AGREEMENT FOR

COUNTY MEDICAL SERVICES PROGRAM GOVERNING BOARD

COUNTY WELLNESS & PREVENTION PILOT PROJECT

between

COUNTY MEDICAL SERVICES PROGRAM GOVERNING BOARD ("Board")

and

SHASTA COUNTY HEALTH AND HUMAN SERVICES AGENCY ("Grantee")

Effective as of:
January 1, 2017

AGREEMENT

COUNTY MEDICAL SERVICES PROGRAM
COUNTY WELLNESS & PREVENTION PILOT PROJECT

FUNDING GRANT

This agreement ("Agreement") is by and between the County Medical Services Program Governing Board ("Board") and the lead agency listed on Exhibit A ("Grantee").

A. The Board approved the funding of the County Wellness & Prevention Pilot Project (the "Pilot Project") in participating County Medical Services Program ("CMSP") counties in accordance with the terms of its Request for Proposals for the County Wellness & Prevention Pilot Project in the form attached as Exhibit B ("RFP").

B. Grantee submitted an Application ("Application") for the County Wellness & Prevention Pilot Project in the form attached as Exhibit C (the "Project"). The Project is a grant project ("Grant Project").

C. Subject to the availability of Board funds, the Board desires to award funds to the Grantee for performance of the Project.

The Board and Grantee agree as follows:

1. Project. Grantee shall perform the Project in accordance with the terms of the RFP and the Application. Should there be a conflict between the RFP and the Application, the RFP shall control unless otherwise specified in this Agreement.

2. Grant Funds.

A. Payment. Subject to the availability of Board funds, the Board shall pay Grantee the amounts in the time periods specified in Exhibit A ("Grant Funds") within thirty (30) calendar days of the Board's receipt of an invoice from Grantee for a Grant Project, as described in Exhibit A. Neither the Board nor CMSP shall be responsible for funding additional Project costs, future County Wellness & Prevention Pilot Projects or services provided outside the scope of the Pilot Project.

B. Refund. If Grantee does not spend the entire Grant Funds for performance of the Project within the term of this Agreement, then Grantee shall immediately refund to the Board any unused Grant Funds.

C. Possible Reduction in Amount. The Board may, within its sole discretion, reduce any Grant Funds that have not yet been paid by the Board to Grantee if Grantee does not demonstrate compliance with the use of Grant Funds as set forth in Section 2.D, below. The Board's determination of a reduction, if any, of Grant Funds shall be final.

D. Use of Grant Funds. As a condition of receiving the Grant Funds, Grantee shall use the Grant Funds solely for the purpose of performance of the Project, and shall not use

the Grant Funds to fund Grantee's administrative and/or overhead costs; provided, however, an amount of the Grant Funds equal to or less than fifteen percent (15%) of the total Project expenditures may be used to fund Grantee's administrative and/overhead expenses directly attributed to the Project. Grantee shall provide Board with reasonable proof that Grantee has dedicated the Grant Funds to the Project. Grantee shall refund to the Board any Grant Funds not fully dedicated to the Project. Grantee shall budget for evaluation expenses (such as time spent performing data collection, analyzing data, or preparing reports) in an amount not to exceed ten percent (10%) of total Pilot Project expenditures.

E. Annual Expenditure Reports. The Grantee shall provide the Board with annual expenditure reports documenting the use of Grant Funds in a form as determined by the Board.

F. Matching Funds. The Grantee is not required to provide in kind and/or matching funds but are strongly encouraged to provide such in kind and/or added funds from other sources to maximize the potential scope and reach of the Project. In kind and/or matching funds may be provided solely by the Grantee or through a combination of funding sources.

3. Grantee Data Sheet. Grantee shall complete and execute the Grantee Data Sheet attached as Exhibit D ("Grantee Data Sheet"). Board may, within its sole discretion, demand repayment of any Grant Funds from Grantee should any of the information contained on the Grantee Data Sheet not be true, correct or complete.

4. Board's Ownership of Personal Property. If Grantee's Application anticipates the purchase of personal property such as computer equipment or computer software with Grant Funds, then this personal property shall be purchased in Grantee's name and shall be dedicated exclusively to the Grantee's health care or administrative purposes. If the personal property will no longer be used exclusively for the Grantee's health care or administrative purposes, then Grantee shall, immediately upon the change of use, pay to the Board the fair market value of the personal property at the time of the change of use. After this payment, Grantee may either keep or dispose of the personal property. Grantee shall list all personal property to be purchased with Grant Funds on Exhibit A. This paragraph 4 shall survive the termination or expiration of this Agreement.

5. Authorization. Grantee represents and warrants that this Agreement has been duly authorized by Grantee's governing board, and the person executing this Agreement is duly authorized by Grantee's governing board to execute this Agreement on Grantee's behalf.

6. Data and Project Evaluation. Grantee shall collect Project data and conduct a Project evaluation. Grantee shall report data and evaluation findings to the Board as part of the Progress and Final Reporting set forth in Section 7, below. The Grantee shall not submit any protected health information ("PHI") to the Board. The Board reserves the right to hire an external pilot project evaluator to conduct an evaluation of the Project ("Pilot Project Evaluator"). The Grantee may be required to participate in one or more interviews with Pilot Project Evaluator, have a minimum of one (1) representative participate in quarterly web-based technical assistance meetings, and participate in surveys with the Pilot Project Evaluator as determined by the Board. Grantee shall maintain and provide the Board with reasonable access

to such records for a period of at least four (4) years from the date of expiration of this Agreement. Grantee shall cooperate fully with the Board, its agents and contractors, including but not limited to the Pilot Project Evaluator, and provide information to any such contractor in a timely manner. The Board may, within its sole discretion, terminate this Agreement at any time and suspend and/or discontinue payment of any Grant Funds if Grantee does not satisfactorily meet data collection and reporting requirements as set forth herein and in the RFP.

7. Progress and Final Reporting. Grantee shall notify the Board of any proposed substantial changes to the Project's components. The Project's components shall include: (a) the Project plan; (b) the target population; (c) the structure and process for providing services/support; (d) the roles and responsibilities of all participating (partnering) agencies; (e) services provided; (f) key Grantee personnel;(g) the budget; and (h) timelines. The Grantee shall submit five (5) biannual progress reports to the Board, that: (a) highlights the Project's key accomplishments, to date; (b) identifies challenges and barriers encountered during the prior six (6) months; (c) describes what the Project has learned, to date, about the target population; and (d) provides an update on data collection and evaluation efforts. In addition, the Grantee shall submit a final report to the Board by March 31, 2020, that: (a) highlights the Project's key accomplishments; (b) identifies challenges and barriers encountered during the Project; (c) describes what the Project has learned about the target population; (d) reports the evaluation findings; and (e) thoroughly describes the Project's future activities following the Pilot Project. The Board may, within its sole discretion, terminate this Agreement at any time and suspend and/or discontinue payment of any Grant Funds if Grantee does not satisfactorily meet reporting requirements as set forth herein and in the RFP.

8. Term. The term of this Agreement shall be from January 1, 2017, to June 30, 2020, unless otherwise extended in writing by mutual consent of the parties.

9. Termination. This Agreement may be terminated: (a) by mutual consent of the parties; (b) by either party upon thirty (30) days prior written notice of its intent to terminate; or, (c) by the Board immediately for Grantee's material failure to comply with the terms of this Agreement, including but not limited to the terms specified in paragraphs 6, 7 and 8. Upon termination or expiration of the term, Grantee shall immediately refund any unused Grant Funds to the Board, and shall provide the Board with copies of any records generated by Grantee in performance of the Project and pursuant to the terms of this Agreement.

10. Costs. If any legal action or arbitration or other proceeding is brought to enforce the terms of this Agreement or because of an alleged dispute, breach or default in connection with any provision of this Agreement, the successful or prevailing party shall be entitled to recover reasonable attorneys' fees and other costs incurred in that action, arbitration or proceeding in addition to any other relief to which it may be entitled.

11. Entire Agreement of the Parties. This Agreement constitutes the entire agreement between the parties pertaining to the subject matter contained herein and supersedes all prior and contemporaneous agreements, representations and understandings of the parties.

12. Waiver. To be effective, the waiver of any provision or the waiver of the breach of any provision of this Agreement must be set forth specifically in writing and signed by the

giving party. Any such waiver shall not operate or be deemed to be a waiver of any prior or future breach of such provision or of any other provision.

13. No Third-Party Beneficiaries. The obligations created by this Agreement shall be enforceable only by the parties hereto, and no provision of this Agreement is intended to, nor shall it be construed to, create any rights for the benefit of or be enforceable by any third party, including but not limited to any CMSP client.

14. Notices. Notices or other communications affecting the terms of this Agreement shall be in writing and shall be served personally or transmitted by first–class mail, postage prepaid. Notices shall be deemed received at the earlier of actual receipt or if mailed in accordance herewith, on the third (3rd) business day after mailing. Notice shall be directed to the parties at the addresses listed on Exhibit A, but each party may change its address by written notice given in accordance with this Section.

15. Amendment. All amendments must be agreed to in writing by Board and Grantee.

16. Assignment. This Agreement shall be binding upon and shall inure to the benefit of the parties to it and their respective successors and assigns. Notwithstanding the foregoing, Grantee may not assign any rights or delegate any duties hereunder without receiving the prior written consent of Board.

17. Governing Law. The validity, interpretation and performance of this Agreement shall be governed by and construed by the laws of the State of California.

18. Counterparts. This Agreement may be executed in one or more counterparts, each of which shall be deemed an original but all of which together shall constitute one and the same instrument.

Dated effective January 1, 2017.

BOARD:

COUNTY MEDICAL SERVICES
PROGRAM GOVERNING BOARD

By: _____
Kari Brownstein, Administrative Officer

Date: _____

GRANTEE:

By: _____
Title: DAVID A. KEHOE, Chairman, Board of Supervisors

Date: _____

ATTEST:

LAWRENCE G. LEES
Clerk of the Board of Supervisors

By: _____
Deputy

Approved as to form:
RUBIN E. CRUSE, JR
County Counsel

By: _____ 5/2/17
Alan B. Cox Date
Deputy County Counsel

RISK MANAGEMENT APPROVAL

By: _____ 05/03/17
James Johnson Date
Risk Management Analyst

EXHIBIT A

GRANTEE: Shasta County Health and Human Services Agency

GRANTEE'S PARTNERS UNDER CONTRACT1

_____
_____
_____

GRANT FUNDS:

Total Amount To Be Paid under Agreement: $300,000
Amount to Be Paid Upon Execution Of This Agreement: $100,000
Amount To Be Paid On January 1, 2018: $100,000
Amount To Be Paid On January 1, 2019: $75,000
Amount To Be Paid On Board's Determination and Acceptance of Grantee's Completion of its Obligations under the Terms of this Agreement: $25,000
If Funds will be Used to Purchase Personal Property, List Personal Property to be Purchased:

_____
_____
_____

NOTICES:

Board:
County Medical Services Program Governing Board
Attn: Alison Kellen, Program Manager
1545 River Park Drive, Suite 435
Sacramento, CA 95815
(916) 649-2631 Ext. 119
(916) 649-2606 (facsimile)

Grantee:
Shasta County Health and Human Services Agency
Attn: Donnell Ewert, HHSA Director
2650 Breslauer Way
Redding, CA 96001
(530) 245-6269
(530) 225-5903 (facsimile)

1 Attach copy of any contract.

EXHIBIT B

REQUEST FOR PROPOSAL

BOARD'S REQUEST FOR PROPOSAL

REQUEST FOR PROPOSALS
County Wellness & Prevention Pilot Project

COUNTY MEDICAL SERVICES PROGRAM GOVERNING BOARD

I. ABOUT THE COUNTY MEDICAL SERVICES PROGRAM

The County Medical Services Program (CMSP) was established in January 1983, when California law transferred responsibility for providing health care services to indigent adults from the State of California to California counties. This law recognized that many smaller, rural counties were not in the position to assume this new responsibility. As a result, the law also provided counties with a population of 300,000 or fewer with the option of contracting back with the California Department of Health Services (DHS) to provide health care services to indigent adults. DHS utilized the administrative infrastructure of Medi-Cal's fee-for-service program to establish and administer the CMSP program.

In April 1995, California law was amended to establish the County Medical Services Program Governing Board (Governing Board). The CMSP Governing Board, composed of ten county officials and one ex-officio representative of the Secretary of the California Health and Human Services Agency, is authorized to set overall program and fiscal policy for CMSP. This law also authorized the Governing Board to contract with DHS or an alternative contractor to administer the program. Between April 1995 and September 2005, the Governing Board contracted with DHS to administer CMSP. Beginning October 1, 2005, Anthem Blue Cross Life & Health (Anthem) assumed administrative responsibility for CMSP medical, dental, and vision benefits. Advanced Medical Management (AMM) assumed this responsibility on April 1, 2015. MedImpact Healthcare Systems, Inc. (MedImpact) assumed administrative responsibility for CMSP pharmacy benefits beginning April 1, 2003 and continues to serve in this role.

Thirty-five counties throughout California now participate in CMSP: Alpine, Amador, Butte, Calaveras, Colusa, Del Norte, El Dorado, Glenn, Humboldt, Imperial, Inyo, Kings, Lake, Lassen, Madera, Marin, Mariposa, Mendocino, Modoc, Mono, Napa, Nevada, Plumas, San Benito, Shasta, Sierra, Siskiyou, Solano, Sonoma, Sutter, Tehama, Trinity, Tuolumne, Yolo and Yuba.

CMSP is funded by State Program Realignment revenue received by the CMSP Governing Board and county general purpose revenue provided in the form of County Participation Fees. CMSP members are medically indigent adults, ages 21 through 64, who meet all of CMSP's eligibility criteria and are not otherwise eligible for Medi-Cal or Covered California. Enrollment in CMSP is handled by county social services departments located in the 35 participating counties. All CMSP members must be residents of a CMSP county and their incomes must be less than or equal to 300% of the Federal Poverty Level (based on net nonexempt income). Depending on individual circumstances, CMSP members may have a share-of-cost. Enrollment terms for CMSP

members are up to 6 months. At the end of the enrollment term, CMSP members must reapply for CMSP to continue eligibility for benefits.

For all CMSP members *except* undocumented members, the CMSP Standard Benefit provides coverage of medically necessary inpatient, outpatient, vision, dental, and prescription drug services based upon a defined benefit package that is determined by the Governing Board. For undocumented CMSP members, the CMSP Standard Benefit provides coverage for medically necessary emergency care services only, including prescription drug services.

