		$ 429,888

OPERATIONS					
Category	***Rate***	***Quantity***			***Py 2 Start-up cost (July -Dec 2017)***
Office Lease	4,000	12	$ 48,000		$ 37,500
Utilities	450	12	$ 5,400		
Telephone/Communications	750	12	$ 9,000		$ 16,000
Equipment	400	12	$ 4,800		$ -
Purchase of Service			$ 150,000		$ 5,966
Office Supplies	500	12	$ 6,000		$ -
Professional Services (IT Consultants)			$ 20,000		$ -
Software and Hardware			$ 50,000		$ 32,817
Mileage	0.535 per mile		$ 15,000		$ 15,000
Staff Training			$ 3,000		$ 2,500
RCFE Placement Expenses			$ 524,753		$ 43,963
Housing Support Services Subcontract			$ 193,154		$ 45,309
Total Operations			**$ 1,029,107**		**$ 199,055**

Total:			$ 1,803,762		$ 628,943
INDIRECT RATE					
Indirect Costs	5%		$ 90,188		$ 31,447
			Years 3-5 annual cost		**Year 2 (6 month implement)**
Total Expenses			$ 1,893,950		$ 660,390
			76 members per month for 12 months = 912 members months		53 members per month for 6 months = 318 members months
			$ 2,076.70		$ 2,076.70

PMPM Bundles of Services Summary:

WPC pilot participants may be in both the Rehabilitation and Peer Supports bundle and one of the three termed Care Coordination bundles (Short, Mid or Long), but cannot be concurrently enrolled in more than one Care Coordination bundle at a time. A participant may not be concurrently enrolled in the Nursing Home Transitions, Diversions and High Intensity Care Coordination bundle and any other PMPM bundle. A participant may move from any one bundle to another, based on patient need and progress. There will be no duplication of services.

		Program Components					
PMPM Bundle	**Assumptions**	**Intensive Care Coordination**	**Tenancy Supports**	**Employment Assistance**	**Transportation Assistance**	**Peer Support**	**Peer Counseling**
Short-Term Care Coordination	assumes 20% of the top 5% of HUMS	X			X		X
Mid-Term Care Coordination	assumes 40% of the top 5% of HUMS	X			X		X
Long-Term Care Coordination	50% of the top 5% of HUMS	X			X		X
Rehabilitation and Peer Support	majority of the top 5% at some point		X	X		X	

Nursing Home Transitions High Intensity Care Coordination PMPM Bundle of Services Summary:

PMPM Bundle	**Assumptions**	**Intensive Care Coordination**	**Tenancy Supports**	**Employment Assistance**	**Transportation Assistance**	**Peer Support**	**Peer Counseling**	**Activities of Daily Living**

Nursing Home Transitions High Intensity Care Coordination PMPM Bundle of Services Summary:

Nursing Home Transitions, Diversions and Care Coordination	assumes 10% of the top 5% of HUMS	X	X	X		X	X	X

Deliverables associated with PMPM Bundles are provided below:

Year	**Deliverable 5.b.: Short-term Care Management**	**Deliverable 6.b.: Mid-term Care Management**	**Deliverable 7.b.: Long-term Care Management**	**Deliverable 9: Rehabilitation and Peer Support Teams**
PY 2	$1,831,043	$4,663,307	$3,972,968	$514,472
PY3	$3,848,121	$9,572,051	$7,945,936	$2,173,049
PY4	$3,848,121	$9,572,051	$7,945,936	$3,202,130
PY5	$3,848,121	$9,572,051	$7,945,936	$3,202,130

Year	**Deliverable 18.b.: Nursing Home Transitions High Intensity Care Coordination**
PY 2 - Ltd	$660,390
PY 3	$1,893,950
PY 4	$1,893,950
PY 5	$1,893,950

F. Pay for Reporting

1. On Time Reporting of Universal and Variant Metrics

Year	**Deliverable 11: On Time Reporting of Universal and Variant Metrics**
PY 2	$2,051,048
PY3	$2,540,332
PY4	$2,169,869
PY5	$2,169,869

Deliverable 11: On Time Reporting of Universal and Variant Metrics is a Pay for Reporting deliverable, with potential payments outlined above for each PY, which will be made available to SCVHHS as incentive payment that will be utilized to develop multidisciplinary teams essential to the assessment, screening, enrollment, and engagement of WPC

participants in various entities throughout Santa Clara County and related supports for participants' wellness. These "Triage Teams" teams will be placed in the SSA enrollment center, SCVMC hospital or clinics. They will help appropriately assess and engage WPC enrollees to connect them with needed services. Payments are requested for on time submissions of the Universal and Variant Metrics on a biannual basis. This deliverable involves 50% payment triggered at on-time submission of the six-month report and the remaining 50% payment of triggered for the on-time submission of the annual report.

