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 the Santa Clara Valley Health and Hospital System) – County of Santa Clara
Annual Narrative Report, Program Year #5
April 1, 2021

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 – Uploaded files on 03/30/2021
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.* ☐ 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

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

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I. REPORTING INSTRUCTIONS

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

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

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

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

II. PROGRAM STATUS OVERVIEW

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

Program year five (PY5), calendar year 2020 (CY 2020), has brought variability, complexity, grief, and hardship across all sectors of our community and across the world. What started as a Whole Person Care (WPC) transition year focused on sustainability, partnership, celebration, and recognition was shifted early in the year to respond to the immediate threat of the COVID-19 pandemic (COVID). The devoted staff, part of the County of Santa Clara Health System (Health System), were tasked as the frontline healthcare workers and were pushed to the limits to care for and support the County's emergency response while maintaining their support of vulnerable populations served in the WPC program. When assigned to alternate COVID-related responsibilities, the WPC team members called to serve as Disaster Service Workers (DSWs) were uniquely able to provide the "whole person" care that they had learned and practiced in their day-to-day work. This experience and knowledge of wraparound services has enhanced the specialized care to be provided to the population in which they have been working with as DSWs. To see this work in action, a video on the *Whole Person Care COVID Response* was created by the Office of System Integration and Transformation (OSIT) team and can be viewed at https://youtu.be/nn4-buEahiU .

Through the year, the team was able to provide ongoing service to enrollees and developed methods to identify and support the additional COVID-related needs. The partnerships developed deeply and quickly across the various county departments and community partners. The previously developed relationships and trust established as part of WPC enabled the OSIT team (includes WPC) to expand efforts and pivot some of the WPC focused work on the education and prevention of COVID, which was rapidly showing higher morbidity and mortality in the very large populations served by WPC. OSIT team was also able to make some significant progress on key initiatives as part of the infrastructure and navigation center. In line with public health orders, guidance, and multi-system collaborative efforts, WPC supported the community at large and developed wellness and additional pilots targeted to the staff, teams, and those individuals at greatest risk. Work with community partners reached a new level of

collaboration, coordination and documentation of quality improvement efforts. Community partners picked up a larger role in enrollment, as the Santa Clara Valley Medical Center (SCVMC) teams were pulled into the DSW roles and were not as available.

The OSIT/WPC team is incredibly proud to share the outcomes, additions, adaptations and tests completed in this year. Just as displayed in the video prior to the COVID outbreak, the WPC team created another video to highlight the work and the importance of providing the opportunity for the right care, at the right time and in the right place. This video, *Whole Person Care: Better Health for All* can be viewed at * .

As with all years in review, we have found areas of great work as well as challenges. Specifically, this year, COVID was unprecedented and taxing across all systems of care. In the middle of the year, with much uncertainty, we prepared our rollover and budget adjustment, we did not anticipate as much to be accomplished. As such, during this reporting cycle, we have found that we accomplished much success related to focused efforts and existing infrastructure. With the structure of the report, we reflect this in noting earned higher than claimed in several categories in hopes to reflect the valuable work accomplished.

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	**197**	**144**	**134**	**153**	**105**	**110**	**843**

Item	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12	Annual Unduplicated Total
Unduplicated Enrollees	103	105	176	123	82	73	1,505

*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	46	30	16	20	52	35	199
Utilization 1	$9,823.76	$6,406.80	$3,416.96	$4,271.20	$11,105.12	$7,474.60	$42,498.44
Service 2	30	*	0	0	*	*	48
Utilization 2	$11,280.60	*	$0.00	$0.00	*	*	$18,048.96
Service 3	12	22	34	52	73	59	252
Utilization 3	$2,953.44	$5,414.64	$8,368.08	$12,798.24	$17,966.76	$14,521.08	$62,022.24
Service 4	328	287	205	136	143	146	1,245
Utilization 4	$32,800.00	$28,700.00	$20,500.00	$13,600.00	$14,300.00	$14,600.00	$124,500.00
Service 5	31	32	26	*	*	18	124
Utilization 5	$31,000.00	$32,000.00	$26,000.00	*	*	$18,000.00	$124,000.00
Service 6	0	0	0	0	0	0	0
Utilization 6	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Service 7	0	0	*	0	*	0	*
Utilization 7	$0.00	$0.00	*	$0.00	*	$0.00	*
Service 8	0	0	0	0	0	0	0

Costs and Aggregate Utilization for Quarters 1 and 2

FFS	Month 1	Month 2	Month 3	Month 4	Month 5	Month 6	Total
Utilization 8	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Service 9	0	0	0	0	0	0	0
Utilization 9	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00

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	25	0	0	39	0	29	292
Utilization 1	$5,339.00	$0.00	$0.00	$8,328.84	$0.00	$6,193.24	$62,359.52
Service 2	89	82	60	78	115	62	534
Utilization 2	$33,465.78	$30,833.64	$22,561.20	$29,329.56	$43,242.30	$23,313.24	$200,794.68
Service 3	47	79	73	69	57	81	658
Utilization 3	$11,567.64	$19,443.48	$17,966.76	$16,982.28	$14,028.84	$19,935.72	$161,946.96
Service 4	159	159	126	144	133	138	2,104
Utilization 4	$15,900.00	$15,900.00	$12,600.00	$14,400.00	$13,300.00	$13,800.00	$210,400.00
Service 5	12	15	25	22	12	14	224

Costs and Aggregate Utilization for Quarters 3 and 4

FFS	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12	Annual Total
Utilization 5	$12,000.00	$15,000.00	$25,000.00	$22,000.00	$12,000.00	$14,000.00	$224,000.00
Service 6	*	*	*	*	0	0	*
Utilization 6	*	*	*	*	$0.00	$0.00	*
Service 7	0	0	*	*	*	*	*
Utilization 7	$0.00	$0.00	*	*	*	*	*
Service 8	0	0	23	296	1,195	684	2,198
Utilization 8	$0.00	$0.00	$575.00	$7,400.00	$29,875.00	$17,100.00	$54,950.00
Service 9	0	0	*	0	*	*	14
Utilization 9	$0.00	$0.00	*	$0.00	*	*	$9,800.00

*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 for Quarters 1 and 2

PMPM	Rate	Month 1	Month 2	Month 3	Month 4	Month 5	Month 6	Total
Bundle #1	$137.19	$150,224.52	$135,270.66	$145,011.25	$164,492.42	$152,419.58	$159,004.76	$906,423.19
MM Counts 1		1,095	986	1,057	1,199	1,111	1,159	6,607
Bundle #2	$1,282.71	$491,276.84	$425,858.78	$491,276.86	$389,942.98	$337,351.98	$310,415.13	$2,446,122.55
MM Counts 2		383	332	383	304	263	242	1,907
Bundle #3	$1,363.54	$1,258,547.42	$1,137,192.36	$1,307,634.86	$1,145,373.60	$1,096,286.16	$1,124,920.50	$7,069,954.90
MM Counts 3		923	834	959	840	804	825	5,185
Bundle #4	$882.88	$836,089.06	$682,467.63	$975,584.38	$835,206.18	$735,440.54	$786,647.68	$4,851,435.47
MM Counts 4		947	773	1,105	946	833	891	5,495
Bundle #5	$2,076.70	$365,499.06	$363,422.36	$377,959.25	$384,189.35	$390,419.45	$394,572.85	$2,276,062.31
MM Counts 5		176	175	182	185	188	190	1,096

Amount Claimed for Quarters 3 and 4

PMPM	Rate	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12	Annual Total
Bundle #1	$137.99	$156,946.89	$154,203.07	$159,416.34	$157,907.23	$137,465.72	$131,703.69	$1,804,066.14
MM Counts 1		1,144	1,124	1,162	1,151	1,002	960	13,150
Bundle #2	$1,282.71	$341,200.10	$336,069.28	$346,330.93	$291,174.53	$282,195.58	$265,520.38	$4,308,613.35
MM Counts 2		266	262	270	227	220	207	3,359
Bundle #3	$1,363.54	$1,190,370.42	$1,156,281.92	$1,258,547.42	$1,214,914.14	$1,041,744.56	$958,568.62	$13,890,381.98
MM Counts 3		873	848	923	891	764	703	10,187
Bundle #4	$882.88	$915,548.42	$836,089.06	$829,908.89	$747,800.88	$709,836.96	$722,197.31	$9,612,816.99
MM Counts 4		1,037	947	940	847	804	818	10,888
Bundle #5	$2,076.70	$301,121.38	$290,737.89	$307,351.48	$326,041.77	$334,348.57	$330,195.17	$4,165,858.57
MM Counts 5		145	140	148	157	161	159	2,006

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

IV. NARRATIVE – Administrative Infrastructure

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

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

Staffing

As COVID response remained a key focus nearly the full program year, some changes to the administrative infrastructure are reflected as the work was reallocated to staff available to support the key functions of WPC. Resources were reduced during this time and several of the persons previously allocated to this section were deployed completely or partially to perform COVID-related duties. As such, all or a portion of their time was billed elsewhere.

