County of Shasta
Contract No. 16-14184-SH-45

WHOLE PERSON CARE AGREEMENT

The overarching goal of the Whole Person Care (WPC) Pilot program is the coordination of health, behavioral health, and social services, as applicable, in a patient-centered manner with the goals of improved beneficiary health and wellbeing through more efficient and effective use of resources.

The Department of Health Care Services (DHCS) published a Request for Application (RFA) relating to the WPC Pilot Program on May 16, 2016. County of Shasta submitted its WPC application (Attachment A), in response to DHCS' RFA on July 1, 2016. DHCS accepted County of Shasta's WPC application to the RFA on October 24, 2016 with an allocation of $1,940,355 in federal financial participation available for each calendar year for the WPC pilot beginning in program year one through program year five subject to the signing of this Agreement.

The parties agree:

A. That "Section 6: Attestations and Certification" of Attachment A shall be amended and replaced by the following:

Section 6: Attestations and Certification
6.1 Attestation

I certify that, as the representative of the WPC pilot lead entity, I agree to the following conditions:

1. The WPC pilot lead entity will help develop and participate in regular learning collaboratives to share best practices among pilot entities, per STC 119.
2. The intergovernmental transfer (IGT) funds will qualify for federal financial participation per 42 CFR 433, subpart B, and will not be derived from impermissible sources, such as recycled Medicaid payments, federal money excluded from use as a state match, impermissible taxes, and non-bona fide provider-related donations, per STC 126.a. Sources of non-federal funding shall not include provider taxes or donations impermissible under section 1903(w), impermissible intergovernmental transfers from providers, or federal funds received from federal programs other than Medicaid (unless expressly authorized by federal statute to be used for claiming purposes, and the federal Medicaid funding is credited to the other federal funding source). For this purpose, federal funds do not include PRIME payments, patient care revenue received as payment for services rendered under programs such as the Designated State Health Programs, Medicare, or Medicaid
3. Within 30 days determining the interim or final payments due based on the mid-year and annual reports, DHCS will issue requests to the WPC pilot for the necessary IGT amounts. The WPC pilot shall make IGT of funds to DHCS in the amount specified within 7 days of receiving the state's request. If the IGTs are made within the requested timeframe, the payment will be paid within 14 days after the transfers are made.

4. This Agreement between DHCS and the WPC pilot lead entity constitutes the agreement that specifies the WPC pilot requirements, including a data sharing agreement, per STC 118. [See Exhibit A "HIPAA Business Associate Addendum (BAA)" of this Application.] The BAA will apply to the transfer and access of Protected Health Information (PHI) and Personal Information (PI) should the need for sharing such data arise. The DHCS BAA applies to any entity that is acting in a business associate capacity as defined by HIPAA specifically for the purpose of the WPC pilot's operation and evaluation. DHCS does not anticipate that PHI or PI will be shared with pilots for the purpose of the WPC pilot's operation or evaluation, and DHCS anticipates only limited, or no, sharing of PHI or PI from the WPC pilot to DHCS. However, the BAA will apply if PHI or PI is shared.
5. The WPC pilot will report and submit timely and complete data to DHCS in a format specified by the state. Incomplete and/or non-timely data submissions may lead to a financial penalty after multiple occurrences and technical assistance is provided by the state.
6. The WPC pilot shall submit mid-year and annual reports in a manner specified by DHCS and according to the dates outlined in Attachment GG. The WPC pilot payments shall be contingent on whether progress toward the WPC pilot requirements approved in this application has been made.
7. The WPC pilot will meet with evaluators to assess the WPC pilot.
8. Payments for WPC pilots will be contingent on certain deliverables or achievements; payments will not be distributed, or may be recouped, if pilots fail to demonstrate achievement or submission of deliverables. Funding for PY1 will be available for this submitted and approved WPC pilot application and for reporting baseline data; this funding is in support of the initial identification of the target population and other coordination and planning activities that were necessary for the submission of a successful application. Funding for PY2 through PY5 shall be made available based on the activities and interventions described in the approved WPC Pilot application. (STC 126). Federal funding received shall be returned if the WPC pilot, or a component of it as determined by the state, is not subsequently implemented.
9. If the individual WPC pilot applicant receives its maximum approved pilot year budget funding before the end of the pilot year, the individual WPC pilot will continue to provide WPC pilot services to enrolled WPC pilot participants at levels established in the approved WPC pilot application through the end of the pilot year.
10. WPC Pilot payments shall not be earned or payable for activities otherwise coverable or directly reimbursable by Medi-Cal.
11. The WPC lead entity has reviewed and compared the activities in the proposed WPC pilot application to its county's Medi-Cal Targeted Case Management Program (TCM), and has made appropriate adjustments to reduce the request for WPC funds as necessary to ensure that the WPC pilot funding for activities and interactions of their care coordination teams do not duplicate payments under the county's TCM benefit. The WPC lead entity has provided documentation for the adjustment(s) in the approved application which was

accepted in accordance with DHCS guidance provided to the lead entity during the DHCS application review process.

12. The lead entity will respond to general inquiries from the state pertaining to the WPC pilot within one business day after acknowledging receipt, and provide requested information within five business days, unless an alternate timeline is approved or determined necessary by DHCS. DHCS will consider reasonable timelines that will be dependent on the type and severity of the information when making such requests.
13. The lead entity understands that the state of California must abide by all requirements outlined in the STCs and Attachments GG, HH, and MM. The state may suspend or terminate a WPC pilot if corrective action has been imposed and persistent poor performance continues. Should a WPC pilot be terminated, the state shall provide notice to the pilot and request a close-out plan due to the state within 30 calendar days, unless significant harm to beneficiaries is occurring, in which case the state may request a close-out plan within 10 business days. All state requirements regarding pilot termination can be found in Attachment HH.

☒ I hereby certify that all information provided in this application is true and accurate to the best of my knowledge, and that this application has been completed based on a good faith understanding of WPC pilot program participation requirements as specified in the Medi-Cal 2020 waiver STCs, Attachments GG, HH and MM, and the DHCS Frequently Asked Questions document.

B. WPC Pilot Program Agreement

Notice

All inquiries and notices relating to this Agreement should be directed to the representatives listed below. Either party may make changes to the information above by giving written notice to the other party. Said changes shall not require an amendment to this Contract.

The Agreement representatives during the term of this Agreement will be:

Department of Health Care Services	**WPC Pilot Lead Entity**
Managed Care Quality & Monitoring Division	County of Shasta
Attention: Bob Baxter	Attention: Dean True
Telephone: (916) 319-9707	Telephone: (530) 225-5900

As a condition for participation in the WPC Pilot program, the WPC pilot lead entity (referred to as "Contractor" below) agrees to comply with all of the following terms and conditions, and with all of the terms and conditions included on any attachment(s) hereto, which is/are incorporated herein by reference:

1. **Nondiscrimination.** Pursuant to Affordable Care Act section 1557 (42 U.S.C. section 18116), during the performance of this Contract, Contractor shall not, and shall also require and ensure its subcontractors, providers, agents, and employees to not, cause an individual, beneficiary, or applicant to be excluded on the grounds prohibited under Title VI of the Civil Rights Act of 1964 (42 U.S.C. 2000d et seq.), Title IX of the Education Amendments of 1972 (20 U.S.C. 1681 et seq.), the Age Discrimination Act of 1975 (42 U.S.C. 6101 et seq.), or section 504 of the Rehabilitation Act of 1973 (29 U.S.C. 794), or subject to any other applicable State and Federal laws, from participation in, be denied the benefits of, or be subjected to discrimination under, any health program or activity offered through DHCS.

2. **Term and Termination.** This Agreement will be effective from the date both DHCS and Contractor have executed this Agreement and terminate on June 30, 2021 unless the application is renewed or the WPC Pilot program is extended, or the WPC pilot is terminated in accordance with procedures established pursuant to STC 120 and Attachment HH thereof.

3. **Compliance with Laws and Regulations.** Contractor agrees to, and shall also require and ensure its subcontractors to, comply with all applicable provisions of Chapters 7 and 8 of the Welfare and Institutions Code, and any applicable rules or regulations promulgated by DHCS pursuant to these chapters. Contractor agrees to, and shall also requires its subcontractors to, comply with all federal laws and regulations governing and regulating the Medicaid program.

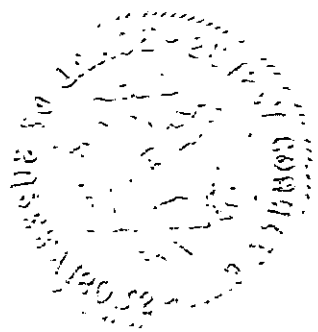
4. **Fraud and Abuse.** Contractor agrees, and shall also require its subcontractors to agree, that it shall not engage in or commit fraud or abuse. "Fraud" means intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or herself or some other person. "Abuse" means provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the Medicaid program or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care.

5. **Governing Law.** This Agreement shall be governed by and interpreted in accordance with the laws of the State of California.

6. **Complete Integration.** This Agreement, including any attachments or documents incorporated herein by express reference is intended to be a complete integration and there are no prior or contemporaneous different or additional agreements pertaining to the subject matters of this Agreement.

7. **Amendment.** No alteration or variation of the terms or provisions of this Agreement shall be valid unless made in writing and signed by the parties to this Agreement, and no oral understanding or agreement not set forth in this Agreement, shall be binding on the parties to this Agreement.

8. **Discrepancy or Inconsistency.** If there is a discrepancy or inconsistency in the terms of this Agreement and Attachment A, then this Agreement controls.



Bill Schappell

Signature of WPC Lead Entity Representative
Date November 16, 2016
FOR
Name: Pam Giacomini

Title: Chairman, Board of Supervisors County of Shasta

Signature of DHCS Representative
Date

Name: Mari Cantwell

Title: Chief Deputy Director, Health Care Programs

Attest
Lawrence G. Lees, Clerk of the Board of Supervisors

By: 11/16/16
Deputy

Approved as to form:
Rubin E. Cruse, Jr., County Counsel

A.B. Cox 11/16/16
By: Alan B. Cox
Deputy County Counsel

Risk Management Approval

By: 11/16/16

Whole Person Care Agreement

Exhibit A – Health Insurance Portability and Accountability Act (HIPAA Business Associate Addendum (BAA)

I. Recitals

A. This Contract (Agreement) has been determined to constitute a business associate relationship under the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191 ("HIPAA"), the Health Information Technology for Economic and Clinical Health Act, Public Law 111-005 ('the HITECH Act"), 42 U.S.C. section 17921 et seq., and their implementing privacy and security regulations at 45 CFR Parts 160 and 164 ("the HIPAA regulations").

B. The Department of Health Care Services ("DHCS") wishes to disclose to Business Associate certain information pursuant to the terms of this Agreement, some of which may constitute Protected Health Information ("PHI"), including protected health information in electronic media ("ePHI"), under federal law, and personal information ("PI") under state law.

C. As set forth in this Agreement, Contractor, here and after, is the Business Associate of DHCS acting on DHCS' behalf and provides services, arranges, performs or assists in the performance of functions or activities on behalf of DHCS and creates, receives, maintains, transmits, uses or discloses PHI and PI. DHCS and Business Associate are each a party to this Agreement and are collectively referred to as the "parties."

D. The purpose of this Addendum is to protect the privacy and security of the PHI and PI that may be created, received, maintained, transmitted, used or disclosed pursuant to this Agreement, and to comply with certain standards and requirements of HIPAA, the HITECH Act and the HIPAA regulations, including, but not limited to, the requirement that DHCS must enter into a contract containing specific requirements with Contractor prior to the disclosure of PHI to Contractor, as set forth in 45 CFR Parts 160 and 164 and the HITECH Act, and the Final Omnibus Rule as well as the Alcohol and Drug Abuse patient records confidentiality law 42 CFR Part 2, and any other applicable state or federal law or regulation. 42 CFR section 2.1(b)(2)(B) allows for the disclosure of such records to qualified personnel for the purpose of conducting management or financial audits, or program evaluation. 42 CFR Section 2.53(d) provides that patient identifying information disclosed under this section may be disclosed only back to the program from which it was obtained and used only to carry out an audit or evaluation purpose or to investigate or prosecute criminal or other activities, as authorized by an appropriate court order.

E. The terms used in this Addendum, but not otherwise defined, shall have the same meanings as those terms have in the HIPAA regulations. Any reference to statutory or regulatory language shall be to such language as in effect or as amended.

II. Definitions

A. Breach shall have the meaning given to such term under HIPAA, the HITECH Act, the HIPAA regulations, and the Final Omnibus Rule.

B. Business Associate shall have the meaning given to such term under HIPAA, the HITECH Act, the HIPAA regulations, and the final Omnibus Rule.

C. Covered Entity shall have the meaning given to such term under HIPAA, the HITECH Act, the HIPAA regulations, and Final Omnibus Rule.

