State of California - Health and Human Services Agency
Department of Health Care Services
Whole Person Care
Lead Entity Mid-Year or Annual Narrative Report

Reporting Checklist

Sonoma County Behavioral Health
PY3 Annual Report (January 1 – December 31, 2018)
Submitted: April 2, 2019

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 ☐ List of participant entity and/or stakeholder meetings *(if not written in section VIII of the narrative report template)*
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
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

NOTE: The WPC Quarterly Enrollment and Utilization Report is submitted on a quarterly basis to the DHCS SFTP site.

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

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.*

*****Limit to 500 words***

Increasing integration among county agencies, health plans, providers, and other entities

Successes

- Service Contracts
    - Executed a service contract with Alliance Medical Center (executed 12/20/2018) to provide outreach and engagement (O&E) and intensive case management (ICM) services to WPC eligible clients in the North Sonoma County region.
        - All other FQHCs contracts were finalized and moved for signatures.
    - A service contract was executed with Sonoma County's Human Services Department (HSD) (executed 8/1/2018) to add an Eligibility Worker who is providing both O&E and ICM services to eligible clients.
- Project Management Contracts
    - Redwood Community Health Coalition (RCHC) contract executed on 12/31/2018. RCHC provides project management services including scheduling community meetings, project planning, and analytic support of intermediate indicators and client outcome data.
- County Agency Integration
    - The WPC team merged with the Interdepartmental Multi-Disciplinary Team (IMDT) in September 2018. Agencies participating in the IMDT include Community Development Commission (CDC) (housing authority), HSD, Department of Health Services (Behavioral Health; DHS-BH), Adult and Aging, Child Support Services, and Probation. The IMDT works closely together on a weekly basis to improve the data sharing and care coordination infrastructure for WPC clients.

Challenges/Lessons learned

- The development, review, and execution of contracts is a time-consuming process. It took months for partners to agree on a scope of work, budget, and processes for how to work best with County agencies and community partners.

- Originally, all FQHCs were brought together to discuss WPC implementation in their respective settings. We quickly learned that WPC would look different in each clinic and the work would vary from setting to setting. We started having one-on-one meetings with each clinic to better understand the needs, expectations, and workflows for each partner.

Increasing coordination and appropriate access to care

Successes

- When DHS-BH WPC staff began participating in the IMDT with other representatives from Safety Net departments, our ability to support clients significantly improved. Working with this team on a weekly basis has expedited care, referrals, and services for the WPC population and has increased access and the quality of care.
- The DHS-BH WPC staff also started meeting with the FQHCs on a weekly basis to discuss care coordination in clinic settings and the transition from County services to community clinics and partners. These meetings have also expedited services for clients, have improved communication with partners, improved engagement with clients and have supported the identification of new WPC eligible clients.
- Additionally, the WPC clinical program manager began meeting with community providers including hospitals, shelters, and non-profit organizations to discuss the referral process into WPC in each of these settings, reviewed services provided under the WPC pilot, and discussed ways to improve communication for shared clients.

Lessons learned

- There were many misconceptions across contractors, County agencies, and community providers about the WPC pilot, who the target population was and which services were provided. We had to hold many meetings to discuss the program in great detail before partners and the community understood.

Reducing inappropriate emergency and inpatient utilization

Successes

- During outreach and engagement, WPC staff are building rapport with eligible clients, assessing clients' immediate needs and screening them in various domains (physical health, mental health, substance use, social/financial needs, and housing needs). Staff also help gather documentation, make appointments, and transport clients to their medical appointments. These activities support clients getting into necessary facilities while avoiding inappropriate utilization of medical services.

Challenges/Lessons Learned

- WPC is not fully integrated with the EDs and Hospitals in our County yet. However, the clinics are triaging recommended care and providing additional education around appropriate uses of hospital and ED utilization.

Improving data collecting and sharing

Successes

- Universal Consent
  - The Sonoma County Privacy Officer developed a Universal Consent form, which allowed the WPC team to share HIPPA and 42 CFR Part 2 data with designated partners to improve care coordination for clients.
- Data Use Agreements
  - Partnership HealthPlan (Sonoma County Medi-Cal payer) executed on 8/10/2018
  - Sonoma County Community Development Commission (Housing Authority) executed on 8/2/2018, supporting access and edit rights to the Homeless Management Information System (HMIS) system.

