Management Audit of the County of Santa Clara Community Health Services

Prepared for the Board of Supervisors of the County of Santa Clara

June 30, 2022

VHC Moorpark

VHC Gilroy

VHC Downtown San Jose

VHC Tully

VHC Lenzen

VHC Milpitas

Prepared by the

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June 30, 2022

Supervisor Otto Lee, Chair
Supervisor Cindy Chavez, Vice Chair
Board of Supervisors' Finance and Government Operations Committee
70 West Hedding Street San Jose, CA 95110

Dear Supervisors Lee and Chavez:

We have completed the Management Audit of Community Health Services. This audit was added to the Management Audit Division's work plan by the Board of Supervisors of the County of Santa Clara, pursuant to the Board's power of inquiry specified in Article III, Section 302(c) of the Santa Clara County Charter. This audit was conducted in conformity with generally accepted government auditing standards as set forth in the 2018 revision of the "Yellow Book" of the U.S. Government Accountability Office. The purpose of this audit was to examine Community Health Services to identify opportunities to increase their efficiency, effectiveness, and economy.

The report includes six findings and 17 recommendations related to reporting on patient referrals and access, social worker workflow inefficiencies, case management referral inefficiencies, the limited hours of Community Health Services, the clinics' website inaccuracies, and data entry delays into the AIDS Regional Information and Evaluation System (ARIES).

In the attached responses to this audit, Community Health Services agrees or partially agrees with 12 of the 13 recommendations directed to them and disagrees with one of these recommendations. Community Health Services disagrees with Recommendation 4.1, which states that "the Ambulatory Outpatient Specialty, Community Health and Administrative Services Director should work with the HIV Commission and Public Health Department to evaluate the need for TB Clinic and Partners in AIDS Care and Education Clinic evening hours." According to the Community Health Services written response, "there is currently no access issue as timely appointments in both urgent, initial consult, and follow up categories meet all associated compliance requirements and enable patients access to a multidisciplinary team". However, we continue to recommend that Community Health Services work with the HIV Commission and Public Health Department to evaluate the need for evening clinic hours. As stated on page 46 of our report, "only providing clinic

services during usual working hours between 8am and 5pm could limit access to services for patients who work during those hours".

The Santa Clara Valley Medical Center chief executive officer agrees with the one recommendation directed to Santa Clara Valley Medical Center, and the Technology Services and Solutions Department (TSS) agrees with the two recommendations directed to TSS. One recommendation concerning requesting annual reports on patient access to the specialty clinics and strategies to improve patient access is directed to the Board of Supervisors Health and Hospital Committee chair.

If implemented, the recommendations would:

- refine existing measures regarding patient access to care and enhance reporting;
- allow clinic management to better assess social worker performance and workload;
- help to close the referral loop and reduce the risk that patients in need of supportive services will experience delays in receiving these services;
- make it easier for patients Community Health Services clinics in access services;
- decrease obstacles to the treatment of infectious diseases and therefore decrease the risks to patients and community members from these infectious diseases;
- help the Public Health Department meet Ryan White Program grant requirements and safeguard future federal healthcare funding for economically vulnerable HIV and AIDS patients.

We would sincerely like to thank Community Health Services and its staff for their thoughtful, patient, and professional cooperation and assistance throughout this audit.

Respectfully submitted,

Cheryl Solov
Management Audit Manager

CC: Supervisor Mike Wasserman
Supervisor Susan Ellenberg
Supervisor S. Joseph Simitian
James R. Williams, County Counsel

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Executive Summary

Section 1: Reporting on Patient Referrals and Access

Reporting on patient access to Community Health Services (CHS) clinic appointments is not consistently documented to allow CHS managers to understand trends in patient access. Documenting clinic no show rates is standardized, but reporting on retention in HIV medical care has changed between years. For example, CHS reported two different calendar year (CY) 2017 rates for retention in HIV medical care, reporting 80% and 73.3% respectively to two different Ambulatory and Community Health Services (ACHS) Quality Consortiums, but the reason for the different reported rates was not provided. Also, the CY 2018 rate for retention in HIV medical care was reported to the ACHS Quality Consortium as 71.6%, and the CY 2019 rate for retention in HIV medical care was reported by CHS to the management audit team as 85%, an increase of more than 13 percentage points, but the reason for this increase was not reported, including the extent to which changes in the definition of "retention in HIV medical care" by the federal Health Resources and Services Administration impacted reporting on the measure.

When developing annual operational priorities, CHS should ensure that the "measures of success" are quantifiable and measurable. For example, the Infectious Disease Clinic's measure for the activity "patient referrals being triaged timely by assigned provider" is "report, review ease of patients getting appointments". The measure is not sufficiently specific to allow clinic managers to determine if triage is occurring in a timely manner; how does a manager determine the level of ease by which a patient gets an appointment? The Health and Hospital Committee Chair should request annual reports from the CHS on patient access to the specialty clinics, including appointment no show rates and retention in HIV medical care, and strategies to improve patient access. These recommendations are intended to refine existing measures on patient access to care and enhance reporting. Implementation of these recommendations should be accomplished within existing staff resources.

Section 2: Social Worker Workflow Inefficiencies

Valley Medical Center's electronic health records system, HealthLink, does not have sufficient functionality to allow Community Health Services (CHS) clinic managers and providers to track social worker referrals and referral outcomes. Clinic staff can view individual referrals submitted through inbox messaging and social worker notes, but CHS cannot generate HealthLink reports to track overall referrals, referral timelines, and outcomes to better evaluate patient population needs and social worker workload. The TB Clinic does not have documented procedures for referring patients to social workers, and discussions with TB Clinic staff did not consistently clarify if TB Clinic patients were eligible for referral to the social workers or only HIV positive patients. The TB Clinic also does not have a documented procedure for conducting regular chart audits to ensure that patients are being appropriately referred to social worker services.

The Partners in AIDS Care and Education (PACE) Clinic medical and psychiatric social workers have work functions not covered by the County job description for social workers. How the medical social worker should engage with various databases used for tracking PACE or TB patients, conduct case management follow-ups, or

facilitate the completion of a referral to services is not documented, and expectations regarding the positions' responsibilities remain unclear. While there are documented clinical competencies developed for other positions within the CHS specialty clinics, there are no service-specific clinical competencies for social workers.

The CHS director should work with Technology Services and Solutions Department staff to facilitate approval of the HealthLink build request in 2022 to allow tracking of patient referrals to social workers. The CHS director should also direct TB and PACE Clinic managers to work with the medical and psychiatric social workers and relevant professional leadership to develop and document the required social worker clinical competencies, and criteria and procedures for referring TB Clinic patients to the social workers; and direct the TB Clinic manager to develop a policy for conducting regular patient chart audits. Implementing these recommendations would not require hiring additional staff, and there would not be additional County costs beyond existing staff time and resources. Documented social worker clinical competencies would allow clinic management to better assess social worker performance and workload.

Section 3: Case Management Referral Inefficiencies

Partners in AIDS Care and Education (PACE) Clinic patients can be referred to The Health Trust through the Public Health Department (PHD), self-referral, or the medical social worker. None of these sources of referrals know which other source is referring unless the patient tells them, which may cause confusion for patients, case managers at The Health Trust, and PACE Clinic staff. This can result in a lack of referral follow-through and the loss of a potential service linkage, in addition to being an inefficient use of staff time. Furthermore, The Health Trust has not complied with reporting requirements in the MOU between the Health and Hospital System and The Health Trust, though it does provide separate reports to the PHD. The Health Trust's continued non-compliance in submitting required reports is impacting the ability of the PACE Clinic to oversee their patients' connection to supportive services.

The Chief Executive Officer of Santa Clara Valley Medical Center (SCVMC) should delegate responsibility for the MOU with The Health Trust, for services to PACE Clinic patients, to the PHD and incorporate MOU requirements into the Interagency Agreement between the PHD and the PACE Clinic. CHS should document policies implementing a centralized referral management process that also establishes that referrals to The Health Trust must be facilitated by the medical social worker. The goal of these recommendations is to improve oversight and efficiency of referrals for case management services and should be achievable with existing SCVMC resources. Shifting oversight of the agreement with The Health Trust from the PACE Clinic to the PHD would improve efficiency by reducing the number of entities The Health Trust must report to, as well as further ensuring that The Health Trust is fulfilling their contractual requirements. There are no additional costs associated with the recommendations. These recommendations will help to close the referral loop and reduce the risk that patients in need of supportive services will experience delays in receiving these services.

Section 4: Limited Hours of Community Health Services Clinics

HIV/AIDS services provided by the Partners in AIDS Care and Education (PACE) Clinic are available in south Santa Clara County nine hours a month, although the Public Health Department (PHD) found a concentration of people living with HIV/AIDS in the more rural southern region of the County. Limited clinic hours in south Santa Clara County requires HIV/AIDS, patients to travel to San Jose for treatment, which could result in patients having difficulty accessing or completing treatment regiments.

The CHS director should work with the HIV Commission and PHD to evaluate the need for PACE Clinic and TB evening hours. Given the concentration of people living with HIV/AIDS in south County the CHS director should also consider establishing additional PACE provider time to deliver specialized HIV care services with support from existing primary care facilities in south County. The CHS director should continue to actively engage with the HIV Commission and with the Facilities and Fleet Department to identify a new location that fulfills both the accessibility needs and clinical needs of PACE Clinic patients. A prior survey by the HIV Commission identified the need to add evening hours at the PACE Clinic and a new survey could require some additional costs. Any new costs would be offset by the benefit to CHS patients in accessing clinic services.

Section 5: Website Inaccuracies

To find information on Community Health Services (CHS) specialty clinics, a website visitor must navigate to the webpage of the correct Valley Health Center location (where the clinic is located). Finding information for the Partners in AIDS Care and Education (PACE) Clinic requires searching through four layers of webpages. Finding information for the other CHS clinics requires searching through three layers of webpages, although a browser search for the PACE, TB, or Refugee Clinic will take a visitor to the webpage. The CHS specialty clinic webpages do not consistently provide information on clinic hours and days, and do not provide detailed information on services available to patients.

CHS should work with the Technology Services Solutions Department (TSS) to improve CHS specialty clinic webpages and provide consistent and more detailed information on available services for patients and clinic locations, hours, and days of services. CHS should also consult with the Public Health Department on creating designated webpages for the Infectious Disease and STI Clinics. Implementing these recommendations would not require additional budgeted positions. County costs would amount to time spent by current staff. Decreasing obstacles to the treatment of infectious diseases however, would decrease the risks to patients and community members from these infectious diseases.

Section 6: ARIES Data Entry Delays

AIDS Regional Information and Evaluation System (ARIES) is a web-based HIV/AIDS client management system used by the Partners in AIDS Care and Education (PACE) Clinic, which is funded in part by the federal Ryan White HIV/AIDS Program. Under the Interagency Agreement between the PACE Clinic and Public Health Department (PHD), the Clinic is required to submit patient data into ARIES within 7–14 days after service delivery, but the PACE Clinic is not able to meet this requirement.

Because ARIES is not currently compatible with the Health and Hospital System's electronic health records system, HealthLink, the PACE Clinic must manually enter patient data into ARIES, which currently takes approximately 30–45 days following service delivery. In addition, the Clinic's paper-based patient services form must be manually transcribed by staff into ARIES. Technology Services and Solutions (TSS) is in the second phase of building an interface between HealthLink and ARIES, which would eliminate the need for manual entry into ARIES. According to discussions with CHS staff, however, this is a long-term project and completion is still distant because of the complexity of the ARIES system, which is shared by multiple agencies. The PHD relies on PACE Clinic-entered data in ARIES for annual reporting to the federal Health Resources and Services Administration for the Ryan White Program as well as ongoing California Office of AIDS compliance, program development, and quality management. According to CHS staff, PACE Clinic data is entered into ARIES in sufficient time to meet federal Ryan White reporting requirements between January and March of each year.

The PACE Clinic should discuss with TSS the feasibility of digitizing the Clinic's paper-based patient services form. TSS should continue to work with the PACE Clinic on the HealthLink - ARIES build interface, which would automate large portions of patient information data entry into ARIES to comply with Ryan White Program timeline requirements and should provide a report to the Board of Supervisors regarding the prioritization of the project. Reducing the number of days it takes PACE Clinic staff to enter patient data into ARIES will assist the PHD in meeting Ryan White Program grant requirements and safeguarding future federal healthcare funding for economically vulnerable HIV and AIDS patients.

INTRODUCTION

This Management Audit of Community Health Services was authorized by the Board of Supervisors of the County of Santa Clara as part of the County's Fiscal Year 2021–22 Management Audit Work Plan pursuant to the Board's power of inquiry specified in Article III, Section 302(c) of the Charter of the County of Santa Clara.

PURPOSE, SCOPE, AND OBJECTIVES

The purpose of the audit was to examine the operations, staffing, management practices, and finances of Community Health Services (CHS), and to identify opportunities to increase their efficiency, effectiveness, and economy. Work on this audit began with an entrance conference on August 11, 2021, and a draft report was issued to Community Health Services on March 21, 2022. The Management Audit Division also sent the audit draft to the Office of the County Counsel, and relevant sections of the audit draft to Technology Service and Solutions for review and comment.

The exit conference was held with Community Health Services on April 6, 2022, and a revised draft incorporating feedback from the exit conference and County Counsel was issued to Community Health Services, Valley Medical Center, and Technology Service and Solutions on June 7, 2022 for written response. This final report includes the written responses as Attachment A on page 65, Attachment B on page 71, and Attachment C on page 73.

AUDIT METHODOLOGY

As part of this management audit the Management Audit Division conducted interviews with all staff levels, executive management to line staff. Interviews were conducted one-on-one with staff members. Additional interviews included meetings with the Department of Tax and Collections and the Public Health Department.

Management Audit Division staff reviewed procedure manuals and intake forms, training materials and procedures, contracts and contract oversight documents, compliance audit reports, aggregated patient appointment data, insurance eligibility and enrollment activity reports, and additional documents relevant to services provided by CHS staff. Management Audit Division staff also conducted site visits of the Tuberculosis Clinic, Refugee Clinic, Partners in AIDS Care and Education (PACE) Clinic, and the Infectious Disease Clinic. All other interviews and work on this audit were conducted remotely due to COVID-19 pandemic health risks.

COMPLIANCE WITH GENERALLY ACCEPTED GOVERNMENT AUDITING STANDARDS

This management audit was conducted under the requirements of the Board of Supervisors Policy Number 3.35 as amended on May 25, 2010. That policy states that management audits are to be conducted under generally accepted government auditing standards issued by the United States Government Accountability Office. We conducted this performance audit in accordance with generally accepted government auditing standards set forth in the 2018 revision of the "Yellow Book" of the U.S. Government Accountability Office. Those standards require that we plan and perform

the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives. In accordance with these requirements, we performed the following management audit procedures:

Audit Planning - This management audit was selected by the Board of Supervisors using a risk assessment tool and an estimate of audit work hours developed at the Board's direction by the Management Audit Division. After audit selection by the Board, a detailed management audit work plan was developed and provided to the Department.

Entrance Conference - An entrance conference was held with Community Health Services managers to introduce the management audit team, describe the management audit program and scope of review, and respond to questions. A letter of introduction from the Board, a management audit work plan, and a request for background information were also provided at the entrance conference.

Pre-Audit Survey - A preliminary review of documentation and interviews with Community Health Services managers and staff were conducted to obtain an understanding of the program, and to isolate areas of operations that warranted more detailed assessments. Based on the pre-audit survey, the work plan for the management audit was refined.

Field Work - Field work activities were conducted after completion of the pre-audit survey, and included:

- interviews with managers and staff of the Public Health Department and the Department of Tax and Collections;
- site visits of the Tuberculosis, Refugee, Partners in AIDS Care and Education, and Infectious Disease clinics;
- further review of documentation and other materials provided by Community Health Services clinics and the Patient Access Department (where non-clinic CHS staff work, roughly half the staff);
- review of publicly available information regarding the Community Health Services clinics;
- analysis of aggregated data provided by Community Health Services, the Public Health Department, and the Department of Tax and Collections.

Draft Report - On March 21, 2022, a draft report was provided to Community Health Services containing our preliminary findings, conclusions, and recommendations.

Exit Conference - An exit conference was held with Community Health Services managers on April 6, 2022, to collect additional information pertinent to our report, obtain their views on the report findings, conclusions, and recommendations, and make corrections and clarifications as appropriate. Following the exit conference, a revised draft was provided to Community Health Services, Valley Medical Center, and Technology Service and Solutions for their use in preparing formal written responses.

Final Report - This final report was issued on June 30, 2022 and includes the written responses from Community Health Services, Valley Medical Center, and Technology Service and Solutions as Attachment A on page 65, Attachment B on page 71, and Attachment C on page 73.

REPORT OMISSIONS

Per GAGAS 9.10(4) the Management Audit Division is disclosing that confidential information has been omitted from this public report on advice of County of Santa Clara Office of the County Counsel;[1] however, pursuant to GAGAS 9.64 and 9.65, this information will be furnished confidentially to the Board of Supervisors.[2]

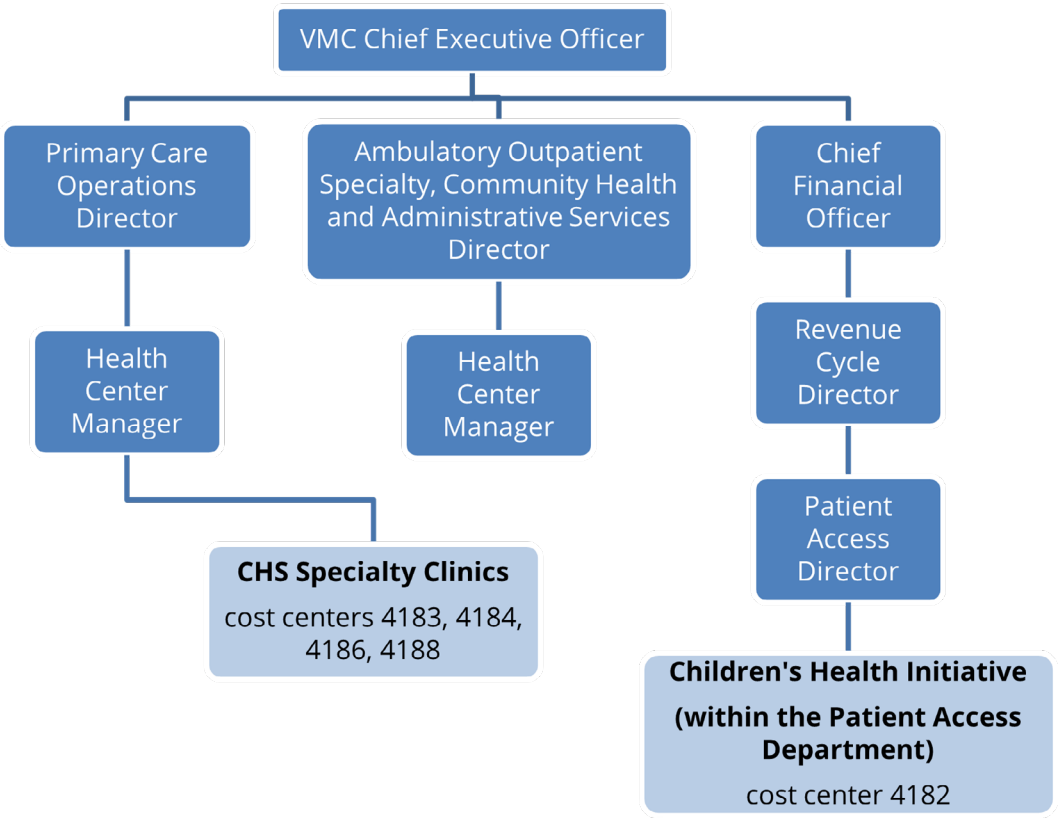
BACKGROUND

Community Health Services (CHS) is a budget unit within the Santa Clara Valley Health and Hospital System (HHS) with 104 full-time equivalent (FTE) staff and an adopted budget of $18 million for Fiscal Year 2020–21. CHS staff are budgeted across five cost centers which are organized in two distinct groups: specialty clinic staff and Patient Access Department staff (budgeted in the Children's Health Initiative cost center) (see Figure I.1 on page 8).

