



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



**Reporting Checklist**

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Santa Clara Valley Health and Hospital System  
 Annual Report – PY2  
 4/2/2018

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

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

**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**

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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](mailto:1115wholepersoncare@dhcs.ca.gov).

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## II. PROGRAM STATUS OVERVIEW

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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.*

### **1. Increasing integration among County agencies, health plans, providers and other entities**

#### Successes

- Successfully contracted and engaged internal and community partners to identify patients, manage risk and improve integration across systems. Partnerships include: Gardner Family Health Network (Gardner), Roots Community Health Center (Roots), Office of Supportive Housing (OSH), Social Services Agency (SSA)
- One insurance plan (Valley Health Plan) was chosen to pilot. The goal was to identify comprehensive picture of use of health care resources from internal Santa Clara County (SCC) and external agencies. As a result, the Santa Clara Valley Health & Hospital System (SCVHHS) has very comprehensive data on our WPC population. The goal is to apply these learnings subsequently to other insurance plans in formulating data use agreements (DUAs) and contracts for sharing of data.

#### Challenges

- Aligning operating services and improving patient access across multiple sites and with community agencies.
- Resolving issues to enable data exchange across all partners; this will be fully optimized when Healthy Planet Link is operational (11/4/18 ETA).
- Special agreements need to be signed by participating agencies and staff (in addition to the contracts/MOUs, DUAs) to be able to use Epic/Health Link electronic health record (EHR).
- Behavioral Health Services Department (BHSD) is on different EHR system: documentation, billing and collection of data is labor intensive.

#### Lessons Learned

- Securing contracts and DUAs is a lengthy process. SCVHHS has been aided by a delegation of authority to the Deputy County CEO/Director of SCVHHS rather than presenting each contract to the Board of Supervisors for approval.
- Importance of building robust relationships with partner agencies, including regular meetings and feedback.

### **2. Increasing coordination and appropriate access to care**

#### Successes

- Established strong partnership with community clinics – Gardner and Roots.

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- Dedicated RN worked with the clinics to help develop staffing, processes and trouble shooting.
- Piloted documentation systems with social work staff in EHR, which is potentially exportable with limited modification to all non-billing providers, acting as care coordinators.
- Community partners expanded to include WPC with better care access across independent entities, such as specialty care for patients followed by Gardner.
- Co-location of services with Mental Health Services and Roots clinic enabled reduction of stigma and ease of access for staff consultation and patient appointments.

## Challenges

- The magnitude of the care coordination in multiple systems (which exist in silos) is very difficult. Despite overarching policies, there is a lack of consistent processes and responsibilities for implementation, with roles & responsibilities clearly identified.
- Lack of resources to address Social Determinants of Health (SDOH) (e.g., transportation and housing) have been identified as ongoing issue for community organizations, Gardner and Roots.
- Lack of ways to consistently document SDOH is a challenge.

## Lessons Learned

- Smaller sites (Gardner and Roots) are easier to engage than changing a whole system (SCVMC).
- Leadership has to buy into integrated systems. SCC went back to the drawing board to relook at integration which led to establishment of Transformation 2020 (described in more detail in Leadership).

### **3. Reducing inappropriate emergency and inpatient utilization.**

## Successes

- Modest reduction in emergency use with Gardner and Valley Health Homeless Program.
- Development of refined dashboards (including PDSA dashboards) to help simplify the data and used to monitor status and address potential issues to ensure positive patient outcomes. Shared with leadership and plan is to rollout to each SCVMC clinic in 2018.

## Challenges

- While data may show improvements, it is necessary to analyze more deeply to look at the relationship to WPC.
- Determine best way or processes to use the data by various stakeholder groups.
- Ensuring that the data is available regularly and close to real-time – difficulty in obtaining external claims data, means that data may change over time.
- No notification from ED of patients seen is currently sent to the PCPs or providers in Specialty Care or BHSD. SCVMC notification via Health Link to be launched.

## Lessons Learned

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- Issues of ED utilization are complex and require multiple interventions for different populations. In 2018, SCVHHS will concentrate on substance use: Opioid Dependence and Alcohol Detox in ED.

#### **4. Improving data collection and sharing**

##### Successes

- Implementation of a Master Person Index in the second half of PY 2.
- Automation of interfaces with external partners supports sustainability of the system and reduces burden on caregiver staff.