D. Electronic Health Record shall have the meaning given to such term in the HITECH Act, including, but not limited to, 42 U.S.C Section 17921 and implementing regulations.

E. Electronic Protected Health Information (ePHI) means individually identifiable health information transmitted by electronic media or maintained in electronic media, including but not limited to electronic media as set forth under 45 CFR section 160.103.

F. Individually Identifiable Health Information means health information, including demographic information collected from an individual, that is created or received by a health care provider, health plan, employer or health care clearinghouse, and relates to the past, present or future physical or mental health or condition of an individual, the provision of health care to an individual, or the past, present, or future payment for the provision of health care to an individual, that identifies the individual or where there is a reasonable basis to believe the information can be used to identify the individual, as set forth under 45 CFR section 160.103.

G. Privacy Rule shall mean the HIPAA Regulation that is found at 45 CFR Parts 160 and 164.

H. Personal Information shall have the meaning given to such term in California Civil Code section 1798.29.

I. Protected Health Information means individually identifiable health information that is transmitted by electronic media, maintained in electronic media, or is transmitted or maintained in any other form or medium, as set forth under 45 CFR section 160.103.

J. Required by law, as set forth under 45 CFR section 164.103, means a mandate contained in law that compels an entity to make a use or disclosure of PHI that is enforceable in a court of law. This includes, but is not limited to, court orders and court-ordered warrants, subpoenas or summons issued by a court, grand jury, a governmental or tribal inspector general, or an administrative body authorized to require the production of information, and a civil or an authorized investigative demand. It also includes Medicare conditions of participation with respect to health care providers participating in the program, and statutes or regulations that require the production of information, including statutes or regulations that require such information if payment is sought under a government program providing public benefits.

K. Secretary means the Secretary of the U.S. Department of Health and Human Services ("HHS") or the Secretary's designee.

L. Security Incident means the attempted or successful unauthorized access, use, disclosure, modification, or destruction of PHI or PI, or confidential data that is essential to the ongoing operation of the Business Associate's organization and intended for internal use; or interference with system operations in an information system.

M. Security Rule shall mean the HIPAA regulation that is found at 45 CFR Parts 160 and 164.

N. Unsecured PHI shall have the meaning given to such term under the HITECH Act, 42 U.S.C. section 17932(h), any guidance issued pursuant to such Act, and the HIPAA regulations.

III. Terms of Agreement

A. Permitted Uses and Disclosures of PHI by Business Associate

Permitted Uses and Disclosures. Except as otherwise indicated in this Addendum, Business Associate may use or disclose PHI only to perform functions, activities or services specified in this Agreement, for, or on behalf of DHCS, provided that such use or disclosure would not violate the HIPAA regulations, if done by DHCS. Any such use or disclosure must, to the extent practicable, be limited to the limited data set, as defined in 45 CFR section 164.514(e)(2), or, if needed, to the minimum necessary to accomplish the intended purpose of such use or disclosure, in compliance with the HITECH Act and any guidance issued pursuant to such Act, the HIPAA regulations, the Final Omnibus Rule and 42 CFR Part 2.

1. Specific Use and Disclosure Provisions. Except as otherwise indicated in this Addendum, Business Associate may:

a. Use and disclose for management and administration. Use and disclose PHI for the proper management and administration of the Business Associate provided that such disclosures are required by law, or the Business Associate obtains reasonable assurances from the person to whom the information is disclosed that it will remain confidential and will be used or further disclosed only as required by law or for the purpose for which it was disclosed to the person, and the person notifies the Business Associate of any instances of which it is aware that the confidentiality of the information has been breached.

b. Provision of Data Aggregation Services. Use PHI to provide data aggregation services to DHCS. Data aggregation means the combining of PHI created or received by the Business Associate on behalf of DHCS with PHI received by the Business Associate in its capacity as the Business Associate of another covered entity, to permit data analyses that relate to the health care operations of DHCS.

B. Prohibited Uses and Disclosures

1. Business Associate shall not disclose PHI about an individual to a health plan for payment or health care operations purposes if the PHI pertains solely to a health care item or service for which the health care provider involved has been paid out of pocket in full and the individual requests such restriction, in accordance with 42 U.S.C. section 17935(a) and 45 CFR section 164.522(a).

2. Business Associate shall not directly or indirectly receive remuneration in exchange for PHI, except with the prior written consent of DHCS and as permitted by 42 U.S.C. section 17935(d)(2).

C. Responsibilities of Business Associate

Business Associate agrees:

1. Nondisclosure. Not to use or disclose Protected Health Information (PHI) other than as permitted or required by this Agreement or as required by law.

2. Safeguards. To implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the PHI, including electronic PHI, that it creates, receives, maintains, uses or transmits on behalf of DHCS, in compliance with 45 CFR sections 164.308, 164.310 and 164.312, and to prevent use or disclosure of PHI other than as provided for by this Agreement. Business Associate shall implement reasonable and appropriate policies and procedures to comply with the standards, implementation specifications and other requirements of 45 CFR section 164, subpart C, in compliance with 45 CFR section 164.316. Business Associate shall develop and maintain a written information privacy and security program that includes administrative, technical and physical safeguards

appropriate to the size and complexity of the Business Associate's operations and the nature and scope of its activities, and which incorporates the requirements of section 3, Security, below. Business Associate will provide DHCS with its current and updated policies.

3. Security. To take any and all steps necessary to ensure the continuous security of all computerized data systems containing PHI and/or PI, and to protect paper documents containing PHI and/or PI. These steps shall include, at a minimum:

a. Complying with all of the data system security precautions listed in Attachment A, the Business Associate Data Security Requirements;

b. Achieving and maintaining compliance with the HIPAA Security Rule (45 CFR Parts 160 and 164), as necessary in conducting operations on behalf of DHCS under this Agreement;

c. Providing a level and scope of security that is at least comparable to the level and scope of security established by the Office of Management and Budget in OMB Circular No. A-130, Appendix III - Security of Federal Automated Information Systems, which sets forth guidelines for automated information systems in Federal agencies; and

d. In case of a conflict between any of the security standards contained in any of these enumerated sources of security standards, the most stringent shall apply. The most stringent means that safeguard which provides the highest level of protection to PHI from unauthorized disclosure. Further, Business Associate must comply with changes to these standards that occur after the effective date of this Agreement.

Business Associate shall designate a Security Officer to oversee its data security program who shall be responsible for carrying out the requirements of this section and for communicating on security matters with DHCS.

D. Mitigation of Harmful Effects. To mitigate, to the extent practicable, any harmful effect that is known to Business Associate of a use or disclosure of PHI by Business Associate or its subcontractors in violation of the requirements of this Addendum.

E. Business Associate's Agents and Subcontractors.

1. To enter into written agreements with any agents, including subcontractors and vendors, to whom Business Associate provides PHI or PI received from or created or received by Business Associate on behalf of DHCS, that impose the same restrictions and conditions on such agents, subcontractors and vendors that apply to Business Associate with respect to such PHI and PI under this

Addendum, and that comply with all applicable provisions of HIPAA, the HITECH Act the HIPAA regulations, and the Final Omnibus Rule, including the requirement that any agents, subcontractors or vendors implement reasonable and appropriate administrative, physical, and technical safeguards to protect such PHI and PI. Business associates are directly liable under the HIPAA Rules and subject to civil and, in some cases, criminal penalties for making uses and disclosures of protected health information that are not authorized by its contract or required by law. A business associate also is directly liable and subject to civil penalties for failing to safeguard electronic protected health information in accordance with the HIPAA Security Rule. A "business associate" also is a subcontractor that creates, receives, maintains, or transmits protected health information on behalf of another business associate. Business Associate shall incorporate, when applicable, the relevant provisions of this Addendum into each subcontract or subaward to such agents, subcontractors and vendors, including the requirement that any security incidents or breaches of unsecured PHI or PI be reported to Business Associate.

2. In accordance with 45 CFR section 164.504(e)(1)(ii), upon Business Associate's knowledge of a material breach or violation by its subcontractor of the agreement between Business Associate and the subcontractor, Business Associate shall:

a. Provide an opportunity for the subcontractor to cure the breach or end the violation and terminate the agreement if the subcontractor does not cure the breach or end the violation within the time specified by DHCS; or
b. Immediately terminate the agreement if the subcontractor has breached a material term of the agreement and cure is not possible.

F. Availability of Information to DHCS and Individuals. To provide access and information:

1. To provide access as DHCS may require, and in the time and manner designated by DHCS (upon reasonable notice and during Business Associate's normal business hours) to PHI in a Designated Record Set, to DHCS (or, as directed by DHCS), to an Individual, in accordance with 45 CFR section 164.524. Designated Record Set means the group of records maintained for DHCS that includes medical, dental and billing records about individuals; enrollment, payment, claims adjudication, and case or medical management systems maintained for DHCS health plans; or those records used to make decisions about individuals on behalf of DHCS. Business Associate shall use the forms and processes developed by DHCS for this purpose and shall respond to requests for access to records transmitted by DHCS within fifteen (15) calendar days of receipt of the request by producing the records or verifying that there are none.

2. If Business Associate maintains an Electronic Health Record with PHI, and an individual requests a copy of such information in an electronic format, Business Associate shall provide such information in an electronic format to enable DHCS to fulfill its obligations under the HITECH Act, including but not limited to, 42 U.S.C. section 17935(e).

3. If Business Associate receives data from DHCS that was provided to DHCS by the Social Security Administration, upon request by DHCS, Business Associate shall provide DHCS with a list of all employees, contractors and agents who have access to the Social Security data, including employees, contractors and agents of its subcontractors and agents.

G. Amendment of PHI. To make any amendment(s) to PHI that DHCS directs or agrees to pursuant to 45 CFR section 164.526, in the time and manner designated by DHCS.

H. Internal Practices. To make Business Associate's internal practices, books and records relating to the use and disclosure of PHI received from DHCS, or created or received by Business Associate on behalf of DHCS, available to DHCS or to the Secretary of the U.S. Department of Health and Human Services in a time and manner designated by DHCS or by the Secretary, for purposes of determining DHCS' compliance with the HIPAA regulations. If any information needed for this purpose is in the exclusive possession of any other entity or person and the other entity or person fails or refuses to furnish the information to Business Associate, Business Associate shall so certify to DHCS and shall set forth the efforts it made to obtain the information.

I. Documentation of Disclosures. To document and make available to DHCS or (at the direction of DHCS) to an Individual such disclosures of PHI, and information related to such disclosures, necessary to respond to a proper request by the subject Individual for an accounting of disclosures of PHI, in accordance with the HITECH Act and its implementing regulations, including but not limited to 45 CFR section 164.528 and 42 U.S.C. section 17935(c). If Business Associate maintains electronic health records for DHCS as of January 1, 2009, Business Associate must provide an accounting of disclosures, including those disclosures for treatment, payment or health care operations, effective with disclosures on or after January 1, 2014. If Business Associate acquires electronic health records for DHCS after January 1, 2009, Business Associate must provide an accounting of disclosures, including those disclosures for treatment, payment or health care operations, effective with disclosures on or after the date the electronic health record is acquired, or on or after January 1, 2011, whichever date is later. The electronic accounting of disclosures shall be for disclosures during the three years prior to the request for an accounting.

J. Breaches and Security Incidents. During the term of this Agreement, Business Associate agrees to implement reasonable systems for the discovery

and prompt reporting of any breach or security incident, and to take the following steps:

1. Notice to DHCS. (1) To notify DHCS immediately upon the discovery of a suspected security incident that involves data provided to DHCS by the Social Security Administration. This notification will be by telephone call plus email or fax upon the discovery of the breach. (2) To notify DHCS within 24 hours by email or fax of the discovery of unsecured PHI or PI in electronic media or in any other media if the PHI or PI was, or is reasonably believed to have been, accessed or acquired by an unauthorized person, any suspected security incident, intrusion or unauthorized access, use or disclosure of PHI or PI in violation of this Agreement and this Addendum, or potential loss of confidential data affecting this Agreement. A breach shall be treated as discovered by Business Associate as of the first day on which the breach is known, or by exercising reasonable diligence would have been known, to any person (other than the person committing the breach) who is an employee, officer or other agent of Business Associate.

Notice shall be provided to the DHCS Program Contract Manager, the DHCS Privacy Officer and the DHCS Information Security Officer. If the incident occurs after business hours or on a weekend or holiday and involves data provided to DHCS by the Social Security Administration, notice shall be provided by calling the DHCS EITS Service Desk. Notice shall be made using the "DHCS Privacy Incident Report" form, including all information known at the time. Business Associate shall use the most current version of this form, which is posted on the DHCS Privacy Office website (www.dhcs.ca.gov, then select "Privacy" in the left column and then "Business Use" near the middle of the page) or use this link: http://www.dhcs.ca.gov/formsandpubs/laws/priv/Pages/DHCSBusinessAssociatesOnly.aspx

Upon discovery of a breach or suspected security incident, intrusion or unauthorized access, use or disclosure of PHI or PI, Business Associate shall take:

a. Prompt corrective action to mitigate any risks or damages involved with the breach and to protect the operating environment; and
b. Any action pertaining to such unauthorized disclosure required by applicable Federal and State laws and regulations.

