State of California - Health and Human Services Agency

Department of Health Care Services

Whole Person Care

Lead Entity Narrative Report

County of Santa Clara Health System (previously Santa Clara Valley Health and Hospital System) ï County of Santa Clara

Annual Narrative Report, Program Year #4

REVISION 2 ï July 15, 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	X Completed Narrative report X 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	X Customized invoice
3. Variant and Universal Metrics Report **Submit to:** SFTP Portal	X Completed Variant and Universal metrics report ï PY4 data submitted on 4/30/20
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	X Care coordination, case management, and referral policies and procedures, which may include *protocols and workflows.* X 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	X Completed WPC PDSA report X Completed PDSA Summary Report
6. Certification of Lead Entity Deliverables **Submit with associated documents to:** Whole Person Care Mailbox and SFTP Portal	X Certification form

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

Whole Person Care

County of Santa Clara Health System
Annual Narrative Report, Program Year #4
Revision 2 ï July 15, 2020

I. REPORTING INSTRUCTIONS

Pursuant to the Whole Person Care Agreement and the Special Terms and Conditions of Californiaôs Medi-Cal 2020 §1115 Medicaid Demonstration waiver, each WPC Program Lead Entity (ñLead Entityò) 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 programôs successes and challenges and any lessons learned during the reporting period. Structure your responses in alignment with the WPC programôs 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.

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

Successes:

- Ongoing stakeholder meetings, forums, trainings, and peer-to-peer learning opportunities have supported and continued significant improvements in collaboration and coordination across the County of Santa Clara Health System (Health System) enterprise and beyond. Some of the stakeholder groups that have contributed to the transformative processes that include: Transformation 2020 (T2020)/WPC Executive Steering Committee, WPC Stakeholder Group, T2020 Domain Leaders, Care Coordination, Patient Navigation Center, and the Communications Team.
- Development, expansion and refinement of cross-departmental, multidisciplinary teamsôreviewing WPC patient/client cases to improve overall care coordination.
- Partnership with the Cross-Agency Service Team (CAST), spearheaded and Board directed by the County Social Services Agency (SSA) to better integrate existing large-scale initiatives for children and families. WPCôs involvement has helped to raise WPC and the population served by this pilot as one of five major countywide initiatives being worked on jointly with internal (County) and external (community organizations) partners to align agendas, strategies and resources.
- The Behavioral Health Services Departmentôs (BHSD) partnership with SSA, Department of Employment and Benefits Services (DEBS) has continued to be strengthened through joint planning, problem solving and training designed to increase staff and client engagement.
- During PY4, eight community clinics participated in WPC. As part of the community clinic model, multidisciplinary teams formed, held regular clinical and operational huddles and developed comprehensive, integrated care plans that are used by all care team members. These agencies also participated in the Plan- Do-Study-Act (PDSA) process in cross agency quality meetings.

Challenges:

- The County's purchase of two new facilities, St. Louise Regional Hospital (SLRH) and O'Connor Hospital (OCH) and the implementation of the same electronic health record (EHR) across all three hospitals (enterprise-wide) shifted priorities away from other Health System priorities.
- Ongoing and competing priorities within BHSD (*e.g.* new programs, network capacity, timely access, transition to new EHR and billing issues) remained and have made it challenging for the department to fully support and integrate efforts with WPC.
- Despite WPC Health Insurance Portability and Accountability Act (HIPAA) authorizations being in place and related to behavioral health, many internal entities needed further coaching about information sharing to understand that discussing client care was legally covered.
- Shifting medical model teams to include a comprehensive assessment and approach inclusive of SDOH. Limited resources for housing and other key components to address and refer at risk individuals further complicates the process.

Lessons Learned:

- Clarity and direction from leadership early in the process to determine resource and personnel allocations and scope of work.
- Need for multi-pronged communications and stakeholder analysis at all phases of implementation and outcome review.

Increasing coordination and appropriate access to care

Successes:

- WPC administrative and physician leadership implemented case review process with teams across the Health System's Primary and Specialty Care clinics for complex cases.
- Health System's care coordination is a decentralized model, with teams functioning at all the Santa Clara Valley Medical Center (SCVMC) clinics (i.e., includes the 11 Valley Health Centers and Valley Specialty clinics).
- Refinement and expansion of policies and procedures to support enrollment, ongoing care coordination and transitions.
- Building on PY3 trainings, continued to provide education and training on a variety of topics including housing, BHSD resources, mental health interventions, Medication Assisted Treatment (MAT), and other WPC initiatives to both internal teams and community partners.
- Expansion of the MAT provider network and locations of care has increased patient access to these services.
- Hired 19 Community Workers (CWs) and provided education on the role, complex systems and resources. A Staff Developer and Quality Improvement

Coordinator were hired to support ongoing education and training, monitoring best practices and closing gaps in care coordination activities.
- Increased standardization of workflows through best practice review with front line teams and EHR enhancements.

Challenges:
- Standardizing models and workflows in a decentralized model bring challenges when working with variation from clinic to clinic due to location, populations served and workforce.
- Standardizing the processes to access the Health System for both internal and external clinics providing care coordination to WPC clients.
- The high cost of living in this community makes it challenging to recruit and retain qualified staff.
- The CW role was unfamiliar to most of the SCVMC medical based clinics and required work to integrate and build trust to incorporate this new role within the clinical settings.

Lessons Learned:
- Identify and escalate issues to executive leadership as needed.
- Establish and develop strong cross-departmental partnerships and look for opportunities to link and leverage mutual work.
- Engage the right people early on. Ensure engagement of technology, compliance, legal, and billing as part of the workgroups.
- Braided and complex funding in the behavioral health and housing systems increase the complexity of billing compliance with Medi-Cal.
- Proper business development, stakeholder buy-in, recognition, and training are essential to ensure that evolving concerns are addressed timely.
- Engagement of providers and understanding the value of care coordination is critical.
- Provide opportunities for networking, peer-to-peer learning across teams is key in building trust and optimizing care coordination practices.

Reducing inappropriate emergency and inpatient utilization

Successes:
- New Epic/HealthLink (EHR) reports have made it possible for the Health System teams to see any WPC enrolled or eligible patient who is receiving care in the acute or emergency medical or psychiatric settings. This allows care coordinators to meet with at risk patients in real time, where they are at. By doing so, coordinators build a relationship to the patient while in care which helps to improve the coordination of care after they leave that setting.

Staff from the Blackbird House (Peer Respite Program) conducted client (or guest) surveys at the end of their stays. In June 2019, forty-five surveys were completed over the previous six-month period and 65% of respondents indicated that this resource prevented them from being hospitalized.

Challenges:

- Without 24-hour, seven day a week coverage, there are not dedicated staff available to engage WPC populations during the off hours in 24-hour operational programs.
- With a focus on acute needs, transition to lower levels of care and immediate safety concerns, the practice and cultural norms in the acute care setting do not typically address the non-urgent social determinants of health (SDOH) needs assessment and longer-term connection to resources.
- Although SDOH are known to play a significant role in acute and emergency care utilization and readmission, there are limited data on clear markers or interventions that can identify or reduce the risk.

Lessons Learned:

- Collaboration with existing staff in the inpatient and emergency department (ED) settings, finding shared values and goals for the WPC populations can serve to increase accepted referral and engagement standards.

Improving data collection and sharing

Successes:

- Data is exchanged with the Health System to support evaluating the enrollment, outreach, care coordination and patient services being rendered by all areas and supports invoices for external agencies. The data is also used to facilitate PDSAs, quality metrics and State aggregate reporting for the WPC population.
- The reverse enrollment process allows us to augment the enrolled pool of patients by having the providers verify the clinical and social qualifying criteria for the program that cannot be validated from the existing data the Health System has on those patients and facilitates Medi-Cal eligibility as a follow-up post submission of the enrollment request.
- The data process was refined to better align with State reporting requirements. Contractual incentives were put in place to improve timely and accurate submissions and to meet collaboratively established enrollment goals.
- Performance metric evaluation was completed by external partner agencies with lead entity support.

