WHOLE PERSON CARE AGREEMENT- Amendment A-02 Program Year 6 Extension

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 January 13, 2017. County of Ventura submitted its WPC application (Attachment A), in response to DHCS' RFA on March 1, 2017. DHCS accepted County of Ventura's WPC application to the RFA on June 12, 2017 with an allocation of (see table below) in federal financial participation available for each calendar year for the WPC pilot beginning in program year one through program year five.

Total Funds PY 1 - PY 5			
PY	Federal Financial Participation	Local Non-federal Funds	Total Funds
PY 1	$9,783,769	$9,783,769	$19,567,538
PY 2	$10,492,494	$10,492,494	$20,984,988
PY 3	$11,210,219	$11,210,219	$22,402,437
PY 4	$11,210,219	$11,210,219	$22,402,437
PY 5	$11,210,219	$11,210,219	$22,402,437

In May 2020, DHCS officially announced the delay of California Advancing and Innovating Medi-Cal Initiative (CalAIM) due to the impact of the public health emergency caused by COVID-19. As a result of the delay of CalAIM, the Centers for Medicare and Medicaid Services approved a 12-month extension of WPC Pilot Program to expire on December 31, 2021.

On December 29, 2020 DHCS extended County of Ventura's WPC pilot with an allocation of (see table below) in federal financial participation available for the program six calendar year subject to the signing of this Agreement.

Total Funds PY 6			
PY	Federal Financial Participation	Local Non-federal Funds	Total Funds
PY 6	$8,548,868.60	$8,548,868.60	$17,097,737.20

Per STC 126, in the event that the number of approved WPC Pilots results in unallocated funding for a given Demonstration year, participating Lead Entities may submit applications to the state in a manner and timeline specified by DHCS proposing that the remaining funds be carried forward into the following program year, or to expand Pilot services or enrollment for which such unallocated funding will be made available. DHCS accepted County of Ventura's application to carry forward any unspent funding from program year five into program year six on March 2, 2021.

The Parties agree:

A. That Terms and Conditions Item 2 shall be amended and replaced by the following:

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, 2022 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.

B. 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 of the determination of the interim payment due based on the mid-year and annual report, 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. The WPC pilot lead entity will enter into an agreement with DHCS that specifies the requirements of the WPC pilot, including a data sharing agreement per STC 118. [See Exhibit A "HIPAA Business Associate Addendum (BAA)" of this Agreement. Many of the provisions in the DHCS boilerplate BAA apply only to BAA-covered information that is shared by DHCS to the pilot specifically for the purpose of Whole Person Care pilot operation and evaluation. DHCS does not anticipate that BAA-covered information will be shared with pilots for the purpose of Whole Person Care pilot operation or evaluation. DHCS anticipates limited, or no, BAA-covered information sharing from the pilot to DHCS. However, DHCS will include a BAA in the case that data need to be shared. The BAA will apply to the transfer of BAA-covered information should the need arise.]
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. 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. Payments for WPC pilots will be contingent on certain deliverables or achievements, and will not be distributed, or may be recouped, if pilots fail to demonstrate achievement or submission of deliverables (STC 126).
10. If the individual WPC pilot applicant expends 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 participants through the end of the pilot year.
11. WPC pilot payments shall not be used for activities otherwise coverable or directly reimbursable by Medi-Cal.
12. The lead entity shall complete an analysis of their proposed WPC pilot and their county's Medi-Cal Targeted Case Management Program (TCM) to ensure that their WPC pilot activities and interactions of their care coordination teams do not duplicate their county's TCM benefit. If the lead entity identifies any overlapping activities or interactions, the lead entity shall 1) apply a TCM budget adjustment, where appropriate, to reduce the request for WPC funds; and 2) document the adjustment(s) in the application in accordance with the DHCS guidance provided to the lead entity during the DHCS application review process.
13. 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.

14. 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.**

C. 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 Ventura
Attention: Michel Huizar	Attention: Barry L. Zimmerman
Telephone: (916) 345-7836	Telephone: (805) 677-5110

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~~ June 30, 2022, unless the application is renewed or the WPC Pilot program is extended.

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.

Signature of WPC Lead Entity Representative

Date

Name: Barry L. Zimmerman

Title: Health Care Agency Director

Signature of DHCS Representative

Date

Name: Nathan Nau

Title: Chief, Managed Care Quality & Monitoring Division

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 Pilot Application

Application due July 1, 2016

Section 1: WPC Lead Entity and Participating Entity Information

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

Name	Ventura County Health Care Agency
Type of Entity (from lead entity description above)	Designated Public Hospital
Contact Person	Johnson K. Gill
Contact Person Title	Deputy Director, Population Health Management and Clinical
Telephone	(805) 677-5110
Email Address	johnson.gill@ventura.org
Mailing Address	5851 Thille Street, 2nd Floor Ventura, California 93003

1.2 Participating Entities

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

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

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

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

1. *WPC Centralized Care Coordination:* A centralized Care Coordination Team (CCT) will connect the new communication and data technology infrastructure and the *Integrated Care Plan* with providers within the VCHCA, other public entities, and community partners. The CCT will also provide field-based coordination and integration support as required by providers. An administrative Care Coordination Manager leads the CCT, as well as the Engagement Teams and the CHWs. The CCT will include: nine (9) Care Managers (1.0 FTE Lead Care Coordination Manager, 3.2 FTE Registered Nurses [RN], 3.2 FTE Licensed Clinical Social Workers [LCSW]), and 1.6 FTE behavioral health specialists (see Section 1.2.3 below). Field-based care management will be provided by 20.8 FTE Community Health Workers (CHWs) will also be a part of the CCT.
2. *WPC Care Coordination through Outreach:* Three Engagement Teams (based out of three retrofitted mobile health vans) will: facilitate integration of services, coordinate outreach and engagement of participants, determine immediate care needs, provide needed prescriptions, offer enrollment and assessment services, connect services with community-based providers, and ensure that there are no gaps between the Integrated Care Plan and the provision of planned services. The teams will be effective in connecting with participants who predominantly access services outside of the VCHCA. Each Engagement Team will include: 1.0 FTE Care Coordination Manager, 1.0 FTE Nurse Practitioner, and 1.0 FTE Clinic Assistants (MAs).
3. *WPC Care Coordination through Field-Based Care Coordinators:* Part of the CCT, 20.8 FTE CHWs are field-based staff members who have a close understanding of the target population and Ventura County communities, and are culturally/linguistically similar and/or competent with the participants they serve. This trusting relationship will enable them to serve as a liaison, link, and intermediary between health, behavioral health, social services, and community resources to facilitate access to services and improve the quality of service delivery. CHWs will build individual and community capacity by increasing the TP's health knowledge and self-sufficiency through a range of activities such as outreach, community education, informal counseling, social support, and advocacy. Under established protocols, CHWs will:

    a. Meet participants where care can be the most integrated for that participant (i.e., clinic, One-Stop Center, supportive/transitional housing).
    b. Administer the *Universal Consent Form,* the *WPC Vulnerability Index* (see Attachment C), and the *WPC Comprehensive Assessment,* which incorporates demographic information, information needed for project enrollment, and social needs such as housing, food, clothing, etc. This information will initiate WPC enrollment, which will be consolidated in the electronic *Integrated Care Plan* platform along with assessments, tests, screening results, and sub-care plans from system-wide WPC care providers.

c. Coordinate and facilitate an initial appointment with a primary care provider (PCP) to assess health care, mental health, and substance abuse treatment needs and to serve as the lead for the participant's Patient-Centered Medical Home (PCMH). PCPs will refer participants with behavioral health needs who cannot be cared for within the primary care/behavioral health integrated care clinic to the Ventura County Behavioral Health Department (i.e., above mild-to-moderate mental health conditions).
d. Provide troubleshooting, relationship building, system navigation, and crisis intervention.
e. Connect participants with services and advocate for them among partners and community resources.
f. Assist participants in overcoming barriers to access care plan services, such as transportation, motivation, language, etc.
g. Work with Care Managers across systems to synchronize, prioritize, integrate, eliminate duplicative services, and adapt the care plan as indicated.
h. Contact and work with families and caregivers to support improvement and assist when emergencies arise.
i. Ensure that care providers are connected through real-time communications about changes in needs or care.

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

4. *Health Care for the Homeless (HCH) Program:* Since 2002, VCHCA has been operating a HCH program serving area homeless persons. Medical teams provide services at 16 sites, including two One-Stop Centers, in eight cities. Services include primary and preventive health care and assessments, and referrals for mental health, substance abuse, and social services. Linkages include multiple social services, housing supports, and non-medical support services. Historically, the care for these patients has not been centrally coordinated. Through the WPC pilot, an electronic centralized care coordination system that tracks service linkages and communicates in real time with the CCT will eliminate gaps and breakdowns in services. Communication alerts will direct care to the appropriate response level and interventions.
5. *Primary and Preventive Care:* VCHCA has 19 primary care FQHCs and 14 clinics providing both primary and specialty care services, with integrated behavioral health professionals located in many clinics. These clinics provide more than 530,000 outpatient visits annually and are located in nine geographically dispersed communities. They are served by 693 physicians and 87 allied health professionals (inpatient and outpatient). VCHCA also operates a renowned UCLA-affiliated Family Medicine Residency program (ranked #2 nationally).[1] This vast network of venues and providers will be integral in meeting the needs of the TP. With the assistance of the clinic staff and the CCT, the use of a *real-time secure*

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

messaging system, which is part of a secure web-based telemedicine platform, will be a conduit via which TP needs are communicated and addressed with PCPs.

6. *Emergency/Urgent Care:* Ventura County Medical Center (VCMC) is a 180-bed hospital with an additional 43-bed Inpatient Psychiatric Unit. Santa Paula Hospital, also operated by the VCHCA, has 49 beds. Seven urgent care centers provide services that help offset Emergency Department (ED) utilization. Patient engagement and early intervention in a well-coordinated environment is the key to managing participants. Keeping the lines of communication open between the TP and CHWs will be the first line of defense against unnecessary utilization of urgent/emergent services.
7. *Specialty Services:* VCHCA clinics provide 60 specialty services. VCMC also offers high quality specialty services, including Neonatal ICU, Level II Adult Trauma Center, and Palliative Care Program. However, access to many of these specialty services remains a challenge. Improving access to specialty care will continue through PRIME projects 1.2, 1.3, 2.2, and 2.3. The WPC project will utilize the real-time secure messaging system between PCPs and specialty services for the WPC TP, and work with GCHP and specialty services to fast-track care, where necessary.

Required Organizations: 1. Medi-Cal Managed Care Health Plan
Organization Name: Gold Coast Health Plan
Contact Name and Title: Nancy Wharfield, MD, Associate Chief Medical Officer
Entity Description and Role in WPC: Gold Coast Health Plan (GCHP) is County Organized Health System (COHS) governed by the Ventura County Medi-Cal Managed Care Commission, serving more than 206,000 Medi-Cal beneficiaries living in Ventura County. GCHP's role in WPC efforts will be as a collaborator and to provide data sharing, assistance in the assessment of appropriate technologies, and coordination of care enhancement. GCHP will provide the following data:

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

GCHP will support WPC technology needs by:

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

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

Required Organizations: 2. Specialty Mental Health Agency/Department
Organization Name: Ventura County Health Care Agency – Ventura County Behavioral Health Department
Contact Name and Title: Elaine Crandall, Director
Entity Description and Role in WPC: The Ventura County Behavioral Health Department (VCBH) is a service delivery system that provides a full array of services and supports that promote the wellness and recovery of individuals by providing and supporting comprehensive mental health and substance abuse services through its six alcohol and drug clinics; eight mental health clinics for adults, youth and families; residential facilities; and psychiatric facilities, and at various community-based locations. Programs and services are provided both directly and with contracted community partners. VCBH's role in the WPC Pilot is: to serve as a project collaborator, to provide care management of behavioral health services, and to provide integrated substance abuse and mental health services for WPC participants, including the following:

1. *WPC Centralized Care Coordination:* Part of the CCT, 4.8 FTE VCBH Care Managers (see Section 1.2.2 above) will support behavioral health care coordination for participants. These staff will include Licensed Mental Health Professionals (LMFT or LCSW) and Substance Abuse Specialists.
2. *Screening, Triage, Assessment, & Referral (STAR) (Mental Health):* The STAR system coordinates access to services so that consumers receive timely, appropriate, and consistent information, thorough screening, triage, assessments, and/or linkage to appropriate mental health services and supports in an efficient, high quality, culturally sensitive manner countywide.
3. *Adult Mental Health Services, Clinic-Based (Mental Health):* Provides individual and group therapy, case management, crisis intervention, rehabilitation services, and medication management.
4. *Youth and Family Mental Health Services, Clinic-Based (Mental Health):* Provides individual and group therapy, case management, crisis intervention, rehabilitation services, parenting support, and medication management.
5. *Adult Intensive (Mental Health):* Empowering Partners through Integrative Community Services (EPICS) provides comprehensive, intensive, "whatever it takes" services for those consumers with intensive needs who most frequently utilize higher levels of care (inpatient hospitalization and other locked settings, or residential treatment placements), who are at high risk to require those levels of care without intervention, and who have been historically underserved in the mental health system due to a variety of barriers that make access to traditional services challenging.
6. *Adult Assisted Outpatient Treatment Services (Mental Health):* The AOT services are designed to provide intensive outreach to individuals who may be treatment resistant. In some instances, services may be court-ordered.
7. *Adult and Children Mobile Crisis Response Team (Mental Health):* Crisis intervention and stabilization services are available 24/7 to individuals who are experiencing an urgent or emergent mental health crisis. *Vi*a mobile field response and/or by telephone, the multi-disciplinary Crisis Team provides rapid mental health services that are supportive and strength-based in nature and that assist the individual to remain in the least restrictive level of care possible.

8. *Crisis Residential Treatment (CRT) (Mental Health):* The licensed 15-bed program serves adults (ages 18-59) throughout the county as an alternative to hospitalization for individuals presenting with sub-acute psychiatric symptoms and possible co-occurring disorders in the least restrictive environment possible, up to 90 days, leading to a reduction in involuntary hospitalizations, incarcerations, and homelessness.
9. *Crisis Stabilization Unit and Short-Term Crisis Residential Program (Mental Health):* This program provides a missing link in the children's crisis continuum of care by offering children and their families a safe, supportive, and home-like environment that meets crisis needs in their home community. The goal of the service is to reduce hospitalization and recidivism.
10. *Short-Term Social Rehabilitation (Mental Health):* Provides adults and transitional-age youth licensed, unlocked residential treatment facility services for up to 18 months.
11. *Mental Health Rehabilitation Center (Mental Health):* The licensed 16-bed program serves adults who receive rehabilitation services in a locked residential environment with a goal of stepping down into a lower level of care within a 12- to 18-month period (opening late 2016).
12. *Peer Support Specialists & Recovery Coaches (Mental Health):* This program provides training, advocacy, and direct service for and by peers and family members through several programs. Recovery Coaches, who are individuals with "lived experience," assist in engaging persons in treatment who have traditionally been un-served and underserved, while helping to ensure that the concepts of empowerment, wellness and recovery are incorporated into services.
13. *Adult and Transitional Age Youth Wellness & Recovery Centers (Mental Health):* These centers are alternative clinic programs serving adults and transitional-age youth who are recovering from mental illness, and often also substance abuse, who are at risk of homelessness, incarceration, and increasing severity of mental illness or addiction.
14. *Older Adult Full Service Partnership (Mental Health):* The Older Adult Program provides rich, community-based, mobile, in-home services including psychiatric treatment, case management (i.e., linkage to housing, benefits, health care, and rehabilitation services), skill-building services to decrease functional impairments, individual and group treatment crisis intervention, recovery and wellness programs, and advocacy and referrals for medical, dental, legal, and benefits support services and community agencies.
15. *Transitional-Age Youth Services (Mental Health):* Treatment and rehabilitation services are designed and provided for persons ages 18-26. The determination between employment and/or receipt of disability benefits is a focus in seeking to promote self-sufficiency for this age group.
16. *Residential Services (Mental Health):* Case management is provided to support a client's stability in their home environment and residential treatment programs. Note that WPC funds will only be used for allowable costs that include individual housing transition services and individual housing and tenancy sustaining services in alignment with the CMCS Informational Bulletin. Residential services and room and board are not covered under WPC.
17. *Transformational Liaisons (Mental Health):* Liaisons assist in navigating a complex system, and providing direction, referrals, and monthly orientation meetings.

18. *Adult Outpatient and Residential Treatment Services (Substance Abuse Services):* Adult Services provides individual and group counseling, family counseling, community referrals, co-occurring disorders programs for individuals with substance use and a mental health diagnosis, programs for court-mandated individuals, drug testing, confidential treatment services, education and support services, intensive outpatient programs for women and children, residential treatment and detoxification referrals, and crisis intervention.
19. *Driving Under the Influence Programs (Substance Abuse Services):* A First Offender DUI Program and a Multiple Offender DUI Program are provided for individuals convicted of driving under the influence. The program consists of education sessions, and group and individual counseling.
20. *Other Programs:* VCBH also offers outreach, prevention and early intervention, and education services.

Required Organizations: 3. Public Agency/Department
Organization Name: Ventura County Health Care Agency – Ventura County Public Health Department (VCPH)
Contact Name and Title: Rigoberto Vargas, Director
Entity Description and Role in WPC: VCPH provides a host of services benefiting Ventura County residents, including: two Public Health clinics; community nursing; Emergency Medical Services (EMS); health coverage assistance; health promotion/education; HIV/AIDS center; Maternal Child Adolescent Health programs: Women, Infants and Children (WIC) programs; and smoking cessation classes, among other services. VCPH's role in the WPC Pilot is to serve as a project collaborator, provide care management to participants utilizing services, and to provide participants the following services:

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

Required Organizations: 4. Public Agency/Department
Organization Name: Ventura County Human Services Agency (VCHSA)
Contact Name and Title: Barry Zimmerman, Director
Entity Description and Role in WPC: The VCHSA provides public services that help protect children and vulnerable adults, and assists with food, housing, health care, and employment. VCHSA's role in the WPC is to serve as a collaborator and to provide the following services to the target population, as needed:

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

Required Organizations: 5. Public Agency/Department
Organization Name: Ventura County Probation Agency
Contact Name and Title: Mark Varela, Chief Probation Officer
Entity Description and Role in WPC: The Ventura County Probation Agency (Probation) is charged by the courts with the direct supervision of approximately 15,500 adult offenders and 2,500 juvenile offenders on probation, as well as performing two mandated functions: the preparation of sentencing reports for the courts and the operation of the juvenile justice facilities. Probation's role in the WPC Pilot is as a collaborator and to provide data about utilization of services by participants. If a participant becomes institutionalized and in the custody of the Probation Agency, the WPC CCT will work with the Probation team on the appropriate continuum of care. The teams will ensure that the participant receives continued WPC care as established in the Integrated Care Plan upon release. The Probation team will be made aware of a WPC participant coming into their system

ahead of time, and the CCT will be made aware that a participant has been institutionalized through the HL7 Admit, Discharge, Transfer (ADT) alert system within the enterprise Care Coordination platform, and vice versa.

