Whole Person Care

Sonoma County Behavioral Health
Annual Narrative Report, Program Year #4
Submitted April 1, 2020

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Annual Narrative Report, Program Year #4
Revised July 23, 2020

REPORTING CHECKLIST

The following items are the required components of the Mid-Year and Annual Reports:

Component	Attachments
1. Narrative Report **Submit to:** Whole Person Care Mailbox	✓ Completed Narrative report
2. Invoice **Submit to:** Whole Person Care Mailbox	✓ Customized invoice
3. Variant and Universal Metrics Report **Submit to:** SFTP Portal	✓ Completed Variant and Universal metrics report (turned in previously)
4. Administrative Metrics Reporting (This section is for those administrative metrics not reported in #3 above - the Variant and Universal Metrics Report.) **Note: If a Policy and Procedures document has been previously submitted and accepted, you do not need to resubmit unless it has been modified.** **Submit to:** Whole Person Care Mailbox	✓ Care coordination, case management, and referral policies and procedures, which may include *protocols and workflows.)* ✓ Data and information sharing policies and procedures, which may include *MOUs, data sharing agreements, data workflows, and patient consent forms.* One administrative metric in addition to the Universal care coordination and data sharing metrics. Describe the metric including the purpose, methodology and results.
5. PDSA Report **Submit to:** Whole Person Care Mailbox	✓ Completed WPC PDSA report ✓ Completed PDSA Summary Report
6. Certification of Lead Entity Deliverables **Submit with associated documents to:** Whole Person Care Mailbox and SFTP Portal	✓ Certification form

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I. REPORTING INSTRUCTIONS

Pursuant to the Whole Person Care Agreement and the Special Terms and Conditions of California's Medi-Cal 2020 §1115 Medicaid Demonstration waiver, each WPC Program Lead Entity ("Lead Entity") shall submit Mid-Year and Annual reports for the duration of the WPC Program. The WPC Reporting and Evaluation guidelines, Attachment GG, provide the requirements for the Mid-year and Annual report.

The Mid-Year Report narrative contains data January-June 30, and is due August 31 for Program Years (PYs) 3-5.

The Annual Report narrative contains data from January 1 through December 31, and is due April 2 each program year. The Annual Report is not meant to be duplicative of narratives provided in the Mid-Year Report, but aims to capture a complete picture of accomplishments and challenges during the Program year.

The Lead Entity is required to submit these reports to the Whole Person Care inbox at: 1115wholepersoncare@dhcs.ca.gov.

II. PROGRAM STATUS OVERVIEW

Instructions: Please provide a brief overview of your program's successes and challenges and any lessons learned during the reporting period. Structure your responses in alignment with the WPC program's goals using the following as headers (from STC 112): increasing integration among county agencies, health plans, providers, and other entities; increasing coordination and appropriate access to care; reducing inappropriate emergency and inpatient utilization; improving data collecting and sharing; achieving quality and administrative improvement benchmarks; increasing access to housing and supportive services; and, improving health outcomes for the WPC population.

Please limit responses to 500 words. If additional information is needed, please contact your assigned Analyst.

Improving data collecting and sharing

In the 2019 Point in Time Homeless Count, Sonoma County has the 3rd highest percentages of unsheltered homeless individuals. Significant contributors to Sonoma County's homeless problems are high housing costs, low vacancy rates, and displacement due to the recent wildfire disasters, lack of adequate behavioral health services.

Whole Person Care Goals include Improving health, well-being and self-sufficiency outcomes of clients, increasing successful shelter and housing placements, increasing the number of people accessing services, improving referrals, access and sustained engagement of clients, increasing coordination of services and reduction in duplicate services, and to decrease expenditures per client.

To do this, we use an integrated data hub that combines data from safety net source systems to give an integrated holistic view of the client. It is a cloud-based, mobile care coordination shared by all including community-based organizations with participation and referral capability.