1 GAGAS 9.10: "Auditors should prepare audit reports that contain (1) the objectives, scope, and methodology of the audit; (2) the audit results, including findings, conclusions, and recommendations, as appropriate; (3) a summary of the views of responsible officials; and (4) if applicable, the nature of any confidential or sensitive information omitted". Retrieved June 6, 2022, from https://www.gao.gov/assets/gao-18-568g.pdf.

2 GAGAS 9.64: "If the report refers to the omitted information, the reference may be general and not specific. If the omitted information is not necessary to meet the audit objectives, the report need not refer to its omission".
GAGAS 9.65: "Certain information may be classified or may otherwise be prohibited from general disclosure by federal, state, or local laws or regulations. In such circumstances, auditors may issue a separate, classified, or limited use report containing such information and distribute the report only to persons authorized by law or regulation to receive it". Retrieved June 6, 2022, from https://www.gao.gov/assets/gao-18-568g.pdf.

Figure I.1: *Organization of Staff Within the Community Health Services Budget Unit*



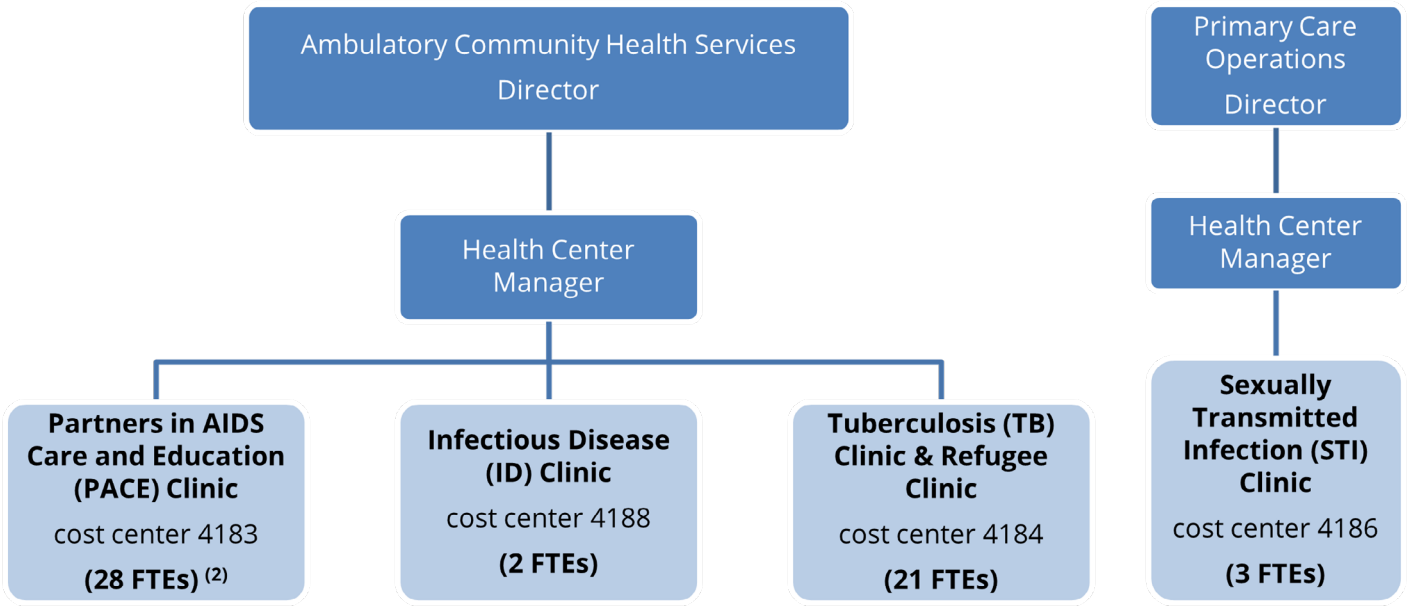
Source: Chart created by the Management Audit Division based on organizational charts provided by Community Health Services and Patient Access Department management.

These distinct groups, the specialty clinics staff and the staff within the Patient Access Department, perform different functions and do not have a common reporting structure any lower than VMC's Chief Executive Officer. Their organization and functions are therefore being presented separately within this report.

Organization and Function of Community Health Services' Specialty Clinics

Roughly half of CHS staff (54 out of 104 FTEs) provide services within five specialty clinics: Partners in AIDS Care and Education (PACE), Tuberculosis (TB), Refugee, Infectious Disease (ID), and Sexually Transmitted Infection (STI) (see Figure I.2 on page 9). Nurses, managers, administrative staff, and social workers are budgeted through CHS, but physicians working within the clinics are budgeted and staffed separately through the Valley Medical Center hospital.

Figure I.2: *Budgeted Staff in Community Health Services Specialized Clinics, as of January 10, 2022*



Source: Chart created by the Management Audit Division based on organizational charts provided by Community Health Services and the January 10, 2022, Position Status Report provided by the Employee Services Agency.

Notes:
(1) The Tuberculosis Clinic and Refugee Clinic are two separate specialties, but they are in the same building and share administrative and some nursing staff.
(2) As of January 10, 2022, there are two vacancies in the CHS PACE Clinic: one health services representative and one psychiatric social worker.

As of February 25, 2022, Community Health Services' services are primarily split between two main Valley Health Center locations in San Jose: 2400 Moorpark Avenue and 976 Lezen Avenue. CHS specialty services are also offered at Valley Health Center locations in Milpitas, Gilroy, and two San Jose (Downtown and Tully) during limited hours and days of the week each month. The clinics are only open on weekdays, 8am to 5pm, except for the PACE and ID clinics, which have evening hours till 8pm on Tuesdays, and the STI Clinic which is only open Wednesday and Thursday evenings (see Figure I.3 on page 10 for clinics' hours and locations). See Section 4, starting on page 43, for further discussion of clinic hours and see Section 5, starting on page 49, regarding the inaccurate or insufficient public-facing information about treatment locations and hours.

Figure I.3: *Community Health Services' Clinic Service Hours and Locations, as of February 25, 2022*

Label	Valley Health Center Location	Specialty	Monday	Tuesday	Wednesday	Thursday	Friday
Main Clinics							
A	Moorpark 2400 Moorpark Ave, San Jose	PACE[1]	8am–5pm	8am–8pm	8am–5pm	8am–5pm	8am–5pm
		Infectious Disease	8am–5pm	8am–8pm	8am–5pm	8am–5pm	8am–5pm
B[1]	Lenzen[3] 976 Lenzen Ave, San Jose	TB[2]	8am–5pm	8am–5pm	8am–5pm	8am–5pm	8am–5pm
		Refugee	8am–5pm	8am–5pm	8am–5pm	8am–5pm	8am–5pm
		STI			5pm–9pm	5pm–9pm	
Services at Satellite Clinics							
C	Downtown 777 E Santa Clara St, San Jose	TB (latent TB only)					8am–5pm
D	Milpitas 143 N Main St, Milpitas	TB (latent TB only)				8am–5pm	
E	Tully 500 Tully Rd, San Jose	TB (latent TB only)			8am–12pm (1st Wed.) 8am–5pm (other Weds.)		
F	Gilroy 7475 Camino Arroyo, Gilroy	PACE			8am–5pm (1st Wed.)		
		TB (latent TB only)			8am–5pm (2nd & 4th Wed.)		

Evening hours
No CHS specialty services available

Source: Valley Health Center Clinic webpages, retrieved by the Management Audit Division January 19, 2022, and additional information provided by clinic management.

Notes:
(1) The PACE Clinic also provides clinic services on the second Wednesday of the month at the Main Jail (1pm–5pm) and the and fourth Wednesday of the month at the Elmwood Jail (1pm–5pm).
(2) The TB Clinic has a nurse advice line, 8am–5pm on weekdays, for patients with treatment questions. There is also an on-call physician available after 5pm if patients need emergency assistance.
(3) The TB and Refugee clinics will be moving to 1996 Lundy Avenue, San Jose. As of January 20, 2022, CHS management anticipates the move will occur at the end of 2022 and that the STI Clinic will remain at VHC Lenzen.

California Code of Regulations, Title 17, Section 2500, requires all healthcare providers to report confirmed or suspected human immunodeficiency virus (HIV), acquired immunodeficiency syndrome (AIDS), and tuberculosis (TB) cases to the local health officer for the jurisdiction where the patient resides. For Santa Clara County that means contacting the Santa Clara County Public Health Department (PHD).[3] The PHD is responsible for tracking reported cases and treatment in the County and it reports this information to the California Department of Public Health. The Santa Clara County PHD investigates all (suspected) case reports they receive and will refer TB, HIV, and AIDS patients to CHS' specialty clinics for testing and/or treatment if the patient is not being treated by another healthcare provider (e.g. Kaiser, Sutter, Stanford Healthcare, etc.). The PHD will continue to track a patient's treatment progress to confirm that they are continuing their treatment plan and, in the case of TB, are no longer infectious. Communication between the PHD and CHS is therefore important (see Section 3, starting on page 35, for further discussion).

Partners in AIDS Care and Education (PACE) Clinic

The PACE Clinic treats patients who have already been informed of their HIV or AIDS positive test results. It typically receives notifications of new diagnoses through the Public Health Department's Positive Connections program (or another entity that conducted the test). The PACE Clinic contacts the newly diagnosed patient to immediately begin the antiretroviral therapy (ART) as soon as possible after diagnosis (part of the PACE Clinic's RapidStart protocol). The ART often begins before the official patient referral process is even complete. Once the patient is officially referred to the PACE Clinic the PACE pharmacist and health services representatives work with the patient to determine their current insurance coverage and potential eligibility. The Clinic's senior health services representatives ("financial counselors") will then assist the patient with enrolling in a health insurance plan or other financial assistance programs if necessary. If the patient is not eligible for Medi-Cal or other insurance, then their treatment is covered by Ryan White funding. Because ART begins before the patient's intake visit this insurance process usually also proceeds the intake visit. Health services representatives will confirm health insurance status when a patient checks in for a Clinic appointment as well.

The PACE Clinic offers intensive support for its patients because of the social and mental stresses associated with HIV and AIDS. Many PACE Clinic patients choose to have their PACE physician as their primary care physician. New patients to the Clinic will also meet with the onsite medical social worker to determine whether they need additional support services (housing, food, mental health support, etc.). The PACE Clinic and the Public Health Department both have an outside contract with The Health Trust, which provides referred patients with ongoing medical and non-medical case management services as needed (see Section 3, starting on page 35, for further discussion).

The PACE Clinic and the ID Clinic share exam rooms and staff.

3 Tuberculosis and acute HIV infections must be reported within one working day of the identification of the (suspected) case. Other stages of HIV infections, including progression to stage 3 (AIDS), must be reported within seven calendar days. Retrieved December 6, 2021, from https://govt.westlaw.com/calregs/Document/I5849DB60A9CD11E0AE80D7A8DD0B623B?transitionType=Default&contextData=%28sc.Default%29.

Infectious Disease (ID) Clinic

The ID Clinic provides care specifically to patients with difficult-to-treat infections. It specializes in medication management and treatment for patients with multiple coinciding infections (for instance concurrent HIV and TB), and therefore receives referrals from the PACE and TB clinics as well as other HHS providers. The ID Clinic shares exam rooms and staff with the PACE Clinic and serves some of the same patients.

Tuberculosis (TB) Clinic

The goal of the TB Clinic is to test for and treat tuberculosis cases as soon as possible. The TB Clinic receives a notification from the Centers for Disease Control and Prevention (CDC) if a newly arriving refugee or special immigrant visa holder needs a TB evaluation. The TB Clinic also receives referrals from the Santa Clara County Public Health Department Tuberculosis Prevention and Control Program ("TB Control"), which investigates all reports of persons with suspected or confirmed cases of TB.[4] TB Clinic staff will then contact the patient for an appointment. If the patient is considered high risk and staff are unable to reach them after calling three times and sending a letter, then TB Control will conduct a home visit.

Since TB is a highly complex infectious disease and requires multiple medications the TB Clinic also operates a nurse advice line, 8am–5pm on weekdays, for patients with treatment questions. There is also an on-call physician available after 5pm if patients need emergency assistance. Treatment for latent TB (non-contagious TB infections which cause no symptoms) is also available at Valley Health Center locations in Milpitas, Gilroy, and two San Jose locations (Downtown and Tully) (see Figure I.3 on page 10), but treatment of active TB infection is available only at the main TB Clinic on Lenzen Avenue.

The main TB Clinic is located in the same building as the Refugee Clinic and some staff are shared between these two clinics.

Refugee Clinic

Refugees approved for admission to the United States are sponsored by a non-profit resettlement agency for reception and placement assistance. Once the Office of Refugee Resettlement (ORR) matches a refugee with a resettlement agency, that agency assigns the refugee to a local resettlement affiliate. Upon arrival in the United States the local resettlement affiliates provide case managers who assist refugees during their initial resettlement process, including accompanying them to their first Refugee Clinic visit, and if necessary, coordinating transportation for follow-up visits.

The Refugee Clinic provides the first comprehensive health assessment for newly arrived refugees in Santa Clara County. Newly arrived families must first quarantine for 10-days, and then be seen in the Clinic for a series of four health assessments, which can be scheduled over a 90-day period. The first health assessment should occur within two-weeks of arrival. Initial health assessments are extensive and include lab tests, x-rays, vaccinations, and mental health screenings. All family members

4 California Code of Regulations, Title 17, Section 2500 requires all healthcare providers to report confirmed or suspected TB cases to the local health officer for the jurisdiction where the patient resides within one working day of identification of the (suspected) case. Retrieved December 6, 2021, from https://govt.westlaw.com/calregs/Document/I5849DB60A9CD11E0AE80D7A8DD0B623B?transitionType=Default&contextData=%28sc.Default%29.

receive an assessment provided by a clinical or licensed vocational nurse. Financial counselors in the Refugee Clinic work with families to help enroll them in Medi-Cal or other medical insurance coverage based on eligibility. The Clinic's health services representatives help them select primary care providers. In the interim, the Refugee Clinic provides primary care services to patients for this transitional period until they can secure a primary care provider. The fourth visit to the Clinic is with one of the PACE Clinic's psychiatric social workers (the Refugee Clinic does not have its own designated social workers). Patients who may require intensive mental health support are referred to Asian Americans for Community Involvement, which provides psychological evaluations and treatment.

If language interpretation is needed the Refugee Clinic will use an in-person medical interpreter, sometimes this is the local resettlement affiliate case manager. When in-person interpretation is not available the Clinic uses a language interpretation line with interpretation services provided by a Valley Medical Center contractor.

Sexually Transmitted Infection (STI) Clinic

The purpose of the STI Clinic is to provide low barrier and low cost STI treatment to high-risk patients. According to CHS staff, STI Clinic patients are referred through the Public Health Department's Crane Center, which offers HIV and STI testing and is located in the same building as the STI, Refugee, and TB clinics. The Crane Center conducts screenings, lab tests, provides some health education then refers the patient to the STI Clinic if the lab test comes back positive. Crane Center patients who test positive are referred to the STI Clinic after being screened for financial eligibility to receive a fee waiver for the STI Clinic. If a patient meets the financial eligibility for a fee waiver, then PHD staff make a note in the patient's appointment information for the Clinic's health services representative, who will check-in the patient at the Clinic. The STI Clinic conducts a physical review, which may involve more testing, and will oversee the treatment program, and further patient education

Patients are seen confidentially in the STI Clinic. A health services representative will discreetly collect a patient's information and hand the patient a color-coded card which is used to call the patient in for their appointment. Though a patient may visit the STI Clinic more than once, the Clinic is not meant to provide ongoing treatment and case management/support services, unlike the other CHS clinics. In addition to STI treatment, the Clinic also offers STI testing services.

The STI Clinic uses the same exam rooms as the Refugee Clinic but does not share the same staff.

Number of Patients Served by Community Health Services Clinics

The data in Figure I.4 on page 14 was provided by CHS regarding unique patients served and the number of complete appointments within each calendar year. These numbers do not include patients seen, or appointments completed, at the four satellite clinics which provide PACE and Latent TB services, or at the Main Jail or Elmwood Jail where PACE services are also delivered. As shown in Figure I.4 on page 14, in the five-year period between 2016 and 2020, the number of PACE Clinic patients increased by 17.52%, and although PACE Clinic appointments decreased between 2019 and 2020, over the five-year period total PACE Clinic appointments

increased by 13.93%. The number of patients and appointments at the TB Clinic and Refugee Clinic, which are tracked as an aggregate in HealthLink, decreased by 44.20% and 50.49% respectively during the five-year period between 2016 and 2020, with the largest decrease between 2019 and 2020.

Figure I.4: *Number of Patients Seen and Number of Completed Appointments By Calendar Year for 2016–2020*[1]

Number of Patients By Calendar Year						% Change
	2016	2017	2018	2019	2020	2016 to 2020
PACE - Moorpark	1,315	1,328	1,364	1,462	1,549	17.79%
PACE - Gilroy	26	28	29	30	27	3.85%
Total PACE:	1,341	1,356	1,393	1,492	1,576	17.52%
ID - Moorpark	502	567	577	554	571	13.75%
STI - Lenzen	842	1,051	1,207	1,230	796	-5.46%
TB/Refugee - Lenzen	2,923	2,817	2,733	2,623	1,631	-44.20%
Latent TB - VHC Clinics[2]	414	91	106	220	276	-33.33%
Number of Completed Appointments By Calendar Year						**% Change**
	2016	**2017**	**2018**	**2019**	**2020**	**2016 to 2020**
PACE - Moorpark	9,410	9,001	10,461	11,154	10,745	14.19%
PACE - Gilroy	89	89	67	78	77	-13.48%
Total PACE:	9,499	9,090	10,528	11,232	10,822	13.93%
ID - Moorpark	1,610	1,839	1,778	1,526	1,490	-7.45%
STI - Lenzen	1,136	1,457	1,868	2,021	1,537	35.30%
TB/Refugee - Lenzen	15,450	13,512	13,271	12,050	7,650	-50.49%
Latent TB - VHC Clinics[2]	1,491	366	392	743	890	-40.31%

Source: Aggregate data provided by Community Health Services.