2. Variant Metric 1 – Administrative: Beneficiary Enrollment and Assessment in WPC Pilot Program

Year	**Deliverable 16: Administrative: Beneficiary Enrollment and Assessment in WPC Pilot Program**
PY 2	$100,000
PY3	$100,000
PY4	$100,000
PY5	$100,000

Deliverable 16: Variant Metric 1 – Administrative: Beneficiary Enrollment and Assessment in WPC Pilot Program is the Pay for Outcome deliverable, with potential payments outlined above for each PY, which will be made available to SCVHHS. The metric measures participant enrollment with patient assessments within 60 days as an outcome to ensure patient engagement and timely identification of needs and services.

Metric ID:	**Variant Metric 1**
Target Population:	All
Measure Type:	Administrative: Beneficiary Enrollment and Assessment in WPC Pilot Program
Description:	New participants enrolled and patient assessments completed within 60 days
Benchmark:	PY 1: Not Applicable PY 2: 1250 PY 3: 2500 PY 4: 2500 PY 5: 3750
Numerator:	Newly enrolled participants with patient assessments completed within 60 days
Denominator:	Number of newly enrolled participants

<u>This deliverable involves proportional payments triggered by achieving the described benchmarks, to the following table:</u>

Benchmark for Payment to SCVHHS	Payment to SCVHHS
PY2: 1250 new participants enrolled and patient assessment completed within 60 days	• 1250 enrolled/completed (100%) = $100,000 (100%) • 1125 (90%) = $90,000 (90%) • 1000 (80%) = $80,000 (80%) • 875 (70%) = $70,000 (70%) • 750 (60%) = $60,000 (60%) • 625 (50%) = $50,000 (50%) • 500 (40%) = $40,000 (40%) • 375 (30%) = $30,000 (30%) • 250 (20%) = $20,000 (20%) • 125 (10%) = $10,000 (10%)
PY3: 2500 new participants enrolled and patient assessment completed within 60 days	• 2500 enrolled/completed (100%) = $100,000 (100%) • 2250 (90%) = $90,000 (90%) • 2000 (80%) = $80,000 (80%) • 1750 (70%) = $70,000 (70%) • 1500 (60%) = $60,000 (60%) • 1250 (50%) = $50,000 (50%) • 1000 (40%) = $40,000 (40%) • 750 (30%) = $30,000 (30%) • 500 (20%) = $20,000 (20%) • 250 (10%) = $10,000 (10%)
PY4: 2500 new participants enrolled and patient assessment completed within 60 days	• 2500 enrolled/completed (100%) = $100,000 (100%) • 2250 (90%) = $90,000 (90%) • 2000 (80%) = $80,000 (80%) • 1750 (70%) = $70,000 (70%) • 1500 (60%) = $60,000 (60%) • 1250 (50%) = $50,000 (50%) • 1000 (40%) = $40,000 (40%) • 750 (30%) = $30,000 (30%) • 500 (20%) = $20,000 (20%) • 250 (10%) = $10,000 (10%)
PY5: 3750 new participants enrolled and patient assessment completed within 60 days	• 3750 enrolled/completed (100%) = $100,000 (100%) • 3375 (90%) = $90,000 (90%) • 3000 (80%) = $80,000 (80%)

Benchmark for Payment to SCVHHS	Payment to SCVHHS
	• 2625 (70%) = $70,000 (70%) • 2250 (60%) = $60,000 (60%) • 1875 (50%) = $50,000 (50%) • 1500 (40%) = $40,000 (40%) • 1125 (30%) = $30,000 (30%) • 750 (20%) = $20,000 (20%) • 375 (10%) = $10,000 (10%)