The model includes:

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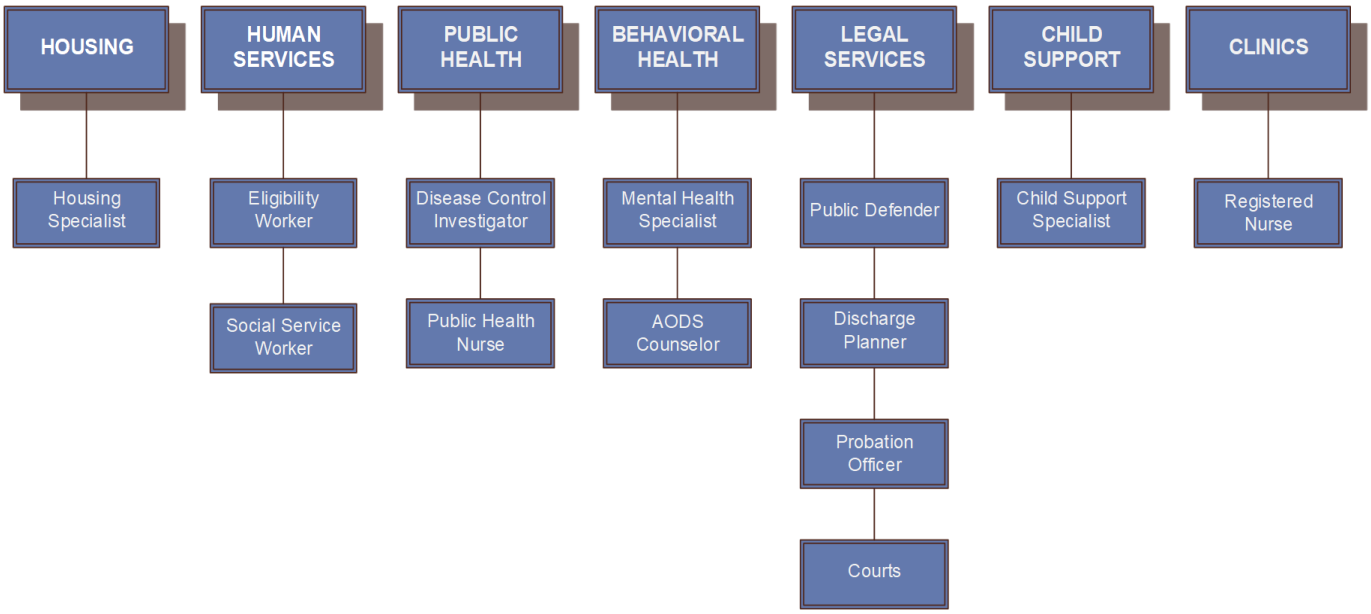

Improving health outcomes for the WPC population

Program Year 4 Outcomes CY 2019

- 1,443 Annual Unduplicated Enrollees
- 71.4% housed or sheltered
- 72.5% enrolled in Coordinated Entry (CE)
- 82.7% enrolled saw a primary care physician (PCP) within 60 days of enrollment
- 21.2% decrease in Emergency Visits (Year 3 to Year 4 improvement)
- 13.6% decrease in incarcerations (Year 3 to Year 4 improvement)
- 94% of enrollees with AOD diagnosis initiated treatment within 14 days of diagnosis, and all 100% of these enrollees engaged in AOD treatment within 30 days of initiation visit.

Team Structure (OE vs. ICM)

Staff are working to balance Outreach and Engagement (OE) and Intensive Case Management (ICM), and improving their skills at identifying what is not working and

coming up with solutions to address problems through continuous quality improvement. In August of 2019 staff were reorganized to better meet the needs.

