State of California - Health and Human Services Agency **Department of Health Care Services**

Whole Person Care

Lead Entity Annual Narrative Report

Reporting Checklist

Santa Clara Valley Health and Hospital System – County of Santa Clara

Annual Report and Program Year 3

April 1, 2019 – Revised July 2, 2019

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

Component	Attachments
1. **Narrative Report** **Submit to:** Whole Person Care Mailbox	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 – Submitted on 3/29/2018
4. **Administrative Metrics Reporting (This section is for those administrative metrics not reported in #3 above - the Variant and Universal Metrics Report.)** **Note: If a Policy and Procedures document has been previously submitted and accepted, you do not need to resubmit unless it has been modified.** **Submit to:** Whole Person Care Mailbox	☐ Care coordination, case management, and referral policies and procedures, which may include *protocols and workflows.)* ☐ Data and information sharing policies and procedures, which may include *MOUs, data sharing agreements, data workflows, and patient consent forms.* One administrative metric in addition to the Universal care coordination and data sharing metrics. Describe the metric including the purpose, methodology and results.
5. **PDSA Report** **Submit to:** Whole Person Care Mailbox	x Completed WPC PDSA report x Completed PDSA Summary Report
6. **Certification of Lead Entity Deliverables** **Submit with associated documents to:** Whole Person Care Mailbox and SFTP Portal	x Certification form

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

I. REPORTING INSTRUCTIONS

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

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

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

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

II. PROGRAM STATUS OVERVIEW

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

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

Successes:

- Transformation 2020 (T2020) increased integration of Substance Use Treatment Services (SUTS) and some for behavioral health staff as well as to and from Santa Clara Valley Medical Center's (SCVMC) Specialty to Primary Care (PC).

Challenges:

- Working from multiple Electronic Health Records (EHR) makes referral connection and tracking of patient engagement between providers and coordinators more difficult.

Lessons Learned:

- Person-to-person contact through T2020 domain work groups has enabled staff to both formally and informally connect to improve communication about patient care with Behavioral Health (BH) and Specialty to PC.

2. Increasing coordination and appropriate access to care

Successes:

- Identification of a broader group of care coordinators (e.g. pharmacists and Diabetes Care Coordinators) has improved appropriate care coordination for WPC patients.

Challenges:

- Training a diverse group of providers with different EHR templates makes pulling data more difficult, when the goal is to minimally impact provider documentation time spent.

Lessons Learned:

- There is a need for team review of patients, so a provider does not get overloaded with patient care concerns that exceeds the provider's scope of care (e.g. Social Determinants of Health (SDOH) for a pharmacist).

3. Reducing inappropriate emergency and inpatient utilization

   Successes:
   - Having staff make the conceptual switch to a primary care medical home and welcoming the patient impacts patient engagement from episodic to coordinated care.

   Challenges:
   - There are multiple ways to access the system and it is confusing to patients; it is easier for patients to go to the Emergency Department (ED) than to get a same day/timely appointment.

   Lessons Learned:
   - Many patients are healthcare naïve; we are looking at handouts about how to access timely primary, urgent and ED care and what is most appropriate.

4. Improving data collection and sharing

   Successes:
   - Defining the elements needed in data collection line by line with IT and clinical staff helped us to verify that the data pulls were accurate. This includes data collection from community partners.

   Challenges:
   - A major turnover of IT contract staff and leadership impacted the whole WPC process from identification of high-risk patients to enrollment and outcome measurements. Though Behavioral Health Services Department (BHSD) is now on HealthLink EHR, contracted providers are using a different EHR, making retrieval of behavioral health (BH) data complex.

   Lessons Learned:
   - Documentation of decisions impacting queries by a joint clinical and IT group at the time of discussion allows tracking of decisions and revisions to the data collection process.

5. Achieving quality and administrative improvement benchmarks

   Successes:
   - We have successfully implemented strategies to increase Medication Assisted Treatment (MAT) in the ED, inpatient and targeted clinics.

   Challenges:
   - Determination of the patient follow-through on the process of referral for treatment is difficult due to different EHRs and the complexity of required contract providers in Substance Use Treatment Services (SUTS).

   Lessons Learned:
   - Bringing targeted clinical groups together to problem solve across the care continuum and including those from other Waiver programs with similar outcomes helps us to improve our processes.

6. Increasing access to housing and supportive services
   Successes:
   - We increased the number of patients being housing that were WPC patients.

   Challenges:
   - Housing demand far exceeds options in this very high cost of living area.

   Lessons Learned:
   - Looking for alternative housing, such as Residential Care Facilities (RCF)/Residential Care Facilities for Elderly (RCFE) and identifying homelessness early in the treatment process in order to complete a housing assessment are key to better placements.

7. Improving health outcomes for WPC population
   Successes:
   - Anecdotal Information about individual patient improvements plus reduced inpatient days and Emergency Department (ED) stays implies that the health outcomes for the WPC population have improved.

   Challenges:
   - Retrieving evidence of improved care for depressed patients and potentially suicidal patients is difficult due to multiple unintegrated EHRs in PC and BHSD for follow-up of PHQ-9 or suicide assessment.

   Lessons Learned:
   - We have improved success with tracking Screening, Brief Intervention and Treatment to Treatment (SBIRT) assessments and substance use treatment. We have a PRIME/health score on all patients, we plan to collect data to demonstrate the improved/non-improved population health in the future.