Required Organizations: 6. Public Agency/Department
Organization Name: Ventura County Sheriff's Office
Contact Name and Title: Ron Nelson, Commander
Entity Description and Role in WPC: Five of the county's ten incorporated cities contract with the Sheriff's Office to provide police services. These cities, plus the unincorporated areas of the county, make up nearly half of the county's population and 95% of its land area. The services provided by the department range from maintaining the county jail system to providing traditional police services. The department utilizes the Community Oriented Policing and Problem Solving (COPPS) philosophy, promoting proactive problem-solving and police-community partnerships. The department's role in the WPC Pilot is to participate as a collaborative partner; notify the collaborative through the community organization portal concerning any encounter that participants have with the Sheriff's Office; and provide data about the number of arrests, confinements, and causes. The Sheriff's Office will notify the CCT that a participant has been arrested or otherwise involved with the Sheriff's Office through a HL7 ADT alert system within the enterprise Care Coordination platform.

Required Organizations: 7. Public Agency/Department
Organization Name: Area Housing Authority of the County of Ventura
Contact Name and Title: Michael Nigh, Executive Director
Entity Description and Role in WPC: The mission of Area Housing Authority of the County of Ventura is to be a leader providing opportunities and assistance to people in need of affordable housing through development, acquisitions, and partnerships. Through its work with several city-level housing authorities, the Area Housing Authority provides and develops quality affordable housing for eligible low-income residents of Ventura County and establishes strong partnerships necessary for customers to achieve personal goals related to: literacy and education, health and wellness, and job training and employment leading to personal growth and economic self-sufficiency. The organization's role in the WPC pilot is as a collaborative member, care management partner, and to provide the following services:

1. *WPC Housing Support and Transition Services:* The Area Housing Authority and city partners will provide:
    a. *Individual Housing Transition Services:* Tenancy screening, housing assessment, housing plan development, housing application assistance, resource identification, move-in support, crisis plan development, housing search, transportation assistance, and assistance in establishing the household, such as setting up utilities and arranging for furnishings.
    b. *Individual Housing and Tenancy Sustaining Services:* Identification/intervention of behaviors that may jeopardize housing status, education, coaching, resolving disputes, advocating, ongoing plan review and training.
2. *Section 8 Program Housing:* Voucher program that pays 30%-40% of housing costs.

3. *Low-Rent Public Housing:* Access to 335 conventional units and 157 units in housing complexes throughout the county, with rents based on adjusted gross income.
4. *Affordable Housing:* Access to 486 units of tax credit financed affordable housing.
5. *Family Self-Sufficiency Program:* A five-year case management program that allows residents to reach economic self-sufficiency for HUD program participants and establish an escrow savings account.
6. *Resident Opportunities and Self-Sufficiency:* Provides coordinators to connect residents with needed services, including: education/lifelong learning, tutoring/homework services, scholarship programs, college applications, career paths, life skills, certification programs, English as a Second Language (ESL), work experience, banking and budgeting, sports programs, and nutrition.

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

Additional Organizations: 8. Public Agency/Department
Organization Name: Ventura County Transportation Commission
Contact Name and Title: Darren Kettle, Executive Director
Entity Description and Role in WPC: The Ventura County Transportation Commission (VCTC) is a regional transportation planning agency working in close partnership with each of the county's ten cities and the rural unincorporated areas. VCTC's inter-city bus service provides connections between the cities of Ventura County and between neighboring Santa Barbara and Los Angeles counties. The role of VCTC is as a collaborative partner that will provide bus tokens/passes to enable participants to access project resources and alleviate transportation as a barrier to access.

Required Organizations: 9. Community Partner
Organization Name: Project Understanding
Contact Name and Title: Benjamin Unseth, Executive Director
Entity Description and Role in WPC: Project Understanding focuses on ensuring that homeless and at-risk families are housed and fed. The organization's role in the WPC pilot is as a collaborative member and to provide essential assistance programs to participants, including:

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

Required Organizations: 10. Community Partner
Organization Name: FOODShare, Inc.
Contact Name and Title: Susan Haverland, Vice President, Program & Services
Entity Description and Role in WPC: FOOD Share distributes millions of pounds of healthy food every year through its own programs as well as through distributions via partner agencies. The organization's role in the WPC pilot is as a collaborative member and to provide data about resource utilization, care management, and to provide the following services to participants:

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

Required Organizations: 11. Community Partner
Organization Name: Ventura County St. Vincent de Paul
Contact Name and Title: Sharon Fleur, President, SVdP-OLA Conference
Entity Description and Role in WPC: The Society of St. Vincent de Paul is a faith-based charity that offers tangible assistance to those in need on a person-to-person basis. Assistance includes intervention, consultation, and fiscal support. Nationally, 12 million persons are helped annually by Vincentians in the United States. The organization's role in the WPC pilot is as a collaborative member and to provide essential Ventura County St. Vincent de Paul assistance programs to participants, including:

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

6. *Ventura County Winter Shelters:* Winter shelters are offered in the cities of Ventura and Oxnard, California, from December 1st to March 31st each year.

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

Additional Organizations: 12. Public Agency/Department
Organization Name: Workforce Investment Board/Job and Career Centers
Entity Description and Role in WPC: The vision of the Workforce Investment Board is that Ventura County will have a high-quality, appropriately skilled workforce that is ready and able to support the changing business needs of employers in a dynamic, competitive, global economic environment. The regional workforce strategy is focused on ongoing skills attainment that is supportive of regional growth industry sectors and clusters and enabled by a braided, leveraged workforce system that addresses business-driven demands and worker needs for steady employment. The organization's role in the WPC pilot is as a contributing community partner and to provide participants job and career support services and training. The county's two American Job and Career Centers provide a direct link to resources that help job seekers choose and pursue careers. The centers offer job listings, career guidance, labor market information, training and education resources, and tools for job preparation. Staff helps job seekers match their skills to available jobs or transition to new careers. Other support services and training are available at no cost and include:

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

Additional Organizations: 13. Community Partner
Organization Name: Ventura County Rescue Mission Alliance
Contact Name and Title: John Saltee, Director
Entity Description and Role in WPC: The Ventura County Rescue Mission Alliance is a faith-based non-profit charity that offers refuge, recovery, and restoration services to the poor and needy in

Ventura County. The role of the Rescue Mission is to serve as a contributing community partner and to provide the following services:

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

Additional Organizations: 14. Community Partner
Organization Name: Ventura County Salvation Army
Entity Description and Role in WPC: Ventura County Salvation Army is a faith-based charity with the goal of doing the most good possible for those in need, with a focus on feeding the hungry, housing the homeless, and changing the lives of individuals and families. The organization's role in the WPC pilot is as a contributing community partner and to provide participants the following services:

1. *Dental Clinic:* Services offered free-of-charge include oral examinations, fillings, simple extractions, and X-rays; dental cleanings are referred to Oxnard College's Dental Hygiene program.
2. *Transitional Living Center:* Short-term housing that also provides case management and supportive services, such as counseling, self-sufficiency education, permanent housing assistance, and information on employment services, job training, and public assistance.
3. *Homeless to Home Program:* A collaborative partnership between The Salvation Army, Project Understanding, and the Turning Point Foundation, the program provides case management that focuses on assisting individuals in obtaining and maintaining a secure income, physical and mental stability, and safe housing. Services include life skills and employment readiness training, assistance with transportation to interviews and work, street outreach, and housing stability services with financial assistance when available.
4. *Winter Homeless Shelter:* Supports the efforts of the West Ventura County winter homeless shelter, providing cots and meals for homeless individuals during the time when the local armory is unavailable.
5. *Safety Net Services:* Provides rent and utility assistance as well as transportation and clothing vouchers.
6. *Food Pantry:* Provides weekly feedings to seniors confined to their homes, sit-down meals to clients during Thanksgiving and Christmas, and more than 200 food baskets per month.

Additional Organizations: 15. Community Partner
Organization Name: Not One More
Contact Name and Title: Pat Montoya, President
Entity Description and Role in WPC: Not One More is a non-profit community organization dedicated to providing support to community members and their families who are struggling with addiction within their lives. The organization's role in the WPC pilot is as a contributing community partner and to provide the following services to participants:

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

Additional Organizations: 16. Community Partner
Organization Name: Jewish Family Services
Contact Name and Title: Debra Hide, Director
Entity Description and Role in WPC: Jewish Family Services is a faith-based charity with a mission to encourage and support the quality and continuity of individual, family, and community life guided by the ethical and spiritual values of Judaism. The organization's role in the WPC pilot is as a contributing partner and to provide the following services to participants:

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

Additional Organizations: 17. Community Partner
Organization Name: Interface Children & Family Services
Contact Name and Title: Erik Sternad, Executive Director
Entity Description and Role in WPC: Interface's mission is to strengthen children, families, and communities to be safe, healthy, and thriving. To establish a foundation of violence prevention and mental health, Interface offers family strengthening resources, centers and services: family violence intervention through a Family Violence Response Team; Safe Haven Emergency Shelter; Safe

Journey Transitional Shelter; women's support groups; individual, family, and youth mental health assessments, treatment planning, and counseling; youth services, including crisis intervention, case management and after care, family mediation, emancipation information, life skills and youth development activities, and shelter assessment. Interface will provide needed information for care managers and CHWs to access the county resources to address the unique needs of each participant through its 2-1-1 Information and Referral Hotline. This hotline connects more than 20,000 Ventura County callers each year with information about services available to them, including: basic needs resources (i.e., food, clothing, and shelter), physical and mental health resources, domestic violence services, substance abuse services, employment support, rent and utility assistance, senior services, services for persons with disabilities, support for children, youth and families, legal assistance, and much more.

1.3 Letters of Participation and Support

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

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

Section 2: General Information and Target Population

2.1 Geographic Area, Community and Target Population Needs

Geographic Area: Ventura County, the service area, is a large dispersed coastal region northwest of Los Angeles with a population of 850,536 residents[2] and more than 206,000 Medi-Cal Managed Care beneficiaries.[3] It is the 12th most populated of California's 58 counties with ten incorporated cities in 1,843 square miles.

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

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

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

[2] U.S. Census. QuickFacts, Ventura County, California. Population estimates July 1, 2015. Available at: https://www.census.gov/quickfacts/table/PST045214/06111.
[3] Gold Coast Health Plan. Ventura County Medi-Cal Managed Care Commission. Available at: https://www.goldcoasthealthplan.org/about-us/ventura-county-medi-cal-managed-care-commission.aspx.
[4] Ventura County. (2015.) Homeless County and Subpopulation Survey: Final Report. Available at: http://www.cityofventura.net/files/file/VC_Homeless_Count_Survey_2015.pdf.

from multiple providers, which may include more than one care manager.

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

WPC Pilot General Description: The WPC pilot design is based on best practices and is consistent with recent findings included in WPC studies of successful frameworks that incorporate a focused target population, collaborative leadership, patient-centered care, coordination of services across systems, shared data, and financial flexibility.[6] The project incorporates these elements in a patient-centered, holistic model, evidence-based care coordination design[7] with the following components:

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

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

[5] Maxwell, 2014.
[6] Tobey R, Maxwell J, Bateman C, Barron C. (Sept. 2014.) *Opportunities for Whole-Person Care in California.* John Snow, Inc., California Association of Public Hospitals and Health Systems, and the California Health Care Safety Net Institue. Available at: http://www.dhcs.ca.gov/provgovpart/Documents/Waiver%20Renewal/Workforce1_WPC2_JSI.pdf.
[7] Families USA. (April 2013.) *The Promise of Care Coordination: Transforming Health Care Delivery. Available* at: http://familiesusa.org/sites/default/files/product_documents/Care-Coordination.pdf.

(see Attachment E: Organizational Structure).[8]

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

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

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

How the WPC Pilot Addresses Current System Problems: Earlier this year, the WPC Collaborative conducted an inventory to understand what care coordination efforts exist and the strength and weaknesses of current systems. While Ventura County has many assets in its systems, partnerships, and current and future initiatives, the collaborative identified some significant system problems that the pilot will overcome or mitigate, including: siloed services, lack of communication between

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

[9] The John D. and Catherine T. MacArthur Foundation Research Network on Socioeconomic Status and Health. (2009.) *Reaching for a Healthier Life: Facts on Socioeconomic Status and Health in the U.S.* Available at: http://www.macses.ucsf.edu/downloads/Reaching_for_a_Healthier_Life.pdf

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

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

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

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

systems, lack of consistent data collected, and multiple, disjointed needs assessments. These gaps will be mitigated through service integration/coordination, communication protocols and technologies, data consolidation through warehousing, and assessments unified to create care plans.

Overarching Vision – Improving Collaboration: The Ventura County WPC Connect project will build upon existing efforts in the community (see Section 3.1) and improve collaboration among participating WPC pilot entities through collaborative leadership, integration (Section 2.2), coordination structures (Section 3.1), and shared data (Section 3.2). Successful collaborative leadership methods[14] will enable participating entities to develop a unified county-level approach to WPC that will successfully align resources, secure commitment from stakeholders, and implement a pilot project that will accomplish proposed performance measures/metrics. Three key components for successful collaborative leadership are integrated into the project: structured coordination, defined roles, and clear understanding of each partner's needs and measures of success.[15]

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

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

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

Pilot Sustainability: This infrastructure and the proposed interventions will be sustained by the initial investment of resources including: 1) VCHCA and DHCS combined funding to establish data systems and technologies for data sharing, reporting, and quality improvement; 2) relationships, collaborations, and agreements that do not require funding to support; and 3) the pilot's integration of services that address the social determinants of health that will lower service utilization resulting in significant cost-savings within all systems. For example, evidence shows that high-cost individuals do not become lower cost over time if they remain homeless.[16] Ensuring that participants are housed can result in a significant reduction in the use of major services, ranging from 28% to

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

[15] Cantor, 2015.

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

79%.[17] These cost-savings will enable participating entities to fund pilot model components, such as the cost of CHWs and informaticists, as the project moves from the pilot phase to full implementation after waiver funding is terminated.

2.2 Communication Plan

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

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

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

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

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

successes.

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

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

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

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

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

2.3 Target Population(s)

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

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

Enrollment Cap: An enrollment cap of a 1,000-participant caseload is anticipated once the pilot is fully implemented. VCHCA will notify DHCS within 90 days of imposing the enrollment cap and will submit to DHCS approval. The rationale for the proposed cap is that project effectiveness will only be achieved if it remains within the maximum caseload of 40 individuals per CHW for complex care models in order to accomplish care goals. A waitlist will be established for eligible participants wishing to be enrolled, and patients will be enrolled and opted in on a rolling basis. The process for establishing and administering the enrollment cap will include: 1) identification for eligibility based on risk stratification, contact by a CHW, and collecting a signed Universal Consent form; 2) notification of being placed of the wait list, with referral and information on care services available based on assessments within the VCHCA until the candidate can be enrolled in the project; and 3) notification of eligibility for enrollment when a spot is open. Enrollment from wait lists will be based on a combination of risk level and time on the wait list.

Methodology to Identify the Target Population: A collaborative data approach was utilized to identify the target population's use of health care and behavioral health services. Data analysis of GCHP,

behavioral health, VCHSA, and HCH records; the 2015 Homeless Count; the VCHCA 2013 Health Care Needs Assessment; collaborative data from community resources regarding homeless and mentally ill service access outside of VCHCA; and Ventura County studies/literature reviews were used inform data analysis. The WPC Collaborative and key leaders reviewed the analysis to determine the characteristics and needs of the highest utilizers, from which a target population was determined.

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

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

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

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

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

Beneficiary Outreach: Any provider who the potential participant accesses will be aware of the patient's eligibility for project inclusion. Providers, care managers, clinical staff, and community partners will be trained about the project and referral protocols. Mobile outreach staff (Engagement Teams and CHWs who provide Fee for Service outreach for persons not yet enrolled) will reach out to those who are identified in a variety of settings, such as clinics, EDs, One-Stops, homeless congregation locations, shelters, transitional housing, etc. The Engagement Teams and CHWs will be trained in motivational interviewing and trauma-informed care to engage the person in motivation to change. The CHWs will outline the project's features and potential benefits. The WPC Universal Consent Form will be signed by the participant. After consent, the CHW will complete the *WPC Comprehensive Assessment,* which will be a tool that determines health, behavioral health, and social needs, and incorporates the Vulnerability Index. The *WPC Vulnerability Index* assessment will prioritize participants for project inclusion. This Vulnerability Index will be a hybrid of assessments from other evidence-based programs,[18] but designed to specifically identify persons who have an increased risk of expensive, frequent service utilization that can be affected by WPC (see Attachment C). The WPC Comprehensive Assessment will be adapted from the National Alliance to End Homelessness Comprehensive Assessment Tool[19] to align with the project's target population. This information will be used as the basis for participant prioritization and integrated care plan development. The Waiver Data Analytics Team will notify the participant's existing providers and pull assessment and care plan information into the *Integrated Care Plan* platform. The CCT will engage these care providers to further develop a consolidated care plan and assess other care providers/managers based on assessed needs. Other community partners' case managers, eligibility staff, and outreach workers will also be trained to engage potential participants to ensure that the WPC CHWs are leveraged by the countywide outreach resources.

[18] O'Connell J. *Vulnerability Index: Prioritizing the Street Homeless Population by Mortality Risk.* Boston Healthcare for the Homeless Program. Available at: http://www.jedc.org/forms/Vulnerability%20Index.pdf.
[19] National Alliance to End Homelessness. (2014.) *Comprehensive Assessment Tool.* Available at: http://www.endhomelessness.org/library/entry/alliance-coordinated-assessment-tool-set.