Challenges

- Collecting consent with this population can be a challenge for WPC staff. It may take many encounters before clients are willing to share basic information, let alone agree to share their personal data with various agencies. Staff describe to them how their information will be used and who will/will not have access to their information. WPC staff will continue to build rapport with clients for as long as it takes to help them understand the program and agree to consent to participate in our program and information sharing.

Achieving quality and administrative improvement benchmarks

Successes

- The first half of PY3 focused on disseminating WPC information to the community and building the infrastructure to achieve the program goals. We held numerous meetings to inform the community, partnering agencies, and providers with shared clients about WPC and discussed collaboration opportunities. After the DHS-BH WPC team was adequately staffed, began integrating WPC in various community settings.
- We completed the analysis of infrastructure needs to stand up and updated our systems to improve data collection, care coordination, and care quality for WPC clients, hired new staff, created new policies and identified and developed new systems to achieve the program goals.

- Due to delays that occurred in PY2, during PY3 we were building the program, policies, and processes as we were implementing the program in the community. By the end of PY3, we finalized processes around referral workflows, care coordination and case management, and data collection/systems workflows and now have more streamlined activities, improve client management, and sharing of information across partners.

Increasing access to housing and supportive services

Successes

- DHS-BH WPC staff teamed up with the CDC to become an access point for clients to enter coordinated entry (CE). Staff were trained to complete and submit all of the required paperwork for CE program enrollment. With access to HMIS, staff can view previous assessments and program enrollment/status, submit new/updated assessments, identify where clients are at on the housing list, and support expediting services for high-need/high risk clients. In addition, a member of the WPC BH staff is attending the Coordinated Entry Case Conferencing meeting once a month to discuss clients who need additional support or services with the larger CE team.

Challenges:

- The partnership with the CDC has expedited the CE process for many clients and increased access to housing services, but there are limitations on enrollment into any one of their numerous programs and no guaranteed housing for our clients. Our County has a deficit in available housing, particularly affordable housing.

Improving health outcomes for the WPC population

Successes:

- WPC clients are experiencing an improvement in their health outcomes largely due to the staff's improved relationships with various community partners, partnering County agencies, and service providers. Case managers often have the strongest rapport with the clients and actively encourage and work with them to address their immediate needs, acquire resources, talk with other service providers, and transport them to appointments where they are receiving quality and appropriate care.
- The IMDT alone has connected countless people to services in a few weeks that would've taken months or years to receive without the various agencies meeting on a weekly basis. Taking the time to discuss shared clients, resource opportunities, updates, and next steps has opened up many more opportunities for both the staff and the clients that did not exist prior to WPC implementation.

Challenges/Lessons learned:

- Even with increased collaboration amongst staff and access to referring agencies, services, and programs, WPC clients are hesitant and distrusting of medical and government agencies. These clients are often not willing to leave their respective locations for an appointment at an organization that only works within their "four walls". If more resources and staffing were available to conduct backpack nursing or other field work opportunities (where services can be provided where the clients are at), we would see even greater improvement in health outcomes.

III. ENROLLMENT AND UTILIZATION DATA

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	NA	NA	NA	103	58	53	214

Item	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12	Annual Unduplicated Total
Unduplicated Enrollees	28	47	28	66	113	112	608

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	NA	NA	NA	$18,598.48	$15,684.88	$27,436.40	$61,719.76
Utilization 1	0	0	0	383	323	565	1271

	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	$17,870.08	$20,006.72	$18,986.96	$38,508.08	$43,558.32	$80,755.28	$281,405.20
Utilization 1	368	412	391	793	897	1663	5,795

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	$	NA	NA	NA	0	$1,366	$1,366	$2,732
MM Counts 1	0	0	0	0	0	1	1	

		Amount Counts						
PMPM	Rate	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12	Total
Bundle #1	$	$4,098	$5,464	$6,830	$8,196	$8,196	$6,830	$42,346
MM Counts 1		3	4	5	6	6	5	31

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

Sonoma County Behavioral Health was a Round 2 WPC pilot recipient. Prior to the 2017 October wildfires in Sonoma County, WPC enrollment was planned for Q4 2017. On October 8, multiple fires broke out in Sonoma County. The Sonoma County Dept. of Health Services' Operation Center was activated on October 9, and continued to operate months after the fire as our county began the recovery phase.