2. Investigation and Investigation Report. To immediately investigate such security incident, breach, or unauthorized access, use or disclosure of PHI or PI. If the initial report did not include all of the requested information marked with an asterisk, then within 72 hours of the discovery, Business Associate shall submit an updated "DHCS Privacy Incident Report" containing the information marked with an asterisk and all other applicable information listed on the form, to the

extent known at that time, to the DHCS Program Contract Manager, the DHCS Privacy Officer, and the DHCS Information Security Officer:

3. Complete Report. To provide a complete report of the investigation to the DHCS Program Contract Manager, the DHCS Privacy Officer, and the DHCS Information Security Officer within ten (10) working days of the discovery of the breach or unauthorized use or disclosure. If all of the required information was not included in either the initial report, or the Investigation Report, then a separate Complete Report must be submitted. The report shall be submitted on the "DHCS Privacy Incident Report" form and shall include an assessment of all known factors relevant to a determination of whether a breach occurred under applicable provisions of HIPAA, the HITECH Act, the HIPAA regulations and/or state law. The report shall also include a full, detailed corrective action plan, including information on measures that were taken to halt and/or contain the improper use or disclosure. If DHCS requests information in addition to that listed on the "DHCS Privacy Incident Report" form, Business Associate shall make reasonable efforts to provide DHCS with such information. If necessary, a Supplemental Report may be used to submit revised or additional information after the completed report is submitted, by submitting the revised or additional information on an updated "DHCS Privacy Incident Report" form. DHCS will review and approve or disapprove the determination of whether a breach occurred, is reportable to the appropriate entities, if individual notifications are required, and the corrective action plan.

4. Notification of Individuals. If the cause of a breach of PHI or PI is attributable to Business Associate or its subcontractors, agents or vendors, Business Associate shall notify individuals of the breach or unauthorized use or disclosure when notification is required under state or federal law and shall pay any costs of such notifications, as well as any costs associated with the breach. The notifications shall comply with the requirements set forth in 42 U.S.C. section 17932 and its implementing regulations, including, but not limited to, the requirement that the notifications be made without unreasonable delay and in no event later than 60 calendar days. The DHCS Program Contract Manager, the DHCS Privacy Officer, and the DHCS Information Security Officer shall approve the time, manner and content of any such notifications and their review and approval must be obtained before the notifications are made.

5. Responsibility for Reporting of Breaches. If the cause of a breach of PHI or PI is attributable to Business Associate or its agents, subcontractors or vendors, Business Associate is responsible for all required reporting of the breach as specified in 42 U.S.C. section 17932 and its implementing regulations, including notification to media outlets and to the Secretary. If a breach of unsecured PHI involves more than 500 residents of the State of California or its jurisdiction, Business Associate shall notify the Secretary of the breach immediately upon discovery of the breach. If Business Associate has reason to believe that duplicate reporting of the same breach or incident may occur

because its subcontractors, agents or vendors may report the breach or incident to DHCS in addition to Business Associate; Business Associate shall notify DHCS, and DHCS and Business Associate may take appropriate action to prevent duplicate reporting. The breach reporting requirements of this paragraph are in addition to the reporting requirements set forth in subsection 1, above.

1. DHCS Contact Information. To direct communications to the above referenced DHCS staff, the Contractor shall initiate contact as indicated herein. DHCS reserves the right to make changes to the contact information below by giving written notice to the Contractor. Said changes shall not require an amendment to this Addendum or the Agreement to which it is incorporated.

DHCS Contract Contact	**DHCS Privacy Officer**	**DHCS Information Security Officer**
Chief, Coordinated Care Program Section	Privacy Officer c/o: Office of HIPAA Compliance Department of Health Care Services P.O. Box 997413, MS 4722 Sacramento, CA 95899-7413 Email: privacyofficer@dhcs.ca.gov Telephone: (916) 445-4646 Fax: (916) 440-7680	Information Security Officer DHCS Information Security Office P.O. Box 997413, MS 6400 Sacramento, CA 95899-7413 Email: iso@dhcs.ca.gov Fax: (916) 440-5537 Telephone: EITS Service Desk (916) 440-7000 or (800) 579-0874

K. Termination of Agreement. In accordance with Section 13404(b) of the HITECH Act and to the extent required by the HIPAA regulations, if Business Associate knows of a material breach or violation by DHCS of this Addendum, it shall take the following steps:

1. Provide an opportunity for DHCS to cure the breach or end the violation and terminate the Agreement if DHCS does not cure the breach or end the violation within the time specified by Business Associate; or
2. Immediately terminate the Agreement if DHCS has breached a material term of the Addendum and cure is not possible.

L. Due Diligence. Business Associate shall exercise due diligence and shall take reasonable steps to ensure that it remains in compliance with this Addendum and is in compliance with applicable provisions of HIPAA, the HITECH Act and the HIPAA regulations, and that its agents, subcontractors and vendors are in compliance with their obligations as required by this Addendum.

M. Sanctions and/or Penalties. Business Associate understands that a failure to comply with the provisions of HIPAA, the HITECH Act and the HIPAA regulations that are applicable to Business Associate may result in the imposition of sanctions and/or penalties on Business Associate under HIPAA, the HITECH Act and the HIPAA regulations.

IV. Obligations of DHCS

DHCS agrees to:

A. Notice of Privacy Practices. Provide Business Associate with the Notice of Privacy Practices that DHCS produces in accordance with 45 CFR section 164.520, as well as any changes to such notice. Visit the DHCS Privacy Office to view the most current Notice of Privacy Practices at: http://www.dhcs.ca.gov/formsandpubs/laws/priv/Pages/default.aspx or the DHCS website at www.dhcs.ca.gov (select "Privacy in the left column and "Notice of Privacy Practices" on the right side of the page).

B. Permission by Individuals for Use and Disclosure of PHI. Provide the Business Associate with any changes in, or revocation of, permission by an Individual to use or disclose PHI, if such changes affect the Business Associate's permitted or required uses and disclosures.

C. Notification of Restrictions. Notify the Business Associate of any restriction to the use or disclosure of PHI that DHCS has agreed to in accordance with 45 CFR section 164.522, to the extent that such restriction may affect the Business Associate's use or disclosure of PHI.

D. Requests Conflicting with HIPAA Rules. Not request the Business Associate to use or disclose PHI in any manner that would not be permissible under the HIPAA regulations if done by DHCS.

V. Audits, Inspection and Enforcement

A. From time to time, DHCS may inspect the facilities, systems, books and records of Business Associate to monitor compliance with this Agreement and this Addendum. Business Associate shall promptly remedy any violation of any provision of this Addendum and shall certify the same to the DHCS Privacy Officer in writing. The fact that DHCS inspects, or fails to inspect, or has the right to inspect, Business Associate's facilities, systems and procedures does not relieve Business Associate of its responsibility to comply with this Addendum, nor does DHCS':

1. Failure to detect or

2. Detection, but failure to notify Business Associate or require Business Associate's remediation of any unsatisfactory practices constitute acceptance of such practice or a waiver of DHCS' enforcement rights under this Agreement and this Addendum.

B. If Business Associate is the subject of an audit, compliance review, or complaint investigation by the Secretary or the Office of Civil Rights, U.S. Department of Health and Human Services, that is related to the performance of its obligations pursuant to this HIPAA Business Associate Addendum, Business Associate shall notify DHCS and provide DHCS with a copy of any PHI or PI that Business Associate provides to the Secretary or the Office of Civil Rights concurrently with providing such PHI or PI to the Secretary. Business Associate is responsible for any civil penalties assessed due to an audit or investigation of Business Associate, in accordance with 42 U.S.C. section 17934(c).

VI. Termination

A. Term. The Term of this Addendum shall commence as of the effective date of this Addendum and shall extend beyond the termination of the contract and shall terminate when all the PHI provided by DHCS to Business Associate, or created or received by Business Associate on behalf of DHCS, is destroyed or returned to DHCS, in accordance with 45 CFR 164.504(e)(2)(ii)(I).

B. Termination for Cause. In accordance with 45 CFR section 164.504(e)(1)(ii), upon DHCS' knowledge of a material breach or violation of this Addendum by Business Associate, DHCS shall:

1. Provide an opportunity for Business Associate to cure the breach or end the violation and terminate this Agreement if Business Associate does not cure the breach or end the violation within the time specified by DHCS; or
2. Immediately terminate this Agreement if Business Associate has breached a material term of this Addendum and cure is not possible.

C. Judicial or Administrative Proceedings. Business Associate will notify DHCS if it is named as a defendant in a criminal proceeding for a violation of HIPAA. DHCS may terminate this Agreement if Business Associate is found guilty of a criminal violation of HIPAA. DHCS may terminate this Agreement if a finding or stipulation that the Business Associate has violated any standard or requirement of HIPAA, or other security or privacy laws is made in any administrative or civil proceeding in which the Business Associate is a party or has been joined.

D. Effect of Termination. Upon termination or expiration of this Agreement for any reason, Business Associate shall return or destroy all PHI received from DHCS (or created or received by Business Associate on behalf of DHCS) that Business Associate still maintains in any form, and shall retain no copies of such PHI. If return or destruction is not feasible, Business Associate shall notify

DHCS of the conditions that make the return or destruction infeasible, and DHCS and Business Associate shall determine the terms and conditions under which Business Associate may retain the PHI. Business Associate shall continue to extend the protections of this Addendum to such PHI, and shall limit further use of such PHI to those purposes that make the return or destruction of such PHI infeasible. This provision shall apply to PHI that is in the possession of subcontractors or agents of Business Associate.

VII. Miscellaneous Provisions

A. Disclaimer. DHCS makes no warranty or representation that compliance by Business Associate with this Addendum, HIPAA or the HIPAA regulations will be adequate or satisfactory for Business Associate's own purposes or that any information in Business Associate's possession or control, or transmitted or received by Business Associate, is or will be secure from unauthorized use or disclosure. Business Associate is solely responsible for all decisions made by Business Associate regarding the safeguarding of PHI.

B. Amendment. The parties acknowledge that federal and state laws relating to electronic data security and privacy are rapidly evolving and that amendment of this Addendum may be required to provide for procedures to ensure compliance with such developments. The parties specifically agree to take such action as is necessary to implement the standards and requirements of HIPAA, the HITECH Act, the HIPAA regulations and other applicable laws relating to the security or privacy of PHI. Upon DHCS' request, Business Associate agrees to promptly enter into negotiations with DHCS concerning an amendment to this Addendum embodying written assurances consistent with the standards and requirements of HIPAA, the HITECH Act, the HIPAA regulations or other applicable laws. DHCS may terminate this Agreement upon thirty (30) days written notice in the event:

1. Business Associate does not promptly enter into negotiations to amend this Addendum when requested by DHCS pursuant to this Section; or

2. Business Associate does not enter into an amendment providing assurances regarding the safeguarding of PHI that DHCS in its sole discretion, deems sufficient to satisfy the standards and requirements of HIPAA and the HIPAA regulations.

C. Assistance in Litigation or Administrative Proceedings. Business Associate shall make itself and any subcontractors, employees or agents assisting Business Associate in the performance of its obligations under this Agreement, available to DHCS at no cost to DHCS to testify as witnesses, or otherwise, in the event of litigation or administrative proceedings being commenced against DHCS, its directors, officers or employees based upon claimed violation of HIPAA, the HIPAA regulations or other laws relating to

security and privacy, which involves inactions or actions by the Business Associate, except where Business Associate or its subcontractor, employee or agent is a named adverse party.

D. No Third-Party Beneficiaries. Nothing express or implied in the terms and conditions of this Addendum is intended to confer, nor shall anything herein confer, upon any person other than DHCS or Business Associate and their respective successors or assignees, any rights, remedies, obligations or liabilities whatsoever.

E. Interpretation. The terms and conditions in this Addendum shall be interpreted as broadly as necessary to implement and comply with HIPAA, the HITECH Act, the HIPAA regulations and applicable state laws. The parties agree that any ambiguity in the terms and conditions of this Addendum shall be resolved in favor of a meaning that complies and is consistent with HIPAA, the HITECH Act and the HIPAA regulations.

F. Regulatory References. A reference in the terms and conditions of this Addendum to a section in the HIPAA regulations means the section as in effect or as amended.

G. Survival. The respective rights and obligations of Business Associate under Section VI.D of this Addendum shall survive the termination or expiration of this Agreement.

H. No Waiver of Obligations. No change, waiver or discharge of any liability or obligation hereunder on any one or more occasions shall be deemed a waiver of performance of any continuing or other obligation, or shall prohibit enforcement of any obligation, on any other occasion.

