

**Solano County Health & Social Services**

Whole Person Care Agreement

**Section 1: Entity Description**

Attachment A

Organization Name	Solano County Health & Social Services (SCH&SS)
Type of Entity	County
Contact Person	Gerald Huber
Contact Person Title	Director
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**1.2 Participating Entities**

This project includes both Medi-Cal managed care plans that operate in Solano County (Partnership Health Plan and Kaiser Permanente), as well as several community partners within the geography of the County. The Solano Coalition for Better health (SCBH) is a coalition representing local health providers and hospitals, which is the contracted entity that will provide the services described in this proposal. Additional participating providers listed below will participate as collaborative, community providers, and contributions from Solano County H&SS are offered in-kind. As appropriate, the other participating agencies will be invited to care planning meetings as part of a comprehensive treatment team with a holistic care approach. The cooperation across the broad range of community providers will work to eliminate the fractured approach that can occur with multiple providers working independently, often toward the same goals with the same client.

In Solano County, Kaiser Permanente serves roughly 12,000 Medi-Cal beneficiaries under a unique contract with Partnership Health Plan. Kaiser provides all services to these Medi-Cal beneficiaries. While this population is “carved out,” Kaiser also receives half of all 911 emergency patients, and so it is an important partner in reviewing the care of Solano County Medi-Cal beneficiaries.

Required Organizations	Organization Name	Contact Name and Title	Entity Description and Role in WPC
Medi-Cal Managed Care Health Plan	Partnership Health Plan	Elizabeth Gibboney, CEO	Medi-cal Managed Care Organization—Steering Committee, Participation and Collaboration
Health Services Agency/Department	Solano County Public Health	Bela Matyas, M.D.	Public Health Nursing, Epidemiology—Steering Committee, Data
Specialty Mental Health Agency/Department	Solano County Behavioral Health	Halsey Simmons, MFT	MH/SUD Treatment In-kind Service Provider
Public Agency/Department	Solano County Medical Services	Michael Stacey, M.D.	Primary Care In-kind Service Provider

Required Organizations	Organization Name	Contact Name and Title	Entity Description and Role in WPC
Public Agency/Department	Solano County Substance Abuse Services	Andrew Williamson, MFT	Substance Use Treatment In-kind Service Provider
Community Partner 1	Solano Coalition for Better Health	Joanie Erickson, Executive Director	Transitional Care Plus Principal Contractor—to provide most non-Medi-cal pilot features.
Community Partner 2	NorthBay Medical Center NorthBay VacaValley Hospital	Konard Jones President, Hospital Operations	Regional ED/Hospital Steering Committee, Participation and Collaboration
Community Partner 3/ Managed Care Health Plan	Kaiser Permanente Vallejo Medical Center Kaiser Permanente Vacaville Medical Center	Kim Menzel, Hospital Administrator	Regional ED/Hospital Steering Committee, Participation and Collaboration
Community Partner 5	Bay Area Community Services	Jamie Almanza, Executive Director	MH Housing/Service Provider, Transitional Supported Housing
Community Partner 6	Fairfield Housing Authority	Nicole Holloway, Housing Coordinator/David White, City Manager	Partnering with HUD vouchers for 10 slots for Pilot participants; assisted BACS/SCBH in identifying and securing property

### 1.3 Letters of Participation and Support – please refer to attached

## Section 2: General Information and Target Population

### 2.1 Geographic Area, Community and Target Population Needs

The target population will geographically reside in Solano County. While a medium-sized county that is part of the east Bay Area, its farming communities, suburban communities and urban areas distinguish it from the more urban Bay Area and add barriers and challenges that diverse geography and community composition can bring with them.

High risk, high utilizing participants may be seen by multiple entities with little coordination around identified needs, interventions and mutual access to information about these services and outcomes. Four hospital Emergency Departments (ED) serve the Solano County community. Additionally, due to the lack of electronic health system interoperability, lack of formal clinical structure in which to share information, lack of dedicated care staff to facilitate coordination and apply assertive engagement practices, service delivery is often ineffective with this complex population. Data analysis demonstrating community need for this project is elaborated upon in the Section 2.3.

This project will seek to eliminate structure barriers to comprehensive, collaborative care, and it will build upon an already existing collaborative program that has begun to tackle these issues, with good

outcomes. The Solano Coalition for Better health (SCBH) is a coalition of local health providers, hospitals, Solano County H&SS, PHC and the Education sector. These partners are well-positioned to build upon the success of the SCBH Transitional Care Program (TCP). The TCP program<sup>1</sup> targets homeless individuals who have a greater need for shelter than actual emergency medical care, yet had a history of avoidable ED visits. It was created in response to increasing demands by the homeless population on local EDs, and is funded by local hospitals and H&SS. To ensure that the proposed new larger and more comprehensive model was sound and based in current needs, a Stakeholder meeting was held on June 22 to discuss the overall plan, solicit and incorporate feedback, and finalize agreements to collaborate.

### **Program Description**

Overview: Building on the success of the current TCP program and review of comparable programs, the program will contain a multi-agency, multi-functional team of service providers, comprising "TCP+." Assertive community outreach and service engagement will be employed to achieve improved outcomes and lower costs for 250 clients. Engagement will be followed by comprehensive team-oriented behavioral and medical evaluations, and a personalized holistic care plan, identifying for each of the principal agencies whose involvement will be required. The project infrastructure, funded by this project and employed by Solano Coalition for Better Health, will include a Project Manager, Data Analyst, Administrative Assistant, Housing Resource Specialist – and an in-kind Behavioral Health Specialist from Solano County H&SS. SCBH will also employ the Complex Care Coordinators (CCC) and Community Health Outreach Workers (CHOW) who will provide the outreach, engagement, access to system resources, and coordination of efforts for improved outcomes.

Roles: Each individual enrolled in the program will be assigned to a CCC who will assure that their medical needs are being actively met, track lapses in treatment, and provide overall care coordination among treating parties. Because of the high rate of non-adherence to treatment plans associated with this high-risk group, their notable incidence of behavioral health disorders, and frequent reluctance to engage in services, a Community Health Outreach Worker (CHOW) informed in both mental health and substance use issues will promote initial engagement and subsequent reengagement in medical/behavioral services. The CCC and CHOW will complement each other as key agents—the CCC mobilizing the relevant care systems and the CHOW engaging the participants. In addition to facilitating prioritized access in each treatment area, a field-based dually-trained substance abuse and mental health counselor will work to engage individuals in harm reduction or recovery.

While the majority of engagement, care coordination and monitoring services will be performed by SCBH's TCP+ personnel, SCH&SS service provision will be assured through case conference participation. Existing co-location throughout H&SS programs will benefit treatment coherence and

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<sup>1</sup> SCBH is being chosen as the contractor for this Pilot under 2 CFR 200,.302(f)(1), which allow for an exception to procurement practices based on the contractor offering a unique service not provided elsewhere and its accumulated experience in the delivery of this unique service.

the participant care experience. Bringing all care providers, represented as participating entities in this proposal, to case conferences will facilitate comprehensive, seamless care for the individual.

Following a Housing First model, housing recently developed by Solano in partnership with Bay Area Community Services (BACS) will be available, in addition to housing existing with SCBH, reaching at least 20 individual beds, with more housing to be developed based on need as determined during PY2 data analysis. Based on research of other successful programs individual enrollment in the program is estimated to average 18 months, with some variation depending on the complexity and severity of co-occurring medical and behavioral conditions. Some individuals may participate in the program longer, due to co-morbid, complex chronic and acute conditions, in order to promote continued improvement in outcomes.

Governance and oversight of partnerships: The project will be overseen by a Steering Committee comprised of 1 SCBH, 1 PHC, 1 hospital, 1 CBO, and 2 SCH&SS representatives. Through these routine communication venues – the Steering Committee, Quality Improvement Committee, and care coordination meetings – any programmatic or client-related issues or barriers can be quickly identified and targeted for a collaborative approach to improvement or resolution.

These partnerships and efforts to coordinate among various service providers will be assisted by technological innovation through HIE and a collaborative care platform for real-time data sharing across participating entities. The HIE will first be piloted within SCH&SS, as the different divisions (public health, behavioral health, etc.) currently utilize different EHRs. These different EHRs currently do not have capacity to interface for data sharing. Upon creation, testing and implementation of an HIE within SCH&SS, the model will be expanded to other entities as soon as possible.<sup>2</sup>

Sustainable Improvements: Demonstrated success in reducing overall hospital utilization through improved outreach and engagement, and comprehensive, coordinated treatment will lay the groundwork for continued project funding from demonstrated cost benefit. TCP results demonstrate decreases in medical costs associated with ED and inpatient admissions, making the return on investment (ROI) roughly 4 dollars for every 1 dollar invested in the current program.<sup>3</sup> These savings are calculated without taking into account collateral use such as the jails, law enforcement, or other community resources typically enlisted by the target population, resulting in an even higher true ROI.