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 Jan	Month 2 Feb	Month 3 Mar	Month 4 Apr	Month 5 May	Month 6 Jun	Unduplicated Total
Unduplicated Enrollees	**209**	**11**	**22**	**49**	**85**	**69**	**445**

Item	Month 7 Jul	Month 8 Aug	Month 9 Sep	Month 10 Oct	Month 11 Nov	Month 12 Dec	Annual Unduplicated Total
Unduplicated Enrollees	32	46	56	84	75	84	822

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

Costs and Aggregate Utilization for Quarters 1 and 2							
FFS	**Month 1**	**Month 2**	**Month 3**	**Month 4**	**Month 5**	**Month 6**	**Total**
Service 1 (Peer Respite)	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Utilization 1 (Peer Respite)	0	0	0	0	0	0	0
Service 2 (Medical Respite)	$7,520.40	$43,994.34	$29,329.56	$26,321.40	$28,577.52	$17,296.92	$153,040.14
Utilization 2 (Medical Respite)	20	117	78	70	76	46	407
Service 3 (Sobering Center)	$0.00	$246.12	$0.00	$246.12	$1,476.72	$0.00	$1,968.96
Utilization 3 (Sobering Center)	0	1	0	1	6	0	8

Costs and Aggregate Utilization for Quarters 3 and 4							
FFS	**Month 7**	**Month 8**	**Month 9**	**Month 10**	**Month 11**	**Month 12**	**Annual Total**
Service 1 (Peer Respite)	$0.00	$0.00	$0.00	$0.00	$0.00	$427.12	$427.12
Utilization 1 (Peer Respite)	0	0	0	0	0	2	2
Service 2 (Medical Respite)	$19,177.02	$29,780.52	$18,801.00	$2,632.14	$22,185.18	$16,168.86	$277,506.01
Utilization 2 (Medical Respite)	51	121	50	7	59	43	738
Service 3 (Sobering Center)	$1,722.84	$738.36	$492.24	$984.48	$1,476.72	$1,722.84	$9,106.44
Utilization 3 (Sobering Center)	7	3	2	4	6	7	37

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

Amount Claimed								
PMPM	**Rate**	**Month 1**	**Month 2**	**Month 3**	**Month 4**	**Month 5**	**Month 6**	**Total**
Bundle #1 (Rehabilitation & Peer Support)	$137.19	$35,532.21	$36,080.97	$38,276.01	$38,961.96	$42,117.33	$41,019.81	$231,988.29
MM Counts 1		259	263	279	284	307	299	1,691
Bundle #2 (Short Term)	$1,282.71	$37,198.59	$19,240.65	$44,894.85	$26,936.91	$53,873.82	$103,899.51	$286,044.33
MM Counts 2		29	15	35	21	42	81	223
Bundle #3 (Medium Term)	$1,363.54	$1,580,342.86	$1,313,089.02	$981,748.80	$886,301.00	$14,998.94	$24,543.72	$4,801,024.34
MM Counts 3		1,159	963	720	650	11	18	3,521
Bundle #4 (Long Term)	$882.88	$0.00	$4,414.41	$474,990.41	$454,684.12	$992,359.14	$992,611.48	$2,919,059.56
MM Counts 4		0	5	538	515	1,124	1,045	3,227
Bundle #5 (Nursing Home Transitions)	$2,076.70	$0.00	$0.00	$0.00	$105,911.66	$232,590.31	$284,507.79	$623,009.76
MM Counts 5 (Nursing Home Transitions)		0	0	0	51	112	137	300

Amount Counts								
PMPM	**Rate**	**Month 7**	**Month 8**	**Month 9**	**Month 10**	**Month 11**	**Month 12**	**Total**
Bundle #1 (Rehabilitation & Peer Support)	$137.19	$41,705.76	$47,056.17	$39,373.53	$46,095.84	$44,586.75	$38,550.39	$489,356.73
MM Counts 1		304	343	287	336	325	281	3,567
Bundle #2 (Short Term)	$1,282.71	$100,051.38	$116,726.61	$142,380.81	$180,862.11	$216,777.99	$242,432.19	$1,285,275.42
MM Counts 2		78	91	111	141	169	189	1,002
Bundle #3 (Medium Term)	$1,363.54	$28,634.34	$31,361.42	$46,360.36	$72,267.62	$88,630.10	$113,173.82	$5,181,452.00
MM Counts 3		21	23	34	53	65	83	3,800
Bundle #4 (Long Term)	$882.88	$898,773.67	$873,170.10	$838,737.71	$880,233.15	$854,629.58	$834,323.30	$8,028,927.05
MM Counts 4		1,018	989	950	997	968	945	9,094
Bundle #5 (Nursing Home Transitions)	$2,076.70	$288,661.19	$313,581.58	$332,271.87	$303,198.08	$272,047.59	$276,200.99	$2,408,971.06
MM Counts 5 (Nursing Home Transitions)		139	151	160	146	131	133	1,160

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

The unduplicated enrollment numbers for Quarters 1 and 2 are **bolded** in the table above and are based on the final submission made for Quarters 1-4 and sent to DHCS on March 15, 2019.

- Robust structures were not in place for system-wide coordination of care for WPC patients assigned to Santa Clara Valley Medical Center (SCVMC) PC clinics. This resulted in limited follow-up of patients. We made the decision to move from auto-enrollment to active face-to-face enrollment in each clinic.
- A pilot SCVMC clinic trialed a new workflow for enrolling and engaging patients. Based on the success of this project, training sheets and a subsequent training manual were completed. This process and materials were used to rollout the enrollment and engagement of WPC eligible patients at all SCVMC clinics.
- The Epic/HealthLink (HL) EHR system was continually refined based on staff feedback at site meetings and trainings provided by a Senior Program Manager and HL staff. The purpose was to enable staff to more inclusively document who was the patient's care coordinator and the interventions completed at each encounter.
- The Stay Healthy Assessment (SHA) was rolled electronically to all SCVMC PC clinic sites. After discussion with stakeholders, it was agreed that it would serve as the comprehensive assessment form in which the goals of care would be determined by the patient and coordinator and replaced internally for SCVMC the 60 item Health Risk Assessment (HRA) developed by the team.
- The two original community partner clinics continued to enroll patients. After a lengthy and difficult contractual process in which the contracts were revised to include outcomes for enrollments as opposed to grant funding, six more community clinics joined the WPC delivery team in October 2018. These additional community clinics began to enroll and follow WPC patients for the last quarter of PY3.
- While the resulting infrastructure was solidly built, the number of new patients that were enrolled in WPC was limited during the rollout process. While the per visit count did not increase during this period, the coordination of care has improved as demonstrated by the improved outcomes in the universal metrics related to ED usage and LOS in the hospital.
- It hard to scale up and integrate at the same time. Now that the integration is mostly complete, we are working to increase enrollment and increase coordination with BHSD/SUTS and Specialty Care programs.