As a result of the disaster, the Sonoma County Board of Supervisors review and acceptance of the WPC grant was postponed from October 24 to December 5. On December 5, the Department presented the pilot project and a request to increase the Department's delegating contract authority to the Board of Supervisors, which was accepted and approved. The Whole Person Care Pilot project began identifying potential clients and conducting outreach and engagement services in Q1 of 2018; intensive case management (ICM) enrollment and services start in May 2018. Due to data infrastructure progress and updates to our systems, we were not able to aggregate enrollment and utilization data for the PY3 Q1.

We have also redefined what enrollment means in Sonoma County. We have updated our enrollment criteria and have revised our reports based on the below definitions:

- **Enrollment in Outreach and Engagement (O&E) program:**
  - Medi-Cal beneficiaries (as indicated by a CIN) who have agreed to actively work with WPC staff by providing information to complete assessments to address immediate needs and screenings to determine eligibility into Intensive Case Management (as indicated by documented client self-reported assessments).
    - Individuals enrolled in O&E who are not eligible for ICM will receive treatment and service referrals, warm hand offs to other programs or organizations, and assistance getting connected to social, financial, medical and housing services.
  - Medi-Cal beneficiaries (as indicated by a CIN) who are receiving short term recuperative care services will also be considered enrolled in O&E, as indicated by their consent to receive short term recuperative care through the Drug Abuse Alternatives Center (DAAC), and completion of self-reported brief screening assessments indicating eligibility for WPC ICM services.

- **Enrollment in Intensive Case Management (ICM) program:**
  - Medi-Cal beneficiaries (as indicated by a CIN) who have completed screening assessments and met eligibility criteria (a. severe and persistent or high moderate mental illness, b. homeless or at risk of homelessness, and any **ONE** of the following: 1. Chronic health conditions, 2. History of substance use, 3. High utilization of medical/psychiatric services, **or** 4. Criminal Justice-involvement) and who have agreed to participate in the ICM program and signed a universal consent that allows their data to be shared across treatment providers for case management purposes (providers include County agencies and community partners).
    - ICM enrollees will be actively case managed and will work to establish a comprehensive care plan, that will address client driven goals and progress in the following domains: medical, substance use, behavioral health, financial, housing, and social.

IV. NARRATIVE – Administrative Infrastructure

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.

Staffing

The administrative staffing infrastructure in quarters 3 and 4 of PY3 focused on project management to finalize internal processes and identify and execute collaborative activities with community partners to support the sustainability of the program. Staff conducted planning around workflow, policies and procedures related to referrals and care coordination and data infrastructure both internally and with community organizations. In addition, the WPC team and Redwood Community Health Coalition (RCHC) team coordinated, scheduled, and facilitated collaborative community meetings ($184,554).

Contractors additionally had upfront administrative costs to ensure the successful implementation of WPC in clinic settings across Sonoma County ($5,229).

IT Infrastructure and Data Coordination

The analysis of infrastructure needs to stand up and update our systems to improve data collection, care coordination, and care quality occurred in PY3 Q3 and Q4. The focus of these efforts were on the ongoing development of a comprehensive system to exchange data to enable holistic care coordination between disparate systems. The WPC team identified and developed new systems to achieve the program goals:

- An electronic, cloud-based ThinkSmart Automation Platform (TAP) that automates mundane business procedures. We built all client screening, assessment, and questionnaire tools in this system so that data could be collected and analyzed more efficiently.
- A cloud based care management solution called IBM Watson Care Manager (WCM), which helps organize and integrate various County source systems to streamline individual-centered care by improving access to client data, improve collaboration across care team members, and improve clients' outcomes across various domains.

An integrated data hub that compiles and aggregates information from the siloed systems used by each agency into a data repository linked to a coordinated referral tool was also developed. This data integration system will communicate with IBM WCM to provide access to a comprehensive client view of the pilot clients and their needs. Access to the aggregated data from multiple systems allows for continued analysis of individual needs, evaluation of outcomes, and predictive analytics to support more proactive and prevention-focused efforts aimed at addressing critical needs of vulnerable populations. ($1,145,654)

V. NARRATIVE – Delivery Infrastructure

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.