Beginning May 1, 2016 and for a two-year pilot project period, all CMSP members with a monthly share-of-cost for their Standard Benefit and all undocumented CMSP members are provided an additional Primary Care Benefit that does not require a monthly share of cost payment. This added benefit provides coverage of the following health care services:

- Up to three (3) medical office visits with a primary care doctor, specialist or for physical therapy (any combination of visits);
- Preventive health screenings, including annual physical, specific lab tests and cancer screenings;
- Specific diagnostic tests and minor office procedures; and,
- Prescription drug coverage with a $5.00 copay for each prescription (maximum benefit limit of $1,500 in prescription costs).

II. ABOUT THE CMSP COUNTY WELLNESS & PREVENTION PILOT PROJECT

The CMSP Governing Board seeks to test the effectiveness of providing local-level wellness and prevention services to CMSP eligible and potentially eligible persons that address any of the following three project areas:

- *Community Wellness:* Community based, collaborative strategies to provide wellness and prevention services for uninsured populations, with a focus on potential CMSP enrollees.
- *Whole Person Care:* Integrated systems development strategies that link local health and human service delivery systems to better serve CMSP enrollees, potential CMSP enrollees, and other publicly funded populations.
- *Addressing the Social Determinants of Health:* Collaborative local efforts to work across five determinants – Economic Stability, Education, Social and Community Context, Health and Health Care, and Neighborhood and Built Environment – to establish policies and strategies that positively influence social and economic conditions and those that support changes in individual behavior for the uninsured, including potential CMSP enrollees.

The target populations for county Pilot Projects must include persons potentially eligible for CMSP or enrolled in CMSP. In addition, the target populations may also include persons potentially eligible for or enrollees of other public programs. The goals of the Pilot Project are to promote timely delivery of necessary medical and support services to the target populations, improve their health outcomes, and link the target populations to other wellness resources and support. County Pilot Projects shall identify and

describe all of its target populations based upon the project area or areas that the Pilot Projects will be giving focus.

III. PILOT PROJECT APPLICANTS

Lead Agency Applicant Requirements

County Pilot Projects may focus within one CMSP county or two or more counties that participate in CMSP. Additionally, they may focus on one geographic region of a county or operate countywide. The Lead Agency Applicant must be a CMSP county that is applying solely for the county or on behalf of a group of CMSP counties working jointly. Lead Agency Applicants may be a County Health and Human Services Agency, County Health Department, or County Public Health Department. The Lead Agency Applicant must describe the community support they have in carrying out the project and provide evidence of that support through Letters of Commitment and/or Support from community based providers or organizations, such as local hospitals, primary care providers, non-profit community service agencies, or the local Medi-Cal managed care plan. In addition, the Lead Agency Applicant must demonstrate their collaboration with other county agencies, as relevant and appropriate for their project focus, as demonstrated by Letters of Commitment and/or Support. Such other county agencies may include Social Services, Mental Health, Drug and Alcohol Services, and the Justice System (including Probation, Sheriff and Courts).

IV. PILOT PROJECT TIMELINE

The following timeline shall guide the County Wellness & Prevention Pilot Project:

7/8/16	Pilot Project Request for Proposals (RFP) Released
8/4/16	RFP Assistance Teleconference
8/8/16	Pilot Project Letters of Intent (LOI) Due
9/2/16	Pilot Project Applications Due
10/27/16	Pilot Project Applications Reviewed and Approved by Governing Board
10/31/16	Pilot Project Awards Announced Via Letter
1/1/17	Pilot Project Agreements Executed and Projects Begin Implementation
12/31/19	Pilot Projects End
3/31/20	Final Pilot Project Reports due from Counties to Governing Board

V. FUNDING AWARDS – ALLOCATION METHODOLOGY

The Governing Board, within its sole discretion, may provide funding to counties participating in CMSP for the County Wellness and Prevention Pilot Project activities described in this RFP. As approved by the Governing Board on May 26, 2016 the maximum amount of funding available to each participating CMSP County is presented in APPENDIX Table 1. The Governing Board, within its sole discretion, may release all or some of the amounts presented in Table 1 based on the overall quality of the Pilot Project proposal submitted by the county or group of counties acting jointly and the manner in it which it addresses the needs of the identified target populations. Total

funding provided by the Governing Board for the County Wellness & Prevention Pilot Project may equal up to $7.65 million over the three-year period.

Following the Governing Board's approval of a County's Wellness and Prevention Pilot Project Application, the County will receive a total 3-year allocation, one-third of which will be allocated each program year, with Year 2 and Year 3 funding allocated on the basis of County compliance with program requirements, including specified Pilot Project reporting on services and outcomes.

Applicants receiving funding under the Pilot Project shall not be required to provide in-kind and/or matching funds to receive the grant, but are strongly encouraged to provide such in-kind and/or added funding from other sources to maximize the potential reach and scope of their Pilot Projects. Administrative and/or overhead expenses shall equal no more than 15% of the total Pilot Project expenditures. No Pilot Projects funds shall be used for administrative and/or overhead costs not directly attributed to the project. In addition, Pilot Projects shall be required to budget for evaluation expenses (such as time spent performing data collection, analyzing data, or preparing reports) in an amount not to exceed10% of total Pilot Project expenditures.

VI. FUNDING AWARDS – METHODOLOGY FOR REVIEW AND SCORING

The Governing Board shall have sole discretion on whether to award funding for a Pilot Project. Pilot Project proposals shall be reviewed and scored to assure that the projects meet minimum standards for receipt of County Wellness and Prevention Pilot Project funding. County Wellness & Prevention Pilot Project Applications will be reviewed and scored based upon the following criteria:

1) Project Narrative (65% in total)
    - Statement of Need (5%)
    - Target Population (5%)
    - Proposed Project/ Approach (15%)
    - Capacity (15%)
    - Organization and Staffing (10%)
    - Project Implementation (15%)
2) Budget (10%)
3) Logic Model (10%)
4) Proposed Evaluation Method (10%)
5) Letters of Commitment/Support (5%)

In order for the Governing Board to consider approving funding for a CMSP county's Pilot Project, the county's proposal must achieve a minimum score of seventy-five percent (75%).

VII. APPLICATION ASSISTANCE

A. RFP Assistance Teleconference

To assist potential applicants, Governing Board staff will conduct an RFP assistance teleconference on August 4, 2016 at 10:00 a.m. *Call-in details (including phone number, pass code, etc.) will be provided at a later time.* Applicants are encouraged to "save the date" for this teleconference, participate on the teleconference, and bring any questions they have regarding Pilot Project requirements and the application process to this teleconference.

B. Frequently Asked Questions (FAQ)

Once the application process gets underway, questions that are received by the Governing Board will be given written answers and these questions and answers will be organized into a Frequently Asked Questions (FAQ) document that will be posted on the Governing Board's website under the Pilot Project tab.

C. Letter of Intent (LOI)

The Governing Board requests that all Pilot Project funding applicants intending to submit an application provide a brief Letter of Intent (LOI) to the Governing Board that is presented on the letterhead of the applicant organization. While the LOI is not required, receipt of an LOI from all likely applicants will assist the Governing Board in planning for application review and related processing. Please submit the LOI no later than August 8, 2016 by 5:00 p.m. PST. The LOI may be submitted by e-mail or fax to the addresses listed below:

Via E-Mail: wellness&preventionpp@cmspcounties.org
SUBJECT: Wellness & Prevention Pilot Project RFP

Via Fax: CMSP Governing Board
ATTN: Wellness & Prevention Pilot Project
916-649-2606

D. Pilot Project Contact Information

Please direct any questions regarding the RFP to: lkemper@cmspcounties.org

VIII. PILOT PROJECT PROPOSAL FORMAT AND REQUIREMENTS

A. Application Cover Sheet

Using the form provided, please include the county name or names (if counties are acting jointly), identified Lead County Applicant and Lead Applicant's contact name(s), address, telephone, and e-mail contact information. The application cover sheet

(Attachment A) is available for download at the Governing Board's website at http://www.cmspcounties.org/about/grant_projects.html.

B. Project Summary (no longer than 2 pages)

Describe the proposed project concisely, including its goals, objectives, overall approach, target population(s), key partnerships, anticipated outcomes, and deliverables.

C. Project Narrative (no longer than 10 pages)

1. Clear Statement of Problem or Need Within Community

All Pilot Projects should be based upon identified needs of the target population(s) within the community. Please describe the target population(s) to be served in your proposed project. Define the characteristics of the target population(s) and discuss how the proposed project will identify members of the target population(s). Provide an estimate of the total number of clients that will be served through each year of the Pilot Project. Include any background information relating to the proposed county or counties to be served, geographical location, unique features of the community, or other pertinent information that helps shape the target population's need within the community.

2. Local Health Care Delivery System Landscape

Describe how medical care is delivered within the proposed county or counties. Identify the main sources of care for the target population(s) as well as strengths and existing challenges in the health care delivery system. Describe the Lead Applicant role and the roles of other counties, if acting jointly, as well as all key planning project partners' roles within the health care delivery system.

3. Description of Proposed Project

Describe and discuss the proposed activities to be performed in the Pilot Project. All activities discussed should correspond with the items listed in the logic model (see Section VIII D below) and be incorporated into the Implementation Work Plan. *As a part of this description, identify how the proposed Pilot Project will educate the public about CMSP and the CMSP Primary Care Benefit and link potential CMSP applicants to the county social services department for CMSP application assistance and processing.*

4. Organization and Staffing

This section should describe and demonstrate the Applicant's organizational capability to implement, operate, and fully participate in the evaluation of the proposed project. In addition, information provided should clearly delineate the roles and responsibilities of the Lead Applicant County, other counties if acting jointly, and key partners and include the following:

- An organizational chart and description of organizational structure, lines of supervision, and management oversight for the proposed project, including oversight and evaluation of consultants and contractors;
- Identification of a project manager with day-to-day responsibility for key tasks such as leadership, monitoring ongoing progress, preparing project reports, and communicating with other partners; and,
- The roles, qualifications, expertise, and auspices of key personnel.

5. Implementation Work Plan

This section should include a Project Implementation Work Plan and timetable for completion of implementation activities.

D. Logic Model

All applicants are required to submit a logic model. A logic model is a series of statements linking target population conditions/circumstances with the service strategies that will be used to address the conditions/circumstances, and the anticipated outcomes. Logic models provide a framework through which both program and evaluation staff can view the relationship between conditions, services and outcomes. (A brief guide on designing logic models is found in Attachment C.) All logic models should include a description of the: 1) target population(s); 2) program theory; 3) activities; 4) outcomes, and 5) impacts.

E. Proposed Evaluation Methodology (no longer than 2 pages)

To inform the Governing Board of the Pilot Project's proposed strategy for providing evidence of the effectiveness of the Pilot Project, all applicants shall outline and describe the specific programmatic, clinical and/or financial metrics that will be used to evaluate the effectiveness of their proposed Pilot Project. As a part of this effort, applicants shall identify the data sources to be used and the frequency of data submission, and provide a brief written assessment of the relative availability and reliability of the data sources. Applicants shall also identify any barriers to data collection or the evaluation that could impede a determination of the effectiveness of the Pilot Project. Finally, applicants shall describe how the Pilot Project will comply with federal and state laws requiring confidentiality of protected health information. Please Note: Pilot Projects may additionally be subject to external evaluation by an evaluation contractor hired by the Governing Board, at the sole discretion of the Governing Board.

F. Budget and Budget Narrative (no longer than 2 pages)

Complete the Detail & Summary Budget Templates (See Attachments B1 and B2) and provide a brief budget narrative detailing all expense components that make up total operating expenses and the source(s) of in-kind and/or direct matching funding. These Budget Templates are available as an Excel spreadsheet for download at http://www.cmspcounties.org/about/grant_projects.html.

As part of the budget narrative, describe all administrative costs and efforts to minimize use of Pilot Projects funds for administrative and overhead expenses. Please note: No Pilot Projects funds shall be used for administrative and/or overhead costs not directly attributed to the project. In addition, administrative and/or overhead expenses shall equal no more than 15% of the total Pilot Project expenditures.

All Pilot Projects are required to budget for evaluation related activities in an amount up to 10% of total Pilot Project expenditures. Evaluation related activities shall include tasks such as data collection, data cleaning, and data analysis. Such funding is intended to support the evaluation component of the Pilot Project as set forth in Section VIII E above. Projects may additionally be required to work with an external project-wide evaluation contractor that is contracted with the CMSP Governing Board.

G. Letters of Commitment and/or Support

Letters of Commitment and/or Support from key partners should be included and will be utilized in scoring (5%). Letters should describe the key partner's understanding of the proposed Pilot Project and their organizations' role in supporting or providing services.

Lead Applicants (CMSP county alone or lead CMSP county acting on behalf of a group of counties working jointly) must provide evidence of support from community based providers or other service organizations in the county or counties, if acting jointly, through Letters of Commitment and/or Support. In addition, the Lead Applicants must demonstrate their collaboration with other county agencies, as relevant and appropriate for their Pilot Project focus. Such other county agencies may include Social Services, Mental Health, and Drug and Alcohol Services, and Justice System (including Probation, Sheriff, and Courts)

IX. APPLICATION INSTRUCTIONS

A. All Pilot Project applications must be complete at the time of submission and must follow the required format and use the forms and examples provided:

   1. The type font must be Arial, size 12 point.
   2. Text must appear on a single side of the page only.
   3. Assemble the application in the order and within the page number limits listed with the Proposal Format & Requirements sections.
   4. Clearly paginate each page.

B. Applications transmitted by facsimile (fax) or e-mail <u>will not be accepted</u>.

C. The application shall be signed by a person with the authority to legally obligate the Applicant.

D. Provide one original hard-copy Pilot Project application clearly marked original, and two (2) hard copies.

E. Provide an electronic copy (CD) of the following application documents: 1) Project Summary (Word document), 2) Project Narrative (Word document), and 3) Budget (Excel document), 4) Logic Model, and 5) Proposed Evaluation Methodology.

F. Do not provide any materials that are not requested, as reviewers will not consider the materials.

G. Folders and binders are not necessary or desired; please securely staple or clip the application in the upper left corner.