This pilot will yield new information about system of care interface issues, access problems, and barriers to care; it will strengthen partnerships between SCH&SS and other agencies to help better achieve the Triple Aim in a culturally responsive, person-centered manner. The Collaborative Care Platform will provide the communicative foundation across geographically distinct providers and professional roles. Sustainability will be assured by leveraging all existing resources to the greatest extent, and ultimately, through partners whose overall costs will be significantly reduced as a benefit of this project.

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<sup>2</sup> Work on HIE is underway at the time of this application.

<sup>3</sup> See Appendix 1 for TCP Annual Report – Return on Investment Analysis

## 2.2 Communication Plan

Project launch and communication will be guided by the development of a Project Implementation Plan. This will outline roles, responsibilities, and expectations. Because shared-team planning and decision making is an established practice among partners in the existing TCP, this can be readily replicated. The bridges that have been built through the initial TCP, and then that will be expanded and enhanced through this pilot, will serve to sustain the collaborative relationships, and most importantly, create the interagency infrastructures that will survive changes in staffing. Collaborative decision-making, centered upon the individual's preferences and a thorough assessment of needs will be core to the communication that will be in place. Clinical decision making and treatment planning will be shared among service providers using a multi-disciplinary team decision-making framework, facilitated by the CCC during weekly team case conferences. A collaboration between the Steering Committee and Program Manager will oversee plans for the communication structures required of a new program implementation.

Several tiers of communication will support team alignment and optimization of resources – Collaborative Care Platform, administrative meetings, case conferences, and routine clinical and case management conferencing and tele-conferencing. Provider communication will occur with ease through the Collaborative Care Platform. In addition to weekly case review discussion, participants will access a dashboard with their individualized outcome progress, according to their own goals, through this Platform. Reviewing the participant progress toward goals will be a foundation to each case review meeting.

Monthly Steering and Quality Committee meetings will be held during the first 24 months of the project, bi-monthly thereafter. During implementation, all County and SCBH TCP+ project staff will meet bi-weekly to discuss program implementation and utilize a plan-do-study-act quality improvement process as the program is developed and delivered. Identified team members critical to the welfare of a participant will also be provided access to the meetings in-person or through telephone or video technology to enable immediate consultation and to decrease lag between TCP+ program identification of an urgent or emergent need and a timely response the service provider.

The CCC ensures that all extended treatment team members are aligned and will be the interface to EDs, other care facilities, jail medical staff, pharmacies, emergency transport, laboratories, behavioral health, etc. They will acquire and share current medical/behavioral information and assure all Care Team members specific to each participant are aware of significant developments.

Project partners will stay in close communication both formally and informally regarding project implementation and involved participants. H&SS will create an email listserv specifically for WPC participating partners and agencies. This email will be encrypted, HIPAA and HITECH compliant. Additionally, H&SS will host a Collaborative Care Platform (pending selection) that will be accessible to all participating entities. This site will serve as a repository for real time access by the individual's treatment team members to track and document service access, enhance treatment collaboration, improve real-time response to changing client needs. For participants with access to smart-phones or

internet access, H&SS can offer personal access the collaborative communication platform and the Network of Care website through its “MY PHR” functionality.

### 2.3 Target Population

In order to properly ground this pilot in community and partner needs, H&SS collaborated with Partnership Health Plan, to obtain a data set for analysis of diagnostic conditions, socio-economic and other barriers adversely affecting individuals in this group, and overall identify the costliest users of the Health Care system. Analysis of an initial data set of 200 high users enables the project to target based upon utilization and risk factors:<sup>4</sup>

- Substance use disorders were identified as present in 78% of the participants whose service costs were highest and accounted for 93% of all ER visits. Only 2.2% of the individuals with noted substance abuse conditions received SUD treatment through H&SS, which is the sole provider of SUD services in the County.
- 78% of this group showed 2 or more behavioral health conditions (e.g., SUD and Depression). Only 18 of the 200 individuals sought treatment in H&SS for Mental Health conditions.
- The average medical cost per person with SUD issues was \$209,000, compared to those with a serious mental illness at \$190,511. Both are significantly higher than individuals with no behavioral health issues at \$149,094.52.
- Those participants involved with County H&SS showed 12% lower medical expenditures compared to individuals who had no health home, although it should be noted that even for the individuals who were enrolled in county services (5%), low or inconsistent service utilization was observed.

Based upon this analysis, the target population of this pilot will be residents with the highest medical utilization, repeated incidents of avoidable emergency department use, and two or more chronic and serious health conditions, at least one of which are mental health and/or substance use disorders. The pattern of comorbid substance abuse disorders, low involvement with any formal health home, and lack of specialty behavioral health services predominated among the group and therefore guide the plans for this pilot. In addition, anecdotal experience and the high prevalence of homelessness in Solano County suggests that many of these individuals are either homeless or at high risk of homelessness. To note, due to the unique location of Solano County being between two urban, metro areas, affordable housing has been significantly inadequate with the increasing suburban sprawl from the Bay Area, and from the State capital. This affordable housing compression has impacted the ability to traditionally house individuals who are homeless or at risk of becoming so.

The target population will be Medi-Cal insured adults who are high inpatient/emergency utilizers based on the “Top 200” data shared by PHC with H&SS, and those who otherwise upon screening evidence a similar high utilization. This data will be refreshed prior to the program launch so that the participants intended for inclusion are the real-time high users. Approximately 250 individuals will be

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<sup>4</sup> See Appendix 2 for corresponding display of data

served over the five-year period. Most of the emphasis during the initial 18 months of the pilot will be on performing outreach to the individuals whose service pattern shows costs average from \$150,000-\$210,000 annually, and then assiduously engaging them. As described above, emergency medical utilization increases considerably with the addition of a substance use condition, beyond whatever complex medical conditions may exist. In addition to the known gaps revealed through initial analysis regarding lack of coherent coordination and access to resources, as well as the prevalence of substance use and mental health disorders, experience suggests that many individuals in this pilot will be homeless, at risk of homelessness, or cyclically incarcerated. The degree to which this is the case will be determined through further data collection as hospitals and emergency departments do not reliably collect this data—in this respect, this pilot will take its cues from the actual profiles of participants as they enter the system and adjust based on a progressive needs analysis, and revisit its assumptions frequently to ensure efficacy. It is a working assumption of this proposal that housing instability will have to be aggressively addressed through assistance with transitional housing, linkage to permanent housing, etc., and that the re-entry of medically vulnerable individuals from the jail to the community is a critical point of intervention which, if missed, can result in costly and adverse care consequences. To that end, we will leverage the efforts of a recently implemented collaborative Mentally Ill Offender Crime Reduction Grant, focused on both jail diversion and reintegration. If emerging data shows additional barriers, then this will inform a continued approach to adapting and improving the project based upon the population's needs.

### **3.1 Services, Interventions and Care Coordination**

The breadth of service involvement and extensive teaming of organizations for interventions provides an opportunity for creative and innovative interventions. This pilot will leverage data, existing relationships, and new infrastructures to address the multitude of health and psychosocial issues faced by this complex population. Further, bringing over one dozen county and community agencies on a shared mission represents a unique opportunity for innovation and leverage of knowledge, skills and resources.

#### **Participant Engagement**

Engagement and assertive outreach will be essential functions performed by CHOW. The point of engagement will be emergency departments, inpatient medical hospital units, outpatient clinics, SUD/MH programs, home, and field locations. For participants already identified by their high utilization patterns, many would require assertive outreach in the field and/or in the participant's home. For those presenting in the ED and meeting criteria, outreach to the ED itself may be most effective, engaging the participant in the midst of a medical crisis. As described, this outreach and engagement staff will be performed by the CHOW staff of SCBH.

Data sharing is further discussed in Section 3.2, but its importance in facilitating coordinated care cannot be overstated. Upon enrollment, participants will be asked to sign a HIPAA-compliant Release of Information allowing all specified providers/organizations to whom the participant is known, to share information to the extent necessary for purposes of coordination and referral. At the point that

the agreement is signed, two types of documentation and information transfer can occur: electronic medical records united through the HIE and, depending on the ultimate functionality of the HIE, an additional Collaborative Care Platform for up to the moment communication among care providers. EMRs are excellent for standard charting and tracking participant activity, but in this project, communicating across disciplines, monitoring milestones and challenges for each participant as they progress in care, may be more easily accomplished in a platform such as TWINE, VOALTE, ZIRMED, or EVERBRIDGE, to name a few examples. By December 31<sup>st</sup>, Solano IT Department will be able to determine whether the communicative needs of the WPC pilot will be adequately met by an enhanced HIE or if additional software is needed.