- The PDSA data acquisition and validation process for external partners improved.
  Automated extracts have been developed from the NextGen system (i.e., main vendor EHR system used by most of the community clinics) to prevent duplicative data entry by providers caring for WPC patients. The automated extracts pull the same points to be reported from the core EHR where the data already exists and facilitates review of that data prior to submission. This simplifies the reporting process significantly.
- Process developed, implemented and rolled out in increments to import external care coordinatorsôcontact information into the EHR.

Challenges:
- Access to accurate Medi-Cal eligibility data for reverse enrollments is cumbersome, allows verification of only one person at a time.
- Eligibility and coverage changes while in custody.
- Timeliness and variation in data submissions.
- BHSD EHR implementation delay and a change made in selected vendor.

Lessons Learned:
- Data collection process needs to be streamlined to incorporate timely submission, complete submission and auto-generated, validated reports for contributing sites both internally and externally.
- Vetting of metrics and processes for partner contracts before implementation.
- Standardize and enforce timeliness to improve efficiencies and overall customer service.
- Frequent changes to ease workflow for documentation need to be inclusive of EHR build and analytics team to decrease impact on reporting.
- Strong stakeholder analysis and engagement in the planning process supports robust workflows, reports and new EHR.

Achieving quality and administrative improvement benchmarks

Successes:
- Regular review of enrollments and utilization at SCVMC and clinics has identified incorrect labeling of eligibility and clarity on HealthLink templates which resulted in corrected measures made by data and HealthLink teams.
- Audits performed by Office of System Integration and Transformation (OSIT) staff on community clinic submissions have helped to support improvements made to care coordination programs.

Challenges:

- Small population outcome analysis requires additional analytical support and workflow validation.
- Panel management validation and risk for duplicate work by clinic assigned verses clinic patient seen in. The complexity is increased with the complex network of community-based partners that is not visible across agencies.

Lessons Learned:

- Clear data definitions for reporting, operational improvements and defined for small populations (e.g. clinics) is essential and supports the identification and ability to spread best practices.
- Value of weekly OSIT team huddles for staff to share priority issues, keepteam members informed of important information, help to hold one another accountable and allow for sharing of collective intelligence.
- Clearly identified expectations, standards, early escalation, and feedback to key leadership allows for rapid improvement processes to adapt and flourish.
- Establishing good working relationships with community clinics is essential to smoothly collaborate on contractual metrics, PDSAs and quality improvement activities.

Increasing access to housing and supportive services

Successes:

- Under guidance of the ñHousing First Approach,òall reasonable steps to reduce barriers to housing by collaborating with agencies contracted with the Office of Supportive Housing (OSH) are established. WPC collaborated with multiple county partners to create an innovative proposal to address unmet needs for housing support for those with substance use issues which was funded through the One Time Housing Funds.
- With a housing shortage, the Institute on Aging (IOA) and the Health System collaborated to find available housing in the community. IOA and the Health System worked to identify Residential Care Facilities for the Elderly (RCFE) sites as an alternative option for those who no longer require skilled care and do not have a safe place to live. IOA has successfully arranged the discharge of 67 persons from SNFs thus freeing up 67 beds for other eligible patients and helped to place and transition 21 WPC eligible persons into RCFEs.

  Medical Social Worker (MSW) on the WPC team serves as a resource and liaison for housing resources.

- WPC MSW coordinated training sessions for 34 staff which has helped to expand the capacity of multiple healthcare and community settings to implement the Vulnerability Index ï Service Prioritization Decision Assistance Tool (VI-SPDAT) assessment and enter eligible participants into the Homeless Management Information System (HMIS) for possible housing resources.
- OSH continues to be a strong partner in work across care coordination. In coordination with OSH/BHSD and with support from WPC, a group of 70 WPC eligible patients were identified and have continued to receive care coordination, as part of Permanent Supportive Housing services, from a contract with New Directions - A Program of Peninsula Healthcare Connection (PHC).
- Completed HealthLink build to include at risk for housing loss.

Challenges:

- Santa Clara County is a dynamic and diverse area with a high cost of living. The City of San Jose Homeless Census Survey 2019 data reveals that 42% of the homeless population experience psychiatric/emotional conditions. There is a dearth of temporary and permanent supportive housing especially for those clients with behavioral health and substance use issues.
- The facility identified for expanded medical respite services was found to require significant construction, permitting, and inspection needs for the successful conversion of the existing property.
- Housing and shelter processes and the criteria change to meet community needs. Communication of these changes does not always get relayed to the healthcare workers who are in direct contact with patients in need.

Lessons Learned:

- Increasing the number of people able to complete VI-SPDAT and enter information into the HMIS system is helping with access to limited housing resources, by highest need.
- Frequent communications to ensure familiarity of the coordinated entry process and changes in the system allows providers to better navigate and assist their patients.
- It takes time, ongoing communications and joint strategizing with housing and community partners to identify housing alternatives (for example supportive care provided in RCFEs).

  While risk of housing loss is a template in the EHR, for hospitalized patients, it needs to be captured consistently early in the hospital admission process to prevent homelessness due to illness, recovery and loss of income.

Improving health outcomes for WPC population

Successes:

- Combining information from several Waiver programs to measure health outcomes.
- Developed chart audit process to review compliance, data validation and clinical quality of care coordination services. Successful links were established, and targeted interventions were completed for medical/behavioral health/SDOH issues leading toward patient improvements or stabilization.

Challenges:

- Small population outcome analysis can help identify which health outcomes are correlated with interventions, Waiver, or clinic/care location. This requires significant resources and additional cross departmental Data Use Agreements (DUAs) to ensure that compliance and privacy standards are met.

Lessons Learned:

- Respectfully engage consumers because they will tell you the real story. Consumers can provide valuable insights and solutions.
- Communication of personal stories that include data and outcomes can serve as critical tools to demonstrate program needs and effectiveness.
- Value of using process related PDSAs as a tool to share details and better align interventions and strategies across programs/departments/agencies. This includes process PDSAs to streamline the efforts of teams.
- When behavioral health and SDOH issues were addressed, the patients experienced more stability to attend to their medical conditions. Warm handoffs and side-by-side staff collaboration has increased coordination.
- Patients that are High Utilizers of Multiple Systems (HUMS) often require more follow up than articulated in the WPC project contract. Most of the patients have exceeded the original assessment of care coordination needs. For example, there are more persons who need long term care coordination services for greater than one year. Care coordination appears to be the only intervention set that has helped to keep these HUMS patients engaged in care.

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	**147**	**93**	**114**	**193**	**279**	**218**	**1,044**

Item	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12	Annual Unduplicated Total
Unduplicated Enrollees	204	344	268	185	115	157	2,317

Whole Person Care

County of Santa Clara Health System
Annual Narrative Report, Program Year #4
Revision 1 - May 21, 2020

*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 (Peer Respite)	$0.00	[redacted]	[redacted]	[redacted]	**$0.00**	**$3,416.98**	**$7,261.08**
Utilization 1	0	[redacted]	[redacted]	[redacted]	**0**	**16**	**34**
Service 2 (Medical Respite)	**$31,962.07**	**$18,425.20**	**$13,160.85**	**$13,160.85**	**$13,912.90**	**$9,400.61**	**$100,022.49**
Utilization 2	**85**	**49**	**35**	**35**	**37**	**25**	**266**
Service 3 (Sobering Station)	**$4,183.98**	[redacted]	**$4,676.22**	**$3,445.63**	[redacted]	**$5,906.80**	**$23,134.97**
Utilization 3	**17**	[redacted]	**19**	**14**	[redacted]	**24**	**94**
Service 4 (Patient Outreach)	**$29,500.00**	**$23,000.00**	**$28,300.00**	**$29,000.00**	**$29,100.00**	**$22,600.00**	**$161,500.00**
Utilization 4	**295**	**230**	**283**	**290**	**291**	**226**	**1,615**