HIPAA BAA
Attachment A
Business Associate Data Security Requirements

I. Personnel Controls

A. Employee Training. All workforce members who assist in the performance of functions or activities on behalf of DHCS, or access or disclose DHCS PHI or PI must complete information privacy and security training, at least annually, at Business Associate's expense. Each workforce member who receives information privacy and security training must sign a certification, indicating the member's name and the date on which the training was completed. These certifications must be retained for a period of six (6) years following contract termination.

B. Employee Discipline. Appropriate sanctions must be applied against workforce members who fail to comply with privacy policies and procedures or any provisions of these requirements, including termination of employment where appropriate.

C. Confidentiality Statement. All persons that will be working with DHCS PHI or PI must sign a confidentiality statement that includes, at a minimum, General Use, Security and Privacy Safeguards, Unacceptable Use, and Enforcement Policies. The statement must be signed by the workforce member prior to access to DHCS PHI or PI. The statement must be renewed annually. The Contractor shall retain each person's written confidentiality statement for DHCS inspection for a period of six (6) years following contract termination.

D. Background Check. Before a member of the workforce may access DHCS PHI or PI, a thorough background check of that worker must be conducted, with evaluation of the results to assure that there is no indication that the worker may present a risk to the security or integrity of confidential data or a risk for theft or misuse of confidential data. The Contractor shall retain each workforce member's background check documentation for a period of three (3) years following contract termination.

II. Technical Security Controls

A. Workstation/Laptop encryption. All workstations and laptops that process and/or store DHCS PHI or PI must be encrypted using a FIPS 140-2 certified algorithm which is 128bit or higher, such as Advanced Encryption Standard (AES). The encryption solution must be full disk unless approved by the DHCS Information Security Office.

B. Server Security. Servers containing unencrypted DHCS PHI or PI must have sufficient administrative, physical, and technical controls in place to protect that data, based upon a risk assessment/system security review.

C. Minimum Necessary. Only the minimum necessary amount of DHCS PHI or PI required to perform necessary business functions may be copied, downloaded, or exported.

D. Removable media devices. All electronic files that contain DHCS PHI or PI data must be encrypted when stored on any removable media or portable device (i.e. USB thumb drives, floppies, CD/DVD, smartphones, backup tapes etc.). Encryption must be a FIPS 140-2 certified algorithm which is 128bit or higher, such as AES.

E. Antivirus software. All workstations, laptops and other systems that process and/or store DHCS PHI or PI must install and actively use comprehensive anti-virus software solution with automatic updates scheduled at least daily.

F. Patch Management. All workstations, laptops and other systems that process and/or store DHCS PHI or PI must have critical security patches applied, with system reboot if necessary. There must be a documented patch management process which determines installation timeframe based on risk assessment and vendor recommendations. At a maximum, all applicable patches must be installed within 30 days of vendor release.

G. User IDs and Password Controls. All users must be issued a unique user name for accessing DHCS PHI or PI. Username must be promptly disabled, deleted, or the password changed upon the transfer or termination of an employee with knowledge of the password, at maximum within 24 hours. Passwords are not to be shared. Passwords must be at least eight characters and must be a non-dictionary word. Passwords must not be stored in readable format on the computer. Passwords must be changed every 90 days, preferably every 60 days. Passwords must be changed if revealed or compromised. Passwords must be composed of characters from at least three of the following four groups from the standard keyboard:

- Upper case letters (A-Z)
- Lower case letters (a-z)
- Arabic numerals (0-9)
- Non-alphanumeric characters (punctuation symbols)

H. Data Destruction. When no longer needed, all DHCS PHI or PI must be cleared, purged, or destroyed consistent with NIST Special Publication 800-88, Guidelines for Media Sanitization such that the PHI or PI cannot be retrieved.

I. System Timeout. The system providing access to DHCS PHI or PI must provide an automatic timeout, requiring re-authentication of the user session after no more than 20 minutes of inactivity.

J. Warning Banners. All systems providing access to DHCS PHI or PI must display a warning banner stating that data is confidential, systems are logged, and system use is for business purposes only by authorized users. User must be directed to log off the system if they do not agree with these requirements.

K. System Logging. The system must maintain an automated audit trail which can identify the user or system process which initiates a request for DHCS PHI or PI, or which alters DHCS PHI or PI. The audit trail must be date and time stamped, must log both successful and failed accesses, must be read only, and must be restricted to authorized users. If DHCS PHI or PI is stored in a database, database logging functionality must be enabled. Audit trail data must be archived for at least 3 years after occurrence.

L. Access Controls. The system providing access to DHCS PHI or PI must use role based access controls for all user authentications, enforcing the principle of least privilege.

M. Transmission encryption. All data transmissions of DHCS PHI or PI outside the secure internal network must be encrypted using a FIPS 140-2 certified algorithm which is 128bit or higher, such as AES. Encryption can be end to end at the network level, or the data files containing PHI can be encrypted. This requirement pertains to any type of PHI or PI in motion such as website access, file transfer, and E-Mail.

N. Intrusion Detection. All systems involved in accessing, holding, transporting, and protecting DHCS PHI or PI that are accessible via the Internet must be protected by a comprehensive intrusion detection and prevention solution.

III. Audit Controls

A. System Security Review. All systems processing and/or storing DHCS PHI or PI must have at least an annual system risk assessment/security review which provides assurance that administrative, physical, and technical controls are functioning effectively and providing adequate levels of protection. Reviews should include vulnerability scanning tools.

B. Log Reviews. All systems processing and/or storing DHCS PHI or PI must have a routine procedure in place to review system logs for unauthorized access.

C. Change Control. All systems processing and/or storing DHCS PHI or PI must have a documented change control procedure that ensures separation of duties and protects the confidentiality, integrity and availability of data.

IV. Business Continuity / Disaster Recovery Controls

A. Emergency Mode Operation Plan. Contractor must establish a documented plan to enable continuation of critical business processes and protection of the security of electronic DHCS PHI or PI in the event of an emergency. Emergency means any circumstance or situation that causes normal computer operations to become unavailable for use in performing the work required under this Agreement for more than 24 hours.

B. Data Backup Plan. Contractor must have established documented procedures to backup DHCS PHI to maintain retrievable exact copies of DHCS PHI or PI. The plan must include a regular schedule for making backups, storing backups offsite, an inventory of backup media, and an estimate of the amount of time needed to restore DHCS PHI or PI should it be lost. At a minimum, the schedule must be a weekly full backup and monthly offsite storage of DHCS data.

V. Paper Document Controls

A. Supervision of Data. DHCS PHI or PI in paper form shall not be left unattended at any time, unless it is locked in a file cabinet, file room, desk or office. Unattended means that information is not being observed by an employee authorized to access the information. DHCS PHI or PI in paper form shall not be left unattended at any time in vehicles or planes and shall not be checked in baggage on commercial airplanes.

B. Escorting Visitors. Visitors to areas where DHCS PHI or PI is contained shall be escorted and DHCS PHI or PI shall be kept out of sight while visitors are in the area.

C. Confidential Destruction. DHCS PHI or PI must be disposed of through confidential means, such as cross cut shredding and pulverizing.

D. Removal of Data. DHCS PHI or PI must not be removed from the premises of the Contractor except with express written permission of DHCS.

E. Faxing. Faxes containing DHCS PHI or PI shall not be left unattended and fax machines shall be in secure areas. Faxes shall contain a confidentiality statement notifying persons receiving faxes in error to destroy them. Fax numbers shall be verified with the intended recipient before sending the fax.

F. Mailing. Mailings of DHCS PHI or PI shall be sealed and secured from damage or inappropriate viewing of PHI or PI to the extent possible. Mailings which include 500 or more individually identifiable records of DHCS PHI or PI in a single package shall be sent using a tracked mailing method which includes verification of delivery and receipt, unless the prior written permission of DHCS to use another method is obtained.

Whole Person Care Agreement

Attachment A

Whole Person Care Pilot Application

Section 1: WPC Lead Entity and Participating Entity Information

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

1.1 Whole Person Care Pilot Lead Entity and Contact Person

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

1.2 Participating Entities

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

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

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

1.3 Letter of Participation and Support

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

Section 2 – General Information and Target Population

2.1 Geographic Area, Community and Target Population Needs

Geographic Area

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

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

Community and Target Population Needs

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

Shasta County has long experienced high rates of homelessness, however the situation has reached a breaking point in the past few years. A review of community data was recently prepared to better understand the incidence and impact of homelessness. Cal-Fresh enrollment records for the County indicate that as many as 3,000 individuals, or 1.6% of the population experienced homelessness in 2015. Shasta County's Point In Time (PIT) Count data over time suggests rates of homelessness are increasing, with an approximately 10% increase in homelessness from 2013-2016. The 2016 PIT counted 934 homeless persons in Shasta County. This represents 0.52% of the population, higher than the state rate of 0.29% (U.S. Census, 2015) or the national rate of 0.18% (HUD Annual Homeless Assessment Report to Congress, 2014). Three-quarters of individuals were unsheltered (74%) and about one-third (31%) have a psychiatric or emotional condition (Shasta County and Redding Continuum of Care, 2016).

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

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

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

Overview of Whole Person Care Pilot in Shasta County

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

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

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

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

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

Community Engagement in Planning

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

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

2.2 Communication Plan

Collaborative Leadership

The WPC pilot will be planned and implemented through the Health and Human Services Agency in close collaboration with the Shasta Health Assessment and Redesign Collaborative (SHARC). A Community Development Coordinator within HHSA will be responsible for oversight of the program, with a Case Manager Coordinator being responsible for day-to-day activities of the program. The SHARC Whole Person Care Committee (WPC Committee) will serve as the

Steering Committee for the WPC Pilot and will meet monthly to review pilot program progress, address challenges and identify solutions, review evaluation and program improvement data, and ensure timely and effective implementation of the program. In addition, the WPC Committee will routinely assess training needs of the case managers, AOD counselors, and the health care professionals serving the WPC enrollees and plan community-wide training events to build capacity across agencies and health systems.

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

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

Cross Agency Coordination

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

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

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

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

2.3 Target Population(s)

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

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

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

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

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

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

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

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

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

3.1 Services, Interventions and Care Coordination

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

Medical Services

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

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

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

Behavioral Health Services

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

Mental Health Resource Center: The mental health resource center will serve as a hub for behavioral health services for the WPC pilot target population, and will serve as an alternative to the ED for individuals experiencing less severe mental health crises. Some of the behavioral health clinical services offered will be directly reimbursed by Medi-Cal for the target population. Any services that are Medi-Cal covered services will not be funded by the WPC Pilot Program. The WPC case management coordinator will support WPC pilot participants in

accessing medical, behavioral, and social non-medical services according to identified needs. The WPC case management coordinator will work in collaboration with the medical case managers and housing case managers to coordinate roles and responsibilities, collaboratively plan shared action plans, and ensure no duplication of services for each WPC participant. Licensed clinicians will be available to evaluate and assess a member's immediate needs upon drop-in to the center or by referral from the ED. As members are stabilized, they will have access to many services on site, including substance use disorder group and individual treatment, through co-located SUD treatment providers, groups that address needs associated with anxiety, depression, and pain management. A warm line staffed by individuals with lived experience will be established and outreach staff will be present in the community to work closely with case managers and other partner organizations. A peer-staffed resource center and peer support program will be developed to enhance the wrap around supports offered to the target population. Hill Country Health and Wellness Center will operate the mental health resource center under a contract with Shasta County HHSA. The facility that will house the center is in a separate location from the primary care clinic this organization operates. The Mental Health Resource Center will also operate the Assisted Outpatient Treatment program.

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

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

Outreach and engagement activities are not Medi-Cal reimbursable, and consist primarily of discussion and education with individuals and/or their families about what mental health services are available, and how these can benefit those with serious mental illness. Such contacts and engagement often must occur many times before an individual feels comfortable in taking the next step toward recovery. It is anticipated that approximately 40% of the work in the AOT program will consist of outreach and engagement activities. Individuals willing to actively engage in treatment, or those who are court ordered to participate, will be enrolled in ongoing AOT/ACT mental health services. Many of these services are eligible for reimbursement under Medi-Cal Specialty Mental Health Services including: rehabilitation activities (skill building and education), medication support with psychiatrist and nurses, limited case management, and individual/group therapy sessions. No WPC funds will be utilized to support Medi-Cal covered services.

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

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

Linkages to Substance Use Disorder Treatment Services: Analysis of the target population for the WPC pilot underscores the importance of connecting these individuals to residential and outpatient substance use disorder (SUD) treatment services. SUD treatment providers will play a key role in the services delivered to WPC pilot program participants. Through the WPC pilot, enhanced referral relationships will be established to ensure coordination between the HHSA ED-based clinicians, three Drug Medi-Cal (DMC) treatment providers, primary care medical homes, housing case management services, and the mental health resource center. Intensive medical case managers will use motivational interviewing in conjunction with DMC providers to encourage patients with SUD disorders to enroll in an appropriate level of SUD treatment. In addition, motivational interviewing will be used to engage patients in the sobering center to encourage them to seek treatment in a detoxification center currently operated by one of the local DMC providers. The FQHCs will continue to expand their outpatient SUD services to provide an integrated setting for individuals with SUDs who also are enrolled in their primary care services. The WPC Steering Committee offers key opportunities to address SUD treatment related issues community-wide. All three Drug Medi-

Cal providers participate (Empire Recovery, Right Roads, Visions of the Cross) and can raise and address challenges and identify collective solutions.