### **Program Orientation and Assertive Engagement**

This will occur at multiple points of contact, beginning with the CHOW specialist, and extending throughout care. The engagement specialist will continue to monitor engagement and work collaboratively with the care team to ensure that lapses in self-care, relapse, and other significant disengagement are addressed immediately; when necessary, team members who have a more treatment specific relationship may also reach out in coordination with the engagement specialist. The team is expected to be agile and responsive

### **Comprehensive, Person-Centered Multi-modal Assessment**

Multi-modal holistic assessment will be arranged and facilitated by the CHOW and include comprehensive medical and behavioral health assessment within the FQHC environment (Solano Family Health Services). A primary care practitioner and behavioral specialist, whose services are not funded with WPC funds, will perform the comprehensive assessment in a combined appointment to reduce inconvenience and redundancy to the participant, improve the show rate for service, and maximize information gleaned. This will facilitate quickly identifying immediate steps that might need to be taken to secure the client's health and well-being. This is intended to initiate a true health home and provider relationship that can serve to engage a person in their healthcare and reduce ED utilization.

In addition to assessing medical and psychiatric needs, the CCC will conduct a comprehensive psychosocial assessment to identify needs in order of priority, including need for immediate shelter, general assistance, detox, or others. For those ready to engage in specialty substance use or mental health care, those linkages will be facilitated.

### **Complex Care Coordination to create a seamless consumer experience**

Assignment to Complex Care coordination will be universal because of the multiple medical and behavioral conditions affecting the population enrolled in this pilot. The CCC will provide:

1. Standard Care Management: comprehensive tracking, facilitating, and realization of care for medical and behavioral needs



2. Care coordination among team members: performed ad hoc and through a weekly Care Team meeting. The latter will require systematic review of all participants each week, with time being apportioned differently depending on the level of activity, concern or other case-related issues.

This service may also be provided in homes and the community. Care coordination and management, while a well-defined activity in managed care settings, will be enhanced by partial co-location of the CCC with the primary care multidisciplinary team and working in careful coordination with the CHOW to enhance progress toward treatment goals.

Complex care management activities will be comprehensive in scope and address participant progress and needs across all major dimensions of care, including consideration of self-care, disease management, treatment adherence, follow-through, obstacles to these that need to be addressed by the team, overall utilization, and overall progress of the participant across all dimensions of care. Complex Care Coordination will be a distinct service separate from other types of case management in that the CCC's role will include responsibility for determining that the participant is continuing to progress across each identified functional and treatment domain. If appropriate progress is not noted, team discussions will be initiated ad hoc and at the weekly Care Team review. The CCC will determine whether participant is progressing on milestones determined in WPC Care Plan and stay in constant communication and entire service team to ensure that services are individualized, streamlined, responsive, and non-duplicative.

### **Field Outreach and Linkage**

Prioritization in service linkage and access will be accomplished by an MOU among all participating parties. Individuals identified for participation in the program will receive priority service access in the FQHC, Mental Health, and Substance Use programs run by the County. Established local funding sources will be used to provide for an array of possible service needs (most funded by Medi-Cal), but interagency prioritization will assure timely intervention and mitigate disengagement or escalation of a health or psychosocial condition.

The CHOW will facilitate linkages by:

1. Assertive outreach and engagement in the field.
2. Partner with the CCC to ensure appointment completion by participant.
3. Find participants and facilitate appointment attendance when necessary.
4. Miscellaneous care support that furthers the WPC Treatment Plan: advocacy, medication procurement, building life skills, transportation coaching, housing placement and troubleshooting, as individually defined.
5. Engage the participant initially and ongoing through motivational interviewing, shared experience (if a peer), and caring, compassionate contacts.

### **Prioritizing Engagement in Substance Use Treatment/Co-occurring Peer Support**

To address the broad prevalence of substance use in the intended population, whether street or prescription drugs, the full-time substance abuse specialist will use a harm reduction approach to provide field-based and clinic-based co-occurring engagement, treatment, relapse prevention and relapse recovery services that are individually tailored. This position will serve as a conduit to the H&SS Behavioral Health Systems, and can assist the CCC and CHOW in assuring that prioritized behavioral health services are received timely, in a coordinated manner congruent with the participant's WPC Care Plan. Working closely with the CCC and CHOW, this position will include peer-informed services and support to each individual challenged by substance use, help inform the Behavioral Health component of the WPC Care Plan, and play a variety of roles in relation to each participant's co-occurring needs: advocate, sponsor, or mentor, flexibly as needed.

### **Housing and Social Service Assistance**

TCP has a history of focused work with the homeless, medically indigent and can expand its current resources and methodology for creating housing resources. As noted, Solano County is additionally committing 10 housing slots to individuals in this proposed Pilot through local resources, costs of which are not included in the WPC budget. Housing advocacy and support services will be provided through a WPC Housing Resource Specialist, and if needed, work with providers to stabilize the participant when they do not have access to a county provided housing placement. When available, housing funds or resources outside the WPC pilot funding will help individuals who are not able to be sheltered. Active agreements with the local Chamber of Commerce, City Housing Authorities, local shelters (Mission Solano, Christian Help Center, Opportunity House), and community organizations already serving County participants with supported housing services (e.g., MHP contractors such Caminar and BACS) will be in place to assure progress is made in prioritized sheltering, transitional housing, and permanent housing.

Basic Social Service needs will be addressed through the work of the CHOW, including assistance accessing food services, transportation resources, SSI applications, Medi-Cal (prior to enrollment) and other assistance programs available to each participant, as well as a number of other areas that might arise with a given participant. County relationships will facilitate many of these services. Social Services assessment and processing will be prioritized through agreements with H&SS Employment and Eligibility Services, the local SSI office, etc. In addition to housing advocacy, the Housing Resource Specialist provides on-site guidance and supervision, supportive counseling and guidance to ensure basic needs are being met, harmony is created and maintained, and the household is managed to optimally support each participants' needs.

### **3.2 Data Sharing**

Information Flow, Access and Permissions among Participating Agencies will reflect program need for flexibility while ensuring HIPAA and HITECH compliance and maximizing participant confidentiality. Information sharing will be governed by MOUs with each participating organization setting forth

binding restrictions on access and use by that organization, including its staff, according to role-specific logic, to maximize appropriate flow of information and avoid excessive access.

As noted, two systems are envisioned for use throughout the life of the project: an HIE, on target for production in December 2017, and a new clinical collaboration software tool that provides a platform within which to easily communicate, summarize and update care events pertinent to the collaborating team. By 6/30/17, Solano will identify a HIPAA compliant care management collaboration platform with functionality necessary for the tight and timely coordination described. With this functionality, basic documents can be uploaded easily, inter-provider communication can occur with a HIPAA secure software medium, and tracking of participant care events will be possible. The table below illustrates information sharing and access by role and organizational identity. Releases to all involved parties are presupposed and achieved by a compliant multi-disciplinary release addressing both HIPAA and 42 CFR.

For analysis of project success and outcomes, the data analyst will be provided various aggregate data sets from the disparate data sources in order to provide a comprehensive reporting of outcomes.

	Care Collaboration Platform	HIE Access	NexGen Medical	Avatar SUD/MH
TCP+ Care Coordinator	Yes	Yes	No	No
TCP+ CHOW	Yes	Yes	No	No
H&SS Direct Medical Providers	Yes	Yes	Yes	No
H&SS Direct Behavioral Providers	Yes	Yes	No	Yes
SUD/Co Peer Wrap Specialist,	Yes	Yes	No	No
External Medical Providers/Specialists	Yes	No	No	No
TCP+ Administration	Yes	Yes	No	No
H&SS Project Oversight	Yes	Yes	No	No
Data Analyst	Yes	No	No	No
Hospital SW, Nurse	Yes	No	No	No
Housing Coordinator	Yes	No	No	No
Primary Responsible for Updating	Care Manager	n/a	H&SS Health	H&SS BH
Available by:	June 30, 2017	December 31 <sup>st</sup> , 2017	Currently	Currently

### Description of Data Tools

The Mirth HIE maintained and designed by H&SS will provide essential case information including treatment plan, assessment information and progress notes—that is, a subset of the data contained in each of the two specialized Electronic Health Records in use within H&SS. These two EH/MRs conform to industry standards and provide for role-based permissions, as will the HIE, to a lesser extent. While

the HIE provides some capacity for information dissemination, it is not a user-friendly tool to large and diverse Care Team looking for quick updates, nor can it be modified.

Therefore, a Clinical Collaboration Platform will be selected that provides the following functionality:

- Dashboard on each participant containing significant updates, care events, and reminders
- Messaging among providers
- Messaging between providers and participants
- Flagging of comments or information that needs to be highlighted
- Alerts regarding outcomes or needs
- Summary Reporting by participant along several dimensions such as attendance, appointment completion, inter-provider communication, etc.

### **Data Structure, Governance, Challenges**

Because of the focus of this project on a small subset of the total population of Medi-Cal beneficiaries in Solano, the lessons learned from this Pilot in the use of the platforms described will contribute to the understanding of how more widespread collaborative care platform use could occur. To ensure full compliance with applicable law and regulation, and timely implementation, an Ad Hoc sub-committee will be formed to include H&SS Compliance Officer, BH Quality Administrator, and IT Management, to ensure goals and deadlines are met. Ongoing, the Quality Team will include a Compliance Analyst to ensure the extended clinical communication systems envisioned are fully compliant in the design and actual implementation.