H. Applications must be received in the office no later than 5:00 p.m. PST on September 2, 2016. Submit all applications to:

CMSP Governing Board
ATT: Wellness & Prevention Pilot Project Applications
1545 River Park Drive, Suite 435
Sacramento, CA 95815

APPENDIX: Table 1 CMSP County Wellness and Prevention Pilot Project Maximum County Allocations			
Population Category	**County**	**County Population**	**3-Year Grant Amount**
> 400,000 population	Sonoma County	500,292	$375,000
	Solano County	431,131	$375,000
> 100,000 population	Marin County	260,750	$300,000
	Butte County	224,241	$300,000
	Yolo County	207,590	$300,000
	El Dorado County	183,087	$300,000
	Shasta County	179,804	$300,000
	Imperial County	179,091	$300,000
	Madera County	154,548	$300,000
	Kings County	150,269	$300,000
	Napa County	141,667	$300,000
	Humboldt County	134,809	$300,000
> 50,000 population	Nevada County	98,893	$225,000
	Sutter County	95,847	$225,000
	Mendocino County	87,869	$225,000
	Yuba County	73,966	$225,000
	Lake County	64,184	$225,000
	Tehama County	63,067	$225,000
	San Benito County	58,267	$225,000
	Tuolumne County	53,831	$225,000
< 50,000 population	Calaveras County	44,624	$150,000
	Siskiyou County	43,628	$150,000
	Amador County	36,742	$150,000
	Lassen County	31,749	$150,000
	Glenn County	27,955	$150,000
	Del Norte County	27,212	$150,000
	Colusa County	21,419	$150,000
	Plumas County	18,606	$150,000
	Inyo County	18,410	$150,000
	Mariposa County	17,682	$150,000
	Mono County	13,997	$150,000
	Trinity County	13,170	$150,000
	Modoc County	9,023	$150,000
< 5,000 population	Sierra County	3,003	$75,000
	Alpine County	1,116	$75,000
	TOTAL	3,671,539	$7,650,000

Attachment A

APPLICATION COVER SHEET
CMSP Wellness & Prevention Pilot Project

1. **CMSP County or Counties Included in the Pilot Project:**

2. **Funding:**
   CMSP Pilot Project Requested Amount: $_____
   In-Kind and/or Other Matching Amount Provided by Applicant (if any): $_____

3. **Applicant:**
   Organization:
   Applicant's Director or Chief Executive:
   Title:
   Applicant's Type of Entity (specific county department):
   Address:
   City: State: CA Zip Code: County:
   Telephone: ( ) Fax: ( )
   E-mail Address:

4. **Primary Contact Person** (*Serves as lead contact person during the application process.)*
   Name:
   Title:
   Organization:
   Address:
   City: State: CA Zip Code: County:
   Telephone: ( ) Fax: ( )
   E-mail Address:

5. **Secondary Contact Person** (*Services as alternate contact during the application process.)*
   Name:
   Title:
   Organization:
   Address:
   City: State: CA Zip Code: County:
   Telephone: ( ) Fax: ( )
   E-mail Address:

6. **Financial Officer** *(Serves as chief Fiscal representative for project.)*
Name:
Title:
Organization:
Address:
City: State: CA Zip Code: County:
Telephone: ( ) Fax: ( )
E-mail Address:

7. By submitting this application for Wellness & Prevention Pilot Project funding, the applicant signifies acceptance of the applicant's responsibility to comply with all requirements stated in this Request for Proposals (RFP) authorized by the County Medical Services Program Governing Board ("Governing Board"). Further, the applicant understands that should the Governing Board award pilot project funding to the applicant, the Governing Board is not obligated to fund the pilot project grant until the applicant submits correct and complete documents as required for the pilot project agreement; the Governing Board is otherwise satisfied that the applicant has fully met all Governing Board requirements for receipt of pilot project funding; and the pilot project agreement between the Governing Board and the applicant has been fully executed. The Governing Board shall have sole discretion on whether or not to award pilot project funding of any amount to the applicant.

   I declare that I am an authorized representative of the applicant described herein. I further declare under penalty of perjury under the laws of the State of California that the information set forth in this Cover Sheet and the attached response to the Wellness & Prevention Pilot Project RFP is true and correct.

Official Authorized to Sign for Applicant:

Signature: Date:

Name:
Title:
Organization:
Address:
City: State: CA Zip Code: County:
Telephone: ( ) Fax: ( )
E-mail Address:

Attachment B1

County Wellness & Prevention Pilot Project Budget Guidelines

Applicants should use the budget detail and summary formats provided. Applicants may either use the actual tables or create a spreadsheet with the same categories and format. ***Pilot Projects*** should budget for anticipated expenditures in all three years of the pilot project.

Budget items should be placed into one of 5 categories. Five categories and a brief description of each category are listed below. Any expenses that are categorized within "Other" should be explained the budget summary.

Personnel
Gross salary and fringe benefits related to staff or funded project. Fringe benefits included employer FICA, unemployment and workers compensation taxes, medical insurance, vacation/sick leave and retirement benefits.

Contractual Services
Payments related to subcontractors and consultants who provide services to the project. Includes all expenses reimbursed including salaries, office expenses, travel.

Office Expenses
Directly attributable expenses for photocopies, postage, telephone charges, utilities, facilities, educational materials, general office supplies, computer equipment and software, and medical supplies.

Travel
Actual project-related travel expenses, including airfare, meals, hotels, mileage reimbursement, parking and taxis. If the organization has an established per diem policy, per diem may be charged to the grant in lieu of actual incurred expenses.

Other
Items that do not fall into any of the other categories listed above. Each item listed in other should be discussed in the brief budget summary.

No grant funding should be used for administrative and/or overhead costs not directly attributed to the project.

Budget Narrative
Provide a brief (no more than 2 pages) budget summary detailing all expense components that make up total operating expenses and the source(s) of in-kind and/or direct matching funding, if any. Describe all administrative costs and efforts to minimize use of pilot projects funds for administrative and overhead expenses.

Attachment B2: Budget Template - Summary Budget
CMSP County Wellness & Prevention Pilot Project

Applicant:

Summary Budget – CY 2017 through CY 2019:

Category	Total Cost (Year 1)	CMSP Funding (Year 1)	Other Funding (Year 1)
Personnel			
Contractual Services			
Office Expenses			
Travel			
Other			
TOTAL YEAR 1			

Category	Total Cost (Year 2)	CMSP Funding (Year 2)	Other Funding (Year 2)
Personnel			
Contractual Services			
Office Expenses			
Travel			
Other			
TOTAL YEAR 2			

Category	Total Cost (Year 3)	CMSP Funding (Year 3)	Other Funding (Year 3)
Personnel			
Contractual Services			
Office Expenses			
Travel			
Other			
TOTAL YEAR 3			

Attachment B2: Budget Template - Detail Budget
CMSP County Wellness & Prevention Pilot Project

Applicant:

Detail Budget – CY 2017 through CY 2019:

Category Item/Service	Qnty (Year 1)	Cost (Year 1)	Qnty (Year 2)	Cost (Year 2)	Qnty (Year 3)	Cost (Year 3)	**Total Cost**
Personnel							
Contractual Services							
Office Expenses							
Travel							
Other							

ATTACHMENT C

Guidelines for Logic Model

I. Purpose

Applicants for County Wellness & Prevention Pilot Project funding must submit a logic model. Designing a logic model will enable applicants to define their program, pinpoint their approach, identify resources and consider outcomes. The purpose of a logic model is to build a foundation for program development, ensure consensus among stakeholders and provide a framework for program evaluation. Each site is responsible for completing an evaluation of their project. A logic model provides a common "map" to be used by program staff and evaluators to design a useful evaluation. Designing an evaluation, before completing a logic model, may lead to collecting information on irrelevant outcomes. Conversely, programs may fail to collect information regarding individuals or services that may contribute to the success of a program. The creation of thoughtful logic model is the first step in designing an effective County Wellness & Prevention Pilot Project.

Applicants are encouraged to use the guidelines that follow, although other forms of logic models are acceptable.

II. Overview

The development of logic models is a useful tool for establishing dialogue between evaluation and system development efforts. Logic modeling is a method of articulating a program's theory or beliefs about how and why services are expected to produce particular results. In its simplest form, a logic model describes the clients that a system of care intends to serve, the services and supports that will be offered, and the short and long term outcomes that are expected to be achieved.

Kumpfer, et al. (1993) believe that logic models are useful tools for local stakeholders for several reasons. First, logic models can elicit consensus among staff and other system stakeholders regarding the service strategies and outcomes for a particular program. Second, they serve as a model to compare the intended program approach with what actually occurred. Third, they facilitate the articulation of specific beliefs about what services and strategies are related to the achievement of outcomes. Finally, logic models provide a framework for evaluation efforts through the linkage of action to results. Overall, logic models provide a framework through which both program and evaluation staff can view the linkages between conditions, services and outcomes.

The first step for stakeholders in developing a logic model is to clearly articulate their service delivery strategy. This means that stakeholders throughout a service system, including administrators, service providers, and inter-agency collaborators, should be able to describe the target population they intend to serve, the services they expect to provide along with the supporting collaborative infrastructures, and the results they expect to achieve (Usher, 1998; Hernandez,

Hodges, & Cascardi, 1998). When these basic questions are answered, stakeholders will be in a better position to complete their logic model.

Logic models depicting a program's approach can be compared to maps with guideposts that help keep program strategies on course (Alter & Murty, 1997). This approach takes into account the slippage or shifts that often occur in service delivery and uses the logic model as a stabilizer for a program or services during times of change. By knowing what changed in a program and when it changed, outcome information can be better interpreted and utilized. In this regard, the logic model becomes the ongoing documentation of changes in a program and enables stakeholders to track them.

Evaluators have the important role of eliciting the underlying service delivery theory by asking service personnel, managers, interagency stakeholders key questions about the target population served, the service approach employed and the goals that the service approach hopes to accomplish. If there is not agreement among program staff and stakeholders in their answers to these questions, then the evaluator helps the group reach consensus through further discussion. This process makes the results of evaluation more relevant to the service strategy under study, and hence more useful toward improving services.

III. Components of a Logic Model

It seems that there is a different vocabulary used for each type of logic model. Although logic models may vary slightly in their purpose (i.e., program logic model vs. evaluation logic model), most models include the same types of components described in slightly different ways. In general, a logic model can be broken down into five (5) basic components: 1) Target Population; 2) Program Theory; 3) Program Activities; 4) Outcomes; and, 5) Impact/Goals. A logic model template is shown in chart 1.

- ***Target Population***

Consider the target population carefully. Ethnicity, race, age, gender, geographic location, primary language spoken, housing status, and medical conditions contribute to the definition of the target population.

Program Theory
This component should discuss the "theory" or the basis of the program or intervention. The "program theory" refers to the underlying assumptions that guide program planning and service delivery. These assumptions are critical to producing change and improvement in the target population. For example, a program theory regarding disease case management for diabetics may state:

> "Case management services for CMSP diabetics should include local coordination of all health and social service providers to address needs in

a timely and efficient manner that conserves resources and eliminates duplication."

The program theory assumes that local coordination across service providers is important for serving an indigent population. Several theories may be combined to define an overall approach to serving the target population. For example, a program to serve children with severe emotional disturbances and their families had the following program theories:

- Family involvement in program design and implementation
- Incentive-oriented for providers
- Wide array of services to address needs in multiple areas
- Broad network of local providers
- Collaboration with multiple sectors
- Collaboration with existing local systems of care

It is important to note that these are theories and approaches, *not* activities. Activities are the actual services offered or the formation of a collaborative body with family members, or the linking of regional providers through a formal referral system. Program theories shape the creation of activities. The formation of program theories is one of the most difficult components of logic model development, however, clearly developed theories will ensure consensus among stakeholders.

- ***Activities***

Activities are the specific processes and/or events that comprise the program. Some examples of activities are:

- Mental health counseling
- Case management
- Community forums
- Creation of a new health service
- Dental referral mechanism

Activities are the interventions focused on the target population that are intended to impact individual health or community health outcomes. Activities are often measured by process outcomes. For example, 35 individuals received case management services for 6 months.....20 individuals received preventative dental care..... 10 injury prevention classes were held during 6 months....12 men and 23 women attended the diabetes self-management workshop.

- ***Outcomes***

Outcomes are the results of the activities provided by the program. Outcomes may be measured on an individual or group level. Outcomes provide a way to measure change in participants' lives and/or community conditions. Outcomes may be short-term, intermediate or long-term depending on how far in to the

future they are measured. For example, a diabetes case management program may not expect to see differences in kidney disease among diabetics for several years (long-term outcome), however, the program may see decreases in hospitalizations due to hypoglycemia during the first year of the program (short-term).

Identifying short-, intermediate- and long-term outcomes also will enable programs to define indicators. Indicators describe outcomes in specific and measurable terms. For example, a disease case management program may target fewer health complications due to diabetes as an outcome. Several indicators may include, a 10% reduction in hypoglycemic episodes among diabetics whom are case managed. Another example may be a substance abuse program that seeks to reduce drug use by 50% among participants. An indicator variable would be the number of clients who tested negative for drug use over a 6-month period. Defining outcomes and indicators will contribute to the development of useful program evaluations.

- ***Impacts***

Impacts are the long-term changes that the program expects to make. They provide direction and focus to the program and should be consistent with the larger mission and vision of the organization. Impacts are often closely influenced by many other factors in addition to the program such as economic conditions, and cultural values. Some examples of impacts are:

- Improved mental health among program participants
- Better health outcomes for the medically under served in the community

IV. Completing a Logic Model

Use the categories above to create a logic model for your Pilot Project. Begin with the overall impacts of the program and then jump to the target population and move forward. As you fill in the program theory, activities and outcomes for your model always go back to the target population and make sure the activities you plan are effecting the appropriate people. Use a flowchart, like the one provided in chart 1, to help visualize the flow of the program as you are constructing the different components.

The logic model should provide your program with a clear map that can be used as a reference for program design, implementation and evaluation.

References

Alter, C. & Murty, S. (Winter 1997). Logic Modeling: A Tool for Teaching Practice Evaluation. *Journal of Social Work Education, 33* (1), 103-117.

Hernandez, M., Hodges, S., & Cascardi, M. (1998). The Ecology of Outcomes: System Accountability in Children's Mental Health. *The Journal of Behavioral Health Services & Research, 25*(2), 136-150.

Kumpfer, K.L., Shur, G.H., Ross, J.G., Bunnell, K.K., Librett, J.J. & Millward, A.R. (1993). Measurements *in Prevention*. Rockville, MD: U.S. Dept. Of Health and Human Services, Public Health Service, Substance Abuse and Mental Health Services Administration, Center for Substance Abuse Prevention.

Usher, C. L. (1998). Managing Care Across Systems to Improve Outcomes for Families and Communities. *The Journal of Behavioral Health Services & Research, 25*(2), 217-229.