Coordinated Entry and Housing Services

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

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

Other Social Non-Medical Services

In addition to housing services, other social non-medical services will be integrated into the services and interventions to support the WPC pilot participants. The mental health resource

center will be the primary hub for coordinating these services, which may include enrollment in CalFresh, General Assistance and other public benefit programs, employment skills training, parenting classes, and other services as identified.

3.2 Data Sharing

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

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

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

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

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

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

The Shasta County HHSA Adult Services Branch operates the specialty mental health plan. Cerner is the electronic health record used for services provided through the County specialty

mental health clinics. As permitted by all relevant state and federal law protecting privacy, information on individuals served through county-operated specialty mental health services may be shared with the mental health resource center in order to coordinate the plan of care across service sites and teams.

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

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

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

4.1 Performance Measures

Shasta County HHSA has established performance measures that utilize both qualitative and quantitative data to monitor implementation of the pilot and achievement of pilot goals. The performance measures outline the impact of the WPC pilot interventions and services for the target population on related health outcomes and health care utilization. Variant metrics selected are currently reported under PHC Quality Improvement Program (QIP) or HEDIS reporting and therefore have gone through extensive clinical review in the region. Responsibility for collecting process and outcome data is shared among the lead entity, the Shasta County Health and Human Services Agency (HHSA), and participating community

partners. Shasta County HHSA will adapt existing data collection tools and protocols for measuring performance over the five-year pilot period.

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

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

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

4.1.a Universal Metrics

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

- ☑ Health Outcomes Measures
- ☑ Administrative Measures

Health Outcomes Measures

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

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

3. Follow-up After Hospitalization for Mental Illness [Adult] (HEDIS).
   Pilot Goal: Increase follow-up within 7 days post-discharge for Mental Illness [Adults] for the WPC target population by 5% per year.

4. Initiation and engagement of alcohol and other drug dependence treatment [Adults] (HEDIS).

Pilot Goal: Increase initiation and engagement of AOD dependence treatment for WPC target population by 3% per year.

Administrative Measures

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

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

4.1.b Variant Metrics

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

4.2 Data Analysis, Reporting and Quality Improvement

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

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

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

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

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

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

4.3 Participant Entity Monitoring

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

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

Section 5: Financing

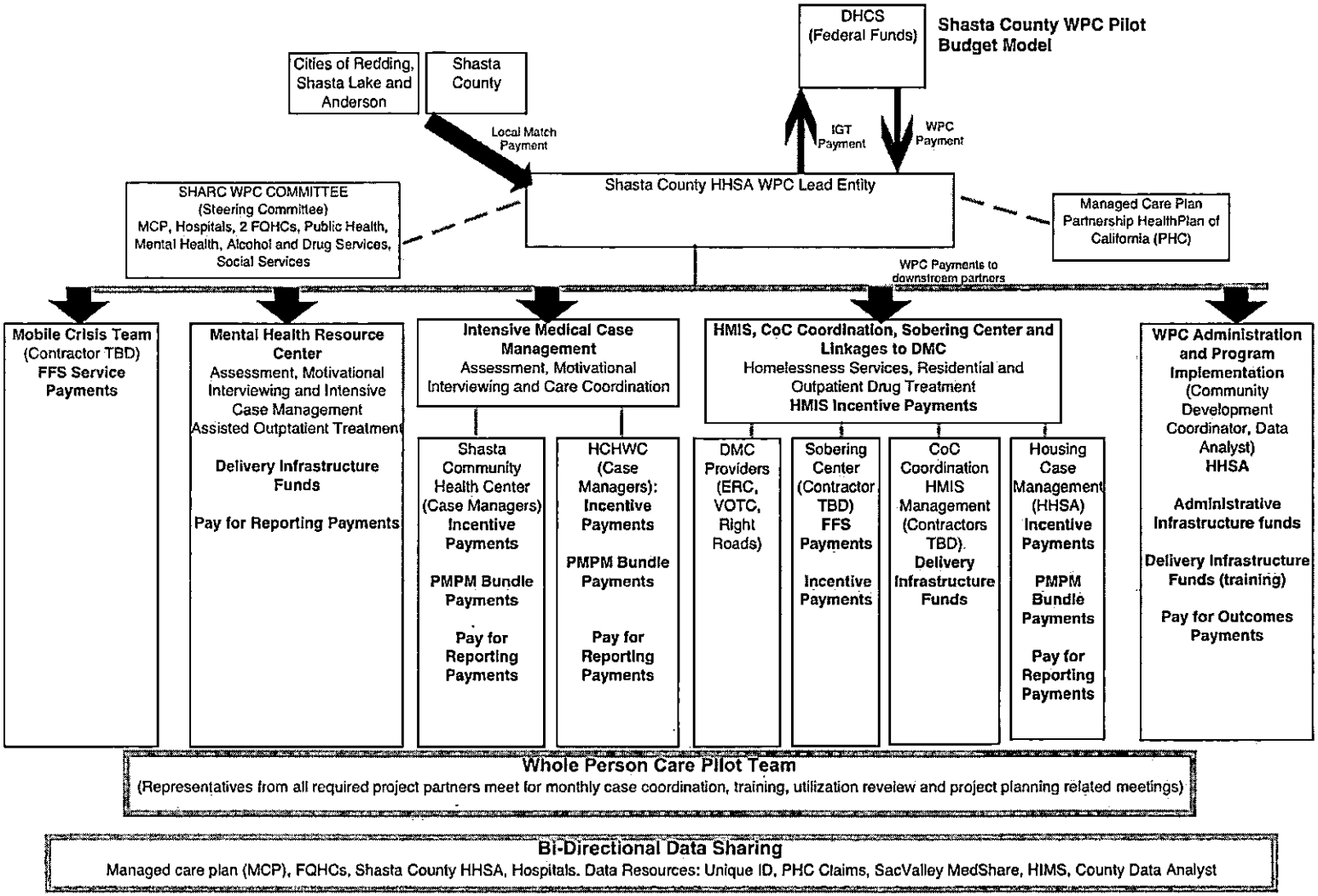
5.1 Financing Structure

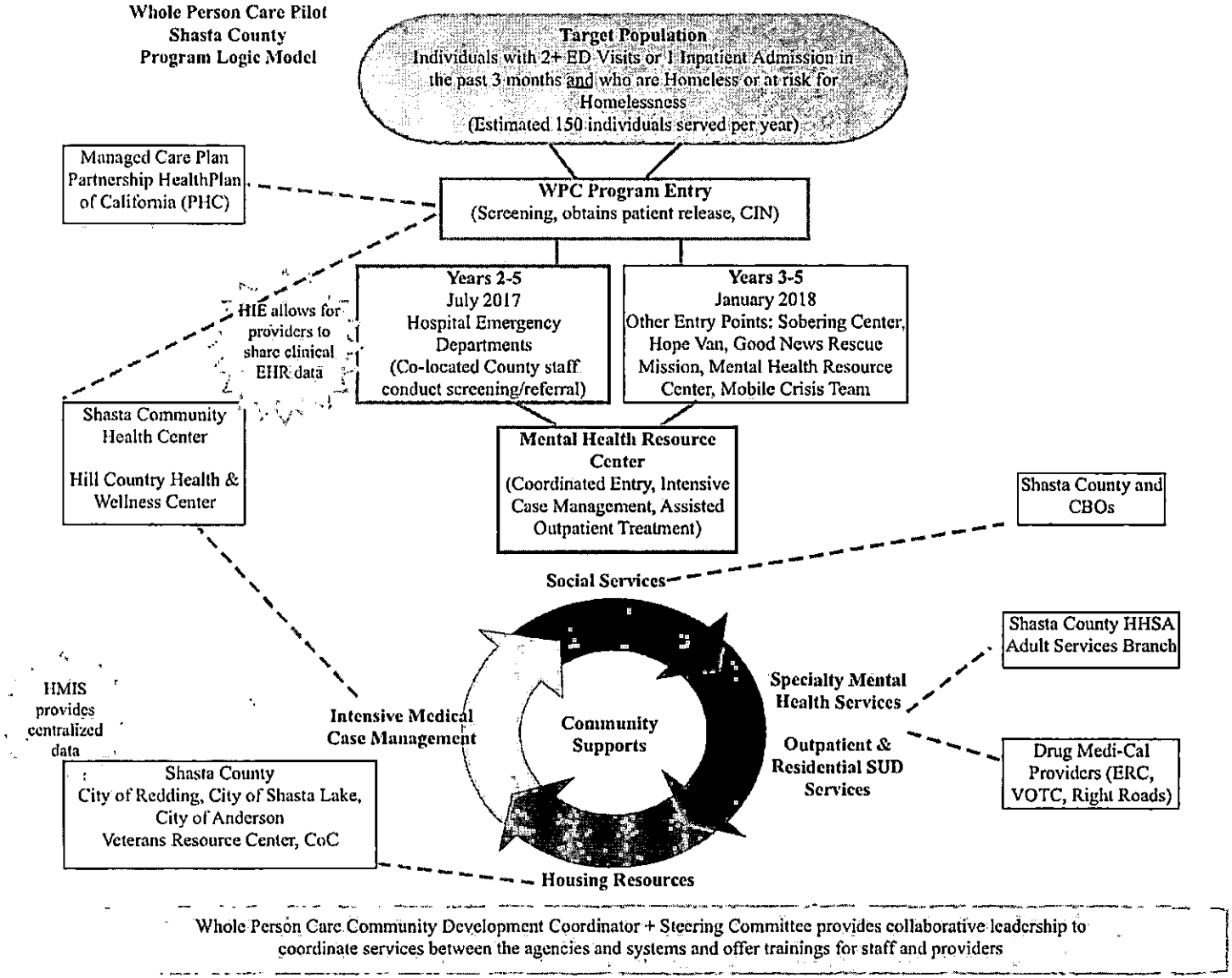
Local funds for the WPC pilot will originate with the County of Shasta and the cities of Redding, Anderson, and Shasta Lake. Agreements between the County of Shasta and the three cities will be needed to transfer the city funds to the county for the pilot. The County of Shasta will conduct the procurement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

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

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

5.2 Funding Diagram




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

5.3 Non-Federal Share

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

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

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

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

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

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

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

5.5 Funding Request

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

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

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

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

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

The following activities are attributable to the identified budget categories:

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

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

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

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

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

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

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

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

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

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

Section 6: Attestations and Certification

6.1 Attestation

Page intentionally left blank. See Whole Person Care Agreement Section A for Attestations and Certification.

PARTNERSHIP
HEALTHPLAN
of CALIFORNIA

June 22, 2016

Sarah Brooks, Deputy Director
Health Care Delivery Systems
Department of Health Care Services
Director's Office, MS 0000
P.O. Box 997413
Sacramento, CA 95899-7413

Dear Ms. Brooks,

Partnership HealthPlan of California (PHC) is pleased to submit this letter of support for the Shasta County Whole Person Care Pilot application. As the Medi-Cal Managed Care Plan (MCP) in Shasta County, PHC is committed to testing intensive interventions that aim to reduce emergency department visits and inpatient admissions, to control health care resource utilization, and to improve health outcomes.

PHC is committed to working in partnership with Shasta County Health and Human Services Agency and the broad collaborative of partners in Shasta County to implement the Whole Person Care Pilot initiative described in this application.

PHC is actively engaged as a member of the Shasta Health Assessment and Redesign Collaborative (SHARC) and with our network of providers to identify needs of Medi-Cal beneficiaries and gaps in the existing service delivery system. We have been part of the planning meetings in preparation for this application and support the services, interventions, and care coordination strategies proposed to engage and support individuals with complex behavioral and physical health conditions who are homeless or at risk of homelessness in Redding and the surrounding communities.

PHC will serve on the Steering Committee for the Whole Person Care Pilot program and support the implementation, monitoring and evaluation of the program through the data sharing activities described in the application, including providing data on high utilizing patients to inform outreach and referral strategies for this initiative.