Challenges expected to be encountered include:

- a) An accelerated timeline for finalizing purchase of the Clinical Collaboration Platform
- b) Training all staff timely—staff trainings will be scheduled in advance of the actual implementation date through company provided training environment
- c) Ensuring full utilization of the product on a daily basis for day-to-day updates and increased team responsiveness—this technical “cultural” challenge will be monitored and measured within the first three months of program operation to ensure progressively higher levels of use, evaluate user feedback and assure that the product is optimally used for the purposes of this WPC Pilot.
- d) Determining thresholds for external care providers to gain access to the Care Collaboration tool—more analysis will be done by the Ad Hoc Data Compliance committee mentioned in order to determine what thresholds of involvement would reasonably trigger awarding access to a given external provider.

### **4.1 Performance Measures**

Performance metrics and data analysis are anticipated to be a weekly activity in preparation for the weekly care conferences, as well as for frequent PDSA cycles. Identified performance measures specific to the project align with the totality of whole health interventions that are likely to be

applied: engagement in the project, engagement in primary care, maintenance of housing, engagement in various social service supports, and engagement in behavioral healthcare.

## Data Sources

### 1. Universal Metrics:

- a. **Health Outcomes – ED visits:** HEDIS, supplied by PHC
- b. **Inpatient Utilization:** HEDIS, supplied by PHC
- c. **Follow-up After Mental Health Hospitalization:** HEDIS and County Mental Health Records--currently collected as Quality Assurance measurement
- d. **SUD Initiation and Engagement:** SUD Outreach/engagement log; SUD Call Center electronic records, Netsmart Avatar service entry by Providers
- e. **Administrative: Participating Beneficiaries with a Comprehensive Care Plan, accessible, within 30 days.** Measured through Collaborative Care Platform, dates of finalization of plan, and based on content analyses with quarterly PDSA quality improvement cycles
- f. **Administrative: Care coordination and Referral Infrastructure:** Approved policies and procedures. Monitoring of need for changes and operationalization will be measured through Collaborative Care Platform user statistics, HIE user statistics, for semi-annual PDSA cycles and analysis of these will occur by the Quality Committee, to identify divergence from Policy and Procedures, or divergence of Policy and Procedures from actual practice, etc.
- g. **Administrative: Data and Information Sharing Infrastructure:** Approved policies and procedures setting forth data and information practices among all participating entities. Additional Data sources: Collaborative Care Platform user statistics, HIE user statistics, comparison of key milestone data in HIE with Collaborative Care Platform by Quality Committee

### 2. Variant (by Outcome Measure) – specific outcomes are based upon findings from analysis of the preliminary high user data set.

- a. **Administrative: Care Team Meetings:** Teams assembled for care plan development.
- b. **Health Outcomes - Hospital Readmissions:** Reduction of 30-day readmission rates.
- c. **PHQ-9:** Increase in percentage initially scoring 9 or more and 12 months later scoring 5 or less.
- d. **Suicide Risk Assessment completed for clients with Major Depressive Disorder:** At initial psychiatric assessment appointment, and at next available follow-up, 90 or more days following the initial psychiatric appointment.
- e. **Housing agreements in place to provide 10-20 spaces. Outcome: 5 new beds available by PY 2 end:** MOU, Lease Agreements, Supportive Services plan signed and executed by PY 2 end.
- f. **For primary SUD enrollees,** engagement in treatment will be available in the Avatar EHR.

- g. **Primary Medical Care will be provided for 50% of homeless participants, in field or at office:** Homeless identifiers on Whole Person Health Inventory, evidence of treatment through NexGen/HIE.
- h. **Health Outcome: Medication and/or Visit Adherence maintained by 50% of individuals after WPC Plan is enacted during PY, and participation exceeds 60 days:** HIE, NexGen, records will provide real time data regarding week to week visit and medication adherence.
- i. **Enrollment and Engagement with a Primary Care Physician:** 50% and ultimately 75% of participants will engage with a PCP.
- j. **Process Measures**
  - i. **IT records sharing activity:** Care Team members: Security log of Weekly Access of shared HIE, Collaborative Care Platform access and training
  - ii. **Records of Steering, Administrative and Clinical Meetings:** Centrally maintained paper records, meeting minutes, attendee sign in, and tailored data capture forms for clinical meetings when by telephone
  - iii. **Housing Status change:** vendor claims, individual agreements, residency logs

### 3. Ongoing data collection, reporting

- a. As Required by Schedule for Reporting requirements<sup>5</sup>
- b. As required by Quality Improvement Activities
- c. As required by Clinical Standards

4.1a Universal Metrics <sup>6, 7</sup>	PY2	PY3	PY4	PY5
<b>Enrollment Goals</b>	50	117	184	250
<b>ED Visits</b>	25 fewer ED visits or 50% of enrolled at least 1 fewer visit annually	58 fewer ED visits or 50% of enrolled at least 1 fewer visit annually	92 fewer ED visits or 50% of enrolled - at least 1 fewer visit annually)	125 fewer ED visits or 50% of enrolled - at least 1 fewer visit annually)
<b>Inpatient Utilization</b>	100 fewer hospital days or 50% of enrolled show reduced inpatient days	200 fewer hospital days or 50% of enrolled show reduced inpatient days	300 fewer hospital days or 50% of enrolled show reduced inpatient days	400 fewer hospital days or 50% of enrolled show reduced inpatient days
<b>F/U service received after MH Inpatient</b>	10 individuals or 40% eligible	20 individuals or 45% eligible	30 individuals or 50% eligible	40 individuals or 50% eligible

<sup>5</sup> See Table 1 in Appendix 2

<sup>6</sup> All outcome measures progress cumulatively year to year; each successive year includes goal/units from prior year in totals. In some cases, progression is linear, in others, modulated by expectations of improved program efficacy/experience. With continuously adding new participants, it is important to note that the denominator for measures will change over time.

<sup>7</sup> The terms "participants," "clients," "individuals" all refer to Medi-Cal enrolled program participants and are considered synonymous.

<b>4.1a Universal Metrics<sup>6, 7</sup></b>	<b>PY2</b>	<b>PY3</b>	<b>PY4</b>	<b>PY5</b>
<b>(for those with such event)</b>				
<b>SUD Initiation and Engagement (for those identified with such needs)</b>	5 participants or 10% eligible	15 participants or 20% eligible	25 participants or 20% eligible	35 participants or 20% eligible
<b>Comprehensive Care Plan within 30 days of individual enrollment</b>	40 participants or 80%	92 participants or 80%	148 participants or 80%	200 participants or 80%
<b>Care Coordination Infrastructure</b>	STC MM 'V1.1.b' completed by June 30, 2017; Semi Annual PDSA begun in this area 'V1.1.c' methodology designed by 9/1/17.	Semi-Annual P&P PDSA Designed and Completed by PY midpoint and endpoint	Semi-Annual P&P PDSA Designed and Completed by PY midpoint and endpoint	Semi-Annual P&P PDSA Designed and Completed by PY midpoint and endpoint
<b>Data and Information Sharing Infrastructure</b>	Initiate use of HIE and Collaborative Care Platform 1/1/17. Open for 100% enrolled.	Maintain and improve HIE/ Collaborative Care Platform, train new Care Team members as needed and appropriate. Open for 100% enrolled.	Maintain and improve HIE, Collaborative Care Platform train new Care Team members as needed and appropriate. Open for 100% enrolled.	Maintain and improve HIE, Collaborative Care Platform train new Care Team members as needed and appropriate. Open for 100% enrolled.

<b>4.1b Variant Metrics</b>	<b>PY2</b>	<b>PY3</b>	<b>PY4</b>	<b>PY5</b>
<b>Enrollment Goals</b>	<b>50</b>	<b>117</b>	<b>184</b>	<b>250</b>
	All metrics do not apply to all participants, as they vary by client need. For these, the % refers to a denominator that is variable and dependent upon the sub-population at enrollment or as needs are identified.			
<b>1. Care Team Meetings assembled</b>	Meeting held for 75% of enrollees	Meeting held for 80% of enrollees	Meeting held for 85% of enrollees	Meeting held for 90% of enrollees
<b>2. Decrease all cause 30-day hospital readmissions</b>	Reduction 5%	Reduction 10%	Reduction 15%	Reduction 20%
<b>3. NQF 0710: Reduction in Depression Score at 12 months – PHQ-9 score of less than 5</b>	Establish baseline % of clients with PHQ score of 9 or more. (None yet enrolled 12 months)	Increase annually by 5% the % which have a score of less than 5 and previously had a score of 9.	Increase annually by 10% the % which have a score of less than 5 and previously had a score of 9.	Increase annually by 15% the % which have a score of less than 5 and previously had a score of 9.
<b>4. Adult Major Depression Disorder (MDD): Suicide Risk Assessment</b>	85% of clients with MDD diagnosis are screened.	90% of clients with MDD diagnosis are screened.	95% of clients with MDD diagnosis are screened.	100% of clients with MDD diagnosis are screened.