During the second half of the year, delivery infrastructure was focused on:

- Finalizing data infrastructure ($26,849)
- Obtaining Tablets/Computers to support field work ($52,000)
- Providing direct service to WPC eligible clients in the community (see Section III for enrollment and utilization figures)

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

July-August

FTE	Position
0.5	Social Services Worker II
0.5	Eligibility Specialist
1.0	Senior Office Assistant
0.5	Health Program Manager
2.0	Senior Client Support Specialist

September

FTE	Position
0.5	Social Services Worker II
0.5	Eligibility Specialist
1.0	Senior Office Assistant
0.5	Health Program Manager
2.0	Senior Client Support Specialist

October

FTE	Position
0.5	Behavioral Health Clinician
0.5	Social Services Worker II
0.5	Eligibility Specialist
1.0	Senior Office Assistant
0.5	Health Program Manager
2.0	Senior Client Support Specialist

November

FTE	Position
0.5	Behavioral Health Clinician
0.5	Social Services Worker II
0.5	Eligibility Specialist
1.0	Senior Office Assistant
0.5	Health Program Manager
3.0	Senior Client Support Specialist

December

FTE	Position
1.0	Behavioral Health Clinician
0.5	Social Services Worker II
0.5	Eligibility Specialist
1.0	Senior Office Assistant
0.5	Health Program Manager
3.0	Senior Client Support Specialist

- Total estimated costs for delivery infrastructure in PY3 Q3 & Q4: $258,669

VI. NARRATIVE – Incentive Payments

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.

A. 80% of those enrolled will have a comprehensive care plan, accessible by the entire care team, within 30 days of: 1. Enrollment into Intensive Case Management services.	**$100,000**

ITEM A: Access to Comprehensive Care Plan (PY3 Incentive).
Enrolling WPC eligible clients into the ICM program supports a more rigorous level of care for clients who need more support and assistance to reach levels of self-sustainability across a variety of domains (physical health, substance use, financial/social services, mental health, and housing).

The DHS-BH WPC staff have the primary responsibility for:

1. Locating clients
2. Establishing a relationship
3. Addressing immediate needs
4. Determining eligibility for ICM
5. Building a level of trust that will lead to obtaining consent to participate in the WPC ICM program Pilot, which involves sharing data across partners, engaging in services, and working with the client to identify goals for their care plan

Incentive: In order to emphasize and support the culture change around shared clients with all members of the WPC multi-disciplinary care team, an incentive will be provided to ensure the comprehensive care plan shall be accessible by the entire care team within 30 days for an average of 80% of clients enrolled in intensive case management services.

Total Care Plans: 16
Care Plans Shared within 30 Days: 13
Percentage: 81.25%

*****Incentive Goal Met*****

B. 20 Regional Meetings held throughout County to identify barriers for WPC clients and propose solutions.	**$78,316**

ITEM B: Active involvement in barrier identification and resolution (PY3 Incentive).

This incentive supports the development of relationships between County agencies and participating agencies (both official members of the multi-disciplinary care team and non-team service support agencies), with the goals of identifying barriers and working though strategies and opportunities to resolve those barriers.

Early identification and resolution of barriers related to client engagement, care coordination, and/or receipt of services is essential to the success of the WPC program. Failure to address these various barriers could critically hinder the program's ability to fulfill WPC beneficiary needs, as well as create negative experiences or stigma towards the program or the County's BH division.

To encourage this process, this incentive requires the organization of monthly regional meetings in five locations throughout the County. The meetings ranged from large, community-oriented gatherings where program processes and overall goals are discussed, to one-on-one meetings with various partners or community organizations to discuss structural barriers and solutions for improving coordination and client care. The focus of these meetings was to identify big picture issues within each region that addressed location specific barriers that effect WPC clients.

The incentive will be measured by sign-in sheets, agendas and meeting notes that specify barriers addressed and any proposed solutions. The incentive will be considered complete if 20 meetings are held in PY 3. This allowed WPC to work up to five meetings a month in five locations each month.