##### Challenges

- Demonstrating the value of engagement in the data integration efforts took a significant amount of investment (e.g., two monthly meetings about data initiated by the Community Health Partners with WPC staff in attendance and quarterly meetings initiated by SCC).
- Prioritization of integration efforts amongst already busy partners.

##### Lessons Learned

- Dedicated focus of clinical and operations staff earlier helps with streamlining user facing analytics later.
- Better communication around the analytical tools needs to be developed in a resources guide/manual for new users.

#### **5. Achieving quality and administrative improvement benchmarks**

##### Successes

- Successfully established baseline for performance.

##### Challenges

- Need to understand processes to meet targets in some cases. For example, with the integration of referrals and data sharing between SSA and BHSD there were no workflows (being addressed in 2018).
- Multiple meetings and ground work occurred to understand the processes in order to establish PY 2 baseline for future benchmark reporting.

##### Lessons Learned

- Understand and analyze the processes and redesign data collection if necessary.
- Analyze the resources needed to complete. In many instances there are limited resources for this work.
- Importance of continuing to improve data integration, collection and sharing.

#### **6. Increasing access to housing and supportive services**

##### Successes

- Launched HUD assessment of housing needs with Vulnerability Index - Service Prioritization Decision Assistance Tool (VI-SPDAT) at Gardner and Roots.
- Convened multiple planning meetings with OSH and SSA.
- Identified universal websites to facilitate referrals tied to SDOH.

##### Challenges

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- Unclear who is coordinating care when referred to housing coordinators, usually not related to overall care needs.
- Need to share who is providing services and how to refer and collaborate with existing partner resources (a central navigation center is needed as a single source of truth for all).

## Lessons Learned

- Importance of sharing resources (e.g., communications and/or training) so that patients are better connected and served by organizations best qualified and have appropriate resources.

## **7. Improving health outcomes for WPC population**

### Successes

- Using PDSA metrics via dashboards to look at improvements made.
- Measured health by meeting of PRIME metrics for all WPC patients.

### Challenges

- Despite intensive efforts and many gains in BHSD, integration of behavioral health in Primary Care has been slow and means referral for patient care has to go to Behavioral Health directly.

### Lessons Learned

- HUMS patients were “sicker” than originally anticipated.
- Helping staff to look beyond current encounter to looking at the long term needs of the patient is difficult. We perceive more awareness by staff but systems and information for referrals needs to be in place (Navigation Center).

Modified bundle services based on needs for PY 3 via Budget Adjustment process.

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**III. ENROLLMENT AND UTILIZATION DATA**

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

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

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

Item	Month 1	Month 2	Month 3	Month 4	Month 5	Month 6	Unduplicated Total
Unduplicated Enrollees	0	0	19	1051	32	1615	*

Item	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12	Annual Unduplicated Total
Unduplicated Enrollees	13	0	0	23	*	*	2765

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.

FFS	Costs and Aggregate Utilization for Quarters 1 and 2						
	Month 1	Month 2	Month 3	Month 4	Month 5	Month 6	Total
Service 1	0	0	0	0	0	0	0
Utilization 1	0	0	0	0	0	0	0
Service 2	0	0	0	0	0	0	0
Utilization 2	0	0	0	0	0	0	0

FFS	Costs and Aggregate Utilization for Quarters 3 and 4						
	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12	Total
Service 1	0	0	0	0	0	1	1
Utilization 1	0	0	0	0	0	\$246.12	\$246.12
Service 2	0	0	0	0	0	0	0
Utilization 2	0	0	0	0	0	0	0

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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.

PMPM		Amount Claimed						
	Rate	Month 1	Month 2	Month 3	Month 4	Month 5	Month 6	Total
PMPM Category 1 (Rehab)	\$137.19	0	0	0	\$*	\$5,761.98	\$5,761.98	\$*
MM Counts 1		0	0	0	*	42	42	*
PMPM Category 2 (Short Term)	\$1,220.70	0	0	0	\$*	\$58,593.60	\$52,490.10	\$*
MM Counts 2		0	0	0	*	48	43	*
PMPM Category 3 (Medium Term)	\$1,363.54	0	0	0	\$*	\$456,785.90	\$484,056.70	\$*
MM Counts 3		0	0	0	*	335	355	*
PMPM Category 4 (Long Term)	\$882.88	0	0	0	\$*	\$*	\$*	\$*
MM Counts 4		0	0	0	*	*	*	*
PMPM Category 5 (Nursing Home Transitions)	\$2,076.70	0	0	0	\$0.00	\$0.00	\$0.00	\$0.00
MM Counts 5		0	0	0	0	0	0	0