For example, early in the pandemic, OSIT had five Program Managers, one Quality Improvement (QI) Manager, one Staff Developer and one Public Communications Specialist positions that were deployed to command centers across the Health System or as DSWs. Two of the five program managers have returned to work on and off through the year and the remaining staff, typically reflected in the Administrative Infrastructure category had to be backfilled to do the essential work of WPC. Executive Assistants supported the printing and labeling for outreach packets. The QI Coordinator took on roles partnering with the community-based organizations (CBOs) and took on much of the care coordination work when the Staff Developer and Program Manager typically performing those duties were reassigned. A Health Care Program Manager took over information distribution and enhanced work with contracts to support the essential contract and community partner support functions and work that was not performed by the deployed staff. The OSIT Director was also deployed to support the command center for nearly 50% of her hours worked in 2020. The Behavioral Health Services Department (BHSD) staff also had to re-direct resources to focus on key WPC functions during PY5 and they continued work with alternate staff members and consultants to support key quality improvement functions through the year.

Wellness Funds

As described in the PY5 Mid-Year Report, the pandemic affected the ability to start some of the more elaborate projects and eliminated gatherings at which our teams could collaborate with the public and outreach to the WPC eligible populations as planned.

Wellness Bundles for Community Clinics

In June 2020 while developing the scopes of work with the community partner clinics, OSIT developed some key COVID wellness and prevention activities as well as some culturally specific opportunities to improve the health and healing that may be related to structural racism and trauma. The most common wellness activity was education by staff related to COVID testing, with over 1,300 episodes completed by seven community clinics. Education of COVID positive patients was another activity, with over 350 persons served. As a part of the contract with co-existing medical and behavioral health entities, seventy-four (74) seriously mentally ill (SMI) patients who had not had a primary care provider (PCP) visit were contacted, scheduled, and completed an annual physical. SMI patients frequently develop life threatening or chronic conditions in late stages, so preventative visits are especially critical for these persons. One agency added a nutrition education class as a part of wellness activities. One agency conducted in person or virtual group meeting for support of chronic stress or trauma related to systemic racism. Over 700 persons not engaged with their PCP were contracted via outreach. Twenty-five (25) persons who had been placed by Institute on Aging completed annual physicals because of staff interventions.

Prediabetes Screening and Intervention in SCVMC Clinics

Prediabetes screening and intervention were successfully piloted at two SCVMC outpatient clinics in November 2018. While impacted by COVID, further work on this initiative continues, the Public Health Department took on the project management of the pilot in 2020. During the COVID pandemic, staff focused on transitioning the diabetes prevention and nutrition classes to an online platform. The team selected a Health Insurance Portability and Accountability Act (HIPAA) compliant platform, purchased equipment, trained staff, completed outreach and recruitment protocols, and wrote orders into the Epic/HealthLink electronic health record (EHR) system, and revised the curriculum for both the diabetes prevention and nutrition classes to accommodate remote learning. In addition, the evaluation survey was revised and approved by the Health System's Internal Review Board (IRB) as a QI project. The newly revised survey now includes questions regarding notification of pre-diabetes

status, referral process, course enrollment and attendance, and self-reported changes in patient behavior. Finally, the HealthLink systems analysts were able to develop an exemption, so that patients no longer had to sign a form regarding financial responsibility for their A1c screening test.

The amount claimed for the PY5 Annual invoice is $334,587.50 (partial payment) for the wellness services provided by the community clinics. This amount does not include the County's work to prepare and execute contracts, review and validate invoices and process payments. This deliverable is paid to the County of Santa Clara because the services are part of numerous contracts with third-party agencies who provided these services on behalf of the County.

NEW Design and Print COVID wellness, safety and prevention flyers

Five flyers were designed and printed to support mailers and packets for eligible and enrolled WPC members.

The amount claimed in the PY5 annual invoice is $10,000 (full payment). This incentive is paid to the County of Santa Clara and supports the work of several agencies and departments within the system.

NEW Design and print flyers for Health System's Patient Access Department to share at community sites

Four flyers were designed (includes translation) and printed to support for the Health System's patient access department and taken to COVID testing sites for distribution.

The amount claimed in the PY5 annual invoice is $8,000 (full payment). This incentive is paid to the County of Santa Clara and supports the work of several agencies and departments within the system.

NEW Patient Navigation Center – Assess and document outcomes related to RN staff additions to the Health System's Valley Connection (call center) related to COVID and develop recommendations for post-COVID RN staffing.

To assess the addition of nurses at Valley Connection, key informant interviews were conducted. The key informant interviews were developed to help evaluate the outcomes related to registered nurse (RN) staff additions and create recommendations

post-COVID. Participants included the Valley Connection manager and nurse leader to assess the impact of this new staffing model.

Recommendations resulting from interviews:

- Recommend shifting from contracted model to having employed nursing staff embedded in the call center.
- The modifications made during COVID would be beneficial post pandemic times.
- The current leadership is supportive and will champion the effort.

Based on the work completed, the budget amount claimed in the PY5 Annual invoice for this deliverable is $10,000 (full amount). This incentive is paid to the County of Santa Clara and supports the work of several agencies and departments within the system.

Evaluation

Annette Gardner, PhD, MPH, T2020 Evaluation Consultant, worked with the OSIT team and other collaborators on finalizing the T2020/WPC evaluation cases by developing five comprehensive narrative reports that describe successful initiatives such as the Peer Respite Program and the Mission Street Sobering Center (four of these are included in Attachment. In addition, Dr. Gardner analyzed the fourth and final set of T2020 Domain Semi-Annual Reports which examined progress and changes in Domain projects and operations and lessons learned that can help to inform OSIT planning. Lastly, a final T2020 survey was launched to explore outcomes as well as analyze pre and post data.

IV. NARRATIVE – Delivery Infrastructure

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

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

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

Categories	Description
Trust Community	Telehealth and the verbal consent models improved support for remote work. With direct access to the Health System network being provided to the Planned Parenthood Organization the first half of 2020, the Trust Community work continued in the second half of PY5 with the following activities some of which were started in the first half of the year and continued through the second half of PY5. **Monthly Trust Community Stakeholder Meetings:** These meetings continue to be run regularly with key stakeholders receiving regular updates on their progress with service data submissions, invoicing and payment and a focus on continuous improvement and process optimization. Some of the key activities completed during the second half of the year are listed below.

	• Invoicing and Payment Processing Optimization for Services Rendered: Payment cycle for services rendered by partners with specific focus on the business rules for processing regular and supplemental invoices and development of reports at the operational and executive levels to allow clinics to review their data submissions and provide feedback. There were regular monthly meetings held with the Community Clinic partners where the data for the prior month was presented, reviewed and feedback used for process improvement to enable timely payment. • Outcomes Analysis Infrastructure Usage: The outcomes analysis infrastructure developed through the first half of the year was leveraged to analyze outcomes for key metrics like Emergency and Inpatient Utilization through the full year. • NextGen Interface Expanded Implementation**:** In addition to the Gardner clinic that went live on the NextGen interface to support export of alternative services to the Trust Exchange, two other clinics – Asian Americans for Community Involvement (AACI) and the School Health Clinics were engaged in the testing of this export interface with the AACI clinics making substantial progress towards completion. The progress with these interfaces represents a leap in the standardization of the export data from these systems and will significantly reduce manual work needed to get service data from these systems when completely deployed in production. The amount claimed for the PY5 Annual invoice is $1,662,412 (full amount). 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 exceeded its capacity at the HomeFirst location. Last year a new site on the SCVMC campus was identified. However, the program expansion has proven to be a challenging undertaking with the space, existing facility and permitting challenges. Despite that, PY5 planning

	was strong, and site was on track for a completion in 2020. COVID added some additional hurdles. Despite that, progress was made during the second half of PY5. Summary of progress includes renderings, schedule and review of parking and traffic needs. The budget amount claimed in the PY5 Annual invoice for these deliverables for this category is $40,000 (partial payment). This incentive is paid to the County of Santa Clara and supports the work of several agencies within the system.
Improve Access to Program Information for Care Delivery – Navigation Center – Change Management Plan & Implementation	In response to COVID, the Valley Connection call center was expanded. Early in PY5, the team completed the proposal for the new navigation center in which the BHSD, Substance Use Treatment Services (SUTS) and Valley Connection call centers would all be integrated into one physical location. However, due to COVID, the operational model changed from traditional brick and mortar to a hybrid form. SUTS continues to be 100% remote, while both BHSD and Valley Connection have become a hybrid form. The ability to flex to meet the needs was possible due to the work that had been done on the navigation center and the implementation was much more effective, efficient and nimble due to the preliminary work completed via WPC. In response to this change, policy and procedures and trainings had to be either updated or developed from scratch. Due to the COVID response, the Health System worked to ensure the staff and triage capacity was in place to support the calls for COVID testing and symptom management. From June through December 2020, a total of 24 extra help nurses (RNs) were hired to support this valuable work. As part of this effort, process structures, documentation, and leadership structure were developed for the nurses and providers allocated from other county departments as well as additional staff hired. As planning and vaccinations were implemented in December 2020, several of the staff were moved to other areas to support the robust vaccination efforts with our healthcare workers, including a small call center structure to support calls about reactions. Although a full department has not been funded to support the large staff required to do the work for COVID, the infrastructure and leadership