IV. NARRATIVE – Administrative Infrastructure

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

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

The T2020 program at the County of Santa Clara Health System (Health System), previously the Santa Clara Valley Health and Hospital System (SCVHHS), has been unfolding since the fall of 2017 when executive leaders were concerned that the WPC structure was not reducing silos between components of the Health System in the rollout of WPC. Over a series of exploratory meetings, the leaders proposed a new model, which was approved by the County Executive. T2020, was created to support the transformative change needed to continue to improve the healthcare services delivery system and to create a path toward sustainability. T2020 launched with a two-day kick-off held on February 12-13, 2018 with 90 executive leaders, directors, managers and operational staff participating. This was the start of the rapid, 90-day assessment phase implemented by five T2020 domain groups which has continued through the second half of 2018. Projects developed from each of the five domains have increased participation of the BHSD and SUTS in cross departmental planning of services, back door numbers for ease of access by providers, and implementation of the PC BH model for patients with mild to moderate behavioral health diagnoses.

With a consultant, the role of each of the various WPC leadership groups was reviewed and several meetings were consolidated; other committees (Consumer Advisory Committee and the WPC Executive Multi-Payer Coalition) that had been placed on hold in PY2 were launched (see descriptions of meetings in Section VIII). The addition of feedback from the Consumer Advisory Committee has been helpful in assuring our communication about the project is targeted effectively.

We have increased the staffing in our system for WPC. In the Office of System Integration and Transformation (OSIT), we have added a second physician to our team in November of 2018. This MD role has been to serve as consultant to clinics/staff in the community and within the Health System. In addition, he has initiated a primary care clinic planning group for our Downtown Behavioral Health Clinic, which treats Seriously Mentally Ill patients (SMI). The clinic is expected to rollout by June 2019. Over 175 patients in the clinic have no known primary care provider, so this will help to address gaps in service.

Secondly, this MD is working with Ambulatory Care Physicians and leadership to develop an Ambulatory Intensivist Model to dedicate a PCP for more intensive needs patients in selected Primary Care clinics.

The Board of Supervisors approved 26 requested positions for WPC, for which recruitment has begun. Included are: 20 Community Workers (CW) that will be assigned to SCVMC Primary Care and Specialty Care clinics to support professional staff by completing non-professional tasks for patients and enrolling patients in WPC. There are also: an educator for the CW group, an associate management analyst, a health care program analyst, a medical social worker to concentrate on developing and sharing resources for housing and 2 pharmacists to ensure better care of patients with complex medication needs. In addition, recruitment has begun for the OSIT permanent director, with expansion of the recruitment to include clinical staff who may be eligible.

Annette Gardner, Assistant Professor at the Institute for Health Policy Studies at UCSF, has been working with the team to develop a robust evaluation process for the Health System. She has worked with the team of Domain Leaders and the Center for Population Health Improvement (CPHI) in developing an evaluation design, work plan, reporting plan and communication plan, which also integrates with the other waiver programs. Data collection will include participant surveys and key informant interviews as well as technical assistance.

V. NARRATIVE – Delivery Infrastructure

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

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

WPC Trust Community Start-Up
Cost are associated with staffing, software, hardware investments for data collection, analysis and reporting.

Peer Respite Start-Up
While the contract was approved by the Board of Supervisors on August 28, 2018 for the Peer Respite home, a beautiful Victorian building in Downtown San Jose, there were delays tied to construction and safety which delayed the planned opening on November 1, 2018 until mid-December. While eventually the house will accommodate 10 guests, it began with 6 approved guest spaces. The first person to use the program was a WPC eligible patient. The staff of the Peer Respite
Program have met with multiple community agencies to promote the program (covered under the incentive section, Section VI).

Medical Respite Start-Up
WPC patients have continued to be served by the Medical Respite Program and met current capacity requirements; however, there was no expansion of services as had been planned. With some security issues, the expansion was tabled. After checking for appropriate community sites, the decision was made to relocate to the SCVMC campus. There are many advantages to locating the program on campus including expansion capability and the ability to provide medical, security and nutrition services more readily. The capacity is expected to increase from 20 to 32 beds with some overflow beds at the new site. The renovations required means that the expansion will not occur until 2019. Approval was granted to relocate the Medical Respite Program from the HomeFirst Shelter to Della Maggiore School located on the SCVMC campus. A space renovation plan has been completed after several site visits. However, due to the delay in the opening date, the stakeholder meetings regarding security and nutrition and food have not occurred. Staff have developed an interim but not final plan for clinic care nor relocation plan.

Systems Modifications
Refer to Table 1 for a description of work completed as part of Delivery Infrastructure – Systems Modifications.