Source

Modified from original source. Originally prepared by Dennis Rose & Associates for the
County Medical Services Program's Wellness & Prevention Program (2001)

ATTACHMENT C

Chart 1: Logic Model Template

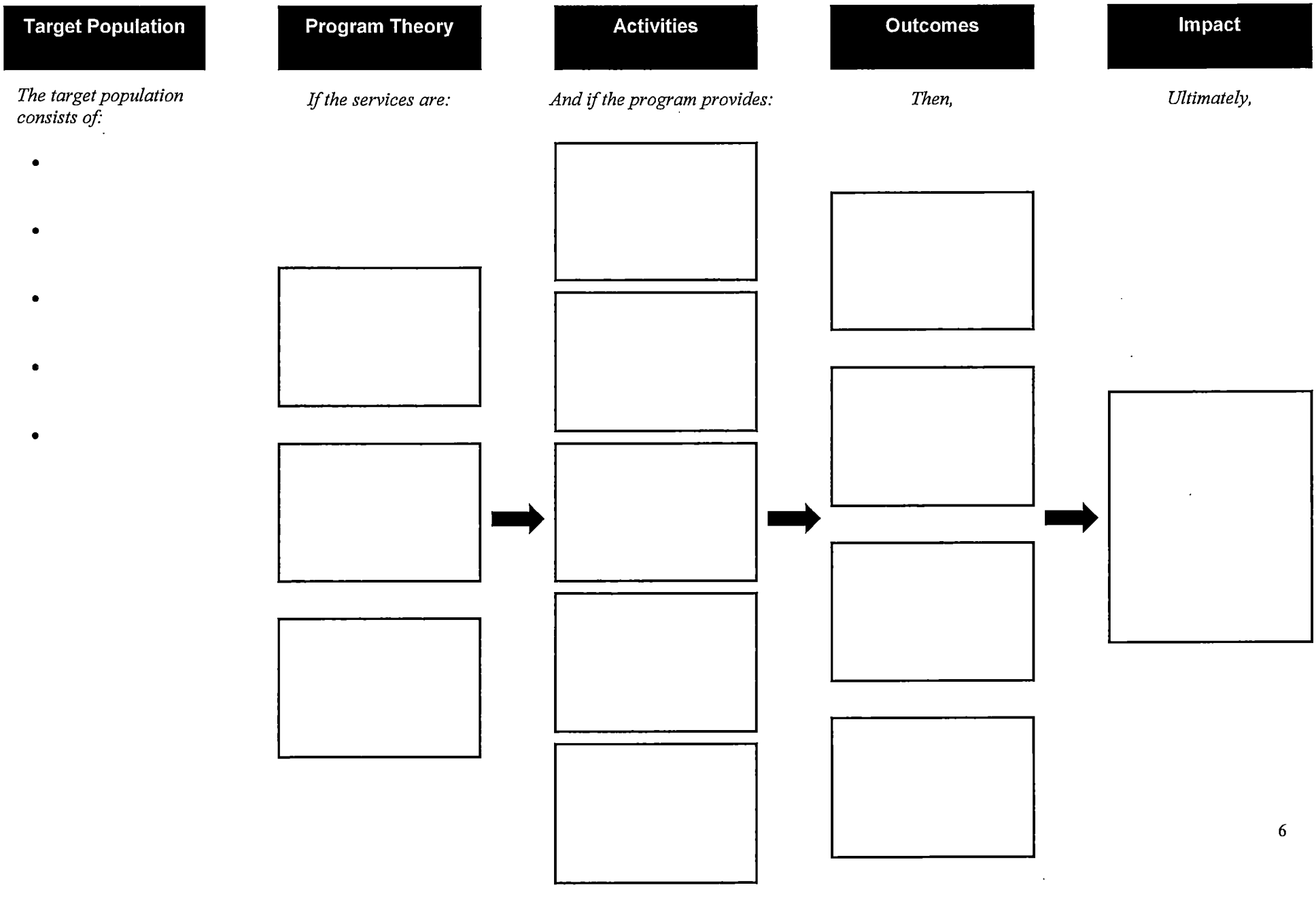


EXHIBIT C

APPLICATION

GRANTEE'S APPLICATION

Attachment A

☐ ORIGINAL

APPLICATION COVER SHEET
CMSP Wellness & Prevention Pilot Project

1. **CMSP County or Counties Included in the Pilot Project:**
   Shasta County

2. **Funding:**
   CMSP Pilot Project Requested Amount: $300,000.00
   In-Kind and/or Other Matching Amount Provided by Applicant (if any): $9,757,092.00

3. **Applicant:**
   Organization: Shasta County Health and Human Services Agency
   Applicant's Director or Chief Executive: Donnell Ewert
   Title: HHSA Director
   Applicant's Type of Entity (specific county department): Health & Human Services
   Address: 2650 Breslauer Way
   City: Redding State: CA Zip Code: 96001 County: Shasta County
   Telephone: (530) 245-6269 Fax: (530) 225-5903
   E-mail Address: dewert@co.shasta.ca.us

4. **Primary Contact Person** (*Serves as lead contact person during the application process.)*
   Name: Dean True
   Title: Branch Director, Adult Services
   Organization: Shasta County Health and Human Services Agency
   Address: 2640 Breslauer Way
   City: Redding State: CA Zip Code: 96001 County: Shasta County
   Telephone: (530) 225-5901 Fax: (530) 225-5977
   E-mail Address: dtrue@co.shasta.ca.us

5. **Secondary Contact Person** (*Services as alternate contact during the application process.)*
   Name: Melissa Janulewicz
   Title: Regional Services Director
   Organization: Shasta County Health and Human Services Agency
   Address: 2650 Breslauer Way
   City: Redding State: CA Zip Code: 96001 County: Shasta County
   Telephone: (530) 225-5066 Fax: (530) 225-5245
   E-mail Address: mjanulewicz@co.shasta.ca.us

Attachment A

6. **Financial Officer** *(Serves as chief Fiscal representative for project.)*
Name: Tracy Tedder
Title: Business and Support Services Director
Organization: Shasta County Health and Human Services Agency
Address: 2650 Breslauer Way
City: Redding State: CA Zip Code: 96001 County: Shasta County
Telephone: (530) 229-8425 Fax: (530) 225-5555
E-mail Address: ttedder@co.shasta.ca.us

7. By submitting this application for Wellness & Prevention Pilot Project funding, the applicant signifies acceptance of the applicant's responsibility to comply with all requirements stated in this Request for Proposals (RFP) authorized by the County Medical Services Program Governing Board ("Governing Board"). Further, the applicant understands that should the Governing Board award pilot project funding to the applicant, the Governing Board is not obligated to fund the pilot project grant until the applicant submits correct and complete documents as required for the pilot project agreement; the Governing Board is otherwise satisfied that the applicant has fully met all Governing Board requirements for receipt of pilot project funding; and the pilot project agreement between the Governing Board and the applicant has been fully executed. The Governing Board shall have sole discretion on whether or not to award pilot project funding of any amount to the applicant.

I declare that I am an authorized representative of the applicant described herein. I further declare under penalty of perjury under the laws of the State of California that the information set forth in this Cover Sheet and the attached response to the Wellness & Prevention Pilot Project RFP is true and correct.

Official Authorized to Sign for Applicant:

Signature:  Date: 9/1/16

Name: Donnell Ewert
Title: Director
Organization: Shasta County Health and Human Services Agency
Address: 2650 Breslauer Way
City: Redding State: CA Zip Code: 96001 County: Shasta County
Telephone: (530) 245-6269 Fax: (530) 225-5903
E-mail Address: dewert@co.shasta.ca.us

Project Summary

Shasta County Health and Human Services Agency (HHSA) is pleased to submit this proposal in response to the County Medical Services Program Governing Board Request for Proposals on County Wellness & Prevention Pilot Projects. Shasta County HHSA is requesting $300,000 over three years to support a Whole Person Care Pilot Project that the agency is developing to better integrate health care systems and deliver services to individuals that address their complex medical, behavioral health, and social determinants of health. Shasta County HHSA has been approved to take part in the Whole Person Care (WPC) Pilot Program under California's 1115 Medi-Cal Waiver. The County Medical Services Program (CMSP) funding will be leveraged to take advantage of the federal match through the WPC Pilot and to deliver Whole Person Care services to CMSP recipients and CMSP eligible individuals that meet the criteria for the pilot program.

Overview of Whole Person Care Pilot in Shasta County

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

- Is connected to a patient centered health home;
- Has a case management system that supports them in accessing medical and social non-medical services;
- Has health needs and chronic conditions that are stabilized through access to medical care;
- Has access to substance use treatment services (outpatient and residential) that support their goals; and
- Has stable housing that supports their behavioral health and physical health through coordination with local housing case managers and housing assistance programs.

In Shasta County, the target population includes CMSP recipients, CMSP eligible individuals, and Medi-Cal members who are homeless or at risk of homelessness that have had two or more hospital ED visits or a hospitalization in the last three months. In addition, the target population may have one or more of the following risk factors: a diagnosis of Serious Mental Illness (SMI), a diagnosis of Substance Use Disorders (SUD), or an undiagnosed opioid addiction.

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

- Screening and enrollment in the WPC Pilot Program (voluntary program) and referral to an intensive medical case management system offered through CMSP contracted primary care health centers;
- Development of a hub for behavioral health, pre-crisis and social non-medical services for the WPC pilot target population through development of a mental health resource center;
- Sobering center that offers a safe and appropriate place for individuals who are intoxicated as an alternative to ED and/or incarceration in the county jail, and which provides referrals and warm handoff to detoxification services;
- Case managers that provide care coordination to connect WPC participants to needed primary care and specialty care, non-medical social services, track referrals, and assist patients in accessing needed care;
- Linkages to residential and outpatient SUD services; and
- Coordinated entry approach to housing services with case managers that assist participants in overcoming housing barriers to find and maintain stable housing that will support SUD treatment and medical and behavioral health care goals.

The services described in this proposal will be offered to CMSP members and CMSP eligible individuals and to adults that have other publicly funded health coverage (e.g. Medi-Cal). The majority of services described above are not Medi-Cal or CMSP billable services, but rather are enhanced coordination, case management and data sharing strategies that improve the organization and delivery of medical and social non-medical services to individuals with complex needs.

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

Project Narrative

1. Clear State of Problem or Need Within Community

Geographic Area

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

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

Health Insurance Coverage

In Shasta County approximately 15.1% of the population were uninsured prior to full implementation of the Affordable Care Act (American Community Survey, 2010-2014). Within the target communities addressed in this proposal there were approximately 19,110 uninsured adults (Table 1 below). Given the uncertainty about the Medicaid expansion under the Affordable Care Act after the November 2016 national election, we cannot predict how many uninsured people may reside in Shasta County during the next three years.

Table 1. Uninsured Adults in Target Service Area

ZIP Code	City Name	Uninsured Population Age 18-64 (%)	Uninsured Population Age 18-64 (#)	Total Population Age 18-64
96001	Redding	18.95%	3,817	20,139
96002	Redding	24.82%	4,834	19,476
96003	Redding	21.84%	6,034	27,630
96007	Anderson	21.14%	2,863	13,542
96019	Shasta Lake	23.33%	1,395	5,980
96084	Round Mountain	30.36%	119	392
96087	Shasta	16.61%	48	289

Source: American Community Survey, 2010-2014

The CMSP County Wellness & Prevention Pilot Projects are intended to improve service delivery systems to better serve CMSP members, potential CMSP enrollees, and other publicly funded populations. Adults age 21-64 with incomes below 300% of the federal poverty level are the primary populations that fall within these groups. Approximately 16,000 (29.6%) adults age 21 to 64 with incomes under 300% of FPL are uninsured in Shasta County (California Health Interview Survey, 2014). Among this population are approximately 7,000 uninsured adults with incomes below 138% of FPL (may be Medi-Cal eligible), and approximately 5,000 with incomes between 138%-199% and approximately 4,000 individuals with incomes between 200% and 299% of FPL that are uninsured and may be CMSP eligible. There are approximately 22,000 adults with incomes below 200% FPL covered by Medi-Cal (California Health Interview Survey, 2014).

The largest providers of primary care services for these communities are two federally qualified health centers (FQHCs) – Shasta Community Health Center and Hill Country Health and Wellness Center. According to federal data obtained from UDS Mapper, the health centers serve approximately 35% of the uninsured population in the target communities. Expansion of coverage options in 2014 significantly reduced the numbers of uninsured patients served by health centers as indicated in Table 2 below.

Table 2. Change in Uninsured Health Center Patients 2013 to 2015

ZCTA	City Name	2013-2014 (1-year) Uninsured Health Center Patient % Change	2013-2015 (2-year) Uninsured Health Center Patient % Change
96001	Redding	-35.8%	-58%
96002	Redding	-33.2%	-50%
96003	Redding	-38.9%	-57%
96007	Anderson	-36.6%	-53%
96019	Shasta Lake	-38.4%	-57%
96084	Round Mountain	-34.8%	-54%
96087	Shasta	-50.0%	-61%

Source: UDS Mapper. Data based on 2014 and 2015 UDS reports.

These health centers are also the two largest providers of primary care services for individuals with CMSP, Medi-Cal, and other publicly funded coverage in these communities.

Community and Target Population Needs

Shasta County has long experienced high rates of homelessness, however the situation has reached a breaking point in the past few years. A review of community data was recently prepared to better understand the incidence and impact of homelessness. Cal-Fresh enrollment records for the County indicate that as many as 3,000 individuals, or 1.6% of the population experienced homelessness in 2015. Shasta County's Point In Time (PIT) Count data over time suggests rates of homelessness are increasing, with an approximately 10% increase in homelessness from 2013-2016. The 2016 PIT

counted 934 homeless persons in Shasta County. This represents 0.52% of the population, higher than the state rate of 0.29% (U.S. Census, 2015) or the national rate of 0.18% (HUD Annual Homeless Assessment Report to Congress, 2014). Three-quarters of individuals were unsheltered (74%) and about one-third (31%) have a psychiatric or emotional condition (Shasta County and Redding Continuum of Care, 2016).

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

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

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

Target Population to Be Served

The target population includes adults with incomes at or below 300% of the federal poverty level that have had two or more Emergency Department (ED) visits or a hospitalization in the last three months and are homeless or at risk of homelessness. Priority will be given to individuals who have had four or more ED visits in the past three months. In addition, individuals may have one or more of the following risk factors: diagnosis of SMI, diagnosis of a SUD, or an undiagnosed/ undisclosed opioid addiction. Adults in the target population will be those that are uninsured, enrolled in or eligible for the CMSP or are enrolled in Medi-Cal. The Shasta County HHSA estimates serving approximately 150 individuals annually under the pilot. At this time it is unknown how many CMSP members or CMSP eligible enrollees are visiting the ED frequently to access care. Additionally, there may be a rise in the number of individuals enrolled in CMSP in coming years due to changes in the Affordable Care Act. However, HHSA will work with the two hospitals in Redding that are contracted with AMM for services to CMSP populations, to review encounter data to better understand the needs of this population. What follows below is a review of data that was available to support planning for the Whole Person Care pilot program.