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PMPM		Amount Claimed						
	Rate	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12	Total
PMPM Category 1 (Rehab)	\$137.19	\$18,795.03	\$18,246.27	\$17,560.32	\$18,520.65	\$15,502.47	\$16,599.99	\$116,885.88
MM Counts 1		137	133	128	135	113	121	852
PMPM Category 2 (Short Term)	\$1,220.70	\$228,270.90	\$209,960.40	\$195,312.00	\$338,133.90	\$324,706.20	\$301,512.90	\$1,708,980.00
MM Counts 2		187	172	160	277	266	247	1,400
PMPM Category 3 (Medium Term)	\$1,363.54	\$702,223.10	\$752,674.08	\$679,042.92	\$576,777.42	\$441,786.96	\$564,505.56	\$4,663,306.80
MM Counts 3		515	552	498	423	324	414	3420
PMPM Category 4 (Long Term)	\$882.88	\$172,161.60	\$169,512.96	\$143,909.44	\$136,846.40	\$146,558.08	\$139,495.04	\$934,087.04
MM Counts 4		195	192	163	155	166	158	1058

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

Overall Cohort - The core group of patients for WPC that SCVHHS was targeting were selected and enrolled during the first half of the year, as outlined in the Mid-Year Report. Four patients were added to the overall count as a result of reverse referrals made into WPC by partner sites including two by Gardner and two by Roots. There were also 298 dis-enrollments that occurred in the second half of Program Year 2 (PY 2) and thus a total of 2,471 patients were enrolled in WPC at the year end.

For the cohorts of patients that were enrolled in the first half of the year, a number of sites including Gardner, Roots, OSH, VHP complex managed care completed by Axis Point Health (APH) and BHSD engaged in assessments and provision of service utilization in the second half of the year with a steady level of service covering about nine hundred to a thousand patients across Short Term (ST), Medium Term (MT), Long Term (LT) and Rehabilitation & Peer Support (Rehab) services. The collection of data

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for assessments and services provided was a combination of automated and manual processes with reconciliation across all sources.

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#### IV. NARRATIVE – Administrative Infrastructure

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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.

The Administrative infrastructure noted in PY 2 mid-year report continued. The Office of System Integration and Transformation (OSIT) provides the infrastructure for the enterprise-wide WPC initiative. The Office consists of a Director, QI Manager, IT Manager, Project and IT leads. In late PY 2, a WPC MD physician with extensive work in population management joined the OSIT team. OSIT manages the contracts, works within SCVHHS, works with other SCC entities such as SSA, OSH and PHD, as well as with community partners and VHP. OptumInsight continued to provide project specific support for program management and deliverables for care coordination integration. OSIT leads the quality improvement efforts with the various clinical initiatives, including enrollment, community partner expansion and reduction of ED usage in the east San Jose area. Annette Gardner was retained to work with the project on program evaluation.

Tracking of contracts and expenses is completed with the Contracts Office of SCVHHS and monitored by the Finance Department. Regular meetings with both offices has ensured the OSIT leadership is up-to-date on resource utilization.

OSIT leads committees engaging stakeholders. (See Attachment) There has been overlap between committee functions and concerns by some participants of repetition between them. This will be addressed through a 2018 PDSA.

In late PY 2, a small group of leaders expressed concern that there were still silos between SCVHHS departments, duplication of efforts, and barriers for patients and families seeking care. With the support of the County Executive and the Deputy County Executive/Director of SCVHHS, they met to brainstorm what an ideal program would look like. The group leaders from VHP, SCVMC, BHSD, the Department of Innovation and Care Management identified five domains that crossed all systems which were both vertically and horizontally integrated. Working with a consultant, the leaders designed a model, met with individual departments in agency leadership, and presented the model to SCVMC and SCVHHS leaders. The five domains identified are: 1) Navigation Center to serve as a resource to patients and families as well as staff seeking the appropriate program or setting for treatment and building on the work completed in PY 2 by the Center for Population Health (CPHI); 2) Integrated Data Systems to leverage technology, inform actions with data, and assure accurate

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reporting from all sites and programs; 3) Population Health to identify gaps in care for patients and propose new strategies for at risk patients; 4) Care Management and Transitions of Care to integrate care with all providers and settings under the direction of one WPC coordinator for each patient to improve patient health proactively and reduce duplicate efforts and emergency utilization; and 5) Community and Preventive Health to identify populations not yet high utilizers but at risk for becoming more disabled, such as pre-diabetics. A rollout was planned for early PY 3, with a two-day intensive workshop to include a large number of staff from the internal stakeholder group. The restructure was labelled Transformation 2020 (T2020). Key goals were to develop sustainable, patient centered, integrated patient flow across departments while reducing duplication.