Table 1: Components of Systems Modifications and Description of Work Completed

Components	Description
Navigation Center	The Navigation Center is dependent upon technology that allows consumers to request information through the "no wrong door" approach. The Navigation Center Domain Group did an assessment of the various call centers throughout the system, including looking at the software and hardware used. A site visit was made to Fluent Health in Albuquerque, New Mexico to determine what were the best options for juggling multiple inquiries. The team requested a specific consultant to support local efforts which did not get approved through the contracting group but has initiated a request for a Cisco Switch upgrade for more configurability and at least two 1-800 numbers (as recommended by Fluent to decrease call response time). Additional technology has been identified as needed to provide a database for call centers to have consistent information at their fingertips for referrals. An RFP will be developed in 2019 for this work.
Community Partner Clinics	The data development and capturing of data was revised with the addition of six more community partner clinics. Trainings for each site occurred. An Access/Excel database was created for each site and loaded with persons that are WPC eligible for care at the site. The staff completed requested data for enrollment, assessment and screening, assignment of care coordinator and services delivered. The same information was used in generating an invoice. Modifications of the system have been made when additional information has been needed – for example the date of service, rather than just the month and the CIN.
Santa Clara Valley Medical Center Hospital and Clinics	Working with the Electronic Health Record (EHR) HealthLink Team, meetings with various disciplines not documenting in HL, or those for whom templates were needed or modified occurred throughout the summer in preparation for rollout of an upgraded system in November 2018. This required the build of forms which indicated who was the care coordinator. Trial demonstrations occurred with the Subject Matter Experts (SMEs) from each role group; training was then provided, targeted to each discipline, as an add-on to regular upgrade training.

Components	**Description**
Electronic Health Record Improvements	Many improvements were made to HL in weekly meetings. The coordinator assigned could identify the enrollment category (ST, MT, LT) for each enrolled patient. The coordinator could review the Stay Healthy Assessment or if a SW, complete an intensive assessment, and identify goals (which serve as the care plan). The assessment and plan for the person which was available to all linked from a view in the HL patient summary. In addition, work was completed for all patients who went by another name, including transgender patients, to be asked the name the person "goes by". This helps to improve the "welcoming" aspect of care for all staff, as many of our Health System patients speak another language than English and chose nicknames that are easier for others to pronounce. The coordination processes for patients with congestive heart failure (CHF) to access a food prescription was developed with the Specialty clinic and social workers. Finally, an organ inventory for at-risk transgender patients was developed in preparation for setting up a gender care clinic and supporting the Homeless LGBTQ clinic.
Custody Health	Custody became the largest "hospital" in the EPIC system, enabling cross information with the health system, if the person is treated at SCVMC. Due to identified mental health issues that were not appropriately identified, including suicidality, upon booking, the Custody and HL staff developed an assessment that helped to drive where the patient was located after booking and able to receive the appropriate level of care. This work was preparation for the discharge, when the persons could be reenrolled/reengaged in healthcare. For those on essential medications, this will prepare staff to follow-up on those high-risk persons.

VI. NARRATIVE – Incentive Payments

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

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

Refer to Table 2 below for a description of the work completed as part of the Incentive Payments and Attachment C with additional detail for each of the Incentive categories below.

Table 2: Components of Incentive Payments and Description of Work Completed

Trust Community Adoption
Two additional organizations joined the Trust Community, Social Services Agency (SSA) and Planned Parenthood Mar Monte signed DUAs as part of the Provider Incentive.

PY3 budget claimed in the Annual Report is $200,000 (partial payment). This incentive is paid to the County of Santa Clara and supports the work of three agencies which includes one subcontractor (third party) that provides services on our behalf.

Social Services Referral Integration
The SSA Integration has proven to be one of the most difficult to complete. After initial meetings to develop the workflow, it was determined that Behavioral Health Services Department (BHSD) needed to hire persons for the integration, in order to preserve HIPAA restrictions on referral. Two Social Workers were hired after appropriate and lengthy recruitment. A team was assembled to revitalize the plan and identify the assessment and referral process to BH. A site designation was needed for HL to ensure data collection. That was completed but configuration of computers was delayed due to the incompatibility of the SSA computers with HL. Laptops were purchased and once the site designation occurred could be configured.
A screening tool was decided upon and the use of the existing call center to make referrals to additional care, who would be responsible for the assessment and care plan for the individual. The initial work, while waiting for computer configuration, followed the agreed upon plan, but documented on paper. Starting in Mid-

December 2018, patients were referred by SSA staff, screened and referred through the call center for care. Of the six eligible patients, two were referred to a primary care provider for follow-up and two for Specialty Mental Health with a County provider. The connectivity and processes have continued in PY4 and will demonstrate the effectiveness of this work. The Master Person Index (MPI) program was not continued during this time frame, though tested once, but is anticipated to be rolled out in PY4.

PY3 budget claimed in the Annual Report is $2,795,383 (partial payment). This incentive is paid to the County of Santa Clara and supports the work done by three agencies in the system.

Provider Incentives (Drug and Alcohol Screening)
Good strides have been made in the Drug and Alcohol Screening this PY. The screening documentation of Substance Use Disorder varied in the EHR by setting. A group met six times with additional side work completed by some members to assess all the locations and varieties of documentation. The implementation of the SHA across clinics which screens for substance use helped to standardize the first identification. Meeting with PRIME and HL staff, the group identified all the potential locations for documentation which were shared with the data retrieval group. The business rules for retrieval of data were codified by the data team. A plan to increase the training for SBIRT was developed and an evidence-based training was provided ten times to staff. The main barrier to identifying those who sought care in Substance Use Treatment Services (SUTS) was the fact that it was on a different EHR (Unicare). This required a separate search by the data team to determine once an individual was screened and referred that the person was seen in SUTS. However, we have improved this year. In addition, the use of Vivitrol and Suboxone as Medication Assisted Treatment (MAT) has also been highlighted in one clinic as well as in the ED.

Outcomes

PY3 (2018)	Outcome 1	Outcome 2	Outcome 3	Outcome 4
Numerator	82	37	30	2
Denominator	658	82	37	30

Outcomes 2, 3, 4 were not measured as noted in PY3 Rollover

PY2 (2017)	Outcome 1	Outcome 2	Outcome 3	Outcome 4
Numerator	8	0	0	0
Denominator	2150	0	0	0

Please see PDSA for SBIRT.

PY3 budget claimed in the Annual Report is $3,325,000 (full amount). Incentive is paid to County of Santa Clara and supports the work of several agencies within the system.