Total Meetings Attended: 22 (Please see below table)

Collaborative Meetings	Date	Status
Regional Meetings: 2018		
Central: Santa Rosa Community Health Center	7/28/2018	Complete
Central: Goodwill Industries	10/15/2018	Complete
Central: Adult Protective Services/HDAP	10/23/2018	Complete
Central: Santa Rosa Community Health Center Lau	11/13/2018	Complete
Central: Regional Kick Off	12/7/2018	Complete
Central: HEAP Meeting	11/27/2018	Complete
East: Sonoma Valley Health Center	7/3/2018	Complete
East: Goodwill Industries	10/15/2018	Complete
East: Regional Kick Off	12/13/2018	Complete
South: Program Planning with Health Centers	5/2/2018	Complete
South: Program Planning with Health Centers	5/30/2018	Complete
South: Program Planning with Health Centers	6/27/2018	Complete
South: Health Center Contract Review #1	8/30/2018	Complete
South: Health Center Contract Review #2	9/20/2018	Complete
South: Mary Issaak, Sober Circle, PHCD	10/29/2018	Complete
South: Regional Kick Off	12/6/2018	Complete
West: West County Health Center	7/23/2018	Complete
West: West County Community Services	10/22/2018	Complete
West: RARRA (Russian River Area)	10/18/2018	Complete
North: Alliance Medical Center	8/6/2018	Complete
North: Alexander Valley Medical Center	8/24/2018	Complete
North: Regional Kick Off	12/3/2018	Complete

*****Incentive Goal Met*****

VII. NARRATIVE – Pay for Outcome

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.

Due to delays in WPC implementation in our County, we had low enrollment in the Intensive Case Management program in PY3 and only reported on 4 clients in our Baseline report. We are, however, revising our Universal and Variant metric reports (Baseline and PY3 (we did not have any clients enrolled in PY2) to include clients enrolled in the Outreach and Engagement and Intensive Case Management to demonstrate program impacts over time across various outcomes. We will be submitting these revisions in the upcoming months.

VIII. STAKEHOLDER ENGAGEMENT

Stakeholder Engagement - In the text below or as an attachment to this report, 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. 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:

TAP
Summary: Development of cloud-based automated platform to store all WPC screenings to streamline process and be able to pull data in a more efficient way.
Participants: SimplyGov Staff (TAP program developers), County Information System Development Staff, WPC management staff and field work staff
Decisions:

- Form structure
- Auto-population options
- Data infrastructure decisions
- Additional data set options

Meeting Dates: 7/31/18, 8/2/18, 8/7/18, 8/8/18, 8/13/18, 8/23/18, 8/29/18, 9/10/18, 9/11/18, 9/19/18, 10/4/18, 10/22/18, 10/30/18, 11/9/18, 11/15/18, 11/28/18, 12/19/18, 12/21/18

WPC Workflow Meetings
Summary: No changes from mid-year report
Participants: No changes from mid-year report
Decisions:

- Refinement of screenings used during outreach and engagement
- Refinement of comprehensive care plan
- Data infrastructure decisions (choosing software for document storage and care team access)
- Refinement of referral and communication workflow processes
- PDSAs of care coordination, comprehensive care plan, and data infrastructure

Meeting Dates: 7/2/18, 7/25/18, 10/18/28, 10/30/18, 11/2/18, 11/5/18, 11/7/18, 11/20/18, 11/27/18, 12/6/18, 12/13/18, 12/20/18, 12/26/18

Safety Net
Summary: No changes from mid-year report
Participants**:** No changes from mid-year report

Decisions: High-level systems and workflow decisions to support WPC integration across Sonoma County Safety Net agencies.

Meeting Dates: 7/16/18, 7/19/18, 7/25/18, 7/31/18, 8/27/18

Data Infrastructure Workgroup
Summary: Members of the DHS-BH WPC staff began meeting with County IT manager, Privacy and Security Officer and representatives from the County Safety Net departments to discuss and develop the data infrastructure to improve coordination of care teams and sharing of client information.
Participants: WPC staff, WPC Program Managers, County IT manager, Privacy and Security Officer and representatives from the County Safety Net departments (Probation, Adult Services, CPS, Human Services, Probation, CDC)
Decisions: Making decisions around indicators that will be integrated into the care plan from source systems and developing the software to support case manager needs and organization of client information for their comprehensive care plans
Meeting Dates: 10/9/2018, 10/10/2018, 10/11/2018, 10/16/2018, 10/17/2018, 10/18/2018, 10/23/2018, 10/24/2018, 10/25/2018, 10/30/2018, 10/31/2018, 11/1/2018, 11/6/2018, 11/7/2018
11/8/2018, 11/13/2018, 11/14/2018, 11/15/2018, 11/27/2018, 11/28/2018, 11/29/2018, 12/13/2018
12/18/2018