(NQF0104) completion for SMI clients.				
5. Supportive Housing (for those referred who need it)	20% of homeless referred	25% of homeless referred	30% of homeless referred	35% of homeless referred
SUD Treatment Enrollment (for those with needs)	5 participants enroll in SUD services (or 10% eligible)	15 participants enroll in SUD services (or 20% eligible)	25 participants enroll in SUD services (or 20% eligible)	35 participants enroll in SUD services (or 20% eligible)
Medication and/or Visit Adherence – after participation exceeds 60 days	Medication and/or Visit Compliance maintained by 25 individuals or 50%	Medication and/or Visit Compliance maintained by 59 individuals or 50%	Medication and/or Visit Compliance maintained by 92 individuals or 50%	Medication and/or Visit Compliance maintained by 125 individuals or 50%
PCP enrollment and engagement	25 individuals enroll and have an annual visit with PCP (or 50%)	70 individuals enroll and have an annual visit with PCP (or 60%)	120 individuals enroll and have an annual visit with PCP (or 65%)	175 of individuals enroll and have an annual visit with PCP (or 70%)

#### 4.2 Data Analysis, Reporting and Quality Improvement

##### Plan for Analysis of Interventions/Strategies, Health Outcomes, and ROI

This project features strong emphasis on data collection, live access, and recurrent implementation of the Plan-Do-Study-Act Model for Improvement (PDSA) in order to maintain a nimble and responsive coordinated system of care. At the participant level, the PDSA process will revolve around real-time communication and treatment plan modifications as new challenges surface. Enrollees will have a Monthly Report of Treatment Progress (RTP), which will summarize utilization for each enrollee on all dimensions of care identified in the WPHI. In addition to informal micro-adjustments that might occur daily, the Care Team will review this Report monthly to anchor clinical discussion with quantitative data and adjust case strategies to include changed intervention and activities.

All process and outcome measures will be collected by the indicated means on an ongoing basis to ensure identification of challenges early on, and to allow for prompt evaluation, care or process modification, and measurement of the effect of modification. The quality assurance cycle will be shortened or lengthened depending on the nature of the variable being measured. For example, SUD compliance would be a variable that is measured weekly, with an eye to early intervention in the case of relapse or treatment compromise. A variable that is measured on a less frequent basis might be sustained improvement of depressive symptoms.

Monitoring of this complex clinical process and outcome data will occur through three levels: the WPC Team, weekly treatment reviews led by the CCC; the Project Manager who will evaluate all open cases for quality measures on an individual basis and in turn, roll up data for the review of the Quality Review Team and submission to the Steering Committee for review and submission to DHCS as



pilot project outcomes. Each of these levels of review will ensure that individuals, teams and systems are being examined regularly and adjusted as needed.

Monitoring of program process measures will be conducted continuously by the Program Manager and summarized to all team members on a monthly and ad hoc basis. Feedback will be invited from the team, participant informants, and Steering Committee members to ensure that participant focus, data infrastructures and other key dimensions of the project are working as expected, and to ensure a dynamic quality improvement feedback loop exists at the process level<sup>8</sup>.

A number of approaches have evolved that focus on better healthcare outcomes through increased integration to ensure whole-person care; these approaches typically include the following elements<sup>9</sup>:

1. Comprehensive services across the care continuum: TCP+ achieves this through physical and virtual care team coordination on a weekly basis across behavioral and health domains.
2. Participant focus: TCP+ offers both a peer-oriented outreach and engagement support framework while ensuring that the medical home is culturally competent, flexible, established and maintained.
4. Geographic coverage and rostering: Participant access is assured by an empowering field-based approach (“*meet them where they are*”), and location of clinic sites in each of the three major cities of Solano.
5. Standardized care delivery through inter-professional teams: Care teams composed of doctors, mid-levels, MH, SUD and other members assure that the complex needs of this high risk population are considered in their totality.
6. Performance management: Continuous quality improvement managed at the level of individual outcomes, team outcomes, and program outcomes.
7. Information systems: Dedicated shared database and HIE with access by collaborating care team members.
8. Organizational culture and leadership: Building on the expressed support of local hospitals, H&SS, Physical and Behavioral Health Services for integrated, flexible services, this pilot brings these to a new level of conscious commitment and leadership by example: each partner will be held to high standards of follow-through, resource commitment, and prioritized access.
9. Physician integration: Accomplished through integrated physical/behavioral healthcare at the medical home, and more indirectly through the broadening of each care team to include outside collaborating physicians, wherever possible.
10. Governance structure: Interagency cooperation is maximized through the Steering Committee, whose appointees shall represent decision making authority for each principal, and the accountability of both the Project Manager and Quality Review Team to this Steering Committee.

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<sup>8</sup> See Appendix 3

<sup>9</sup> See Appendix 4 - According to a meta-research article by *Ten Key Principles for Successful Health Systems Integration—Authors: E.Suter, et al* citation)

11. Financial management: In addition to the pay for performance model, enhanced care coordination will be used to stabilize participants, and a focus on prioritized stabilization of conditions undermining health and well-being will ensure this is a sustainable and expandable model.

#### **How data analysis will guide change management**

The pilot will include a multi-disciplinary continuous quality improvement committee (Quality Review Team). This committee will be comprised of compliance, clinical/service, fiscal and administrative personnel to assess the quality improvement aspects from various perspectives. While fiscal savings are important as an outcome, the larger frameworks of meeting the Triple Aim, as well as making strides toward improving on the social determinants of health, are of key importance. The Quality Review Team will meet monthly and participate in specific review components, as well as project PDSA activities to improve results associated with identified trends in population demographics, clinical outcomes, fiscal activities and administrative process outcomes. The Team will report findings to the Steering Committee as components of total pilot oversight and accountability.

All quality improvement activities will be based on the established framework of the Model for Improvement (MFI)<sup>10</sup>, articulated through the Agency for Healthcare Research and Quality<sup>11</sup>. This model embodies the philosophy that errors are seen as opportunities for learning and process improvement. Steering and Quality Committee members are certified as Certified Professionals in Healthcare Quality (CPHQ), while the Public Health and Mental Health Service leadership have experience in short, medium and long term PDSA quality improvement cycles at all levels. Solano Coalition staff leadership have successfully employed PDSA principles in the current TCP program. SCH&SS currently has staff who are experienced with the California Council for Excellence and Malcolm Baldrige criteria for performance excellence, and these principles will provide a framework for ensuring total quality is in fact managed to success<sup>12</sup>. Deming, whose work the MFI is heavily reliant upon, identifies 14 areas that must be monitored for total quality management. As noted by AHRQ, these 14 points are inherent in all QI methodologies and have become part of health care planning and service delivery<sup>13</sup>.

During the initial stages of the project, it is expected that rapid-cycle PDSAs will be key in the identification of successful and less successful strategies and structures in all levels of the pilot. This will occur whether strategies are administrative, inter-organizational, informational, or clinical, and will quickly inform the team of any needed modification to maximize benefits for participants.

#### **4.3 Participant Entity Monitoring**

As the lead agency, SCH&SS will monitor through a Program Performance Liaison who will receive direction from the Steering Committee and as outlined by the performance goals in this proposal. The

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<sup>10</sup> See Appendix 5

<sup>11</sup> *Improvement Guide: A Practical Approach to Enhancing Organizational Performance* (1996).

<sup>12</sup> See Appendix 6

<sup>13</sup> See Appendix 7

Liaison will provide and summarize program performance data to the Steering Committee and SCH&SS for the purposes of determining ongoing efficacy, identifying potential areas for improvement, arranging technical assistance in the implementation of improvement strategies. If minimal improvement occurs, SCH&SS would be responsible for imposing corrective action plans and/or sanctions if necessary. As the holder of 70 contracts ranging from early childhood services to services for the disabled, SCH&SS has a wealth of experience partnering with and monitoring contractor organizations and programs to ensure their success and responsible use of fiscal resources.

In the case of TCP+, data will inform the Steering Committee about all dimensions and be gathered by the Program Quality Analyst, with the cooperation of the project staff, and available shared data systems. Process measures, universal and variant outcomes and overall program functioning will be quantified and shared to the greatest degree possible. The Liaison will also keep the Steering Committee informed of the progress of these improvements and ensure that the Quality Review Team's observations are being used to refine program quality. The Program Performance Liaison will serve as a continuous monitor of total performance, and report back monthly to the Steering Committee on the following areas, among others:

- Are all project elements and infrastructure in place, on time, delivering expected results?
- Are the universal and variant metrics properly calibrated and achieved?
- Are obstacles noted at the team, program and community resource level being addressed?
- Model adherence: is there fidelity to the design among the staff?
- Are there substantive infrastructure barriers that need to be remedied?
- If barriers cannot be remedied, are appropriate workarounds and workflow modifications occurring?