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

3.1 Services, Interventions, and Care Coordination

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

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

1. *WPC Centralized Care Coordination:* A centralized Care Coordination Team (CCT) will connect the new communication and data technology infrastructure and the *Integrated Care Plan* with providers within the VCHCA, other public entities, and community partners. The CCT will oversee the day-to-day activity of ensuring the participants are appropriately identified, enrolled, and linked to resources. This centralized staff will have access to a multi-level, interdisciplinary support team of subject matter experts who will advise WPC staff about appropriate resources, services, and interventions, including PCPs, specialists, pharmacists, nurses, behavioral health specialists, housing services representatives, social service representatives, etc. The CCT will also provide field-based coordination and integration support as required by providers. The CCT will include: 9.0 FTE Care Managers (1.0 FTE Lead Care Coordinator, 3.2 FTE Registered Nurses [RN] and 4.8 FTE behavioral health specialists (see Section 1.2.3 below). 20.8 FTE Community Health Workers (CHWs) will also be a part of the CCT.
2. *WPC Care Coordination through Outreach:* Three Engagement Teams (based out of retrofitted mobile health vans) will facilitate integration of services, outreach and engagement of participants, determine immediate care needs, provide needed prescriptions, offer enrollment and assessment services, connect services with community-based providers, and ensure that there are no gaps between the Integrated Care Plan and the provision of planned services. The team will be effective in connecting with participants who predominantly access services outside of the VCHCA. The Engagements Team will include: one (1) Care Coordination Manager, one (1) Nurse Practitioner, and two (2) MAs.
3. *WPC Care Coordination through Field-Based Care Coordinators:* CHWs (20.8 FTE), who are

[20] Colletti J, Herrera S. (April 2015.) *Ventura County 2015 Homeless Count and Subpopulation Survey: Final Report.* Institute for Urban Initiatives. Available at: http://www.cityofventura.net/files/file/VC_Homeless_Count_Survey_2015.pdf.
[21] Ventura County Health Care Agency. (November 2013.) *Transforming Ventura County Communities: Understanding the Health Status and Needs of Ventura County.* Available at: http://www.vchca.org/docs/public-health/transforming-vc_-report_final.pdf?sfvrsn=0.

part of the CCT, will be field-based staff members who have a close understanding of the target population and Ventura County communities, and are culturally/linguistically similar and/or competent with the participants they serve. This trusting relationship will enable them to serve as a liaison, link, and intermediary between health, behavioral health, social services, and the community resources to facilitate access to services and improve the quality of service delivery. CHWs will build individual and community capacity by increasing health knowledge and self-sufficiency through a range of activities such as outreach, community education, informal counseling, social support, and advocacy. CHWs will administer the WPC Comprehensive Assessment, connect with the CCT to identify needed services, initiate the WPC Integrated Care Plan with the CCT based on the Comprehensive Assessment, link participants with community resources, reduce access barriers, provide in-person ongoing care management and support, and work with system-wide care managers to provide care (see Section 1.2.2).

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

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

Behavioral Services: A host of mental health and substance abuse services will be provided by the *Ventura County Behavioral Health Department* (VCBH) outside of Medi-Cal funding streams (see Section 1.2.3.). In addition, 4.8 FTE VCBH Care Managers who are part of the CCT (see Section 1.2.2 above) will support behavioral health care coordination for participants. The role of the VCBH Care Managers is to integrate behavioral health services with other medical, social, and non-medical services according to the Integrated Care Plan. The centralized behavioral health specialists will: 1) interact with CHWs, patients, physicians, behavioral health professionals, social service providers, and community partners to ensure that behavioral health protective factors are integrated with all aspects of care; 2) track service utilization, health outcomes, and care plan changes; 3) work closely with field-based CHWs to ensure timely behavioral health care; 4) bring all care providers to serve the participant during urgent/emergent behavioral health situations; 5) ensure behavioral health services are accessible in primary care settings; and other services as indicated. At least one Care Manager will be a Licensed Mental Health Professional (LMFT or LCSW) and at least one will be a Substance Abuse Specialist.

Other non-Medi-Cal services include those that are provided through the Mental Health Services Act, Realignment Funds, SAMHSA and other grants, County General Funds, Veteran's

Administration, and other sources. SAMHSA grants include Projects for Assistance in Transition from Homelessness (PATH) funding for case management and outreach. Integration with primary care is also provided through a co-located behavioral health professional in some clinics.

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

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

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

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

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

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

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

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

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

As indicated in Section 2.1 and described in the CMCS Informational Bulletin,[25] housing services will include: individual housing transition services and individual housing and tenancy sustaining services. Housing support services provided by the Area Housing Authority of the County of Ventura and city housing authority partners will include a host of housing supports including: developing housing plans, housing searches, paperwork and legal support, relationship-building with landlords, setting up utilities, etc. Housing authorities will prioritize the project's homeless participants for housing

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

[23] CSH, 2014.

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

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

vouchers.

Residential Services (Mental Health): Case management is provided to support a client's stability in their home environment and residential treatment programs. Note that WPC funds will only be used for allowable costs that include individual housing transition services and individual housing and tenancy sustaining services in alignment with the CMCS Informational Bulletin. Residential services and room and board are not covered under WPC.

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

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

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

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

7. CHWs will integrate services through outreach and coordination with participants and system providers.
8. The centralized *Care Coordination Team* will integrate services as defined by the *Integrated Care Plan.*

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

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

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

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

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

Care Plan platforms.

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

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

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

Plan-Do-Study-Act (PDSA) Process: The *Model for Improvement*[31] will drive system-wide

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

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

[28] New England Healthcare Institute. (March 2010.) A Matter of Urgency: Reducing Emergency Department Overuse. Available at: http://www.nehi.net/writable/publication_files/file/nehi_ed_overuse_issue_brief_032610finaledits.pdf.

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

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

[31] Langley GL, Moen R, Nolan KM, Nolan TW, Norman CL, Provost LP. *The Improvement Guide: A Practical Approach to Enhancing*

improvement, and PDSA methodology[32] will be the basis for testing quality improvement processes and change management. The WPC administrators/management and the Waiver Analytics Team will be consistently monitoring project progress, both in relation specifically to PDSA cycles and through dashboards tracing overall quality indicators. Outlier data and notable trends will indicate opportunities for quality improvement. Needed changes will be identified through root cause analysis, development of change concepts, and Lean processes. Value stream mapping will help to identify the needed change and change concept. Once a targeted change is identified, PDSA processes will test the proposed change to determine if it will be successful, the degree of change expected, and the costs and other impacts associated with the change. Change will be carried out through incremental tests of change, and change modifications through iterative PDSA cycles (see Section 4.2). A Quality Improvement Coordinator will drive PDSA processes, work with leaders to implement and test change, tie VCHCA quality improvement processes and committees in with PDSA processes, use participant feedback to drive improvements, and interact with project staff to optimize the quality of services. PDSA processes will take place at the collaboration and individual systems level (i.e., administrative, field-based, centralized care coordination, mobile engagement, technology, providers) at least monthly to ensure that continuous quality improvement provides excellence in care.

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

Participating entities will be responsible for providing case managers to link participant care with WPC care plans and resources; providing data on utilization, cost, and outcomes; and linking with new collaboration platforms to plan and execute services. Care coordination will be *linked with other participating entities* through the *WPC Care Collaboration* platform, *eReferral* technologies, *Real-Time Secure Messaging* telemedicine consultation services, access to an *Integrated Care Plan* platform, and communication with assigned CHWs. *Care coordination will be seamless* to the

Organizational Performance (2nd edition). San Francisco: Jossey-Bass Publishers; 2009.

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

beneficiary by integrating key care coordination administrative elements:[33] 1) structured coordination with regularly scheduled contacts and co-location of some key services; 2) defined roles and systems that facilitate participants being provided rapid access to partners with appropriate training and expertise when problem situations arise; and 3) understanding how each partner perceives similar needs. Because it is anticipated that participants will to move along a continuum of health/behavioral health and other social service needs over time, a single lead entity/CHW and single funding stream for WPC services will facilitate more seamless patient care.

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

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

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

- Failure to take advantage of necessary health care services, or
- Non-compliance with their prescribed medical regime, or
- An inability to coordinate multiple medical, social and other services due to the existence of an unstable medical condition in need of stabilization, or
- An inability to understand medical directions because of comprehension barriers, or

[33] Cantor, 2015.

- A lack of community support system to assist in appropriate follow-up care at home, or
- Substance abuse, or
- A victim of abuse, neglect or violence; and
- In need of assistance in accessing necessary medical, social, educational, or other services, when comprehensive case management is not being provided elsewhere.

The target population for the Whole Person Care Pilot, however, is the highest utilizers of Ventura County ED, inpatient hospital services who have at least four ED visits and/or two inpatient visits, and are using additional services such as Behavioral Health, Public Health, Social Services, and may be in and out of the justice system due to SUD or mental illness. The identified participants will also have risk factors for readmission. The distinction is different because the targeting mechanism is different. Targeted Case Management will evaluate participants based on the above conditions, rather than high utilization of multiple systems (HUMS). Although a very small percentage of this population may overlap, the Whole Person Care pilot will have electronic alerts built into the enterprise Health Registry to notify the CCT of eligibility in other care systems.

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

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

Management.

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

3.2 Data Sharing

Data Sharing Between Entities: Data sharing will occur between entities through a centralized enterprise web-based solution offering real-time notification and communication interfaces that will promote collaboration. Participants will sign a Universal Consent Form, allowing their data to be shared among entities for the purpose of care coordination. Data sharing will occur via the following modalities (see the Data Sharing Structure in Attachment G):

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

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

Data to be Shared: Data shared will be used to evaluate individual as well as population progress, track utilization and cost over time, track universal and variant metric progress, facilitate care

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

coordination, improve the quality of care, and improve access to care. Four major spheres of data will be shared: eligibility, health, behavioral health (including mental health and substance use), and social services (including utilization of county services and community-based social services such as housing). Health and behavioral health outcomes (and other performance and process metrics) will be measured to evaluate the project impact.

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

Infrastructure/Data Sharing Evolution: The first phase (Year 2) will launch the operation of Care Coordination and Integrated Care Plan platforms and UOMS. Data sharing within the VCHCA departments will be initiated. Needs assessments for technology development and planning for data sharing among project and collaborative partners will be developed. During this development process, data sharing will occur through secure email systems and/or through reports distributed at meetings.

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

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

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

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

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

Timeline/Implementation Plan:
Year 1: Secure contracts with vendors to develop the enterprise data system, collaborative development and agreements pertaining to data sharing protocols.
Year 2: Audit systems to determine data structure needs, develop data governance protocols, develop data technology infrastructure for the Integrated Care Plan and Care Coordination platform (member repository, data repository, interfaces); beta test system; launch pilot data sharing system (3rd quarter); develop the Outcome and Utilization Monitoring System data warehouse; determine data sharing needs of project partners; plan partner data sharing technology implementation.
Year 3: Develop technology infrastructure, test, and launch eReferral; and develop, test, and launch partner data sharing technologies.
Year 4 and 5: Continue to implement quality improvement processes and adapt systems to be responsive to the project's requirements to provide quality care, collect and share data, and enable provider collaboration; and expand data sharing capabilities to health care providers outside of the VCHCA system.

Building a Sustainable Data Infrastructure: When completed, this data infrastructure will: be sustainable through the initial investment in technology; have a phased implementation that will overcome challenges as development is ongoing; offer safe encrypted data access through secure tunnels to provide comprehensive provider-to-provider connectivity; provide cost savings to the

system by lowering expensive avoidable utilization that will enable VCHCA to maintain the ongoing cost of the data sharing system; develop a health registry that will further inform countywide care providers and community partners about target population needs; and develop a data warehouse that will enable data sharing and coordination.

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

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

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

4.1 Performance Measures

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

YEAR 1

WPC Pilot:

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

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

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

YEAR 2

WPC Pilot:

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

Gold Coast Health Plan

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

VCHCA/Lead Entity:

1. *Short-Term Process Measure:* By 7/1/2017, hire and train WPC staff, as measured by employment records/contracts.
2. *Short-Term Process Measure:* By 7/1/2017, initiate WPC enrollment and project services, as measured by signed consent forms.

3. *Long-Term Outcome Measure:* By 12/31/17, CHWs will have at least 600 encounters with identified potential participants to conduct enrollment processes, as measured by signed Universal Consent forms.

Public Agencies/Community Partners:

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

YEARS 3-5

WPC Pilot:

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

Gold Coast Health Plan:

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

VCHCA/Lead Entity:

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

Public Entities/Community Partners:

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

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

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

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

4.1.a Universal Metrics

- ☒ **Health Outcomes Measures**
- ☒ **Administrative Measures**

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

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

Metric i. Health Outcomes Goal i.2: ED visits will maintain baseline measurements in project Year 2, be reduced among enrolled participants by at least 15% from baseline in project Year 3, will be

reduced at least 20% from baseline in Year 4, and will be reduced at least 25% from baseline in project Year 5. (Adults and total only. No children in the project.) (Pay for Outcome metric.)

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

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

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

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

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

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

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

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

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

Metric v. Health Outcomes Goal v1: At least 60% of participants will have a comprehensive care plan, accessible by the entire care team, within 30 days of enrollment into the WPC Pilot. (Incentive metric)

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

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

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

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

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

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

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

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

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

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

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

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

4.1.a Variant Metrics

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

Variant Metrics	PY 1	PY 2	PY 3	PY 4	PY 5
Administrative Metric: Percentage of CHWs receiving quarterly in-service training based on gaps identified through field work via PDSA	N/A	60%	65%	70%	75%
Health Outcomes Metric. Comprehensive Diabetes Care: HbA1c Poor Control <8%: Percentage of patients 18 - 75 years of age with Diabetes (type 1 and type 2) who had Hemoglobin A1c <8.0% during the measurement period	N/A	Maintain Baseline	+5% of baseline	+10% of baseline	+15% of baseline
Health Outcomes Metric. NQF 0710: Depression Remission at 12 Months: Percentage of patients aged 18 and older with a diagnosis of major depression or dysthymia and an initial PHQ-9 score greater than 9 during an outpatient encounter who achieve remission at twelve months as demonstrated by a twelve	N/A	Maintain Baseline	+5% of baseline	+10% of baseline	+15% of baseline
Health Outcomes Metric. NQF 0104: Suicide Risk Assessment: Percentage of patients aged 18 years and older with a new diagnosis or recurrent episode of major depressive disorder (MDD) who had suicide risk assessment completed at each visit in which a new diagnosis or recurrent episode was	N/A	Maintain Baseline	+5% of baseline	+10% of baseline	+15% of baseline
Housing Metric: Housing Services: Percentage of homeless receiving housing services in the project year that were referred for housing	N/A	50%	55%	60%	65%
Optional Metric: Percentage of participants who have at least six encounters with a CSW during the project year.	N/A	50%	55%	60%	65%

4.2 Data Analysis, Reporting and Quality Improvement

Data Collection: Data collection will be consolidated into the Utilization and Outcome Monitoring System (UOMS) data warehouse to determine the effectiveness of service strategies and the impact they have on participants' health outcomes. This central repository used for data analysis and reporting will derive its data from the CC platform data repository, EHR, and health registry. A standardized data collection procedure and protocols through standardized forms, data variables, and system data entry requirements will be developed to ensure data validity. A separate database

will collect project fiscal, staffing, infrastructure development, and other administrative data, such as income/expense statements, project monitoring, PDSA data, etc.

Reporting: Reporting will occur through standardized reports from the CC platform and UOMS data warehouse utilizing dashboards. These reports will inform data analysis processes and the development of the monthly WPC Project Status reports, PDSA reports, DHCS reports, and WPC fiscal reports, among other reports. For the DHCS mid-year and annual reports, the project will report on all Universal and Variant metrics, and describe early trends, potential explanations, and plans to incorporate lessons into a continual cycle of performance improvement (using a PDSA methodology) during project years 2 and 3. In project years 4 and 5, the project will additionally report on the direction of the changes shown in the health outcomes data, if changes are in the predicted direction, what contributed to the improvement or hindrance, and how interventions will be adapted to improve performance. Collaborative reporting will take place at monthly meetings where WPC Project Status reports will be presented, through email updates, and through quarterly trainings. Project reports will also be used to inform stakeholders and other national pilot project managers through the WPC learnings (see Section 2.2).

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

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

[35] Mahalik P. (2016.) *Learning to Think Lean: Six Steps with Review Points.* iSixSigma. Available at: https://www.isixsigma.com/methodology/lean-methodology/learning-think-lean-six-steps-review-points/.
[36] Cantor, 2015.
[37] Culhane DP, Parker WD, Poppe B, et al. (2007.) *Accountability, Cost-Effectiveness, and Program Performance: Progress since 1998.* Available at: http://aspe.hhs.gov/hsp/homelessness/symposium07/culhane/.

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

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

Quality Improvement/Change Management Approach: The project will utilize and report PDSA processes and changes, which will not only be used for Universal and Variant metrics, but also to inform quality improvements throughout the project. As indicated in Attachment MM, the pilot will utilize the DHCS template's change-management plan, including a mechanism for identifying needed adjustments, a process for carrying out each change, a process for observing and learning from the implemented change(s) and their implications, and a process to determine necessary modifications to the change based on the study results and implement them. National agencies have extensively analyzed change management and quality improvement processes which are effective among Medicaid care collaboratives and providers.[38] The *Model for Improvement*[39] will be used for change management, which includes setting aims, establishing measures, selecting changes, testing changes, implementing changes, and communicating/disseminating changes. Quality improvement and change will use a team approach both for the collaborative and the pilot staff utilizing PDSA methods.

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

Value Stream Mapping will help identify the needed change and change concept, and ensure that the change will add value to the project and close the gap between expectations and the

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

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

current status. Data to inform needed adjustments will be collected from a variety of sources. For example, the Gold Coast Health Plan HEDIS reports will inform metric improvements and field questions from CHWs will inform training improvements.

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

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

Determining Change Modifications/Implementation: Change modifications will be accomplished through the application of a sequence of iterative PDSA cycles. The use of quantitative data at monthly or more frequent data intervals will inform the progression of cycles. The team will continue linking tests and refining the changes until new/modified strategies are ready for broader implementation. People are more willing to test for a change when they know the change(s) can and will be modified as needed. Linking small tests of change helps an organization to overcome its natural resistance to change and helps promote buy-in from the staff/stakeholders. An improvement tracking tool will be developed (similar to the Institute for Healthcare Improvement's [IHI] Improvement Tracker Tool[40]) to enable the collaborative, staff, and stakeholders to see how each specific change has transformed the project.

4.3 Participant Entity Monitoring

Monitoring Participating Entities: Services and interventions provided by participating entities will be conducted under the parameters of the Letters of Agreement and/or contracts (as appropriate), and WPC bylaws, which will be established during project years 1-2. As the Lead Entity, VCHCA will ensure that participating entities' actions are aligned with the DHCS requirements, applicable state and federal laws, contracts, and the bylaws. The Community Partner platform will collect data about service utilization and outcomes coordination with the Integrated Care Plan entities outside of the VCHCA. This platform will communicate with the UOMS centralized dashboard that will monitor progress of all participating entities on predetermined metrics and goals. This will enable the Waiver Analytics Team, WPC Informaticist, and Project Director to monitor

[40] Institute for Healthcare Improvement. (2016.) *Improvement Tracker.* Available at: http://app.ihi.org/Workspace/tracker/.

community partner participant services and outcomes in an integrated manner along with data from departments within the VCHCA. Monitoring will also occur through entity reports/presentations at WPC collaborative meetings, site visits, and fiscal reports.