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 (Peer Respite)	[redacted]	$5,979.68	[redacted]	$8,328.84	$6,193.24	$13,454.28	$45,701.84
Utilization 1	[redacted]	28	[redacted]	39	29	63	214
Service 2 (Medical Respite)	$15,793.02	$12,784.83	$37,602.44	$31,586.05	$8,648.56	$11,656.76	$218,094.15
Utilization 2	42	34	100	84	23	31	580
Service 3 (Sobering Station)	$4,183.98	$4,183.98	$3,445.63	$5,660.68	$6,891.27	$4,183.98	$51,684.51
Utilization 3	17	17	14	23	28	17	210
Service 4 (Patient Outreach)	$25,500.00	$27,500.00	$18,900.00	$14,400.00	$13,300.00	$14,300.00	$275,400.00
Utilization 4	255	275	189	144	133	143	2,754

Whole Person Care

County of Santa Clara Health System
Annual Narrative Report, Program Year #4
Revision 1 - May 21, 2020

*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 ñBundle #òbelow, 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 (Rehabilitation & Peer Support)	$137.19	**$76,004.00**	**$81,491.66**	**$88,351.22**	**$94,799.22**	**$113,868.81**	**$104,951.38**	**$559,466.29**
MM Counts 1		**554**	**594**	**644**	**691**	**830**	**765**	**4,078**
Bundle #2 (Short Term)	$1,282.71	**$243,714.36**	**$265,520.38**	**$334,786.57**	**$356,592.59**	**$466,905.41**	**$437,403.14**	**$2,104,922.45**
MM Counts 2		**190**	**207**	**261**	**278**	**364**	**341**	**1,641**
Bundle #3 (Medium Term)	$1,363.54	**$460,876.52**	**$511,327.50**	**$569,959.72**	**$634,046.10**	**$805,852.14**	**$857,666.66**	**$3,839,728.64**
MM Counts 3		**338**	**375**	**418**	**465**	**591**	**629**	**2,816**
Bundle #4 (Long Term)	$882.88	**$740,737.83**	**$743,386.47**	**$867,872.81**	**$774,287.33**	**$795,476.50**	**$836,089.06**	**$4,757,850.00**
MM Counts 4		**839**	**842**	**983**	**877**	**901**	**947**	**5,389**
Bundle #5 (Nursing Home Transitions)	$2,076.70	**$286,584.55**	**$309,428.24**	**$301,121.44**	**$296,968.04**	**$263,740.85**	**$280,354.45**	**$1,738,197.57**
MM Counts 5		**138**	**149**	**145**	**143**	**127**	**135**	**837**

Amount Claimed								
PMPM	Rate	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12	Total
Bundle #1 (Rehabilitation & Peer Support)	$137.19	$124,295.36	$165,315.57	$155,163.41	$148,578.22	$133,898.75	$136,368.19	$1,423,085.78
MM Counts 1		906	1,205	1,131	1,083	976	994	10,373
Bundle #2 (Short Term)	$1,282.71	$447,664.80	$569,521.98	$610,568.61	$632,374.63	$615,699.44	$608,003.19	$5,588,755.10
MM Counts 2		349	444	476	493	480	474	4,357
Bundle #3 (Medium Term)	$1,363.54	$983,112.34	$1,179,462.10	$1,310,361.94	$1,269,455.74	$1,262,638.04	$1,298,090.08	$11,142,848.88
MM Counts 3		721	865	961	931	926	952	8,172
Bundle #4 (Long Term)	$882.88	$774,287.33	$870,521.45	$878,467.39	$898,773.67	$881,998.91	$919,962.83	$9,981,861.58
MM Counts 4		877	986	995	1,018	999	1,042	11,306
Bundle #5 (Nursing Home Transitions)	$2,076.70	$290,737.94	$315,658.34	$323,965.14	$361,345.73	$367,575.83	$375,882.63	$3,773,363.18
MM Counts 5		140	152	156	174	177	181	1,817

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

Fee for Service:

FFS 1 ï Peer Respite Program

- Based on identified need, the Board of Supervisors approved an expanded length of stay from a maximum of one week (7 days) to a maximum of two weeks (14 days) beginning in October 2019.
- Within the first year of operations (and as of December 31, 2019), Blackbird House served 98 participants who were WPC eligible.

FFS 3 ï Sobering Center

- ¶ Since opening of Mission Street Sobering Center (MSSC) in the fall 2017, of the 768 clients served, 253 were WPC eligible. For PY4, 424 clients had an eligibility check completed and of these participants, 175 were identified as WPC eligible. The population currently served by this program has had a lower than expected volume of WPC eligible participants, though most persons who were not eligible had Medi-Cal, but without the allowable Aid codes. Some were also not eligible because they were not Santa Clara County residents.
- ¶ Increased follow up on all persons utilizing this service and connecting the participants to additional resources/services.
- ¶ Utilized tool of reverse enrollment.
- ¶ VI-SPDAT training for staff and administered to participants. Referrals made to substance use disorder (SUD) treatment.

FFS 4 ï Outreach and Engagement

- ¶ This was a new initiative to capture the outreach that occurred before persons were enrolled/engaged in WPC. It has been a useful way to identify the efforts required to engage those served.

Enrollment and PMPM:

In PY4, the program reached 92.68% of the targeted enrollment goal for the year.

SCVMC Clinics and Public Health Department

- ¶ About two-thirds of the enrollments occurred in the SCVMC clinics. The number of care coordinators expanded this program year at all sites. Education in additional algorithms and resources has increased the skill level of the staff in the clinics. While the type of staff that make up the care coordination teams differ by location, there has been greater staff involvement at each site. Staff were involved in suggesting EHR care and reporting changes. The addition of a pharmacist at the Valley Homeless Healthcare Program (VHHP) has increased the ability to see patients that require medication review and adjustments thus freeing up the physician time to focus on other patient needs.

Community Clinics

- About one-third of the enrollments occur in the eight community clinics, not associated with SCVMC, though patients seen at many of these clinics receive Emergency Department (ED), Inpatient and Specialty Clinic care at SCVMC. Care coordination is a difficult shift to make in small clinics especially used to episodic care. In attempts to improve enrollment in care coordination, an incentive for enrollment was added to the contracts. The number of new enrollments was agreed upon between the clinics and OSIT, based on learnings from the first year.

Behavioral Health Services Department

- While most patients followed by the BHSD are covered under separate financing, newly referred patients from SCVMC clinics and emergency care areas, are covered until following up with a BHSD provider. Staff doing rounds in ED and the inpatient setting have assisted in improving referrals for follow-up care.

IV. NARRATIVE ï 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.

Leadership: During PY4, Michelle de la Calle, Director, Office of System Integration and Transformation (OSIT) led efforts to expand and refine WPC integration across the enterprise while concurrently and strategically working with the team on the next iteration of WPC that has been branded as Transformation 2025 (T2025), working closely and collaboratively to share learnings and plan for California Advancing and Innovating Medi-Cal (CalAIM) with the Medi-Cal managed care plans and community partners.

Staffing: Since the PY4 Mid-Year Report, other positions authorized by the Board of Supervisors and filled include: Quality Improvement (QI) Coordinator, Staff Developer, and ten additional Community Workers (for a total of 19 of 20 approved positions). The community workers (CWs) are assigned to the 11 outpatient clinics to work with identified Care Coordinators and staff. Two of the CWs are located within the OSIT and are supporting coordination and follow-up with participants of the sobering center and custody health. All CWs have completed an educational training program developed by a cadre of leaders with the current standardization of work being completed by the newly hired Staff Developer. Education has included utilization and completion of the VI-SPDAT to determine eligibility of at risk of homelessness and homeless persons for housing programs under the OSH as well as the use and capture of data related to SDOH into Epic/HealthLink. The QI Coordinator is working on data and operational quality control issues to support system level changes.

Goals Met: During PY4, the following enterprise-wide goals were achieved:

- Increased number and capacity of care coordinators.
- Increased number of WPC enrollments.
- Enterprise expansion of EHR and data sharing capacity to support the care coordination of WPC patients being served in different geographic areas across the county.
- Piloted a prediabetes/diabetes preventive health initiative that provided valuable data on the incidence of prediabetes within two SCVMC clinics and supported need to standardize workflows and take pilot to scale.
- Operationalized an Ambulatory Intensivist Model (AIM) with the SCVMC specialty care center to provide face-to-face clinic visits with the most challenging, high need patients to better meet their higher level of care and coordination needs.