Notes:
(1) Gradient shading by row, lowest to highest count for each clinic across the five-years.
(2) Specialty services are also provided during limited hours each month at four Valley Health Center satellite clinic locations: Milpitas, Gilroy, and two in San Jose (Downtown San Jose and Tully). Only the totals across these four locations were available for patient and appointments. These numbers also do not include PACE services at the Main Jail and Elmwood Jail.

Funding

To provide these specialty clinic services CHS receives funding from the Federal Ryan White HIV/AIDS Program, the California Department of Public Health: Office of Refugee Health, and Medicare and Medi-Cal reimbursements. CHS is subsidized by the County's General Fund and as of Fiscal Year 2021–22 its 104 FTE staff were budgeted through the General Fund.

The CHS Refugee Clinic has consistently received an annual non-competitive funding award from the California Department of Public Health's Office of Refugee Health. However, in FY 2018–19 the grant funding model shifted to a fee-for-service model, which resulted in a significant decrease in the total amount awarded to all applicants. The Refugee Clinic has therefore required additional County subsidies

through VMC, and it shares staff with the TB Clinic. With the increase in new refugee arrivals, especially from Afghanistan, it is hoped that the State will either adjust the funding model or increase available funds, but CHS management has not received information to this effect as of the start of 2022.

Organization and Function of Community Health Services' Children's Health Initiative

As of March 2022, the other half of CHS staff (50 out of 104 full-time equivalent staff) are funded through CHS' Children's Health Initiative cost center (4182) and work within the Patient Access Department ("Patient Access") providing financial support services to patients within the Health and Hospital System (e.g. financial eligibility screenings, insurance counseling, insurance enrollment, and financial program assistance enrollment). This includes one full-time equivalent (FTE) program manager, three FTE supervising health services representatives, 43.0 FTE senior health services representatives, two FTE administrative support positions, and one FTE clerical support position (see Figure I.5 below).

Figure I.5: *Patient Access Department Staff, as of March 21, 2022*

Budget Unit 418 – Community Health Services		
Cost Center	**Classification**	**FTE Staff**
4182 - Children's Health Initiative	Program Manager	1.0
4182 - Children's Health Initiative	Supervising Health Services Representative	3.0
4182 - Children's Health Initiative	Senior Health Services Representative	43.0
4182 - Children's Health Initiative	Administrative Assistant	1.0
4182 - Children's Health Initiative	Public Health Assistant	1.0
4182 - Children's Health Initiative	Supervising Patient Business Service Clerk	1.0
	BU 418 Subtotal:	**50.0**
Budget Unit 921 – Valley Medical Center		
Cost Center	**Classification**	**FTE Staff**
6980 - Patient Access	Director of Patient Access	1.0
6980 - Patient Access	Senior Health Services Representative	0.5
8484 - Patient Access	Senior Health Services Representative	5.6
8684 - Patient Access	Senior Health Services Representative	2.0
8684 - Patient Access	Patient Business Service Clerk	1.0
	BU 921 Subtotal:	**10.1**

Source: Position Status Reports provided by the Employee Services Agency.

In addition to the 43.0 FTE senior health services representatives budgeted through the CHS' Children's Health Initiative (budget unit 418, cost center 4182), there are 8.1 FTE senior health services representatives budgeted through the Patient Access Department within Valley Medical Center's budget unit (BU 921, cost centers 6980, 8484, and 8684) (see Figure I.5 above).

The 43.0 FTE senior health services representative positions funded through CHS' cost center 4182 are assigned to 770 Bascom Avenue outpatient and other ambulatory clinics, inpatient units at Valley Medical Center, and insurance verification functions for Valley Medical Center hospital and Emergency Department patients. The 8.1 FTE senior health services representative positions funded through the Patient Access Department provide identical services at O'Connor Hospital and Saint Louise Regional Hospital. They all report to the Patient Access Department director.

The Patient Access Department is spread across the Valley Medical Center, Saint Louise Regional, and O'Connor hospitals and ambulatory clinics. Patient Access provides bi-annual training to financial counselors and has a revenue cycle management team (consisting of the Patient Access director and program manager) who meet bi-monthly to review activity reports of financial counselors working in the Patient Access Department. The reports include information like the number patients enrolled into new health insurance plans by plan name, the number of "ability to pay determinations" conducted, and the number of financial screenings conducted by each financial counselor.

DEPARTMENT ACCOMPLISHMENTS

Audits typically focus on opportunities for improvements within an organization, program, or function. To provide additional insight into CHS, we requested that CHS Clinic management, and management overseeing CHS staff within the Patient Access Department, provide some of their noteworthy achievements. These are highlighted as Attachment D on page 75 and Attachment E on page 81 to this report.

RECOMMENDATION PRIORITIES

The priority rankings shown for each recommendation in the audit report are consistent with the audit recommendation priority structure adopted by the Finance and Government Operations Committee of the Board of Supervisors, as follows:

Priority 1: Recommendations that address issues of non-compliance with federal, State and local laws, regulations, ordinances and the County Charter; would result in increases or decreases in expenditures or revenues of $250,000 or more; or, suggest significant changes in federal, State or local policy through amendments to existing laws, regulations and policies.

Priority 2: Recommendations that would result in increases or decreases in expenditures or revenues of less than $250,000; advocate changes in local policy through amendments to existing County ordinances and policies and procedures; or, would revise existing departmental or program policies and procedures for improved service delivery, increased operational efficiency, or greater program effectiveness.

Priority 3: Recommendations that address program-related policies and procedures that would not have a significant impact on revenues and expenditures but would result in modest improvements in service delivery and operating efficiency.

ACKNOWLEDGMENTS

We would like to thank the management and staff of Community Health Services and the Patient Access Department for their assistance and cooperation with this audit. In addition, we are extremely grateful to the Public Health Department and the Department of Tax and Collections for the assistance and time they provided.

Section 1: Reporting on Patient Referrals and Access

Background
Community Health Services (CHS) tracks patient access to clinic appointments, including the percentage of patients who do not show for an initial or return appointment ("no show" rate) and the percentage of patients retained in HIV medical care. Increasing patient access to the CHS specialty clinics is an ongoing area of concern; Valley Medical set "improve overall access and capacity" as an operational priority in 2021.

Problem, Cause, and Adverse Effect
Reporting on patient access to clinic appointments is not consistently documented to allow CHS managers to understand trends in patient access. Documenting clinic no show rates is standardized, but reporting on retention in HIV medical care has changed between years. For example, CHS reported two different calendar year (CY) 2017 rates for retention in HIV medical care, reporting 80% and 73.3% respectively to two different Ambulatory and Community Health Services (ACHS) Quality Consortiums, but the reason for the different reported rates was not provided. Also, the CY 2018 rate for retention in HIV medical care was reported to the ACHS Quality Consortium as 71.6%, and the CY 2019 rate for retention in HIV medical care was reported by CHS to the management audit team as 85%, an increase of more than 13 percentage points, but the reason for this increase was not reported, including the extent to which changes in the definition of "retention in HIV medical care" by the federal Health Resources and Services Administration impacted reporting on the measure.

When developing annual operational priorities, CHS should ensure that the "measures of success" are quantifiable and measurable. For example, the Infectious Disease Clinic's measure for the activity "patient referrals being triaged timely by assigned provider" is "report, review ease of patients getting appointments". The measure is not sufficiently specific to allow clinic managers to determine if triage is occurring in a timely manner; how does a manager determine the level of ease by which a patient gets an appointment?

Recommendations
CHS managers should document the methodology for calculating retention in HIV medical care and implement quantifiable and measurable "measures of success" in annual operational priorities. The Health and Hospital Committee Chair should request annual reports from the CHS on patient access to the specialty clinics, including appointment no show rates and retention in HIV medical care, and strategies to improve patient access.

Savings, Benefits, and Costs
These recommendations are intended to refine existing measures on patient access to care and enhance reporting. Implementation of these recommendations should be accomplished within existing staff resources.

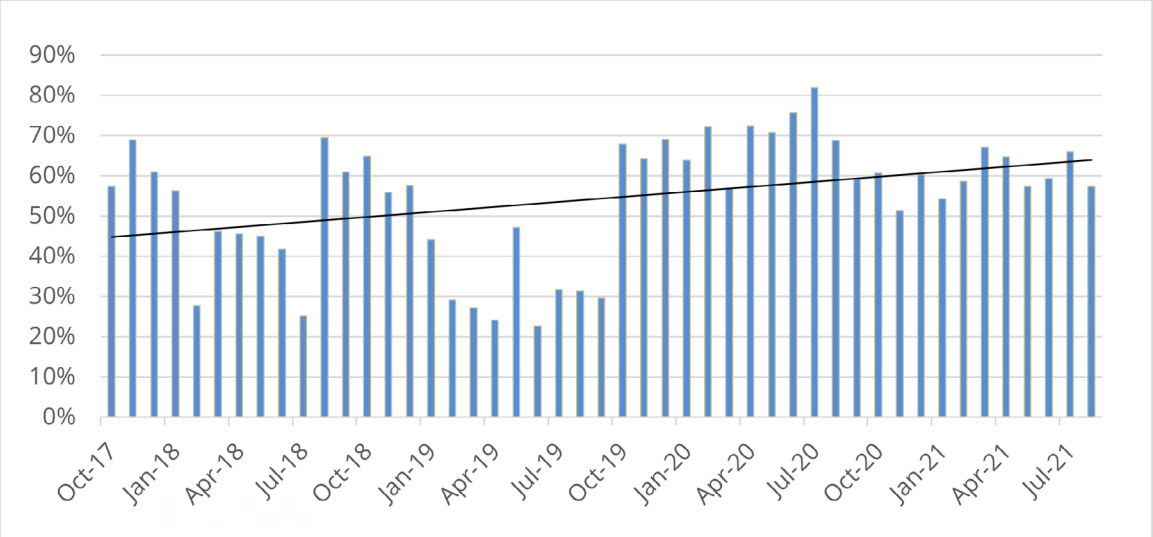
FINDING

Patient Referrals, Percent of Patients Seen, and Turnaround Time

Community Health Services (CHS) reports performance metrics, including patient access to care. One measure of patient access to care is the number of patients referred to and seen by an infectious disease provider; these referrals are tracked in Health Link, the Health and Hospital System's electronic medical record, and reported monthly in the e-consult referral turnaround time report. The e-consult report tracks referrals at the level of the infectious disease provider rather than the level of the CHS specialty clinics.

Approximately three-quarters of patients referred to an infectious disease provider are authorized for care but less than two-thirds of patients authorized for care are seen by an infectious disease provider. Between 2017 and 2021, the percentage of patients authorized for care and seen by an infectious disease provider increased, but the percentage of patients seen by an infectious disease provider decreased in 2021 compared to 2020. According to the e-consult report, the percentage of patients authorized and seen by an infectious disease provider in 2020 was 66% and in 2021 (through August) was 61%. The percentage of patients authorized for infectious disease care and seen by an infectious disease provider by month between October 2017 and August 2021 is shown in Figure 1.1 below.

Figure 1.1: *Percentage of Patients Authorized for Care and Seen by an Infectious Disease Provider from October 2017 to August 2021*

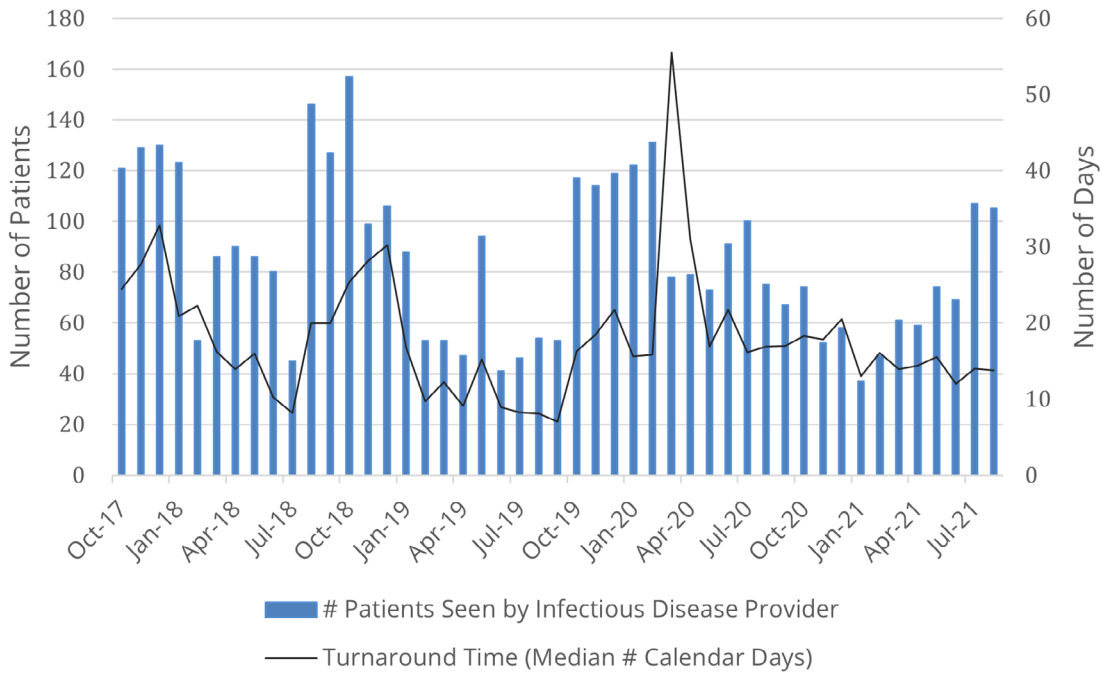


Source: HealthLink e-consult reports October 2017–August 2021.

Note: (1) The number of authorized patients includes both urgent and non-urgent care, but the number of patients authorized and seen by an infectious disease provider includes only non-urgent care. Referrals to urgent care made up 3% of total referrals between 2017 and 2021.

The median turnaround time for a patient to be seen by an infectious disease provider in 2021 was approximately 14-calendar days, as shown in Figure 1.2 on page 19, which conforms to the target set by the California Department of Managed Health Care that at least 90% of patients are seen in an appointment within 21-days.

Figure 1.2: *Median Turnaround by Month from October 2017 to August 2021*



Source: HealthLink e-consult reports October 2017–August 2021.

Notes:
(1) Total turnaround time is the median number of calendar days before a patient is seen by an infectious disease provider.
(2) The number of patients includes both urgent and non-urgent care, but the number of patients seen by an infectious disease provider includes only non-urgent care. Referrals to urgent care made up 3% of total referrals between 2017 and 2021.

According to discussion with CHS managers, reasons for patients not being seen in an appointment could include incomplete referral information, referral back to the primary care physician, or referral requiring "advice only". According to CHS managers, the e-consult reports are discussed biweekly with providers and nurse managers, although these meetings were less frequent during the pandemic, and if a referred patient does not show up for an appointment, the primary care physician is notified. The e-consult reports do not identify which clinics have a high percentage of patients authorized for care who are not seen in an appointment, but this information can be inferred from the appointment "no show" rates reported by the clinics and discussed below.

Health Service Clinics Reported Measures for Patient Access

The appointment "no show" rate and "retention in HIV medical care" rate are other measures of patient access to care in the CHS specialty clinics. These measures were included in the 2018 and 2019 ACHS Quality Consortium presentations but the ACHS Quality Consortium did not meet in 2020 and 2021 due to reallocation of staff resources in response to the pandemic .

Clinics No Show Rates

The CHS specialty clinics no show rates include first appointments, also captured in the e-consult report, and return appointments. The CHS clinics identified high patient no show rates as an area of concern in the 2018 and 2019 ACHS Quality Consortium presentations but reporting on the no show rates was not consistent between clinics and years making it difficult to see if the clinics' no show rates increased or decreased between years. In the 2019 ACHS Quality Consortium presentation, the PACE (Partners in AIDS Care and Education) Clinic reported that the no show rate reduced from 28% to 23% although the time frame for that reduction was not shown. The Infectious Disease Clinic reported that the no show rate reduced from 23% in 2018 (January to June) to 18% in 2019 (January to June). The TB Clinic did not report the no show rate in 2019.

According to the 2019 ACHS Quality Consortium presentation, actions taken by staff to reduce the no show rate included phone calls, texts, and messaging via the patient's My Health Online account. The TB/Refugee Clinic also increased tracking of the referral queue. The PACE Clinic reported an increase in patient visits in 2019 due to efforts to reduce no show rates, although the number of visits decreased in 2020 following the onset of the pandemic (see Figure I.4 on page 14 in the Introduction). The Infectious Disease Clinic reported that 91% of patients requiring a follow up appointment showed up for the appointment. The TB Clinic did not report the outcomes of the efforts to reduce the no show rate; according to discussions with public health nurses in the Public Health Department, the TB Clinic will notify them if a patient does not show for an appointment.

Figure I.3 below shows the no show rates for the PACE, TB/Refugee, and Infectious Disease Clinics in calendar years 2019, 2020, and 2021. While the no show rates provided by CHS for 2019 through 2021 are reported differently than the 2018 rates in the 2019 ACHS Quality Consortium presentation, the reduction in no show rates in the ACHS Quality Consortium presentation appears to have been maintained.

Figure 1.3: ***Percentage of Patients Who Did Not Show for Scheduled Appointments (No Show Rate) by Clinic in 2019 Through 2021***

	2019	2020	2021
No Show Rate by Clinic/Provider			
PACE Clinic			
Physician Appointments	23%	21%	22%
Psychiatrist Appointments	27%	19%	29%
Other Provider Appointments[1]	18%	16%	16%
TB/Refugee Clinic			
TB Clinic Physician Appointment	14%	13%	10%
Refugee Clinic Appointment	n/a	9%	10%
Infectious Disease Clinic			
Infectious Disease Clinic Appointment	19%	13%	10%

Source: Community Health Services.

Note: (1) Other providers include social workers, pharmacists, dieticians, and benefit counselors.

According to CHS staff, the no show rate is a standardized report created by the CHS Analytics and HealthLink team and used for all ambulatory care clinics. If the patient does not show for a scheduled appointment, the appointment is converted to "no show" in HealthLink. The HealthLink reports are reviewed quarterly in staff meetings and annually by CHS managers.

PACE Clinic Measure for Retention in Care

"Retention in HIV medical care" reported by the PACE Clinic is a standard measure implemented by the federal Health Resources and Services Administration, which administers Ryan White grants. The retention in HIV medical care measure reported by CHS to the 2019 ACHS Quality Consortium changed from the measure reported to the 2018 ACHS Quality Consortium. For example, the reported rate for retention in HIV medical care for calendar year (CY) 2017 was 80% in the 2018 ACHS Quality Consortium presentation and 73.3% in the 2019 ACHS Quality Consortium presentation.