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

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

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

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

Section 5: Financing

5.1 Financing Structure

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

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

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

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

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

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

The Lead Entity will also include a report on all projected payments (amounts and timing) during the current period and will prepare an IGT to the upon DHCS notification.

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

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

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

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

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

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

available for prevention, assistance, and interventions in the issues faced by the target population.

5.2 Funding Diagram

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

5.3 Non-Federal Share

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

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

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

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

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

the IGTs associated with the WPC pilot are appropriately sourced and in compliance with STC 113 and with WPC pilot requirements.

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

Targeted Case Management Non-Duplication of Services: As indicated in Section 3.1, Targeted Case Management Program Overlap, there are few anticipated activities and interactions of the care coordination teams that would duplicate Medi-Cal's targeted case management (TCM) benefit due to the nature of the specific target population and planned interventions. Specifically, centralized care coordination Care Manager infrastructure, web-based Integrated Care Plan, infrastructure that provides technology-assisted care coordination, and risk stratification methods for identifying participants depart significantly from the encounter-based structure of TCM. In cases when there are encounters between the CHWs and Engagement Teams with the participants, the service would not be eligible for reimbursement under TCM, as the CHWs and outreach staff would not meet the education/experience requirements for TCM case workers or the Nurse Practitioner would be in a supervisory role and would have few, if any, direct contact with clients. Moreover, the scope of care support and coordination activities available through WPC is intended to be more robust than available through Medi-Cal TCM. WPC teams will engage in activities such as peer support, trust-building, motivational interviewing, disease specific education, and general reinforcement of health concepts, which are distinct from and outside the TCM benefit. WPC will also provide direct social and other services that would not be recognized as TCM, such as transitional housing support services. For these reasons, the budget has accounted for a 5% overlap for the work of the lead Care Coordination Manager in identifying targeted individuals, reviewing the Health Registry to determine if identified potential participants are utilizing Targeted Case Management services prior to enrollment, working with the Targeted Case Management Program Administrator to ensure that all persons at risk are being served by one or the other program as applicable based on their condition in alignment with the specified and divergent eligibility of the target populations to the two programs, and avoiding duplication of services in Whole Person Care and Targeted Case Management programs. Medi-Cal TCM is not currently operating in Ventura County, and its services are in the planning stage. An anticipated launch date is still to be determined.

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

condition in alignment with the specified and divergent eligibility of the target populations to the two programs, and conducting PDSA processes focused on avoiding duplication of services in Whole Person Care and Targeted Case Management programs.

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

5.5 Funding Request

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

Section 6: Attestations and Certification

6.1 Attestation

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

- The WPC pilot lead entity will help develop and participate in regular learning collaboratives to share best practices among pilot entities, per STC 119.
- 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
- Within 30 days of the determination of the interim payment due based on the mid-year and annual report, 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.
- The WPC pilot lead entity will enter into an agreement with DHCS that specifies the requirements of the WPC pilot, including a data sharing agreement per STC 118. [See Exhibit A "HIPAA Business Associate Addendum (BAA)" of this Application. Many of the provisions in the DHCS boilerplate BAA apply only to BAA-covered information that is shared by DHCS to the pilot specifically for the purpose of Whole Person Care pilot operation and evaluation. DHCS does not anticipate that BAA-covered information will be shared with pilots for the purpose of Whole Person Care pilot operation or evaluation. DHCS anticipates limited, or no, BAA-covered information sharing from the pilot to DHCS. However, DHCS will include a BAA in the case that data need to be shared. The BAA will apply to the transfer of BAA-covered information should the need arise.]
- 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.
- 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.
- The WPC pilot will meet with evaluators to assess the WPC pilot.
- Federal funding received shall be returned if the WPC pilot, or a component of it as determined by the state, is not subsequently implemented.

- Payments for WPC pilots will be contingent on certain deliverables or achievements, and will not be distributed, or may be recouped, if pilots fail to demonstrate achievement or submission of deliverables (STC 126).
- 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.
- 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.

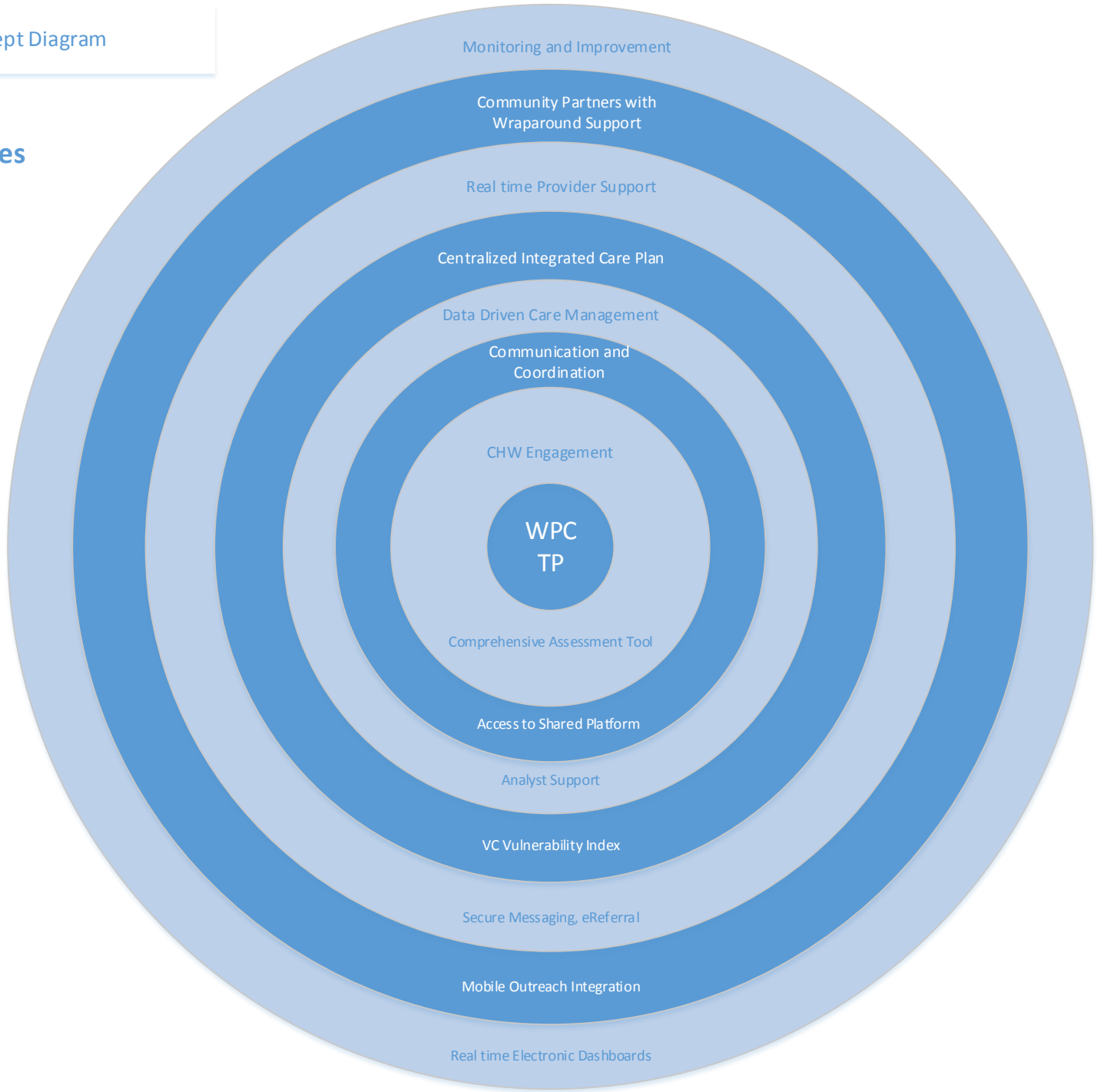
9/20/2016

Signature of WPC Lead Entity Representative Date

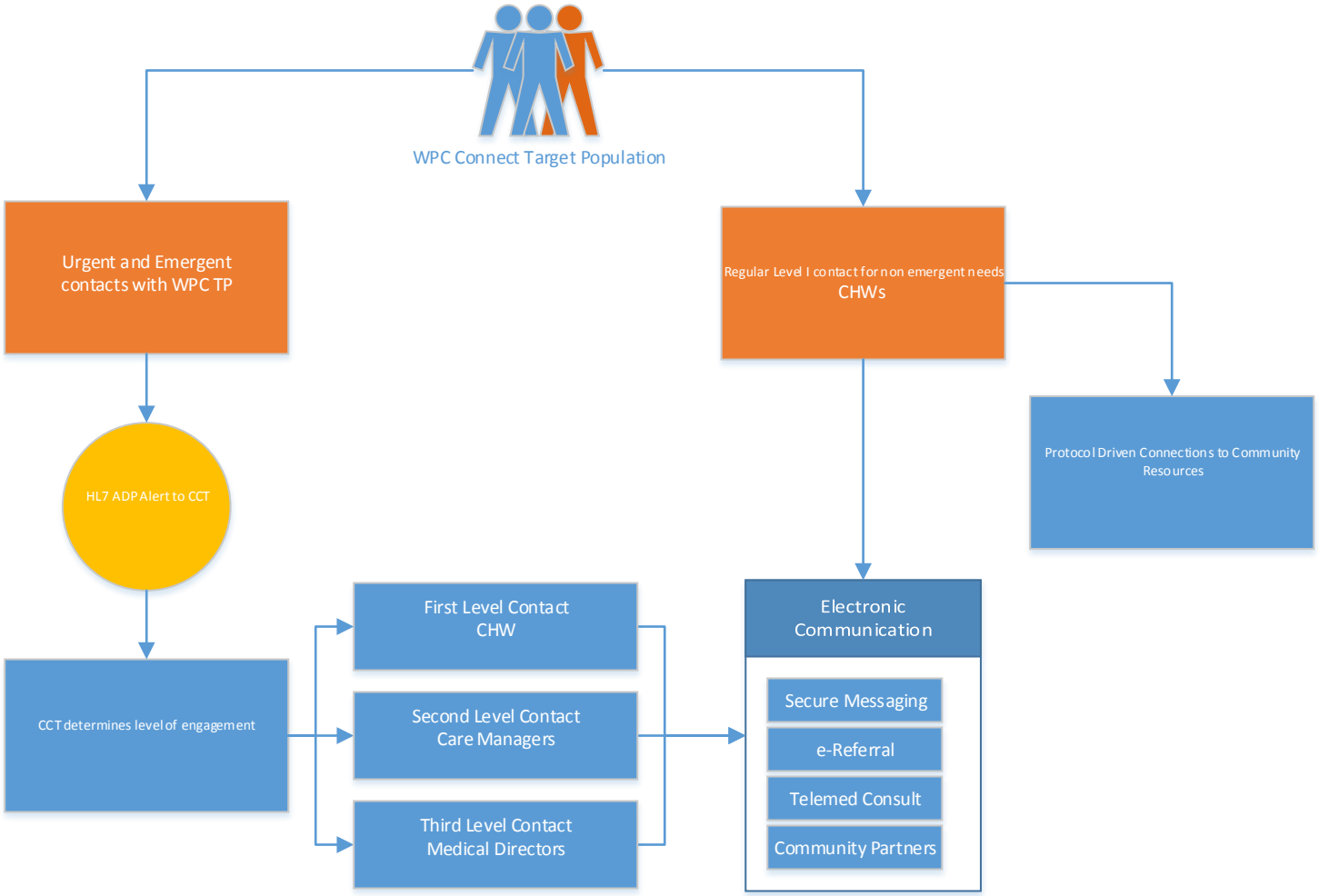
California Medi-Cal 2020 Demonstration
Approved December 30, 2015 through December 31, 2020
Amended: May 12, 2016

Attachments Table of Contents

Attachment A: Concept Diagram



Attachment B: VCHCA WPC Connect Workflow



Attachment C: Ventura County Whole Person Care Vulnerability Index

VCVI

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

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

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

2 points: Major condition with increased potential for harm

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

1 point: Health concern requiring management

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

Thousand Oaks - Lutheran Social Services
80 E. Hillcrest Dr #101 497-6207

MEALS (also see Food)
Simi Valley - Samaritan Center (call for info)
280 Royal Ave 579-9166
Thousand Oaks - Lutheran Social Services
80 E. Hillcrest Dr. #101 (call for info) 497-6207

MEDICAL
- Health Care for the Homeless 652-6694

Countywide
- Children's Medical/Dental Services 652-5960
- WIC (women, infants, children) 1-800-433-2611

Moorpark
- Family Care Center - 35 W. Los Angeles Ave. 529-4624

Simi Valley
- Public Health Department
660 E. Los Angeles Ave 578-3675
- Sierra Vista Family Care Center
127 E. Los Angeles Ave 582-4000
- Free Clinic of Simi Valley - 2060 Tapo St.
(Tuesdays, 9 a.m. - 1 p.m.) 522-3733
- Simi Valley Hospital - 2975 Sycamore Dr. 955-6000

Thousand Oaks
- Conejo Valley Family Medical Group
125 W. Thousand Oaks Blvd. #300 481-9100
- Los Robles Hospital - 215 W. Janss Rd 497-2727
- Westminster Free Clinic - at the United Methodist Church - 1000 E. Janss Rd.
(Wednesdays, 4 - 9 p.m.) 241-8366

MENTAL HEALTH
Countywide
- Adult Crisis Team - 24 hour 1-866-998-2243
- Mental Health Liaison 981-4227
Bilingual Mental Health Liaison 981-3331
- NAMI (support / Advocacy) 641-2426
- RISE Team / OD Line 981-4233
- STAR (Access to Mental Health Services) 1-866-998-2243

Simi Valley
- Ventura County Behavorial Health Clinic
1227 E. Los Angeles Ave. - (also serves Moorpark) 582-4075

Thousand Oaks
- Conejo Behavorial Health Clinic
72 Moody Ct. 777-3500

SENIOR CITIZENS SERVICES
- 24-hour Helpline ..... dial 211
- Adult Protective Services (abuse/neglect) 654-3200
- Area Agency on Aging
646 County Square Dr. #100, Ventura 477-7300
- Mental Health, Older Adult Services 777-3500
- Ombudsman Services (visit nursing homes) 656-1986
- Senior Nutrition (meal site info) 477-7300

SHELTERS
Domestic Violence Shelters
- Coalition for Family Harmony 656-1111
Spanish Hotline 1-800-300-2181
- Interface Children & Family Services 1-800-339-9597

Year-round Shelters
There are no year-round shelters in the Simi-Conejo area
- Lighthouse - (women & children) Oxnard 385-7200
- Rescue Mission - (men only)
234 E. 6th St, Oxnard 487-1234
- Turning Point Foundation - Our Place Shelter (mentally ill)
538 E. Thompson Blvd, Ventura 652-2151

Winter Shelters
- Simi Valley - P.A.D.S. (November - April) - call for information 579-9166
- Thousand Oaks - Conejo Valley Winter Shelter
(December - March) - call for information 497-6207

SHOWERS/TOILETS
- Rescue Mission - 234 E. 6th St, Oxnard 487-1234
- Samaritan Center - 280 Royal Ave, Simi Valley
Monday - Thursday, 9 a.m. - noon 579-9166
- Lutheran Social Services (Monday - Friday, 9 a.m. - noon)
80 E. Hillcrest Dr. #101, Thousand Oaks 497-6207

TRANSITIONAL HOUSING
- RAIN Transitional Living Center (families & singles
Camarillo - Applications call 383-7505
- Sarah's House (Maternity Home) 581-1910
- Tender Life (Maternity Home) 653-7471
- Veteran Transitional Housing (Ventura) 652-0000 x102

VETERANS' SERVICES
- County of Ventura Veteran Services
5740 Ralston St. #300, Ventura 477-5155
- Department of Veterans Affairs - Outpatient Clinic
Veterans Center - Counseling Services
Monday - Friday, 8 a.m. - 4:30 p.m.
4440 Calle Real, Santa Barbara ..... (805) 683-1491
- Disabled Veterans Outreach (EDD) 582-8763
- Oxnard VA Outpatient Clinic
2000 Outlet Ctr Dr. #225, Oxnard 604-6960
- Ventura Vet Center (Counseling)
790 E. Santa Clara St. #1000 585-1860
- Veteran's Home of Ventura
10900 Telephone Rd, Ventura 659-7502
- Veteran Transitional Housing (Ventura) 652-0000 x102

YOUTH SERVICES
- Interface Youth Crisis Line / Shelter 469-5882
- Interface Youth Services Drop-In Center
Monday - Friday, 2 - 6 p.m.
260 W. 4th St, Oxnard 469-5882
- Independent Living Program (former Foster Youth) 654-3245
- Pacific Clinics, Transition Age Youth (TAY Tunnel)
141 W. 5th St. #D, Oxnard 240-2538
- Teen Runaway Helpline 1-800-RUN-AWAY
- Transitions (VC Behavioral Health) 1-866-998-2243

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

County of Ventura

This brochure was prepared by:
County of Ventura - Human Services Agency
Homeless Services Program
(805) 385-1800
www.vchsa.org
56-15-069 (5/16)

Resources *for Homeless People* Eastern Ventura County

Moorpark • Simi Valley
Thousand Oaks

This information current as of
May 2016

ALCOHOL & DRUG SERVICES
- 24-hour Helpline ..... dial 211
- County Alcohol/Drug Line 981-8200
- Alcoholics Anonymous – Countywide Info 389-1444
- Alanon 495-0270
- Simi Valley Center - 3150 Los Angeles Ave. 577-1724
- Khepera House (men) treatment 653-2596
- Lighthouse Recovery (Oxnard) 385-7200
- Palmer Drug/Alcohol Abuse Program 482-1265
- Prototypes (women/children) 382-6296
- Rescue Mission (men) - 234 E. 6th St, Ox 487-1234
- Salvation Army – Canoga Park/ARC ..... (818) 883-6321
- Teen Challenge 648-3295
- Victory Outreach 988-4102

BENEFITS
- Human Services Agency (CalWORKs, General Relief, CalFresh [Food Stamps], Medi-Cal)
Simi Valley - 2900 N. Madera Rd. 584-4842
Moorpark - 612B Spring Rd, #301 523-5444
Thousand Oaks
80 E. Hillcrest Dr. #200 449-7320
- Social Security - Countywide Registration 1-800-772-1213
T.O. Office - 322 E. Thousand Oaks Blvd. 1-888-397-4807
- Unemployment Benefits Claims
English 1-800-300-5616
Spanish 1-800-326-8937