Peer Navigation
Peer Navigation was envisioned for the total health care system but unavoidable delays in hiring Community Workers for Primary and Specialty (medical) care areas meant that the work started in BHSD. Staff developed criteria for selection of an agency to do training, based on a focus group, and included interviews with staff from a special program at UCSF covered by Anthem, and review of selected resources for training. Intentional Peer Support was identified as an agency meeting the criteria, a contract was developed and signed, a training curriculum was customized from an existing certification training program and three trainings occurred with community peer navigators.

PY3 budget claimed in the Annual Report is $240,000 (partial payment). Incentive is paid to County of Santa Clara that supports the work of several agencies within the system.

Navigation Center
The Navigation Center group has done a complete analysis of the call centers related to the Health System and their capabilities.
While waiting for a contract assessment of the ability to hire a specific consultant, the Domain group identified training needed by all sides. One of the three overarching projects of the Navigation Domain was the enhancement of the Customer Delivery Model. The Customer Relations Office had already developed tools around customer service engagement and a robust training. With the backing of the WPC leadership and the Navigation Domain initiative, these trainings were enhanced to support an expanded training that supported the goals of the Navigation Domain. Within the past four months, 49 trainings were offered to various programs within the County of Santa Clara. Currently, the Virtual Patient Navigation CICARE training is now being offered at all new staff Health System orientation trainings. This training helps achieve one of the main tenets of patient navigation – "to ensure that staff understands how a high-quality service experience improves and patient outcomes." Also planned Call Center observations were completed. Initial workflows were proposed, and were to be validated by a known consultant, but due the lengthy process for contracting, this was not possible. Focus group surveys were completed and shared with group. Finally, patient orientation tours were piloted and completed with Customer Service.

PY3 budget claimed in the Annual Report is $1,825,000 (partial payment). Incentive is paid to County of Santa Clara which supports the work of three agencies within the system.

Provider Incentives (Community)
Multiple meetings occurred with community partner clinics to discuss metrics for WPC. Benchmarks were developed and added to the contracts, for example incentives for a quarter of enrollments to be completed by December 31st and disincentives for not treating highest utilizers as 10% of the persons treated. Refinement of the WPC Access database was made to capture the summary of services, services list of care coordination, eligible patient data and development of separate categories for high utilizers of multiple systems (HUMS). It was piloted with four clinics: Roots, Gardner, MayView and School Health. Quality Improvement process has been presented at the preplanning meetings. A staff guide was developed with policies, procedures, workflows outlined and presented during preplanning meetings. Access Database training occurred at the two new sites: MayView and Planned Parenthood. This is still a cumbersome process for all concerned. Plans are to contract for canned reports from the clinics on certain levels of NextGen.

PY3 budget claimed in the Annual Report is $428,410 (full amount). This incentive is paid to the County of Santa Clara because we have contracted with third parties to provide these services on our behalf.

PHD Population Health Data Vault
The turnover of IT staff impacted the initiation of the PHD population health vault. One meeting began before the team was no longer available. The decision was made to change the vault design to look at prediabetic persons in SCVMC, to match the work in diabetes from population health. An interdisciplinary group met six times. The group discussed data and data collection timeframes. It developed a flow diagram. It was determined that there are 1.6 million patient records from the SCVMC HL system in the Vault. Each patient record is anonymized. The history of the data spans from the implementation of the HL system on May 1, 2013 up to the present. The data from HL is refreshed daily. Of the 1.6 million patients represented in the Vault, roughly 984,000 of them have at least one encounter at SCVMC.

For the first iteration of the prototype, vital measures and lab results related to diabetes and prediabetes were loaded and integrated for reporting on the following metrics:

- What is the count and percent of adults with pre-diabetes or diabetes seen at SCVMC during the last 12 months?
- What is the count and percent of adults with pre-diabetes or diabetes who are obese or overweight seen at SCVMC during the last 12 months?
- What is the count and percent of adults with elevated A1C levels seen at SCVMC during the last 12 months?
- What is the count and percent of adults with poorly controlled A1C levels seen at SCVMC during the last 12 months?

Patients' addresses can be reported on at the Zip Code level. Tracking at the census tract level is planned for development in PY4. A scalable and agile design was used to facilitate the onboarding of additional data sources and entities.

A specialized security model was implemented on an "Honest Broker" server to accommodate security needs/concerns of SCVMC and future entities. The security is unified from the "Honest Broker" server to the presentation layer (currently Tableau). The Vault is fully auditable and will be able to generate access reports.

In PY4, the final plan will be presented to the leadership group for this metric. The group recommended that VHP (Valley Health Plan) be the second entity that will supply claims data for integration with the current SCVMC patient data. Development on the VHP data elements is slated to begin in March 2019.

PY3 budget claimed in Annual Report is $219,559 (partial payment). This incentive is paid to County of Santa Clara and supports the work done by three agencies within the system.

Sobering Center
[Mission Street Sobering Center – (MSSC)]
Staff were trained on completion of VI-SPDATs, the housing eligibility screening, including access to the Homeless Management Information System (HMIS) database. Eight new VI-SPDATs were completed and many more validated as existing in HMIS. With the support of IT staff, the VI-SPDAT and the documentation of follow-up of patient's discharge were added to the data file. An orientation/training video was completed to support use of MSSC by law enforcement. The evaluation by law enforcement was not doable as they wanted to return to patrol. Emergency Medical Services (EMS) procedures, for example, the MOU was signed for alternate destination with EMS for South County. Access to evaluate eligibility for Medi-Cal was arranged by the vendor. An MOU was signed with San Jose Police Department, the largest contributing department for MSSC and the number of patients rose quickly. Epic Link was established so MSSC staff could see if there was a HL record on the persons entering MSSC.

PY3 budget claimed in Annual Report is $105,200 (partial payment). This incentive is paid to the County of Santa Clara because we have contracted with a third party to provide these services on our behalf.