	structure was developed for a longer-term solution. This infrastructure has helped build a business model and proforma to support the permanent structure. The budget amount claimed in the PY5 Annual invoice for these deliverables for this category is $112,500 (partial payment). This incentive is paid to the County of Santa Clara and supports the work of several agencies within the system.
Improve Access to Program Information for Care Delivery *Navigation Center* – Operational Standards	While work has continued to address the changing needs within the call centers, no funds will be claimed in the PY5 Annual invoice for this deliverable.
Improve Access to Program Information for Care Delivery *Navigation Center* – Outreach and Engagement	The deployment of clinical staff to help to respond to patient calls at the call centers based on volume and needs (rather than non-clinical call center agents escalating calls to clinical staff located offsite in the Valley Health Centers or ambulatory care clinics to assist customers) has resulted in more rapid resolution of many patient issues. Outreach and engagement by after-service hours nurse advisory doubled or sometimes tripled over the last six months. Most of the issues addressed during these calls were COVID-related. The Interactive Voice Record (IVR) system optimization was initiated in response to complaints received by patients of poor phone menu and agent interactions, an investment was made into addressing the gaps in the IVR system, through a one-time contract. At the end of the project, analysis and recommendations will be provided to redesign the IVR system: 1. Analyze overall inbound calls, including caller treatment. 2. Define caller identification and authentication strategies. 3. Evaluate proactive/personalization opportunities. 4. Identify self-service and automation use cases. Currently, the team is close to completing the first analysis of

	this project described above. To meet the demands of non-English speaking clients at the testing and vaccination centers, interpretation iPads on rolling carts were used at the flu and COVID testing and vaccination sites to provide limited English proficient patient information on consent forms, educational information such as symptoms and possible side effects, the importance of getting vaccinated, wearing masks, social distancing, and hand washing. A total of 26 iPads were purchased between July to December 2020 at the cost of $1,099 per iPad. The deployment of clinical staff to help to respond to patient calls at the call centers based on volume and needs (rather than non-clinical call center agents escalating calls to clinical staff located offsite in the Valley Health Centers or ambulatory care clinics to assist customers) has resulted in more rapid resolution of many patient issues. The budget amount claimed in the PY5 Annual invoice for the deliverables within this category is $100,000 (partial payment). This incentive is paid to the County of Santa Clara and supports the work of several agencies within the system.
Improve Access to Program Information for Care Delivery – *Navigation Center* – Process Improvement & Quality Assurance	The Calabrio surveillance system enabled monitoring of calls at the call center and helped to provide just in time quality improvement trainings to call agents and nursing staff. This was incredibly valuable when staff went remote following the COVID rearrangements of call centers when there was no opportunity to observe, in person, the interaction between a caller and agent. Post Call Customer Experience Survey: Currently, the call centers do not have any evidence-based analysis of caller experience. Most of the information is based on staff or patient anecdotes or based on crude in-house reports. To address this gap, Valley Connection contracted with Qualtrics and NTT to deploy a post-call IVR and email survey for every call made into the call center. By the end of this project, not only will the Health System have advanced analytics to understand the patient experience, but will

	be better able to address in real-time, complaints by clients (or staff) by escalating the calls to a lead or supervisor and thus reducing the number of complaints/grievances. The budget amount claimed in the PY5 Annual invoice for the deliverables within this category is $50,000 (partial payment). This incentive is paid to the County of Santa Clara and supports the work of several agencies within the system.
NEW Provide community clinic partners with startup funding to support the setup, implementation and running of chronic trauma support groups related to health inequity considering COVID and systemic racism and police justice overlap	Only one agency set up a chronic trauma support group. Most of the community clinic partners were overwhelmed with testing and education related to testing to complete this activity as planned. The budget amount earned for this activity ($10,000) was claimed in the Administrative Infrastructure section in the VHP - Wellness and Case Management Program Administration line item. This amount is paid to the County of Santa Clara because services are contracted by this third-party agency that provided these services on behalf of the County.
NEW Develop COVID at risk and WPC trigger for outreach populations and current	Current eligibility and enrolled lists were augmented to highlight those with identified risk for morbidity and mortality for COVID illness as learnings were available from local, national and global sources. Additional filters were made to race and ethnicity to further prioritize outreach. PDSA work started with phone outreach with enrollees at risk and a mailer sent to those when they did not respond to call. Mailers for outreach were developed that included

enrollees that would benefit from additional outreach	COVID prevention and education materials as well as with a non-surgical mask and hand hygiene supplies. No funds will be claimed in the PY5 Annual invoice for this deliverable; however, the work was completed in full.

NARRATIVE – Incentive Payments

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

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

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

Categories	Description
Provider Incentive – Integrated Medical / Psychiatric Skilled Nursing Facilities (SNFs) and Enrollment of Viable Candidates	A good working partnership has been established with the SCVMC inpatient team and the WPC staff to identify appropriate patients and skilled nursing facilities (SNFs) for this resource. The Medical Social Worker (MSW) assigned in OSIT attends weekly Multidisciplinary Rounds (MDR) at SCVMC and collaborates with medical staff. Transitions of care for long length of stay patients with challenges are discussed as are those with complex medical and psychological needs. As identified, the patient is engaged, and WPC is discussed. If patient agrees, enrollment and care coordination is supported by the MSW through the transition and subsequent care coordination in the SNF or community setting, as needed. Family is also engaged when available even when out of the area. This labor-intensive process has not resulted in increased contracts during the second half of PY5, partially related to the impact of COVID on SNF patients and nursing home operations. Letters of Agreement (LOAs) were executed for two additional patients and SNFs received incentives in the amount of $26,240. OSIT does not recommend continuation of this initiative in the current format. The amount of funds needed to offer “special” services for a behaviorally difficult patient in a nursing home is not covered by the dollars requested for this initiative. In addition, it is a tight, competitive market in which most nursing homes are full and can accept any patients; this was true pre-COVID and even more

	so during the pandemic. Therefore, SNFs are less interested in accepting difficult patients who require more monitoring and care. The budget amount claimed in the PY5 Annual invoice for this deliverable is $26,240 (partial amount). 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.
Social Services Referral Integration	Due to the rapid changes required to support the COVID response, the team assigned to this part of the pilot were remote and not performing the duties related to this integration. This pilot will not be continued in PY6. No funds will be claimed in the PY5 Annual invoice for this deliverable.
Provider Incentives - Drug and Alcohol Screening	As noted in previous reports, the initial proposal for this incentive relied on linear logic: the person is screened, if a positive result is documented then a further assessment is completed with Screen, Brief Intervention, and Referral to Treatment (SBIRT), if this results in positive results then a referral for care is made and the patient is followed. Some of the reasons this thinking is flawed are as follows: • The person being screened does not answer truthfully because they are embarrassed or feel ashamed (affecting Outcome 1 and subsequently Outcomes 2-4). • The person being screened may be answering truthfully but may not want services or referrals and/or is not ready to make a change (affecting Outcomes 3-4). • The person screened bypasses Outcomes 1-3 and ends up at Outcome 4 for which maybe they were finally ready for services and initiated the services themselves or were following up on a verbal referral (from the Outcome 1). • Additionally, others can be ending up in Outcome 4 because our logic was not able to capture them, we are missing the connection in the EHR system, and they are being captured manually (e.g., in the Medicated Assisted Treatment (MAT) Emergency Department (ED) project).

Pulling the data this year has been difficult due to the implementation of MyAvatar (a new EHR for BHSD). A report has not yet been built which will allow OSIT to directly compare the persons referred with those getting services in MyAvatar; therefore, this may be underreported.

During this last six months, the OSIT team met with the California Public Hospital Redesign and Incentives in Medi-Cal (PRIME) team discuss staff education about substance use disorder (SUD) interventions, as the PRIME team was regularly meeting with providers about their own initiative for Drug and Alcohol Screening. Both teams shared lessons learned, including validation of the process and documentation of intervention and referral. In addition, work was done on warm handoffs to BHSD's SUTS staff. A back-door number for staff to call for a warm handoff when referring patients, rather than the main line which is often busy, was circulated to staff.

Below are the results of completion for Outcomes 1-4:

		2019 Values		2020 Values Mar 19, 2021		
Outcome	**Time Range**	**Values**		**Values**	**Difference**	**Symbol**
1	Full Year	31.57%		34.62%	3.05%	▲
2	Full Year	34.59%		46.50%	11.91%	▲
3	Full Year	43.76%		67.17%	23.41%	▲
4	Full Year	77.20%		84.51%	7.31%	▲

The target goals for PY5 have been met with 100% improvement, in all four outcomes, mainly due to better tracking of EHR entries in the older BHSD system for referral and treatment. Therefore, the

	full amount is claimed for this initiative. For the future, we have learned that the last outcome measure, how many people enrolled who sought care, is the most reliable. It is more appropriate for Outcomes 2 and 3 to be considered under the PDSA in trying to improve the overall result of more people enrolled in care. The budget amount claimed in the PY5 Annual invoice for this deliverable is $366,088 (partial amount). This incentive is paid to the County of Santa Clara and supports the work of several agencies within the system.
Enterprise Best Practice Spread of WPC Care Coordination, Outreach and Referral	Following the population outreach with mailers, as noted in the Administration - Wellness section, calls increased to the WPC call line inquiring about Whole Person Care. Persons interested in enrolling were enrolled via verbal consent and assigned to a care coordinator in the OSIT office or with a primary care clinic when a coordinator was available. Redistribution is planned for when DSW team members are back onsite. The OSIT team developed a customized version in HealthLink (Epic based medical record) to establish and spread an enterprise-wide standardization of identifying patients with the new sites in SCVMC hospital and clinics. The WPC program provided support across several teams in multiple settings to implement Epic's Continuity of Care Management (CoCM) module. The CoCM module provides task management functionality via a centralized care coordination dashboard. The dashboard identifies eligible WPC persons allowing each staff member including care coordinators in any location to review those patients seeking care from the Emergency Department, inpatient, Ambulatory Care specialty or primary care settings for enrollment into WPC. Targets and goals are developed in collaboration with the patient and include social determinants of health (SDOH or DOH), reminders, assessments, and paneling the patient to a medical home. Administrative targets include completion of enrollment documentation, enrollment and annual assessment/ screening reminders, execution of WPC/HIPPA authorization form at time of enrollment and annually, it also includes monthly patient contact reminders, enrollment of patient into myHealth Online, paneling patient with PCP, notification of ED utilization and/or admission.