BUS
- ADA/Dial-A-Ride 583-6464
- Camarillo Area Transit 988-4228
- Gold Coast Transit - Countywide Transportation Information 1-800-438-1112
- Greyhound Bus 1-800-231-2222
- Simi Valley Transit 583-6456

CAMPGROUNDS
- County Park Information 654-3951
- State Park Info ..... 968-1033 / 1-800-444-7275
- **Camping**
Fillmore - Kenny Grove - 823 N. Oak 524-0750
Santa Paula - Steckle Park - 8080 Mistletoe Rd. 654-3951
- **Short-Term Camping** (14 days maximum)
Moorpark - Oak Park - 901 Quimesa 654-3951
Oxnard - McGrath St Beach - 2211 Harbor Blvd
Ventura -
Emma Wood - Rincon Parkway, Hwy 1 654-8444
Faria Beach - 4350 W. PCH 654-3951
Hobson Park - 5210 W. Pacific Coast Hwy 654-3951
Lake Casitas - 11311 Santa Ana Rd 649-2233
Ventura Beach Resort - 800 W. Main St. 643-9137

CHILDREN'S SERVICES
- Children's Crisis Team 1-866-431-2478
- Child Development Resources (CDR) (childcare, Head Start) 485-7878
- Children & Family Services (abuse, adoption, foster care) 582-8062
- Children's Medical Services 652-5960
- County Schools Homeless Education Project 437-1526
- School on Wheels (tutoring/supplies) 1-800-923-1100

CITIZENSHIP/IMMIGRATION
- El Concilio Del Condado
301 S. "C" St, Oxnard 486-9777 x232

CLOTHES
- Catholic Charities - 612 Spring Rd, Moorpark
(Monday - Thursday 9 a.m. - noon) 529-0720
- Lutheran Social Services
80 Hillcrest Dr #101, Thousand Oaks 497-6207
- Samaritan Center - 280 Royal Ave., Simi Valley
(Monday - Thursday, 7 - 11 a.m.) 579-9166

DENTAL
- Children - referrals from CHDP 981-5291
- Clinicas Del Camino Real (fee for services)
Oxnard - 650 Meta St. 487-5351
Ventura - 200 S. Wells Rd 659-0560
- Free Clinic of Simi Valley (call for appt.) 522-3733
- Salvation Army Free Clinic - Oxnard
(call for appointment) 483-9235

DISABLED PERSONS
- Department of Vocational Rehabilitation
1701 Pacific Ave #120, Oxnard 385-2400
- Independent Living Resource Center 650-5993
- Tri-Counties Regional Center
1900 Los Angeles Ave, Simi Valley 522-8030

DOMESTIC VIOLENCE
- Adult Abuse & Neglect 654-3200
- Child Abuse & Neglect 654-3200
- Coalition for Family Harmony 656-1111
- Interface Children & Family Services 1-800-636-6738

DROP-IN SERVICES
- One Stop Centers
- Conejo Valley Family Medical Group - 125 W. Thousand Oaks Blvd, Thousand Oaks (Monday 9 a.m. - noon)
- Sierra Vista Family Medical Clinic - 1227 E. LA Ave, Simi Valley (Monday 2 - 5 p.m.)
- Samaritan Center - 280 Royal Ave, Simi Valley - showers, clothing, mail, messages, job coach
(Monday - Thursday, 9 a.m. - noon) 579-9166

EMPLOYMENT/JOB TRAINING
- California Conservation Corps (18-25 years) 278-2787
- Catholic Charities - 612 Spring Rd #101, Moorpark 529-0720
- East County Job & Career Center
2900 N. Madera Rd, Simi Valley 955-2282
- Goodwill Industries - 130 Lombard, Oxnard 981-0130
- Job Corps (16-24 yrs.) 1-800-733-5627
- Lutheran Social Services Re-employment Program
80 E. Hillcrest Dr #101, Thousand Oaks
call for appointment 497-6207
- Moorpark Community Service Center
612B Spring Rd #301 523-5444
- Thousand Oaks Community Service Center
80 E. Hillcrest Dr #200 374-9006
- Unemployment Benefit Claims
English 1-800-300-5616
Spanish 1-800-326-8937

FOOD (also see Meals)
- FOOD Share - countywide food pantry
(call for referral in your area) 983-7100

Moorpark
- Catholic Charities - 612 Spring Rd #101 529-0720
(Mon - Thurs 9 am - 1:30 pm, Sat 9 am - 1 pm)

Simi Valley
- Salvation Army - 1407 E. Los Angeles Ave #P
(Monday - Thursday, 10 am - 2 pm) 527-1070

Thousand Oaks
- Lutheran Social Services - 80 E. Hillcrest Dr #101 497-6207
- Manna Conejo Valley Food Bank - 3020 Crescent Way (Tues 11 am - 4 pm, Fri 10 am - 4 pm, Sat 10 am - 1 pm) 497-4959

HOUSING/HOMELESS SERVICES
- Area Housing Authority (does NOT provide emergency housing) - serves Camarillo, Fillmore, Ojai, Moorpark, Simi Valley, Thousand Oaks and unincorporated areas
1400 W. Hillcrest Dr, Newbury Park 480-9991
or 1-800-800-2123
- Cabrillo Economic Development Corporation (affordable housing) 659-3791
- Housing Rights Center 1-800-477-5977
- Catholic Charities - 612 Spring Rd #101, Moorpark 529-0720
- HSA Homeless Services Program 385-1800
- HPRP Homeless Prevention & Rental Deposit . 385-8585
- Lutheran Social Services
80 E. Hillcrest Dr. #101, TO 497-6207
- Many Mansions / Housing Central (Mon. - Thurs.)
1425 E. Thousand Oaks Blvd, TO 497-0344
- Mental Health Housing / STAR 1-866-998-2243
- Salvation Army
1407 E. Los Angeles Ave #P, Simi 527-1070
- Samaritan Center - 280 Royal Ave, Simi Valley
(mornings Mon. - Thurs.) 579-9166
- St. Vincent de Paul 487-1558

INFORMATION AND REFERRAL
Dial 211 for Info 24 hours/7 days/week about Community Resources near you
- Area Agency on Aging (seniors) 477-7300
- County of Ventura 1-800-660-5474
- Homeless Services Program Info 385-1800

LAUNDRY
- Lutheran Social Services - 80 E. Hillcrest Dr #101, Thousand Oaks - (Mon. - Fri. mornings) 497-6207
- Samaritan Center - 280 Royal Ave, Simi Valley - (Monday - Thursday, 7 a.m. - 11 a.m.)

LEGAL SERVICES
- Conejo Free Clinic - 80 E. Hillcrest Dr. #211, TO
(call for information) 497-3575
- Self Help Legal Access Center - 800 S. Victoria Ave, Ventura (Courthouse 1st floor) 654-3962
- Simi Free Clinic - 2060 Tapo St, Simi Valley
(by appointment only) 522-3733

Countywide
- California Rural Legal Assistance
338 S. "A" St, Oxnard 483-8083
- Grey Law (60 yrs.+)
290 Maple Court #128, Ventura 658-2266
- Housing Rights Center 1-800-477-5977

MAIL/MESSAGES
Moorpark - Catholic Charities
612 Spring Rd #101 529-0720
Simi Valley - Samaritan Center - 280 Royal Ave.
(mornings) 579-9166

County of Ventura • Human Services Agency • Homeless Services Program • (805) 385-1800

- Self Help Legal Access Center Ventura
  800 S. Victoria Ave. (Courthouse, 1st fl) ... 654-3962

MAIL/MESSAGES

Oxnard
- Catholic Charities - 402 N. "A" St. ... 486-2900
- Community Action Program of Ventura County
  621 Richmond ... 436-4000

Ventura
- Catholic Charities - 303 N. Ventura Ave. ... 643-4694
- Turning Point Foundation (mentally ill)
  536 E. Thompson Blvd. ... 652-2151

MEALS (also see Food)

Oxnard
- Catholic Charities - sandwiches - 402 N. "A" St. Lyons Park - 9th & "G" St. - Sat & Sun. 8:30 a.m. - 1 p.m.
- Rescue Mission - 6th & Meta - Dinner 5:30 - 6 p.m. Mon - Fri 11 - 11:30 a.m. - Sat & Sun 12 - 12:30 p.m.

Santa Paula
- Many Meals - 121 Davis St. - Wed. 5 - 6 p.m.

Ventura
- Family to Family - 305 N. Ventura Ave. Mon, Wed, Fri 11:30am - 12:30pm - Sat, Sun 8 - 9am

MEDICAL
- Health Care for the Homeless. ... 652-6694

Countywide
- Children's Medical/Dental Services. ... 652-5960
- Ventura County Medical Center (VCMC)
  3291 Loma Vista Rd, Ventura ... 652-6000
- WIC (women, infants, children) ... 1-800-433-2611

Oxnard
- Clinicas del Camino Real - 650 Meta St. ... 487-5351
- Las Flores Women's Center
  2500 S. "C" St, #B. ... 385-9142
- Las Islas Medical Clinic
  325 W. Channel Islands Blvd. ... 240-7000
- Public Health Clinic - 2500 S. "C" St. ... 385-8652
- Salvation Army - 622 W. Wooley Rd. - free clinic
  Monday & Thursday ... 483-9235

Santa Paula
- Public Health Clinic - 620 W. Harvard. ... 933-5505
- Santa Paula Hospital - 825 N. 10th St. ... 933-8600

Ventura
- Clinicas del Camino Real - (dental & medical)
  200 S. Wells Rd ... 647-6322
- Public Health Clinic - 3147 Loma Vista Rd
  ... 1-888-285-5012

MENTAL HEALTH
- Crisis Team - 24 hours ... 1-866-998-2243
- Rise Team / OD line. ... 981-4233
- Mental Health Liaison. ... 981-4227
  Bilingual Liaison. ... 981-3331
- NAMI (support / advocacy)
  5251 Verdugo Way #K, Camarillo ... 641-2426
- STAR (Access to Mental Health Svcs). ... 1-866-998-2243
- Turning Point Foundation
  New Visions Center 1065 E. Main, Ventura. ... 652-0596
  Oxnard Club House - 426 W. 5th St ... 247-0750
- Ventura County Mental Health Services
  4258 Telegraph Rd, Ventura ... 477-5700
  1911 Williams Drive, Oxnard. ... 981-4200
  2500 S. "C" St. #C, Oxnard ... 385-9420
  333 W. Harvard Blvd, Santa Paula ... 933-8480

SENIOR CITIZENS SERVICES
- 24-hour Helpline. ... dial 211
- Adult Protective Services (abuse/neglect). ... 654-3200
- Area Agency on Aging
  646 County Square Dr. #100, Ventura. ... 477-7300
- Mental Health, Older Adult Services. ... 777-3500
- Ombudsman Services (visit nursing homes). ... 656-1986
- Senior Nutrition (meal site information). ... 477-7300

SHELTERS

Domestic Violence Shelters:
- Coalition for Family Harmony ... 656-1111
  Spanish Hotline. ... 1-800-300-2181
- Interface Children & Family Services. ... 1-800-636-6738

Year-Round Shelters
- Rescue Mission - (men only) 234 E. 6th St, Oxnard. ... 487-1234
- Turning Point Foundation - Our Place Shelter (mentally ill)
  538 E. Thompson Blvd, Ventura. ... 652-2151
- Lighthouse - (women & children) ... 385-7200
- Women's Shelter/Kingdom Center, Oxnard ... 487-3445

Winter Shelters - (December - March)
- Ojai Valley Family Shelter - for info ... 804-7094
- West County Winter Shelter - for info ... 385-1800

SHOWERS/TOILETS
- Community Action Program of Ventura County
  621 Richmond, Oxnard. ... 436-4000
- Our Place Shelter (mentally ill)
  538 E. Thompson Blvd, Ventura. ... 652-2151
- Rescue Mission - 234 E. 6th St, Oxnard. ... 487-1234

TRANSITIONAL HOUSING
- City Center - 837 E. Thompson Blvd, Ventura ... 628-9035
- Kingdom Center (Gabriel's House)
  1450 Rose Ave, Oxnard ... 487-3445
- Lighthouse Family Center, Oxnard. ... 385-7200
- Lutheran Social Services TLC. ... 497-6207
- RAIN Transitional Living Ctr, Camarillo - (families & singles)
  ... 389-3308
  Call for an application ... 383-7505
- Salvation Army (families/single women) Ventura 648-4977
- Tender Life Maternity Home ... 653-7474
- Turning Point Countywide Supported Housing -
  Wooley House (Oxnard) ... 652-0596
  River Haven (Ventura) ... 652-2151
- Veterans Transitional Housing (Ventura) ... 652-0000x102

VETERANS' SERVICES
- County of Ventura Veteran Services
  5740 Ralston Street, #340, Ventura ... 477-5155
- Department of Veterans Affairs - Outpatient Clinic
  Veterans Center - Counseling Svcs Mon-Fri 8 am - 4:30 pm
  4440 Calle Real, Santa Barbara ... (805) 683-1491
- Disabled Veterans Outreach (EDD)
  635 S. Ventura Rd, Oxnard ... 382-8626
- Oxnard VA Outpatient Clinic
  2000 Outlet Center Dr. #225, Oxnard. ... 604-6960
- Ventura Vet Center (Counseling)
  790 E. Santa Clara St. #1000 ... 585-1860
- Veteran's Home of Ventura
  10900 Telephone Rd, Ventura. ... 659-7502
- Veterans Transitional Housing (Ventura) ... 652-0000 x102

YOUTH SERVICES
- Interface Youth Crisis Line / Shelter ... 469-5882
- Independent Living Prog (former Foster Youth). ... 654-3245
- Interface Youth Svcs Drop-In Center - Mon-Fri 2 - 6 p.m.
  260 W. 4th St, Oxnard. ... 469-5882
- Pacific Clinics, Transition Aged Youth (TAY Tunnel)
  141 W. 5th St. #D, Oxnard ... 240-2538
- Teen Runaway Helpline ... 1-800-RUN-AWAY
- Transitions (VC Behavioral Health). ... 1-866-998-2243

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

County of Ventura

This brochure was prepared by:
County of Ventura - Human Services Agency
Homeless Services Program

(805) 385-1800

www.vchsa.org

56-15-670 (5/16)

Resources *for Homeless People* Western Ventura County

Camarillo • Fillmore • Ojai • Oxnard
Port Hueneme • Santa Paula • Ventura

This information current as of

May 2016

ALCOHOL & DRUG SERVICES
- 24-hour Helpline. ... dial 211
- County Alcohol / Drug Line. ... 981-8200
- Alcoholics Anonymous - countywide information
  ... 389-1444
  Español (Spanish). ... 988-0329
- Alanon ... 495-0270
- Oxnard Center - 1911 Williams Dr. ... 981-9200
- Ventura Center - 24 E. Main St. ... 652-6919
- Khepera House - 330 N. Ventura Ave, Vta 653-2596
- Lighthouse Recovery. ... 385-7200
- New Start for Moms - 1911 Williams St, Ox.. 981-9250
- Palmer Drug/Alcohol Abuse Program ... 482-1265
- Prototypes (women/children). ... 382-6296
- Rescue Mission (men) - 234 E. 6th St, Ox 487-1234
- Teen Challenge. ... 648-3295
- Victory Outreach ... 988-4102

BENEFITS
- Human Services Agency (CalWORKs, General Relief, CalFresh [Food Stamps], Medi-Cal)
  Oxnard, Port Hueneme, Camarillo
  1400 Vanguard Dr. Oxnard. ... 385-9363
  Santa Paula - 725 E. Main. ... 933-8300
  Fillmore - 828 Ventura St. #200 ... 524-8666
  Ventura & Ojai
  4651 Telephone Rd. #100, Ventura ... 658-4100
- Social Security - registration. ... 1-800-772-1213
  Oxnard - 2000 Outlet Center Dr #250
  Ventura - 6477 Telephone Rd. #1
  Monday – Friday 9 a.m. - 3:30 p.m.
- Unemployment Benefits Claims
  English ... 1-800-300-5616
  Spanish ... 1-800-444-7275

BUS
- ADA / Dial-a-Ride. ... 583-6464
- Gold Coast Transit - countywide transportation information. ... 1-800-438-1112
- Camarillo Area Transit. ... 988-4228
- Greyhound Bus - 201 E. 4th St, Oxnard ... 487-2707
  Information. ... 1-800-231-2222
- Gold Coast Transit
  Oxnard. ... 487-4222
  Ventura ... 643-3158

CAMPGROUNDS
- County Park Information ... 654-3951
- State Park Information ... 1-800-444-7275/968-1033
- **Camping**
  Fillmore - Kenny Grove - 823 N. Oak ... 524-0750
  Ojai - Lake Casitas - 11311 Santa Ana Rd. .. 649-2233
  Santa Paula - Steckle Park
  8080 Mistletoe Rd. ... 654-3951
- **Short-Term Camping** (14 days maximum)
  Ojai - Camp Comfort - 11969 N. Creek Rd. ... 654-3951
  Oxnard - McGrath State Beach, 2211 Harbor Blvd
  Ventura -
  Emma Wood - Rincon Parkway, Hwy 1 ... 654-8444
  Faria Beach - 4350 W. PCH. ... 654-3951
  Hobson Park - 5210 W. PCH ... 654-3951
  Lake Casitas - 11311 Santa Ana Rd. ... 649-2233
  Ventura Beach Resort - 800 W. Main St. ... 643-9137

CHILDREN'S SERVICES
- Children's Crisis Team ... 1-866-431-2478
- Child Development Resources (CDR) (childcare, Head Start Preschool) ... 485-7878
- Children & Family Services (abuse/neglect, adoption, foster care). ... 654-3200
- Children's Medical Services ... 981-5281
- Children's Mental Health (access line) ... 1-800-671-0887
- County Schools Homeless Education Project. ... 437-1526
- School on Wheels (tutoring/supplies). ... 1-800-923-1100

CITIZENSHIP/IMMIGRATION
- El Concilio Del Condado - 301 S. "C" St, Ox.... 486-9777 x232

DENTAL
- Children - referrals from CHDP ... 981-5291
- Clinicas Del Camino Real (fee for services) -
  Oxnard - 650 Meta St. ... 487-5351
  Ventura - 200 S. Wells Rd. ... 659-0560
- Oxnard Dental Group. ... 278-9499
- Salvation Army Free Clinic - 622 W. Wooley Rd, Oxnard (call for appointment) ... 483-9235