Integrated Medical/Psychiatric Skilled Nursing Facility (SNF) Provider
A small task group of Care Management, Social Work, OSIT, finance and VHP met on five occasions to work out the process for designating eligible patients for the SNF placement of behavioral problem patients. The Interim OSIT Director did two face-to-face meetings with participating agencies as part of the Interact IV Skilled Nursing Home meetings to request feedback from participating agencies about the

proposed dollars and plans. The feedback was that the dollars did not cover the cost of care when providing 24-hour sitters, the usual method of working with these patients, though other options such as consultation and training of staff were explored. The team developed a policy, including the mechanism for reimbursement, but for PY3 no patient has been place in the SNF due to the limitations described. Therefore, the dollars claimed are related to the preparation alone. Electronic identification of WPC enrolled/eligible patients has been added to HL for Care Management staff to better identify eligible persons. Though referrals have been made previously, the persons have not been eligible for WPC.

PY3 budget claimed is $115,000 (partial payment). The incentive is paid to the County of Santa Clara and supports the work of two organizations within the system.

Barrier Identification and Resolution

Ambulatory Intensivist: The work plan for two Ambulatory Intensivist programs were developed in PY3. Potential populations were identified for an Ambulatory Intensivist program in Primary Care from the HUMS list. The rollout is proposed for a pilot with expansion to several clinics for the challenging patients who do not qualify for specialty care (Medical or Behavioral Health) and need more time than a 15 minutes visit. The physician has interviewed physicians, learned about the model from a site visit and has developed the beginning staff model to be continued in the next year.

PY3 budget claimed in Annual Report is $125,000 (partial payment). This incentive is paid to the County of Santa Clara and supports the work done by three agencies in the system.

Imbedded PCP in BHSD Clinic: Of 750 patients seen in Specialty Behavioral Health, more than 175 patients have had no PCP. The OSIT team physician has had several meetings with BHSD and PC leadership to identify a location for services, adjustments needed in the clinic room, workflow and clinic staffing, with the goal of implementing the clinic in June 2019. Since patients in Specialty BHSD do not like to receive care in a PC clinic setting, it is thought this will improve care for this highly vulnerable population.

PY3 budget claimed in Annual Report is $25,000 (partial payment). This incentive is paid to the County of Santa Clara and supports the work done by three agencies in the system.

Prediabetes/Diabetes: A regularly scheduled group with membership from across several domains is the “All Things Diabetes” group which looks at care across the continuum from identification of pre-diabetes to complications of diabetes, such as dialysis, loss of limbs. The group has focused on a pilot in two clinics to screen

Medi-Cal patients through a A1c for prediabetes and referral to a prediabetes education program of two different types. The group has identified a community resource for education (YMCA) and an internal group for Spanish speaking patients which is soliciting an educator to run at one of the clinics.

PY3 budget claimed in Annual Report is $225,000 (full amount). This incentive is paid to the County of Santa Clara and supports the work done by three agencies in the system.

Pharmacy: One of the barriers to care was the need for a thorough review of the patients on multiple possibly conflicting medications. While a provider can do the review, the real expert is a pharmacist. Two positions were sought from the Board of Supervisors to provide better care in the homeless program and in the Public Health Nursing Home visit program. A card study was completed in each case to determine workload. The physician/provider can provide care to more patients by turning over medication reconciliation and counselling to the pharmacist.

PY3 budget claimed in Annual Report is $90,000 (full amount). This incentive is paid to the County of Santa Clara and supports the work done by three agencies in the system.

Nursing Home Transitions: It has been difficult for the Institute on Aging (IOA), contracted to move patients from SNFs into community settings to meet the goal due to a high demand for services and lack of housing available. Faced with this problem, the OSIT/IOA team had regular planning meetings with the long-term insurance provider of Santa Clara County, Santa Clara Family Health Plan (SCFHP). Since IOA was already working on adding resources for the Alternative Living Waiver (ALW) program opened by the State, the decision was made to develop RCF/RCFEs as an option with a supportive services bundle to improve the care for frail patients into a less restrictive setting. Background work with experts in the field including the Office of Supportive Housing and IOA executive staff have resulted in a plan for a financial contract adjustment, covered under the original application, for supportive services in PY4.

PY3 budget claimed in Annual Report is $55,000 (full amount). This incentive is paid to the County of Santa Clara as we have contracted with subcontractor (third party) to provide services on our behalf.

Sobering Center: MSSC obtained a van and was able to pick up and transport participants in the community and from the ED to the MSCC. To engage additional law enforcement, a series of briefings we conducted to explain the services, eligibility criteria, and the process to bring participants to the MSSC. To better connect the ED with MSSC, a series of meetings were conducted with leadership and resulted in a new partnership between the two agencies and engagement of ED

to transition medically stable, intoxicated individuals that are willing to go to the sobering center to be transported there. See PDSA related to the Sobering Center.

PY3 budget claimed in Annual Report is $83,400 (full amount). This incentive is paid to the County of Santa Clara and supports the work done by three organizations, two internal and one subcontractor (third party) who is providing services on our behalf.

Peer Respite Program - Outreach and Engagement
Staff from BHSD and staff from Blackbird House, the Peer Respite named house, have completed an outreach and marketing plan to notify county organizations, other stakeholders, and consumers about the option to seek Peer Respite instead of Emergency Psychiatric Services (EPS) or inpatient care. Multiple presentations have been given, a brochure developed as well as a flyer, ecard and wall card in English and Spanish. An open house had more than 100 attendees and those attending had an opportunity for a guided tour, explanation of the daily interaction and supports for persons electing to refer themselves for Peer Respite.

PY3 budget claimed is $290,000 (partial payment). This incentive is paid to the County of Santa Clara as we have contracted with a third party to provide these services on our behalf.