Outreach and Engagement (OE) Staffing:

Position	**FTE**
Senior Client Support Specialist	2.5
Behavioral Health Clinician	0.5
VACANT Clinician	0.5

Challenges:

- Difficulty filling the part time OE clinician position
- Because we are understaffed, the time between receiving a referral and starting to engage with the person referred has increased
- Because we are understaffed and have a high volume of referrals, outreach staff feel overwhelmed and frustrated

Successes:

- Increase in the number of referrals we are receiving; including orgs that had not referred previously
- As a result of meetings held with hospitals there has been an increase in referrals from them
- October 2019 Kindcade Fire provided a unique opportunity to do OE with a group of homeless individuals that would normally not want to engage. Many of these individuals who would not usually go to a traditional homeless shelter were willing to go to the Red Cross Shelter. They became a captive audience and we had a place to locate them. Because individuals were there for several days, staff were able to build relationships and take care of some immediate needs, which led to trust and ultimately individuals being willing to work with staff after the shelter closed.

Intensive Case Management (ICM) Staffing:

Position	FTE
Senior Client Support Specialist	1.0
Behavior Health Clinician	1.0
AODS Counselor II	1.0
Social Services Worker II	0.5

Challenges:

- The current staffing limits how many individuals we can have open to ICM (our ratio is 1FTE to 20 individuals)

Successes:

- Staff are able to focus solely on case management making them more effective in supporting clients on their care plan.

Partnerships

One health center is still not fully up and running with WPC. We continue to have conversations with them to identify how to support them in moving forward. One that had previously not participated is now staffed and working on OE in their community.

Providers and Other Entities/Regional Meetings

Each region of Sonoma County [North (Healdsburg), East (Sonoma), Central (Santa Rosa), South (Petaluma) and West (Guerneville)] has regular monthly or quarterly meetings to discuss the approaches to outreach and support the WPC target population, as well as how the WPC pilot program is working, where improvements need to be made and how collaboration can increase. Participants include law enforcement, health center, homeless provider, community-based organizations, hospitals, library of the specific region that is meeting. Additional meetings held this year:

- The Haven
  As the only homeless provider/program in Sonoma Valley, a multidisciplinary meeting was held with all organizations that collocate at this location. The purpose was to get to know what each organization offers and explore leveraging housing opportunities for shared clients.

- Humanidad
  Community based counseling center specializing in working with the Latino population, was unfamiliar with WPC and wanted a better understating of the services offered and how to cross-refer.

- Santa Rosa Community Health Centers (SRCHC) Jail Program
  Many referrals come from the jail and SRCHC has staff specifically working with them. WPC staff wanted to ensure efforts were not duplicated. Now that staff person joins the weekly IMDT meetings.

- Wellness Center (Goodwill Industries)
  Presentation on WPC to consumers who access the Wellness Center located on the Behavioral Health campus. This included not only what WPC is and what services they offer, but also how they as individual consumers can access services directly.

Increasing Coordination and Appropriate Access to Care

Using Adults Needs and Strengths Assessment (ANSA) - an evidence- based, nationally used mental health assessment that helps determine level of care has enabled us to ensure individuals we are serving get connected to and receive the right level of care based on their symptoms and how those symptoms effect daily functioning.

III. ENROLLMENT AND UTILIZATION DATA

Instructions: For the Mid-Year report, provide data for January-June 30 of the Program Year and for the Annual Report, provide data for January-December 31 of the Program Year.

The tables below should reflect enrollment and utilization numbers, consistent with your invoice and quarterly enrollment and utilization reports.

For revisions of enrollment and utilization data submitted during the Mid-Year Report (Months 1-6), changes should be made in bold. Additionally, note explicitly in the additional box at the end of this section if no changes were made to the Mid-Year reported data.