- Successfully rolled out an expanded patient navigation model (with CWs) within the Health System designed to increase patient/client enrollments, engagement and support care coordination teams.
- Expanded overall communications to share outcomes and lessons learned.

Wellness: These funds were scheduled to be spent on a Valley Health Plan (VHP) program but due to limited success, the funds were redeployed to help with educational pilots and community linkages to support the prediabetes/diabetes populations.
Prediabetes screenings were set up at two pilot Valley Health Centers beginning in November 2018. This pilot was part of the T2020 Community and Preventive Health Domain initiative, under the ñAll Things Diabetesò Governance Group and included the collaborative efforts of a multidisciplinary, multi-agency stakeholder group. Over the one-year pilot, 6,333 patients were screened for prediabetes. Nearly 85% of those screened had a Hemoglobin A1c lab test and of those patients, approximately 23% screened positive for prediabetes and 4% for diabetes. This equates to nearly one in four patients. For those who screened positive, several culturally and linguistically competent educational options were provided to patients. By the end of July 2019, 118 patients completed the newly established onsite nutrition classes and based on a small scale phone survey (i.e., 16 English speaking patients), 62 percent of these patients reported making behavioral changes to their diets as a result of the information and strategies learned. Planning efforts are underway to collaborate with and expand wellness resources through the Public Health Department in PY5 to support innovative community focused wellness initiatives to meet the needs of the WPC populations.

Evaluation: Annette Gardner, Assistant Professor at the Institute for Health Policy Studies at UCSF, has been working with the T2020 team to develop a robust evaluation process for the WPC project and its relationships within the Health System. Evaluation methods completed in PY4 included: 1) annual Domain survey; 2) T2020 stakeholder survey; 3) case studies (in process); and 4) secondary data analysis of WPC, GPP and PRIME data.

Based on the results of the T2020 Evaluation Report Findings: March 2018 ï October 2019 there were full or partial achievement of the following T2020 short-term outcomes:

- Increased system integration among agencies and with community partners
- Increased care coordination
- Improved communications between providers, community partners and/or clients
- Increased understanding, attitudes and behaviors of staff to support a patient- centered, interagency, interdisciplinary approach to providing care
- Improved patient experience of care
- Improved provider experience of care

IV. NARRATIVE ï 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.

Table 1: Delivery Infrastructure Categories, Description of Progress Achieved and Requested Payment by Category

Categories	Description
WPC Trust Community	1) For external clinics - streamlined data, billing and invoice processes were completed. Invoice templates are now automated and are generated from data files from the WPC office. The process outlined below has resulted in more timely payment of funds for the services provided as well as automatic identification of eligibility for incentive payments. The process used: a. Clinics submit their data to the Health System by the tenth of the month for previous monthôs services. b. Data is aggregated and validated by WPC data and administrative teams and returned to clinics monthly. c. Verified accurate data files are turned over to contractual team who generate invoice templates by the seventeenth of the month. d. Each clinic reviews the prepared invoice and upon approval submits it. e. Incentive dollars are provided to clinics with their submission of accurate and timely data. f. When data discrepancies are identified, the community clinics are notified on what needs correction. Items identified as needing additional information are corrected for in the next monthôs data submission and billing cycle.

	2) Nextgen integration project was developed and is being piloted by several community clinics. 3) Ongoing engagement of the community partners for continuous quality improvements. 4) Standardized updates developed for the community clinics that reported out on the following: a. Review of data entry procedures for invoice data and PDSA data with data maps provided to the clinics to outline where the data needs to be entered in the system for compliance. b. WPC contract deliverables and actuals reviewed with each clinic to ensure progress is made against their specific contractual goals. c. WPC monthly report produced and reviewed which includes enrollment, assessments and care coordination. d. WPC clinic meetings are focused on continuous improvements tied to data quality and data exchange. e. Use of WPC incentives. f. Outcomes/Quality metrics ï trended data for ED and inpatient utilization reviewed for community clinics overall, individual clinics and individual patient lists provided for follow-up. The budget amount claimed in the PY4 Annual invoice for this category is $1,662,412.50. This incentive is paid to the County of Santa Clara because services are contracted by numerous third-party agencies that provide these services on behalf of the County.
Medical Respite Start-Up	For vulnerable persons discharged from the hospital, the Medical Respite Program (MRP) exceeded its capacity in the current location at HomeFirst. Resources supported the identification, planning and preparations required for the new site (e.g., Della Maggiore Center) located on the SCVMC campus. This new site will have an increased bed capacity and access to additional services (e.g., food, laundry and security) that are available on the hospital campus. Delays in permitting and construction have prevented its opening and hence the move from its current site. A new architect and project manager were hired to help expedite the stalled process. The architectural plan was updated, and accompanying budget was almost three times the initial estimate and thus alternatives, to trim costs, are being explored. With leadership support, the new Medical Respite location is anticipated to be completed by the end of 2020. No funds will be claimed in the PY4 Annual invoice for this delivery

	infrastructure category. The approved budget of $541,590 is being rolled over to PY5.
Systems Modifications ï *Navigation Center*	The Navigation Center is a ñback officeò function critical to the WPC project. Its goal is the integration of multiple sources of information into one *virtual* location, usable by all those answering questions for those seeking access or by staff seeking resources for referral for their patients. To achieve this goal, the group completed assessments of the requirements for 21 call centers within the Health System and determined that both software and hardware upgrades were needed to have a system which seamlessly accessed information or supported transfer via a warm handoff to the services needed (i.e., joining Behavioral Health call center with primary care sites). In PY4, the following activities have been advanced or completed. ¶ Integrate Customer Relationship Management (CRM) into existing data sources ¶ Application functional requirement definitions ï analysis of NovelVox system ¶ Application functional requirement definition ï completed role-based data access analysis for NovelVox ¶ Software and Hardware acquisitions ï NovelVox, Calabrio, Trados, Servers for CISCO & Calabrio, HealthLink CRM, ¶ Identified departments that needed telecom upgrades Finalized the Request for Proposal (RFP) for the Resource Directory. Unable to release it because currently all new RFPs associated with the Technology Services & Solutions (TSS), the Countyôs IT department, are on hold ï since that department had been severely impacted by the acquisition of the two hospitals. However, work is underway with TSS to develop an internal resource directory using the newly acquired CISCO software, Finesse/NovelVox. In the process of piloting the resource directory with one call center, one outpatient ambulatory clinic and a volunteer services program at SCVMC. Have successfully completed many hardware and software acquisitions related to call management and call surveillance. Upgrade schedule and implementation plan are in process. The budget amount claimed in the PY4 Annual invoice for this delivery infrastructure category is $566,288.37. This is paid to the County of Santa Clara that supports the work of several agencies within the system.

Improve Access to Program Information for Care Delivery ï *Navigation Center* ï Change Management Plan & Implementation	Convened a series of stakeholder meetings with executive leadership to collaboratively guide the development of a master plan for change management required and identified key champions to support the implementation processes. The master plan includes two projects for the patient navigation center that will support improved access to program information for WPC eligible patients/clients. One project is the physical relocation of several existing call centers onto one site which is anticipated to improve the integration of services as well as to improve communications to better meet the needs of consumers and staff. Additionally, the call management information technology (IT) infrastructure for Valley Connection, the appointment line for the SCVMCôs primary care clinics, is under expansion. This will include the rollout of three different types of call resource management (CRM) desktop agent software applications that will be used by each call center agent and managers. Preliminary work was completed during PY4 which resulted in the identification of the resources needed to support the change management strategies in PY5 and identified a potential consultant(s) that will be used to facilitate these processes. The budget amount claimed in the PY4 Annual invoice for this delivery infrastructure category is $100,000. This is paid to the County of Santa Clara that supports the work of several agencies within the system.
Improve Access to Program Information for Care Delivery ï *Navigation Center* ï Operational Standards	Implemented call surveillance process at key access points. No funds will be claimed in the PY4 Annual invoice for this delivery infrastructure category.
Improve Access to Program Information for Care Delivery ï *Navigation Center* ï Outreach and Engagement	An additional five WPC enrollee orientation and tour sessions were completed in the second half of PY4. The budget amount claimed in the PY4 Annual invoice for this delivery infrastructure category is $125,000. This is paid to the County of Santa Clara that supports the work of several departments within the system.