DISABLED PERSONS
- Department of Vocational Rehabilitation
  1701 Pacific Ave. #120, Oxnard. ... 385-2400
- Independent Living Resource Center
  1802 Eastman Ave. #112, Ventura. ... 650-5993
- Tri-Counties Regional Center
  2401 E. Gonzales Rd. #100, Oxnard ... 485-3177

DOMESTIC VIOLENCE
- Adult Abuse & Neglect ... 654-3200
- Child Abuse & Neglect. ... 654-3200
- Coalition for Family Harmony ... 656-1111
- Interface Children & Family Services ... 1-800-636-6738

DROP-IN SERVICES
- Community Action Program of Ventura County
  621 Richmond, Oxnard. ... 436-4000
- Community Assistance Program - 108 Fox St, Ojai... 640-3320
- One Stop Centers ... 652-6111
  Ox - CAP, 621 Richmond Ave. (Wed 8:30-11:30)
  Vta - Public Health Auditorium, 3147 Loma Vista (Tue10-1)

EMPLOYMENT/JOB TRAINING
- California Conservation Corps (18-25 yrs.). ... 278-2787
- Candelaria (Native Americans)
  1445 Donlon St. #18, Ventura. ... 650-8352
- Center for Employment Training (CET) - 761 S. "C" St, Oxnard ... 487-9821
- Community Action Agency - 621 Richmond, Oxnard.. 436-4000
- Employment Development Department (EDD)
  1400 Vanguard Drive, Oxnard ... 382-8610
- Employee Aptitude & Placement
  660 N. Ventura Ave, Ventura (M-F 9-11 a.m.) 648-5868
- Fillmore Community Service Center - 828 W. Ventura St, Fillmore. ... 933-8300
- Goodwill Industries - 130 Lombard St, Oxnard ... 981-0130
- Job Corps (16-24 yrs.) ... 1-800-733-5627
- Labor Finders - 3431 Telegraph Rd, Ventura ... 650-6964
- Labor Ready - 731 St. Marys Dr, Oxnard ... 988-4650
  1963 E. Main St, Ventura. ... 477-0418
- Santa Clara Valley Job & Career Center
  725 E. Main St, Santa Paula ... 933-8300
- Unemployment Benefit Claims - English. ... 1-800-300-5616
  Spanish ... 1-800-326-8937
- Ventura Job & Career Center - 4651 Telephone Rd. .. 654-3434
- Oxnard Job & Career Center - 1400 Vanguard Dr. 204-5100
- Workforce Development Board (WDB)
  1400 Vanguard Dr, Oxnard. ... 204-5100

FOOD (also see Meals)
- FOOD Share - countywide food pantry info. ... 983-7100

Ojai
- Community Assistance Program - 108 Fox St ... 640-3320

Oxnard
- Catholic Charities – 402 N. "A" St ... 486-2900
- Community Action of Ventura Co - 621 Richmond. ... 436-4000
- Salvation Army (call first) - 622 W. Wooley Rd. ... 483-9235
- St. John's Outreach - 535 Cooper Rd. (pre-register) . 988-2651

Santa Paula
- Community Assistance of Santa Paula (CASP)
  133 N. Mill St. (Monday). ... 525-8890
- Spirit of Santa Paula (Call first) ... 340-5025

Ventura
- Catholic Charities - 303 N. Ventura Ave ... 643-4694

HOMELESS & HOUSING SERVICES
- Catholic Charities - 303 N. Ventura Ave, Ventura 643-4694
  402 N. "A" St, Oxnard ... 486-2900
- Cabrillo Economic Development Corporation (affordable housing). ... 659-3791
- Community Action Program
  621 Richmond, Oxnard. ... 436-4000
- Housing Rights Center ... 1-800-477-5977
- HSA Homeless Services Program. ... 385-1800
- HPRP Homeless Prevention & Rental Deposit ... 385-8585
- Many Mansions - Housing Central. ... 497-0344
- Project Understanding
  2734 Johnson Dr, Ventura. ... 652-1326
- St. Vincent de Paul ... 754-2089
- The Salvation Army, Safe Sleep Ventura ... 648-5032
- Turning Point Foundation (mentally ill)
  538 E. Thompson Blvd, Ventura. ... 652-2151

HOUSING AUTHORITIES
(No emergency housing provided)
- Housing Rights Center ... 1-800-477-5977
- Area Housing Authority (Ojai & unincorporated areas)
  1400 W. Hillcrest Dr, Newbury Park. ... 480-9991
  or ... 1-800-800-2123
- Oxnard Housing Authority - 1470 Colonia Rd.
  Public Housing. ... 385-8114
  Sec 8. ... 385-8097
- Port Hueneme Housing Authority
  250 N. Ventura Rd ... 986-6551
- Santa Paula Housing Authority
  15500 W. Telegraph Rd ... 525-3339
- Ventura Housing Authority
  Public Housing - 995 Riverside St. ... 648-5008
  Section 8 - 11122 Snapdragon St, #100 647-5990

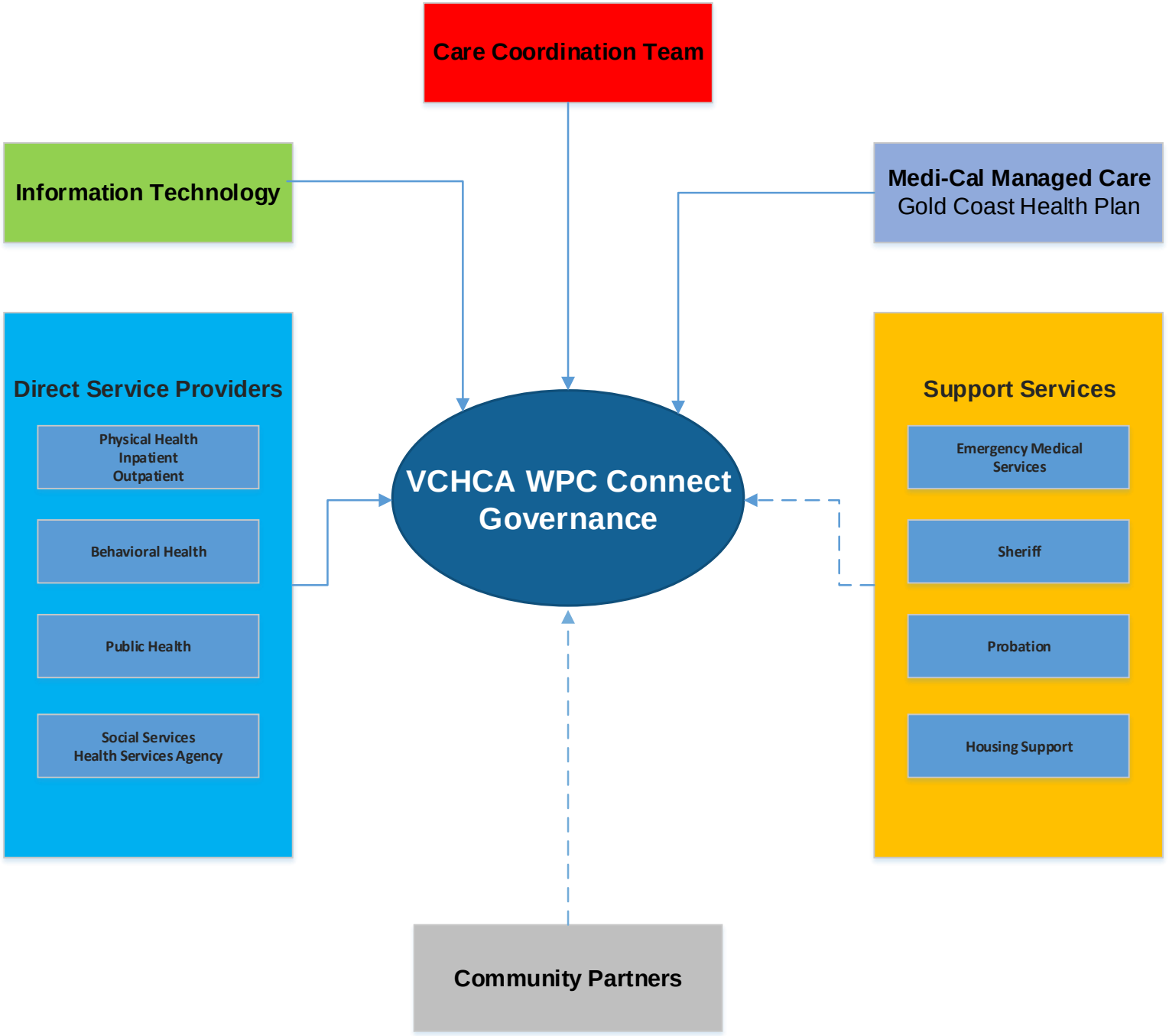
INFORMATION AND REFERRAL
Dial 211 for Info 24 hours/7 days/week about Community Resources near you
- Area Agency on Aging (seniors) ... 477-7300
- County of Ventura ... 1-800-660-5474
- Homeless Services Program Info ... 385-1800

LAUNDRY
- Community Action Program of Ventura County
  621 Richmond, Oxnard. ... 436-4000
- Community Assistance Program
  108 Fox St, Ojai. ... (805) 640-3320
- Laundry of Love V.C.
  Mission Plaza - 110 N. Olive - 1st Tues 5:30 - 8 p.m.
  Quik Wash - 9298 Telephone Rd. - 2nd Tues 5 - 7 p.m.
  2611 E. Thompson Blvd. - 3rd Tues 5:30 - 8 p.m.
- Turning Point Foundation (mentally ill)
  536 E. Thompson Blvd, Ventura. ... 652-2151

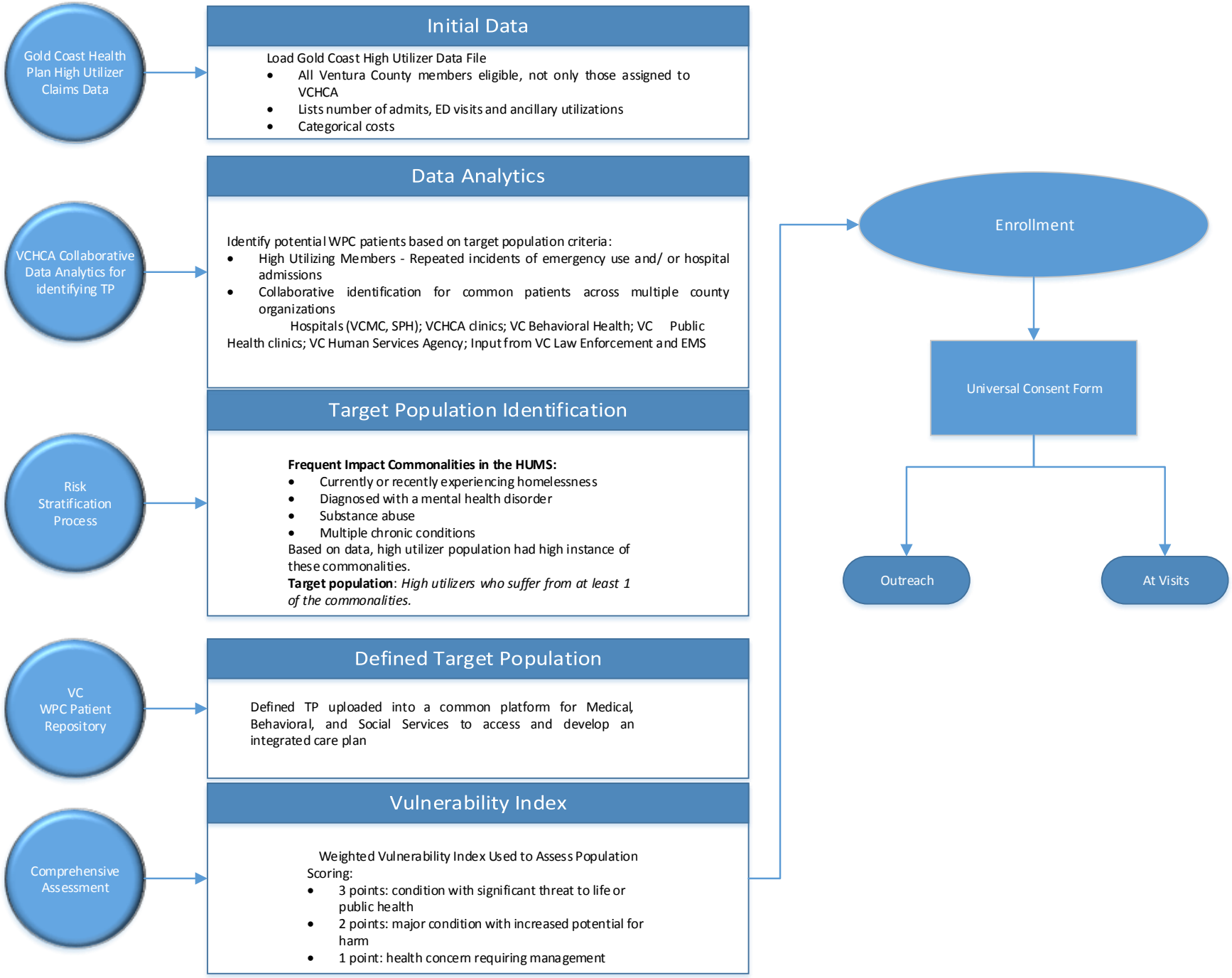
LEGAL SERVICES
- California Bar Assn. Legal Clinic - (family law /tenant / landlord / bankruptcy) - Mon. - Fri. ... 650-7599
- California Rural Legal Assistance
  338 S. "A" St, Ox. ... 483-8083
- Grey Law (60 yrs.+)
  290 Maple Ct #128, Ventura ... 658-2266
- Housing Rights Center ... 1-800-477-5977
- Jewish Family Services
  1915 E. Main St, Ventura. ... 641-6565

County of Ventura • Human Services Agency • Homeless Services Program • (805) 385-1800

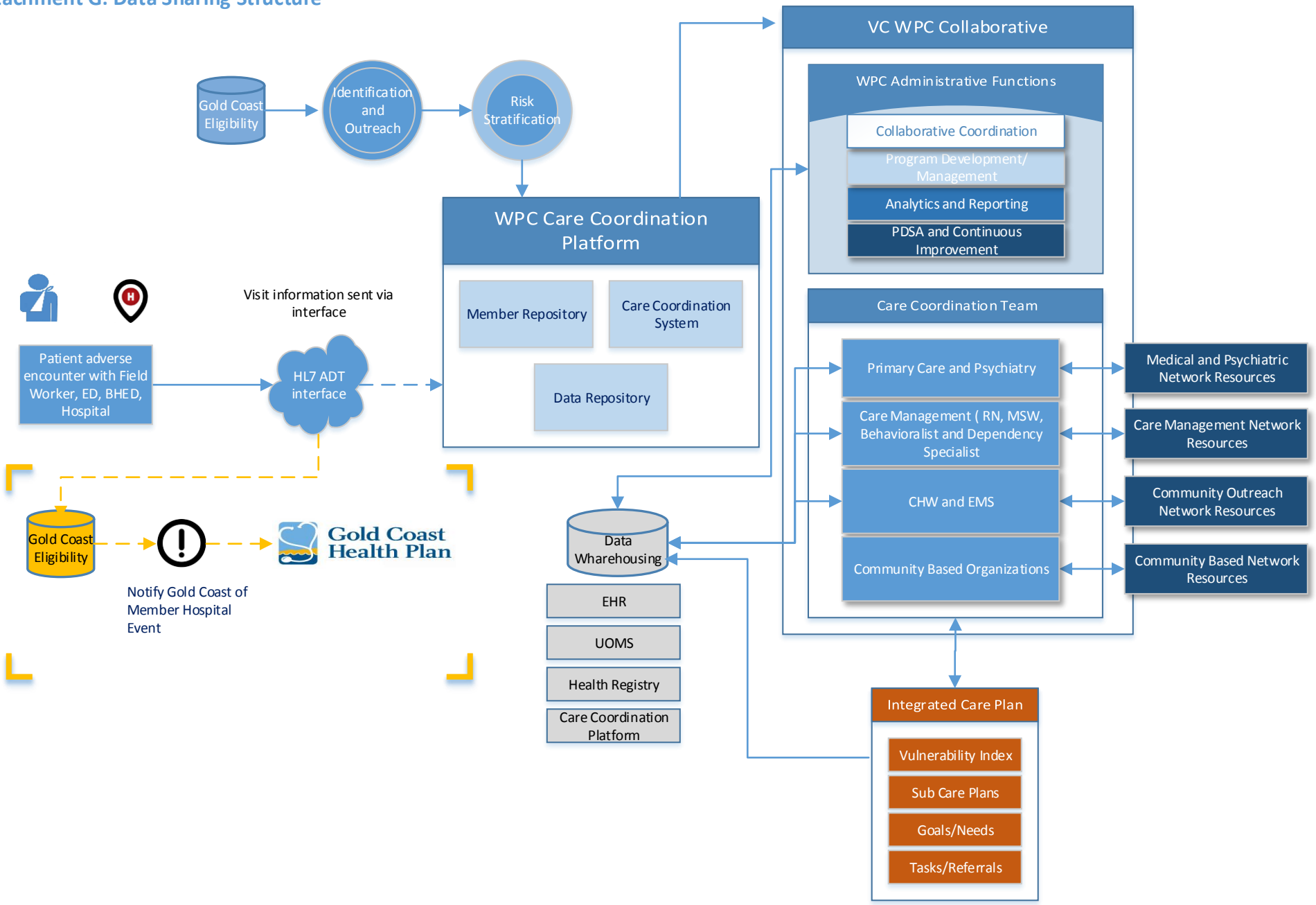
Attachment E: Organizational Structure



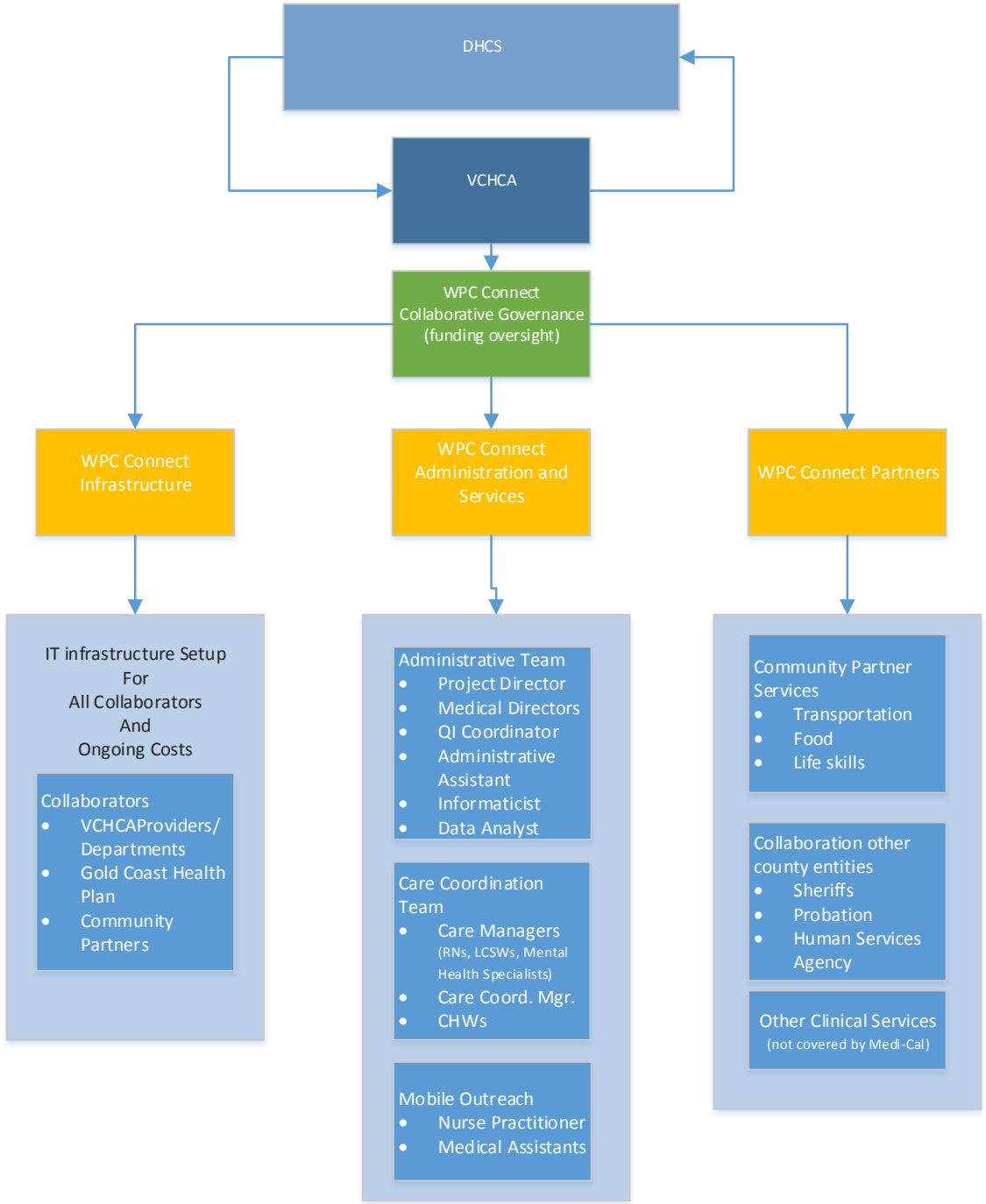
Attachment F VC WPC Identification and Enrollment Process