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## V. NARRATIVE – Delivery Infrastructure

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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.

The Trust Community Start-up began during the first half of the year and significant progress was achieved during the second half of PY 2:

- 1) The internal match algorithms used in the first half of the year were replaced by the implementation of the IBM Initiate Electronic Master Person Index (EMPI).
- 2) Significant effort was expended in automating the data exchange processes that were started during the first half of the year and for the main pilot partner, Gardner, weekly automated extracts were created for the following forms of data: Care Plans, Health Risk Assessments (HRAs), Services, and Communications. These datasets are now exchanged on a weekly basis with no human intervention with the exception of error resolution.
- 3) Fully executed Data Use Agreements (DUAs) with seven external partners in the second half of the year.
- 4) Further demonstrations, final evaluation and procurement was completed during the second half of the year into the Epic Healthy Planet Link tools that would extend the care coordination infrastructure into the community settings.
- 5) Significant progress made in the Trust Exchange build out and most notably with the expansion of datasets integrated from BHSD.
- 6) WPC dashboards were enhanced based on user feedback and incorporated the following changes: a) Metric comparison data for WPC metrics between different populations; and b) Analytic level metric performance dashboard that breaks down performance by site and programs and shows trends in performance.

The second half of the year saw investment in a number of technical operational guides being developed to support ongoing operations of the system, including the addition of new clients to the system and also supporting transitions of operations to County staff.

Some of the key WPC Trust Community Start up activities completed in the second half of the year include:

- Purchase of the IBM EMPI
- Phase 1 – EMPI Implementation
  - Server software
  - Connection of five data feeds covering six sources to the EMPI
    - Epic (HealthLink System)

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- Valley Medical Center (VMC)
- Custody Health Services
- QNXT System
  - Valley Health Plan (VHP)
- Unicare System
  - BHSD
- Nextgen System
  - GFHN
- Homeless Management Information System (HMIS)
  - OSH
- Linked IBM Patient Identity data to some analytic dashboards
- Implementation of a role based security model for the Enterprise Data Warehouse
- Automation of data sharing with Gardner for the following datasets
  - Care Plans
  - HRAs
  - Service Utilization
  - WPC Universal and Variant Metric related data extracts
- Development of Operational Documents
  - Integration and Interfaces Operational Guide
  - WPC Engagement Process Guide
  - WPC Enrollment Process Guide
  - WPC Reporting Guide

It should be noted that the implementation processes, templates and technology developed for Gardner are intended to be used with additional community clinics that will be engaged in PY 3 (2018).

Additional information about four other Care Coordination programs: Peer Respite, Medical Respite, Sobering Center, and Nursing Home Transitions are included in Appendix A.

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## VI. NARRATIVE – Incentive Payments

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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.

### **Provider Incentive Trust Community Adoption**

Most community entities elected to participate in the Trust Community (TC) and earning the incentives through signed DUAs and developed implementation plans. There are important entities that have not yet participated. The incentives were established to facilitate the completion of DUAs for entities integrating into the TC and establishing work plans for data sharing and they have been important to help defray expenses incurred by the participating entities. During PY 2, there was significant investment in the development of governance processes to support the creation of the DUAs with involvement by business, technical and legal staff. The development of DUAs facilitated discussions amongst community partners about the benefits of automating data exchange and ensuring there were the necessary protections to safeguard their business interests. The DUAs are a reflection of business partners having enough confidence in each other to share data and this is proving invaluable in providing a complete picture of patients as they progress through the continuum of care. Early adopters (e.g., Gardner and Roots) have served as catalysts to engage additional partners and have showcased the value of sharing information for care coordination, performance improvement and value-based payments.