Improve Access to Program Information for Care Delivery ï *Navigation Center ï* Process Improvement & Quality Assurance	Additional client feedback received as part of the ongoing WPC Consumer Advisory Committee has been reviewed and addressed as part of continued quality improvement process. No funds will be claimed in the PY4 Annual invoice for this delivery infrastructure category.

NARRATIVE ï 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.

Table 2: Incentive Payment Categories, Description of Progress Achieved and Requested Payment by Category

Categories	Description
Provider Incentive ï Integrated Medical / Psychiatric Skilled Nursing Facilities (SNF) and Enrollment of Viable Candidates	Collaborative efforts intensified between the SCVMC inpatient team and WPC staff to identify patients to test the process and determine viability of this incentive to increase receptivity and willingness of SNF to accept long-stay patients for whom placement is more difficult. The interest in this provider incentive payment remains high for the SNF partners and is conceptually supported by the Health System but it has been challenging to implement. Significant efforts were put into the establishment/refinement of workflow processes and legal agreements as well as participation in Health System workgroups which focus on long-term placements and the ongoing promotion of this resource internally (within the Health System) and with SNF partners. The WPC eligibility criteria and the agreement process remain challenging but there have been several successes to date. There is commitment internally to identify and implement strategies to make this incentive a viable resource for WPC eligible patients. This process was initiated and tested with four patients during PY4. The amount claimed in the PY4 Annual invoice is $733.00. This incentive is paid to county partners that have contracted with several third-party agencies to provide these services.

Categories	Description
Social Services Referral Integration	Two Social Workers (SW) from BHSD are co-located at the County's Social Services Agency, Department of Employment and Benefit Services (DEBS) office in San Jose beginning in mid-December 2018 (PY3).

Outcome 1: Percent of handoffs to BH for assessments

A total of 8,650 new General Assistance (GA) intakes were completed by eligibility workers (EW) at SSA in PY4. Clients identified with possible behavioral health (BH) concerns were referred to onsite BHSD SWs. As part of this appointment, SWs completed a BH assessment with clients, determined WPC eligibility and enrolled interested clients. The primary reasons for ineligibility were because ñsubscriber not foundò or ñno recorded eligibility for requested date of serviceò. From the 8,650 clients seen by SSA, 7,319 clients (or 84.6%) were identified as WPC eligible. From the GA clients seen by SSA, 182 were identified with possible BH concerns and referred by EW to onsite BHSD SWs for BH assessment and possible BH referrals. From the group referred, 154 clients were WPC eligible and enrolled. From the group of GA clients seen at SSA during 2019, 2% were assessed by the onsite BH SWs.

Outcome 2: Time (in days) from formal handoff to BH assessment

Typically, clients are seen the same day. From the 154 clients referred, 1[redacted] clients were seen for a BH assessment the same day as SSA made the referrals and [redacted] individuals were seen the following day (at clientsô requests). The average time between handoff and assessment was 1.04 days.

Outcome 3: Percent of BH assessments completed

From the 154 WPC eligible clients referred, all eligible clients (100%) had BH assessments completed.

Outcome 4: Percent of new Medi-Cal GA WPC clients with BH treatment plan

From the 154 WPC eligible (enrolled) GA clients assessed, 121 were referred to mental health services (78.5%). From this group of 121 clients, 39 individuals (32%) were referred to MH services, most to Specialty Mental Health (SMH) services and several to primary care providers (PCP) at health center locations where BH services are co-located.

The budget amount claimed in the PY4 Annual invoice this incentive is $375,000. This is paid to the county partners that

<table>
<tr><td></td><td>support the work of several agencies within the system.</td></tr>
<tr><td>Provider Incentive ï Drug and Alcohol Screening</td><td>Logic was revised by the operational and data teams on how the data is pulled from the EHR for this incentive. Discovered that data was being missed as entries are located in different sections of the EHR. Worked to capture data by eligible providers, types of medications and through additional reports. Conducted PDSA to validate changes to logic used.

<table>
<tr><th>Comparison</th><th>Outcome 1</th><th>Outcome 2</th><th>Outcome 3</th><th>Outcome 4</th></tr>
<tr><td>Change from PY3 to PY4</td><td>10.99%</td><td>-0.76%</td><td>20.14%</td><td>41.03%</td></tr>
</table>

<table>
<tr><th>PY4 (2019)</th><th>Outcome 1 *</th><th>Outcome 2 *</th><th>Outcome 3 *</th><th>Outcome 4 *</th></tr>
<tr><td>Numerator</td><td>1460</td><td>505</td><td>221</td><td>149</td></tr>
<tr><td>Denominator</td><td>4624</td><td>1460</td><td>505</td><td>193</td></tr>
<tr><td>Percentage</td><td>31.57%</td><td>34.59%</td><td>43.76%</td><td>77.20%</td></tr>
</table>

*This data was pulled from Epic/HealthLink, ED MAT and BH EHR/Unicare.

<table>
<tr><th>PY3 (2018)</th><th>Outcome 1**</th><th>Outcome 2**</th><th>Outcome 3**</th><th>Outcome 4**</th></tr>
<tr><td>Numerator</td><td>563</td><td>199</td><td>47</td><td>17</td></tr>
<tr><td>Denominator</td><td>2735</td><td>563</td><td>199</td><td>47</td></tr>
<tr><td>Percentage</td><td>20.59%</td><td>35.35%</td><td>23.62%</td><td>36.17%</td></tr>
</table>

** Data pulled from Epic/HealthLink.

The budget amount claimed in the PY4 Annual invoice this incentive is $1,081,761. This is paid to the county partners that support the work of several agencies within the system.</td></tr>
<tr><td>Provider Incentive ï Trust</td><td>Two Data Access Requests (DAR) were completed during PY4 with the managed care health plans (e.g., Santa Clara Family Health Plan and Anthem Blue Cross) to receive supplemental files from the Health System to support 2019 HEDIS performance measurements.</td></tr>
</table>

Community Adoption	The budget amount claimed in the PY4 Annual invoice this incentive is $120,000. This is paid to the county partners that support the work of several agencies/departments within the system.
Peer Navigation	Nineteen Community Workers (CWs) were hired and joined the Health Systemôs care coordination teams in PY4 at the Santa Clara Valley Health Centers (VHCs), Specialty Care, SCVMC inpatient and ED and provided support to the Sobering Center and Custody Health teams. As part of the integrated care coordination teams, the CWs initiate and complete WPC enrollments, assist WPC patients/clients navigate and access services, assist patients in achieving identified goals under supervision of professional staff and document activities in the EHR (HealthLink). Monthly meetings were held with the clinics to work on strategies to best integrate CWs within the clinic workflows, identify gaps and develop solutions to create stronger multidisciplinary teams. Content specific trainings and CW mentoring meetings took place monthly (or more frequently) to support CWs in building their knowledge of internal and community resources, Health System processes and the skills required to work with the challenging, high need WPC patients/clients. The budget amount claimed in the PY4 Annual invoice for three of the six incentives is $330,000. Incentive is paid to the county partners that support the work of several departments/agencies within the system.
Navigation Center	Developed and released an RFP for the Navigation Center Consultant. While the RFP was released, no proposals were submitted for these services. Therefore, many of the tasks identified in the scope of work were successfully implemented in-house. Created current and ideal state workflow document for several of the existing agencies within the Health System. The budget amount claimed in the PY4 Annual invoice is for $50,000. The incentive is paid to the county partners that support the work of several agencies within the system.
Public Health Department (PHD) Population	Most IT initiatives were put on hold because of the hospital acquisitions and the role out of EHR system. Work has resumed on the PHD Population Health Vault and its use with the diabetes efforts.