Attachment G: Data Sharing Structure



VCHCA WPC Connect – Funding Diagram



Letters of Participation and Support Attachments

Letters of Participation – Required Organizations

1. Medi-Cal Managed Care Health Plan: Gold Coast Health Plan

2. Ventura County Health Care Agency Letter (one letter for departments with the agency)
   a. Health Services Agency/Department: Ventura County Medical Center/Ambulatory Care Department
   b. Specialty Mental Health Agency/Department: Ventura County Behavioral Health Department
   c. Public Agency/Department: Ventura County Public Health Department

3. Public Agency/Department: Ventura County Human Services Agency

4. Public Agency/Department: Ventura County Probation Agency

5. Public Agency/Department: Ventura County Sheriff's Office

6. Public Agency/Department: Area Housing Authority of the County of Ventura

7. Public Agency/Department: Ventura County Transportation Commission

8. Community Partner: Project Understanding

9. Community Partner: FOODShare

10. Community Partner: Ventura County St. Vincent de Paul

Letters of Support

1. Ventura County Continuum of Care Alliance

2. Las Islas Family Medical Group, Oxnard, Miguel Cervantes, MD, Medical Director

3. Magnolia Family Medical Center, Oxnard, Stan Patterson, MD, Medical Director

4. Santa Paula West & Hospital Clinic, Santa Paula, Lisa Solinas, MD, Medical Director

5. West Ventura Medical Clinic, Ventura, Ramsey Ulrich, MD, Medical Director

Gold Coast Health Plan℠
A Public Entity

www.goldcoasthealthplan.org

June 15, 2016

Sara Brooks, Deputy Director
Health Care Delivery Systems
Department of Health Services
1500 Capitol Avenue
Sacramento, CA 95814

Dear Ms. Brooks,

Gold Coast Health Plan (GCHP) has worked collaboratively with the Ventura County Health Care Agency (VCHCA) to benefit local communities and vulnerable populations for five years. The Whole Person Care 1115 Waiver Project has the potential to make a genuine impact on the most vulnerable of VCHCA's Medi-Cal clients including those with complex needs who are not demonstrating health improvement, but are high utilizers of multiple care systems. Through effective care coordination, appropriate services, and data sharing, the ***Ventura County Whole Person Care Pilot Project*** (the "Pilot Project") will ensure that clients with complex needs are provided care through a holistic approach that is tailored to the client's unique needs and built on an understanding and commitment to partnering with each client. The goal of this evidence-based approach is well-being and self-sufficiency for clients who are provided these integrated services.

GCHP is committed to participating in this locally designed Pilot Project. Specifically, GCHP will work with VCHCA to plan and develop appropriate interventions to support change and integration, develop and/or adopt data sharing protocols and technology, participate in project decision making, attend collaborative ad-hoc and Steering Committee meetings, and create an integrated delivery system that provides patient-centered coordination of health, behavioral health, and social services to improve the health and wellbeing of each client served.

We encourage the California Department of Health Care Services to fund this critically needed project. The proposed pilot concept will provide an effective Whole Person Care best practices model that can transform communities throughout California to better serve those with complex needs and create improved health outcomes statewide.

Sincerely,

Dale Villani
Chief Executive Officer

711 East Daily Drive, Suite 106, Camarillo, CA 93010-6082 | Member Services: 888-301-1228 | Administration: 805-437-5500 | Fax: 805-437-5132

VENTURA COUNTY
HEALTH CARE AGENCY

Setting the Standard in Health Care Excellence

Barry R. Fisher, MPPA
Health Care Agency Director
VCMC Administrator

Timothy R. Patten
Chief Deputy Director
Health Care Agency

Joan R. Araujo, RN, MHSA
Chief Deputy Director
Hospital Replacement Wing
Compliance Officer

Ann L. Bucholtz, MD
Chief Medical Examiner

Elaine Crandall
Behavioral Health Director

Johnson Gill
Deputy Director
Population Health Management/
Clinical Integration

Kim S. Milstien
Deputy Director
VCMC / SPH Chief Executive Officer

Brighton Ncube
Deputy Director
Ambulatory Care Administrator

Dee Pupa
Deputy Director
Managed Care / Patient Accounting
Health Care Plan Administrator

Catherine Rodriguez
Interim Chief Financial Officer

Rigoberto Vargas, MPH
Public Health Director

June 24, 2016

Sara Brooks, Deputy Director
Health Care Delivery Systems
Department of Health Services
1500 Capitol Avenue
Sacramento, CA 95814

Dear Ms. Brooks,

Ventura County Health Care Agency (VCHCA) is committed to all components of the 1115 Waiver 2020. VCHCA has given a tremendous amount of thought to the Whole Person Care (WPC) Pilot project. I want to assure you that VCHCA and its various entities (Ambulatory Services, Hospitals, Behavioral Health, Public Health and Emergency Medical Services) along with other county departments and our community partners, will all work collaboratively to make the WPC Pilot a success. We see the value of working collaboratively and setting the stage for other collaborative initiatives to collectively meet the needs of our community.

As you will see in our WPC application, a very methodical approach will be taken to focus on individuals that are currently utilizing multiple medical, behavioral and social services with less than optimal outcomes. Our approach will be to guide these individuals to appropriate care while keeping them engaged so we can co-manage and achieve goals that are mutually beneficial. This will have the potential of making a genuine impact on the most vulnerable of VCHCA's Medi-Cal population through a holistic approach tailored to the client's unique needs and built on an understanding and commitment to partnering with each client. Through collaborative-care coordination, appropriate services, and data sharing, the goal of this evidence-based approach is well-being and self-sufficiency for clients who are provided these integrated services.

VCHCA is dedicated to participating in this locally designed pilot project which is based on best practices and intended to improve the health outcomes of patients with complex needs. VCHCA will work collaboratively with other county departments and community partners to plan and develop appropriate interventions to support change and integration, develop/adopt data sharing protocols and technology, participate in project decision making, attend collaborative meetings, and create a unified system to provide wrap-around care coordination.

We encourage the California Department of Health Care Services to fund this critically needed project. The proposed pilot concept will provide an effective Whole Person Care best practices model that can transform communities throughout California to better serve those with complex needs and create improved health outcomes statewide.

Sincerely,

Barry R. Fisher
Health Care Agency Director

5851 Thille Street #2 • Ventura, California 93003 • TEL: (805) 677-5110 • www.vchca.org

COUNTY OF VENTURA
HUMAN SERVICES AGENCY

Barry L. Zimmerman
Director

June 22, 2016

Sara Brooks, Deputy Director
Health Care Delivery Systems
Department of Health Services
1500 Capitol Avenue
Sacramento, CA 95814

Dear Ms. Brooks,

County of Ventura Human Services Agency (VCHSA) works collaboratively with the Ventura County Health Care Agency (VCHCA) to benefit Ventura County communities. As Departments within County of Ventura, we are well aligned to cross-manage programs and services to reach the most vulnerable populations.

The Whole Person Care 1115 Waiver Project has the potential to make a genuine impact on the most vulnerable of VCHCA's Medi-Cal clients, including those with complex needs who are not demonstrating health improvement, but are high utilizers of multiple care systems. Through effective care coordination, appropriate services, and data sharing, the ***Ventura County Whole Person Care Pilot Project*** will ensure that clients with complex needs are provided care through a holistic approach that is tailored to the client's unique needs and built on an understanding and commitment to partnering with each client. The goal of this evidence-based approach is well-being and self-sufficiency for clients who are provided these integrated services.

VCHSA administers Medi-Cal eligibility and determination throughout Ventura County. Our agency is well aligned to support this project through our administrative Medi-Cal role and our similar experiences partnering on many projects with VCHCA. VCHSA also serves as a safety net to Ventura County's most vulnerable populations, providing a wide range of critical social services to those that would also be served by the Whole Person Care project. We look forward to the Whole Person Care Pilot Project being implemented in our community.

We encourage the California Department of Health Care Services to fund this critically needed project. The proposed pilot concept will provide an effective Whole Person Care best practices model that can transform communities throughout California to better serve those with complex needs and create improved health outcomes statewide.

Sincerely,

BARRY L. ZIMMERMAN
Director

Ventura County Probation Agency

Mark Varela
Director/Chief Probation Officer

Patrick Neil
Chief Deputy

Patricia Olivares
Chief Deputy

Gina Johnson
Chief Deputy

Sandra Solorzano
Chief Deputy

June 28, 2016

Sara Brooks, Deputy Director
Health Care Delivery Systems
Department of Health Services
1500 Capitol Avenue
Sacramento, CA 95814

Dear Ms. Brooks,

The Ventura County Probation Agency (VCPA) is committed to The Whole Person Care 1115 Waiver Project and its potential to make a genuine impact on the most vulnerable of Medi-Cal clients including those with complex needs who are not demonstrating health improvement, but are high utilizers of multiple care systems. Many of these individuals are being monitored and managed by VCPA. Through effective care coordination, appropriate services, and data sharing, the ***Ventura County Whole Person Care Pilot (WPC) Project*** will ensure that clients with complex needs are provided care through a holistic approach that is tailored to the client's unique needs and built on an understanding and commitment to partnering with each client. The goal of this evidence-based approach is well-being and self-sufficiency for clients who are provided these integrated services. VCPA is committed to working collaboratively with the Ventura County Health Care Agency (VCHCA) and other county departments, as well as our community partners, to make WPC Pilot a success.

The Public Safety Realignment of 2011 (AB109 and companion bill AB117) transferred responsibility for specific prison populations from the State prison system to county jails and probation officers, making counties responsible for jail inmates and for post-release supervision of parolees. These populations could be reasonably expected to access the county's health and human services program. VCPA is As probation officers, we see the value of working collaboratively to meet this population's needs and how it underscores the need for Whole Person Care.

VCPA is dedicated to participating in this locally designed pilot project, which is based on best practices and intended to improve the health outcomes of clients with complex needs. Specifically, VCPA will work with the VCHCA and Ventura County Human Services Agency to plan and develop appropriate interventions to support change and integration, develop/adopt data sharing protocols and technology, participate in project decision making, attend collaborative meetings, and create a unified system to provide wrap-around care coordination.

We encourage the California Department of Health Care Services to fund this critically needed project. The proposed pilot concept will provide an effective Whole Person Care

County Government Center, L#3200 • 800 South Victoria Avenue • Ventura, CA 93009 • (805) 654-2106 • FAX (805) 654-3566

best practices model that can transform communities throughout California to better serve those with complex needs and create improved health outcomes statewide. A healthy community is a thriving community. This remains a goal for all of us.

Sincerely,

Mark Varela
Director/Chief Probation Officer

VENTURA COUNTY SHERIFF'S OFFICE

- GEOFF DEAN
  Sheriff
- GARY PENTIS
  Undersheriff
- STEVE DE CESARI
  Assistant Sheriff
- GUY STEWART
  Assistant Sheriff

800 SOUTH VICTORIA AVENUE, VENTURA, CA 93009 PHONE (805) 654-2380 FAX (805) 645-1391

June 29, 2016

Sara Brooks, Deputy Director
Health Care Delivery Systems
Department of Health Services
1500 Capitol Avenue
Sacramento, CA 95814

Dear Ms. Brooks,

The Ventura County Sheriff's Office has worked collaboratively with the Ventura County Health Care Agency (VCHCA) to benefit local communities and vulnerable populations for several years. The Whole Person Care 1115 Waiver Project has the potential to make a genuine impact on the most vulnerable of VCHCA's Medi-Cal clients including those with complex needs who are not demonstrating health improvement, but are high utilizers of multiple care systems. Through effective care coordination, appropriate services, and data sharing, the ***Ventura County Whole Person Care Pilot Project*** will ensure that clients with complex needs are provided care through a holistic approach that is tailored to the client's unique needs and built on an understanding and commitment to partnering with each client. The goal of this evidence-based approach is well-being and self-sufficiency for clients who are provided these integrated services.

The Sheriff's Office is dedicated to participating in this locally designed pilot project, which is based on best practices and intended to improve the health outcomes of clients with complex needs. Specifically, the Sheriff's Office will work with the VCHCA to plan and develop appropriate interventions to support change and integration, develop/adopt data sharing protocols and technology, participate in project decision making, attend collaborative meetings, and create a unified system to provide wrap-around care coordination. The Sheriff's Office will assist and coordinate with data collection and sharing, and care coordination for the vulnerable population within our jail facilities, understanding that this population of individuals tends to be high-end users of medical and mental health services within our medical provider systems.

We encourage the California Department of Health Care Services to fund this critically needed project. The proposed pilot concept will provide an effective Whole Person Care best practices model that can transform communities throughout California to better serve those with complex needs and create improved health outcomes statewide.

Sincerely,

Commander Ron Nelson

☐ SPECIAL SERVICES (805) 383-8791 Fax (805) 389-6549
☐ PATROL SERVICES (805) 494-8260 FAX (805) 494-8295
☐ DETENTION SERVICES (805) 654-2305 FAX (805) 654-3500
☐ SUPPORT SERVICES (805) 654-5134 FAX (805) 677-8715

Visit Us on the Web
www.vcsd.org

Area Housing Authority of the County of Ventura

1400 West Hillcrest Dr. Newbury Park, CA 91320-2721
www.ahacv.org • (805) 480-9991 • FAX (805) 480-1021

Serving Camarillo, Fillmore, Moorpark, Ojai, Simi Valley, Thousand Oaks, and the unincorporated areas of Ventura County

June 21, 2016

Sara Brooks, Deputy Director
Health Care Delivery Systems
Department of Health Services
1500 Capitol Avenue
Sacramento, CA 958114

Dear Ms. Brooks,

The Ventura County Health Care Agency (VCHCA) provides an extensive array of programs and coordinated care services to ensure all residents have access to quality, cost effective, and culturally sensitive healthcare. VCHCA strives to provide superior public service and support in order that all residents have the opportunity to improve their quality of life and enjoy the benefits of a safe, healthy community. VCHCA provides the foundation for county-wide health and medical needs, especially those residents served by the Area Housing Authority of the County of Ventura (AHA).

The AHA was formed in February 1972 through a Joint Powers Agreement with the County of Ventura and individual jurisdictions. As an independent agency, the AHA serves the unincorporated areas of Ventura County and cities of Camarillo, Fillmore, Moorpark, Ojai, Simi Valley, and Thousand Oaks. The AHA's primary goal is to provide affordable housing and support services to low income individuals. The AHA administers 2,532 Federal Section 8 Housing Choice Vouchers (rental assistance); owns and operates 355 units of HUD-funded Low Rent Public Housing properties; owns nine housing complexes providing 157 housing units of affordable housing; and developed and manages 486 units of tax credit financed affordable housing. We understand that housing is an essential element to a healthy community and a key component in maintaining a healthier and higher quality of life. The AHA is committed to providing services through collaborative partnerships and cooperative agreements on both formal and informal levels to pursue healthy outcomes and achieve the shared vision of everyone living better for longer.

The *Ventura County Whole Person Pilot Program* is an exciting opportunity to bring much needed integrated care to those we serve who struggle to navigate the health care system, have lower successful outcomes due to challenges in providing services, and may have complex issues. The AHA is committed to participating in the *Ventura County Whole Person Pilot Program* and working closely with VCHCA to design and implement a pilot program that provides comprehensive coordinated care for better health outcomes. As housing providers, we recognize that access to stable housing is vital in achieving successful health care outcomes. We stand committed, ready to support and participate in the *Ventura County Whole Person Pilot Program.*

Sincerely,

Michael Nigh, Executive Director

Equal Housing Opportunity

June 29, 2016

Sara Brooks, Deputy Director
Health Care Delivery Systems
Department of Health Services
1500 Capitol Avenue
Sacramento, CA 95814

Dear Ms. Brooks,

The Ventura County Transportation Commission (VCTC) is pleased to offer this letter of support for the Ventura County Health Care Agency's Whole Person Care Pilot Project.