	Collaboration has been ongoing with Anthem Blue Cross (Blue Cross) and Santa Clara Family Health Plan (SCFHP) to work toward data use agreements (DUAs) and alignment of eligibility. In addition, the OSIT data team worked to integrate and support a data infrastructure project with BHSD's legacy and new electronic health record. California Advancing and Innovating Medi-Cal (CalAIM) meetings with county agencies and managed care plans to discuss transition from WPC to Enhanced Care Management (ECM) and In Lieu of Services (ILOS) were halted due to the COVID pandemic. Meetings and discussions resumed at the end of 2020 and resumed in earnest when the new proposal was presented and are ongoing. The budget amount claimed in the PY5 Annual invoice for this incentive is $102,635 (partial amount). This incentive is paid to the County of Santa Clara and supports the work of several agencies within the system.
Enterprise VI-SPDAT Expansion	Twelve additional team members from across the system were educated about the Vulnerability Index – Service Prioritization Decision Assistance Tool (VI-SPDAT) tool from August through December. Of note, additional team members from St. Louise Regional Hospital (SLRH) were trained as well as individuals at Valley Health Plan (VHP). Ongoing review of individuals in skilled nursing facilities (SNFs) was supported to ensure capture of their housing status and completion of VI-SPDAT when indicated during the SNF stay to ensure housing priority was made for those without secure discharge plan to community. Referrals with our partnership with the Institute on Aging (IOA) were also made when engaged population met the criteria and would benefit from their contracted service. The OSIT Medical Social Worker (MSW) manages this program. She has a close collaborative relationship with the Office of Supportive Housing (OSH), attending regular meetings with OSH, getting regular updates from that office which she shares will all those trained on the VI-SPDAT and the Universal Pass for Life

	Improvement From Transportation (UPLIFT) program. Training also requires technical support by our MSW. Each staff member who is being trained goes through an initiation process which includes an introduction letter about guiding principles of VI-SPDAT. Santa Clara County Continuum entities are also introduced, and a step-by-step instruction to pursue the three required trainings needed before one is granted privilege to perform VI-SPDAT. The MSW acts as primary point of contact for new user (initiate new user ID) and offers individual support/updates and work closely with Homeless Management Information System (HMIS) staff to assist one through any arising issues. She resets IDs when inactivated, follows up with individual instruction as needed, sends updates to users and communicates errors to each user when report by the HMIS staff, supporting the fix of errors and updating files. She also works to enroll the same staff as UPLIFT providers. The budget amount claimed in the PY5 Annual invoice for this incentive is $50,000 (partial amount). This incentive is paid to the County of Santa Clara and supports the work of several agencies within the system.
Enterprise Engagement & Practices Implementation	Alignment of care coordination across community partners and enterprise was undertaken in PY5. Care Coordination activities were aligned in this program year with the goal of sustainability and support of robust support system for the most vulnerable populations with a “no wrong door” philosophy for care coordination, WPC or otherwise. To integrate referrals and access to care across the Health System, extensive work was completed in upgrading the HealthLink System referral, assessment for SDOH, and notifications of tracking due dates which affected all medical healthcare areas with HealthLink (HL) in SCVMC and Clinics, O’Connor Hospital and St. Louise Regional Hospital). In preparation for the transition to CalAIM, the WPC program was relabeled to reflect care coordination, no matter what the source of funds. This was augmented by the purchase, customization, and implementation HealthLink’ s CoCM module as noted above. Clinically, CoCM provides task management functionality via a centralized care coordination dashboard that includes links to prospective and individual patients within each care coordinators’

	caseload, tracking of targets and tasks (care plans as well as administrative housekeeping) with reminder and due dates, frequently used HL reports, HL In-Basket/ myHealth Online (MHO) messaging capabilities, and customizable end-user and/or provider schedules. Targets and their associated tasks were created around two specific buckets (a) patient specific needs, including care plans and (b) administrative needs including WPC contract requirements and incentives. Targets and goals are developed in collaboration with the patient and include social determinants, reminders, assessments, and paneling the patient to a medical home. In addition to manual entry, targets and tasks are auto populated based on previous screening, current screening or assessment responses. The design eliminates duplicate questions, if already entered by another service, for example, Social Work determines housing is a need. The care coordinator in another service can view the auto populated answer from the Social Work entry. They also reflect overdue and missing data within patient EHRs. Developing auto population involved extensive review with electronic assessments and with each care coordination contributing department to assure comprehensiveness and acceptability for professional standards. Examples of patient related targets include closing care gaps, recurring health maintenance items, food insecurity, housing stabilization, substance use, transportation, patient driven goals, etc. While administrative targets include completion of enrollment documentation, assessment/screening reminders, WPC/HIPPA authorization forms, it also includes monthly patient contact reminders, enrollment of patient into MyHealth Online, paneling, notification of ED utilization and/or admission. A comprehensive staff guide, or Care Coordination Services and Programs (CCSP) Staff Guide, was created for both internal and external users. The all-inclusive staff guide (found in Attachment 4D) provides background information on WPC, state reporting eligibility requirements, implementation (including but not limited to outreach and engagement, enrollment, reverse enrollment, screenings/assessments, care coordination, goals, care plans, changes in care settings/providers, graduation/disenrollment, quality improvement activities, workflows, resources, and reports). It provides a sustainable infrastructure relating to care coordination services that can be utilized and built upon as WPC sunsets at the

	end of PY6. The staff guide, which reflects the programming in HealthLink, supports teams across the enterprise system, behavioral health, public health, custody health, and our community partner agencies. Input was obtained from care coordinators and adapted to the meet the needs of all partners. An electronic resource directory was also expanded to partners across the Health System departments, enterprise, and community partners, described in a separate initiative. This allowed for shared resources to engage participation in populations across the system for the shared population. More details of this innovation are covered under the incentive for rapid implementation of a resource directory. The Office of Supportive Housing and the OSIT worked collaboratively to support a key data and outcomes analysis project for OSH. The work in 2020 included meetings and document exchanges to evaluate the current analytics support for outcomes and evaluate what needed to be done for the County to be self-sufficient in supporting the outcomes analysis needed by OSH. Towards the end of 2020 a determination was made that the County WPC data infrastructure and related technology infrastructure could support the needed analysis. The data that needed to be exchanged to support the cross-system analysis was determined and the requirements and design covering demographic data and outcomes data for key metrics like Emergency Utilization and Inpatient Utilization in accordance with the State specifications for WPC were also completed. The budget amount claimed in the PY5 Annual invoice for this incentive is $500,000 (partial amount). This incentive is paid to the County of Santa Clara and supports the work of several agencies within the system.
Enterprise Referral Workflow Development and Expansion for WPC FFS Options	Due to unmet needs in our community, the Mission Street Sobering Center (MSSC) updated criteria to include additional referral sources and inclusion criteria in March 2020. Despite the drop in capacity related to COVID, referrals for the new Mental Health and Drug Triage enabled the increase of utilization at the site. The additional services increased the referral volumes from Emergency Psychiatric Services (EPS) for both sobering and mental health

	triage services. Referral volumes maintained through the year. The connection to services post MSSC visit was maintained by contacting or attempting to contact all eligible clients to provide WPC services, connection to housing services and support other needs (i.e., Medi-Cal application, social support, connection to primary care, housing, etc.). Sustaining funding discussions began in May of 2020 with increased involvement and support from our county partners in the Reentry program for post custody care. These discussions have led to long-term funding plans with commitment to maintain services and invest in the permanency of the program through construction costs to increase capacity. DUA discussions began in November of 2020 between the Reentry Center and OSIT for increased collaboration and continuity of care for individuals using the sobering center. COVID response required additional collaboration to support patients and hospitalization management across all county agencies. As WPC staff were deployed, they were able to link individuals to services and support programs with a whole person perspective. Referrals to services from the deployed teams were managed by those working in the ongoing essential functions of WPC pilot. Two RNs were added to OSIT in an extra help capacity to support the COVID education and WPC referral from the motel and hotel programs developed for individuals at risk or with COVID illness. Staff were allocated to support BHSD teams for support the clients at a congregate living area for those post incarcerations. Workflows for referral and capture of care coordination interventions were implemented. <u>Custody Health</u>: Santa Clara County is in a unique position in that Custody Health shares the HealthLink platform at all sites. Every person admitted to jail is entered into the HealthLink system, to document the initial physical and mental status on arrival. Medication Assisted Treatment was initiated under a separate grant for persons while in Custody. This presented a need and opportunity to integrate care post discharge for eligible incarcerated persons including follow up for Medi-Cal application and housing resources when indicated. Meetings with the Custody Health Services (CHS) team were held on June 6, July 7, September 8, and December 4, 2020 to discuss continued services to at risk populations receiving MAT for