In the second half of the year, six additional DUAs with external entities were successfully executed bringing the total number executed to seven. This was in addition to the seven internal collaborative arrangements reported at mid-year. Project Plans were augmented and managed to implement the following activities:

- 1) Completion of automation tasks for interface feeds related to WPC.
- 2) The replacement EMPI effort with five sources of data used to match person data from all of these sources using IBM's EMPI as opposed to using internal match algorithms.
- 3) Acquisition of data for WPC utilization from six sources using a combination of manual and automated processes.

### **Social Services Referral Integration**

SCVHHS has worked with SSA to create integrated workflows between SSA, Custody Health, (CHS), BHSD and transitional youth/General Assistance persons that will streamline referral processing, tracking of evaluations and engagement of individuals transitioning between systems. Discovery sessions have been completed between

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SSA and SCVHHS with the key finding is the need for an electronic means to refer patients to the BHSD for evaluation and treatment. Additional feedback demonstrated the need for comprehensive information on SSA services, such as Medi-Cal renewal dates for the Care Managers and staff within SCVHHS. Definitions of inbound and outbound datasets to be exchanged have also been completed, as well as the baseline data for the metrics was defined and collected. The work to document and streamline the integration between the parties was significant. Additionally, prioritization of the overall project by the agencies was not the same and there was initial inertia in the launch. Furthermore, acquiring an Electronic Master Person Index (EMPI) was delayed, which stalled the project launch for a significant period of time. The EMPI has been acquired, implemented and tested and will provide better person matching across the stakeholder agencies. Therefore, SSA has not received the incentive as planned but will meet the requirements in 2018.

### PY 2 Whole Person Care Incentive Payments

Incentive	Total Amount	Payment Recipients
Trust Community Adoption	\$ 1,620,000.00	<p>The following groups met the Tier 1 benchmark, generating payments of \$180,000 (gross) per entity.</p> <p>The following seven agencies completed the required activities to receive net incentive payments of \$430,000 in PY 2.</p> <ul style="list-style-type: none"> <li>• Gardner Family Health Network (Gardner)</li> <li>• MayView Community Health Center</li> <li>• Asian Americans for Community Involvement (ACCI)</li> <li>• School Health Clinics of Santa Clara County</li> <li>• Roots Community Health Center</li> <li>• Institute on Aging (IOA)</li> <li>• Indian Health Center</li> </ul> <p>Gardner and ACCI billed and received incentives in PY 2. The remaining funds were held and issued in early 2018.</p> <p>A net incentive of \$380,000 was received by SCVHHS for the internal collaborative arrangements completed with the seven entities listed below, as also noted in the mid-year report.</p>



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		<ul style="list-style-type: none"> <li>• Santa Clara Valley Medical Center (SCVMC)</li> <li>• Valley Health Plan (VHP)</li> <li>• Public Health (PH)</li> <li>• Behavioral Health Services Department (BHSD)</li> <li>• Emergency Medical Services (EMS)</li> <li>• Office of Supportive Housing (OSH)</li> <li>• Community Health Services (CH)</li> </ul>
Social Services Referral Integration	\$ 1,242,392.50	SCVHHS – partial incentive payment for work toward completion of SSA contract
Drug and Alcohol Screening	\$ 475,000.00	SCVHHS – partial incentive payment earned
TOTAL	\$ 3,337,392.50	

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## VII. NARRATIVE – Pay for Outcome

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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.

### Achievements:

#### Universal and Variant Metrics

The metrics were run at year-end for the WPC enrolled population. The data used for evaluation of the metrics came primarily from the Epic/HealthLink system. The results are shown in the table below. A baseline was run using the enrolled WPC population at year-end against the 2016 timeline for these patients and the annual numbers reflect the measure evaluation for the enrolled patients during the 2017. The last column color (coded in green in some cases) showcases improvements made in the metric during the measurement period. It should be noted that data collection for the metrics is preliminary. In some cases the datasets may have been recently incorporated into the Warehouse or are pending incorporation into the Warehouse and thus these numbers are expected to be revised over time.

#### Drug and Alcohol Screening

The Drug and Alcohol Screening, Referrals, Intervention and Treatment (SBIRT) activity that was started in the first half of the year was continued. The number of WPC enrollees that had an SBIRT administered increased from 65 at Mid-Year to 299 at the end of 2017. This equates to 10.8 percent of the WPC enrollee population of 2,765 patients.

### Challenges:

For the Universal and Variant Metrics, the primary challenge was the need to run separate queries to pull the required metrics from multiple sources.