Sincerely,

Liz Gibboney
Chief Executive Officer
Partnership HealthPlan of California

4665 Business Center Drive, Fairfield, CA 94534
(707) 863-4100 • fax (707) 863-4117

Health and Human Services Agency

Donnell Ewert, MPH, Director

2650 Breslauer Way
Redding, CA 96001-4246
Phone: (530) 225-5899
Fax: (530) 225-5903
CA Relay Service: (800) 735-2922

June 17, 2016

Sarah Brooks
Deputy Director, Health Care Delivery Systems
Department of Health Care Services
Director's Office, MS 0000
P.O. Box 997413
Sacramento, CA 95899-7413

Dear Ms. Brooks,

Please accept this letter of participation on behalf of the Shasta County Health and Human Services Agency for the Shasta County Whole Person Care Pilot application. 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 as the lead agency 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 our residents can be full of healthy people in thriving and safe communities. Our agency is now made up of five branches that include the functions of Public Health, Mental Health, Alcohol and Drug Services, and Social Services. Through the Whole Person Care pilot initiative we will test strategies to coordinate services across our agency and work with our community partners, local hospital systems, federally qualified health centers, other contract providers, and Partnership HealthPlan of California to more efficiently address the needs of individuals targeted under this initiative. The local funds identified in the proposed budget demonstrate this agency's commitment to achieving the goals of this initiative.

Shasta County HHSA is an active member of the Shasta Health Assessment and Redesign Collaborative (SHARC) 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,

Donnell Ewert, MPH
Shasta County HHSA/Social Services Director
530.245.6269
dewert@co.shasta.ca.us

Shasta County

DEPARTMENT OF HOUSING AND COMMUNITY ACTION PROGRAMS

Shasta County Administration Center
1450 Court Street, Suite 108
Redding, CA 96001-1661
Phone (530) 225-5160 Fax (530) 225-5178

RICHARD KUHNS, PSY.D., DIRECTOR
HOUSING AUTHORITY
COMMUNITY ACTION AGENCY

June 20, 2016

Sarah Brooks
Deputy Director, Health Care Delivery Systems
Department of Health Care Services
Director's Office, MS 0000
P.O. Box 997413
Sacramento, CA 95899-7413

Dear Ms. Brooks:

Please accept this letter of participation on behalf of the Shasta County Housing Authority for the Shasta County Whole Person Care Pilot application. Our agency is committed to addressing the needs of our residents, particularly those that are homeless or at risk of homelessness. The need for enhanced supports and resources to help individuals find and maintain safe housing 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 housing supports, health care and community resources. The opportunity to test intensive interventions to engage and coordinate housing supports and medical 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 Housing Authority is committed to partnering with the Shasta County Health and Human Services Agency to plan and implement the housing support services described in this application including case management, housing support services, peer support, and more.

We support the efforts of the Shasta County Health and Human Services Agency and the Shasta Health Assessment and Redesign Collaborative (SHARC) to redesign services, interventions, and care coordination strategies to improve the health and outcomes of the target population and the broader population of our county. We look forward to opportunities to support the goals of this initiative.

Sincerely,

Richard Kuhns, Psy.D
Director

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

June 29, 16

Sarah Brooks
Deputy Director, Health Care Delivery Systems
Department of Health Care Services
Director's Office, MS 0000
P.O. Box 997413
Sacramento, CA 95899-7413

Dear Ms. Brooks,

Please accept this letter of commitment for the Shasta County Whole Person Care Pilot application on behalf of Hill County 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. We will work with the Whole Person Care committee and with our Health and Human Service Agency partners to build strong linkages between primary care, intensive case management and community-based services to support the goals of this initiative. 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
californiahealth+

COMMUNITY HEALTH CENTER FQHC QUALITY SM

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

June 21, 2016

Sarah Brooks
Deputy Director, Health Care Delivery Systems
Department of Health Care Services
Director's Office, MS 0000
P.O. Box 997413
Sacramento, CA 95899-7413

Dear Ms. Brooks,

Please accept this letter of commitment for the Shasta County Whole Person Care Pilot application 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. We will work with the Whole Person Care committee and with our Health and Human Service Agency partners to build strong linkages between primary care, intensive case management and community-based services to support the goals of this initiative. 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,

C. Dean Germano, CEO

Shasta Health Assessment and Redesign Collaborative (SHARC)

2280 Benton Drive, Bldg C, Ste C
Redding, CA 96003
530-247-1560

June 24, 2016

Sarah Brooks
Deputy Director, Health Care Delivery Systems
Department of Health Care Services
Director's Office, MS 0000
P.O. Box 997413
Sacramento, CA 95899-7413

Dear Ms. Brooks,

Please accept this letter of support for the Shasta County Whole Person Care Pilot application on behalf of the Shasta Health Assessment and Redesign Collaborative. As a local health collaborative that brings together health care delivery partners across Shasta County to catalyze improvements in our local system of care, we would like to express our full support of this pilot initiative.

Rural communities like ours suffer from lack of access to health care resources, including the coordination of resources to support the needs of the whole person. 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 Health Assessment and Redesign Collaborative (SHARC) has been meeting monthly since 2009 to build a more organized system of health care delivery for Shasta County. Our collaborative will partner closely with the Shasta County Health and Human Services Agency to provide leadership and support decision making for the pilot. The SHARC Whole Person Care committee will serve as the steering committee for the initiative and through monthly meetings will monitor the progress of the initiative, build opportunities for enhanced coordination of care across agencies and systems, identify and engage additional community partners to support the initiative, and raise awareness of the initiative with community stakeholders and policy leaders.

We support the efforts of the Shasta County Health and Human Services Agency and their partners to redesign services, interventions, and care coordination strategies to improve the health and outcomes of the target population and hope you will fund this most important initiative for our community.

Sincerely,

Dave Jones, Chair
Shasta Health Assessment and Redesign Collaborative

CITY OF REDDING
777 CYPRESS AVENUE, REDDING, CA 96001
P.O. BOX 496071, REDDING, CA 96049-6071

MISSY MCARTHUR, MAYOR
530.225.4447
530.225.4463 FAX

June 15, 2016
A-050-060-450

Mari Cantwell, Chief Deputy Director
Department of Health Care Services
Director's Office, MS 0000
P.O. Box 997413
Sacramento, CA 95899-7413

Dear Ms. Cantwell,

Please accept this letter of support for the Shasta County Whole Person Care Pilot application on behalf of the City of Redding. The City of Redding is committed to addressing the needs of our at-risk residents, particularly those that suffer from drug and alcohol addictions.

Rural communities like ours suffer from a 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 will be of great benefit to our community.

To demonstrate our support of this initiative, the City of Redding has committed $375,000, contingent on the sale of a real property owned by the City, to the development of a sobering center. Also, the City of Redding has placed a half-cent sales tax measure on the November 2016 ballot that would generate approximately $11 million per year. Of that revenue, the City proposes to commit an additional $375,000 toward the development of the sobering center, for a total of $750,000.

We support the efforts of the Shasta County Health and Human Services Agency and the Shasta Health Assessment and Redesign Collaborative (SHARC) to redesign services, interventions, and care coordination strategies to improve the health and outcomes of the target population and

the broader population of our city and county. We look forward to working with the County of Shasta and other community partners on opportunities to support the goals of this initiative.

Sincerely,

Missy McArthur
Mayor

MM:KS:ls
C:\Documents and Settings\shank\My Documents\Mayor-CC\2016\L06-15-16WPC-App.doc
c: Shasta County Health and Human Services Agency

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

Dignity Health.

Sarah Brooks
Deputy Director, Health Care Delivery Systems
Department of Health Care Services
Director's Office, MS 0000
P.O. Box 997413
Sacramento, CA 95899-7413

Dear Ms. Brooks,

Please accept this letter of support for the Shasta County Whole Person Care Pilot application 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.

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

June 21, 16

Sarah Brooks
Deputy Director, Health Care Delivery Systems
Department of Health Care Services
Director's Office, MS 0000
P.O. Box 997413
Sacramento, CA 95899-7413

Dear Ms. Brooks,

Please accept this letter of support for the Shasta County Whole Person Care Pilot application 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.

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 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

EMPIRE RECOVERY CENTER

FOR THE RESIDENTIAL TREATMENT OF SUBSTANCE ABUSE

June 17, 2016

Sarah Brooks
Deputy Director, Health Care Delivery Systems
Department of Health Care Services
Director's Office, MS 0000
P.O. Box 997413
Sacramento, CA 95899-7413

Dear Ms. Brooks,

Please accept this letter of support for the Shasta County Whole Person Care Pilot application on behalf of the Empire Recovery Center. As one of the three Drug Medi-Cal providers serving Shasta County, we extend our full support and participation in the pilot initiative.

Rural communities like ours suffer from lack of access to health care resources, including substance use disorder treatment 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 communities.

The Empire Hotel Alcoholic Rehabilitation Center (EHARC, Inc., dba Empire Recovery Center) is a private, nonprofit 501(c)3 organization whose mission is to provide substance use disorder treatment through its detox, intensive residential treatment, and outpatient SUD programs.

We have been part of the planning meetings 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 planning and coordination of services. We will work with the Whole Person Care committee and with our Health and Human Service Agency partners to build strong linkages between the mental health resource center, the sobering center, and our community-based services to support the goals of this initiative. 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,

Marjeanne Stone, Executive Director

1237 California Street, Redding, CA 96001-6018 • (530) 243-7470
E-Mail: empirerecovery@att.net • Fax (530) 243-7477
www.empirerecoverycenter.org

Member Agency of the United Way

VOTC, Inc.

California State Licensed & Certified Alcohol & Drug Residential and Outpatient Treatment Facility with Transitional Housing

June 22, 16

Sarah Brooks
Deputy Director, Health Care Delivery Systems
Department of Health Care Services
Director's Office, MS 0000
P.O. Box 997413
Sacramento, CA 95899-7413

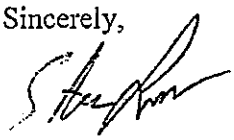
Dear Ms. Brooks,

This letter is being sent in support of the Shasta County Whole Person Care Pilot application on behalf of VOTC, Inc., d.b.a., Vision Of The Cross, one of the Drug Medi-Cal providers serving Shasta County. Recognizing the overwhelming need that communities such as ours have for access to health care resources, including substance use disorder treatment resources, Visions Of The Cross fully supports and desires to participate in this innovative pilot initiative. Being able to offer intensive interventions that will involve and coordinate services for individuals who are homeless or at risk of homelessness and who have manifold behavioral and physical health issues has the potential to significantly improve our communities.

Visions Of The Cross is a private, nonprofit organization whose mission is to improve the quality of life in Shasta County through lowering the impact and incidence of alcohol and other drug use, misuse, and abuse. Visions offers both state licensed and certified perinatal and non-perinatal residential and outpatient SUD treatment as well as providing multiple sober living environments for those in recovery.

As a participant in planning meetings for the preparation for this application through the Whole Person Care committee organized by the Shasta Health Assessment and Redesign Collaborative (SHARC), Visions Of The Cross is committed to continuing support of the initiative through planning and coordination of services. With the Whole Person Care committee and with our local Health and Human Service Agency partners we will work to build strong connections between existing community-based services, the mental health resource center, and the sobering center to support the objectives of this initiative. We look forward to the opportunity to further build and enhance our relationships with our county and other health system partners in creating an integrated system of whole person care.

Sincerely,



Steve Lucarelli
Executive Director
3648 El Portal, Redding, CA 96002 ◆ Office (530) 722-1114 ◆ Fax (530) 722-1115 ◆
visionsofthecross@charter.net

June 23, 16

Mari Cantwell
Chief Deputy Director
Department of Health Care Services
Director's Office, MS 0000
P.O. Box 997413
Sacramento, CA 95899-7413

Dear Ms. Cantwell,

Please accept this letter of support for the Shasta County Whole Person Care Pilot application on behalf of the Good News Rescue Mission. As a community organization serving Shasta County, we would like to express our full support of the pilot initiative.

Rural communities like ours suffer from lack of access to health care resources, including the coordination of resources to support the needs of the whole person. 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 communities.

Good News Rescue Mission is a private, nonprofit organization whose mission is to provide emergency shelter and sustenance to the homeless and needy of Shasta County while also providing a variety of supportive services designed to help people break the cycle of poverty through mental health, educational, physical, emotional and spiritual avenues.

We support the efforts of the Shasta County Health and Human Services Agency and the Shasta Health Assessment and Redesign Collaborative (SHARC) to redesign services, interventions, and care coordination strategies to improve the health and outcomes of the target population and the broader population of our county.

Sincerely,

Jonathan D. Anderson
Executive Director

P.O. Box 991626 • Redding, California 96099-1626 • 2842 S. Market St. • Redding, California 96001
(530) 242-5920 • Fax (530) 242-5924

United Way of Northern California

June 14, 2016

Sarah Brooks
Deputy Director, Health Care Delivery Systems
Department of Health Care Services
Director's Office, MS 0000
P.O. Box 997413
Sacramento, CA 95899-7413

Dear Ms. Brooks,

Please accept this letter of support for the Shasta County Whole Person Care Pilot application. As a community organization serving Shasta County, we would like to express our full support of the pilot initiative.

Rural communities like ours suffer from lack of access to health care resources, including the coordination of resources to support the needs of the whole person. 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 communities.