Item	Month 1	Month 2	Month 3	Month 4	Month 5	Month 6	Unduplicated Total
Unduplicated Enrollees	**179**	**155**	148	**121**	**89**	**82**	774

Item	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12	Annual Unduplicated Total
Unduplicated Enrollees	119	108	101	124	136	81	1,443

*For **Fee for Service (FFS),** please report your total costs and utilization for each service. These reports should tie to your budget, invoice and utilization report. Add rows as needed.*

Costs and Aggregate Utilization for Quarters 1 and 2							
FFS	Month 1	Month 2	Month 3	Month 4	Month 5	Month 6	Total
Service 1 *Outreach & Engagement*	**$97,654**	**$110,571**	**$134,608**	**$148,739**	**$115,961**	**$101,539**	**$709,073**
Utilization 1	**2,011**	**2,277**	**2,772**	**3,063**	**2,388**	**2,091**	**14,602**
Service 2 Short-term *Recuperative Care Services*	$17,030	$17,810	$28,990	**$18,460**	$23,270	$26,260	**$131,820**
Utilization 2	131	137	223	**142**	179	202	**1,014**

Costs and Aggregate Utilization for Quarters 3 and 4							
FFS	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12	Annual Total
Service 1 *Outreach & Engagement*	$126,256	$150,876	$185,208	$169,037	$154,809	$189,918	$1,685,178
Utilization 1	2,600	3,107	3,814	3,481	3,188	3,911	34,703
Service 2 Short-term *Recuperative Care Services*	$19,110	$18,460	$13,390	$17,030	$35,230	$17,550	$252,590
Utilization 2	147	142	103	131	271	135	1,943

*For **Per Member Per Month (PMPM),** please report your rate, amount claimed and member months by PMPM type. These reports should tie to your budget, invoice and utilization reports. For "Bundle #" below, use the category number as reported in your submitted Quarterly Enrollment and Utilization Report. Add rows as needed*

Amount Claimed								
PMPM	Rate	Month 1	Month 2	Month 3	Month 4	Month 5	Month 6	Total
Bundle #1 – PMPM Category 1 (Intensive Case Management)	$1,366	$17,758	**$24,588**	$32,784	$45,078	$49,176	$69,666	**$239,050**
MM Counts 1		13	**18**	24	33	36	51	**175**

Amount Claimed								
PMPM	Rate	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12	Total
Bundle #1 – PMPM Category 1 (Intensive Case Management)	$1,366	$66,934	$68,300	$69,666	$66,934	$68,300	$71,032	$650,216
MM Counts 1		49	50	51	49	50	52	476

Please provide additional detail, if any, about your enrollment and utilization for this reporting period. (Optional)

NA

IV. NARRATIVE – Administrative Infrastructure

Instructions: Please describe the administrative infrastructure that has been developed specifically for the WPC program and how it relates to achievement of program goals. Reimbursement will be based on actual costs expended and employees hired/employed for the WPC pilot, and only up to the limit of the funding request in the approved budget.

Please note the narrative submitted during the Mid-Year report will be considered part of the Annual report and will not need to be resubmitted. Include updates, notable trends, and highlights of achievements/progress as well as any changes since the report. Please limit your responses to 500 words.

The administrative staff in PY4 focused on identifying and solving any trouble spots in the project's infrastructure; continuing collaboration activities with the ACCESS program; additional software development and utilization management; work to reduce data entry and systems barriers; and ongoing data collection and analysis for evaluation. Contractors additionally had administrative costs to ensure the successful implementation of WPC in health clinic settings across Sonoma County.

IV. NARRATIVE – Delivery Infrastructure

Instructions: Please describe the delivery infrastructure that has been developed as a result of these funds and how it relates to achievement of pilot goals. Reimbursement will be based on actual pilot expenditure for the final deliverable or outcomes, up to the limit projected or estimated costs in the approved budget.

Please note the narrative submitted during the Mid-Year Report will be considered part of the Annual Report and will not need to be resubmitted. Include updates, notable trends, and highlights of achievements/progress as well as any changes since the prior report. Please limit your responses to 500 words.

During PY4, Quarters 3 & 4

- Staff support and input to improve and continue to build data infrastructure
- Support for providing direct service to WPC eligible clients in the community
- Staff transitions resulted in less hours being used in this time period.