Health Data Vault	No funds will be claimed in the PY4 Annual invoice since the budget tied to this deliverable was fully claimed with the Mid-Year invoice.
Sobering Center [Mission Street Sobering Center (MSSC)]	Staff were trained in PY3 to complete the housing eligibility screenings (or VI-SPDATs) and enter information into the Homeless Management Information System (HMIS) database. Sixteen VI-SPDATs were completed during PY4, 12 during the second first half of PY4. MSSC staff also completed training in PY3 on how to assist clients to complete Medi-Cal applications, and during FY4 staff supported the completion of 25 Medi-Cal applications for clients initially served by the MSSC. Sixteen of these applications were completed during the second half of PY4. The amount claimed in the PY4 Annual invoice is $20,000. This incentive is paid to the county partner that has contracted with a third party to provide these services on the Countyôs behalf.
Barrier Identification & Resolution ï Ambulatory Intensivist Program	A plan was developed to identify the highest need patients within the Health System to be supported by an Ambulatory Intensivist (AI) program that would provide longitudinal care plans, offer services and coordinate care as well as to assess the outcomes of using this AI model of care. Implementation of an AI team at Valley Specialty Care in collaboration with WPC was successfully initiated in June 2019, recruitment and training of team occurred between July to October and initiation of face-to-face clinic visits with clients has taken twice a week since November 2019. Given that thirty percent of the cardiology clinic patients were identified as having cardiovascular complications from methamphetamine use, the WPC physician identified a need for an intensivist program for persons not yet eligible to return to, or not utilizing primary care. Working with a team, the AI program has successfully enrolled and followed 20 patients to date. With a new contract, this service will also include the addition of acupuncture services in early PY5. Acupuncture has been documented to help individuals in decreasing their methamphetamine cravings. In addition, predictive modeling for PCP panels is being designed to identify populations that create burden to the current PCP panels with high acuity patients. This is being vetted by the Health Systemôs Center of Population Health Improvement (CPHI) and the Epic/HealthLink teams. Group consulted with UCSF leaders on a phenotype model and continue to look internally at current capacity to develop a model.

	Work continues with the AI program. No funds will be claimed in the PY4 Annual invoices since budget tied to this deliverable was fully claimed with the Mid-Year invoice.
Barrier Identification & Resolution ï Imbed PCP at BHSD Clinic	No additional progress made. No funds will be claimed in the PY4 Annual invoice for this incentive. Funds tied to this incentive were claimed in full as part of the PY4 Mid-Year invoice.
Enterprise Health Record Expansion	The County purchased two hospitals, a sub-acute rehabilitation center and one health center which nearly doubled the capacity of the Health System. On March 1, 20119, The County of Santa Clara officially assumed ownership of the 358-bed O0Connor Hospital (OCH) which includes a sub-acute rehabilitation center located in San Jose, 93-bed St. Louise Regional Hospital (SLRH) in Gilroy and De Paul Health Center in Morgan Hill. With the ownership, the County has worked to integrate the overall healthcare operations at an enterprise level. County investments were made to upgrade the equipment, facilities and systems at the newly acquired facilities. The EHR (HealthLink) went live at OCH and SLRH on August 17, 2019. From a technology standpoint, the expansion of HealthLink enterprise-wide has allowed for the aggregation of additional patients because of the shared database instance. The business implications are significant too because of the ability to access detailed utilization for the two additional hospitals which cover a significant number of patients across their inpatient service lines providing access (when authorized) to the demographics, inpatient utilization data for HUMS scoring and thus potentially expanding the HUMS population that can be managed. Operationally, this implementation opens the use of the same Point-of-Care (PoC) tools at OCH and SLRH for enrollment of WPC eligible patients, patient care workflows for assessments, care planning, intervention documentation and disenrollment upon graduation. The budget amount claimed in the PY4 Annual invoice for this incentive category is $1,000,000. This is paid to the county partners that support the work completed by several organizations within the system.

Enterprise Outreach, Engagement and Enrollment	After the expansion of EHR implementation in August 2019, WPC outreach, enrollment, enhanced care management and care coordination was initiated with OCH and SLRH. In late 2019, four meetings were convened with OCH leadership and one in-service training was provided with frontline case managers and social workers from OCH about WPC, how to enroll WPC eligible patients, discussion on workflows, care coordinatorsô assignments and the required documentation processes. The budget amount claimed in the PY4 Annual invoice for this incentive is $100,000. This is paid to the county partners that support the work completed by several organizations within the system.

V. NARRATIVE ï 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 programôs 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.

Table with the universal and variant metric results by program year is found on the following page. The OSIT program has monitored three indicators most closely to determine the evidence of the success of the program. These are also reflected in the PDSAs withthe external clinics. The three indicators are: ED utilization (AMB), Inpatient Length of Stay (IPU) and All Cause Readmission (ACR). As can be noted on the attached table, each of these three indicators have shown improvements during the project. These results have been shared with staff in all settings. Working with patients to seek a lower level of care sooner than needing the ED (i.e., Urgent Care calling the care coordinator) continues to be a high priority for care management staff to articulate. To address care, coordinators do frequent follow-up with patients, especially in the beginning of the relationship. As noted elsewhere, there may be up to three contacts a month for the first months; then as the plan agreed upon by the patient and coordinator continues, interventions can drop to one or two a month.

We have consistently failed to meet the indicators for depression and alcohol/substance use screening. We believe this is because of the delinked EHR between BHSD/SUD services and the OSIT data collection process. Many caregivers in BHSD/SUD services are contracted and may be using paper records or a third type of EHR (Epic/HealthLink is one, BHSD Unicare is the second). While we believe compliance is higher than noted, we are unable to prove this fact.

There has been improvement in both the numerators and denominators of the depression screening and follow-up as well as the Major Depressive Disorder (MDD). This reflects implementation of primary care behavioral health in clinics, warm handoffs to behavioral health and increased attention by providers as a result of the implementation of the Staying Healthy Assessment (SHA).

WPC has supported a contract for supportive housing services for 70 patients. The contractor has filled the supportive housing slots this program year. However, as the VI-SPDAT has been rolled out to more sites, more needs have been identified, thus decreasing the percentage served. Increasing capacity is being discussed in PY5 but

discussions are currently off track due to the priority of COVID-19 response.

Care Plans are required within the period after enrollment. The retrieval of the care plans has been related to the various methods of documentation in the EHR. The newly hired Quality Improvement Coordinator has systematically reviewed all the templates in the EHR, including the care plans. He has sought specific feedback from each discipline involved and has designed a more comprehensive single method of documentation to be implemented in PY5.

Whole Person Care

County of Santa Clara Health System
Annual Narrative Report, Program Year #4
Revision 1 - May 21, 2020

Universal and Variant Metrics

Table 3: Universal and Variant Metrics Comparison by Program Year

			Updated Baseline			**PY2 Annual**			**PY3 Annual**			**PY4 Mid-Year**			**PY4 Annual**		
			Enrollments from Jan 2017- Jun 2018 (all their 2016 data)			Same as before.			For patients in enrolled status in PY3								
Metric Group	Metrics	Desired Trend	Numerator	Denominator	Rate	Numerator	Denominator	Rate	Numerator	Denominator	Rate	Numerator	Denominator	Rate	Numerator	Denominator	Rate
AMB	*AMB*	Ź	11,413	39,990	285	9,640	33,180	290	8,719	38,212	279	984	20,532	48	4,929	57,444	85.805
IPU	*IPU*	Ź	1,996	39,990	0.050	1,784	33,180	0.054	1,542	31,212	0.049	563	20,532	0.027	1,894	57,444	0.033
FUH	*FUH7*	ŷ	[redacted]	[redacted]	67.44 %	[redacted]	[redacted]	73.61 %	[redacted]	[redacted]	70.31 %	[redacted]	[redacted]	62.50 %	[redacted]	[redacted]	52.21 %
FUH	*FUH30*	ŷ	[redacted]	[redacted]	74.06 %	[redacted]	[redacted]	83.80 %	[redacted]	[redacted]	81.53 %	[redacted]	[redacted]	81.25 %	[redacted]	[redacted]	68.38 %
IET	*IET - Initiation*	ŷ	[redacted]	[redacted]	81.34 %	[redacted]	[redacted]	87.17 %	[redacted]	[redacted]	84.74 %	[redacted]	[redacted]	86.69 %	[redacted]	[redacted]	34.89 %
IET	*IET - Engagement*	ŷ	[redacted]	[redacted]	12.09 %	[redacted]	[redacted]	15.74 %	[redacted]	[redacted]	12.13 %	[redacted]	[redacted]	14.96 %	[redacted]	[redacted]	10.14 %
ACR	*ACR*	Ź	[redacted]	[redacted]	21.23 %	[redacted]	[redacted]	23.09 %	[redacted]	[redacted]	24.36 %	[redacted]	[redacted]	23.00 %	[redacted]	[redacted]	22.95 %