ACHS Quality Consortium meetings have been postponed or cancelled since the beginning of the pandemic in March 2020, and therefore, retention in HIV medical care measures for CY 2019, 2020, and 2021 were not reported as part of the Quality Consortium.[5] CHS reported the annual measure of retention in HIV medical care to the management audit team for CY 2019 through CY 2021. The measures reported by CHS for these calendar years are not consistent with the measures in the 2019 ACHS Quality Consortium presentation. The CY 2018 retention in HIV medical care measure in the 2019 ACHS Quality Consortium presentation was 71.6%. The CY 2019 retention in HIV medical care measure reported by CHS to the management audit team was 85%, an increase of more than 13 percentage points from the CY 2018 measure. The retention in HIV medical care rates reported by CHS to the management audit team for CY 2020 and CY 2021 were 84% and 89 % respectively. The federal Health Resources and Services Administration, which administers the Ryan White grant, set a goal for 2020 that 90% of patients would be retained in HIV medical care. According to CHS staff, the retention in HIV medical care rate reported to the management audit team for CY 2019 – CY 2021 was based on the percentage of patients who had a visit with a physician, nurse practitioner, or pharmacist.

Retention in HIV medical care can be measured in different ways. Centers for Disease Control and Health Resources and Services Administration have different measures for retention in HIV medical care, and in 2019 the Health Resources and Services Administration revised its definition of retention in HIV medical care. The Centers for Disease control defines retention in HIV medical care as at least two viral load tests performed at least three months apart for the evaluation year. The Health Resources and Services Administration defines retention in HIV medical care as at least two medical visits that were at least 90 days apart in the measurement year and modified the definition to define the first visit in the measurement year to be by September 1 rather than July 1, as previously defined. The Health Resources and Services Administration further revised the measure in 2019 to define retention in HIV medical care as "percentage of patients regardless of age who had at least two encounters within the measurement year". The revised definition does not require

5 The Interagency Agreement between the PACE Clinic and the Public Health Department requires monthly reporting on the percentage of Ryan White patients who have a six-month medical appointment or viral load test, setting the goal that 90% of patients will have a visit every six-months by the end of the fiscal year.

that both encounters in the measurement year be with a medical provider; one encounter must be with a provider with prescribing privileges and one encounter can be for a viral load test. In reporting on retention in HIV medical care to the ACHS Quality Consortium and Board of Supervisors, CHS should report the methodology for calculating this measure to ensure consistency and clarity in reporting and provide an explanation for variances in reporting across time periods.

Community Health Service Clinics Priorities in 2021 for Patient Access

Increasing patient access to the CHS specialty clinics is an ongoing area of concern. Valley Medical Center set six operational priorities in 2021, one of which was to "improve overall access and capacity". The three Community Health Services specialty clinics (PACE, TB/Refugee, and Infectious Disease)[6] developed objectives, activities, and measures addressing the operational priority to improve access and capacity. The three clinics objectives to increase patient access and the actions to be taken, shown in Figure 1.4 on page 23, some of which are continuation of actions identified in the 2019 report to the ACHS Quality Consortium.

6 While the STI Clinic is organizationally under CHS, the clinic is considered primary care rather than a specialty clinic.

Figure 1.4: *Patient Access Objectives, Activities, and Measures of Success*

Objective	Activities	Measures of Success
Infectious Disease (ID) Clinic		
Patient ID referrals being seen in a timely manner	Patient referrals being triaged timely by assigned provider	Report review, ease of patients getting appointments
	ID team to update and review ID WQ	Ensure patients are being scheduled appropriately
	Ensure follow up appointments are scheduled before discharging patient	Patients are scheduled appropriately
	Set up patients for MHO to enable virtual visits	Patients given multiple options to be seen by provider
PACE Clinic		
Decrease no show rates	Continue clinic NO SHOW Follow up workflow	Check in with staff to ensure it is being followed
	Continue reminder calls and MyHealthOnline messaging to patients	Outreach will continue to call/ send messages to patients for appointment reminders
	Continue to share NO SHOW rates at staff meeting for clinic awareness	Run monthly report and share
TB/ Refugee Clinic		
Ramp up to 75% of pre COVID-19 numbers	Ensure all Referrals are processed, and appointments are scheduled	Review Referrals and reports
	Increase number of Refugee arrivals and Class B.	Welcoming new arrivals and schedule appointments as soon as possible
	Ensure patients are scheduled, review work queue back log and increase in video visits instead of telephone visits	Review work queue frequently and increase the volume of in video visits
	Ensure follow up appointments are scheduled prior to discharging the patient	Staffs will review patients discharge instructions
	Promoting E-check in's for easy and smooth patient arrival at registration	Encourage signing up for my health online
	Re-opening of satellite LTBI clinics	Continue providing accessible services to patients in Milpitas, Tully, Gilroy and DTN locations

Source: 2021 Operational Priorities.

The three clinics' measures of success for the operational priority to improve overall access and capacity are qualitative, not providing specific achievable targets. For example, the Infectious Disease Clinic's measure for the activity "patient referrals being triaged timely by assigned provider" is "report, review ease of patients getting appointments". The measure is not sufficiently specific to allow clinic managers to determine if triage is occurring in a timely manner; how does a manager determine the level of ease by which a patient gets an appointment?

Activities to address the objective and measures of the success of the activity are not always differentiated. For example, the Pace Clinic's activity to address the objective of "decrease no show rates" is "Continue reminder calls and MyHealthOnline messaging to patients" and the measure is "Outreach will continue to call/send messages to patients for appointment reminders", which is the same sentence restructured.

While CHS has reporting tools to track operational priorities, such as the median turnaround time reported in the e-consult reports and the appointment no show data, the measures of success defined in the operational priorities should more specifically define outcomes, such as "x percent of patient referrals will be triaged by the assigned provider within one day" or "x percent of patients received an appointment reminder notice one day prior to the appointment". Ongoing measures, such as tracking an increase in the number of patients who show up for an appointment after receiving a reminder call, would be useful.

CONCLUSION

CHS could improve some aspects of reporting by better tracking and evaluating patients' access to care at CHS specialty clinics. This would include reporting the methodology for calculating retention in HIV medical care and developing measurable and quantifiable "measures of success" for patient access to care when developing annual operational priorities.

RECOMMENDATIONS

The Ambulatory Outpatient Specialty, Community Health and Administrative Services, director should:

1.1 Direct the Ambulatory Care Quality, Education, Standards & Utilization Management director, Regulatory and Analysis director, and Health Center manager to document and report methodology for calculating retention in HIV medical care to ensure clarity and consistency in reporting. (Priority 2)

1.2 Direct the Health Center manager to implement quantifiable and measurable "measures of success" in FY 2022–23 Operational Priorities. (Priority 2)

The Board of Supervisors Health and Hospital Committee chair should:

1.3 Request annual reports from the Ambulatory Outpatient Specialty, Community Health and Administrative Services, director on patient access to the specialty clinics, including (i) appointment no show rates by clinic, and retention in HIV medical care; and (ii) strategies to improve patient access. (Priority 2)

SAVINGS, BENEFITS, AND COSTS

These recommendations are intended to refine existing measures on patient access to care and enhance reporting. Implementation of these recommendations should be accomplished within existing staff resources.

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Section 2: Social Worker Workflow Inefficiencies

Background
Community Health Services' (CHS) Partners in AIDS Care and Education (PACE) Clinic has three budgeted full-time equivalent (FTE) social worker positions (one medical social worker and two psychiatric social workers). All new PACE Clinic patients are evaluated by the medical social worker and PACE Clinic providers can refer patients to the medical and psychiatric social worker when the need is identified. While the social workers primarily serve PACE Clinic patients, the Tuberculosis (TB) Clinic may also refer patients to the social workers.

Problem, Cause, and Adverse Effect
Valley Medical Center's electronic health records system, HealthLink, does not have sufficient functionality to allow clinic managers and providers to track social worker referrals and referral outcomes. Clinic staff can view individual referrals submitted through inbox messaging and social worker notes, but CHS cannot generate HealthLink reports to track overall referrals, referral timelines, and outcomes to better evaluate patient population needs and social worker workload.

The TB Clinic does not have documented procedures for referring patients to social workers, and discussions with TB Clinic staff did not consistently clarify if any TB Clinic patient was eligible for referral to the social workers or only HIV positive patients. The TB Clinic also does not have a documented procedure for conducting regular chart audits to ensure that patients are being appropriately referred to social worker services.

The PACE Clinic medical and psychiatric social workers have work functions not covered by the County job description for social workers. How the medical social worker should engage with various databases used for tracking PACE or TB patients, conduct case management follow-ups, or facilitate the completion of a referral to services is not documented, and expectations regarding the positions' responsibilities remain unclear. While there are documented clinical competencies developed for other positions within the CHS specialty clinics, there are no service-specific clinical competencies for social workers.

Recommendations
The CHS director should work with Technology Services and Solutions Department staff to facilitate approval of the HealthLink build request in 2022 to allow tracking of patient referrals to social workers. The CHS director should also direct TB and PACE Clinic managers to work with the medical and psychiatric social workers and relevant professional leadership to develop and document the required social worker clinical competencies, and criteria and procedures for referring TB Clinic patients to the social workers; and direct the TB Clinic manager to develop a policy for conducting regular patient chart audits.

Savings, Benefits, and Costs
Implementing these recommendations would not require hiring additional staff, and there would not be additional County costs beyond existing staff time and resources. Documented social worker clinical competencies would allow clinic management to better assess social worker performance and workload.

FINDING

Clinic Referrals to Social Worker Services

Social worker services are budgeted in the PACE (Partners in AIDS Care and Education) Clinic, which is considered the medical home for HIV positive and AIDS patients, who often receive long-term and primary care through the clinic. Other CHS specialty clinic patients, including Tuberculosis (TB) Clinic patients, may access social worker services through the PACE Clinic, but patient services in the other specialty clinics are generally shorter term than services provided in the PACE Clinic, extending only for the duration of the patient's illness.

The PACE Clinic has three budgeted full-time equivalent (FTE) social worker positions, one medical social worker and two psychiatric social workers.[7] The primary responsibilities of the medical social worker include conducting new patient consultations, reporting patient outcomes as part of Ryan White Federal grant requirements, and participating in monthly case conferences and intensive case management group meetings with other providers. The primary responsibilities of the psychiatric social workers involve providing psychiatric support, counseling, and psychotherapy to PACE patients.

PACE Clinic Referral Processes for the Medical Social Worker and Psychiatric Social Worker

The medical social worker administers a biopsychosocial assessment to all new PACE patients to determine whether they need to be seen regularly, referred for additional services, or do not need any additional follow-up appointments. The biopsychosocial assessment involves assessment of the patient's housing situation, support system, financial health, insurance status, need for food resources, mental health history, and substance use history, among other factors. The medical social worker then develops an intervention plan based on any identified issues in the assessment. The medical social worker will refer patients to the psychiatric social worker if the patient indicates mental or behavioral health needs.

PACE Clinic providers will refer patients to the medical social worker if the patient indicates that they are unstably housed in the pre-intake assessment that is conducted by a Clinic nurse. Each Clinic visit includes questions related to housing, COVID-19 symptoms, and allergies to medications. If the patient answers that they are unstably housed, and indicates a need for emergency shelter, the provider will conduct a "warm handoff" referral. A warm handoff referral involves introducing the patient to the medical social worker and attempting to schedule a visit directly after their existing clinical appointment, or as soon as possible thereafter. If the patient is unstably housed but not in need of immediate shelter (e.g. in transitional housing, "couch surfing", etc.), the patient will be referred to the medical social worker through the normal channels (via HealthLink inbox messaging or chat function).

PACE providers will also refer a patient to the medical social worker if the patient indicates a need for additional resources or supportive services (including nutrition services, dental treatment, etc.). Additionally, providers will administer a diagnostic assessment to determine whether a patient is experiencing depression or suicidal ideation. This assessment is conducted during the initial intake visit and every six-months thereafter. If a patient meets the diagnostic criteria for depression, but not

7 As of November 2021, one of the psychiatric social worker positions is vacant.

for suicidal ideation, the patient will be referred to the psychiatric social worker. If the patient is indicating suicidal ideation or very severe depression, the provider will conduct a "warm handoff" referral to the psychiatric social worker, who will then meet with the patient as soon as possible. The intake nurse also conducts a substance use diagnostic assessment, and if the patient meets the criteria for substance use disorder a referral will be made to the psychiatric social worker.

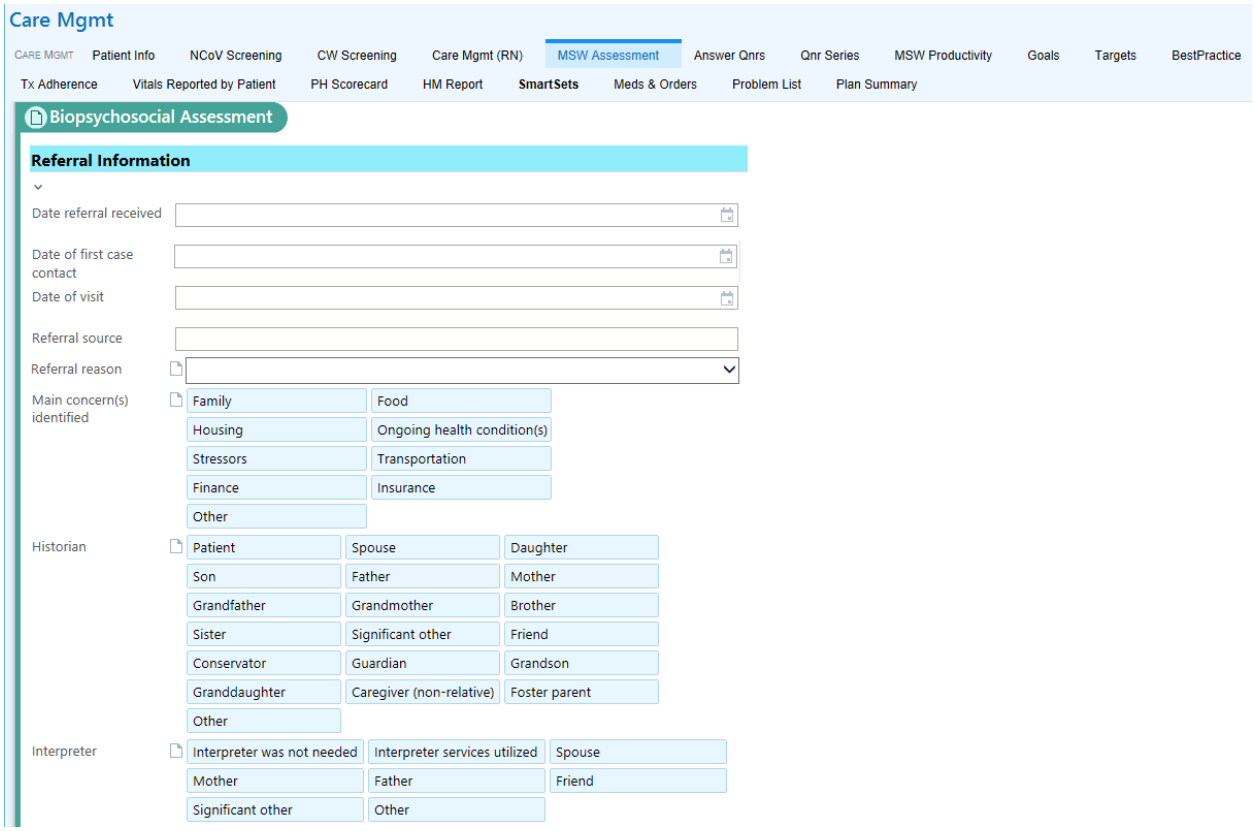
TB Clinic Referral Processes for the Medical Social Worker and Psychiatric Social Worker

Within the TB Clinic, patients are assessed for housing or food insecurity during the intake process, according to TB Clinic staff, and if the patient indicates an unstable housing situation, TB Clinic staff will typically refer the patient to the PACE Clinic's medical social worker, as there is no social worker position within the TB Clinic. The HealthLink intake page includes a question regarding housing stability, but the process for referring TB Clinic patients to the PACE Clinic social worker is not documented. Our discussions with CHS staff did not identify consistent procedures that would result in a TB patient referral to the PACE Clinic social worker, including whether only HIV positive TB patients are referred to the medical social worker or if HIV negative TB patients may also be referred. The lack of documented referral practices may result in some patients receiving a referral and not others. To avoid such inconsistencies, the PACE and TB Clinic assistant nurse managers should work with TB Clinic staff and the PACE Clinic medical social worker to document procedures for TB patients' referrals to the PACE Clinic social worker for support services.

Lack of HealthLink Functionality for Tracking and Managing Referrals

Referrals by PACE Clinic and TB Clinic staff to the medical social worker are entered through HealthLink, the County's electronic health records system. HealthLink is used across the Health and Hospital System to manage patient information, including but not limited to: appointments, medical treatments, medications, and referrals. As of February 11, 2022, staff send referral requests in HealthLink through inbox messaging or via the chat function because HealthLink lacks a field for PACE or TB Clinic staff to refer a patient to a CHS social worker. Phone calls are also used as a means of referring patients to social workers and are also not tracked. While PACE and TB Clinic staff can view individual patient referrals to the social worker, the Clinics cannot generate HealthLink reports to track overall referrals to the social worker and referral outcomes. During the initial assessment process, the medical social worker uses an assessment form within HealthLink to collect patient data (see Figure 2.1 on page 30).

Figure 2.1: *Medical Social Worker Intake Form*



Source: Received from Community Health Services.

This HealthLink form, however, is designed to store notes and does not have query or report functions. Consequently, while clinic staff can review the notes for a specific patient, they are not able to generate reports on the data collected in this form.

Clinic managers and providers are unable to see the total referrals to the social worker and reasons for the referrals, the average time it takes for a social worker to connect with a referred patient, or how many patients referred to a social worker required follow-up services after their initial intake assessment. Referral tracking can provide a better understanding of patient population needs and social worker workload. Referrals to case management coordination provided by The Health Trust or other future community provider should be incorporated into the HealthLink referral field.

The County of Santa Clara's Technology Services and Solutions (TSS) oversees the "IT build request" process, wherein County departments submit technology project proposals. The IT Governance Committee evaluates and prioritizes IT project proposals according to the perceived greatest value add. As part of this project build request process, the PACE Clinic Health Center manager submitted an official request for converting the existing HealthLink questionnaire into a flowsheet (a tool that enables providers to document patient data) and to enable a referral tracking system for CHS patients. This change would allow providers to view and track the referral status of individual patients, as well as generate reports on the number of referrals received in HealthLink. The CHS director should work with TSS staff to facilitate approval of the HealthLink build request in 2022 to allow tracking of patient referrals to social workers and referral outcomes.

Internal Chart Auditing Processes

Chart audits can be used as a further tool for measuring performance, determining compliance, and quality control and improvement, among other uses.[8] Clinics can use chart audits to determine whether screening questions for services are consistently being asked, and whether patients are consistently being referred to social worker services when needed.