External Meeting Descriptions:

Community
Summary: Description of WPC program, input/suggestions from community partners/members
Participants: DHS-BH WPC Staff, Community partners, community members
Decisions:
- Best way to incorporate WPC into the community

Meeting Dates: 10/18/18, 10/23/18, 11/27/18

Contracts
Summary: Meetings held to determine collaboration between contracted partners.
Participants: SCBH-WPC Staff, Health Centers, RCHC
Decisions:
- Scope of Work
- Staff Roles
- Workflow
- Referral Process
- Ongoing Communication
- Care Coordination
- Invoicing
- Data Collection

Meeting Dates: 5/2/18, 5/30/18, 6/27/18, 7/23/18, 7/28/18, 8/6/18, 8/24/18, 8/30/18, 9/20/18, 11/13/18

Peer Outreach Worker
Summary: Meetings held to determine collaboration between contracted partners that specialize in peer (lived experience in: homelessness, mental health, substance use, chronic medical conditions, high utilizer of services) related services.
Participants: SCBH-WPC Staff, Community Providers in specified regions (Reach for Home,
Decisions:
- Scope of Work
- Staff Roles
- Workflow
- Referral Process
- Ongoing Communication
- Care Coordination
- Invoicing
- Data Collection

Meeting Dates: 10/15/18, 10/29/18

Regional Kickoff
Summary: Meeting to introduce purpose and intent of monthly regional meetings.
Participants: Community partners (health center, law enforcement, homeless provider, social service provider, library,) participating in each of the regions.
Decisions: Initial meeting: introductions, review of WPC program, input from providers of what they would like to get out of the meetings.
Meeting Dates: 12/3/18, 12/6/18, 12/7/18, 12/13/18

Training
Summary: Various trainings for WPC staff to learn new systems (HMIS & WCM), new processes (Universal Consent & Coordinated Entry
Participants: WPC Staff, IBM staff, Public Health staff, Coordinated Entry staff, and Health Center staff
Decisions: Trainings based on staff input.
Meeting Dates: 10/31/18, 11/6/18, 12/7/18, 12/19/18

IX. PROGRAM ACTIVITIES

a.) Briefly describe 1-2 successes you have had with care coordination.

1. We have had many successful connections with WPC staff building relationships with the community and many different services providers, which are improving the delivery and quality of services for clients while also reducing duplication of services. The biggest successes with improved relationship and collaboration are with the following organizations and agencies: Homeless shelters, health clinics, probation, drop in centers, law enforcement, hospitals, and social services providers. By having multiple disciplines wrapping services around the client, the client is better served, services are not duplicated and the process is streamlined to get clients into appropriate care.

2. The most successful relationships that we have engaged in with clients have been with individuals who have moved past pre-contemplation (a common term used for clients who are not yet mentally ready to accept the help they need); those who are ready to do something new and establish self-sufficiency. These individuals have been able to really engage in the ICM program and work with case managers to develop specific goals around their needs and hopes. These individuals are able to successfully sit through an interview for housing, or supportive housing, they are willing to engage in Behavioral Health treatment, they are willing to take medication if needed, and they are willing to work on recovery.

b.) Briefly describe 1-2 challenges you have faced with care coordination, and lessons learned from those challenges.

1. Staff experience many challenges when referral agencies do not provide enough information on the clients being referred. Important elements WPC staff look for include any information about location, where the clients hang out or frequent, friend or family phone numbers, etc. Staff are learning to make better connections with some of the referral sources, so they're able to communicate about particular pieces of information required for the WPC team to be successful when locating or working with the referred client(s). It takes a lot of time to build trust within the homeless community.

2. Another challenge is not having the resources needed to help people, especially when there are gaps in the system. Often, housing (affordable/supportive/permanent) is not available in our community, and the housing that is available often falls within fairly narrow eligibility requirements.