G. Deliverables Summary

		Deliverables								
Deliverable	**Investment**	**Year 1: 2016**	**Year 2: 2017**	**Year 2 Dollars for payment**	**Year 3: 2018**	**Year 3 Dollars for payment**	**Year 4: 2019**	**Year 4 Dollars for payment**	**Year 5: 2020**	**Year 5 Dollars for payment**
1	**Data Exchange**	[Planning & Baseline Data]	Finalize all DUAs	$6,375,001	Deploy master data management for patient, provider, location and other key master indexes	$1,840,707	Support of clinical data exchange in the form of HL7 2.x messages from partners	$1,662,413	Support of clinical data exchange in the form of HL7 2.x messages from partners	$1,662,412
2	**Data Exchange**	[Planning & Baseline Data]	Define Workflows	$6,375,001	Integrate Existing CCDA and HL 7 2.x messages and business processes improvement	$1,840,707	Support of clinical data exchange in the form of CCDA summary documents and business processes improvement	$1,662,413	Support of clinical data exchange in the form of CCDA summary documents and business processes improvement	$1,662,412
3.a.	**Medical Respite**	[Planning & Baseline Data]	Medical Respite Start-up	$ 988,787	N/A	N/A	N/A	N/A	N/A	N/A
3.b.	**Medical Respite**	[Planning & Baseline Data]	N/A	N/A	Medical Respite FFS	$2,744,978	Medical Respite FFS	$2,744,978	Medical Respite FFS	$2,744,978
4.a.	**Peer Respite**	[Planning & Baseline Data]	Peer Respite Start-up	$ 647,649	N/A	N/A	N/A	N/A	N/A	N/A

4.b.	**Peer Respite**	[Planning & Baseline Data]	N/A	N/A	Peer Respite FFS	$1,558,996	Peer Respite FFS	$1,558,996	Peer Respite FFS	$1,558,996
5.a.	**Care Coordination S/T**	[Planning & Baseline Data]	Care Coordination S/T start-up	$ 915,522	N/A	N/A	N/A	N/A	N/A	N/A
5.b.	**Care Coordination S/T**	[Planning & Baseline Data]	PMPM Rate	$1,831,043	PMPM Rate	$3,848,121	PMPM Rate	$3,848,121	PMPM Rate	$3,848,121
6.a.	**Care Coordination M/T**	[Planning & Baseline Data]	Care Coordination M/T start-up	$1,192,778	N/A	N/A	N/A	N/A	N/A	N/A
6.b.	**Care Coordination M/T**	[Planning & Baseline Data]	PMPM Rate	$4,663,307	PMPM Rate	$9,572,051	PMPM Rate	$9,572,051	PMPM Rate	$9,572,051
7.a.	**Care Coordination L/T**	[Planning & Baseline Data]	Care Coordination M/T start-up	$2,024,491	N/A	N/A	N/A	N/A	N/A	N/A
7.b.	**Care Coordination L/T**	[Planning & Baseline Data]	PMPM Rate	$3,972,968	PMPM Rate	$7,945,936	PMPM Rate	$7,945,936	PMPM Rate	$7,945,936
8	**Trust Community Adoption**	[Planning & Baseline Data]	•Signed DUAs with each participating entity earning incentive •Implementation plans from each participating entity earning incentive	$4,000,000	N/A	N/A	N/A	N/A	N/A	N/A

9	**Rehabilitation and Peer Support Teams**	[Planning & Baseline Data]	Wellness Services Start / PMPM Rate	$ 514,472	PMPM Rate	$2,173,102	PMPM Rate	$3,202,046	PMPM Rate	$3,202,046
10	**Integrated Medical-Psychiatric Skilled Nursing Facility Provider Incentive Payments**	[Planning & Baseline Data]	N/A	N/A	Providers accept enrollees into Med-Psych SNF beds	$ 736,665	Providers accept enrollees into Med-Psych SNF beds	$1,605,270	Providers accept enrollees into Med-Psych SNF beds	$1,605,270
11	**Performance Monitoring**	[Planning & Baseline Data]	Submission of Annual and Six Month Progress Reports w/Outcome Data	$2,051,048	Submission of Annual and Six Month Progress Reports w/Outcome Data	$2,540,332	Submission of Annual and Six Month Progress Reports w/Outcome Data	$2,169,869	Submission of Annual and Six Month Progress Reports w/Outcome Data	$2,169,869
12	**Social Services Referral Integration**	[Planning & Baseline Data]	Begin implementation of improvements to social services integration with behavioral health services	$2,484,785	1% change in outcomes that improve social services integration with behavioral health services	$2,484,785	1% change in outcomes that improve social services integration with behavioral health services	$2,027,131	1% change in outcomes that improve social services integration with behavioral health services	$2,027,131
13	**Drug and Alcohol Screening**	[Planning & Baseline Data]	Begin implementation of improvements to alcohol and drug screening, referral and intervention	$1,900,000	1% change in outcomes that improve alcohol and drug screening, referral and intervention	$1,900,000	1% change in outcomes that improve alcohol and drug screening, referral and intervention	$1,442,346	1% change in outcomes that improve alcohol and drug screening, referral and intervention	$ 1,442,346