The PACE Clinic conducts monthly audits of approximately 20–30 patient charts, in addition to daily chart review of each patient seen that day to reconcile errors or missing information. However, according to TB Clinic staff, chart audits are not conducted at the TB Clinic, including identifying if patients needing housing or nutritional support are referred to social worker services. Although the HealthLink intake page has fields for assessing housing and nutritional stability, our discussions with Technology Services and Solutions staff indicated that these are *recommended* but not *required* fields to be completed in the TB Clinic's intake questionnaire. Routine chart audits would allow the TB Clinic assistant nurse manager to identify consistency in assessing patients' housing and nutritional stability and appropriately referring patients to social worker services, and to implement improvements in the assessments and referrals as needed.

Need to Document PACE Clinic Social Worker Functions

Since medical social workers often connect patients with 'safety net' support in clinical settings, these positions can be prone to 'role blurring' and a lack of defined expectations and responsibilities.[9] The lack of role definition and expectations can result in burnout and may negatively impact the system of patient care coordination overall. As such, social workers in clinical settings should have defined expectations about their role and how their role fits within a clinic's multidisciplinary team.

Ambulatory Services, which includes CHS specialty clinics, has documented the required clinical competencies establishing performance standards and further clarifying role expectations for 19 positions within CHS clinics.[10] These performance standards extend beyond the Santa Clara County job specifications and include further clarification of each role's clinical responsibilities and requirements, including overarching tasks (e.g. "data collection", "program development", or "admissions/ discharge process") and additional sub-tasks nested within.[11] However, the medical social worker and psychiatric social worker positions do not have documented clinical competencies. The only guiding documents outlining the roles of either social worker position are the medical social worker and psychiatric social worker job descriptions as defined in the Santa Clara County job specification.

8 Gregory, Barbara H., Van Horn, Cheryl, and Kaprielian, Victoria S. 2008. *8 Steps to a Chart Audit for Quality.* American Academy of Family Physicians (AAFP).

9 Kirschbaum, Sarah. 2017. *The Social Work Perspective: A Systematic Review of Best Practices for Social Workers in Healthcare Teams.* Master of Social Work Clinical Research Papers, St. Catherine University.

10 "Clinical competency" refers to the core skillsets and abilities required for fulfilling one's role within a medical setting. . Fukada, Mika. 2018. *Nursing Competency: Definition, Structure and Development.* Yonago Acta Med Journal of Medical Sciences, Totorri University Medical Press.

11 There are position-related policies for the following positions within the CHS Clinics: assistant nurse manager, benefits counselor, clinical nurse I, clinical nurse II, clinical nurse (RN) III, community worker, health education specialist, health services representative, senior health services representative, licensed vocational nurse, medical assistant, medical office specialist, public health assistant, clinic medical director, clinical nurse III, health center manager, community outreach specialist, chest x-ray technician, and medical laboratory assistant.

Additionally, there is no information in the County Job Specification that indicates how the psychiatric social worker should be tracking patient referrals or following up with patients. The only reference to patient referrals within the psychiatric social worker's job specification is that their typical tasks include "referring patients to appropriate community agencies."

Without further clarification regarding the roles of the medical or psychiatric social workers, expectations regarding the positions' responsibilities remain unclear. Although the social worker positions are assigned to the PACE Clinic, these positions serve the TB Clinic as well but don't have defined expectations for responding to and managing referrals and following up with Clinic staff, which could lead to inefficient or insufficient communication in serving clinic patients.

CONCLUSION

The CHS clinics does not have documented policies or performance standards specific to either the medical social worker or psychiatric social worker positions, beyond the County of Santa Clara Job Specification. Without policies to further clarify the tasks and expectations of the social workers, particularly that of the medical social worker, the clinics risk patients potentially missing out on needed services due to confusion and inefficiencies surrounding patient management and care coordination. A documented policy more clearly defining the roles of social workers would increase workflow efficiencies and potentially improve outcomes for patients in need of supportive services. A formal chart audit process in the TB Clinic would provide quality control and decrease the risk that patients may not be consistently screened in the TB Clinic for housing or nutritional stability. Additionally, County approval of the PACE Clinic's 2022 HealthLink build request would better enable information sharing and communication between providers. Approval of this request would allow the PACE Clinic to track and monitor referrals, which would improve linkage to care and help the clinic management to gauge the performance of providers.

RECOMMENDATIONS

The Ambulatory Outpatient Specialty, Community Health and Administrative Services, director should:

2.1 Work with Technology Services and Solutions Department staff to facilitate approval of the HealthLink build request in 2022 to allow tracking of patient referrals to social workers and referral outcomes, including referrals to case management coordination provided by The Health Trust or other future community provider. (Priority 2)

2.2 Direct TB Clinic and Partners in AIDS Care and Education Clinic managers to work with the medical and psychiatric social workers, SCVMC's director of social work, and the ambulatory medical social work manager to develop service-specific clinical competencies that would further define (a) social worker roles and expectations; (b) referral timelines and documentation of referral outcomes; and (c) criteria and procedures for referring TB Clinic patients to the social workers. (Priority 2)

2.3 Direct the TB Clinic manager to develop a policy for conducting regular patient chart audits. (Priority 2)

SAVINGS, BENEFITS, AND COSTS

Implementing these recommendations would not require hiring additional staff, and there would not be additional Clinic costs beyond existing staff time and resources. The development of social worker clinical competencies would allow Clinic management to better assess performance and workload of social workers.

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Section 3: Case Management Referral Inefficiencies

Background
PACE (Partners in AIDS Care and Education) Clinic patients may receive case management from different sources, each with different levels of support. PACE Clinic patients can receive case management coordination from The Health Trust to support compliance with treatment, provide financial assistance, and other forms of support. The Health and Hospital System has a no-cost Memorandum of Understanding (MOU) with The Health Trust to coordinate case management services to Ryan White-eligible patients; the MOU corresponds to an agreement between the Public Health Department and The Health Trust for these services.

Problem, Cause, and Adverse Effect
PACE Clinic patients can be referred to The Health Trust through the Public Health Department, self-referral, or the medical social worker. None of these sources of referrals know which other source is referring unless the patient tells them, which may cause confusion for patients, case managers at The Health Trust, and PACE Clinic staff. This can result in a lack of referral follow-through and the loss of a potential service linkage, in addition to being an inefficient use of staff time. A policy that establishes a process for closing the referral loop in a timely manner could improve utilization of case management services.

The Health Trust has not complied with reporting requirements in the MOU between the Health and Hospital System and The Health Trust, though it does provide separate reports to the Public Health Department. The Health Trust's continued non-compliance in submitting required reports is impacting the ability of the PACE Clinic to oversee their patients' connection to supportive services. Shifting oversight of the agreement with The Health Trust from the PACE Clinic to the Public Health Department would improve efficiency by reducing the number of entities The Health Trust must report to, as well as further ensuring that The Health Trust is fulfilling their contractual requirements.

Recommendations
The Chief Executive Officer of Santa Clara Valley Medical Center (SCVMC) should delegate responsibility for the MOU with The Health Trust, for services to PACE Clinic patients, to the Public Health Department and incorporate MOU requirements into the Interagency Agreement between the Public Health Department and the PACE Clinic. CHS should document policies implementing a centralized referral management process that also establishes that referrals to The Health Trust must be facilitated by the medical social worker.

Savings, Benefits, and Costs
The goal of these recommendations is to improve oversight and efficiency of referrals for case management services and should be achievable with existing SCVMC resources. There are no additional costs associated with the recommendations. These recommendations will help to close the referral loop and reduce the risk that patients in need of supportive services will experience delays in receiving these services.

FINDING

Background

Qualifying HIV/AIDS patients within Community Health Service's (CHS) Partners in AIDS Care and Education (PACE) Clinic may receive case management from a few different sources, each with different forms and levels of support.

Positive Connections Case Management

Santa Clara County Public Health Department's Early Intervention Services Program ("Positive Connections") coordinates HIV/AIDS medical treatment referrals to the CHS PACE Clinic for patients who are not already receiving treatment through another medical provider (e.g. Kaiser, Sutter Health, Stanford Health Care, etc.).[12]

After referring a patient for medical treatment, Positive Connections' case managers will provide short-term, high-touch, case management for patients who need more intensive support for adherence to treatment. Their goal is to eventually connect the patient to PACE's financial counselors, for eligibility assessment for health coverage or financial aid, or to The Health Trust, the community provider under contract with Santa Clara County Department of Public Health, for case management services for Ryan White-eligible PACE patients. The process and timeline for transitioning newly diagnosed PACE Clinic patients to support services in the PACE Clinic or The Health Trust depends on:

- the level of patient need,
- the type of insurance coverage they receive, and
- the patient's own preference for receiving care.

If a patient does not need intensive case management but still needs some additional support, or if they are ready to move on from the case management they were receiving through Positive Connections, they may be referred directly to The Health Trust (if they are Ryan White-eligible), or to PACE's financial counselors. However, PACE patients referred to The Health Trust are only eligible to receive services if they can be successfully enrolled in the Ryan White program.

PACE Clinic Case Management

The PACE Clinic's case management scope is limited primarily to patients who only require minimal support regarding insurance enrollment/reenrollment (including enrollment into the Ryan White program, which provides treatment coverage for HIV+ patients that are not eligible for other insurance coverage or Medi-Cal). The Santa Clara Valley Health and Hospital System has a separate Memorandum of Understanding (MOU) with The Health Trust to coordinate access to supportive services for Ryan White patients at the PACE Clinic.

12 Positive Connections is partially funded through the Public Health Department's Ryan White Part C Early Intervention Services (EIS) grant.

The MOU outlines the cooperative effort between the County and The Health Trust to provide support service referrals and referral outcome tracking; no payment is made to The Health Trust under the MOU. Health Trust provides services to PACE patients, and although the MOU does not specify that the patients must be Ryan White-eligible, the MOU specifies that the County receives Ryan White grant funding. The Health Trust is to coordinate access for PACE patients to dental and vision services, non-medical case management, and complex medical case management.

The PACE Clinic's medical social worker refers patients to The Health Trust during the initial biopsychosocial assessment for Ryan White-eligible patients (see Section 2, starting on page 27, for discussion of social worker workflow). According to discussions with CHS staff, Clinic providers request referrals to The Health Trust through a paper form that is scanned and mailed. While the intent of CHS management is that all referrals go through the medical social worker, this requirement is not documented, and according to discussions with CHS staff, providers other than the medical social worker may refer to The Health Trust on occasion. Patients may also self-refer to The Health Trust at any point for additional case management and whole patient support services.

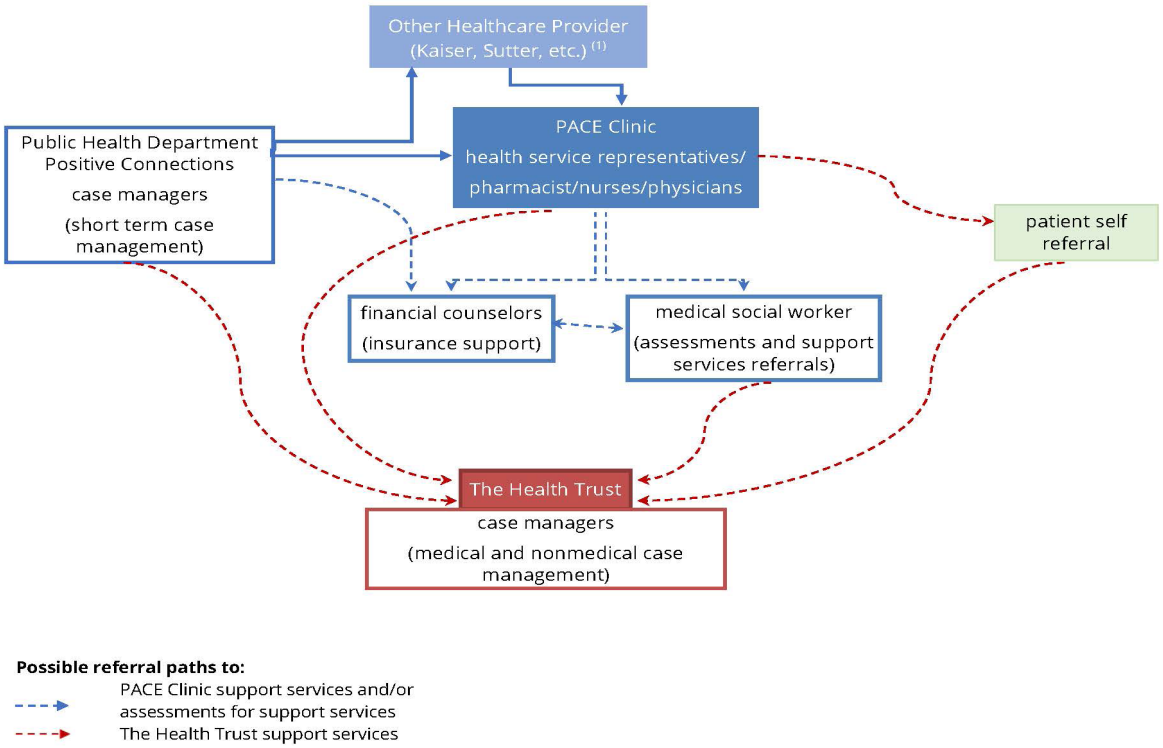
The Health Trust Case Management

The Health Trust is contracted separately by the Public Health Department to provide medical and nonmedical case management services. The services provided by The Health Trust are more comprehensive than the case management provided through the PACE Clinic. The Health Trust's medical case management entails coordination of patient medical treatment, one-on-one support from case managers during medical visits, and in-home assessments, in addition to coordinating access to other services such as dental and vision. Nonmedical case management provided by The Health Trust includes Ryan White certification and enrollment, service plans, referrals to community resources, food bank access, medical transportation, and other support services. Between November 1 and December 31, 2021, The Health Trust reported serving 454 unique clients through their nonmedical case management services, and 69 unique clients through medical case management. The Health Trust also provides access to their food pantry for eligible patients.

Lack of Documented Referral Process to Health Trust

For qualifying patients there are several potential referral paths to The Health Trust for case management from both Positive Connections and the PACE Clinic (see Figure 3.1 on page 38). According to discussions with CHS staff, the medical social worker makes most referrals from the PACE Clinic to Health Trust, but other Clinic providers may on occasion also make referrals. The Health Trust MOU does not specify a referral process and CHS does not have a documented procedure.

Figure 3.1: *Possible Referral Paths for Qualifying Patients*



Source: Workflow information provided to the Management Audit Division by Community Health Services and Public Health Department staff.

Note: (1) Sometimes a patient may be referred directly to the PACE Clinic by an external provider if the patient wants to begin treatment right away, and there is no indication that the patient may experience obstacles to care.

- *Positive Connections Case Managers*
  Qualifying patients can be referred to The Health Trust by Positive Connections case managers, however, there is no way for PACE Clinic staff, including the PACE Clinic's medical social worker, to know whether Positive Connections has referred a PACE patient to The Health Trust unless they are informed by the patient.

- *PACE Clinic Medical Social Worker*
  Qualifying patients are generally referred to The Health Trust by the PACE Clinic medical social worker, although CHS does not have a documented referral process and other PACE Clinic providers may on occasion directly refer to The Health Trust. There is not a way for other PACE Clinic staff to see whether a referral to The Health Trust was previously made by Positive Connections or patient self-referral unless they are informed by the patient.

- *Patient Self-Referral*
  According to PACE Clinic staff, sometimes qualifying patients are given the contact information for The Health Trust so they can contact The Health Trust directly and self-refer for services. There is no way for PACE Clinic staff, including the PACE Clinic's medical social worker or Positive Connections staff, to know if a PACE patient has contacted The Health Trust to request support services unless the patient shares this information with staff.

Risk of Duplicate Referrals and Delays in Support Services for Patients

As of February 11, 2022, there is no centralized system or documented process in place to allow PACE Clinic staff to track and follow-up on referrals to The Health Trust to close the referral loop. There is also no way for PACE Clinic staff to know whether referrals have already been made by Positive Connections or if a patient already self-referred to The Health Trust. The separate referral tracks and the lack of a centralized referral tracking system can result in duplicate referrals from multiple entities to The Health Trust, which may cause confusion for patients, case managers at The Health Trust, and PACE Clinic staff. Confusion stemming from duplicate referrals may interfere with the process of facilitating support service for patients, resulting in a lack of referral follow-through and the loss of a potential service linkage, in addition to being an inefficient use of staff time. To prevent the possibility of delays or drop-offs in patient care, the PACE Clinic should document processes for closing the referral loop and formalize the role of the medical social worker in facilitating referrals to the Health Trust (or future case management provider).[13] As the referral process is a "point of patient vulnerability," a documented process for managing referrals to external providers is necessary to ensure patient safety and access to care.[14]

Due to the timing of the referral process between the Public Health Department and the Community Health Services clinics, PACE patients will likely receive referrals for additional support services from a Public Health Department nurse before they are seen by a PACE Clinic social worker. As such, an updated policy for external referrals to The HealthTrust that shifts responsibility for coordinating referrals from PACE Clinic staff to the Public Health Department would improve accountability and potentially increase rates of service linkage.

Incomplete Reporting by The Health Trust to the PACE Clinic

The MOU between the Health and Hospital System and The Health Trust for the coordination of access to support services (including medical and nonmedical case management) for qualifying PACE Clinic patients requires The Health Trust to submit monthly tracking reports to the PACE Clinic's health center manager on individual patients' referral status and outcomes for that month. These tracking reports are supposed to include patient name, service type, status of referral, date of status, and additional comments.

13 American College of Physicians. *Closing-the-Loop.* Transforming Clinical Practice Initiative.
14 Patel, Malhar P. et al. *Closing the Referral Loop: an Analysis of Primary Care Referrals to Specialists in a Large Health System*. Journal of General Internal Medicine. 2018 May; 33(5): 715-721. Duke University School of Medicine.

No Monthly Reports to the PACE Clinic from The Health Trust

Despite the MOU, The Health Trust has not been reporting on these individual patient referral outcomes to the PACE Clinic. According to multiple PACE Clinic staff, The Health Trust does not provide the required monthly reports and PACE Clinic staff do not receive any other information from The Health Trust regarding patient referrals, outcomes, or assigned case managers for patients that they refer to The Health Trust. The PACE medical social worker has requested a list of the case manager assignments and referral outcomes for all patients referred by the PACE Clinic to the Health Trust, but The Health Trust has not provided such reports.

The PACE Clinic monitors the MOU with The Health Trust, using the Health and Hospital System contract monitoring tool. According to PACE Clinic staff, and the most recent contract monitoring report for April 2020 through March 2021, The Health Trust does not submit reports in accordance with the MOU. According to the contract monitoring report: "There has been difficulty in receiving reports on a timely basis. Reports would be late and incomplete. Reports are not provided as one aggregate report, but as disaggregated reports from multiple people from The Health Trust." Because The Health Trust does not provide reports on referrals and connection to services, CHS cannot know how many CHS clinic patients are successfully being referred to services by case managers at The Health Trust.