The following staff were used to provide the above named services:

Senior Client Support Specialist (.01 FTE)
Senior Office Assistant (.38 FTE)
Eligibility Worker II (.1 FTE)
Health Program Manager (.14 FTE)

Contracted partners also provided indirect administrative support to delivery of direct services including data entry, scheduling, and billing

V. NARRATIVE – Incentive Payments

Instructions: Please provide a detailed explanation of incentive payments earned during the Reporting Period. Elaborate on what milestones were achieved to allow the payment, the amount of each payment, and to whom the payment was made. The lead entity will only be permitted to invoice for actual incentive payments made.

Please note the narrative submitted during the Mid-Year Report will be considered part of the Annual Report and will not need to be resubmitted. Include updates, notable trends, and highlights of achievements/progress as well as any changes since the prior report. Please limit your responses to 500 words.

Staffing Incentive for Health Centers & Peers during Q3 & Q4

Incentives are to be provided to the six community health centers for the hiring and retention of nurse outreach and engagement and case management staff. Each community health center will be eligible for a maximum $10,000 incentive payment each PY based on their ability to hire and retain WPC Pilot staff. Each health center will be evaluated individually and will be able to earn their incentive based on their individual performance whether or not the other health centers achieved their staffing goals. For this period, Sonoma was able to meet 67% of their targeted achievement. Total payment earned: $40,000

Peers: All five regions employed full-time peer providers during these quarters.

-North Region: Reach For Home

-South Region: Mary Isaac Center

-West Region: West County Community Center

-Central Region: Goodwill Industries

-East Region: Goodwill Industries

FQHCs: 4/6 federally qualified health centers employed staff during these quarters.

-North Region: Alexander Valley Community Health Center

-South Region: Petaluma Health Center

-West Region: West County Health Center

-Central Region: Santa Rosa Community Health Center

Started in January - East Region: Sonoma Valley Community Health Center

Still pending - North Region: Alliance Medical Center

Increased Care Management Competencies Incentive through Training: Completed in PY4 Midyear.

Please elaborate: milestones were achieved to allow the payment, the amount of each payment, and to whom the payment was made

Importance of ongoing training:

- Increased job satisfaction
- Increased employee motivation.
- Increased efficiencies in processes
- Increased capacity to adopt new technologies and methods.
- Increased innovation in strategies
- Reduced employee turnover

Training	Presenter	Date
Disease Control and Universal Precautions	Mary Miller	1/11/19
Watson Care Manager – Care Plan Development – Day 1	Jacob Redd	1/18/19
Coordinated Entry Training	Josh Swanson	1/22/19
Watson Care Manager – Care Plan Development – Day 2	Jacob Redd	1/23/19
Law & Ethics	Lawyer	2/6/19
Motivational Interviewing	Megan Murphy	2/13/19
Suicide Risk Assessment and Safety Planning	Melissa Ladrech, Karin Sellite, Selena Torres	3/3/19
Cultural Competencies: LGBTQ Communities	Positive Images & LGBTQ Connections	5/1/19
Assessing and Managing Suicide Risk	Melissa Ladrech	5/7/19
Table Top – De-escalation and Active Shooter Safety	Ben Vieth	5/8/19
Coordinated Entry Access Point	Araceli Rivera	5/21/19

Training	Presenter	Date
Changes in High Needs/Risk/Vulnerable Positions	Cruz Lopez	7/31/19
The Era of Marijuana	DHS-BH	10/2/19

- ✓ Changes in High Needs/Risk/Vulnerable Populations- The population we work with is one of the most challenging to move towards change. Often the change is very small and incremental. There are times that staff become frustrated or feel like they are not making a difference because it can look like no progress is being made. This training addressed this particular issue, specifically around looking how small change can build in each other and lead to bigger changes and that in this population sliding back is often part of the journey.
- ✓ WPC Health Program Managers attended the WPC Fall Convening in Sacramento on 9/10/19.
- ✓ The Era of Marijuana-Training explored the way marijuana is now viewed in our society and how it affects the clients we work with, specifically when it comes to mental health issues.