	substance use disorders, supporting additional Medi-Cal applications and brainstorming gap closure for special high-risk populations in custody health settings and the transition back into the community. The Reentry Services, reporting to the Santa Clara County Board of Supervisors, requested a review of care for those with Traumatic Brain Injury. The referral regarding follow-up for Traumatic Brain Injury was researched during PY5 with collaborative processes and data analysis between CHS, BHSD and SCVMC was initiated. The data infrastructure work supported through the OSIT team allowed for more comprehensive review of information and patient matching to support to identify special populations. <u>Specialty Clinics</u>: The Ambulatory Intensivist program continued through PY5. Designed as a primary care provider within specialty care for those with Congestive Heart Failure (CHF). The goal was increased compliance with care, in a one stop care program. This also included referrals to the SUTS clinic as many persons with Methamphetamine addiction develop CHF. The team saw 51 clients in 2020 with 462 distinct encounters. Of the population all 51 had five or more clinical issues documented; 42 had behavioral or substance use disorders documented; 49 had identified gaps in SDOH. Post first visit with team utilization both ED and inpatient days were noted to have decreased. <u>Behavioral Health Services Department:</u> In addition to taking on following persons in the community, a BHSD care coordinator was newly assigned to review ED and inpatient admissions. The coordinator notified BHSD and CBO staff of patient's ED visits or the additional health issues or appointments scheduled. This has resulted in increased coordination of care, increased collaboration, and decreased duplication of efforts or resources. The collaboration and relationships developed allow for shared care plans and follow up to support client centered care. The infrastructure work was monumental leading all members of the health system increased visibility and accessibility to key

	information to spread practices. Frequently, the client has expressed gratitude for the added support, assistance with problem solving and linkage to information in HealthLink. The result is increased appointment attendance, access to reliable transportation, stabilization via medication compliance as well as reduction in ED/EPS contacts. Behavioral health teams were trained on outreach encounters and other functionality to be utilized in HealthLink in this program year. This allowed ease of capture of this work and ability to visualize across the three hospitals if there was an emergency or inpatient encounter. <u>Office of Supportive Housing (OSH</u>): The MSW assigned to OSIT is a lynch pin to coordinating services. She has worked very collaboratively with OSH on behalf of the WPC program. She serves as a link to the inpatient care settings, where she is a part of the SCVMC Multidisciplinary Rounds (MDR) in which options are reviewed and addressed for the long stay or more complex patients who are usually homeless. Further she has attended the Santa Clara County Community Living Connection (CLC) Core Group meetings facilitated by the Institute on Aging (IOA) where some of the same issues regarding eligibility for permanent supportive housing (PSH) are frequently raised. Some of the topics addressed in her frequent meetings with OSH have been related to the coordinated assessment workflow (for example discussion of the relationship of current living situation to the Department of Housing and Urban Development (HUD) definition of homelessness), electronic tracking system issues, including data accuracy, benefits, point in time counts, homeless statistics and UPLIFT services and procedures. The MSW shares information gained at the team meetings noted above. The MSW has been a passionate driver of the VI-SPDAT training and follow-up, addressed earlier. The budget amount claimed in the PY5 Annual invoice for this incentive is $475,000 (partial amount). This incentive is paid to the

	County of Santa Clara and supports the work of several agencies within the system.
Enterprise Spread of Collaborative Practices with BHSD, PHD, Custody and OSH	Several projects were undertaken in PY5 that involved significant cross system work to help analyze and triage populations common to multiple systems such as the SCVMC and Clinics, Community Partners, BHSD, OSH and Custody. Some key examples are noted below. <u>Cross System Analysis of the Sobering Center Population</u>**:** A cross functional team across the Behavioral Health, Reentry Services and the Health System were engaged to analyze the sobering center population and related service connections and associated outcomes. This team met regularly and outlined requirements to track referral sources and volumes, service connections to WPC, BHSD, OSH/VI-SPDAT, Reentry Services and CSP and associated outcomes for clients receiving these services. Data agreements and backend technical Infrastructure and dashboards were built to support the related analysis being provided to the cross functional operational team on a regular basis. <u>Identification of the COVID at Risk Population</u>**:** At the onset of the COVID pandemic, requirements were developed to facilitate the identification of the population at risk of detrimental COVID outcomes to facilitate outreach efforts. The requirements considered were based on clinical, social and behavioral factors and factored for the severity level of those base conditions. As an example, a patient with chronic obstructive pulmonary disease (COPD) who is on oxygen would be added to the “at risk” population. Using these requirements data was mined across clinical, behavioral, and social datasets to flag these patients. This data was then incorporated into the WPC Master Candidate List (MCL) and data marts to allow for identification of patients for outreach activities such as targeted COVID-related mailers. <u>Behavioral Health Data Warehouse</u>**:** The WPC subpopulation with behavioral issues is significant and the ability to link to Behavioral Health data for cross population analysis is key for WPC. This task has always been challenging and the complexity of this task was further exacerbated by the fact

	that the BHSD is in the middle of a transition to a new EHR platform, with a need to support synchronized data access to both sets of data based on several factors. A project was undertaken to support the BHSD in the development of some crucial data vault based warehousing technology that isolated users and analysts of data from having to deal with two disparate datasets, instead providing one seamless connection to one record per patient with the associated service data. The requirements gathering, architecture and vault design, project planning and governance work to support this effort and a part of the build represented crucial progress in this area. The budget amount claimed in the PY5 Annual invoice for this incentive is $375,000 (partial amount). This incentive is paid to the County of Santa Clara and supports the work of several agencies within the system.
Trust Community Provider Incentives (DUAs)	No DUA's were signed in CY 2020, due to the uncertainty of the continuation of Whole Person Care. Once it was clear in late December that WPC was to continue in 2021 (PY6); then OSIT initiated new DUAs which were processed in PY6. No funds will be claimed in the PY5 Annual invoice for this incentive.
Peer Navigation Complete one training of supervisors of peer navigators and workers on supervision. Provide monthly technical assistance / mentoring session for agencies employing peer navigators and	Given the COVID pandemic, it was not possible to convene the planned in-person "effective supervision" training that was developed and rescheduled multiple times. In lieu of the planned training, a series of trainings were identified by the WPC Staff Developer that were available through the County's SCCLearn professional development training and resources. The RNs were asked to complete four training modules over several months (June-August) and submit their certificates of completion. A total of *20 RNs* successfully completed these sessions. This incentive was completed and thus $30,000 (full amount) is claimed in the PY5 Annual invoice. With the launch of the new Coordinated Care Module, as part of the Epic/HealthLink system, several trainings were held and were customized based on job duties/job classifications. Two trainings were provided by the OSIT/WPC and Technology Services & Solutions (TSS) teams for the Community Workers on October 28

workers. Hold monthly group supervision / mentorship meetings for peer navigators and workers to support problem solving.	and 30, 2020. To spend down the remaining allocated budget of $20,000 ($20,000 per session) one of these two trainings will apply toward this incentive. The total amount invoiced for this incentive as part of the PY5 Annual invoice is $20,000 (full amount). Given that many Community Workers have been redeployed as DSW, one of the ways to maintain regular communications and updates has been through the *Community of Practice* meetings facilitated by the OSIT Director and coordinated the by OSIT/WPC team. The purpose of the *Community of Practice Meetings* is to engage care coordination teams from across the enterprise and includes care coordinators from SCVMC Primary Care, SCVMC Specialty Clinics, VHHP, O'Connor Hospital, and St. Louise Regional Hospital. As part of these meeting OSIT Director provides inspiration; provides system updates and facilitates a discussion(s) on current issues (e.g., COVID; health and racial equity issues); offers and engages staff to share best practices, help identify areas of concern and possible mitigation strategies, share lessons learned and success stories with other WPC team members; offers education on community resources and tools (often by guest speakers); and offers a forum to support networking and learning from their peers. These meeting have all been done remotely since the Shelter in Place orders were first put into effect. A total of three sessions were convened on September 11, October 29, and November 19, 2020. To spend down the remaining allocated budget of $20,000 ($10,000 per session) two of these three meetings will apply toward the completion of this incentive. The total amount invoiced in PY5 Annual invoice is $20,000 (full amount). The amount claimed for the three incentives tied to Peer Navigation in the PY5 Mid-Year invoice total $70,000 (full amount). This incentive is paid to the County of Santa Clara and supports the work of several agencies within the system.
Navigation Center - Workflow Analysis	The gaps in the current after hour nurse advisory workflow. This work is done by an out of state contracted agency, which does not have access to HealthLink, the EHR, so information about patient contact is sent via a message and thus they are unable to record any client specific information into the health records. The agency also does not send daily updates on the number and types of calls