Two of the key challenges identified as part of the SBIRT rollout included: 1) the underestimation in the amount of time needed to achieve system-wide adoption of the screening tool by all providers; and 2) the lack of consistency in documenting in the EHR which made the data challenging to retrieve.

### Lessons Learned:

The key learning for the Universal and Variant Metrics data collection was gaining an improved understanding of what constituted DHCS's defined Medi-Cal enrollment for WPC eligibility. Locally, WPC followed the strict criteria that for individuals to be eligible, the participants needed to be enrolled for the full one year period. With greater clarity received from DHCS and the expanded definition, Santa Clara County will be

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resubmitting the metrics (see table above) by the June 30, 2018 deadline and anticipate to see additional improvements.

For SBIRT, the lessons learned included: 1) the value of collaborating with the PRIME team to support rollout the tool and provide the necessary SBIRT training and technical assistance; and 2) working toward a consist documentation by internal and external partners which will support improvements in the data retrieval process. These learnings will be applied and implemented in PY 3.

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## VIII. STAKEHOLDER ENGAGEMENT

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

The WPC stakeholder groups include representation from internal County) and external (community) organizations and are comprised of executive leaders, managers, operational staff and consumers. The formation of these groups, many of which had not worked together previously, have been instrumental in helping inform and guide WPC planning activities, implementation and continuous quality improvement processes.

During PY 2, four external stakeholder groups met regularly to guide and move the WPC efforts forward included the following groups:

1. Executive Committee comprised of executive leadership and responsible for monitoring progress and setting overall strategic and operational direction;
2. Steering Committee comprised on directors and operational managers and responsible for making WPC-related operational and clinical decisions;
3. Community Integration Partners for the WPC Trust Community which includes SCVMC and community organizations that support the planning, DUAs, policies and procedures to support the Data Warehouse; and the
4. HUMS: Regional Hospital which includes funded and unfunded partners working to develop and test strategies to reduce ED utilization at the Regional Hospital.

The Quality Improvement (QI) team planned and supported eleven internal, external and PDSA stakeholder groups. Most of these groups were successfully launched, met and made good traction forward in supporting WPC deliverables. While background research was completed for three planned external stakeholder groups (Community Working Group, Consumer Advisory Committee and Gilroy), these groups were temporarily placed on hold until PY 3.

The QI team provided technical assistance and training on an ongoing basis. As the year progressed, the stakeholder groups' solidified and there was an increased sense collaboration and trust. The facilitated meetings served as an opportunity for members to gain a greater understanding about their partners' organizational structures, work, priorities, barriers and challenges, and gaps. Discussions included looking at current state, future state and identify gaps. This helped to establish work plans for service model implementation, data integration and PDSA strategies for testing. Detailed stakeholder group documentation is available on both the SCVHHS OSIT SharePoint site and in the Performance Logic Project Portfolio Manager (PPM) created for WPC.

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See PDSA Summary Report and PDSA Reports attached as of December 31, 2017. Also see Attachment B “SCVHHS WPC Participating Entities” and Attachment C “SCVHHS WPC Stakeholder Group Meetings” for documentation of stakeholder activities from July 1 – December 31, 2018.

Trust Community:

Stakeholder engagement for the Trust Community occurred through a variety of forums, namely Trust Community Stakeholder Group, Community Health Partnership (CHP) Trust Exchange and CHP Data Committee.

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## IX. PROGRAM ACTIVITIES

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

- (1) Community partner clinics have been the most successful in developing coordinated care of high risk patients. It is easier to begin in a small setting than to develop strategies across a large integrated health system. Our community partners have worked with a RN leader from the WPC team who meets with each team weekly to help them develop workflows, modifications to documentation and strategies for engaging patients. Each team at Gardner and Roots have included the use of patient navigators with “lived experience”. These peer support staff have been critical to the team effectiveness as they are approachable and understanding. As a result the patients have shared information they might be reluctant to share with professional staff. In weekly staff meetings, information from patients is shared and plans for care and interaction are made and discussed.
- (2) An extensive review of HealthLink records and records in BHSD gave WPC leadership insight into gaps in care, gaps in care documentation and led to more detailed planning for PY3 work with Care Coordination staff. In order to effectively retrieve information system wide, the staff had to convert from notes to specific assessment fields and intervention fields. The HealthLink build team worked with the WPC project managers who had manned the pilot call center as well as other clinical leaders, for example in Social Work and Care Management, to learn their workflow and current documentation in building a more comprehensive, retrievable documentation system. The Trust Community data team was integrally involved in the design as well.