Coordinated Entry

Goal: 85% of clients enrolled in ICM in PY4 will be in Coordinated Entry, with a maximum incentive of $70,000, as measured by matched entry dates to CE and WPC/ICM.

- **Not achieved**: [redacted] were enrolled in Coordinated Entry.

Housing Programs

40% of WPC clients enrolled in ICM in PY4 will be housed by a housing program (Permanent Supportive Housing, Rapid Re-Housing, Transitional, SNAP 10) in Sonoma County, with a maximum incentive of $70,000, as measured by housing data collected by CE and housing partners.

- **Achieved:** [redacted] were housed by a housing program in 2019

40% of WPC clients in PY4 will have been linked to and seen by a primary care provider within 60 days of enrollment in ICM, with a maximum incentive of

$70,000, as measured by data collected by FQHCs. If earned, incentive funds will be split evenly between the six FQHCs and DHS.

- **Achieved:** [redacted] clients who enrolled in Whole Person Care in 2019) saw a primary care physician within 60 days of enrollment.

VI. NARRATIVE – Pay for Outcome

Instructions: Referencing the Whole Person Care Universal and Variant Metrics Technical Specifications, please provide a detailed explanation of the status of your program's performance on the pay-for-outcome metric(s). For the Mid-year report, only report those measures that are reported semi-annually; for the Annual report, please report all. Provide details that demonstrate what was achieved for each outcome, any challenges, and any lessons learned. Reimbursement will occur for achieved outcomes based on proposed annual target and methodology. Please limit your responses to 500 words.

We **achieved** our goals on the following metrics:

- **Universal Metric: Ambulatory Care – Emergency Visits:**
  - PY4: 5% reduction from PY3, $70,000 payment if achieved
  - **Achieved:** LE data shows a [redacted] decrease observed from PY3 to PY4 [redacted]
  - **Achieved:** This metric is paid based on DHCS run data, the trigger for payment was achieved. DHCS data showed a reduction from PY3 to PY4 that surpassed 5%.

- **Variant Metric: Decrease Jail Recidivism:**
  - PY4: 5% reduction from PY3, $70,000 payment if achieved
  - **Achieved:** LE data shows a [redacted] decrease in incarcerations observed from PY3 to PY4 [redacted]

We **did not achieve** our goals on the following metrics:

- **Universal Metric: Inpatient Utilization – General Hospital/Acute Care:**
  - PY4: 5% reduction from PY3, $70,000 payment if achieved
  - **Not achieved:** LE data shows a [redacted] reduction in inpatient utilization observed from PY3 to PY4 [redacted]
  - **Achieved:** This metric is paid based on DHCS run data, the trigger for payment was achieved. DHCS data showed a reduction from PY3 to PY4 that surpassed 5%.

- **Variant Metric: 30 day All-Cause Readmissions:**
  - PY4: 5% reduction from PY3, $70,000 payment if achieved

- **Not achieved:** LE data shows a [redacted] increase in all-cause readmissions observed from PY3 to PY4 [redacted]
- **Not achieved:** This metric is paid based on DHCS run data, the trigger for payment was not achieved. DHCS data showed no reduction from PY3 to PY4.

- **Variant Metric: Percent of homeless receiving housing services that were referred to housing services:**
  - PY4: 5% increase from PY3, $70,000 payment if achieved
  - **Not achieved**: LE data shows a [redacted] decrease between PY3 and PY4 in homeless receiving housing that who referred for housing services [redacted]

One challenge we encountered in achieving our goals were that both Outreach and Engagement Clients and ICM clients were incorporated in PY3 analyses, while only ICM clients were included in our PY4 analyses and the differing sample sizes impacted the variance. For example, we had a small number of index hospital stays in 2019 [redacted], and the readmission rate was greatly influenced by the high utilization needs [redacted]

In 2019, there was a 21% decrease in ED utilization which may have been due in part to targeted outreach by case managers specifically to high utilizers of ED services enrolled in WPC. Each of the three major hospitals in Sonoma County provided the County with the names of their highest utilizers of services, some of whom were enrolled in WPC. WPC staff then worked with these clients to connect them with primary care and alternate resources. 82.7% of 2019 enrollees saw a primary care provider within 60 days of their WPC enrollment.