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

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

- Pain, suicidal ideation or anxiety represented 8 of the top 20 most frequent diagnosis codes for ED visits (9.5% of visits).
- Approximately 167 patients were served in the two EDs through 334 visits for mental health and/or substance use related conditions. Among them, 23% also had visited the ED during the quarter for pain related reasons.
- Approximately 595 patients accounted for 780 visits in the quarter with pain as the primary reason. Among them 9% also had a visit coded with a primary diagnosis related to a mental health condition or alcohol and other drug use related visit.
- Approximately 175 to 215 individuals visit the ED each month for visits related to mental health, substance use, or pain related reasons, which would allow for an opportunity to enroll them in the WPC pilot program.
- Mercy Medical Center reported that 71 (28%) of the 250 behavioral health patients in its ED in May and June 2016 were homeless.

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

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

evaluations shows that approximately 12% of adults evaluated are uninsured and may be eligible for CMSP.

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

2. Local Health Care Delivery System Landscape

Shasta County is a mostly rural county in far northern California that increasingly struggles with provider shortages, both for behavioral and physical health care practitioners. Shasta does not have a county hospital or clinic system, but benefits from a strong collaboration of community health centers, along with county health and behavioral health administrators, hospitals, and the Medi-Cal managed care plan, Partnership HealthPlan of California (PHC).

CMSP Delivery System

The core of the CMSP delivery system in the urbanized Interstate 5 corridor of Shasta County consists primarily of the two Redding hospitals – Mercy Medical Center Redding and Shasta Regional Medical Center – and two federally qualified health centers – Shasta Community Health Center and Hill Country Health and Wellness Center. These four organizations hold contracts with AMM to deliver services covered under the CMSP benefit to eligible individuals enrolled in the program. Shasta County has a small population of adults enrolled in CMSP. Anecdotally we understand that this population is primarily uninsured individuals who visit the ED when health issues go unaddressed and become emergencies. The ED staff work to enroll eligible uninsured individuals into health care programs using the Single Streamlined Application and then county eligibility staff determine eligibility for health care programs, including CMSP.

All applicants are provided information packets, which include information about CMSP. Additionally, a courtesy letter, along with a CMSP Supplemental Application, is sent by eligibility staff to all individuals determined ineligible for the Medi-Cal program.

Given that the proposed Whole Person Care pilot program described in this application includes these four delivery system partners ensures that the strategies implemented will enhance and strengthen the CMSP delivery system for CMSP populations, particularly for those with complex medical, behavioral health, and social non-medical needs. The proposed project will help to build stronger connections for CMSP enrollees to a primary care medical home to reduce the use of the emergency department as the primary source of care and will build linkages for enrollees to social services to connect enrollees to other public benefits and supports.

Medi-Cal Managed Care Delivery System
Shasta County has a County-Operated Health System model of Medi-Cal managed care, with PHC as the sole public Medi-Cal plan. PHC contracts with Beacon Health Strategies to administer its behavioral health services benefits.

Shasta County's health care delivery system is primarily comprised of private health systems and health care providers. Shasta County Health and Human Services Agency (HHSA) does not operate a public hospital system. The only services the county provides directly are immunizations, specialty mental health and California Children's Services. There are two private hospitals and one district hospital in the county that provide for the medical care needs of county residents. The hospitals include Shasta Regional Medical Center and Mercy Medical Center in Redding, and Mayers Memorial Hospital in Burney.

There are four federally qualified health centers (FQHCs) operating in Shasta County that provide comprehensive primary care for county residents, with a priority on populations that are low-income, underserved and uninsured. The four health centers in the county are Hill Country Health & Wellness Center, Mountain Valleys Health Centers, Shasta Community Health Center and Shingletown Medical Center. These FQHCs serve approximately 65% of Medi-Cal beneficiaries in the county. The primary care provider network also includes private medical offices located primary in Redding with a few additional providers spread throughout the county.

Local Delivery System Partner Engagement in Planning
The Shasta Health Assessment and Redesign Collaborative (SHARC) has been meeting monthly since 2010 to build a more organized system of healthcare for Shasta County. Membership includes FQHCs, hospitals, PHC, North Valley Medical Association, and HHSA. SHARC convenes a Whole Person Care committee monthly. This committee has been the primary vehicle for partner involvement in planning for this initiative. Table 3 below identifies key project partners and their primary roles.

Table 3. Whole Person Care Project Partners

Organization Name	Entity Description and Role in WPC
Shasta County Health and Human Services Agency (includes Public Health, Mental Health, Alcohol and Drug Services, and Social Services)	Leads design, implementation, administration and evaluation of the WPC pilot. Implements housing case management intervention.
Partnership HealthPlan of California (PHC)	Serve on the Steering Committee, support evaluation of the program through sharing of claims data on identified metrics.
Hill Country Health & Wellness Center	FQHC, CMSP provider and Full Service Partnership provider providing primary care and behavioral health care in Redding. Responsible for implementation of services related to mental health resource center and assisted outpatient treatment. Also responsible for intensive medical case management and comprehensive primary care for assigned CMSP and

	Medi-Cal members in the pilot.
Shasta Community Health Center	FQHC and CMSP provider offering primary care and healthcare for the homeless services in Redding. Responsible for intensive medical case management and comprehensive primary care for assigned CMSP and Medi-Cal members in the pilot.
Mercy Medical Center Redding Shasta Regional Medical Center	Operate the two hospital emergency departments in Redding. Will support identification and referral of potential WPC pilot participants.

3. Description of Proposed Project

The WPC pilot will be planned and implemented through the Health and Human Services Agency in close collaboration with the Shasta Health Assessment and Redesign Collaborative (SHARC). In collaboration with the SHARC WPC Committee, Shasta County HHSA has designed services, interventions and care coordination strategies as part of the pilot program to better integrate and coordinate care according to the needs of this population as described below.

Medical Services

Preliminary screening for potential entry in the WPC Pilot Program will begin in the two hospital EDs. This will ensure a focus on high utilizers as the primary target for enrollment of the target population in the program. The personnel responsible for outreach in the WPC Pilot Program will be HHSA mental health clinicians that are currently co-located in the EDs to perform assessments on individuals who are on a 5150 or 1799 hold. A work flow will be established so that the clinician can assess and discuss the pilot program with individuals identified as a potential fit for the pilot. Enrollment will be voluntary. Potential WPC participants will be referred to an intensive medical case manager employed by one of the FQHCs for further assessment and enrollment as appropriate. The pilot program's initial focus at the ED ensures that CMSP members and individuals potentially eligible for CMSP that meet the pilot criteria will be identified as this is primarily where CMSP eligible individuals access care. After the first year of implementation additional settings will conduct screening and referral of the eligible population, including the mental health resource center, Good News Rescue Mission, Hope Van, and other community provider entities that serve the population.

Follow-up on referrals from the ED will be conducted by nurse case managers at the two FQHCs and enhanced services will include outreach, care coordination, referral management, that currently are not Medi-Cal billable services. The services that will be offered to WPC Participants as part of the Medical Case Management include:

- Outreach: develops trusting relationship with patient; Serves as a link to primary, specialty and ancillary services. This outreach will be done in coordination with any outreach conducted by the mental health resource center to ensure there is no duplication of service
- Assessment: identify acuity level using standard scale, identify medical and social risks, identify substance use (diagnosed or not), assess level of self-care and patient activation

- Care Coordination and Patient Empowerment: Works with WPC participant and care team to develop and adhere to shared action plan and meets with care team to support coordination of plan of care; home visits (frequency based on acuity level) to support achievement of goals
- Education: Provides coaching in self-management skills and behavior change
- Reduce Cost and Utilization: Reviews admissions, discharges, ED visits from last 24 hours and conducts follow-up

In addition, medical case management services will include referrals to and coordination with the County Eligibility staff to assist CMSP enrollees and uninsured individuals to apply for available health care programs and other public benefits, including CalFresh and CalWORKs. Shasta County Eligibility staff raise public awareness of the CMSP program using posters displayed in the Regional Offices and through information packets distributed to potentially eligible CMSP enrollees. Individuals who express interest in other public benefit programs receive follow-up by Eligibility staff with more information on the program as well as the corresponding program application.

Medical services that are covered under the CMSP benefit will be delivered in accordance with program guidelines by providers within the FQHC practice as appropriate.

Behavioral Health Services

The key strategies and interventions describe below will provide behavioral health services for the target population.

Mental Health Resource Center: The mental health resource center will serve as a hub for behavioral health services for the WPC pilot target population, and will serve as an alternative to the ED for individuals experiencing less severe mental health crises. Some of the behavioral health clinical services offered will be directly reimbursed by Medi-Cal for the target population. The WPC case management coordinator will support WPC pilot participants in accessing medical, behavioral, and social non-medical services according to identified needs. This position will also work closely with the medical case management teams and housing case managers to coordinate services and resources for the WPC participant. Licensed clinicians will be available to evaluate and assess a member's immediate needs upon drop-in to the center or by referral from the ED. As members are stabilized, they will have access to many services on site, including substance use disorder group and individual treatment, through co-located SUD treatment providers, groups that address needs associated with anxiety, depression, and pain management. A warm line staffed by individuals with lived experience will be established and outreach staff will be present in the community to work closely with case managers and other partner organizations. A peer-staffed resource center and peer support program will be developed to enhance the wrap around supports offered to the target population. These services will be offered to CMSP members and potentially eligible enrollees.

Mobile Crisis Team (MCT): The MCT will serve as an entry point for WPC Target population individuals who are experiencing an urgent/immediate mental health or substance use crisis situation in the community. There will be 3 teams, each consisting of one clinician and one case manager. At least one MCT will be available to respond to the field/community at large from 6:00 am-12:30 am, seven days a week. Calls to the MCT for assistance and/or service may be initiated by law enforcement, concerned community members (family, friends, etc), or by the individual themselves. These services will be offered to CMSP members and potentially eligible enrollees.

Linkages to Substance Use Disorder Treatment Services: Analysis of the target population for the WPC pilot underscores the importance of connecting these individuals to residential and outpatient substance use disorder (SUD) treatment services. SUD treatment providers will play a key role in the services delivered to WPC pilot program participants. Through the WPC pilot, enhanced referral relationships will be established to ensure coordination between the HHSA clinicians, three Drug Medi-Cal (DMC) treatment providers, case management services, and the mental health resource center. Intensive medical case managers will use motivational interviewing in conjunction with SUD providers to encourage patients with SUD disorders to enroll in an appropriate level of SUD treatment. The FQHCs will continue to expand their outpatient SUD services to provide an integrated setting for individuals with SUDs who also are enrolled in their primary care services. For CMSP enrollees or eligible individuals referred to SUD providers for treatment, SAPT block grant funding will be used to cover the costs of services, ensuring access to care for these pilot participants.

Coordinated Entry and Housing Services

The Shasta County and Redding Continuum of Care is developing a strategic plan for expansion of housing services. This effort presented an opportunity to integrate evidence-based solutions to address homelessness in Shasta County. The two local housing authorities, local non-profits, Shasta County HHSA, the WPC Committee and the CoC are working to align strategies in this strategic plan and the housing services and supports offered through the WPC pilot.

Housing case management, and linkages to social services, will be provided to WPC enrolled participants that are homeless or have unstable housing and at risk of homelessness. A team of social workers within the Shasta County HHSA housing case management program will support the WPC pilot population.

The housing case management services include:

- Assistance Level Triage assessment, which is a tenancy barriers assessment. This assessment provides guidance as to the amount of time the client will be enrolled in the program as well as the intensity of interactions with staff and volunteers.
- Case planning,
- Housing identification and landlord relationship establishment,
- Credit repair, financial planning and education,

- Landlord and tenant rights and responsibilities education, and resolution of landlord and tenant issues,
- Basic tenancy skills building, resolution of landlord and tenant issues, and Individual housing transition services.

The housing case managers are embedded with the General Assistance and Eligibility/Social Services within the Regional Services Branch of Shasta County Health and Human Services Agency. The housing case managers will include review of eligibility for other publicly funded benefits and services to stabilize income for participants to assist them in maintaining housing. They will work in partnership with the intensive medical case managers and Eligibility staff to ensure that individuals are provided application assistance to access available health coverage options.

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

Cross Agency Coordination

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

Through the WPC pilot, Shasta County will build a hub at the mental health resource center that serves to connect the siloed services and systems. In order to increase

collaboration across health, housing, and social service agencies and more effectively utilize community resources to meet the needs of WPC enrollees, the mental health resource center behavioral health clinicians and WPC Case Management Coordinator will convene monthly multi-disciplinary case manager trainings to build capacity for coordination and integrate evidence-based strategies into practice.

Training content may include the American Society of Addiction Medicine (ASAM) criteria and assessment, Milestones of Recovery Scale (MORS), Wellness Recovery Action Planning (WRAP), motivational interviewing, and trauma-informed care. Trainings will also be an opportunity to network and build relationships across agencies, troubleshoot challenges in accessing resources, coordinate services across systems, and identify resource availability or gaps in the community. WPC case manager meetings may include:

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

These individuals will also be important resources for understanding how the pilot program is working and will be involved in planning and implementing PDSAs or other continuous quality improvement activities.

4. Organization and Staffing

Shasta County HHSA will serve as the lead for the pilot project. Responsibility for project implementation, evaluation and reporting will be maintained by the agency. Key leadership of HHSA including the Health and Human Services Director and the Directors of the Adult Services and Regional Branches will participate in the WPC Steering Committee to oversee implementation of the pilot program.

HHSA Key Personnel

Donnell Ewert - Donnell is the Director of Shasta County Health and Human Services Agency (HHSA), a position he has held since November 2012. This Agency includes the functional areas of Alcohol and Drug Services, Mental Health Services, Public Health Services, and Social Services, organized into five branches. Prior to this assignment, Donnell was the Director of the Public Health Branch of the HHSA from 2006 to 2012, also serving for limited time periods as the interim director of the Regional Services Branch and the Adult Services Branch. Donnell started his work in Shasta County as an epidemiologist back in 1999 and held a variety of supervisory and management positions prior to becoming the Public Health Director in 2006. Donnell was employed as a communicable disease epidemiologist at the Los Angeles County Department of Health Services (1988-1993) and the Indiana State Department of Health (1993-1995) before working abroad in Kazakhstan (1995-1998) for a non-profit organization called Interlink Resources.

Donnell has participated in a variety of statewide organizations during his tenure in Shasta County, including the County Health Executive Association of California

(CHEAC), the County Behavioral Health Directors Association (CBHDA), the County Welfare Directors Association (CWDA), the California Mental Health Services Authority (CalMHSA), the County Alcohol and Drug Administrators Association of California (CADPAAC), the Child Nutrition Advisory Council of the California Board of Education, and the Office of Health Equity Advisory Committee of the California Department of Public Health. Additionally, he serves on the governing commission of Partnership Healthplan of California, the Medi-Cal managed care plan for 14 northern California counties, including Shasta.