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

1. A multi-agency Universal Consent form was implemented in the early summer during PY3, with over 25 agencies listed for which clients can choose to share their information as part of their care coordination and treatment. This form was adopted by many WPC partners, so clients are consenting to participate in the program and share their information from various touchpoints in the community for the purposes of the WPC program. This consent allows the clients' care team members to have thorough and extensive conversations with the listed agencies to better understand the clients' needs and to support their various treatment and service options moving forward in the ICM program.

2. The WPC team meets with the IMDT on a weekly basis to discuss care coordination amongst the Sonoma County Safety Net agencies. During these meetings, case managers and care team members from the various agencies discuss the active enrolled ICM and O&E enrollees who are seeking services and discuss strategies in this intimate setting to expedite care for the clients. The care team helps locate clients, identify potential referral or service opportunities, upcoming appointments or deadlines, and other opportunities based on the clients' needs. This group has been extremely successful getting clients in supportive housing, on general assistance programs, supporting upcoming court dates, and getting clients' into treatment.

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

1. Although the WPC admin team has made significant enhancements to our data infrastructure, client data is not yet stored in one communal place, making it cumbersome and challenging to share all of the necessary information with partners and care team members. Billing, encounter and enrollment information is in one system, screening and assessment information in another, and the comprehensive care plan in a third location. These systems are not yet coordinated to work with one another, but plans in PY4 are connecting these systems to streamline data sharing and the availability of information.

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

1. The various screening assessments that we use during Outreach and Engagement to validate eligibility and assess immediate needs ended up being a tremendous source of information for our agency. During the screening process, clients' data is collected across over 130 variables to describe client demographics, housing/stability status, physical health, mental health, substance use, medical and psychiatric service utilization, and finances. These intermediate indicators will allow for our County to describe the WPC population in detail, compare O&E clients to ICM clients, identify clients who are eligible for other programs/services, and support policy and decision making.

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

1. Sonoma County went through numerous PDSAs before we identified the right data solutions for our WPC reporting needs, for the DHS-BH staff, and for the sustainability of these services and high level of care coordination after the completion of the pilot. We worked with multiple vendors (FEi and OnBase) before we learned the limitations and barriers of those systems and had to significantly alter our data infrastructure strategy before finding a solution that collected the right information, in the right place, that could be securely shared with partners (TAP, IBM Connect 360, Watson Care Manager). Those systems are expensive and extremely time consuming to develop. In addition, the field workers and end users of the systems MUST be involved in the development and key decision making. We quickly learned that individuals in the planning department or IT department could not come up with all of the solutions; it was essential to bring the WPC staff onto the team, understand their workflow, and gather their feedback so that the systems met the direct service staffs' needs.

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

1. The management and response of incoming referrals is a challenge for our WPC staff. Now that we are fully integrated in the community, we are working on procedures to ensure that we are able to (a) adequately screen and process everyone, (b) have enough staff to distribute referrals to, and (c) staff do not experience burnout

2. Very limited availability of housing units is another significant challenge. There is a deficit in all of the following housing opportunities within our county: affordable housing, supportive housing, skilled nursing, sober housing, wet housing and shelters. Furthermore, there are very limited options or programs to support individuals with unique characteristics, such as older adults, those coming out of prison or jail, and those with challenging behavioral health symptoms.

3. There are very limited case management services available for high risk/high need populations who are not eligible for WPC, but whom would greatly benefit from more supportive and engaged services. WPC has a distinct set of people that we are trying to serve but we need to be able to refer clients who don't exactly fit this criteria to other case management services in the community.

X. PLAN-DO-STUDY-ACT

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 PY3 Annual Report.

1. Ambulatory Care – PY3
    a. Q1, Q2, Q3 & Q4
2. Inpatient utilization – PY3
    a. Q1, Q2, Q3 & Q4
3. Comprehensive Care Plan – PY3
    a. Q1, Q2, Q3 & Q4
4. Care Coordination – PY3
    a. Q1/Q2 & Q3/Q4
5. Data Infrastructure – PY3
    a. Q1, Q3/Q4
6. Other – PY3:
    a. Health Center Contracting – Q2

Summary:

PY3 Q1 & Q2 PDSAs focused extensively on planning and analysis strategies to enhance Sonoma County's Administrative, Delivery and Data Infrastructure in support of the WPC pilot. In PY3 Q3 & Q4, the focus was on implementation and identifying what areas in the aforementioned domains (admin, delivery, and data) needed improvements or changes.