VII. STAKEHOLDER ENGAGEMENT

Instructions: Please provide a complete list of all program policy meetings you have held with participating entity/ies and/or stakeholders during the reporting period, and a brief summary, with topics and decisions, of the proceedings. The list of meetings will not count against your word limit. An attachment to this report is also acceptable, please note below if this option is being used. Please Note: Do not include meetings held as part of providing WPC services (e.g. care planning, MDT meetings). Meeting information provided in the Mid-Year Report does not need to be resubmitted.

Internal Meeting Descriptions:

Whole Person Care Interdepartmental Multi-Disciplinary Team (IMDT) Care Coordination - meetings held every Wednesday. Agencies include Community Development Commission (housing authority), Human Services, Department of Health Services (Behavioral Health; DHS-BH), Adult and Aging, Child Support Services, Probation. WPC Intensive Case Management clients are discussed and the group utilizes Watson Care Manager to add client notes and track program progress/updates.

WPC Workflow Meetings - Goodwill Industries (Peer Outreach Worker) - Adding a peers to our team has been AMAZING and EXTREMELY valuable. In partnership with our peer providers we reviewed work flows of how to do cross referring and how to best identify individuals who would benefit from being connected to a peer.

Data Meetings - SWITS is our internal billing system. This second half of the year staff needed additional support from our SWITS administrator and wanted to meet and review processes and receive technical assistance on an as-needed basis.

IBM continues to be onsite with us on a regular basis, (2-4 times a month, each time for about 3 days). The IMDT works closely with the IBM and Watson teams to review the progress made with all aspects of system integration and configurations in Watson Care Manager. Early in the partnership, County leadership identified priorities for upcoming phases of the work to be completed, including:

a) Utilizing technology to improve care coordination across agencies and with community partners,
b) Improving communication and engagement with clients,

c) Decreasing case managers duplicate efforts when working in multiple systems, and
d) Improved reporting.

External Meeting Descriptions:

Community - WPC BH Staff attend Coordinated Entry (CE) Case Conferencing meetings on 1-2 times a month basis. The purpose is to identify existing and potential WPC clients who are in need of CE.

Regional Meetings -

- Santa Rosa (1/11, 2/8, 3/8, 4/12, 5/10, 6/14, 10/11)
- Petaluma (1/14, 2/11, 3/11, 4/8, 5/13, 6/10, 10/14, 12/9)
- Sonoma (1/15, 2/19, 3/19, 4/16, 6/18, 8/20, 9/17, 10/15)
- Guerneville (2/4, 4/8, 5/6, 6/10, 8/5, 10/7, 12/2)
- Healdsburg (2/25, 3/25, 4/22, 6/24, 8/26, 9/19, 10/17, 11/21)

PROGRAM ACTIVITIES

Briefly describe 1-2 successes you have had with care coordination.
1. The WPC team continues to play an integral part of Sonoma County's Interdepartmental Multi-Disciplinary Team (IMDT). The IMDT meets on a weekly basis to discuss individual client cases to improve care coordination within our county system. We have successfully added other partners (Communicable Diseases, Maternal, Health, and Peers, one of the health centers). Since the last report we have added substance use disorder representation, an additional health center representative (the second largest in our county, largest health center had already been attending), and a homeless provider representative. The jail discharge planner (WellPath) has shown great interest and we anticipate they will join IMDT in the spring of 2020. We have learned that having everyone in the room reduces duplication and gives the best outcome for our clients. 2. Connecting clients with health care and financial resources and the medical/mental health interventions that lead to medication compliance and better outcomes. Our care coordination style breaks down the barriers to these services and provides flexibility.