If SCBH is unable to perform on any key metrics, a Corrective Action Plan shall be drawn up identifying the areas for improvement, with a schedule of areas to improve in, quantified with enough specificity such that the Program Performance Liaison, the Quality Review Team, and Steering Committee, can collaboratively determine whether a deficiency has been remedied. An initial schedule for remediation shall consist of three months. If at the end of the three months, no progress is made, another three-month period will be granted at the end of which the program will face possible termination and the pilot relocated within another contractor, with consultation from DHCS, and at the recommendation of the Steering Committee. The Steering Committee shall employ Robert's rules and also provide for program testimony/appeal before making any final decision about program termination. All provisions of contracting that normally occur between SCH&SS and its contractors shall be observed in the case of termination including notice, etc.

Technical assistance, in any given area, will be freely given by any of the participating partners depending on the subject, whether clinical, programmatic, technical, legal, etc. By signing letters of participation/support, stakeholders understand they may be called upon to offer in-kind resources to ensure the success of this innovative project.

## **5.1 Financing Structure**

A Steering Committee will meet monthly during PY2 and PY3 and then semi-monthly for PY4 and PY5. The steering committee will review pilot outcomes and metrics, which will be prepared by the Project Manager, Program Data Analyst and clerical support staff. In addition to the required program reports and measures, the Project Manager and Analyst will be responsible to track all expenses and monies received through the pilot and will ensure that the expenses are not double billed. During PY2 and PY3, the program will focus on data collection and relevant reporting tools to accurately track the program deliverables and metrics. These staff will prepare financial reports for review by the Steering Committee to ensure that intake and payment of funds, timelines for payment and payment process are in conformity with standard accounting principles.

Solano County will contract with SCBH to provide services to the target population. Because this pilot is driven by deliverables and outcomes, the PMPM bundled payment structure will best suit the pilot by allowing the Complex Care Coordinator and Community Health Outreach Worker to individualize and create a care plan in a performance driven, outcome oriented fashion, instead of a fee-for-service systems. The flexibility of the PMPM payment will enable the staff to serve the participant first without limitation as to the number and types of services and/interventions provided. It allows the staff to focus on the end result or outcome rather than specific encounters or services, which may or may not have direct correlation with the desired participant outcomes. Through regular program tracking and reports, the staff providing the services will be able adjust their efforts accordingly. The PMPM structure will be built based upon the staff required to carry out the various deliverables. More detail regarding the budgeting methodology behind the PMPM payment will be discussed in section 5.5.

As the program will be subcontracted, Solano County will pay the vendor in accordance with County established policy and procedures. The County will receive funding after the successful submission of the Mid-year and Annual reports. The mechanism for funding the vendor will be negotiated after the application is approved.

## **5.2 Funding Diagram**

See attached. Payments will be made from SCH&SS to Solano Coalition for Better Health for service delivery under this project.

### **5.3 Non-Federal Share**

Solano County, as the lead entity, will provide the non-federal share to be used for payments under the WPC Pilot.

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

SCH&SS is requesting funding for staff to provide services that are not otherwise reimbursable through Medi-Cal or other available funding sources. The positions in the pilot are two Complex Care Coordinators, and four Community Outreach Health Workers (CHOW). The staff will provide outreach and coordination of care services, which are currently not reimbursable by any source. These coordinated efforts will lead to participant engagement in services that are reimbursable by Medi-Cal; however, the pilot will not be seeking reimbursement of those services through this program. The pilot's target population will be Medi-Cal beneficiaries. Non-insured individuals identified in the target population will be enrolled in Medi-Cal as a required criterion for enrollment in this project. Monthly eligibility checks will be performed by project administrative support staff to ensure continued Medi-Cal enrollment, and in those circumstances in which a participant's Medi-Cal lapses, will immediately work to re-enroll them.

As can be seen, the activities and interactions of the care coordination teams will not duplicate Medi-Cal's targeted case management (TCM) benefit. Specifically, the roles of the CHOW and the CCC depart from the encounter based structure of TCM, because of the mentor and advocacy nature of the activities, the qualifications of the CHOWs, the lack of face to face contact and medical communication promotion (CCC). The services provided under the PMPM Bundle are services that are not ordinarily offered through Medi-Cal TCM: peer support, meeting facilitation between medical personnel and other professionals, live communication with a virtual care team, disease management education, field engagement using highly assertive strategies, and so forth. For these reasons, we have concluded that the proposed services funded through the PMPM Bundle would not be duplicative of TCM.

The Program Manager and Analyst will be responsible for ensuring that services are validated and ensuring claims are correctly submitted. SCH&SS will ensure through existing compliance procedures that there is no duplication of billing for any services or submission of any prohibited expenses. Per guidance offered by a DHCS email on 8/26/16, fiscal monitoring includes attention to preventing possible "double-dipping" for payment of services already funded by other public dollars.

### **5.5 Funding Request**

The total amount requested for the WPC Pilot Program is \$4,667,010 (\$933,402 annually.)

For PY 1, the requested budget is for the submission of the application and the baseline data.

In order to properly staff and provide needed support, SCH&SS is requesting funding for the following staffing and program support costs. These staff will be employed by the subcontractor, Solano Coalition for Better Health for PY2-5 below:

Executive Director (0.25 FTE)

This position is responsible for overall administrative, inter-organizational, planning, evaluation, reporting and quality improvement activities and provides direction to all staff. Serves as Interagency liaison, provides monthly reports to the Steering Committee, intervenes with organizational partners when needed to improve collaboration; responsible for oversight and management of project goals, financial management, evaluations; housing contracts, acquisition and readying; ensures necessary reports/documentation are submitted to PHC. This position relates to all program objectives.

Project Manager (1.0 FTE)

This position, working under the direction of the Executive Director, oversees the implementation of the WPC Pilot; it is responsible for hiring, managing, and coordinating the work of staff who together will achieve the program goals of the WPC Pilot and ensure that the stated outcomes are met. It is focused on the delivery of the services in conformity with the Pilot design and maintaining fidelity to that design. It is distinguished from the Executive Director's role by its specificity, day-to-day operational nature and the concrete care outcomes that the teams are tasked with promoting with participants.

Data Analyst (1.0 FTE)

Gathering data from responsible parties, translating numbers and data collected into reports that can be used by the team to monitor deliverables and make program adjustments, if warranted. Organize and capture data from diverse systems and ensure Pilot's quality cycles are ongoing, productive and yield program improvements; assemble and provide evaluation data on a planned and ad hoc basis. Work with each data source to design or learn efficient data capture systems.

Administrative Assistant (1.0 FTE)

Administrative assistant duties, including coordination assistance and implementation of goals.

Complex Care Coordinator - CCC (2.0 FTE)

Contact with emergency departments, hospitals, other care facilities, jail medical staff, pharmacies, emergency transport, laboratories, behavioral health, etc. They will be the holder of up-to-date information affecting the client's welfare and will take primarily responsibility for ensuring all partners and care team members are aware of significant developments. They will reconcile different disciplinary perspectives and work with the CHOW and other team

members to craft and follow a meaningful Whole Person Care Plan, with daily or weekly adjustments as the client's progress dictates.

#### Community Health Outreach Worker - CHOW (4.0 FTE)

Reach out to, engage, and work with the client on a frequent basis to maximize investment in wellness and assure s/he has the support needed to manage their medical, mental health, behavior health and substance abuse treatment needs. Point of engagement will be emergency departments, inpatient hospital units (medical), clinics, SUD/MH programs, home and field locations, though clients will be identified by their utilization patterns. Arrange multi-modal assessment at the Medical Health Home within the FQHC environment (Family Health Services). As the client's investment grows or decreases, or indications of success or failure, the CHOW will intervene to improve participant retention, resolve challenges and provide practical solutions, while relaying critical information back to the Complex Care Coordinator and the WPC Team.

#### Housing Resource Specialist (0.725 FTE)

Housing advocacy and support services will be provided through this position, and if needed, work with providers to stabilize the participant when they do not have access to a county provided housing placement.

#### Computers

Six laptops for staff participating in WPC grant

#### Desk Phones

The amount of \$1000 was requested for desk phones to support the 6.0 FTE staff for communication in the office.

#### Office Furniture

The amount of \$4000 was requested for ergonomic desk, cubicles, chairs, and items related to office use for the 6.0 FTE staff.

#### Training

Meetings and/or trainings surrounding CHOW and Complex Care Coordination process and procedures.

#### Meetings

SCBH will hold 24 convening meetings to discuss objectives, metrics, goals, program needs etc. SCBH will provide food and refreshments at this meeting. We anticipate a budget of approximately \$80 per meeting.

#### Office Supplies

General office supplies will be used to support 6.0 FTE staff to carry out daily activities of the program. Education fliers, and program related office materials.