	handled; and does not have access to or training on any of the county specific COVID resources and hence we have no way of knowing what kind of resources or engagement is being provided. We do know that since the pandemic started their call volume has nearly doubled/tripled monthly. Because of the deployment of nursing staff at the call centers, we have identified the strengths and advantage to having nursing staff managing calls and know first had that this is highly viable staffing model which would be critical in addressing a significant gap in our workflow. To capitalize on the current momentum gained through response to the pandemic, OSIT is actively engaging with the nursing and clinical leadership at the hospital to make this staffing change a permanent solution to fix this problem. No funds will be claimed in the PY5 Annual invoice, as this was claimed in the PY5 Mid-Year invoice.
Sobering Center– Medi-Cal Applications for those without insurance	A consistent process for doing Medi-Cal applications was set up in the sobering center. As a result, six new applications were completed in the sobering center for Medi-Cal (as billed in FFS 6) This appears to be an underestimation, based on staff feedback. It is most likely due to non-integrated EHR systems. OSIT/WPC would also like to acknowledge team members assistance to clients for Medi-Cal renewals as well. The budget amount claimed in the PY5 Annual invoice for this incentive is $3,000 (full amount). This incentive is paid to the County of Santa Clara that has contracted with a third party to provide these services on the County's behalf.
NEW Provide community clinic partners with an incentive to stand up low barrier / high volume testing sites (i.e., >100 tests available / site / day	Contracts in mid PY5 were developed to support our community partners to set up community sites to support COVID testing by the following community clinic partners: Asian Americans for Community Involvement (ACCI), Gardner Family Health Network (Gardner), Indian Health Center of Santa Clara Valley (IHC), and Roots Community Health Center (Roots). ACCI, Gardner, IHC, and Roots are the clinics with the biggest workload of all the community clinics. Over 1,300 individuals received testing and education at all community sites, most of those served came from Gardner, IHC and Roots. These clinics

	exceeded the numbers of sites set up and this will be readjusted as part of the invoicing process. AACI also used the opportunity of testing to set up screenings for those attending to be offered blood pressure checks as well. The budget amount claimed in the PY5 Annual invoice for setting up this structure which required updating of all contracts is $20,000 (full amount). The services are included in the Administrative Infrastructure category under the Wellness line item. This incentive is paid to the County of Santa Clara because the services are contracted by numerous third-party agencies that provide these services on behalf of the County.
NEW Provide community clinic partners an incentive to provide follow-up education and connection to services for COVID+ to individuals in the community they serve (per community clinic site).	Contracts in mid PY5 were developed to support our community partners reaching out to COVID positive patients. Over 350 patients were contacted after receiving a COVID positive result by RNs at the various clinics. No funds will be claimed in the PY5 Annual invoice for this incentive. Instead the services will be reimbursed as part of the Wellness activities in the Administrative Infrastructure category.
NEW Care Coordination with patients in SNF and WPC Eligible	Unable to complete due to SNFs concentration on getting patients and staff tested for COVID and reducing all but essential interaction with SNF staff and patients. The OSIT MSW has supported connection and support during the COVID shelter in place orders and was instrumental in care coordination with the skilled nursing facility staff patients and families. There are 23 individuals supported in this work referred from Multidisciplinary Rounds in the hospital. It is anticipated with vaccines for staff and patients in SNFs, this work can continue to ramp up in PY6. No funds will be claimed in the PY5 Annual invoice for this incentive.

NEW Rapid Deployment of Resource Directory for Use with WPC Populations to Support COVID Response	After nearly four years of effort, due to this initiative we were able to pilot an online resource directory at multiple departments within the Health and Hospital system, Behavioral Health and Custody Health. Aunt Bertha is the nation's largest cloud-based online search and referral platform for free and reduced cost social programs such as food, housing, transportation, goods and other SDOH. The goal of the project is to: • create a comprehensive customizable resource directory for county agencies, • enable users to be more efficient in their search for resources, • increase collaboration with internal and external providers, • move away from using traditional binders/home-grown referral data systems and • have up-to date accurate information on available resources. • conduct logged or direct referrals, track and monitor the status of referrals to support linkage to needed resources. • Future goal: With the patient facing portal, empower the patient to build skills to navigate the system and connecting to needed resources. • Benefit: Easily connect non-English speaking patients with translated resources. During Phase 1, the safe integration of the Aunt Bertha resource directory platform was verified, end users were trained to use the directory and identified improvement and expansion opportunities. About 8 external, 23 internal and 3 road shows were held to implement and execute the Aunt Bertha Resource Directory Phase 1 and Phase 2 projects. Fifty-seven users from county sites are using Aunt Bertha: • SCVMC Hospital and Clinics – 24 users

	• O'Connor Hospital – 8 users • St. Louise Regional Hospital – 8 users • Behavioral Health Services Department – * users • Public Health Department – * users • Custody Health – * users • Office of System Integration and Transformation – * users Based on feedback from the end users we have embarked on Phase 2 of the project which includes 1. Large scale expansion of users across enterprise level 2. Integration into Epic or any agnostic client record systems 3. Use Protected Health Information (PHI) for making close loop referrals. The budget amount claimed in the PY5 Annual invoice for this incentive is $50,000 (full amount). This incentive is paid to the County of Santa Clara because the services are contracted by numerous third-party agencies that provided these services on behalf of the County.
NEW Development of Reporting Tool to Identify All Individuals Touching the Health System for Services and Further Provide Breakdown of Demographics	To date this has required ~60 hours of time and will require ongoing iterations and build by our data infrastructure and architecture teams (anticipate a minimum of 200 hours required). The target outcome of this work will be a dynamic Tableau report that can be used for high level aggregate summary information or for more focused outreach for the at risk and vulnerable populations. Through the building of this report, there will be additional capacity to expand to additional demographic or at-risk considerations using similar coding and structures. Although area of great interest across the county, there has not been other funding identified or earmarked for this project. The requirements to support Health System's system-wide collection of summary data on basic demographics and services to support an overall view of the counts of clients served by the Health System for the entire population served by these systems and counts within each departmental/key service area such as the main Health System, Behavioral Health, Custody Health were developed, and work was done in the following areas. **Requirements Gathering**

	Report and Dashboard Requirements Gathering: The development team worked with administrative users to create requirements for the reports and dashboards to support the project. County district Zip Code Map Research and Data Gathering: The development team also met with representatives from the County Registrar of Voters to acquire accurate district zip code mappings to use are part of the project. **Development Work** Code Normalization and Mappings: Given the disparity of race and ethnicity values in the various clinical records such as HealthLink and Unicare an effort was made to standardize the race/ethnicity representation in accordance with what the representation used by the Census, mapping tables were implemented against the aggregate data source to facilitate using a standardized race/ethnicity value set. Cross System Patient Matching: Data was matched across the BHSD and the larger Health System to provide an unduplicated person count across the systems. Cross System Persons Receiving Services**:** Work was also started to evaluate the people receiving services within a given timeframe with a focus on representing the broadest set of services provided by the systems while filtrating out invalid services. Dashboard and Report Development: For the integrated Health System and BHSD dataset dashboards were developed to represent. a. Overall count of patients with services b. Service line based and departmental breakdowns of counts of patient served. c. Demographic breakdowns including a. Race/Ethnicity b. Age Bands c. Sex d. Gender Identity d. Patient Address to County Zip Code Mappings: Zip code based mappings for patients with services that can be linked to various elected official districts. The budget amount claimed in the PY5 Annual invoice for this incentive is $500,000 (full amount). This is paid to the County of

	Santa Clara as it supports the work on several agencies within the system.
NEW Staffing Education: Coping, Resilience and Work with Vulnerable Populations	To support staff education in coping, resilience and work with vulnerable populations during the COVID response we contracted with an agency to provide trauma response work in 1:1 session as well as provided opportunities to attend group sessions of Tai Chi and Qigong via remote sessions. Sessions were open to all WPC staff as well as any DSW working in the COVID response. The feedback was positive from the provider as well as the staff who attended. There were 73 total sessions completed. Additionally, through the County's Employee Assistance Program approximately 380 employees were provided education on social justice issues during 16 sessions held during July-December 2020. The dates of training were as follows: July 9, 16, 23 and 30; August 13, 20, 27; September 3, 10, 17, 24; October 1 and 15; November 5 and 19; and December 1, 2020. The budget amount claimed in the PY5 Annual invoice for this incentive is $60,000 (full amount). This incentive is paid to the County of Santa Clara because the services are contracted by numerous third-party agencies that provided these services on behalf of the County.