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

- (1) Work required to change systems includes delineation of more detailed workflow changes and modification than anticipated. Information/data and people to do the work is not enough. We realized the need for additional resources to coordinate processes, such as a coordinator role, especially in light of the many initiatives staff are tackling besides WPC.
- (2) There was no single point person for all of the Care Coordination initiatives to bring the plethora of programs across all settings together. This is being addressed in 2018 with the T2020 structure.

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

- (1) The replacement of the internally built matching algorithms with a standard Electronic Master Person Index (EMPI) in the second half of the year, and connection of five sources of data to this EMPI was a key success during the second half of PY 2. This implementation also led to more robust discussion around the stewardship aspects of maintaining a common EMPI.
- (2) The automation of interfaces from external entities during the second half of the year has allowed us on a periodic basis to receive updates to key WPC community data including Care Plans, HRA's, Service Data, and Clinical data to evaluate metrics on a periodic basis without human intervention. The effort to convince partners to fully automate their data exchange is significant, and getting a few key participants to fully automate will be key to sharing the benefits of doing this with additional partners to ensure that the flow of data is seamless and will best support WPC patients.

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

- (1) While technology existed to automate interfaces with certain partners, it took significant effort to demonstrate the value in automating the exchange of data without manual intervention despite safeguards and best practices being applied the County had to invest in winning over certain partners with a significant amount of investment on the County's part to push for automation of data exchange with a goal of having sustainable interfaces that don't require manual intervention.
- (2) Prioritization of integration efforts by partners who have several priority projects has meant that County resources have had to implement technology for data sharing in some instances within very short timeframes and across multiple partners. Additional resourcing for technical services at some partner sites and with domain experts on the business side has been scarce which has result in delays in decision making and compliance.

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

- (1) The enhancements of the data governance processes related to the Data Warehouse and implementation of additional processes to ensure standardization of data requests and data release procedures and greater acceptance of these processes during the second half of the year was a key accomplishment.
- (2) The Implementation of a role based security model for the Enterprise Data Warehouse was a significant accomplishment the latter half of PY 2, this model allows us to integrate complex datasets and ensure that we have the software systems to be able to restrict access to data based on minimum access requirements based on pre-defined user roles.

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

- (1) Documentation practices in a number of operational environments still are based on documentation in electronic medical record (EMR) notes as opposed to discrete fields making standardized data collection process across all partners challenging.
- (2) When evaluating WPC and the participants in WPC, the types of systems that are used by a number of partner entities are not mainstream vendors with robust systems, this has led to the need to develop custom solutions with a number of partners and resulted in the strategy to deploy some common tools into these environments to facilitate standardized data collection.

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

While there have been significant investments made in planning for sustainability of the efforts and investments related to creating a technology infrastructure for WPC, ongoing engagement of partners from a technology and process standpoint requires vigilance and diligence within a support structure that allows constant feedback from all stakeholders. It is very difficult to transform a system from individual efforts to a coordinated cross system structure which all staff can navigate. Staff are more aware of options, but to better coordinate care, a navigation center is key. Planning of the navigation center will be completed in more detail in PY3. But the initial gap analysis has revealed many sources of duplication and confusing messages to patients and staff through various call-in centers.



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## X. PLAN-DO-STUDY-ACT

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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.

- Whole Person Care Summary Report
- PDSA Documents:
  1. Decrease Regional Hospital Emergency Department Utilization: Gardner Clinic WPC HUMS Patients Regional Hospital
  2. Enrollment/Outreach Health Risk Assessment (HRA): Gardner Clinic (Long Form)
  3. Enrollment HRA: VMC/VHP (Short Form)
  4. Improve WPC Patient Identification Opt-Out Enrollment Notification & Internal Operations
  5. Develop/Pilot Communication Strategies between Valley Medical Center's Emergency Department, Family Health Plan/Valley Health Plan, and Community Health Clinic Primary Care Providers focusing on Early Primary Care Provider Notification of Patients Discharged from the Emergency Department
  6. Provide Enrollment (Long Form); Care Coordination; Complex Case Management Targeting African Americans/African
  7. Sobering Station: Enrollment/Care Coordination/Community Living Plan
  8. Care Coordination/Care Plan/Enrollment/Outreach HRA: Gardner Clinic (Long Form) (Planning PDSA)
  9. Trust Community