VII. NARRATIVE – Pay for Outcome

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

Metric Group	Metrics	Baseline Numerator	Baseline Denominator	Baseline Rate	PY2 Numerator	PY2 Denominator	PY2 Rate	PY2 Numerator	PY2 Denominator	PY2 Rate
AMB	AMB	11,413	39,990	285	9,640	33,180	290	8,719	38,212	279
IPU	IPU	1,996	39,990	4.99%	1,784	33,180	5.38%	1,542	31,212	4.94%
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	9	123	7.32%	6	91	6.59%	1	103	0.97%
MDD	MDD	8	490	1.63%	6	644	0.93%	2	668	0.30%
OSH	Supportive Housing	99	123	99	28	44	63.64%	69	100	69.00%
CCP1	CCP1	1,793	2,170	82.63%	36	2,756	1.31%	1,831	2,929	62.51%
CCP2	CCP2	1,887	2,170	86.96%	128	2,756	4.63%	1,934	2,2929	66.03%

Improvements are highlighted in green in table above. We have improved our care as evidenced by the Universal and Variant Metrics, through the introduction of the Stay Healthy Assessment (SHA) (which screens for substance use and behavioral health issues), the focus on MAT treatment and follow-up of patients in inpatient and EPS as well as BH inpatient program and finally, concerted efforts to reduce length of stay in all settings. These efforts have resulted in continued or improved outcomes for reduction of ED visits, reduction of length of stay in the inpatient program, follow-up of admitted behavioral health persons, both at 7 days and at 30 days, and improved referral and engagement of persons with substance use. We are particularly pleased to see our efforts in placing patients in housing have improved.
Areas that require further work are as follows: a.) The reduction of the PHQ-9 after one year of care as the numbers are small and difficult to retrieve; b.) Further the suicide assessment of persons diagnosed with Major Depressive Disorder (MDD), is difficult as the persons in primary care who screen positive on the PHQ-9 are not necessarily given the diagnosis of major depressive disorder in the problem list or CPT codes, and again resulting in small numbers; c.) Our care plans remain an area for further work and the ability to see across all settings is not still achieved (the rates in the table above are for 30 days (CP1) and 60 days (CP2). We are investigating an external vendor, given the multiple EHRs in the inpatient, community partner clinics and behavioral health/substance use vendors who must see the plan of care. d.) We have worked to reduce our readmission rate but are unable to improve this area of measurement so far.

VIII. STAKEHOLDER ENGAGEMENT

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

Please see attachment for detailed leadership and stakeholder meetings

The WPC stakeholder groups include representation from internal and external organizations and are comprised of executive leaders, managers, operational staff and consumers. These groups have been key in helping to inform, guide and provide feedback on WPC activities, implementation and ongoing quality improvement processes.

During PY3, there was some restructuring and consolidation of the three of the leadership groups (Executive, Stakeholder and Waiver Planning & Coordination Committees) and the formation of two new groups to meet the changing needs and issues of WPC (WPC Executive Multi-Payer Coalition and Transformation 2020 (T2020) Domain Leaders). The Consumer Advisory Committee was launched. Community Working Group will start in fall and be incorporated into T2020 Population Health Domain Group. Below is a list of the groups:

1. Internal T2020/WPC Executive Committee – replaced PY2 WPC Executive Committee and T2020 Executive Committee (formed late in 2017) into one consolidated team of executive leaders. This tactical group elevates and discusses issues, identifies risks, mitigations and makes final decisions.
2. WPC Executive Multi-Payer Coalition – this new group of executive leaders representing local health plans to work collaboratively on strategies that collectively impact County residents/health plan members.
3. Stakeholders Committee – replaced the PY2 WPC Steering Committee and includes directors and operational managers; is responsible for setting strategic operational direction and monitor progress.
4. T2020 Domain Leaders – new group comprised of directors and operational managers; responsible for reviewing progress on T2020 projects, make strategic recommendations for the five domains (1. Patient Navigation Center; 2. Integrated Data Center; 3) Population Health; 4) Community and Preventive Health; and 5) Care Coordination) and supports the integration of care across the SCVHHS, County departments/agencies and in the community.

5. Waiver Integration and Coordination – PY2 Waiver Integration Team Executive Leads has been discontinued and this group has replaced it. This group is comprised of directors, managers and operational staff working together to coordinate and standardize the efforts of the County Waiver Initiatives [e.g., Global Payment Plan (GPP) and Public Hospital Redesign and Incentives in Medi-Cal (PRIME), and Dental Transformation Initiative (DTI)].
6. Consumer Advisory Committee – includes clients/patients who share their experiences with SCVHHS staff, help to identify areas in which there are care gaps and together as a team work to identify corrective action(s) needed.

Most of last year's eleven internal, external and PDSA stakeholder groups were reconfigured and integrated into the new T2020 framework. For example, the T2020 Care Coordination Domain includes twenty smaller workgroups, each focused on specific components of care coordination, and together help to breakdown this complicated endeavor and help to link and leverage the smaller efforts into the larger whole. Some additional groups were added to help lift the WPC initiatives, with a focus on clinical structures and needs and to build the inter-agency and community support needed to successfully meet the needs of our high-risk populations. The facilitated meetings have offered opportunities for members to gain greater understanding on one another's organizational structures, work, priorities, barriers, challenges and gaps. These groups successfully addressed the current state, future state, identified gaps and possible solutions. The groups have developed project work plans, sharing data and developing and testing strategies using PDSA. For a full listing of Stakeholder Group see Attachment B.

IX. PROGRAM ACTIVITIES

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

(1.)The expansion of MAT for Opioid Use Disorder (OUD) has been a highly successful Population Health Domain project/program area. Over the last year, there has been increased interest and engagement for MAT for OUD among our system and broader community. Reasons for this project's success include having a passionate clinical champion to advocate for the expansion of services and engage other providers in this work; engaging key partners (e.g., SUTS, Community Health Partner clinics, ED) in training and keeping them involved; and having project management and operational support staff for advancing the work outside of T2020 and Population Health Domain meetings.