#### Cell Telephone/Communication

The amount of \$3300 was requested for communication expense for the 6.0 FTEs in this project. The cell phones allow for constant communication with clients, and management staff and internet access (Wi-Fi).

#### Travel

Staff and/or CHOW may be required to travel as much as 15,600 miles annually or 60 miles per day for outreach trips and site visits to build relationships with clients and partners in the community, transport clients when appropriate, attend trainings, etc.

#### Rent

Rent is allocated at SCBH to programs based on square footage used. The annual rent expense for SCBH is \$54,720 in which 50% or \$27,360 of this amount will be allocated to the WPC project.

#### Enhanced Care Coordination

Funds used for necessary supports for Enhanced Care Coordination.

#### Indirect Cost

We calculated the indirect costs for the program using a 5% rate.

### **Administrative Infrastructure**

#### Program Year 2

The Executive Director, Project Manager, Data Analyst and Administrative Assistant will focus on data collection methodology, data collection itself, analysis and the crafting of policies and procedures as required in the specified universal metrics, and those activities additionally associated with set-up and tracking of the proposed variant metrics (See above detail, Section 4.1 a and 4.1 b). Activities will include coordinating staff development, IT set-up and integration into clinical delivery system, design of clinical, communicative systems and implied processes, MOUs, inter-organizational relationship building, overall management of the project in order to meet the deliverables specified, Medi-Cal eligibility status tracking, personnel development, and miscellaneous other activities typically associated with a new program. Also included in this



budget category are one-time costs, such as computer purchases, desk phones and office furniture associated with getting the pilot started.

#### Program Years 3 – 5

The administrative staff will continue to provide accurate, timely and relevant reports to the Steering Committee. Based on the analyses of the data reviewed at the meetings, adjustments will be made to the program accordingly. Attendance and contributions by the staff in the Learning Collaborative meetings will be required.

### **Delivery Infrastructure**

#### Program Year 2

Because a significant amount of time will be dedicated to getting the pilot up and running, we have included a category for funding under Delivery Infrastructure in PY2 only. Approximately 75% of staffing costs for the CCCs and CHOWs and a portion of the operating costs, such as rent, travel, training, supplies, cell phones, meetings for the program are included. SCH&SS is requesting reimbursement for these costs for the first 6 months at a monthly unit cost of \$75,270. The staff and ongoing operating costs will become part of the PMPM rate calculation. It will take some time to get the enrollment up to the program capacity of 100 clients. By the end of PY2, we expect to have approximated 50 members, for a total of 220 member months.

During the ramp up time, the CCCs and CHOWs will focus a significant amount of time building their own infrastructure, creating clinical and data capture/evaluation systems, inter-organizational agreements, relationships, training, learning all of the county systems, shadowing and training at the County FQ's (Health Homes), at the ED's, and many other things in relation to their specific roles. For example, the CHOW will specifically have to become extremely familiar with homeless encampments, hang out at each ED to get a feeling for the population, work to connect with and locate the individuals we have identified through their abstract expenditure profiles, locate them, and in the second six months or thereabouts, begin the very challenging task of outreach and engagement.

The CCC's will be challenged with building relationships with a core group of medical and behavioral colleagues, learning their systems, learning the HIE/Platform, and familiarizing themselves with the complexity of the clients through case studies, leading up to actual formation of initial teams, staging of phone conferences, recording in the HIE/Platform the results of these virtual rounds, etc.

#### Program Years 3 -5

There is no Delivery Infrastructure budget. The costs which were included in PY2 for the development of the pilot are now included in the PMPM calculation for PY3, PY4, and PY5. The breakdown of costs included are discussed below under PMPM Bundle Rationale and Detail. The pilot expects to service approximately 100 members/month for a total of 1200 member months yearly.

**Incentive Payments**

No incentive payments

**FFS Services**

No fee for service payments

**PMPM Bundle Rationale and Detail**

The pilot is expected to serve approximately 50 participants by the end of Program Year 2 because a significant amount of time will be spent planning, coordinating and training in this year. For Program Years 3-5, the pilot will serve a maximum of 100 participants at one time, but 250 total by the end of the project.

Initial services for our target population will consist of outreach and engagement by the CHOW. As the pilot grows and matures, time will be split between outreach efforts and engagement efforts, meeting the basic social service needs of the participants, and working as the “extended arm” of the Complex Care Coordinator. The CHOW will be primarily responsible for direct work with the participant to ensure their attendance initially and subsequently in treatment, to facilitate linkage and services through the participating partners.

The Complex Care Coordinator will focus their efforts on overall care coordination for the participant, which will include ensuring a multi-modal assessment is completed, a Whole Person Comprehensive Plan is in place, and that ongoing linkage occurs between professionals delivering all dimensions of care (e.g. Mental Health, SUD or medical services.), as described earlier.

The Complex Care Coordinators will be responsible to make sure participants continue to progress toward their treatment plan objectives, and ensure treatment approaches are changed to fit the evolving circumstances of the participants. This will be accomplished through weekly shared case conferences and if needed, with the help of the CHOW to encourage and support the individuals in complying with the care plan set out for them.

**Eligibility Criteria for PMPM Bundle of Services:**

Eligibility for the above services is going to be based on ranking of the top 300 or more individuals on the basis of medical expenditures, additionally conditioned upon presence of homelessness, a substance abuse condition, and/or a co-occurring mental health condition. Individuals will be selected from the highest ranking expenditure level to the next highest, and so on. If individuals are not locatable or are not able to be engaged in services after a period of no less than 3 months of outreach, they will be placed on an alternate list, and the next individual on the list will be given outreach, engaged and complex care management, in addition to non-bundled services noted.

### Expected Duration of Services

The target population has only been partially characterized in terms of care access patterns; however, based on prior experience with somewhat less severely impaired individuals, it is expected that bundled services, including initial and episodic outreach and (re)/engagement services, and complex care management, would be offered a minimum of 12 months with duration of active participation averaging out for the annual expected caseload before full stabilization would likely be achieved. Of course, as the program pilot progresses, continuous evaluation of client progress will be made and may result in program adjustments that require shorter or longer periods of active enrollment. When totaled up as member months this would amount to 1200 member months.

### Program Graduation, Termination, and Pending status

Individuals could be dis-enrolled or placed on pending status based on successful graduation from the program:

1. Successful graduation will be defined for each individual somewhat differently based on their overall holistic care plan, but would at a minimum be based on enrollment in and compliance with medical care; increased and demonstrated ability to engage in appropriate self-care and to continue to comply with chronic disease management tasks and responsibilities, such as attending medical appointments, picking up medications in the pharmacy, reduction in harmful behaviors that result in recurrent hospitalization, and so on.
2. Suspension of enrollment can occur under several circumstances: an individual has moved or appears to have transiently relocated, but is expected to return based on past behavior during the life of the project; an individual has been incarcerated, but is expected to be released within 90 days; an individual becomes medically impaired and requires placement in a SNF; an individual deteriorates mentally, and requires placement in an augmented Board and Care not within County boundaries, or an Institute for Mental Disease, or other structured setting that would prohibit the delivery of the bundled services due to distance, access or other issues; non-compliance, disinclination to engage after a period of enrollment and participation. Such individuals will be placed on an alternate list and could be reenrolled as space in the program becomes available.
3. Involuntary termination can occur due to any number of circumstances, but only as a last resort: serious violence or threats of violence toward a staff member; complete disregard for program rules; refractory substance use; refusal to take psychiatric medications when the consequence is psychosis or mania, making any meaningful participation impossible.

Permissible Coincident PMPM Bundle Services and non PMPM Services: CCC, tenancy advocacy, outreach/engagement, Medical Care.

As already described elsewhere, it is part of the programmatic intent of this pilot to address multiple dimensions of the individual's needs. These include housing, tenancy

advocacy/supportive services intended to stabilize an individual in an existing living situation to avoid homelessness or needless ejection; intensive street-based substance abuse outreach, mentorship, and 'assertive' outreach (finding individuals at high traffic drug and alcohol hot spots, for example, or at remote or informal encampments, etc.); harm reduction work that is client centered, uses motivational techniques.

Additionally, each client is going to receive, as a cornerstone of their care, assignment to a medical home (one of three or four area Federally Qualified Health Centers, a primary care physician, a medical/psychiatric social worker at the FQHC, specialty dentistry or other medical services available through the FQHC or through the medical network of providers pursuant to their comprehensive care plan.)

PMPM bundled services proposed do not preclude nor are duplicative of these other services in any way. Complex Care Coordination as intended is not a reimbursable service under Medi-Cal, neither is tenancy advocacy and congregate household management, nor is street outreach and engagement by the CHOWs for the purpose of facilitating program engagement, enrollment, appointment attendance or medication adherence.