VCTC provides intercity transit services, oversees the annual review of unmet transit needs within the County, and administers the countywide ADA certification process for persons with disabilities. We support the Health Care Agency's efforts to coordinate health, behavioral health, and social services for vulnerable residents within our County. Improved coordination of services including transportation services will help to improve both health and social outcomes for our residents with complex needs served by multiple agencies.

We look forward to coordinating with the Health Care Agency on this project and encourage the California Department of Health Care Services to give favorable consideration to funding this important project.

Sincerely,

Darren Kettle
Executive Director

950 County Square Dr., Suite 207 • Ventura, California 93003 • (805) 642-1591 • fax (805) 642-4860 • www.goventura.org

PROJECT Understanding
at San Buenaventura

Mission Statement: Project Understanding provides hope by developing and directing resources for the purpose of transforming lives and community through justice, mercy & compassion.
Vision Statement: Through collaboration, we envision transformed lives and community as we assist people to reach their highest attainable level of independence.

July 1, 2016

Sara Brooks, Deputy Director
Health Care Delivery Systems
Department of Health Services
1500 Capitol Avenue
Sacramento, CA 95814

Dear Ms. Brooks,

Project Understanding has worked collaboratively with the Ventura County Health Care Agency (VCHCA) to benefit local communities and vulnerable populations for nearly 40 years. The Ventura County Whole Person Connect 1115 Waiver Project has the potential to make a genuine impact on the most vulnerable of VCHCA's Medi-Cal clients including those with complex needs who are not demonstrating health improvement, but are high utilizers of multiple care systems. Through effective care coordination, appropriate services, and data sharing, the Ventura County Whole Person Connect Project will ensure that clients with complex needs are provided care through a holistic approach that is tailored to the client's unique needs and built on an understanding and commitment to partnering with each client. The goal of this evidence-based approach is well-being and self-sufficiency for clients who are provided these integrated services.

Project Understanding is dedicated to participating in this locally designed pilot project, which is based on best practices and intended to improve the health outcomes of clients with complex needs. Specifically, Project Understanding will work with the VCHCA to support short-term shelter and transitional housing services, and offer food pantry/food delivery services, and educational tutoring services to struggling homeless individuals and families including veterans, foster care children, pregnant women, and the elderly. A Project Understanding representative will attend monthly collaborative meetings to enhance wrap-around care coordination.

We encourage the California Department of Health Care Services to fund this critically needed project. The proposed pilot concept will provide an effective Whole Person Care best practices model that can transform communities throughout California to better serve those with complex needs and create improved health outcomes statewide.

Sincerely,

Ben Unseth

Benjamin Unseth,
Executive Director

P.O. Box 25460 Ventura CA 93002-2280
2734 Johnson Dr Suite E Ventura, CA 93003
Phone: 805-652-1326, Fax 805-652-1389
www.projectunderstanding.org

FOOD SHARE
Ventura County's Food Bank
MEMBER OF FEEDING AMERICA

June 29, 2016

Sara Brooks, Deputy Director
Health Care Delivery Systems
Department of Health Services
1500 Capitol Avenue
Sacramento, CA 95814

Dear Ms. Brooks:

FOOD Share, Ventura County's foodbank, has worked collaboratively with the Ventura County Health Care Agency (VCHCA) nearly since our founding in 1984, to benefit local communities and vulnerable populations in our mission to both feed the hungry and address the root causes of hunger. We have learned that effective, multidisciplinary collaboration is key to meeting the needs of the most vulnerable of our residents. We believe the Ventura County Whole Person Care Pilot Project has the potential to positively affect the well-being and self-sufficiency of the clients it will serve.

As resources permit, FOOD Share will work with the VCHCA to plan and develop appropriate interventions to support change and integration; develop/adopt data sharing protocols and technology; participate in project decision making; attend collaborative meetings; and work toward the creation of a unified system to provide wrap-around care coordination.

Among the services FOOD Share offers are free distributions of fresh produce and nutritious shelf-stable foods, nutrition education in several formats, mobile pantry healthy cooking demonstrations and taste testing ; CalFresh outreach; and volunteer recruitment. In addition, we have a host of collaborators who may be meaningful contributors to the program

We encourage the California Department of Health Care Services to fund this critically needed project and hope FOOD Share has the opportunity to collaborate toward its success.

Sincerely,

Susan Haverland
Vice President, Programs & Services

4156 Southbank Road • Oxnard, California • 93036 • www.foodshare.com • Phone: (805) 983-7100 • Fax: (805) 983-2326

Saint Vincent de Paul Society
Our Lady of the Assumption Conference
3175 Telegraph Road, Ventura, CA 93003
(805) 642-4104

June 27, 2016

Sara Brooks, Deputy Director
Health Care Delivery Systems
Department of Health Services
1500 Capitol Avenue
Sacramento, CA 95814

Dear Ms. Brooks,

The St. Vincent de Paul Society has worked collaboratively with the Ventura County Health Care Agency (VCHCA) to benefit local communities and vulnerable populations for more than 10 years. The Ventura County Whole Person Connect 1115 Waiver Project has the potential to make a genuine impact on the most vulnerable of VCHCA's Medi-Cal clients including those with complex needs who are not demonstrating health improvement, but are high utilizers of multiple care systems. Through effective care coordination, appropriate services, and data sharing, the ***Ventura County Whole Person Connect Project*** will ensure that clients with complex needs are provided care through a holistic approach that is tailored to the client's unique needs and built on an understanding and commitment to partnering with each client. The goal of this evidence-based approach is well-being and self-sufficiency for clients who are provided these integrated services.

The St. Vincent de Paul Society is dedicated to participating in this locally designed pilot project, which is based on best practices and intended to improve the health outcomes of clients with complex needs. Specifically, the St. Vincent de Paul Society will work with the VCHCA to offer support and resources for struggling homeless individuals and families. A St. Vincent de Paul representative will attend collaborative meetings to enhance wrap-around care coordination.

We encourage the California Department of Health Care Services to fund this critically needed project. The proposed pilot concept will provide an effective Whole Person Care best practices model that can transform communities throughout California to better serve those with complex needs and create improved health outcomes statewide.

Sincerely,

Sharon Fleur

Sharon Fleur
President, SVdP-OLA Conference

VENTURA COUNTY
CONTINUUM OF CARE ALLIANCE

ENDING HOMELESSNESS IN VENTURA COUNTY

June 16, 2016

Sara Brooks, Deputy Director
Health Care Delivery Systems
Department of Health Services
1500 Capitol Avenue
Sacramento, CA 95814

Dear Ms. Brooks,

The Ventura Countywide Continuum of Care Alliance is a collaborative group dedicated to promoting a safe, desirable and thriving community by ending homelessness in Ventura County. The Governance Board acts on behalf of the Alliance and is representative of the organizations and projects serving homeless subpopulations within the Ventura County region. To that end, our organization collaborates with many agencies and individuals from our health care system including hospitals, one-stops, behavioral health, drug and alcohol, and our emergency response providers in the pursuit of ending homelessness in our County.

With the deployment of 'Pathways to Home', our local Coordinated Entry System, the Whole Person Care 1115 Waiver Project is positioned to make a genuine impact on the most vulnerable of VCHCA's Medi-Cal clients including those with complex needs – most of whom are homeless - who are not demonstrating health improvement, despite their high frequency utilization of multiple systems of care. Through effective care coordination, appropriate services, and data sharing, the ***Ventura County Whole Person Care Pilot Project*** shares with the Ventura Countywide Continuum of Care valuing the dignity of every human life. Using evidence based practices to meet client needs housing stability, well-being and self-sufficiency is improved.

The Countywide Continuum of Care is dedicated to participating in this locally designed pilot project to improve the health outcomes of clients with complex needs. Specifically, the Countywide Continuum of Care commits to facilitate access to information and resources to satisfy unmet needs for each homeless client served by the program through Coordinated Entry. We know that increased resources, in the form of supportive services to address unmet physical, mental and social supports are needed to achieve our mutual goal of improving the lives of those with complex needs in our community.

The Ventura County Continuum of Care Board, on behalf of the entire Alliance, encourages the California Department of Health Care Services to fund this important and critically needed project. This pilot project will provide a model to be emulated by other communities throughout the State of California resulting in not only reduced demand upon publicly funded systems of care, but will more importantly improve the lives of the persons we serve.

Sincerely,

Mike Taigman
Chair of the Board

Hall of Administration L#1940 * 800 S. Victoria Avenue * Ventura, California 93009 * www.venturacoc.org

LAS ISLAS
FAMILY MEDICAL GROUP

Associated with UCLA School of Medicine

Miguel Cervantes, M.D.
Medical Director

Irene Guerrero
Administrator

June 10, 2016

Sara Brooks, Deputy Director
Health Care Delivery Systems
Department of Health Services
1500 Capitol Avenue
Sacramento, CA 95814

Dear Ms. Brooks,

Las Islas Family Medical group works collaboratively with the Ventura County Health Care Agency (VCHCA) to benefit local communities and vulnerable populations for more than twenty years. The Whole Person Care 1115 Waiver Project has the potential to make a genuine and significant impact on the most vulnerable of VCHCA's Medi-Cal clients including those with complex needs who are not demonstrating health improvement, but are high utilizers of multiple care systems. Through effective care coordination, appropriate services, and data sharing, the **Ventura County Whole Person Care Pilot Project** will ensure that clients with complex needs are provided care through a holistic approach that is tailored to the client's unique needs and built on an understanding and commitment to partnering with each client. The goal of this evidence-based approach is well-being and self-sufficiency for clients who are provided these integrated services.

Las Islas Family Medical Group provides a medical home for a unique patient demographic, many of whom are high utilizers of multiple medical, psychological and social services throughout the county. These high utilizers are at considerable risk for disease progression, admission and re-admission to the hospital as well as poor clinical and social outcomes.

Las Islas Family Medical Group supports the implementation of this locally designed pilot project, which is based on best practices and intended to improve the health outcomes of clients with complex needs. This project will result in improved infrastructure to serve clients with complex needs and improved health outcomes for those clients participating in the pilot project.

We encourage the California Department of Health Care Services to fund this critically needed project. The proposed pilot concept will provide an effective Whole Person Care model that can transform communities throughout California to better serve those with complex needs and create improved health outcomes statewide.

Sincerely,

Miguel Cervantes, M.D.
Medical Director

Affiliated with Ventura County Medical Center

2400 South C Street | Oxnard, CA 93033 | Tel: 805.240.7000 | Fax: 805.486.0636
325 W. Channel Islands Boulevard | Oxnard, CA 93033 | Tel: 805.204.9500 | Fax: 805.240.7409

Magnolia Family Medical Center

Stanley C. Patterson, M.D., Medical Director

A satellite clinic of Ventura County Medical Center
Associated with UCLA School of Medicine

June 13, 2016

Sara Brooks, Deputy Director
Health Care Delivery Systems
Department of Health Services
1500 Capitol Avenue
Sacramento, CA 95814

Dear Ms. Brooks,

Magnolia Family Medical Center has maintained a collaborative relationship with the Ventura County Health Care Agency (VCHCA) to benefit the Greater Oxnard (and surrounding communities) for more than 21 years. Our facility wholeheartedly supports The Whole Person Care 1115 Waiver Project because we understand it has the potential to make a genuine impact on the most vulnerable of VCHCA's Medi-Cal clients including those with complex needs who are not demonstrating health improvement, but are high utilizers of multiple care systems. The Ventura County Whole Person Care Pilot Project will ensure our clients will be provided care through effective care coordination, appropriate services, and data sharing. The pilot project will accomplish this through a holistic approach that is tailored to the client's unique needs and built on an understanding and commitment to partnering with each client. The goal of this evidence-based approach is well-being and self-sufficiency for clients who are provided these integrated services.

Magnolia Family Medical Center provides a medical home for a unique patient demographic, many of whom are high utilizers of multiple medical, psychological and social services throughout Ventura County. These high utilizers are at considerable risk for disease progression, admission and re-admission to the hospital, as well as poor clinical and social outcomes. We have implemented a program of data analysts, RN Case Managers, as well as Care Extenders to bridge the gap in healthcare for this vulnerable population. We have a specific focus on health disparities which have the greatest personal and financial impact on our population, such as Diabetes.

Magnolia Family Medical Center supports the implementation of this locally designed pilot project, based on best practices, and intended to improve the health outcomes of clients with complex needs. This project will result in improved infrastructure to serve clients with complex needs and improved health outcomes for those clients participating in the pilot project.

2240 Gonzales Road
Suite 100
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(805) 981-5151
(805) 981-5150 Fax

Magnolia Family Medical Center

Stanley C. Patterson, M.D., Medical Director

A satellite clinic of Ventura County Medical Center
Associated with UCLA School of Medicine

We encourage the California Department of Health Care Services to fund this critically needed project. The proposed pilot concept will provide an effective Whole Person Care model that can transform communities throughout California to better serve those with complex needs and create improved health outcomes statewide.

Sincerely,

Stan Patterson, M.D.

2240 Gonzales Road
Suite 100
Oxnard, California 93036

(805) 981-5151
(805) 981-5150 Fax

Santa Paula
West & Hospital Clinic
Affiliated with VCMC

Lisa Solinas, M.D., Medical Director

Santa Paula West and
Santa Paula Hospital Clinic
845 N. 10th Street, Suite 3
Santa Paula, CA 93060
Tel 805-525-0215 | Fax 805-525-8031

A satellite clinic of Ventura County Medical Center

June 08, 2016

Sara Brooks, Deputy Director
Health Care Delivery Systems
Department of Health Services
1500 Capitol Avenue
Sacramento, CA 95814

Dear Ms. Brooks,

Our Santa Paula Hospital Clinic, Inc. supports the implementation of this locally designed pilot project, The Whole Person Care 1115 Waiver Project, which is based on best practices and intended to improve the health outcomes of clients with complex needs regardless of economic or social background. We have been affiliated with the Ventura County Health Care Agency (VCHCA) for the last 11 years, which has enabled us to benefit our Santa Paula population and its surrounding communities.

The Whole Person Care1115 Waiver Project would make a significant impact on our underserved vulnerable populations of VCHCA's and our Medi-Cal clients including those with complex needs who are not demonstrating health improvement, but are high utilizers of multiple care systems. The goal through the Whole Person Care Pilot Project will ensure that our clients with complex needs are provided care through a holistic approach that is tailored to the client's unique needs and built on an understanding and commitment to partnering with each client. The goal of this evidence-based approach is well-being and self-sufficiency for clients who are provided these integrated services.

Here at Santa Paula Hospital Clinic, Inc. we provide a medical home for a unique patient demographic, many of whom are high utilizers of multiple medical, psychological and social services throughout the county. These high utilizers are at considerable risk for disease progression, admission and re-admission to the hospital, as well as poor clinical and social outcomes. Currently we are running the outreach programs listed below to benefit these populations:

- Pride Clinic that serves the lesbian, gay, bisexual, transgender, and questioning (LGBTQ) populations, which has managed to capture 100 new clients in the last year. We provide multiple services in our Pride Clinic which include: Therapy, Dietary consultations, HIV management, PEP and PrEP, free rapid HIV testing, condom dispensary, hormone replacement therapy, and in the future would like to provide speech therapy and group counseling for transgender clients.

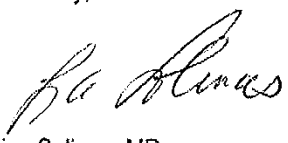
- Breastfeeding Café for our new lactating mothers run by our Certified Lactation counselors. We provide free tutoring services for children grades K through grade 5.

- We are currently working with the American Diabetic Association in creating a program to serve our diabetic clients to improve health care outcomes and compliance. Our Registered Nurse Case Managers work diligently to assist our high risk clients by connecting them with various resources in our system and community.

The Whole Person Care 1115 Waiver Project, will result in improved infrastructure to serve clients with complex needs and improved health outcomes for those clients participating in the pilot project.

We encourage the California Department of Health Care Services to fund this critically needed project. The proposed pilot concept will provide an effective Whole Person Care model that can transform communities throughout California to better serve those with complex needs and create improved health outcomes statewide.

Sincerely,



Lisa Solinas, MD
Medical Director

WEST VENTURA
MEDICAL CLINIC
IN ASSOCIATION WITH VCMC

June14, 2016

Sara Brooks, Deputy Director
Health Care Delivery Systems
Department of Health Services
1500 Capitol Avenue
Sacramento, CA 95814

Dear Ms. Brooks,

I am an internist and have been medical director of West Ventura Medical Clinic (WVMC), Inc. for over 16 years. WVMC is a primary care clinic affiliated with Ventura County Health Care Agency (VCHCA) and we have worked collaboratively with VCHCA to benefit local communities and vulnerable populations, including the underserved Medi-Cal population. The Whole Person Care 1115 Waiver Project has the potential to make a significant impact on the most vulnerable of VCHCA's Medi-Cal clients including those with complex needs who are not demonstrating health improvement, but are high utilizers of multiple care systems. Through effective care coordination, appropriate services, and data sharing, the ***Ventura County Whole Person Care Pilot Project*** will ensure that clients with complex needs are provided care through a holistic approach that is tailored to the client's unique needs and built on an understanding and commitment to partnering with each client. The goal of this evidence-based approach is well-being and self-sufficiency for clients who are provided these integrated services.

WVMC provides a medical home for a unique patient demographic, many of whom are high utilizers of multiple medical, psychological and social services throughout the county. These high utilizers are at considerable risk for disease progression, admission and re-admission to the hospital, as well as poor clinical and social outcomes. As a safety net institution, WVMC cares for numerous homeless and socially disadvantaged patients, many of whom have numerous medical and psychological morbidities, in addition to substance abuse and medical non-compliance.

One example of how we currently assist these individuals is our clinic case management program in which providers refer high risk patients such as those with multiple hospitalizations, numerous emergency department visits and/or cognitive impairments such as dementia. Case managers then connect patients with various resources such as home nurse visits, taxi vouchers for clinic appointments, applications for pharmaceutical assistance programs, telephonic support and appointment reminders. A second example is many of our patients have substance use disorders; and we collaborate with Ventura

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www.westventura.vchca.org

County Behavioral Health Alcohol and Drug Treatment Program to serve as a medical home for clients and provide PPD testing prior to entry into drug counseling.

WVMC supports the implementation of this locally designed pilot project, which is based on best practices and intended to improve the health outcomes of clients with complex needs. This project will result in improved infrastructure to serve clients with complex needs and improved health outcomes for those clients participating in the pilot project.

We encourage the California Department of Health Care Services to fund this critically needed project. The proposed pilot concept will provide an effective Whole Person Care model that can transform communities throughout California to better serve those with complex needs and create improved health outcomes statewide.

Sincerely,

Ramsey Ulrich, MD
Medical Director