Dean True – Dean is Director of the Adult Services Branch within Shasta County Health and Human Services Agency. Dean has responsibility for specialty mental health services for adults and Alcohol and Drug Services. Dean has been a Registered Nurse for over 30 years, working primarily in mental health settings since 1987. Since 2000 he worked within several different county mental health systems in California, including Tehama and Butte, before assuming his current position with Shasta in 2012. Dean's county work has focused on management positions responsible for areas of program development and oversight, public policy, managed care, quality assurance, and privacy/compliance. In addition to being an RN, Dean holds a Master's in Public Administration from the California State University, Chico.

Melissa Janulewicz – Melissa is Director of the Regional Services Branch within Shasta County Health and Human Services Agency. Melissa is responsible for services eligibility and employment programs including CalFresh, CMSP, Medi-Cal, CalWORKs, and General Assistance. Melissa has been with the Regional Services Branch since 2012 as Director and before that as Deputy Director beginning in 2009. Melissa worked within Shasta County Public Health for more than ten years working in Family Health, Communicable Disease, and as Director of Nursing. Melissa began her nursing career in 1985 as a labor and delivery nurse at Immanuel Medical Center in Omaha, Nebraska. She received her Nursing Degree in 1985 from Midland Lutheran College in Fremont, Nebraska and graduated with a Masters in Nursing from California State University, Chico in 2008. Melissa has served on numerous boards and committees including her current membership on the California Welfare Directors Association Self Sufficiency Committee and Executive Committee of the Shasta County Homeless Continuum of Care (CoC).

A Community Development Coordinator (CDC) within HHSA will be responsible for oversight of the program and will be responsible for day-to-day activities of the program. The Coordinator will report to a HHSA Program Manager, who in turn reports to Dean True, Branch Director - Adult Services. The Coordinator will lead pilot project planning and implementation activities, establish and monitor contracts with key participating entities, prepare project reports, and communicate with the steering committee. The Shasta County HHSA will also hire a Senior Data Analyst, reporting to the Community Development Coordinator, who will be responsible for collecting and reporting project data and lead quality improvement activities to support achievement of pilot targets. The organization chart attached with this project narrative identifies key staff and partners.

A Supervising Housing Social Worker and Assistant Housing Social Workers will be hired, reporting to Melissa Janulewicz through a supervisor, to provide robust case management services to support housing placement, identify and address tenancy barriers, and build basic tenancy skills of WPC participants. The Housing Socials Workers are embedded with County Eligibility Services ensuring close coordination between these agency services.

An Organizational Chart for Shasta Health and Human Services Agency, which depicts the services organized under each Branch Director, is included on the next page.

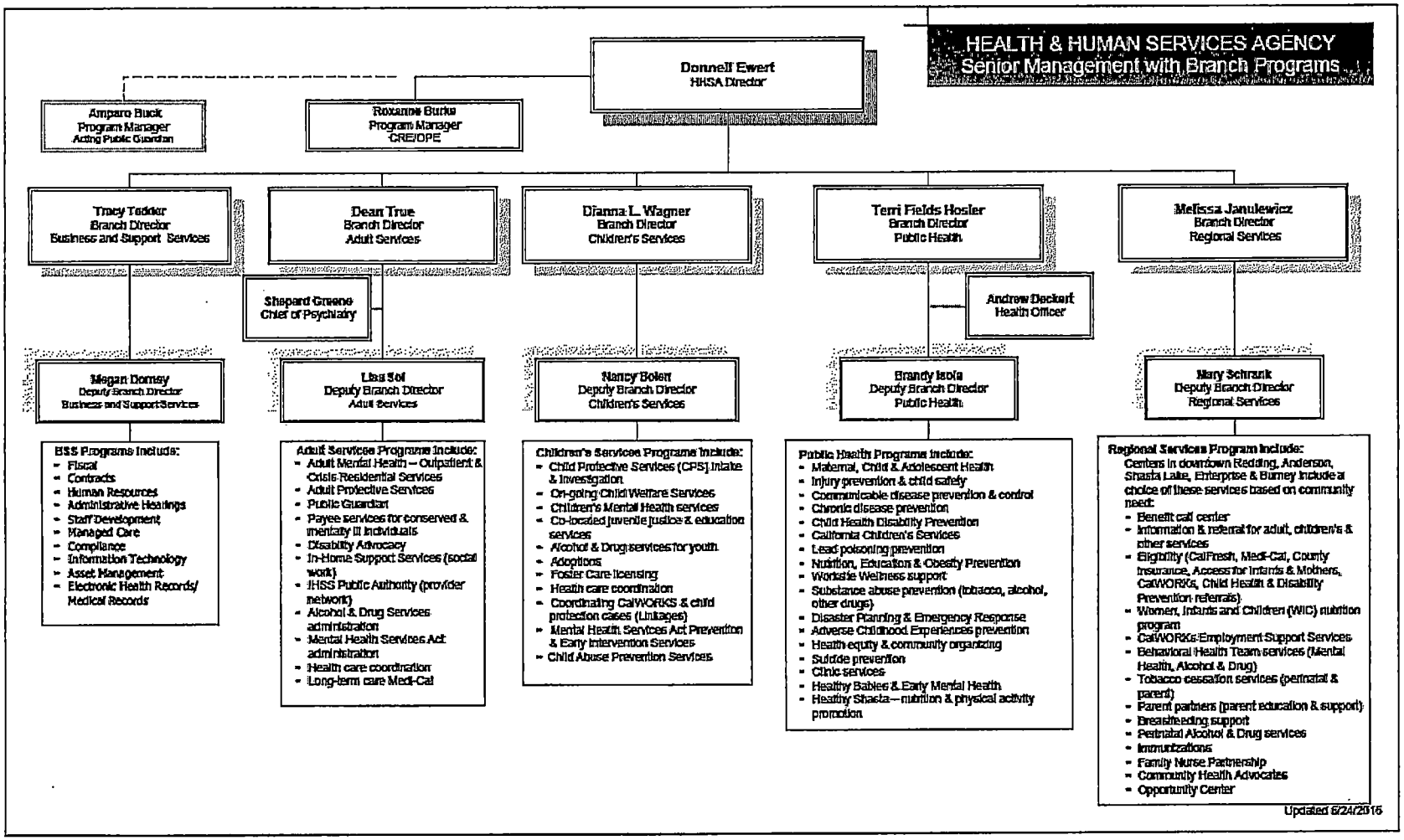


Figure 1. Shasta County HHSA Organizational Chart

The SHARC Whole Person Care Committee (WPC Committee) will serve as the Steering Committee for the WPC Pilot and will meet monthly to review pilot program progress, address challenges and identify solutions, review evaluation and program improvement data, and ensure timely and effective implementation of the program. In addition, the WPC Committee will routinely assess training needs of the case managers, AOD counselors, and the health care professionals serving the WPC enrollees and plan community-wide training events to build capacity across agencies and health systems. The current membership of the WPC Committee will be expanded to ensure that all partners are represented. The committee currently includes HHSA, FQHCs, substance use disorder treatment providers, local elected officials, and PHC. The steering committee members that may be added include representatives from Mercy Medical Center and Shasta Regional Medical Center, the Continuum of Care (CoC) Council, and the local Housing Authorities.

Two health centers are key partners in the proposed project and will offer intensive medical case management services under the pilot:

Hill Country Health & Wellness Center (HCHWC) operates two clinic sites in Shasta County in Round Mountain and in Redding. HCHWC offers comprehensive primary care, dental services, and behavioral healthcare. Hill Country has a strong relationship with Shasta County Health and Human Services Agency. HCHWC has a contract with Shasta County to use MHSA funds to provide behavioral health services to the uninsured and to provide a Full-Service Partnership (FSP). FSPs offer a full range of community and mental health services to allow seriously ill individuals to make progress toward recovery.

Shasta Community Health Centers (SCHC) operates four primary care clinics in Shasta County in Redding, Anderson, Shasta Lake and Happy Valley. SCHC offers comprehensive primary care, dental services, and behavioral health care. SCHC also operates a Primary Care Neuropsychiatry unit that offers specialty mental health services and medication-assisted treatments (MATs) to patients with substance use disorders. SCHC is a healthcare for the homeless grantee, providing primary care and dental care to homeless individuals primarily through a mobile clinic van. The HOPE van is equipped with two exam rooms and offers services in locations in Redding and the other communities SCHC serves.

5. Implementation Work Plan

The proposed implementation work plan outlines the major objectives, tasks and activities to establish and operate the Whole Person Care pilot in Shasta County. This work plan reflects services and infrastructure development that are part of the WPC pilot application approved by the Department of Health Care Services and CMS.

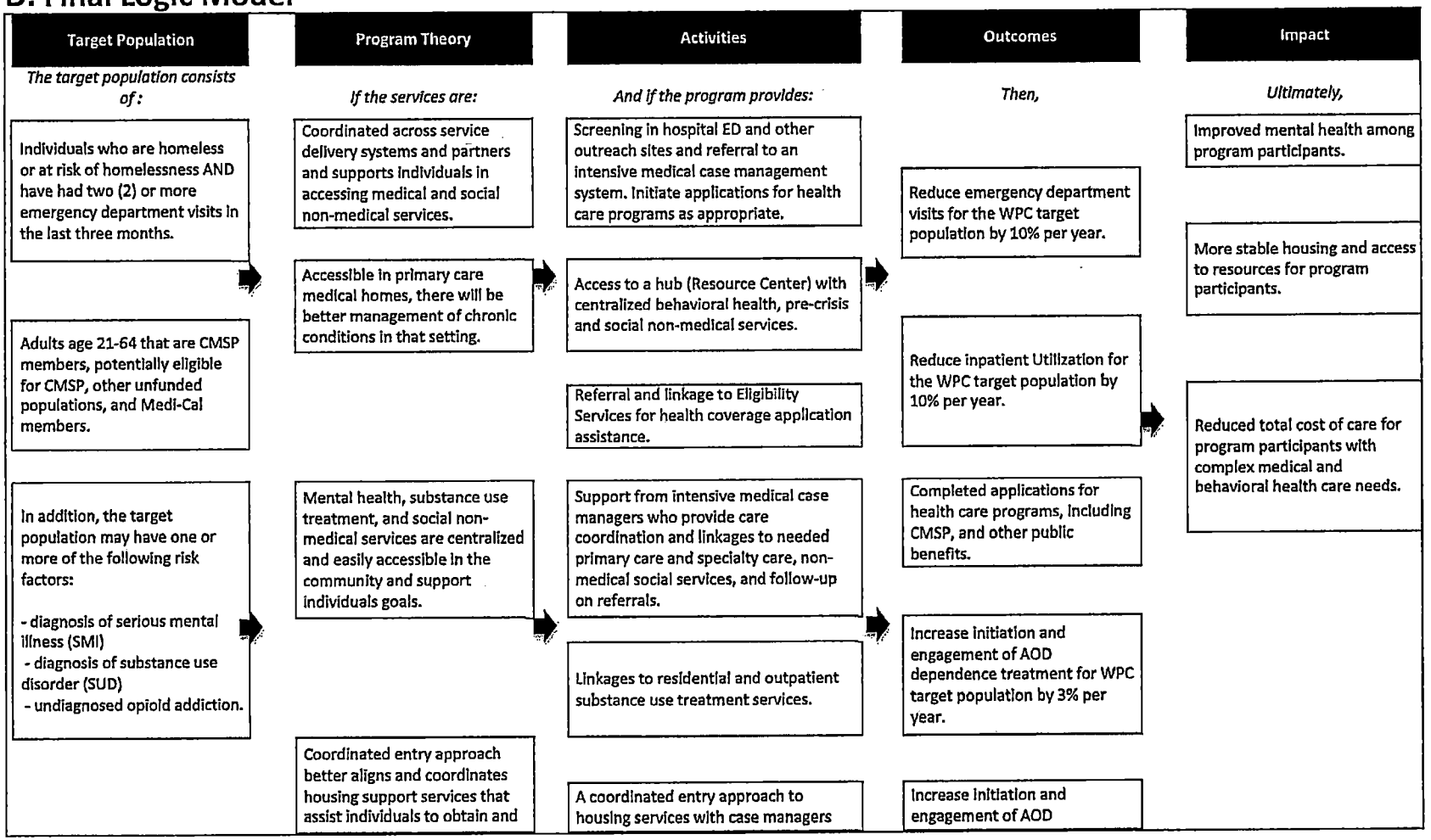
Major Objectives	Major Functions, Tasks and Activities	Timeline	Responsible	Deliverable
1. Establish care coordination, case management and referral policies and	1. Establish protocol for hospital ED staff identify individuals for entry to WPC Pilot Program & referral to HHSA mental health	By March 30, 2017	HHSA Community Development Coordinator,	Policies and procedures established

Major Objectives	Major Functions, Tasks and Activities	Timeline	Responsible	Deliverable
procedures across the WPC Pilot lead and all participating entities.	clinician for screening. 2. Establish policies and procedures for care coordination, case management, and referral across WPC Pilot lead and participating entities 3. Review and update workflow for enrolling uninsured patients into health care programs, such as CMSP, and referring uninsured patients to county Eligibility Services for application assistance. 4. Develop data and information sharing infrastructure and procedures that support comprehensive care plans accessible across WPC Pilot lead and participating entities.	June 30, 2017 December 31, 2017	Hospital partners, WPC Committee	Workflows and process for referring CMSP and uninsured patients to Eligibility Services, and for initiating health care applications reviewed and updated
2. Enroll individuals into WPC Pilot Program	1. Screen individuals in ED for SMI, SUD and homelessness and refer to intensive medical case management and SUD treatment as appropriate. 2. Expand enrollment in WPC Pilot to additional outreach sites including Hope Van, homeless shelter, substance use treatment services, and mental health resource center. 3. Contact FQHC medical case managers to alert them of WPC participant and to make referral for enrollment in medical case management.	Begin by April 1, 2017 January 2018	HHSA Clinicians embedded in ED	Enroll up to 150 individuals into Pilot annually
3. Provide intensive medical case management to WPC Pilot participants	1. Case managers provide care coordination and case management to connect WPC participants to needed primary care and specialty care, non-medical social services, health coverage application assistance, track referrals, and assist patients in accessing needed care. 2. Referrals for needed health care services made and health services delivered by FQHCs covered under Medi-Cal managed care or CMSP benefit.	Begin by April 1, 2017 Ongoing	FQHC Case Managers	Provide case management to 100 individuals annually
4. Establish mental	1. Open mental health resource	Open by	Hill Country	Serve up to

Major Objectives	Major Functions, Tasks and Activities	Timeline	Responsible	Deliverable
health resource center as a hub for behavioral health, pre-crisis intervention, and social non-medical services.	center and begin to offer drop-in and appointment-based services including assisted outpatient treatment, pre-crisis services, wellness classes, and access to social non-medical services to individuals in the community. 2. Conduct outreach in the community to raise awareness of resource among individuals, family members, law enforcement, and other community providers. 3. Build referral relationships and formal linkages between mental health resource center and substance use treatment providers.	Jan - June 2017 June – December 2017	Health & Wellness Center, HHSA	150 WPC participants annually
5. Offer housing case management to assist WPC participants obtain and maintain stable housing.	1. Promote a coordinated entry approach to housing services with case managers that assist participants in overcoming housing barriers to find and maintain stable housing that will support SUD treatment, medical and behavioral health care goals. 2. Expand Continuum of Care (CoC) coordination in Shasta County to implement newly adopted strategic plan and align resources with WPC pilot. 3. Implement HMIS system that supports data and information sharing across WPC Pilot lead and participating entities. 4. Coordinate with Social Services for application assistance for health coverage and other public benefit programs.	Begin by April 1, 2017 June 30, 2017 December 31, 2017	HHSA Housing Social Workers	Serve up to 100 WPC participants annually HMIS system implemented
6. Develop opportunities for cross agency coordination and training.	1. Host monthly training sessions offered by mental health resource center clinicians and /or WPC Community Development Coordinator for staff from all project partners and county agencies (mental health, eligibility services, housing case management, etc). 2. WPC Coordinator to offer	Monthly beginning June 2017		At least 10 sessions offered annually

Major Objectives	Major Functions, Tasks and Activities	Timeline	Responsible	Deliverable
	training on data and information sharing procedures and systems.			
7. Evaluation and Data Collection to monitor implementation and impact of pilot program.	1. Host monthly meetings of the WPC Committee to provide oversight and support for data reporting and pilot evaluation. 2. HHSA Data Analyst to develop data collection reporting tools to be used by pilot partners for collecting and monitoring services, clinical data, and outcomes for pilot participants. 3. Review data collection strategies for CMSP enrollees and eligible individuals to ensure that services and outcomes are captured for this population. 4. Collect data from Eligibility Services on application assistance provided and applications completed for health coverage and other public benefit programs.	Monthly beginning January 2017	HHSA Community Development Coordinator and Data Analyst, WPC Committee	Semi- and Annual progress reports developed reporting on pilot outcomes. Reports submitted to CMSP.