PMPM Bundle: Team to client ratio assumptions:

It is assumed that at full operation beginning PY3:

- each CHOW will be responsible for outreaching, engaging and retaining 25 clients
- each Complex Care Coordinator will be responsible for coordinating the care of 50 clients overall

Because of the very high acuity and multiple comorbidities of this target population, it is expected that a great deal of time and energy will be required to initially engage individuals in the program, to enroll them in their medical homes, to identify and mitigate any impediments to their full participation, and to reengage them after they have eloped, lapsed, or returned from a period of suspended enrollment (for example, reentry after jail). The level of attention given to each individual will be high by the CHOW, and a trusting relationship of demonstrated benefit to the client will be built over multiple encounters and through warm handshakes and warm hand-offs, with the CHOW being a figure of advocacy, faith in the individual, and constant encouragement.

By PY3 the pilot will feature a caseload of 100 clients who are actively participating in their care coordination and whose case is being watched over and reviewed weekly by the CCC and the client's virtual care team, which may include specialists, other disciplines beyond those in the medical home, and so on. The majority of the work for each CCC is likely to occur in the first 3-6 months, when the virtual care teams are being assembled, basic documentation is being entered into the charts for universal reference, whole person care plans are being composed and modified, and relationships are being built among the physical and virtual care team members.

This front loading of work for the CCC will therefore average out as the pilot progresses with some cases being relatively stable, and others either because at the beginning of enrollment or due to an episodic setback, not as stable and requiring more coordination.

Justification of PMPM Bundle in Relation to Treatment Needs of the Target Population:

98% of the individuals that will be selected for this project from the list of highest medical utilizers, or as they are now being called 'super utilizers' have comorbid behavioral conditions in addition to multiple comorbid medical conditions. Due to the complexity of their disease profiles, their motivational profile, their resource profile, and their addiction and serious mental illnesses, 'care-as-usual' is not likely to be an effective approach. Experience with traditional, siloed care, even when multi-disciplinary, is that several elements are lacking which the PMPM Bundled services will address: the need for a central figure with whom a person can have a constant nourishing relationship of trust as a go-to advocate and model for recovery; the need for a medically sophisticated care manager whose work is to ensure that all care team members are on the same page as each grapples with distinct health and behavioral health challenges, moving the client in the same direction, and communicating live, in a person-centered manner that ensures that care is efficient, effective and satisfying across different treatment domains.

As can be seen, the activities and interactions of the care coordination teams will not duplicate Medi-Cal's targeted case management (TCM) benefit. Specifically, the roles of the CHOW and the CCC depart from the encounter based structure of TCM, because of the mentor and advocacy nature of the activities, the qualifications of the CHOWs, the lack of face to face contact and medical communication promotion (CCC). The services provided under the PMPM Bundle are services that are not ordinarily offered through Medi-Cal TCM: peer support, meeting facilitation between medical personnel and other professionals, live communication with a virtual care team, disease management education, field engagement using highly assertive strategies, and so forth. For these reasons, we have concluded that the proposed services funded through the PMPM Bundle would not be duplicative of TCM.

Functioning at capacity, the TCP+ should adequately serve a population of 100 participants at a given time. Full staffing for the program will be 2.0 FTE Care Coordinators and 4.0 FTE Community Health Outreach Workers (CHOW) and the operating costs for them to run the program. The PMPM bundle structure will begin in the latter part of PY2 and continue for the duration of the pilot. For PY3 – PY5, the PMPM bundle assumes 1200 member months yearly.

## PMPM Methodology

TCP+ Program	Units	Annual Cost Per Unit	Total
<b>Personnel</b>			
Care Coordinator	2.0	101,171	202,342
Community Health Outreach Worker	4.0	66,560	266,240
<b>Operating</b>			
Rent			27,360
Travel			8,424
Training			2,500
Supplies			1,200
Cell Phones			3,300
			5,000
Meeting and Convening			2,000
Indirect Costs	5%	26,434	26,434
<b>Total Budget from PMPM</b>			<b>\$544,800</b>
<b>Member Months</b>	<b>100 members</b>	<b>1200 member/months</b>	<b>\$454 PMPM</b>

## Payment for Outcomes

**Housing Services** – Activities performed by Housing Resource Specialist. A big risk of our target population is that of homelessness or at risk of becoming homeless. A large part of the duties of this staff member will be to have housing options readily available. The time to fulfill the duties of this position is difficult to monitor on a monthly basis, therefore we will be measuring the outcomes on a quarterly basis. The amounts to be funded are based on the salary of a part time Housing Resource Specialist. Funds paid for these outcomes will be paid to SCBH.

PROGRAM YEAR	OUTCOME MEASURES OR DELIVERABLES FOR PAYMENT	FREQUENCY	AMOUNT
PY2	<p>Q1: Document of housing resources is created. Evidence of at least one property leased and ready for occupancy.</p> <p>Q2: Housing is provided or obtained for at least 1 individual.</p> <p>Q3: Housing is provided or obtained for at least 5 individuals (including prior quarter).</p> <p>Q4: Housing is provided for at least 10 individuals (Cumulative unduplicated count, including prior quarters, not necessarily all in housing at the same time as some are transitioning out and other beginning placement.) Outcomes are met if fewer than 10 need housing.</p>	Quarterly	<p>\$9,425 / qtr</p> <p>Annual budget: \$37,700 (\$9,425 X 4)</p>
PY3/PY4/PY5	<p>Housing is provided or obtained for least 10 individuals per quarter (unduplicated count, not necessarily all in housing at the same time as some are transitioning out and other beginning placement).</p> <p>Outside housing assistance is provided to all clients demonstrating housing instability based on multi-modal assessment and Care Plan.</p>	Quarterly	<p>\$9,425 / qtr</p> <p>Annual budget: \$37,700 (\$9,425 X 4)</p>

**Comprehensive Care Plans** – Activities performed by Complex Care Coordinator (CCC) and the Community Health Care Worker. The incentive payment for achievement of this outcome was calculated based on 50% of the savings of the approximate cost of an inpatient hospital day. One of the goals of this pilot is to reduce the number of inpatient hospital days. With outreach efforts, enrollment, engagement and interventions based on their Comprehensive Care Plan, there should be decrease in the inpatient admissions. In PY2, the enrollment goal is 50 participants. In PY3, PY4, and PY5, the pilot is expected to have served a cumulative number of clients of 117, 184, and 250 respectively. Payments for this outcome will be paid to the lead agency, Solano County H&SS.

PROGRAM YEAR	OUTCOME MEASURES OR DELIVERABLES FOR PAYMENT	FREQUENCY	AMOUNT
PY2	Clients will have a Comprehensive Care Plan within 30 days of enrollment.  PY2 Goal: 40 participants or 80% enrolled.	Monthly	\$500 / new client  Annual: \$25,000  Maximum payout for 50 clients
PY3	Clients will have a Comprehensive Care Plan within 30 days of enrollment.  PY3 Goal: 92 cumulative participants or 80% enrolled.	Monthly	\$500 / new client  Annual: \$35,000  Maximum payout for 70 clients
PY4	Clients will have a Comprehensive Care Plan within 30 days of enrollment.  PY4 Goal: 148 cumulative participants or 80% enrolled.	Monthly	\$500 / new client  Annual: \$35,000  Maximum payout for 70 clients
PY5	Clients will have a Comprehensive Care Plan within 30 days of enrollment.  PY5 Goal: 200 cumulative participants or 80% enrolled.	Monthly	\$500 / new client  Annual: \$35,000  Maximum payout for 70 clients



**SUD Treatment Participation** – If the client has been identified as a candidate for SUD treatment, the CHOW will assist in connecting the client to the appropriate service and follow up to ensure the client participates in the treatment. By helping these clients access available treatments, the client will avoid unnecessary trips to the ED or possible inpatient admission. The rate of payment is \$500 per client and based on a portion of the savings from the ED visit. In PY2, the pilot expects to serve five SUD identified participants. In PY3, PY4, and PY5, the pilot is expected to have served a cumulative number of unduplicated SUD clients of 15, 25, and 35 respectively. Payments for this outcome will be paid to the lead agency, Solano County H&SS.

PROGRAM YEAR	OUTCOME MEASURES OR DELIVERABLES FOR PAYMENT	FREQUENCY	AMOUNT
PY2	Clients enrolled and participate in SUD treatment. Clients are unduplicated.  PY2 Goal: 5 participants or 10% eligible.	Monthly	\$500 / client  Annual budget: \$2,500
PY3	Clients enrolled and participate in SUD treatment. Clients are unduplicated.  PY3 Goal: 15 cumulative participants or 20% eligible.	Monthly	\$500 / client  Annual budget: \$5,000  Maximum payout for 10 clients
PY4	Clients enrolled and participate in SUD treatment. Clients are unduplicated.  PY4 Goal: 25 cumulative participants or 20% eligible.	Monthly	\$500 / client  Annual budget: \$5,000  Maximum payout for 10 clients
PY5	Clients enrolled and participate in SUD treatment. Clients are unduplicated.  PY5 Goal: 35 cumulative participants or 20% eligible.	Monthly	\$500 / client  Annual budget: \$5,000  Maximum payout for 10 clients