The Health Trust participates in monthly medical case management calls with PACE Clinic staff where they discuss the status of individual patients enrolled in medical case management and their barriers to receiving care, but they do not provide written reports with the status of all PACE Clinic patients referred to The Health Trust for these monthly calls. Additionally, patients enrolled in nonmedical case management are not discussed, however, CHS staff have indicated that they will begin monthly clinical discussions on nonmedical case management patients in April 2022.

In August 2021 the MOU between the Health and Hospital System and The Health Trust was renewed through March 2023, despite The Health Trust's lack of compliance with monthly reporting requirements. The Board of Supervisors approved the third amendment to the existing contract between the Public Health Department and The Health Trust at the June 22, 2021, meeting but the MOU was not subject to Board of Supervisors approval. According to the contract monitoring report, there is an ongoing need for nonmedical case management services that are currently not being provided by the PACE Clinic. According to the Public Health Department's report to the Board of Supervisors, the Department will issue a new solicitation in January 2022 for these services.

Public Health Department Oversight of The Health Trust

Although The Health Trust does not submit required reports to the PACE Clinic, they do submit quarterly and monthly reports to the Santa Clara County Public Health Department on their progress towards various objectives specific to medical case management, nonmedical case management, food bank services, and medical transport services, as required per their contract with the Public Health Department. Some of these objectives include:

- "By June 30, 2021, 100% of clients will have care plan developed or updated, including time specific goals and objectives, according to the Case Management (non-medical) Standard of Care."

- "By June 30, 2021, 75% of clients with a food plan will meet or exceed the goals established in their food plan."
- "By June 30, 2021, 90% of clients will have two medical visits at least once every 6 months."

Overlapping Patient Populations and Reports

As of February 11, 2022, The Health Trust is responsible for reporting to two separate entities (the Public Health Department and the PACE Clinic) regarding the number and status of referrals for services for an overlapping population of patients: PACE patients referred by Positive Connections and PACE patients referred by the PACE Clinic. A proposed change in oversight, delegating authority over supportive service referrals and referral outcomes for PACE patients from the PACE Clinic to the Public Health Department, would align with the reporting currently being submitted by The Health Trust to the Public Health Department. Additionally, this change would result in The Health Trust reporting to a single entity and would further ensure that The Health Trust is adequately fulfilling its contract in facilitating service referrals for PACE patients. Streamlining the reporting process would enable better engagement with patient care coordination and the referral process, as well as aligning with the reporting requirements for the PACE Clinic to the Public Health Department regarding patient treatment (see Introduction for further discussion).

CONCLUSION

PACE Clinic patients can be referred to The Health Trust through the Public Health Department, self-referral, or the medical social worker. None of these sources of referrals know which other source is referring unless the patient tells them, which may cause confusion for patients, case managers at The Health Trust, and PACE Clinic staff, resulting in a lack of referral follow-through and the loss of a potential service linkage, in addition to being an inefficient use of staff time. A policy that documents a process for closing the referral loop in a timely manner could improve utilization of case management services.

The Health Trust has not complied with reporting requirements in the MOU between the Health and Hospital System and The Health Trust. The Health Trust's continued noncompliance in submitting required reports is impacting the ability of the PACE Clinic to oversee their patients' connection to supportive services. Shifting oversight of the agreement with The Health Trust from the PACE Clinic to the Public Health Department would improve efficiency by reducing the number of entities The Health Trust must report to, as well as further ensuring that The Health Trust is fulfilling their contractual requirements.

RECOMMENDATIONS

The Santa Clara Valley Medical Center chief executive officer should:

3.1 Delegate responsibility for the Memorandum of Understanding with The Health Trust, for services to Partners in AIDS Care and Education (PACE) Clinic patients, to the Public Health Department and incorporate Memorandum of Understanding requirements into the Interagency Agreement between the Public Health Department and the PACE Clinic. (Priority 2)

The Ambulatory Outpatient Specialty, Community Health and Administrative Services, director should:

3.2 Document a centralized referral policy to formally clarify the role of the medical social worker as the facilitator of referrals to The Health Trust or future contractor, to be included as a medical social worker required clinical competency developed in conjunction with Santa Clara Valley Medical Center social worker leadership (see Recommendation 2.2 on page 33). (Priority 2)

3.3 Develop an updated referral policy, in collaboration with the Partners in AIDS Care and Education (PACE) Clinic medical social worker, for PACE Clinic patients in need of support services through the Health Trust or future contractor, who were not initially referred by Public Health Department staff, to be referred to the Public Health Department who can then facilitate a referral. (Priority 2)

SAVINGS, BENEFITS, AND COSTS

The goal of these recommendations is to improve oversight and efficiency of referrals for case management services, which should be achievable with existing SCVMC resources. There are no additional costs associated with the recommendations. These recommendations will help to close the referral loop and reduce the risk that patients in need to support services will experience delays in receiving these services.

Section 4: Limited Hours of Community Health Services Clinics

Background
Community Health Services (CHS) provides specialty medical and support services to patients with tuberculosis, HIV, AIDS, and other infectious diseases through five clinics: Partners in AIDS Care and Education (PACE), Tuberculosis (TB), Refugee, Infectious Disease (ID), and Sexually Transmitted Infection (STI). Clinics are located in two main locations in San Jose, and treatment is also offered during limited hours each month at satellite locations in Milpitas, Gilroy, and two additional San Jose clinics. The high risk associated with infectious diseases, to patients and the community at large, necessitates that CHS ensure that clinic hours and locations provide patients reasonable access to treatment.

Problem, Cause, and Adverse Effect
No evening hours are available for TB patients, and the PACE Clinic only has evening hours until 8pm one day per week. None of the CHS specialty clinics have weekend hours. Our review of clinics in other counties did not show that clinics offer weekend hours or evening hours except for UCSF Benioff Children's Hospital, Oakland, for which the Tuberculosis clinic is open Monday-Friday, 8am–7pm, and the HIV/AIDS clinic is open Monday-Friday, 8am–8pm.

HIV/AIDS services provided by the PACE Clinic are available in south Santa Clara County nine hours a month, although the Public Health Department found a concentration of people living with HIV/AIDS in the more rural southern region of the County. Limited clinic hours in south Santa Clara County requires HIV/AIDS patients to travel to San Jose for treatment, which could result in patients having difficulty accessing or completing treatment regiments.

Recommendations
The CHS director should work with the HIV Commission and Public Health Department to evaluate the need for PACE Clinic and TB evening hours. Given the concentration of people living with HIV/AIDS in south County the CHS director should also consider establishing additional PACE provider time to deliver specialized HIV care services with support from existing primary care facilities in south County. The CHS director should continue to actively engage with the HIV Commission and with the Facilities and Fleet Department to identify a new location that fulfills both the accessibility needs and clinical needs of PACE Clinic patients.

Savings, Benefits, and Costs
A prior survey by the HIV Commission identified the need to add evening hours at the PACE Clinic and a new survey could require some additional costs. Any new costs would be offset by the benefit to CHS patients in accessing clinic services.

FINDING

Community Health Services Clinic Locations and Hours

Community Health Services (CHS) provides specialty medical and support services to patients with tuberculosis, HIV, AIDS and other infectious diseases. These services are provided through five clinics: Partners in AIDS Care and Education (PACE), Tuberculosis (TB), Refugee, Infectious Disease (ID), and Sexually Transmitted Infection (STI). Given the risk to the patients and community from these infectious diseases, CHS needs to ensure that clinic hours and locations provide patients reasonable access to treatment.

CHS Clinic Locations

Most CHS clinic services are provided at the two main clinic sites in central San Jose. As of February 25, 2022, CHS provides services on weekdays at two Valley Health Center locations in central San Jose near Valley Medical Center and Diridon Transit Center: Moorpark and Lenzen.

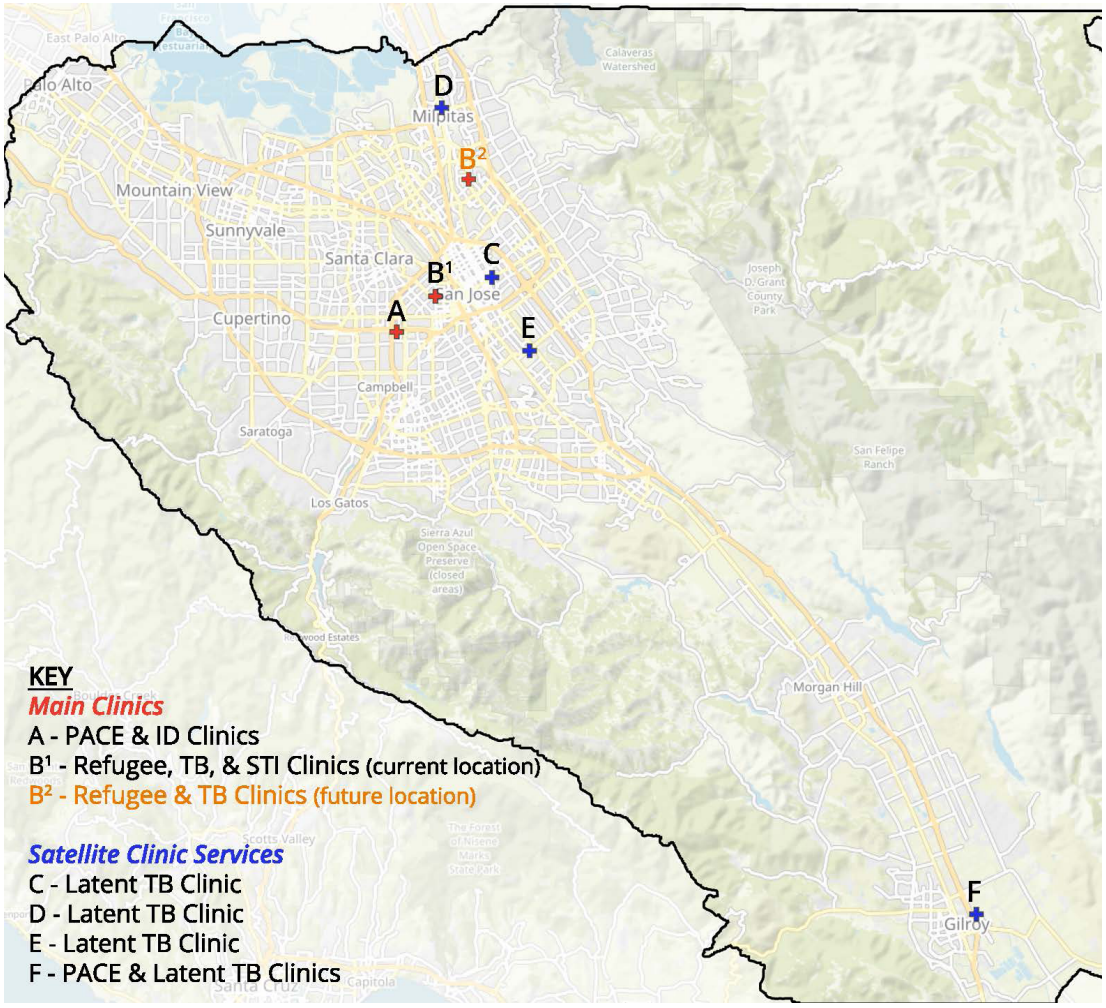
The PACE Clinic, which is the largest CHS clinic serving approximately 1,500 unduplicated patients and providing approximately 10,700 appointments in 2020, is located on Moorpark Avenue near Valley Medical Center, shown in Figure 4.1 on page 45. The Moorpark clinic location is generally within the geographic location with the highest concentration of people living with HIV/AIDS in Santa Clara County. According to the Santa Clara County Public Health Department *Sexually Transmitted Infections and HIV Epidemiology Annual Report, 2019 and 2020,* people living with HIV/AIDS were concentrated in the north central part of the County with a second concentration in the more rural southern region of the County. PACE services are also provided during limited hours each month at the Valley Health Center satellite clinic, located in Gilroy in southern Santa Clara County as well as the Main Jail and Elmwood Jail.

The TB Clinic and Refugee Clinic patients are tracked together and comprise the second largest group of CHS clinic services, with approximately 1,600 unduplicated patients in 2020 (reduced from approximately 2,600 patients in 2019) and providing approximately 7,700 appointments.[15] Treatment for latent TB (a non-contagious TB infection which causes no symptoms) is available at Valley Health Center satellite clinic locations in Milpitas, Gilroy, and two San Jose locations (Downtown and Tully). Treatment of an active TB infection, which requires clinic space with negative air pressure to contain the spread of the infection, is only available at the main Lenzen Avenue TB Clinic in downtown San Jose near the Diridon Transit Center (see main and satellite clinic locations in Figure 4.1 on page 45). The TB and Refugee clinics will be moving from Lenzen Avenue to 1996 Lundy Avenue, San Jose in 2022.[16] The Lundy Avenue location is closer to eastern San Jose and Milpitas, which according to one Public Health Department report, has a higher cluster of tuberculosis cases than other Santa Clara County locations.

15 TB patients and Refugee patients are tracked together in the data received from CHS. Distinct counts TB Clinic patients versus Refugee Clinic patients was not available.

16 As of January 20, 2022, CHS management anticipates the move will occur at the end of 2022.

Figure 4.1: *Location of CHS Clinics, as of February 25, 2022*



Source: Created by the Management Audit Division.

Note: As of January 20, 2022, CHS management anticipates the Refugee and TB clinics will move to their new location at 1996 Lundy Avenue, San Jose, at the end of 2022.

Available Hours at Main CHS Clinic Locations

As of January 19, 2022, the CHS specialty clinics are generally only open Monday-Friday, between 8am and 5pm, except for the STI Clinic which is only open evenings. The PACE and ID clinics also have extended hours on Tuesdays until 8pm (see Figure 4.2 on page 46). According to discussions with the CHS Director, PACE Clinic evening hours were implemented in response to requests from the community following an HIV Commission survey. There are no evening hours available for either the TB or Refugee clinics. The TB Clinic provides a nurse advice line, 8am–5pm on weekdays, for patients with treatment questions. There is also an on-call physician available after 5pm on weekdays if patients need emergency assistance.

Except for the STI Clinic, which is open two evenings per week, the only evening clinic hours are the PACE Clinic, which is open until 8pm on Tuesday evenings, as shown in Figure 4.2 on page 46. None of the clinics offer weekend hours.

Figure 4.2: *Community Health Services' Clinic Hours, as of February 25, 2022*

Label	Valley Health Center Location	Specialty	Monday	Tuesday	Wednesday	Thursday	Friday
Main Clinics							
A	Moorpark 2400 Moorpark Ave, San Jose	PACE(1)	8am–5pm	8am–8pm	8am–5pm	8am–5pm	8am–5pm
		Infectious Disease	8am–5pm	8am–8pm	8am–5pm	8am–5pm	8am–5pm
B1	Lenzen(2) 976 Lenzen Ave, San Jose	TB	8am–5pm	8am–5pm	8am–5pm	8am–5pm	8am–5pm
		Refugee	8am–5pm	8am–5pm	8am–5pm	8am–5pm	8am–5pm
		STI			5pm–9pm	5pm–9pm	
Services at Satellite Clinics							
C	Downtown 777 E Santa Clara St, San Jose	TB (latent TB only) (3)					8am–5pm
D	Milpitas 143 N Main St, Milpitas	TB (latent TB only) (3)				8am–5pm	
E	Tully 500 Tully Rd, San Jose	TB (latent TB only)(4)			8am–12pm (1st Wed.) 8am–5pm (other Weds.)		
F	Gilroy 7475 Camino Arroyo, Gilroy	PACE(4)			8am–5pm (1st Wed.)		
		TB (latent TB only) (4)			8am–5pm (2nd & 4th Wed.)		

Evening hours
No CHS specialty services available

Source: Valley Health Center Clinic webpages, retrieved by the Management Audit Division January 19, 2022, and additional information provided by CHS management.

Notes:
(1) The PACE Clinic also provides clinic services on the second Wednesday of the month at the Main Jail (1pm–5pm) and the and fourth Wednesday of the month at the Elmwood Jail (1pm–5pm).
(2) The TB and Refugee clinics will be moving to 1996 Lundy Avenue, San Jose. As of January 20, 2022, CHS management anticipates the move will occur at the end of 2022 and that the STI Clinic will remain at VHC Lenzen.
(3) Specialty service not listed on Valley Health Center webpage as of February 26, 2022.
(4) Specialty listed on the Valley Health Center webpage but no other information available.

As of February 25, 2022, there are no evening hours available for TB patients and evening hours only on Tuesday for PACE patients. Only providing clinic services during usual working hours between 8am and 5pm could limit access to services for patients who work during those hours. Our review of clinics in other counties did not show that other clinics offer weekend hours or evening hours except for UCSF Benioff Children's Hospital, Oakland, for which the Tuberculosis clinic is open Monday-Friday, 8am–7pm, and the HIV/AIDS clinic is open Monday-Friday, 8am–8pm.

PACE services are only available for a limited number of hours in south Santa Clara County (9-hours a month), and no active TB treatment is available. These limits put the burden on HIV, AIDS, and active TB patients living in south Santa Clara County to travel to San Jose for treatment. When a PACE or TB patient living in south County travels from Gilroy to the PACE Clinic or TB Clinic locations in San Jose the trip takes roughly an hour to two-hours in a car, and over four-hours using public transportation. Consequently, these limited CHS clinic hours and locations may result in patients having difficulty accessing these specialty clinic services and completing treatment regiments. This is especially the case for patients who work during the week and/or live in south Santa Clara County. Given the concentration of people living with HIV/AIDS in the southern region, as identified by the Santa Clara County Public Health Department, Community Health Services should consider establishing additional PACE provider time to deliver specialized HIV care services with support from existing primary care facilities in south County.[17]

In 2020, 27 unduplicated patients were served by the PACE Clinic in Gilroy, but CHS has not previously collected zip code data of patients to determine if a larger number of people living with HIV/AIDS in south Santa Clara County could be served by the PACE Clinic in Gilroy. Given the risk to the patients and community members from these infectious diseases, CHS needs to ensure that clinic hours and locations provide patients reasonable access to treatment.

Information About CHS Services at Satellite Clinics is Incomplete or Missing From Webpages

The availability of specialty services at Valley Health Center satellite clinic locations is not mentioned on dedicated CHS Moorpark or Lenzen clinic webpages, nor on most of the other Valley Health Center webpages, according to our review of webpages on February 26, 2022. Valley Health Center Gilroy is one of only two CHS satellite clinic VHC webpages that lists the availability of CHS specialty services (in this case TB Clinic and PACE Clinic); however it does not provide the hours of availability. Valley Health Center Tully lists a 'Pediatric TB Clinic', also with no associated hours, and the other Valley Health Center webpages for Milpitas and Downtown San Jose do not list the TB specialty services available at those locations. Not providing accurate and complete information on Valley Health Center webpages regarding treatment locations and hours makes it even more difficult for patients to access services. See Section 5, starting on page 49, for further discussion and recommendations regarding CHS webpages.