D. Final Logic Model



E. Proposed Evaluation Methodology

Data Sharing Activities to Support Evaluation

The WPC Pilot program will employ several primary sources of data on program participants to coordinate services, monitor progress and assess performance and outcomes on identified metrics. These sources include:

- Electronic health records (EHR) maintained by HHSA, FQHCs, and hospitals for primary care, behavioral health services, and ED visits,
- Program reports and tracking logs from case managers and other pilot partners,
- HMIS system to track housing assistance, and
- Health plan claims data provided by Partnership HealthPlan of California (PHC).

Encounter data on CMSP members and CMSP potentially eligible enrollees will be collected from the FQHC and hospital partners to assess the pilots impact on access to care, appropriate utilization of health care resources, and clinical outcomes. In addition to data collected by the provider partners, the pilot will utilize Medi-Cal claims data to assess impact on the Medi-Cal members enrolled in the pilot. PHC currently provides select providers in their primary care network with information on the highest cost members through their Intensive Outpatient Case Management program. Under the WPC pilot, similar strategies to identify members that are eligible for enrollment in the pilot will be explored. PHC will also support measurement on the universal and variant metrics described in this application.

Any data sharing activities related to Personal Health Information/Personal Information (PHI/PI), mental health or substance use disorder services information, between HHSA, Partnership HealthPlan, and participating network providers will comply with all applicable state and federal law. Required patient consent to share information across provider entities will be obtained as appropriate to support data sharing activities.

Performance Measures

Shasta County HHSA has established performance measures that outline the impact of the WPC pilot interventions and services for the target population on related health outcomes and health care utilization. Metrics selected are those that are required or selected by Shasta County HHSA as part of the Medi-Cal 1115 Waiver Whole Person Care Pilot as well as measures specifically focused on the CMSP and unfunded populations served by the pilot.

Table 4. Final Performance Measures

Measure	Pilot Goal	Data Source
Health Outcomes Measures		
1. Ambulatory Care – Emergency Department	Reduce emergency department visits for the WPC target population	PHC claims data, FQHC tracking workbook,

Visits [Adults] (HEDIS).	by 10% per year.	Hospital encounter reports
2. Inpatient Utilization – General Hospital/Acute Care [Adults] (HEDIS).	Reduce inpatient Utilization for the WPC target population by 10% per year.	PHC claims data, FQHC tracking workbook, Hospital encounter reports
3. Initiation and engagement of alcohol and other drug dependence treatment [Adults] (HEDIS).	Increase initiation and engagement of AOD dependence treatment for WPC target population by 3% per year.	SUD treatment provider reports, County AOD report
4. Comprehensive Diabetes Care: Hemoglobin A1c control (HEDIS)	Increase A1c control for WPC target population within three years.	FQHC PDSA reports
Administrative Measures		
5. Proportion of participating beneficiaries with a comprehensive care plan, accessible by the entire care team within 30 days of enrollment in WPC pilot.	Achieve 75% of participating beneficiaries with a comprehensive care plan within 30 days of enrollment in the pilot. Achieve 50% of participating beneficiaries with a comprehensive care plan within 30 days of anniversary of enrollment in the pilot.	FQHC tracking workbook,
6. Develop care coordination, case management, and referral infrastructure.	Establish care coordination, case management and referral policies and procedures across the WPC Pilot lead and all participating entities by June 30, 2017.	WPC Community Development Coordinator progress reports
7. Develop data and information sharing infrastructure.	Establish data and information sharing policies and procedures across WPC Pilot lead and all participating entities by December 31, 2017.	WPC Community Development Coordinator progress reports
8. Average number of monthly contacts by WPC pilot case manager per WPC Participant.	Maintain 4-6 monthly contacts by WPC pilot case manager per participant.	Housing Case Manager tracking workbook
9. Completed applications for health care coverage and other public benefit programs.	Assist WPC participants that are CMSP enrollees or are uninsured to apply for and obtain affordable health care coverage through available options (Medi-Cal, Covered California, etc.) and other public benefits (e.g. CalFresh, GA, etc)	Eligibility Services project reports

Data Analysis, Reporting and Quality Improvement

Shasta County HHSA staff will develop and document data collection, reporting and analysis procedures for the WPC Pilot interventions, strategies, and participant health outcomes. Program data related to interventions will be collected through the following sources:

- Intensive Medical Case Managers – will report on with WPC enrolled participants, engagement in outreach activities, and related outcomes for WPC participants.

- Housing Case Managers – will report on contacts with WPC enrolled participants, engagement in outreach activities, and related outcomes for WPC participants.
- Mental Health Resource Center – will submit data on WPC participants served and utilization of behavioral health services.
- Eligibility Services – will report on health care program and other public benefit application assistance provided to WPC participants who are CMSP enrollees or uninsured.
- Hospitals – will be asked to report on ED visits and admissions for CMSP enrollees or CMSP potentially eligible individuals enrolled in the WPC pilot.

WPC Pilot data will be collected through standardized reporting templates (excel spreadsheet) developed by the HHSA Data Analyst. These processes are currently utilized to manage contractors. Dashboards on services provided will be produced and analyzed to monitor performance, assess gaps and evaluate impact on outcomes. HHSA will explore opportunities to procure a data system that can support collection of relevant WPC pilot data across services, interventions and existing data systems.

A Utilization Review Committee will be convened to review and inform data analysis and ongoing monitoring of performance. This committee will inform WPC pilot PDSA activities developed under the pilot to address areas for improvement. The Utilization Review (UR) Team will reviewing data collected from across the provider entities involved the pilot. These meetings would convene staff across all WPC pilot provider entities. The Community Development Coordinator and Data Analyst (ASSA) will convene meetings monthly during PY 1 and 2 with the option to move these meetings to quarterly in PY 3- 5 once systems are established.

Attachment B2: Budget Template - Summary Budget FINAL BUDGET
CMSP County Wellness & Prevention Pilot Project

Applicant: Shasta County Health and Human Services Agency

Summary Budget – CY 2017 through CY 2019:

Category	Total Cost (Year 1)	CMSP Funding (Year 1)	Other Funding (Year 1)
Personnel	763,774	55,000	708,774
Contractual Services	2,588,590	45,000	2,543,590
Office Expenses	50,000		50,000
Travel	0		0
Other	478,346		478,346
TOTAL YEAR 1	3,880,710	100,000	3,780,710

Category	Total Cost (Year 2)	CMSP Funding (Year 2)	Other Funding (Year 2)
Personnel	763,774	55,000	708,774
Contractual Services	2,588,590	45,000	2,543,590
Office Expenses	50,000		50,000
Travel	0		0
Other	478,346		478,346
TOTAL YEAR 2	3,880,710	100,000	3,780,710

Category	Total Cost (Year 3)	CMSP Funding (Year 3)	Other Funding (Year 3)
Personnel	763,774	55,000	708,774
Contractual Services	2,588,590	45,000	2,543,590
Office Expenses	50,000		50,000
Travel	0		0
Other	478,346		478,346
TOTAL YEAR 3	3,880,710	100,000	3,780,710

Attachment B2: Budget Template - Detail Budget FINAL BUDGET
CMSP County Wellness & Prevention Pilot Project

Applicant: Shasta County Health and Human Services Agency

Detail Budget – CY 2017 through CY 2019:

Category / Item/Service	Qnty (Year 1)	Cost (Year 1)	Qnty (Year 2)	Cost (Year 2)	Qnty (Year 3)	Cost (Year 3)	Total Cost
Personnel							
Community Development Coordinator	1	100,000	1	100,000	1	100,000	300,000
Data Analyst/ASSA	1	80,000	1	80,000	1	80,000	240,000
Housing Support Volunteer Program Coordinator	1	50,000	1	50,000	1	50,000	150,000
Assistant Housing Social Worker	5	371,610	5	371,610	1	371,610	1,114,830
Housing Supervising Social Worker	1	102,164	1	102,164	1	102,164	306,492
Fiscal and Contract Administrative Services	0.75	60,000	0.75	60,000	0.75	60,000	180,000
Contractual Services							
Intensive Medical Case Management		588,752		588,752		588,752	1,766,256
Mental Health Resource Center		1,296,250		1,296,250		1,296,250	3,888,750
Mobile Crisis Team		483,588		483,588		483,588	1,450,764
CoC Coordination / HMIS Infrastructure		220,000		220,000		220,000	660,000
Office Expenses							
Software Licenses		50,000		50,000		50,000	150,000
Travel							
Other							
Individual Housing Transition Support Services		198,750		198,750		198,750	596,250
Evaluation Support (Pay for Reporting and Incentives for Pilot Partners)		254,596		254,596		254,596	763,788
Training for WPC Pilot Staff		25,000		25,000		25,000	75,000

Final Budget Narrative

Shasta County Health and Human Services Agency (HHSA) is requesting $300,000 over three years to support a Whole Person Care Pilot Project that the agency is developing to better integrate health care systems and deliver services to individuals that address their complex medical, behavioral health, and social determinants of health. Shasta County HHSA has been approved to take part in the Whole Person Care (WPC) Pilot Program under California's 1115 Medi-Cal Waiver. The CMSP funding will be leveraged to take advantage of the federal match through the WPC Pilot and to deliver Whole Person Care services to CMSP recipients and CMSP eligible individuals that meet the criteria for the pilot program. The first section of this narrative provides detail on how the CMSP funding would be expended to support the WPC Pilot Project. The latter section of the narrative provides a broad overview of the overall WPC Pilot Budget.

CMSP Budget Request

1. Personnel - $55,000 per year for 3 years

Item	Salary	Benefits*	Operating**	Budgeted Costs	CMSP Request
Community Development Coordinator (to be hired by HHSA)- responsible for day-to-day management of all pilot contractors, activities, and reporting. (1.0 FTE)	60,721	39,029	250	100,000	30,000
Data Analyst / Senior Agency Staff Services Analyst (to be hired by HHSA)- responsible for collecting and aggregating pilot data for universal and variant metrics, evaluation metrics, and reporting of program data to CMSP/DHCS. Leads PDSA activities to support achievement of pilot targets. Works with PHC, FQHCs and other CMSP delivery system partners to review claims data and clinical data to assess pilot program performance. (1.0 FTE)	45,220	34,530	250	80,000	15,000
Assistant Housing Social Worker (to be hired by HHSA) – responsible for case management services to WPC participants who are homeless or at risk of homelessness. Ensures coordination with Eligibility Services for application assistance.	39,058	35,014	250	74,322	10,000
Total CMSP Request					55,000

2. Contractual Services - $45,000 per year for 3 years

Intensive Medical Case Management Services – Intensive medical case management will be provided to WPC enrolled participants (not eligible for 2703 Health Home). A clinician case manager and patient navigator or health coach team will be developed to support the target population. These teams will be operated out of Shasta Community Health Center and Hill Country Health & Wellness Center. Contractors will be paid on a Per Member Per Month (PMPM) bundled rate for services. The rate is developed based on the following contractor costs.

Position	Salary	Units	Budgeted Costs
Intensive Case Manager - RN provides intensive case management for participants in the WPC pilot. Approximate caseload is 1:20 to 1:30.	78,000	4.00	312,000
Patient Navigators - supports engagement and management of chronic conditions and access to social non-medical services for participants in the WPC pilot. Approximate caseload is 1:20 to 1:30.	41,000	3.00	123,000
Intensive Health Coach - supports engagement and management of chronic conditions for participants in the WPC pilot. Approximate caseload is 1:20.	36,000	1.00	36,000
Fringe Benefits (25%)			117,752
TOTAL Intensive Medical Case Management Team			588,752
Total CMSP Request			45,000

TOTAL CMSP REQUEST PER YEAR IS $100,000.

WPC Pilot Budget Summary

CMSP funding would be used for the purpose of enhancing the CMSP delivery system to better coordinate comprehensive health care services delivered to CMSP enrollees and eligible individuals with complex medical and behavioral health conditions and to improve linkages to social non-medical services to better meet the needs of this population. The table below provides an overview of the key services to be delivered and how CMSP funding will be used to fund those services.

	CMSP Enrollees and Eligible		**Medi-Cal Members**	
Core Services	Primary Funding	Match	Primary Funding	Match
Delivery System Coordination and Integration	CMSP	Public Health Realignment	Public Health Realignment	Other local match Federal Match
Intensive Medical Case Management	CMSP	N/A	Public Health Realignment	Other local match Federal Match
Housing Case Management and links to Eligibility Services	Public Health Realignment	N/A	Public Health Realignment	Other local match Federal Match
Mental Health Resource Center	MHSA	N/A	MHSA	Other local match Federal Match
Mobile Crisis Team	MHSA	N/A	MHSA	Other local match Federal Match
Substance Use Disorder Services	SAPT Block Grant	N/A	Drug Medi-Cal	N/A

WPC Pilot Budget Summary Detail

Per the approved WPC pilot application, the following categories describe the overall WPC Pilot project budget. The Other Funding detailed in the CMSP County Wellness and Prevention Pilot Project Summary Budget forms ($3,780,710 per year) is allocated across these categories and is funded through local Shasta County funding, other local funding, and

50% federal financial participation match dollars per the Special Terms and Conditions of the 1115 Waiver and the WPC Pilot Program.