Briefly describe 1-2 challenges you have faced with care coordination, and lessons learned from those challenges.
1. We are still missing some representation (District Attorney, Hospitals). We have figured out WHO should be in the room, it is finding time from very busy people that is challenging. We use these opportunities to decide who the best person to follow-up with the hard-to-get people. We are working around issues where we can. 2. The connection between WPC and ACCESS (gateway to County services) is not well developed. We have no way to schedule appointments for ACCESS and must bring clients in on a drop-in basis which makes it difficult for us to connect clients with DHS-BHD services.

Briefly describe 1-2 successes you have had with data and information sharing.

1. All WPC staff are trained to enter assessments into the Coordinated Entry/ Homeless Management Information System (HMIS) system. This allows for more timely screening and the ability to check statuses, update information, and coordinate with CDC directly. CDC has been great at providing ongoing training and support to staff as needed. As a result we are seeing clients find access to housing services faster.

2. Receiving alerts on Watson Care has allowed less information to be missed and ensures clients stay active on their financial benefits and aware of their legal status.

Briefly describe 1-2 challenges you have faced with data sharing, and lessons learned from those challenges.

1. Outreach data is not in Watson Care so we are not sharing the amount of information that we could be with ICM. Lesson for the future: If we were in Watson Care from the get-go we could be starting to input contact, demographic, and clinical information and this information would not get lost in the transition from O&E to ICM. We are working in too many systems (TAP, SWITS, Avatar) and so information gets lost between systems.

Briefly describe 1-2 successes you have had with data collection and/or reporting.

1. This area is coming along, although changes and adding services and functionality does not move as quickly as we would like it to. Fortunately, this year IBM was able to complete Phase 4 of their work. The following items are now live in Watson Care Manager Production Environment:
   - Automated Rule-based Referrals
   - Client Registration Button
   - MDM Prioritization
   - Virtual Client Record with updated Design (tables, subcategories), Assessments, and Program Participation information.
   - Automated Rule-based Alerts

Briefly describe 1-2 successes you have had with data collection and/or reporting.

- Mental Health Diversion Cohort Analysis/Configurations
- Notes API from Source Systems to the WCM UI.
- Prioritized TFS Defects

We learned that patience and clear communication are key to success with achieving our data collection goals.

Briefly describe 1-2 challenges you have faced with data collection and/or reporting.

1. We continue to be in multiple systems, which can be very burdensome.
2. Staff don't always record things in TAP, SWITS, or Watson in the same way. Increased standardization, training, and workflow sheets are needed

Looking ahead, what do you foresee as the biggest barriers to success for the WPC Program overall?

Many needs remain to create success for clients we serve:

- More housing resources (shelter beds, low-income housing, vouchers, Permanent Supportive Housing)
- More substance use treatment options
- Expanded services for persons with TBI

Working in multiple software systems will continue to be a barrier until those are streamlined.

VIII. PLAN-DO-STUDY-ACT

Instructions: PDSA is a required component of the WPC program. The WPC PDSA Report template will be used for each PDSA that the LE is conducting. Summary and status reports are required components of your Mid-Year and Annual reports. Please attach all required PDSA documents and completed template demonstrating your progress in relation to the infrastructure, services, and other strategies as described in the approved WPC LE application and WPC STCs. Note: For the Mid-Year Report, submit information from January – June 30. For the Annual Report, submit information inclusive of all PDSAs that started, are ongoing, or were completed during the Program Year

The following PDSA attachments are included in the PY4 Mid-Year Report:

1. Ambulatory Care – PY4
   Q3, Q4
2. Inpatient utilization – PY4
   Q3, Q4
3. Comprehensive Care Plan – PY4
   Q3, Q4
4. Care Coordination – PY4
   Q3, Q4
5. Data Infrastructure – PY4
   Q3, Q4
6. Other – PY4
   Health Center Contracting – Q3, Q4