Patient Needs Assessment By Facilities For TB, Refugee, and PACE Clinics' Space Request

The TB and Refugee clinics are moving to the new location on Lundy Avenue, San Jose, and CHS management anticipates that the move will occur at the end of 2022 and that the STI Clinic will remain at the VHC Lenzen location. The PACE Clinic is also in need of more space and CHS management has been working on a space request to move the PACE Clinic to a new, larger, location, but as of March 18, 2022, this space request has not yet been provided to the Facilities and Fleet Department (FAF). According to FAF, the PACE Clinic currently occupies a leased space which will expire in September 2024.

17 Sexually Transmitted Infections and HIV Epidemiology Annual Report, 2019 and 2020. County of Santa Clara Public Health Department, Infectious Disease Response Branch. November 2021. Page 62.

CHS selected the new Lundy location based on space availability within the County, as well as the special clinical needs for treatment of an active TB infection, which requires clinic space with negative air pressure to contain the spread of the infection. CHS should continue to actively engage with the HIV Commission and with the Facilities and Fleet Department to identify a location that fulfills both the accessibility needs and clinical needs of PACE Clinic patients.

CONCLUSION

The high risk associated with infectious diseases, to patients and the community at large, necessitates that CHS ensure that clinic hours and locations provide patients reasonable access to treatment. As of February 25, 2022, there are no evening hours available for TB patients, even for latent TB treatment. The hours of available services at the PACE Clinic are also limited. Furthermore, PACE services are only available nine hours a month in south Santa Clara County, and no active TB treatment is available. These limits put the burden on HIV, AIDS, and active TB patients to travel to San Jose for treatment. All of this may result in patients having difficulty accessing or completing treatment regiments. Furthermore, not providing accurate and complete information on Valley Health Center webpages regarding CHS services makes it more difficult for patients to access treatment

RECOMMENDATIONS

The Ambulatory Outpatient Specialty, Community Health and Administrative Services, director should:

4.1 Work with the HIV Commission and Public Health Department to evaluate the need for TB Clinic and Partners in AIDS Care and Education Clinic evening hours. (Priority 2)

4.2 Work to establish additional Partners in AIDS Care and Education Clinic provider time to deliver specialized HIV care services with support from existing primary care facilities in south County. (Priority 2)

4.3 Continue to actively engage with the HIV Commission and with the Facilities and Fleet Department to identify a new location that fulfills both the accessibility needs and clinical needs of Partners in AIDS Care and Education Clinic patients. (Priority 2)

SAVINGS, BENEFITS, AND COSTS

A prior survey by the HIV Commission identified the need to add evening hours at the PACE Clinic and a new survey could require some additional costs. Engaging with the HIV Commission and the Facilities and Fleet Department to optimize the future location of the PACE Clinic will similarly cost current staff time, but any new costs would be offset by the benefit to CHS patients in accessing clinic services.

Section 5: Website Inaccuracies

Background
Online information about the Community Health Services (CHS) specialty clinics–Partners in AIDS Care and Education (PACE), Tuberculosis (TB), Refugee, Infectious Disease (ID), and Sexually Transmitted Infection (STI)–is provided on the Valley Medical Center (VMC) website. CHS specialty clinics are mostly split between two main Valley Health Centers (VHC) in San Jose, Moorpark and Lenzen, and some treatments are also offered during limited hours each month at satellite VHC locations in Milpitas, Gilroy, San Jose Downtown, and San Jose Tully (see Section 4, starting on page 43, for further discussion). The VMC "Hospitals & Clinics" webpage includes a list of each Valley Health Center location, and information about some of the CHS specialty clinic services can be found on the associated Valley Health Center webpage.

Problem, Cause, and Adverse Effect
To find information on CHS specialty clinics, a website visitor must navigate to the webpage of the correct Valley Health Center location (where the clinic is located). Finding information for the PACE Clinic requires searching through four layers of webpages. Finding information for the other CHS clinics requires searching through three layers of webpages, although a browser search for the PACE, TB, or Refugee Clinic will take a visitor to the webpage. The CHS specialty clinic webpages do not consistently provide information on clinic hours and days, and do not provide detailed information on services available to patients.

Recommendations
CHS should work with the Technology Services and Solutions Department (TSS) to improve CHS specialty clinic webpages and provide consistent and more detailed information on available services for patients and clinic locations, hours, and days of services. CHS should also consult with the Public Health Department on creating designated webpages for the Infectious Disease and STI Clinics.

Savings, Benefits, and Costs
Implementing these recommendations would not require additional budgeted positions. County costs would amount to time spent by current staff.

FINDING

Background

Online information about the Community Health Services (CHS) specialty clinics–Partners in AIDS Care and Education (PACE), Tuberculosis (TB), Refugee, Infectious Disease (ID), and Sexually Transmitted Infection (STI)–is provided on the Valley Medical Center (VMC) website. The main PACE Clinic and Infectious Disease Clinic are at Valley Health Center Moorpark and the main TB Clinic, Refugee Clinic, and STI Clinic are at Valley Health Center Lenzen. Latent TB treatment is also offered during limited hours each month at Valley Health Centers: Milpitas, Gilroy, Downtown San Jose, and Tully San Jose. PACE Clinic services are provided during limited hours each month at Valley Health Center Gilroy. (See Section 4, starting on page 43, for further discussion).

Access to Webpage Information

The PACE, TB, and Refugee clinics' webpages are found online via the Santa Clara Valley Medical Center (VMC) website and can be most easily found by using the search function. The clinics themselves are not listed on the VMC webpage menu bars. A website visitor would need to navigate to the correct Valley Health Center location (where a clinic is located) to find information about the clinic. The organization of the webpages can mean that information about services is more difficult to find.

Access to specialty clinic information on the VMC website is through the "Hospitals & Clinics" tab, which lists links for nine Valley Health Center location webpages. Accessing information about a specialty clinic requires searching each Valley Health Center tab for the specific clinic. The CHS specialty clinic webpages do not consistently provide information on clinic hours and days.

PACE Clinic Webpage

A patient can access information about the PACE Clinic in two different ways, with different levels of information. Both require that the patient navigate through the Valley Health Center Moorpark webpage. If the patient clicks on the link for "Specialty Care" at the bottom of the page, "PACE Clinic (HIV Care/Treatment)" is listed, but no information about PACE Clinic hours or days is provided. However, PACE Clinic information can also be accessed through a "Related Links" dropdown menu on the Valley Health Center Moorpark or Specialty Care pages. Selecting "PACE Clinic" from this dropdown menu will bring the patient to a PACE Clinic homepage, which provides more information on hours and days of service. Therefore, a prospective patient must navigate through four webpages before finding information for the PACE Clinic: the VMC homepage, the Hospitals & Clinics page, the Valley Health Center Moorpark page, and the Specialty Care page. Accessing information about PACE Clinic satellite services provided at Valley Health Center Gilroy also requires accessing four webpages, and once accessed, the webpage only lists "PACE Clinic (HIV Care/Treatment)" as a service and does not provide any Clinic hours or days of service.

Other Specialty Clinic Websites

Hours and days of operation for the Infectious Disease Clinic is accessed on the Valley Health Center Moorpark webpage; therefore, a prospective patient must access three pages before finding information for the Infectious Disease Clinic: the VMC homepage, the Hospitals & Clinics page, and the Valley Health Center Moorpark page. The Valley Health Center Moorpark page provides the days and hours of the Infectious Disease Clinic, but no further information.

Information about the TB Clinic, Refugee Clinic, and STI Clinic are accessed on the Valley Health Center Lenzen "Overview" webpage; therefore, a prospective patient must access three pages before finding information about these three clinics. The Valley Health Center Lenzen "Overview" webpage provides information on hours and days of service for the TB Clinic, Refugee Clinic, and STI Clinic.

Clinic services for latent TB are offered at six Valley Health Center locations: Lenzen, Gilroy, Tully San Jose, Downtown San Jose, and Milpitas. The Valley Health Center Lenzen and Valley Health Center Gilroy webpages note these services, but not the Valley Health Center Tully, Valley Health Center Milpitas, or Valley Health Center Downtown San Jose webpages. Specialty clinic information on Valley Medical Center/ Valley Health Center webpages is summarized in Figure 5.1 below.

Figure 5.1: *CHS Clinic Webpage Information*

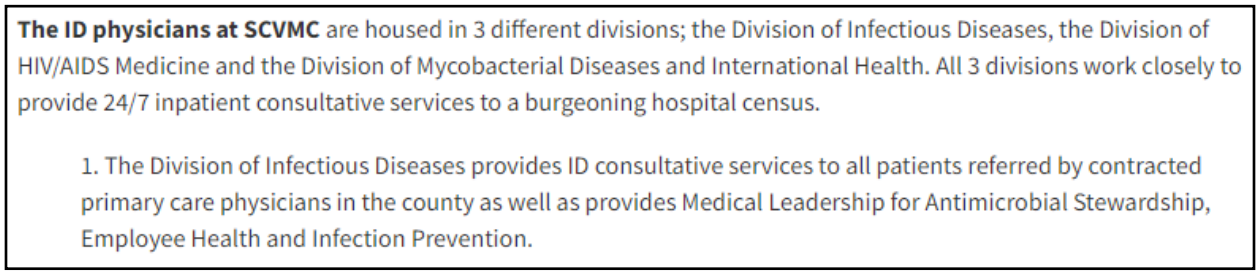
Hours and Location Available on a VHC Webpage						
	Moorpark	**Lenzen**	**Gilroy**	**Tully**	**Milpitas**	**Downtown**
Infectious Disease	Yes					
PACE Clinic	Yes		No			
Refugee Clinic		Yes				
STI Clinic		Yes				
TB Clinic (active)		Yes				
TB Clinic (latent)		Yes	No	No	No	No
Number of Webpages to Navigate from VMC Homepage to Access Clinic Information						
	Moorpark	**Lenzen**	**Gilroy**	**Tully**	**Milpitas**	**Downtown**
Infectious Disease	3					
PACE Clinic	4		NA(1)			
Refugee Clinic		3				
STI Clinic		3				
TB Clinic (active)		3				
TB Clinic (latent)		3	NA(1)	NA(3)	NA(2)	NA(2)

Source: Management Audit Division review of VMC website, as of February 26, 2022.

Notes:
(1) Specialty listed on the VHC webpage but no other information available.
(2) Specialty is not listed on the VHC webpage.
(3) The specialty listed on the Tully VHC webpage is for a 'Pediatric TB Clinic', however CHS informed the Management Audit Division that general latent TB treatment is available at this location. No other information is provided.

Dedicated webpages for the PACE Clinic can be accessed through on the VHC Moorpark webpage and the TB and Refugee clinics have dedicated webpages linked through the VHC Lenzen webpage.[18] The Valley Health Center Moorpark's webpage provides hours and days of service for the Infectious Disease Clinic, but the only other online information specific to Infectious Disease Clinic services was found on the Stanford Medicine website (see Figure 5.2 below).

Figure 5.2: ***Description of ID Clinic on Stanford Medicine Infectious Diseases Webpage***



The ID physicians at SCVMC are housed in 3 different divisions; the Division of Infectious Diseases, the Division of HIV/AIDS Medicine and the Division of Mycobacterial Diseases and International Health. All 3 divisions work closely to provide 24/7 inpatient consultative services to a burgeoning hospital census.

1. The Division of Infectious Diseases provides ID consultative services to all patients referred by contracted primary care physicians in the county as well as provides Medical Leadership for Antimicrobial Stewardship, Employee Health and Infection Prevention.

Source: Stanford Medicine Infectious Diseases Webpage. Retrieved February 27, 2022, from https://med.stanford.edu/id/people/scvmc.html.

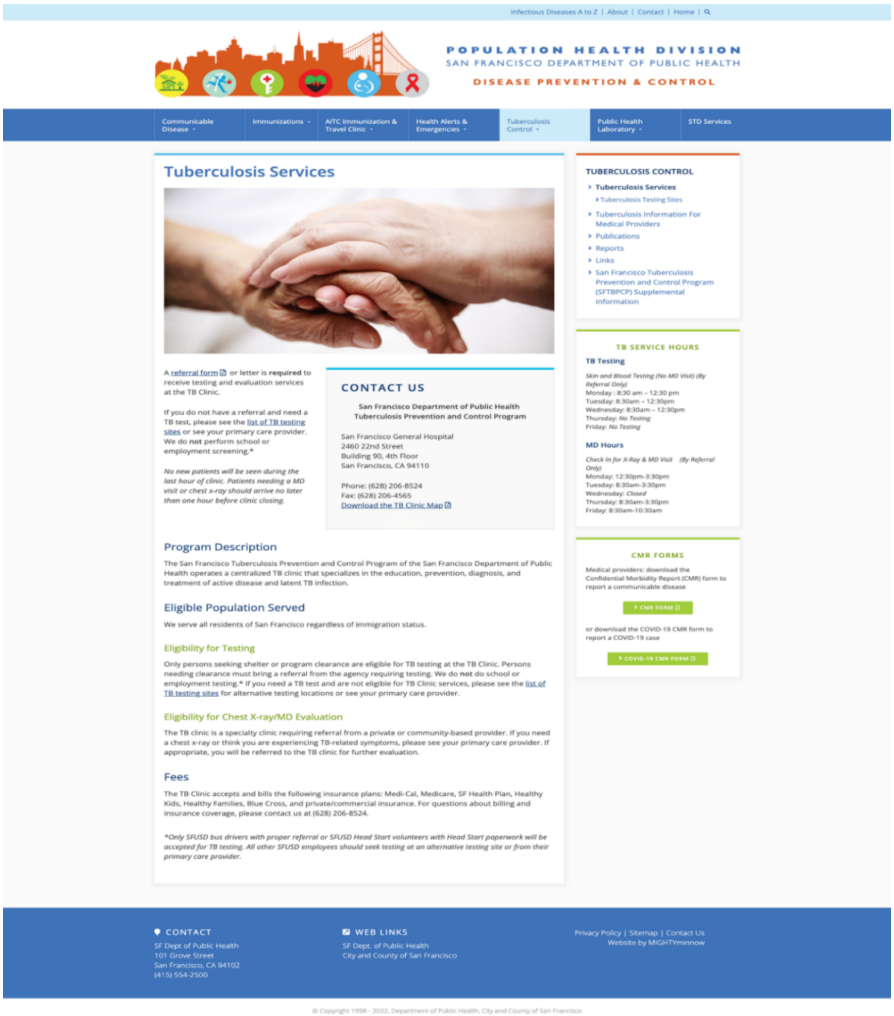
The director for Ambulatory Outpatient Specialty, Community Health and Administrative Services, should consult with the Public Health Department on the need for designated webpages describing services at the STI Clinic and Infectious Disease Clinic.

Limited Information on Refugee Clinic and TB Clinic Homepages

There are other jurisdictions in California that operate TB Services and Refugee Clinic websites that include information on patient eligibility, hours, location, fees, contact information, and services. Figure 5.3 on page 53 shows the Tuberculosis Services webpage for the San Francisco Department of Public Health's Disease Prevention and Control and Figure 5.4 on page 54 shows the Refugee Health Program webpage for Stanislaus County. Both webpages include information on populations served, hours, location, services, and contact information.

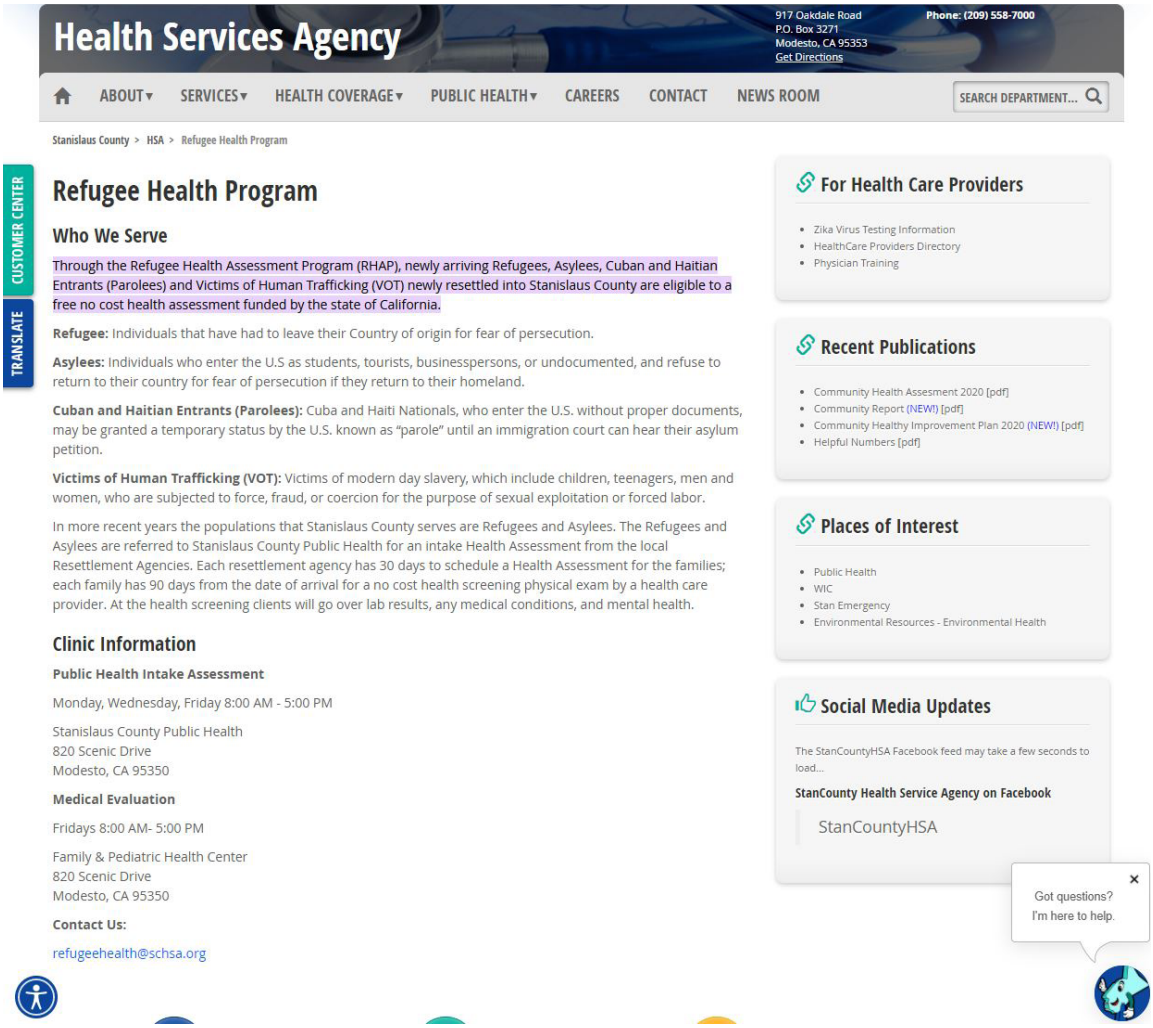
18 Partners in AIDS Care and Education (PACE) Clinic homepage: https://www.scvmc.org/hospitals-clinics/valley-health-center-moorpark/pace-clinic. Retrieved February 27, 2022.
TB Clinic homepage: https://www.scvmc.org/hospitals-clinics/valley-health-center-lenzen/tb-clinic. Retrieved February 27, 2022.
Refugee Clinic homepage: https://www.scvmc.org/hospitals-clinics/valley-health-center-lenzen/refugee-clinic. Retrieved February 27, 2022.