Whole Person Care

County of Santa Clara Health System
Annual Narrative Report, Program Year #4
Revision 1 - May 21, 2020

			Updated Baseline			PY2 Annual			PY3 Annual			PY4 Mid-Year			PY4 Annual		
			Enrollments from Jan 2017- Jun 2018 (all their 2016 data)			Same as before.			For patients in enrolled status in PY3								
Metric Group	Metrics	Desired Trend	Numerator	Denominator	Rate	Numerator	Denominator	Rate	Numerator	Denominator	Rate	Numerator	Denominator	Rate	Numerator	Denominator	Rate
PHQ 9	*PHQ9*	ŷ	[redacted]	[redacted]	7.32 %	[redacted]	[redacted]	6.59 %	[redacted]	[redacted]	0.97%	[redacted]	[redacted]	0.00 %	[redacted]	[redacted]	1.59%
MDD	*MDD*	ŷ	[redacted]	[redacted]	1.63 %	[redacted]	[redacted]	0.93 %	[redacted]	[redacted]	0.30%	[redacted]	[redacted]	0.00 %	[redacted]	[redacted]	14.50 %
OSH	*Supportive Housing*	ŷ	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	63.64 %	[redacted]	[redacted]	69.00 %	[redacted]	[redacted]	72.22 %	[redacted]	[redacted]	46.15 %
E&A	*Enrollment & Assessment*	ŷ							[redacted]	[redacted]	99.54 %	[redacted]	[redacted]	99.97	[redacted]	[redacted]	83.39 %
CCP 1	*CCP1*	ŷ	[redacted]	[redacted]	82.63 %	[redacted]	[redacted]	1.31 %	[redacted]	[redacted]	62.51 %	[redacted]	[redacted]	99.00 %	1,[redacted]	[redacted]	57.82 %
CCP 2	*CCP2*	ŷ	[redacted]	[redacted]	86.96 %	[redacted]	[redacted]	4.63 %	[redacted]	[redacted]	66.03 %	[redacted]	[redacted]	99.00 %	[redacted]	[redacted]	34.95 %

Note: Green: Going in the right direction. Red: Not going in the right direction.

Beneficiary Enrollment & Assessment ï PY4

Every patient enrolled in WPC has an assessment completed electronically which is supplemented by the care coordinator after enrollment. A total of 2,317 new participants of the proposed 2,500 were successfully enrolled (93%). Of the new participants, approximately two-thirds were from the Health System and one-third from community partners. The amount claimed for this Pay for Outcome measure in the PY4 Annual invoice is $53,390 (overall payment for PY4 at 83.39% level; 30% claimed at Mid-Year).

Peer Respite Program

The Peer Respite Program (Blackbird House) is a 24 hour, up to 14-day stay, peer run, self-referral program for persons in a behavioral health crisis. The goal is to avoid needing a higher level of care, such as being seen in Emergency Psychiatric Services (EPS) or having an acute inpatient admission for behavioral health care crisis. It is also an alternative to seek support earlier in the progression toward crisis and to provide a supportive environment for respite and recovery. Persons (e.g., guests) seen in the Peer Respite Program must have a discharge location, so individuals experiencing homelessness are not eligible for care in this setting. Within the first year of operations (and as of December 31, 2019), the Blackbird House had served a total of 98 WPC eligible participants.

The results for both inpatient hospitalization and ED/EPS utilization of 88 peer respite guests, with equivalent periods of six months pre and post engagement (following a stay at Blackbird House) are shown in the below (Table 3).

Table 3: Pre and Post Engagement Outcomes for Peer Respite Program Participants

Timeframe (6 months)	Inpatient Days	ED/EPS Visits
Pre-Engagement	43	211
Post-Engagement	0	138
Outcome	100% (Reduction)	34.6% (Reduction)

None of the guests had an acute inpatient behavioral health admission for at least six months after their participation at the Blackbird House. This represents a 100% reduction in hospitalizations. This group of Blackbird House participants also showed a 34.6% reduction in emergency visits during the same time period. The results for the program for a six-month period after or post entry is very promising (Figures 2 and 3). And these results remain promising even beyond the initial timeframe assessed.

Figure 2: Inpatient Hospitalization Relative to Blackbird House Assessment Date
[Redacted]

Figure 3: Emergency Utilization Relative to Blackbird House Assessment Date
[Redacted]

There was a 100% reduction in hospitalizations at least six months following guestsô participation in the Blackbird House services. This exceeds the Pay for Outcome goal of at least a 75% reduction in hospitalizations at least six months post participation. Therefore, the amount to be claimed for the Peer Respite Program - Pay for Outcome measure in the PY4 Annual invoice is $210,000 (full amount).

The total amount to be claimed for the Pay for Outcomes measures in the PY4 Annual invoice is $263,390.

VI. 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.

The WPC stakeholder groups include representation from both internal and external departments/organizations and are comprised of executive leaders, managers, operational and technical staff as well as consumers and advocates. These groups have continued to inform, guide and provide feedback on WPC activities, implementation, ongoing quality improvements, and future direction.

During the second half of PY4, the stakeholder group structure was consolidated and/or refined to eliminate redundancies and maximize reach. There are currently four leadership groups and one active, engaged consumer group. A description for each of these six groups is as follows:

1. Internal T2020/WPC Steering Committee

This committee of executives meet bimonthly and these tactical meetings are designed to elevate and discuss key issues, identify risks for mitigations and make final decisions. One of the outcomes of this group is identifying new projects/initiatives which are likely to impact WPC (i.e., implementation of new EHR system, NetSmart in BHSD, integration of two hospitals purchased in 2019 and added to the enterprise, changes in procurement and TSS processes, partnership with Health Homes Program (HHP), CalAIM planning and financial predictions and mitigation).

2. WPC Stakeholders Group

This group of directors, managers and operational staff from internal and external organizations work with the WPC eligible populations and meet quarterly to work together to set strategic direction, identify opportunities for collaboration, monitor progress and share lessons learned. This group includes WPC funded and non- funded partners. On September 19, 2019 this group held a 1.5-hour event with 125+ attendees from 27 departments/organizations and included a 40-minute poster session with 19 poster displays and a 45-minute panel presentation with three funded partners (i.e., Blackbird House (Peer Respite Program), Institute on Aging and the Gardner Clinic). Panelists described how their respective programs worked through the lens of a patient/client/guest and discussed many of the challenges faced in working with high need WPC population and the often-heroic efforts required to overcome barriers. Feedback from participants: 1) Several participants recapped their experiences and

shared how palpable the energy, passion, sense of community, and dedication was at this meeting; 2) All respondents indicated that they would consider coming to the next meeting, with 88% indicating that they would come again; and 3) 71% of respondents liked the meeting format (with both posters and presentations) and suggested the same format be used again. This format will be repeated in PY5.

3. T2020 Domain Leaders

This leadership group includes directors and operational managers from across the Health System. During the first half of PY4 the group met bimonthly and during the second half of the year, the meeting structure changed and moved to a quarterly based schedule. With leadership transitions, changes that took place across the enterprise and many competing priorities, this group's focus waned but with restructuring is planned to resume its work in PY5. There is joint agreement in the strong need to coordinate efforts to advance the transformative work that supports integration across the Health System enterprise, with County departments/agencies and the greater community.