United Way of Northern California is a private, nonprofit organization whose mission is to improve lives by mobilizing community resources in the areas of Education, Financial Stability, and Health. United Way raises funds for local non-profit agencies; operates 2-1-1, a 24-hour human services helpline; and connects volunteers to agencies through volunteernorcal.org. You can find out more about us by visiting www.norcalunitedway.org.

United Way has found the County of Shasta to be a strong partner in efforts to improve lives in our community. We support the efforts of the Shasta County Health and Human Services Agency and the Shasta Health Assessment and Redesign Collaborative (SHARC) to redesign services, interventions, and care coordination strategies to improve the health and outcomes of the target population and the broader population of our county.

Best,

Larry Olmstead

Larry Olmstead
President & CEO
530-241-7521 / lolmstead@norcalunitedway.org

Shasta County Whole Person Care Pilot
Budget Justification

The following provides a justification of annual budgeted costs for the Whole Person Care (WPC) Pilot. Costs represent strategies, interventions and services that will be directed to individuals who meet the eligibility criteria described in the application and are enrolled in the WPC Pilot. Services included in the budget are those that are not reimbursed directly by Medi-Cal.

Infrastructure Development

Administrative Infrastructure - $290,000

Item	Salary	Benefits*	Operating**	FTE	Budgeted Costs
Shasta County HHSA – WPC Pilot Administration					
Community Development Coordinator (to be hired)- responsible for day-to-day management of all pilot contractors, activities, and reporting.	60,721	39,029	250	1.00	100,000
Data Analyst / Senior Agency Staff Services Analyst (to be hired)- responsible for collecting and aggregating pilot data for universal and variant metrics, evaluation metrics, and reporting of program data to DHCS. Leads PDSA activities to support achievement of pilot targets. Works with PHC, FQHCs and other partners to review claims data and clinical data to assess pilot program performance.	45,220	34,530	250	1.00	80,000
Fiscal and Contract Administrative Services – 0.25 FTE Accountant-Auditor, 0.25 FTE contract analyst, and 0.25 FTE Account Clerk will be needed to develop contracts, track expenditures, and pay claims	33,815	26,185	250	0.75	60,000
Software for tracking program metrics – software to track client encounters, as well as program process and outcome measures, will be needed to meet the metric reporting obligations of the WPC Pilot. Anticipated that this will be purchase of software licenses for WPC lead and participating entity staff. During PY 2 will explore and identify software solution.					50,000
TOTAL WPC Pilot Administration					290,000

*Benefits: Are composed of FICA at 7.650%, PERS at 16.975%, Health and Life Insurance at 22.7%, Workers Compensation at 1.38%

** Operating: includes costs per FTE for communications (phone) and computer equipment, facilities, and office supplies.

Delivery Infrastructure

Behavioral Health

Mental Health Resource Center: $789,279

To be operated by Hill Country Health & Wellness Center

The Mental Health Resource Center will serve as a hub for the WPC Pilot in Shasta County. This innovative program will offer behavioral health services, wellness classes, and access to a range of community resources available through drop-in or referral. The center will also operate Assisted Outpatient Treatment Services. Costs associated with the program are detailed below. Costs are budgeted for an annual total of 150 individuals served through the mental health resource center.

Item	Salary	Benefits*	FTE	Budgeted Costs
Mental Health Resource Center				
WPC Case Management Coordinator	44,837	11,209	1	56,046
Licensed Clinical Social Worker / MFT	75,000	18,750	1.75	164,063
Case Manager	44,837	11,209	2.6	145,720
Office Staff	32,000	8,000	1.75	70,000
Outreach Staff	32,000	8,000	1.75	70,000
Information Analyst	49,782	12,446	0.46	28,625
TOTAL PERSONNEL			9.31	534,454
Item	Unit Cost	Units	Budgeted Costs	
Mental Health Resource Center				
Contracted Services – costs for outside contractors to support program operations			4,900	
Rent & Lease Expense / Utilities – facility costs for contractor to operate program (Reflects 80% of total expense to account for use of facility for clients served that are not enrolled WPC Participants)			22,360	
Supplies – office supplies and general supplies for contractor staff to operate program			23,045	
Small Equipment (Reflects 80% of total expense to account for use of facility for clients served that are not enrolled WPC Participants)			4,200	
Training (to support clinicians in integrating evidence-based practices such as motivational interviewing)			23,500	
Travel & Transportation for contractor staff to operate program			4,400	
TOTAL OPERATING COSTS			82,405	
Other Expenses – facility improvements, fixed assets for contractor facility to operate program			134,835	
Indirect	5%		37,585	
TOTAL Mental Health Resource Center			$789,279	

Assisted Outpatient Treatment: $484,250
To be operated by Hill Country Health & Wellness Center

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

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

Outreach and engagement activities are not Medi-Cal reimbursable, and consist primarily of discussion and education with individuals and/or their families about what mental health services are available, and how these can benefit those with serious mental illness. Such contacts and engagement often must occur many times before an individual feels comfortable in taking the next step toward recovery. It is anticipated that approximately 40% of the work in the AOT program will consist of outreach and engagement activities. Individuals willing to actively engage in treatment, or those who are court ordered to participate, will be enrolled in ongoing AOT/ACT mental health services. Many of these services are eligible for reimbursement under Medi-Cal Specialty Mental Health Services including: rehabilitation activities (skill building and education), medication support with psychiatrist and nurses, limited case management, and individual/group therapy sessions. No WPC funds will be utilized to support Medi-Cal covered services. WPC participants enrolled in AOT/ACT are still eligible to receive PMPM bundled services of housing case management and medical case management as the vast majority of these services are not Medi-Cal covered services and do not duplicate the services received under AOT/ACT.

Assisted Outpatient Treatment - Position	Salary	Benefits*	FTE	Budgeted Costs
Licensed Clinical Social Worker / MFT	75,000	18,750	1.0	93,750
Case Manager	44,837	11,209	2.0	112,093
Office Staff	32,000	8,000	1.0	40,000
Outreach Staff	32,000	8,000	1.0	40,000
TOTAL PERSONNEL			5.0	285,843
Assisted Outpatient Treatment - Item	Unit Cost	Units	Budgeted Costs	
Enhanced care coordination	433	150	65,000	
Contracted Services – costs for external contract services for contractor to operate program			2,500	
Rent & Lease Expense / Utilities – facility costs for contractor to operate program (Reflects 40% of total expense to account for use of facility for services that will not be funded through the WPC pilot such as Medi-Cal covered ACT services and services to non-WPC Pilot Participants)			8,000	

Supplies – office supplies and general supplies for contractor staff to operate program (per month)	1,666	12	19,995
Small equipment (Reflects 40% of total expense to account for use of facility for services that will not be funded through the WPC pilot such as Medi-Cal covered ACT services and services to non-WPC Pilot Participants)			2,000
Travel & Transportation for contractor staff to conduct outreach and care coordination to operate program			15,510
TOTAL OPERATING COSTS			113,005
Other Expenses – facility improvements, fixed assets for contractor facility to operate program			62,343
Indirect	5.0%		23,060
Total cost Assisted Outpatient Treatment			$484,250

Note: Hill Country Health & Wellness Center is contracted by Shasta County HHSA to operate the Mental Health Resource Center and the Assisted Outpatient Treatment services. This partner is also an FQHC and will provide medical case management services through a distinct line of service at their Primary Care Clinic site in Redding, CA. The Mental Health Resource Center facility will be not be utilized for providing Medical Case Management PMPM bundle services.

Infrastructure Development in PY2

In PY2 50% of the costs for medical case management teams are included in Delivery Infrastructure to account for the time these teams will spend developing internal systems for referral, data collection and reporting, and service model development. In addition, this allows these individuals to participate in activities in PY2 to develop data sharing agreements with pilot partners to coordinate care for WPC participants across the distinct agencies.

Position	Salary	Units	Budgeted Costs
Medical Case Management Program Development - Hill Country and Shasta Community			
Intensive Case Manager - RN provides intensive case management for PHC members in the WPC pilot.	81,347	1.89	153,745
Patient Navigators - supports engagement and management of chronic conditions and access to social non-medical services for PHC members in the WPC pilot.	41,000	2.00	82,000
Fringe Benefits (25%)			58,936
WPC Project Management Supplies			2,819
TOTAL Intensive Medical Case Management Team PY2			297,500

Item	Salary	Benefits*	Operating **	FTE	Budgeted Costs
Shasta County HHSA Housing Case Management					
Housing Support Volunteer Program Coordinator (to be hired) - responsible for recruiting and supporting	34,192	15,558	125	0.5	25,000

volunteer peers to work with WPC participants once they are placed in housing.					
Housing Supervising Social Worker (to be hired) - responsible for day-to-day management of housing case managers (social workers)	60,817	41,097	125	0.5	51,082
Assistant Housing Social Workers (to be hired) - provides case management services to WPC participants who are homeless or at risk of homelessness. Approximate caseload is 1:20 with an estimate of 100 individuals served annually.	39,058	35,014	125	2.5	185,305
WPC Pilot project management supplies					99,875
TOTAL Housing Case Management Program Development					361,262

Additional Infrastructure

Additional strategies and interventions to support the behavioral health care needs of the target population will be developed under the WPC Pilot, including the following.

Item	Budgeted Costs
Continuum of Care (CoC) Coordination – Procurement process to be determined. Represents increased investment (over historic costs) to facilitate the CoC for Redding and Shasta County. The investment to enhance Continuum of Care Coordination will provide necessary infrastructure to develop a County-wide Coordinated Entry system for Homeless services that currently is lacking, but is critical to the success of the WPC Pilot program. Coordinated Entry systems help people move through the system faster, which reduces the amount of time people spend moving from program to program before finding the right match. The approach also reduces new entries into homelessness by offering diversion resources up front and improves data collection and quality by providing accurate information on what kind of assistance consumers need. Coordinated entry is the best strategy to serve the target population for this pilot. This system will ensure that WPC participants served by the WPC pilot project are receiving the housing resources from the most appropriate agency. Specific activities will include convening of local housing service providers to better coordinate services, sharing information about the WPC pilot program to enhance community buy-in and referrals, building relationships and trust across providers in the county, evaluating coordinated entry tools and identifying those that will work best in Shasta County, collecting and reporting program data to support the project, and informing selection, implementation and training on the HMIS system.	120,000
HMIS System Infrastructure - Procurement process to be determined. Implement new HMIS data system to manage homelessness services and data collection.	100,000
Training for WPC Pilot Staff – monthly trainings (non-clinical) to be offered across services and agencies for case managers, clinicians, and other staff to build capacity for coordination and support data collection, reporting, and PDSA activities.	25,000

Incentive Payments

- HMIS incentive to input a homeless person's intake information into the Homeless Management Information System (HMIS). Estimate total 150 WPC participants per year $10 per HMIS entry. This activity will be conducted by CoC Coordinator, Drug Medi-Cal providers, homeless services providers, and HHSA housing case managers.
- Sobering Center incentive for each WPC participant in the sobering center who enters detox program and stays at least 72 hours. Estimate that of WPC participants served by sobering center 50 will enter detox annually.
- Housing Support Volunteers incentive will be paid to HHSA Housing Support Volunteer Program for each 100 home visits to WPC participants completed per volunteer. Estimate 5,000 home visits per year.
- Housing case management incentive for each WPC enrolled participant who stays in permanent housing for at least 6 consecutive months. Estimate 50 per year @ $500 for $25,000 total:
    - 75% of incentive paid to housing case management (HHSA) – ($18,750)
    - 25% to intensive medical case management. Of the 50 WPC participant successes per year it is estimated that 40 will be case managed by SCHC ($5,000) and 10 will be case managed by HCHWC ($1,250) based on projected case loads.
- Reduced ED utilization incentive for each WPC enrolled participant who has <2 emergency department visit for 6 consecutive months. Estimate 50 per year @ $500 for $25,000 total:
    - 25% of incentive paid to housing case management (HHSA) – ($6,250)
    - 75% to intensive medical case management. Of the 50 WPC participant successes per year it is estimated that 40 will be case managed by SCHC ($15,000) and 10 will be case managed by HCHWC ($3,750) based on projected caseloads.

Discrete Services

WPC participants are eligible to receive services from more than one service bundle (i.e., medical and housing case management) and/or FFS service as there is no duplication of services across these distinct service lines. Participants will receive services according to the eligibility criteria established for each distinct type of service as described in the application.

FFS Services

Sobering Center – $ 162,500

Procurement process to be determined. Operates a 24-hour facility for intoxicated individuals as an alternative to ED. Costs are estimated at the average rate per day for residential drug and alcohol treatment services. Estimated the sobering center will serve 2 individuals per day. Supports achievement of reducing ED visits goal for the WPC pilot.