County of Santa Clara Health System (previously the Santa Clara Valley Health and Hospital System) – County of Santa Clara
Annual Narrative Report, Program Year #5
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V. NARRATIVE – Pay for Outcome

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

Baseline - Program Year 3

			Updated Baseline			PY2 Annual			PY3 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
AMB	AMB	↓	11,413	39,990	285	9,640	33,180	290	8,719	38,212	279
IPU	IPU	↓	1,996	39,990	0.050	1,784	33,180	0.054	1,542	31,212	0.049
FUH	FUH7	↑	611	906	67.44%	887	1,205	73.61%	1,222	1,738	70.31%
FUH	FUH30	↑	671	906	74.06%	1,009	1,204	83.80%	1,417	1,738	81.53%
IET	IET - Initiation	↑	545	670	81.34%	720	826	87.17%	594	701	84.74%
IET	IET - Engagement	↑	81	670	12.09%	130	826	15.74%	85	701	12.13%
ACR	ACR	↓	204	961	21.23%	202	875	23.09%	190	780	24.36%
PHQ9	PHQ9	↑	*	*	*	*	91	*	*	103	*
MDD	MDD	↑	*	*	*	*	644	*	*	668	*
OSH	Supportive Housing	↑	99	123	99	28	44	28	69	100	69
CCP1	CCP1	↑	1,793	2,170	82.63%	36	2,756	*	1,831	2,929	62.51%
CCP2	CCP2	↑	1,887	2,170	86.96%	128	2,756	*	1,934	22,929	66.03%
	Enrollment and Assessment										

Program Years 4 and 5

		PY4 Mid-Year			PY4 Annual			PY5 Mid-Year			PY5 Full Year		
Metrics	Desired Trend	Numerator	Denominator	Rate	Numerator	Denominator	Rate	Numerator	Denominator	Rate	Numerator	Denominator	Rate
AMB	↓	968	20,448	47.34	4,929	57,444	85.805	2,810	27,030	103.96	6,107	61,872	98.7038
IPU	↓	563	20,532	0.027	1,894	57,444	0.033	771	27,030	0.030	1,700	61,872	0.027
FUH7	↑	20	32	62.50%	142	272	52.21%	15	30	50.00%	55	90	61.11%
FUH30	↑	26	32	81.25%	186	272	68.38%	20	30	66.67%	67	90	74.44%
IET - Initiation	↑	482	556	86.69%	337	966	34.89%	109	346	31.50%	173	508	34.06%
IET - Engagement	↑	73	556	13.13%	98	966	10.14%	26	346	7.51%	50	508	9.84%
ACR	↓	74	318	23.27%	252	1098	22.95%	91	421	21.62%	233	996	23.39%
PHQ9	↑	0	34	0.00%	*	630	*	*	*	*	*	*	*
MDD	↑	*	*	*	*	*	*	*	*	*	*	*	*
Supportive Housing	↑	26	36	72.22%	90	195	46.15%	38	77	49.35%	131	182	71.98%
CCP1	↑	671	1,135	59.12%	1,508	2,608	57.82%	529	829	63.81%	1046	1,540	67.92%
CCP2	↑	1,337	3,483	38.39%	1,539	4,403	34.95%	1050	4,362	24.07%	1349	4,886	27.61%
Enrollment and Assessment		3482	3483	99.97%	1953	2342	83.39%	691	806	85.73%	864	1,372	62.97%

(AMB) Emergency Room utilization, (IPU) Inpatient Days and (ACR) All Cause Readmission

Compared to baseline, the utilization has dropped. Compared to PY 4 while both the Mid-year and the Annual rates are higher, the PY5 Annual rate is lower than the mid-year. This may be attributed to the reduction in ambulatory care access during COVID. Also, as the Sobering Center has expanded its scope, it is clear from the data how compromised the health of those individuals are, with Behavioral Health, Substance Use, and medical problems. The internal data has indicated that these patients have sought emergency care more often. The bigger issue is that this metric really does not reflect the true performance of the WPC program. Our internal data, measured from the date of enrollment, shows a reduction in ED utilization and inpatient days, while not necessarily a reduction in All Cause Readmission (ACR).

FUH7, FUH30, PHQ-9, IET, MDD

The mental health metrics are small numbers and difficult to pull as we have limited access to the Behavioral Health Database, so follow-up is difficult to measure. While we have seen an increase in follow-up for Substance Use as listed under the incentive initiatives, when pulling the larger numbers for this metric, it is not so apparent. Work on MyAvatar, the Behavioral Health EHR and data reporting may improve this by the end of PY6, or it may take longer.

Housing

With an increased emphasis on assessment of housing needs (through the VI-SPDAT) and collaborative work with OSH, we have increased the number of individuals in PSH year compared to PY4.

Enrollments and Assessments within 30 days

When WPC started, 10,000 High Utilizer patients (HUMS) were identified. Over time that number has dropped, probably due to several factors, including other quality improvements in healthcare. As noted above those enrolled in WPC have also reduced their ED visits and length of stay in hospitalizations, thus affecting two factors responsible for the scores of HUMS patients. Therefore, the total population of those with HUMS scores from 9 points and above is smaller.

When the enrollments and assessments were first completed, OSIT conveyed to DHCS that the number was largely based on enrollments as we did not have a robust way to pull the date of assessments from our EHR, except for those clinics reporting data to us.

Therefore at least two-thirds of the data was not available to us and was reported based on the proxy of enrollments alone. Since then, our HealthLink entry and thus data collection has dramatically improved. In addition, further work on reporting from external sources, has resulted in confidence that the numbers included in this report are refined and accurate.

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.

During the second half of PY5, the stakeholder groups continued to be impacted by the pandemic, redeployment of staff as DSW or to other COVID-related duties to meet the ongoing need within the healthcare system and in the community as well as dealing with the uncertainty of whether WPC would be extended for another year.

Internal T2020/WPC Steering Committee

This committee had been made up of key executives who shifted to a monthly meeting schedule at the end of PY4. During the first two months of PY5, this committee focused on strategic planning as PY5 (or CY 20) was the anticipated final year for both T2020 and the WPC pilot. As this end day approached, this group began to work concurrently on CalAIM planning. Then came the COVID crisis and leadership's attention was redirected to addressing the current needs. Based on the relationships built from this work, and the frequent collaboration between key Health System executives in the Command Center activities, issues, as they arose for the key initiatives were managed in real time and adaptations were made to address acute needs with T2020 and WPC learnings throughout the year.

WPC Stakeholders Group

This group of directors, managers and operational staff from internal and external organizations with the WPC eligible populations had been meeting quarterly to work on integration, identify opportunities for collaboration, monitor progress and share lessons learned. Again, meetings were put on hold with the COVID crisis, but informal networking continued. On September 24, 2020, a group of sixty people reconvened and participated in an interactive session via zoom. WPC partners from seven departments/organizations showcased their work and collaboration on two COVID-related projects. The meeting started with introductions, updates and a preview of newly produced *Whole Person Care COVID Response* video. Panel discussions included the following topics: Mission Street Sobering Center and Expansion to Support Mental Health/Substance Use Triage; Joint Department Operations Center (JDOC) to Assist Homeless Individuals in Need of Shelter; and Contract Tracing in Santa Clara County. The meeting was very well received by the sixty participants.

T2020 Domain Leaders

An assessment of leadership by domain and new engagement techniques were deployed to further engage in the goal setting, outcome alignment and planning for PY5. COVID prevented the frequency and commitment to the meetings; however, the work and goals met today may have contributed to the resiliency in some of the response needed for the immediate work for COVID. Official meetings did not occur routinely, yet outcomes included: MAT: Custody work toward spreading best practices; and care coordination to include greater telehealth components and streamlined documentation and workflow. The second half of PY5 focused on outcomes and lessons learned across the Domains.

Waiver Planning Team

PY5 brought additional changes to this team and their focus as CalAIM and additional managed care initiatives and reporting requirements needed a more focused effort in streamlining. The leadership and participation of this team was in final decision making as COVID hit. Although the meeting frequency and focus was affected, the result was a strong and this cohesive team focused on alignment around the work with focus on patient/client centered care and population health management principles. This team has also focused on determining care coordination current state across multiple programs and has begun the work on developing a gap analysis and best practice guide to what CalAIM notes as ECM and ILOS.

The leadership and waiver groups went through some reorganization during PY5. The key focus was on alignment and planning for waivers and data management. A series

of preliminary meetings with executive leadership and key decision makers were held to decide the best structure to work collaboratively and meet the integration goals across the Health System enterprise. As a result, two new groups came out of several of the existing stakeholder groups which will continue into PY6.

Healthcare Transformation Steering Committee Group replaced the Executive Steering Committee and Waiver Planning Team. Key leaders from all waiver programs worked to align metrics and focused on workflows and reports to serve the primary care departments to have visibility on key metrics. Although some focus was pulled to support COVID initiatives, meetings continued to take place and the feedback was used to inform the population health technology services team on prioritization of key improvements and projects to implement for the EHR. Three meetings convened on July 16, September 17, and November 19, 2020. To help to operationalize the work identified by the Healthcare Transformation Steering Committee, a Population Health Advisory Team began meeting in July and met biweekly (10 meetings) throughout the year. Led by a strong program manager, she helped to guide the prioritization and the teams to complete the work prioritized by leadership decisions.

Consumer Advisory Committee

This committee of Health System staff, community advocates and patients/clients had met monthly prior to COVID. This committee helped to promote WPC, help identify gaps in care and collaboratively work together to support possible corrections and improvements. During the June meeting, the committee discussed transition planning to help find a home and maintain the committee's function and contributions to the system. At the August 24, 2020, the WPC Consumer Advisory Committee (WPC CAC) agreed to begin the transition process and join forces with the existing consumer group, Patient-Family Advisory Team (PFAT). PFAT is coordinated by SCVMC staff and meeting are held monthly at each of the Valley Health Center locations. The addition of WPC CAC members to PFAT will help to raise the issues for high need patients seen in the Health System. PFAT membership enthusiastically welcomed the integration of the two group. The OSIT team continued to support this transition through the end of year.