The four domain workgroups include:

- ¶ Patient Navigation Center
- ¶ Population Health
- ¶ Community and Preventive Health [focused on prediabetes/diabetes and medication assisted treatment (MAT)]
- ¶ Care Coordination

4. Waiver Planning Team

The meeting format and frequency of meetings were modified in the second half of PY4 to maximize information sharing, identify opportunities for coordination, work on shared metrics and improved sharing of learnings across the Waiver programs (i.e. WPC, Global Payment Plan (GPP), Public Hospital Redesign and Incentives in Medi-Cal (PRIME), Dental Transformation Initiative (DTI) and with other programs/initiatives that support and/or integrate with the Waiver programs.

5. Consumer Advisory Committee

This committee of Health System staff, community advocates and patients/clients meet monthly to promote WPC, collaboratively identify gaps in care and work together to make corrective actions happen.

Back in PY3, most of the WPC stakeholder groups had been reconfigured and integrated into the T2020 framework. The T2020/WPC Care Coordination Domain is made up of 15 smaller project/program groups focused on a specific component(s) of care coordination. By combining the work of these smaller workgroups, it has helped to improve linkages, communication, and sharing of outcomes and lessons learned within the larger domain.

Additional groups help to support the WPC initiative and are designed to build improved interagency and community support which is necessary to meet the needs of the high need WPC populations. Most of these groups continue to be facilitated by the WPC team.

WPC has been actively engaged in the community engagement to provide input from Santa Clara County on the CalAIM proposals and has been working collaboratively with the Medi-Cal managed care health plans to share WPC experience and learnings.

A list of current stakeholder partners (Appendix A) and detailed listing of meetings convened (Appendix B) during the second half of PY4 (July-December 2019) is saved as combined document in Attachment 2.

VII. PROGRAM ACTIVITIES

Briefly describe 1-2 successes you have had with care coordination.
1. There were significant improvements made to the enrollment and WPC workflow documentation within the HealthLink system in the second and third quarters of PY4. These changes significantly enhanced what used to be a cumbersome workflow and made the workflow more intuitive for the end users. In addition, the external care coordinator information for external partners was imported into the HealthLink system so that when patients from external clinics come into the Health System there can be follow-up with a contact at the community clinic sites. 2. Improvement to the quality of WPC related documentation of interventions and patient goals in the HealthLink system. This data entry resulted in analytical work that demonstrated an average of three care coordination interventions documented per patient following enrollment in the HealthLink system. The number of interventions decreased to monthly after the first four to six months post enrollment. This provided the data basis to begin to review caseloads for care coordinators across the SCVMC clinics.

Briefly describe 1-2 challenges you have faced with care coordination, and lessons learned from those challenges.
1. While progress has been made with care coordination in individual clinic settings, there continues to be challenges with transitions of patients across care settings with referral information, discharge and follow-up information needing to be processed manually rather than being automated. 2. While there is an assignment of a primary care coordinator for WPC enrolled patients based on each patientôs designed health home, when the patientôs care spans multiple settings the coordination of care across all the entities engaging with the patient is still cumbersome, and with changes in patientôs needs over time only exacerbates this issue.

Briefly describe 1-2 successes you have had with data and information sharing.
1. Launch and progress on the NextGen data sharing project: A project was launched with four community partners who all use NextGen to support the automated extraction and delivery data needed for WPC from these partners. The development work for this project was completed in conjunction with the Gardner Family Health Network (Gardner) and testing on the project started before the end of PY4. After the testing and deployment process at Gardner it will be deployed at ACCI and School Health Clinics.

2. Improvements/automation made to the partner invoicing process. The previous process used was labor intensive for both partners and WPC team because invoice data and service data were submitted separately. The updated process was changed to generate the invoice data from the services data submitted, the invoice data was generated by the Health System and sent back to the community clinics to be reviewed and reconciled. The implementation of this process has streamlined invoice processing significantly and has resulted in improvement in payment turnaround time.

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

1. Timeliness, completeness and accuracy of data submissions from community partners ï use of training and incentives have improved performance of data submissions.
2. Accuracy and timeliness of Medi-Cal eligibility information from payer partners ï additional staff needed for some of the manual checking from the State website; need for automated checks from the State website.

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

1. Standardization of patient and service information into single source data tables for all our external partners which has streamlined the processing and linking of this dataset with our internal HealthLink based data.
2. Several new dashboards were implemented that include the following:
    - ¶ Enrollment and Services dashboard
    - ¶ Universal and Variant Metrics dashboard
    - ¶ Care Coordination dashboard
    - ¶ Incentive Metrics dashboard
    - ¶ PDSA dashboard

    In addition, outcome trend dashboards were developed which outlined trends with inpatient and emergency utilization and normalized against the enrollment date of the patients. The implementation of these dashboards has allowed the WPC data and analytics team to support the program team with both operations and strategic planning.

Briefly describe 1-2 challenges you have faced with data collection and/or reporting.
1. Our biggest struggle continues to be accurate payer eligibility data for WPC patients with several sources for this data, all with some level of inconsistencies. The County has had to resort to manual checking of the State website to ensure that eligibility data is as accurate as possible. 2. There continues to be a lack of standardization in terminology for social datasets.

Looking ahead, what do you foresee as the biggest barriers to success for the WPC Program overall?
¶ Behavioral Health EHR implementation and streamlining connection to WPC. ¶ Hard to follow Behavioral Health patients due to lack of compatibly of EHRs, especially because patient with mild to moderate needs and those diagnosed with severe mental illness (SMI) are treated in different settings that use different EHRs. ¶ Comprehensive review and assessment of cross agency and Health System care management and care coordination programs to align to new models proposed in CalAIM. ¶ Increasing housing resources. ¶ Long term care (LTC) transitions remain a critical area for patients to be in the least restrictive and expensive environment; by implementing the Nursing Home Transitions (NHT) PMPM, the bed capacity in the SNF has increased while the patients have not been readmitted. ¶ Further options needed for LTC patients needing more community care once the WPC program ends. ¶ Developing monitoring and reporting tools for complex metric sets and programs (including HEDIS, QIP, WPC, PRIME, etc.) ¶ Eligibility and funding stream validation to provide complex care across all settings. ¶ Further integration of EHRs with the community clinics.

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 ï June 30. For the Annual Report, submit information inclusive of all PDSAs that started, are ongoing, or were completed during the Program Year.

PDSA Attachments:

- Whole Person Care Summary Report ï Attachment 4a
- First 12 PDSA documents combined and submitted as Attachment 4b. PDSAs 13 to 19 are included as individual pdf documents.

1. Asian American Community Improvement (ACCI) ï Ambulatory Care (ED Utilization), Comprehensive Care Plans and Care Coordination (combined)
2. East Valley Community Clinic - Ambulatory Care (ED Utilization), Comprehensive Care Plans and Care Coordination (combined)
3. Gardner Clinic ï Ambulatory Care (ED Utilization), Comprehensive Care Plans and Care Coordination (combined)
4. Indian Health Center ï Ambulatory Care (ED Utilization), Comprehensive Care Plans and Care Coordination (combined)
5. MayView Clinic ï Ambulatory Care (ED Utilization), Comprehensive Care Plans and Care Coordination (combined)
6. Patient Transition Model for Community Clinics ï Other
7. Planned Parenthood Mar Monte (PMPM) ï Ambulatory Care (ED Utilization), Comprehensive Care Plans and Care Coordination (combined)
8. Communication Strategy ï Other
9. Roots Clinic - Ambulatory Care (ED Utilization), Comprehensive Care Plans and Care Coordination (combined)
10. SBIRT ï Other
11. School Health Clinics ï Ambulatory Care (ED Utilization), Comprehensive Care Plans and Care Coordination
12. Community Partner Invoicing Improvement ï Other
13. Ambulatory Care - ED Utilization ï SCVMC (Q1, Q2, Q3, Q4 combined)
14. Inpatient Utilization ï SCVMC (Q1, Q2, Q3, Q4 combined)
15. Comprehensive Care Plan ï All Sites (Q1)
16. Comprehensive Care Plan ï All Sites (Q2)
17. Comprehensive Care Plan ï All Sites (Q3)

18. Comprehensive Care Plan ï All Sites (Q4)
19. Invoice Optimization ï Community Clinics ï Data (Q2, Q3, Q4 combined)