14	**Care Coordination Infrastructure**	[Planning & Baseline Data]	Development of: • Care coordination documentation • Referral policies and procedures for WPC lead and participating entities • Communication structures • Monitoring and oversight procedures (with regular review) • Method for compiling and analyzing monitoring findings	$2,271,563	Access to beneficiary information for key (TBD) participating entities	$2,945,092	Write capabilities to beneficiary information for key (TBD) participating entities & PDSA in SCVHHS to refine care coordination, case management, and referral infrastructure	$2,843,016	PDSA in SCVHHS and Participating Agencies to refine care coordination, case management, and referral infrastructure	$2,843,017
15	**Data and information sharing infrastructure**	[Planning & Baseline Data]	Development of: • Policies and procedures for WPC lead and participating entities • Monitoring and oversight procedures (with regular review) • Method for compiling and analyzing monitoring findings	$3,407,344	Development of: • Access and updates to beneficiary information for all participating entities • Process for modifying policies and procedures	$4,417,638	PDSA to refine care coordination, case management, and referral infrastructure	$4,264,525	PDSA to refine care coordination, case management, and referral infrastructure	$4,264,525

16	**Pay for Outcome Metric - Variant Metric 1**	[Planning & Baseline Data]	1250 new participants enrolled and patient assessments completed within 60 days	$ 100,000	2500 new participants enrolled and patient assessments completed within 60 days	$ 100,000	2500 new participants enrolled and patient assessments completed within 60 days	$ 100,000	3750 new participants enrolled and patient assessments completed within 60 days	$ 100,000
17.a.	**Sobering Station**	[Planning & Baseline Data]	Restoration Center Sobering Station Start-up	$1,346,240	N/A	N/A	N/A	N/A	N/A	N/A
17.b.	**Sobering Station**	[Planning & Baseline Data]	Sobering Station FFS	$ 450,410	Sobering Station FFS	$3,593,304	Sobering Station FFS	$3,593,304	Sobering Station FFS	$ 3,593,304
18.a.	**Nursing Home Transitions, Diversions and High Intensity Care Coordination**	[Planning & Baseline Data]	Nursing Home Transitions, Diversions and High Intensity Care Coordination start-up	$ 466,912	N/A	N/A	N/A	N/A	N/A	N/A
18.b.	**Nursing Home Transitions, Diversions and High Intensity Care Coordination**	[Planning & Baseline Data]	PMPM Rate	$ 660,390	PMPM Rate	$1,893,950	PMPM Rate	$1,893,950	PMPM Rate	$ 1,893,950

WPC Budget Template: Summary and Top Sheet

WPC Applicant Name:	Santa Clara County Health and Hospital System

	Federal Funds *(Not to exceed 90M)*	**IGT**	**Total Funds**
Annual Budget Amount Requested	26,068,182	26,068,182	52,136,363

PY 1 Budget Allocation (Note PY 1 Allocation is predetermined)	
PY 1 Total Budget	45,143,059
Approved Application (75%)	33,857,294
Submission of Baseline Data (25%)	11,285,765
PY 1 Total Check	6,993,304

PY 2 Budget Allocation	
PY 2 Total Budget	48,639,711
Administrative Infrastructure	5,678,908
Delivery Infrastructure	20,332,380
Incentive Payments	8,384,785
FFS Services	450,410
PMPM Bundle	11,642,180
Pay For Reporting	2,051,048
Pay for Outomes	100,000

PY 3 Budget Allocation	
PY 3 Total Budget	52,136,363
Administrative Infrastructure	7,362,730
Delivery Infrastructure	3,681,413
Incentive Payments	5,121,450
FFS Services	7,897,278
PMPM Bundle	25,433,160
Pay For Reporting	2,540,332
Pay for Outomes	100,000

PY 4 Budget Allocation	
PY 4 Total Budget	52,136,363
Administrative Infrastructure	7,107,541
Delivery Infrastructure	3,324,825
Incentive Payments	5,074,747
FFS Services	7,897,278
PMPM Bundle	26,462,104
Pay For Reporting	2,169,869
Pay for Outomes	100,000

PY 5 Budget Allocation	
PY 5 Total Budget	52,136,363
Administrative Infrastructure	7,107,541
Delivery Infrastructure	3,324,824
Incentive Payments	5,074,747
FFS Services	7,897,278
PMPM Bundle	26,462,104
Pay For Reporting	2,169,870
Pay for Outomes	100,000