Additional groups help to support the WPC pilot and are designed to build improved interagency, interdepartmental and community support which is necessary to meet the needs of the WPC populations. Most of these groups continue to be facilitated by the WPC team; however, there are some in which WPC is an active member.

A list of current stakeholder partners (Attachment 4A) and detailed listing of meetings convened and attended during the second half of PY5 (July 1 – December 31, 2020) are outlined in Attachment 4B.

VII. PROGRAM ACTIVITIES

Care Coordination

A. Briefly describe 1-2 successes you have had with care coordination.
    1. Implementation of comprehensive module in EHR and completion of staff guide.
    2. Reverse enrollment program allowed for clinicians and care coordinators to start engagement and care coordination activities on first visit with eligibility check after engagement. (10% of enrollments)
B. Briefly describe 1-2 challenges you have faced with care coordination, and lessons learned from those challenges.
    1. Deployment of WPC staff to COVID response teams pulling from outreach, engagement and care coordination activities. We learned to coordinate more efficiently with internal and external partners.
    2. Shelter in place limited in person clinics and encounters that required increase focus on mail and phone outreach which is less engaging to some of the populations we serve in WPC, particularly homeless individuals with limited access to communication. Santa Clara will reorganize our strategy in the next program year.

Data Sharing

A. Briefly describe 1-2 successes you have had with data and information sharing.
    1. Eligibility – Eligibility interface with Santa Clara Family Health Plan (SCFHP) – the build and deployment of an automated standards-based eligibility interface with SCFHP that significantly improved the quality of data for eligibility and Aid code validity when compared to previous source. Development of a batch process to bulk check eligibility on an as need basis for any payer.
    2. Integration Infrastructure with Behavioral Health – Deployment of a data vault based integrated reporting system for BHSD that pull together client and service information from multiple BHSD systems making it easier to do population analysis work for subpopulation on a case-by-case basis based on County Compliance's approval.
    3. COVID at Risk Population Identification – To support the identification of the COVID at risk population, data mining of clinical, behavioral and social determinants of health datasets was done. The COVID at risk population was then identified using these base clinical, behavioral and social factors and considering the severity of those base conditions. This data was then

integrated into the WPC Master Candidate List and data marts to support outreach activities.

B. Briefly describe 1-2 challenges you have faced with data sharing, and lessons learned from those challenges.
    1. Legal and compliance hurdles take time and focused energy to complete. Delays occurred and allocation of resources were shifted in PY5 related to the COVID response required across agencies.
    2. The lack of a unified care coordination platform across all entities participating in WPC still leads to patient transitions being suboptimal, with evidence that when the transition is not smooth, the outcomes are problematic. More effort will be focused to address this barrier in the next program year.

Data Collection

A. Briefly describe 1-2 successes you have had with data collection and/or reporting.
    1. Investment and stakeholder engagement from community partners in refining and simplifying data collection from multiple external sites. Ongoing data quality improvements also continued through review of data at Trust Community meetings.
    2. The integration of community clinic care coordination data was further automated in 2020 leading to improved timeliness of data received from the community clinic partners.
B. Briefly describe 1-2 challenges you have faced with data collection and/or reporting.
    1. Staff turnover (due to reassignment as DSWs) during the pandemic caused data quality issues due to new staff needing to come up to speed on data submission processes. Continue effort on staff training and turnover in the coming program year.
    2. Data submission definitions unclear to new team members; solved by meetings and development of the staff guide.

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

The transition to CalAIM will be the biggest challenge in program year six while managing the ongoing pandemic response. The largest hurdle and barrier to cross in the program year will be data integration and sharing from multiple community partners,

Health System departments, and the managed care plans in prompt and efficient manner. This will be further complicated if the managed care plan directly contracts with all independent providers versus directly with the County who has developed significant infrastructure through the pilot. The second largest barrier anticipated is the challenge of eliminating overlap of services across the County's departments providing ECM which will again be increased with independent provider contracts versus direct with the County.

VIII. PLAN-DO-STUDY-ACT

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

PDSA Attachments:

1. Whole Person Care PDSA Summary Report.
    a. The file is named *3.County of Santa Clara PY5 WPC Pilot PDSA Summary_04-01-21.xlsx*
    b. The items highlighted in light gray are the PDSAs submitted for the PY5 Mid-Year Report and those that are not highlighted are the additional PDSAs completed for the PY5 Annual Report.

2. Compressed file that contains the 13 PDSA submitted with the PY5 Mid-Year Report and the 16 PDSA completed for the PY5 Annual Report.
    a. The file name is *4C.County of Santa Clara WPC PY5 PDSAs_04-01-21*

    PY5 Mid-Year PDSAs
    1. Asian American Community Involvement (ACCI) – Ambulatory Care (ED Utilization), Comprehensive Care Plans and Care Coordination (combined) – Q1 & Q2
        a. File named: 01. ACCI Care Coordination Q1 Q2 PDSA.pdf
    2. Ambulatory Care - ED Utilization - SCVMC – Q1 & Q2
        a. File named: *02. Ambulatory Care ED Utilization Q1 Q2.pdf*
    3. Comprehensive Care Plans – All Sites – Q1 & Q2

   a. File named: *03. Comprehensive Care Plans Q1 Q2.pdf*
4. ED Targeted Outreach – Q1 & Q2
   a. File named: *04. ED Targeted Outreach Q1 Q2 PDSA.pdf*
5. East Valley Community Clinic (EVCC) - Ambulatory Care (ED Utilization), Comprehensive Care Plans and Care Coordination (combined) – Q1 & Q2
   a. File named: *05. EVCC Care Coordination Q1 Q2.pdf*

6. Gardner Family Health Network (Gardner Clinic) - Ambulatory Care (ED Utilization), Comprehensive Care Plans and Care Coordination (combined) – Q1 & Q2
   a. File named: *06. Gardner Care Coordination Q1 Q2 PDSA.pdf*
7. Indian Health Center (IHC) - Ambulatory Care (ED Utilization), Comprehensive Care Plans and Care Coordination (combined) – Q1 & Q2
   a. File named: *07. IHC Care Coordination Q1 Q2 PDSA.pdf*
8. Inpatient Utilization – SCVMC – Q1 & Q2
   a. File named: *08. Inpatient Utilization Q1 Q2 PDSA.pdf*
9. Planned Parenthood Mar Monte (PPMM) - Ambulatory Care (ED Utilization), Comprehensive Care Plans and Care Coordination (combined) – Q1 & Q2
   a. File named: *09. PPMM Care Coordination Q1 Q2.pdf*
10. Ravenswood/MayView - Ambulatory Care (ED Utilization), Comprehensive Care Plans and Care Coordination (combined) – Q1 & Q2
    a. File named: *10. Ravenswood MayView Care Coordination Q1 Q2 PDSA.pdf*
11. Roots Clinic - Ambulatory Care (ED Utilization), Comprehensive Care Plans and Care Coordination (combined) – Q1 & Q2
    a. File named: *11. Roots Care Coordination Q1 Q2 PDSA.pdf*
12. School Health Clinics - Ambulatory Care (ED Utilization), Comprehensive Care Plans and Care Coordination (combined) – Q1 & Q2
    a. File named: *12. School Health Care Coordination Q1 Q2 PDSA.pdf*
13. Technology Eligibility Infrastructure – Data – Semi-Annual
    a. File named: *13. Technology Eligibility Infrastructure Data Q1 Q2 PDSA.pdf*

<u>PY5 Annual PDSAs</u>

1. File named *01.Ambulatory Care ED Utilization Q3 Q4 PDSA.pdf*
2. File name *02.ACCI Annual Reassessment Process Q4 PDSA.pdf*
3. File name *03.CoCM Module Implementation Q2 Q3 Q4 PDSA.pdf*
4. File name *04.Community Clinics Chart Review Transition Q3 Q4 PDSA.pdf*
5. File name *05.Community Clinics PDSA Transition Q3 Q4 PDSA.pdf*

6. File name *06.COVID Outreach Project Q4 PDSA.pdf*
7. File name *07.Drug & Alcohol Screening Q1 Q2 PDSA.pdf*
8. File name *08.Eligibility Processing Infrastructure Q1-Q4 PDSA.pdf*
9. File name *09.Gardner ED Utilization Follow Up Q4 PDSA.pdf*
10. File name *10.IHC PHQ-9 Screening Q4 PDSA.pdf*
11. File name *11.Inpatient Utilization Q3 Q4 PDSA.pdf*
12. File name *12.PPMM MMCC SHA Q4 PDSA.pdf*
13. File name *13.Ravenswood Screeners Q4 PDSA.pdf*
14. File name *14.Reverse Enrollment Process Q1-Q4 PDSA.pdf*
15. File name *15.Roots PCP Utilization Q4 PDSA.pdf*
16. File name *16.School Health Homeless & ACES Screenings Q4 PDSA.pdf*