1. **Administrative Infrastructure** includes HHSA personnel required for the day-to-day implementation, monitoring and evaluation of the WPC pilot program. The personnel included in administrative infrastructure will be responsible for data collection and program reporting, management of contract partners, management of program budgets and fiscal administration, and data analysis and PDSA activities. These personnel will also convene CMSP delivery system partners and other pilot partners to build processes that enhance coordination within the delivery system and promote linkages to social non-medical services, including to Social Services for application assistance and enrollment. This category also includes costs for licensing software for HHSA personnel and partner entities to collect and analyze program data and support reporting on pilot program metrics.
2. **Delivery Infrastructure** includes funding for the mental health resource center, coordination of the Continuum of Care (CoC) for Redding and Shasta County, licensing of a new Homeless Management Information System (HMIS), and training for WPC pilot staff and partners to build capacity for cross agency coordination, educate staff on data and information sharing policies and procedures, and support data collection, reporting, and PDSA activities.
3. **Fee-for-Service Payments: Mobile Crisis Team (MCT)** will include 3 teams, each consisting of one clinician and one case manager. At least one MCT will be available to respond to the field/community at large from 6:00 am in the morning until 12:30 am at night, seven days a week. The MCT will be paid on a FFS rate based on projected cost and estimated face-to-face contacts of 300 per month or 3,600 annually.
4. **PMPM Bundle: Intensive Medical Case Management** will be provided to WPC enrolled participants (not eligible for 2703 Health Home). A clinician case manager and patient navigator or health coach team will be developed to support the target population. Bundled services will include a comprehensive assessment, patient-centered care plan, care coordination, nursing support for management of chronic conditions, home visits, coordination with housing case manager, coordination with mental health resource center and substance use providers, and medication monitoring support.
5. **PMPM Bundle: Housing Case Management** will be provided to WPC enrolled participants that are homeless or at risk of homelessness. A team of social workers will provide case management and housing support services designed to assist individuals to find stable housing. Social workers and volunteer peer support specialists will conduct home visits to assess barriers to maintaining housing and address identified needs. Peer support will encourage participation in substance use treatment, mental health resource center wellness programs, and other community programs to promote recovery and maintain housing.
6. **Evaluation Support: Incentives and Pay for Reporting** this funding is available to support data collection and reporting to ensure effective and robust evaluation of the WPC pilot program. This includes payments to support time spent on collecting and reporting the data required under the WPC pilot program on services delivered to WPC participants, program outcomes, and activities designed to share data across delivery system partners to enhance care coordination.
7. **Pay for Metric Outcome Achievement** includes payments for achievement of one outcome measure. The measure selected is Increase follow-up within 7 days post-discharge for Mental

Illness [Adults] for the WPC target population. The WPC pilot goal is to increase follow-up by 5% per year for 5 years. In PY2 the metric payment is based on maintaining baseline established through reporting in PY1. For PY 3 the estimated target is 50%; PY 4 the target is 55%; and in PY 5 the target is 60%.

Mercy Medical Center Mt. Shasta
Mercy Medical Center Redding
St. Elizabeth Community Hospital

Dignity Health.

August 28, 2016

Lee Kemper
c/o CMSP Governing Board
1545 River Park Drive, Suite 435
Sacramento, CA 95815

Dear Mr. Kemper,

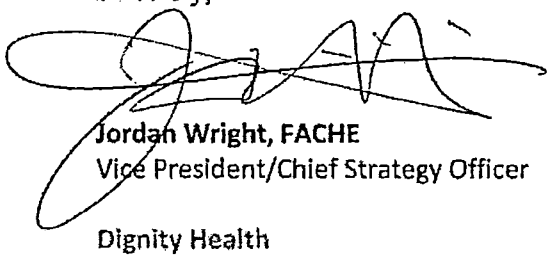
Please accept this letter of support for the CMSP County Wellness & Prevention Pilot Project proposal on behalf of Dignity Health North State. As one of the health and hospital systems serving Shasta County, we would like to express our full support and participation in the pilot initiative. The available funding will serve as critical leverage to support Shasta County's Whole Person Care Pilot project application currently under consideration by the Department of Health Care Services.

Our hospitals are at the front lines of caring for individuals with complex behavioral and physical health conditions who are homeless or at risk of homelessness as many are served by our Emergency Departments. Too often patients are being housed in the Emergency Department due to lack of other options for appropriate placement to address their physical health, behavioral health, and social non-medical needs. The situation has become quite critical and is affecting the hospital in terms of safety concerns for both staff and patients and increased costs of care.

Dignity Health is a vibrant, national health care system known for service, chosen for clinical excellence, standing in partnership with patients, employees and physicians to improve the health of all communities served. Our organization is a member of the Shasta Health Assessment and Redesign Collaborative (SHARC) and will continue to support the initiative through planning and coordination to help address the needs of this population of high utilizers and reduce the total cost of care through more appropriate placement in the community.

We look forward to the opportunity to further build and strengthen our relationships with our county and other health system partners towards an integrated system of whole person care.

Sincerely,



Jordan Wright, FACHE
Vice President/Chief Strategy Officer

Dignity Health
North State
2175 Rosaline Ave
Redding, CA 96001
Office: 530-225-6109
Mobile: 530-941-2476
Assistant Lynn Strack: 530-225-6103
jordan.wright@dignityhealth.org

SHASTA REGIONAL
MEDICAL CENTER

August 29, 2016

Lee Kemper
c/o CMSP Governing Board
1545 River Park Drive, Suite 435
Sacramento, CA 95815

Dear Mr. Kemper,

Please accept this letter of support for the CMSP County Wellness & Prevention Pilot Project proposal on behalf of Shasta Regional Medical Center. As one of the health and hospital systems serving Shasta County, we would like to express our full support and participation in the pilot initiative. The available funding will serve as critical leverage to support Shasta County's Whole Person Care Pilot project application currently under consideration by the Department of Health Care Services.

Our hospital is at the front lines of caring for individuals with complex behavioral and physical health conditions who are homeless or at risk of homelessness as many are served by our Emergency Department. Too often patients are being housed in the Emergency Department due to lack of other options for appropriate placement to address their physical health, behavioral health, and social non-medical needs. The situation has become quite critical and is affecting the hospital in terms of safety concerns for both staff and patients and increased costs of care.

Shasta Regional Medical Center is a 226-bed acute care facility and has become a regional medical center serving far Northern California. The Hospital offers a diverse range of services from emergency medicine, critical care, general/specialty surgery, cardiovascular, neurosciences to orthopedic care designed to meet the needs of the area. Our mission is to provide comprehensive, quality healthcare in a convenient, compassionate and cost effective manner.

Our organization is a member of the Shasta Health Assessment and Redesign Collaborative (SHARC) and will continue to support the initiative through planning and coordination to help address the needs of this population of high utilizers and reduce the total cost of care through more appropriate placement in the community. We look forward to the opportunity to further build and strengthen our relationships with our county and other health system partners towards an integrated system of whole person care.

Sincerely,

Cyndy Gordon, RN, BSN, MBA
Chief Executive Officer

Health and Human Services Agency

Donnell Ewert, MPH, Director

Regional Services

Melissa Janulewicz, RN, PHN, Branch Director

1506 Market Street
Redding, CA 96001-1023
Phone: (530) 225-5450
Fax: (530) 225-5245
CA Relay Service: (800) 735-2922
Customer Service Center: 877-652-0731

November 10, 2016

Lee Kemper
c/o CMSP Governing Board
1545 River Park Drive, Suite 435
Sacramento, CA 95815

Dear Mr. Kemper,

Please accept this letter of support for the CMSP County Wellness & Prevention Pilot Project proposal on behalf of Shasta County HHSA, Regional Services. We look forward to full participation in opportunities to test intensive interventions to engage and coordinate care for CMSP enrollees and other potentially eligible individuals with complex behavioral and physical health conditions who are homeless or at risk of homelessness. The need for enhanced services and supports to coordinate medical care and social non-medical services for our most vulnerable residents is a priority and as such we would like to express our full support and participation in the pilot initiative.

Rural communities like ours suffer from lack of access to health care and community resources. The opportunity to test intensive interventions to engage and coordinate care for individuals with complex behavioral and physical health conditions who are homeless or at risk of homelessness will be of great benefit to our community.

The Shasta County Health and Human Services Agency (HHSA) offers an array of services so that every person may enjoy a safe, healthy and productive life. Critical to these services is assisting uninsured individuals apply for available health coverage options. Funding from the County Medical Services Program in support of this pilot program will allow us to coordinate eligibility and enrollment services with the other services offered under the pilot program model: medical case management, housing case management, physical and behavioral health care, and support for social non-medical services to CMSP enrollees and individuals potentially eligible for CMSP who are enrolled in the pilot program.

Shasta County HHSA is an active member of the Shasta Health Assessment and Redesign Collaborative (SHARC), which is providing leadership for implementation of the pilot, and looks forward to the opportunity to work closely with our partners to implement the services, interventions, and care coordination strategies proposed in this application.

Sincerely,

Melissa Janulewicz R.N., P.H.N.
Branch Director, Regional Services

Shasta County Health and Human Services Agency
1506 Market St.
Redding CA 96001-1023
Phone: (530) 225-5066

P O Box 228
29632 Highway 299E
Round Mountain, CA 96084
530.337.5750, phone
530.337.5754, fax
www.hillcountryclinic.org
Health Care for the Whole Community

November 7, 16

Lee Kemper
c/o CMSP Governing Board
1545 River Park Drive, Suite 435
Sacramento, CA 95815

Dear Mr. Kemper,

Please accept this letter of support for the CMSP County Wellness & Prevention Pilot Project proposal on behalf of Hill Country Health and Wellness Center. We look forward to full participation in opportunities to test intensive interventions to engage and coordinate care for individuals with complex behavioral and physical health conditions who are homeless or at risk of homelessness.

Hill Country is a Federally Qualified Health Center whose mission is…

> *"With kindness, Hill Country Health and Wellness Center works in partnership with our patients and community, providing to everyone the health care services, education and support needed to live whole, healthy and satisfying lives."*

This mission statement reflects our long-standing commitment to treating the whole person by addressing the social determinants of health.

We have been an integral part of the planning process in preparation for this application through the Whole Person Care committee convened by the Shasta Health Assessment and Redesign Collaborative (SHARC) and will continue to support the initiative through collaborative planning, development and implementation of services. With the successful award of our Whole Person Care pilot project, we are working with the Whole Person Care committee and with our Health and Human Service Agency partners to prepare for implementation and build strong linkages between primary care, intensive case management and community-based services to support the goals of this initiative.

Funding from the County Medical Services Program will allow us to deliver comprehensive and well-coordinated services including medical case management, physical and behavioral health care, and support for social non-medical services to CMSP enrollees, individuals potentially eligible for CMSP, and Medi-Cal members who are enrolled in the pilot program. As a contracted CMSP provider we look forward to the opportunity to further build and strengthen our relationships with our county and other health system partners towards an integrated system of whole person care.

Sincerely,

Lynn Dorroh

Lynn Dorroh, CEO

SHASTA COMMUNITY
HEALTH CENTER

COMMUNITY HEALTH CENTER
FQHC
QUALITY

P.O. Box 992790, Redding, California 96099-2790
(530) 246-5710

November 14, 2016

Lee Kemper
c/o CMSP Governing Board
1545 River Park Drive, Suite 435
Sacramento, CA 95815

Dear Mr. Kemper,

Please accept this letter of support for the CMSP County Wellness & Prevention Pilot Project proposal on behalf of Shasta Community Health Center. As Shasta County's largest clinic system, we look forward to full participation in opportunities to test intensive interventions to engage and coordinate care for individuals with complex behavioral and physical health conditions who are homeless or at risk of homelessness.

Shasta Community Health Center is a Federally Qualified Health Center. Shasta Community Health Center (SCHC) was established in 1988 and has a mission to provide high quality health care services to the medically underserved populations of our community. SCHC's primary role is prevention and improving the health of the community. SCHC provides primary and specialty medical care, dental services, mental health services in their Redding, mobile and rural satellite health centers.

We have been an integral part of the planning process in preparation for this application through the Whole Person Care committee convened by the Shasta Health Assessment and Redesign Collaborative (SHARC) and will continue to support the initiative through collaborative planning, development and implementation of services. With the successful award of our Whole Person Care pilot project, we are working with the Whole Person Care committee and with our Health and Human Service Agency partners to prepare for implementation and build strong linkages between primary care, intensive case management and community-based services to support the goals of this initiative.

Funding from the County Medical Services Program will allow us to deliver comprehensive and well-coordinated services including medical case management and linkages to County Social Services, physical and behavioral health care, and support for social non-medical services to CMSP enrollees, individuals potentially eligible for CMSP, and Medi-Cal members who are enrolled in the pilot program.

As a contracted CMSP provider we look forward to the opportunity to further build and strengthen our relationships with our county and other health system partners towards an integrated system of whole person care.

Sincerely,

Dean Germano

EXHIBIT D

COUNTY MEDICAL SERVICES PROGRAM GOVERNING BOARD
GRANTEE DATA SHEET

Grantee's Full Name:	SHASTA COUNTY HEALTH AND HUMAN SERVICES AGENCY
Grantee's Address:	2650 Breslauer Way Redding, CA 96001
Grantee's Executive Director/CEO: (Name and Title)	Donnell Ewert, HHSA Director
Grantee's Phone Number:	(530) 245-6269
Grantee's Fax Number:	(530) 225-5903
Grantee's Email Address:	dewert@co.shasta.ca.us
Grantee's Type of Entity: (List Nonprofit or Public)	Public
Grantee's Tax Id# [EIN]:	94-6000535

I declare that I am an authorized representative of the Grantee described in this Form. I further declare under penalty of perjury under the laws of the State of California that the information set forth in this Form is true and correct.

GRANTEE:

By: _____
Title: DAVID A. KEHOE, Chairman, Board of Supervisors
Date: _____

ATTEST:

LAWRENCE G. LEES
Clerk of the Board of Supervisors

By: _____
Deputy

Approved as to form:
RUBIN E. CRUSE, JR
County Counsel

By: _____ 5/2/17
Alan B. Cox Date
Deputy County Counsel

RISK MANAGEMENT APPROVAL

By: _____ 05/03/17
James Johnson Date
Risk Management Analyst