(2.)PY3 has been devoted to revising infrastructure to identify, assign and engage clinical staff in serving as Care Coordinators. The Complex Care nurses in all the primary care clinics have taken the lead in this process. Infrastructure has been developed for them to use in meeting with identified WPC eligible patients and to engage them in coordinated care in a medical home setting. This is a huge conceptual switch from episodic care to coordinated care, but with Health Homes around the corner for Santa Clara County, the wave of the future is determining who is high risk and meeting the need. It is difficult for staff to not feel alone in trying to meet patient needs, so we have implemented consultation with our new physician for our community clinics and our Complex Care Coordinators as a support for them. The OSIT team is and has been available to care coordinators seeking ways to "breakthrough" the barriers in the system, which has resulted in positive patient outcomes.

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

(1.)Engagement of staff in moving from episodic care to coordination of care takes time, site visits and regular interaction and follow-up. We would like it to move faster but there are many competing demands. The Senior Program Managers have been critical to the success. Critical to this endeavor has been to listen to staff concerns and address issues or acknowledge what has yet to be learned. While many barriers to coordination of care are reduced, working with multiple care systems on different electronic records, makes coordination of care across BHSD, SUTS, and Specialty care difficult for those in Primary Care.

(2.)With 21 different call centers within our system, it is hard for a patient who is health care naïve to get the correct information about where to seek care for what problem. We are looking at providing guidance to patients that they can take home as a refrigerator magnet or handout to address alternatives to Emergency Department use for avoidable or easily treated diseases or injuries.

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

(1.)Despite the challenges in collecting and sharing data, there has been an improvement in the processes between the community partner clinics and the Secure File Transfer Protocol (SFTP). The SFTP is also used for the Global Payment Program data, so the data collection is consistent among the two waiver programs.

(2.) We have expanded the use of the Access or Excel databases with other partner agencies to ensure consistent data collection and identification of patients.

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

(1.)It has been difficult to share data across all electronic record systems. With Epic Link we have been able to share with some partners, but for others, especially those with an existing EHR, it is too cumbersome. Even pulling data with the best support of prepopulated fields in a secure file via an Access Database is cumbersome for external sites. We had to develop a media tab specifically for consents, but it is not consistently used or entered at the right time, affecting the accuracy of some of our enrollment dates.

(2.)We have had inaccuracies of patient assignments and the way the patient eligibility shows up in the header. One Senior Program Manager monitors this closely, so that errors are quickly identified by staff and corrected by the IT team.

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

(1.) We have aligned external and internal data collection, by going back and reviewing the data collection process at all sites. This makes entry into the Electronic Data Warehouse less subject to the variations from one site to another. We have also aligned it with billing processes for external agencies.

(2.) Due to the need to reconstruct the database, related to new implementation of HL fields and loss of the IT team until it could be replaced, the clinical and IT team members went over all aspects of data gathering, reporting and clarification of terms. The team members handling data streamlined many processes in data collection and developing the report. All the decisions were codified for both clinical and IT team members.

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

(1.) We need more quick mini analyses to determine the best strategies. For example, a review of all the patients seen by one clinic eligible for WPC. We then need to share them more quickly for PDSA efforts to identify process improvement goal setting.

(2.) We need programs that assist with housing through County Office of Supportive Housing and medical record information through EPIC HealthLink connected to our HL Electronic Health Record, in other words two-way communication for non-EPIC sites.

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

- Most staff are concerned about the sustainability of the program. Our community partners and others have expressed a concern that they will ramp up to treat more patients and the funding for sustainability will not last.
- There is also a concern about the impact of Health Homes on a population that crosses with WPC patients.
- The real non-funded need is for housing resources for our patients. In the heart of a high demand and high cost housing this will continue to be a barrier for our WPC patients/clients.
- Other initiatives and competing issues demand time from clinical staff and leadership
- The ability of health care to convey to persons seeking care the desirability of the preventive health model.

X. PLAN-DO-STUDY-ACT

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

List PDSA attachments
Whole Person Care Summary Report
PDSA Documents and Name of Each File.

Combined files submitted as **Attachment C** which contains the following:

1. **Data: Reporting Analytics**
   a. 01_Data Reporting Analytics_PDSA_2018 Annual Report_12-31-2018.docx
2. **East Valley Community Clinic - Care Coordination**
   a. 02_East Valley Community Clinic_Care Coordination PDSA_2018 Annual Report_12-31-2018.docx
3. **Enrollment Process – Enrollments & PMPMs**
   a. 03 Enrollment Process_Enrollment PMPM PDSA_2018 Annual Report_12-31-2018.docx
4. **Gardner – Care Coordination**
   a. 04_Gardner_Care Coordination PDSA_2018 Annual Report_12-31-2018.docx
5. **Indian Health Center – Care Coordination**
   a. 05_Indian Health Center_Care Coordination PDSA_2018 Annual Report_12-31-2018.docx
6. **MayView Clinic – Care Coordination**
   a. 06_MayView_Care Coordination PDSA_2018 Annual Report_12-31-2018.docx
7. **Planned Parenthood Mar Monte (PMPM) – Care Coordination**
   a. 07_PPMM_Care Coordination PDSA_2018 Annual Report_12-31-2018.docx
8. **Roots Clinic - Care Coordination**
   a. 08_Roots_Care Coordination PDSA_2018 Annual Report_12-31-2018.docx
9. **SBIRT – Alcohol and Drug Screening**
   a. 09_SBIRT_PDSA_2018 Annual Report_12-31-2018.docx
10. **School Health Clinics – Care Coordination**
    a. 10_School Health_Care Coordination PDSA_2018 Annual Report_12-31-2018.docx
11. **Sobering Center – Emergency Department (ED) Referrals**
    a. Sobering Center_ED Referrals PDSA_2018 Annual Report_9-30-2018.docx
12. **Sobering Center – Law Enforcement (LE) Engagement**
    a. Sobering Center_LE Engagement PDSA_2018 Annual Report_9-30-2018.docx