Item	Unit Cost	Units	Budgeted Costs
Sobering Center	250 / day	650	162,500

Mobile Crisis Team (MCT) - $483,588

The Mobile Crisis Team will serve to divert individuals experiencing acute mental health crisis away from the ED and law enforcement and into treatment by providing timely professional intervention in the field. A contractor will be identified through a request for proposal process to operate this program. 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 seven days a week. Estimated costs associated with the program are detailed

below. Costs are budgeted for 300 face-to-face contacts in the field per month for a total of 3,600 contacts annually.

Item	Salary	Benefits*	FTE	Budgeted Costs
Licensed Clinical Social Worker / MFT	75,000	18,750	3.0	281,250
Case Manager	44,837	11,209	3.0	168,138
TOTAL PERSONNEL				$449,388
Item	Unit Cost	Units	Budgeted Costs	
MCT local mileage reimbursement (50,000 mi annually @ avg. 14 mi per encounter)	$0.54	50,000		27,000
MCT communication reimbursement (6 staff cell phones @ $100/mo for 12 mo.)	$100	72		72,000
TOTAL DIRECT COSTS				$34,200
TOTAL BUDGETED COSTS				$483,588
Fee for Service Payments		3,600		$134.33

PMPM Bundle

Medical 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.

The nursing support (RN Case Manager) included in the Intensive Medical Case Management PMPM Bundle do not overlap with services currently covered by Medi-Cal in the FQHCs. The services provided by the nurse case manager will be restricted to 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 PMPM Bundle 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

The PMPM budgeted costs include nurse case managers, patient navigators and Intensive health coach that make up the teams providing the described bundle of services. The PMPM bundle cost is $595 and is based on the sub-set of 100 WPC Participants estimated to be served per year with an estimated 10 months on service. For a total of 1,000 member months (detail for estimated provided below). In PY2 50% of the costs for medical case management are included in Delivery Infrastructure to account for the time these teams will spend developing internal systems for referral, data collection and reporting, and service model development. In

addition, this allows these individuals to participate in activities in PY2 to develop data sharing agreements with pilot partners to coordinate care for WPC participants across the distinct agencies. The PMPM bundle cost will remain consistent in PY2 at $595 but will be calculated based on an estimate of 50 WPC participants served and 500 member months.

PY2 Budgeted Costs

Position	Salary	Units	Budgeted Costs
Medical Case Management - Hill Country and Shasta Community			
Intensive Case Manager - RN provides intensive case management for PHC members in the WPC pilot.	81,347	2.00	162,695
Patient Navigators - supports engagement and management of chronic conditions and access to social non-medical services for PHC members in the WPC pilot.	41,000	2.00	82,000
Fringe Benefits (25%)			61,955
TCM Budget Adjustment (3% reduction)			-9,150
TOTAL Intensive Medical Case Management Team PY2			297,500
PMPM Payments PY2 (based on 500 member months)		500	$595.00

The table below provides the estimated costs and PMPM bundle cost for PY 3-5. This assumes that there is a full case load for all teams – serving the sub-set of 100 WPC Participants estimated to be served with an average of 10 months on service per participant for a total of 1,000 member months. The PMPM Bundle costs in PY3-5 is $595.

Position	Salary	Units	Budgeted Costs
Medical Case Management - Hill Country and Shasta Community			
Intensive Case Manager - RN provides intensive case management for PHC members in the WPC pilot.	81,347	4.00	325,388
Patient Navigators - supports engagement and management of chronic conditions and access to social non-medical services for PHC members in the WPC pilot.	41,000	4.00	164,000
Fringe Benefits (25%)			122,347
TCM Budget Adjustment (3% reduction)			-16,735
TOTAL Intensive Medical Case Management Team			595,000
PMPM Payments PY 3-5 (based on 1,000 member months)		1,000	$595.00

Eligibility, Intensity and Discontinuation of PMPM Bundle Services:
WPC Pilot Participants will be referred to the Medical Case Manager by the County staff stationed at the Emergency Department (Year 2) as well as other community providers (Years 3-5). The Medical Case Manager will assess the individual and enroll them into the WPC Pilot Program. Eligibility criteria for Medical Case Management PMPM Bundle Services include 2 or more visits to the ED or an inpatient admission in the past 3

months. In addition, WPC participants may have one or more risk factors including SMI or SUD diagnosis or an undiagnosed opioid addiction. The case manager will also review whether the individual is eligible for 2703 Health Home Program. If the individual is determined not to be eligible for the 2703 Health Home program they will be enrolled into WPC Medical Case Management PMPM Bundle service. The program will be modeled after the Intensive Outpatient Care Management Program that both Shasta Community Health Center and Hill Country Health & Wellness have piloted in collaboration with Partnership HealthPlan. Patient assessments will help determine acuity scores and assist teams in planning the intensity of services to WPC Participants. It is anticipated that once WPC Participants are enrolled in medical case management services they will remain in service for as long as they are deemed eligible for the PMPM bundle service and/or the WPC pilot.

The approximate caseload for a medical case management team (RN case manager + patient navigator) is between 20 to 25 WPC Participants based on their assessed acuity score and level of intensity of service. Individuals with the highest level of acuity (Level 5) may require weekly home visits and daily phone calls to support their adherence to the shared action plan. Individuals that are stabilizing to some degree (Level 3) may only require a monthly home visit and weekly phone call. Budget projections are based on the sub-set of 100 WPC Participants estimated to be served in medical case management and a total of 1,000 member months.

Housing Case Management – Housing case management 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 PMPM bundle was calculated based on the all-inclusive costs of housing case management services. The client services bundle includes:

- 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 PMPM bundle includes staff salaries for social workers, social worker supervisor, volunteer coordinator, operating costs, and direct costs for rent and deposit assistance. The costs are detailed in the table below. The PMPM bundle cost is $816.41 and is based on the sub-set of 100 WPC Participants estimated to be served per year with a total of 885 member months (detail for estimate described below). In PY2 50% of the costs for housing case management are included in Delivery Infrastructure to account for the time these teams will spend developing internal systems for referral, data collection and reporting, and service model development. In addition, this allows these individuals to participate in activities in PY2 to develop data sharing agreements with pilot partners to coordinate care for WPC participants across the distinct agencies. The PMPM bundle cost will remain consistent in PY2 at $816.41 but will be calculated based on an estimate of 50 WPC participants served and 442 member months.

PY2 Budgeted Costs

Item	Salary	Benefits*	Operating**	FTE	Budgeted Costs
Shasta County HHSA Housing Case Management					

Housing Support Volunteer Program Coordinator (to be hired) - responsible for recruiting and supporting volunteer peers to work with WPC participants once they are placed in housing.	34,192	15,558	125	0.5	25,000
Housing Supervising Social Worker (to be hired) - responsible for day-to-day management of housing case managers (social workers)	60,817	41,097	125	0.5	51,082
Assistant Housing Social Workers (to be hired) - provides case management services to WPC participants who are homeless or at risk of homelessness. Approximate caseload is 1:20 with an estimate the sub-set of 100 individuals served annually.	39,058	35,014	125	2.5	185,305
Individual housing transition services – support for one-time costs to assist WPC Participants transition into new housing placement (may include identifying and securing services to establish a basic household such as first month utilities; no room and board costs will be covered).					99,875
TOTAL Housing Case Management					361,262
PMPM Payments PY2 (based on 442 member months)				442	816.41

The table below provides the estimated costs and PMPM bundle cost for PY 3-5. This assumes that there is a full case load for all teams – serving the sub-set of 100 WPC Participants with an average of 885 member months on service. The PMPM Bundle costs in PY3-5 is $816.41.

Item	Salary	Benefits*	Operating**	FTE	Budgeted Costs
Shasta County HHSA Housing Case Management					
Housing Support Volunteer Program Coordinator (to be hired) - responsible for recruiting and supporting volunteer peers to work with WPC participants once they are placed in housing.	34,192	15,558	250	1.00	50,000
Housing Supervising Social Worker (to be hired) - responsible for day-to-day management of housing case managers (social workers)	60,817	41,097	250	1.00	102,164
Assistant Housing Social Workers (to be hired) - provides case management services to WPC	39,058	35,014	250	5.00	371,609

participants who are homeless or at risk of homelessness. Approximate caseload is 1:20 with an estimate of the sub-set 100 individuals served annually.					
Individual housing transition services – support for one-time costs to assist WPC Participants transition into new housing placement (may include identifying and securing services to establish a basic household such as first month utilities; no room and board costs will be covered).					198,750
TOTAL Housing Case Management					722,523
PMPM Payments (based on 885 member months)					816.41

*Benefits: Are composed of FICA at 7.650%, PERS at 16.975%, Health and Life Insurance at 22.7%, Workers Compensation at 1.38%
** Operating: includes costs per FTE for communications (phone) and computer equipment, facilities, and office supplies.

Eligibility, Intensity and Discontinuation of PMPM Bundle Services:
WPC Participants will be referred to housing case management after enrollment in the WPC pilot if they have had 2 or more visits to the ED or an inpatient admission in the past 3 months and are found to be at risk of homelessness or are currently homeless. Brief assessments will be conducted at the Emergency Department or by Intensive Medical Case Managers and referrals will be made to HHSA Housing. This referral of enrolled WPC Participants will serve as the eligibility determination for Housing Case Management PMPM bundle services. HHSA believes that many potential WPC Participants are currently on a waiting list for housing assistance. At the start of the pilot, individuals on this wait list will be assessed for eligibility for the WPC pilot program.

Based on current experience within HHSA housing programs an average of 104 hours of case management time is estimated per client. The range is expected to be from 15 hours to 200 hours per client depending on the "Assistance Level" determined at the time of enrollment into the service. The housing case manager will assess the WPC participant and determine their level of need as the first activity within the PMPM Bundle by the case manager using a standardized assessment tool. The breakdown of estimated months that WPC participants will be eligible for housing case management by Assistance Level includes:
Level 1 –3 months (approx. 15 hours)
Level 2 –6 months (approx.50 hours)
Level 3 – 9 months (approx. 100 hours)
Level 4 – 12 months (approx. 200 hours)

The case will be closed when the established case plan goals have been successfully achieved. For most WPC participants this will include achievement of goals including housing has been secured and a financial plan has been established and implemented to sustain the housing that was secured. The WPC Pilot program target population includes participants that have very complex psycho-social needs. Housing case managers will meet participants where they are at and work with them based on their needs and goals. The concepts of harm reduction and rapport building will be considered as measures of success as well as the actual placement of the client in housing.

Estimates for numbers of WPC Participants served (the sub-set of 100 WPC Participants estimated to be served) per level per year include:
Level 1 – 5 clients
Level 2 – 30 clients
Level 3 – 40 clients
Level 4 – 25 clients

The number of hours and client mix result in an estimated need of five full time Social Workers to provide Housing Case Management services and a total of 885 member months annually. In addition to the bundled costs of the personnel, HHSA Housing estimates an average of $1,987 per client for individual housing transition services.

Pay for Reporting

Description	Amount per Unit	Units	Max. Incentive
FQHC pay for reporting, 2 clinics includes 8 hours per month for data collection and reporting and time to prepare 2 semi-annual reports (8 hrs/each) (112 hrs per clinic)	$75	224	$16,800
Housing case management program pay for reporting includes 8 hours per month for data collection and reporting and time to prepare 2 semi-annual reports (8 hours each). (112 hrs)	$75	112	$8,400
Housing volunteer program pay for reporting includes 4 hours per month for data collection and reporting and time to prepare 2 semi-annual reports (4 hrs/each). (56 hrs)	$75	56	$4,200
Mental health resource center pay for reporting includes 8 hours per month for data collection and reporting and time to prepare 2 semi-annual reports (8 hrs/each). (112 hrs)	$75	112	$8,400

Pay for Metric Outcome Achievement
The Shasta County WPC Pilot budget includes one pay for metric outcome measure. The measure selected and the identified annual targets are identified below. Pay for Metric Outcome Achievement incentives will only include enrolled WPC Participants in the measurement of performance on the measure.

Metric	PY 1	PY 2	PY 3	PY 4	PY 5
Follow-up After Hospitalization for Mental Illness	Baseline	Maintain Baseline	50%	55%	60%
Budgeted payments for metric achievement		15,520	15,520	15,520	15,520

This measure was selected given the high proportion of individuals in the target population presenting in the emergency department for reasons related to a serious mental illness and the number being admitted to inpatient hospitalization for mental illness. Shasta County currently has a number of individuals who fall into this category who are cycling in and out of hospitals without receiving the necessary case management, resources and supports to stabilize them upon release and maintain their health in the community.

This metric was selected as achievement of increased follow-up for enrolled WPC participants will contribute significantly to cost savings through reduced emergency department visits and reduced inpatient admissions. It is also believed that follow-up after hospitalization for mental illness will contribute to a reduction in "administrative" days where individuals in the WPC target population are kept in the hospital for lack of an appropriate and safe setting for their discharge.

WPC Budget Template: Summary and Top Sheet

WPC Applicant Name:	Shasta County Health and Human Services Agency

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

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

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

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

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

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