Figure 5.3: *San Francisco Department of Public Health's Tuberculosis Services Webpage*



Source: Screenshot of San Francisco Department of Public Health TB Services webpage. Retrieved March 1, 2022, from https://www.sfcdcp.org/tb-control/our-services/.

Figure 5.4: *Stanislaus County's Refugee Health Program Webpage*



Source: Screenshot of Stanislaus County's Refugee Health Program webpage. Retrieved March 17, 2022, from http://www.schsa.org/PublicHealth/programs/pages/refugeeHealthProgram.shtm#:~:text=Through%20the%20Refugee%20Health%20Assessment,by%20the%20state%20of%20California.

Comparatively, as seen in Figure 5.5 on page 55, the Refugee Clinic and TB Clinic webpages have limited information regarding services. Information on hours and days of service and on nearby bus stops or public transportation routes is available on the Valley Health Lenzen webpage but not on the dedicated Refugee Clinic and TB Clinic webpages.

Figure 5.5: *CHS Refugee Clinic and TB Clinic Homepages*

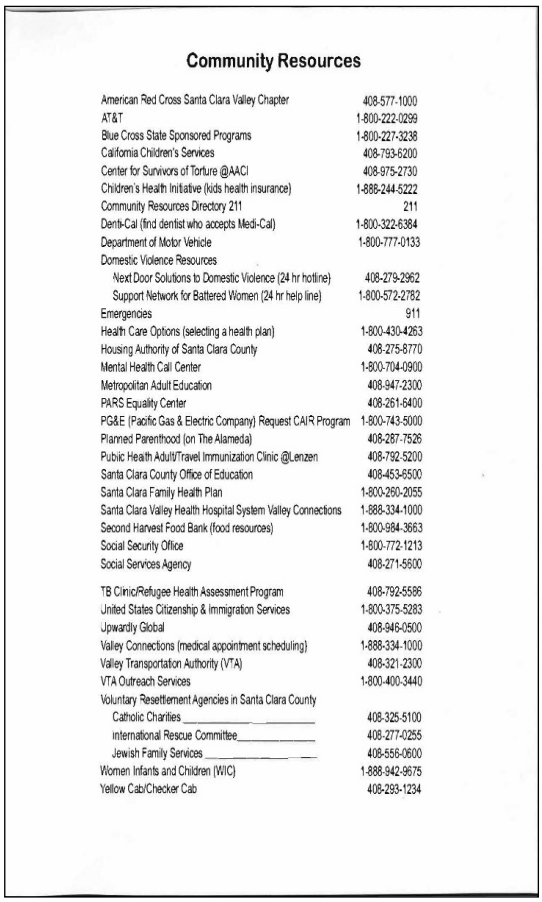
Source: Screenshot of Refugee Clinic and TB Clinic homepages taken by Management Audit Division. Retrieved January 19, 2022, from https://www.scvmc.org/hospitals-clinics/valley-health-center-lenzen/tb-clinic *and* https://www.scvmc.org/hospitals-clinics/valley-health-center-lenzen/refugee-clinic.

No Community Resources Provided on Refugee Clinic Webpage

The Refugee Clinic currently provides patients with a Santa Clara County Community Resources Guide binder with reference information as part of their intake and orientation to Santa Clara County (see table of contents and a list of community phone numbers from the inside cover in Figure 5.6 on page 56).

Figure 5.6: *Information Contained in the Refugee Clinic's Santa Clara County Community Resources Guide Binder*

Inside Cover



Community Resources

American Red Cross Santa Clara Valley Chapter	408-577-1000
AT&T	1-800-222-0299
Blue Cross State Sponsored Programs	1-800-227-3238
California Children's Services	408-793-6200
Center for Survivors of Torture @AACI	408-975-2730
Children's Health Initiative (kids health insurance)	1-888-244-5222
Community Resources Directory 211	211
Denti-Cal (find dentist who accepts Medi-Cal)	1-800-322-6384
Department of Motor Vehicle	1-800-777-0133
Domestic Violence Resources	
Next Door Solutions to Domestic Violence (24 hr hotline)	408-279-2962
Support Network for Battered Women (24 hr help line)	1-800-572-2782
Emergencies	911
Health Care Options (selecting a health plan)	1-800-430-4263
Housing Authority of Santa Clara County	408-275-8770
Mental Health Call Center	1-800-704-0900
Metropolitan Adult Education	408-947-2300
PARS Equality Center	408-261-6400
PG&E (Pacific Gas & Electric Company) Request CAIR Program	1-800-743-5000
Planned Parenthood (on The Alameda)	408-287-7526
Pubic Health Adult/Travel Immunization Clinic @Lenzen	408-792-5200
Santa Clara County Office of Education	408-453-6500
Santa Clara Family Health Plan	1-800-260-2055
Santa Clara Valley Health Hospital System Valley Connections	1-888-334-1000
Second Harvest Food Bank (food resources)	1-800-984-3663
Social Security Office	1-800-772-1213
Social Services Agency	408-271-5600
TB Clinic/Refugee Health Assessment Program	408-792-5586
United States Citizenship & Immigration Services	1-800-375-5283
Upwardly Global	408-946-0500
Valley Connections (medical appointment scheduling)	1-888-334-1000
Valley Transportation Authority (VTA)	408-321-2300
VTA Outreach Services	1-800-400-3440
Voluntary Resettlement Agencies in Santa Clara County	
Catholic Charities	408-325-5100
International Rescue Committee	408-277-0255
Jewish Family Services	408-556-0600
Women Infants and Children (WIC)	1-888-942-9675
Yellow Cab/Checker Cab	408-293-1234

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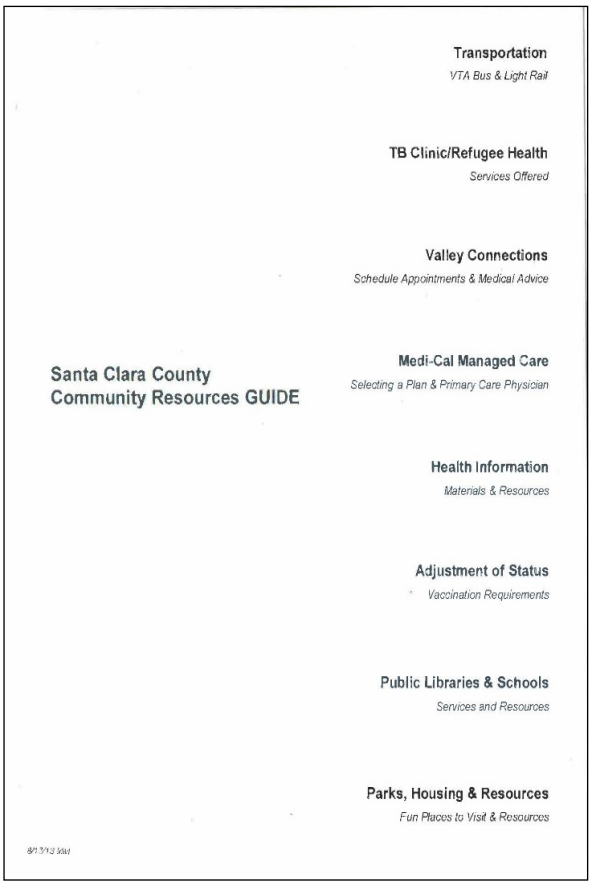

Transportation
VTA Bus & Light Rail

TB Clinic/Refugee Health
Services Offered

Valley Connections
Schedule Appointments & Medical Advice

Medi-Cal Managed Care
Selecting a Plan & Primary Care Physician

Health Information
Materials & Resources

Adjustment of Status
Vaccination Requirements

Public Libraries & Schools
Services and Resources

Parks, Housing & Resources
Fun Places to Visit & Resources

Santa Clara County
Community Resources GUIDE

Source: Scanned from the Refugee Clinic's Santa Clara County Community Resources Guide binder, provided to the Management Audit Division by CHS.

However, no such information or links are provided on the Clinic's website.

CONCLUSION

Information on the CHS Clinics' hours, locations, and services is not easily found and in some cases is missing online. These barriers increase the risk that patients will not complete treatment regiments, which poses potential harm to these individuals and added risk to the community.

RECOMMENDATIONS

The Ambulatory Outpatient Specialty, Community Health and Administrative Services, director should:

5.1 Work with the Technology Services and Solutions Department to (a) provide hours and days of Partners in AIDS Care and Education Clinic services at Valley Health Center Gilroy, and hours and days of TB (latent) Clinic services on Valley Health Center Gilroy, Valley Health Center Tully, and Valley Health Center Milpitas webpages, and future webpages as applicable; and (b) provide information on available services on the dedicated TB Clinic and Refugee Clinic webpages. (Priority 1)

5.2 Consult with the Public Health Department on creating designated webpages for the Infectious Disease and STI Clinics. (Priority 2)

SAVINGS, BENEFITS, AND COSTS

Implementing these recommendations would not require additional budgeted positions. County costs would amount to time spent by current staff. Decreasing obstacles to the treatment of infectious diseases however would decrease the risks to patients and community members from these infectious diseases.

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Section 6: ARIES Data Entry Delays

Background
AIDS Regional Information and Evaluation System (ARIES) is a web-based HIV/AIDS client management system that helps providers coordinate client services and centralize data for program monitoring. ARIES is meant to be used in real time, with patient information entered immediately following receipt of service, although the California Office of AIDS (OA) requirement for data entry is two-weeks from the date of patient encounter.

Problem, Cause, and Adverse Effect
ARIES is used by the Partners in AIDS Care and Education (PACE) Clinic, which is funded in part by the federal Ryan White HIV/AIDS Program. Under the Interagency Agreement between the PACE Clinic and Public Health Department (PHD), the Clinic is required to submit patient data into ARIES within 7–14 days after service delivery, but the PACE Clinic is not able to meet this requirement.

Because ARIES is not currently compatible with the Health and Hospital System's electronic health records system, HealthLink, the PACE Clinic must manually enter patient data into ARIES, which currently takes approximately 30–45 days following service delivery. In addition, the Clinic's paper-based patient services form must be manually transcribed by staff into ARIES. Technology Services and Solutions (TSS) is in the second phase of building an interface between HealthLink and ARIES, which would eliminate the need for manual entry into ARIES. According to discussions with CHS staff, however, this is a long-term project and completion is still distant because of the complexity of the ARIES web-based system which is shared by multiple agencies.

The PHD relies on PACE Clinic-entered data in ARIES for annual reporting to the federal Health Resources and Services Administration for the Ryan White Program as well as ongoing OA compliance, program development, and quality management. According to CHS staff, PACE Clinic data is entered into ARIES in sufficient time to meet federal Ryan White reporting requirements between January and March of each year.

Recommendations
The PACE Clinic should discuss with TSS the feasibility of digitizing the Clinic's paper-based patient services form. TSS should continue to work with the PACE Clinic on the HealthLink - ARIES build interface, which would automate large portions of patient information data entry into ARIES to comply with Ryan White Program timeline requirements and should provide a report to the Board of Supervisors regarding the prioritization of the project.

Savings, Benefits, and Costs
Reducing the number of days it takes PACE Clinic staff to enter patient data into ARIES will assist the Public Health Department in meeting Ryan White Program grant requirements and safeguarding future federal healthcare funding for economically vulnerable HIV and AIDS patients.

FINDING

AIDS Regional Information and Evaluation System (ARIES)

AIDS Regional Information and Evaluation System (ARIES) is a web-based HIV/AIDS client management system that helps providers coordinate client services and centralize data for program monitoring and scientific evaluations. ARIES was developed by the California Department of Public Health Office of AIDS (OA); Riverside/San Bernardino County, California; San Diego County, California; and the State of Texas Department of State Health Services. ARIES was implemented statewide in Texas in 2005, and then in California in 2006. The OA, which manages the California ARIES database, states that "the optimum goal for entering data into ARIES is in real-time. Some agencies may not be able to meet this goal due to staffing levels, lack of computers, or other business practices. Agencies which are unable to enter data in real-time have up to two-weeks from the service date to enter the data."[19]

ARIES Data and Ryan White Program

In California, provider agencies are required to use ARIES to enter data for HIV care programs, as well as for the Housing Plus Project and the Medi-Cal Waiver Program. The Ryan White HIV/AIDS Program is a federal program that grants funds to jurisdictions and community organizations to provide medical care and support services to low-income HIV/AIDS patients. The Santa Clara County Public Health Department (PHD) is a Ryan White Program Part A recipient and Part B subrecipient.[20] As a Part A recipient, PHD reports directly to the federal Health Resources and Services Administration (HRSA), and as a Part B subrecipient, PHD reports to the State OA, who then reports to HRSA. To be eligible for the Ryan White Program in Santa Clara County, a patient must have a diagnosis of HIV or AIDS, meet all financial qualifications, and live in the County. To apply for the Ryan White Program, individuals can schedule an enrollment appointment at the PACE (Partners in AIDS Care and Education) Clinic.

PACE Clinic Provider Requirements

The PACE Clinic treats patients in all stages of HIV Infection and is funded in part by the Federal Ryan White HIV/AIDS Program, managed on behalf of PACE by the PHD via an Interagency Agreement effective February 26, 2019, through June 30, 2023. The Interagency Agreement requires the PACE Clinic to submit patient data into ARIES within seven-business-days after patient encounter and within the month of the patient encounter (i.e. if a patient is seen on January 10 the data must be entered within seven-business-days; however, if a patient is seen on January 29 there may only be three business days remaining to submit the data within ARIES).[21; 22] Neither of these requirements are being met by the PACE Clinic.

19 ARIES Policy Notice E1- Timeliness of Data Entry, Issued October 2010. Retrieved February 25, 2022, from https://projectaries.org/wp-content/uploads/2018/02/APN-E2.pdf.

20 A recipient ("grantee") is an organization that receives Ryan White HIV/AIDS Program funds directly from HRSA. A subrecipient ("provider") is the legal entity that receives funds directly from a recipient. The PHD is a Ryan White Part A recipient and Part B subrecipient.

21 A "patient encounter" includes all encounters, both in person and telehealth, where providers supply a service to the patient.

22 Agreement between PHD and PACE for HIV/AIDS Services, Exhibit D-1, Program Reports HIV/AIDS Care and Treatment Services, July 1, 2021-June 30, 2023.

PACE Clinic Process and Timeliness of Data Entry into ARIES

One associate management analyst is responsible for manually inputting all discrete data from HealthLink (the Health and Hospital System's electronic health records system) into ARIES, such as patient lab results and medications. The analyst is also responsible for uploading descriptions of patient encounters and transcribing written fields from the Clinic's paper forms into the ARIES database.[23]

The PACE Clinic's current median time from service delivery to data entry is approximately 30–45 days, which does not meet the PHD/PACE Clinic Interagency Agreement requirements of seven-business-days after patient encounter and within the same month as the patient encounter. The current ARIES data entry timeline also does not comply with the State of California Department of Public Health Office of AIDS (OA) guidelines of 14-days from date of service. Once patient information is entered into ARIES, Public Health Department staff and other care providers can see that data.

Reasons for Delays in ARIES Data Entry

Several factors may contribute to the observed delays in ARIES data entry. The PACE Clinic Gilroy and PACE Clinic Moorpark had a combined unique patient count of nearly 1,600 in 2020 (Introduction Figure 4 shows patient counts since 2016). This is a large volume of data for one analyst position to update and manage continuously. Furthermore, HealthLink and ARIES do not currently communicate. The County Technology Services and Solutions (TSS) Department is in the second phase of building an interface between HealthLink and ARIES, which, according to discussions with CHS staff, is a multi-year process due to the complexity of interfacing HealthLink with the ARIES web-based system shared by multiple agencies. Until the interface is completed, manual data entry is required. TSS has begun the second phase of the HealthLink and ARIES interface as it begins to shift away from emergency COVID response, which included setting up telehealth and other remote systems. Ultimately, TSS will build into HealthLink individual data fields which mirror the ARIES fields for physicians to complete.

Impact of Data Entry Delays

The PACE Clinic is out of compliance with the Interagency Agreement and State Office of AIDS requirements to submit patient data into ARIES within 7 to 14-days. PHD relies on PACE Clinic-entered data in ARIES for annual federal reporting to HRSA via the Ryan White HIV/AIDS Program Services Report (RSR), as well as ongoing OA monitoring (compliance), program development, and quality management. Data entry includes tracking all clients who are enrolled in Ryan White, including eligibility information, services received, referrals provided, and care plans. Without timely entry, PHD is unable to verify the accuracy of invoices for provider services to PACE Clinic patients. While manual entry of PACE Clinic data into ARIES does not comply

23 Four other Clinic staff are ARIES database authorized users. These include three senior health services representatives who mainly update and upload financial documents required for Ryan White Part A eligibility, and a medical social worker who refers qualified patients to other services. These four staff are not just dedicated to the Ryan White Program, they work on meeting the documentation and data entry requirements of other programs as well.

with the Interagency Agreement timeline of 7-days or the State Office of AIDS timeline of 14-days, according to discussions with CHS staff, PACE Clinic data entries into ARIES are expected to be entered in sufficient time to meet federal Ryan White reporting requirements between January and March of each year.

CONCLUSION

The PACE Clinic is aware that the ARIES data entry delay is problematic. Automating the workflow to facilitate quicker data entry rather than relying on manual processes will help the Clinic meet the seven-business-days from service delivery requirement in its Interagency Agreement with the PHD.

RECOMMENDATIONS

The Ambulatory Outpatient Specialty, Community Health and Administrative Services, director should:

6.1 Discuss with Technology Services and Solutions the feasibility of digitizing the Clinic's paper-based patient services form for patients to submit electronically, using their personal device or a Clinic tablet, to eliminate a portion of the manual data entry process. (Priority 1)

The Technology Services and Solutions Department should:

6.2 Provide a report to the Board of Supervisors regarding the prioritization of the build interface between Valley Medical Center's electronic health records system, HealthLink, and the State's AIDS Regional Information and Evaluation System (ARIES) which would automate large portions of patient information data entry into ARIES, as to comply with Ryan White Program timeline requirements. (Priority 1)

6.3 Continue to work with the PACE Clinic on the build interface between Valley Medical Center's electronic health records system, HealthLink, and the State's AIDS Regional Information and Evaluation System. (Priority 1)

SAVINGS, BENEFITS, AND COSTS

Reducing the number of days it takes PACE Clinic staff to enter patient data into ARIES will assist the Public Health Department in meeting Ryan White Program grant requirements and safeguarding future federal healthcare funding for economically vulnerable HIV and AIDS patients.

Attachments A-E

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GO PUBLIC!

SANTA CLARA VALLEY MEDICAL CENTER
Hospital & Clinics

Ambulatory Administration
2325 Enborg Lane, 4H420
San Jose, CA 95128
Tel: 408-885-5700
scvmc.org

DATE: June 21, 2022

TO: Board of Supervisors' Management Audit Division

FROM: Sonia Menzies, Executive Director
Ambulatory & Community Health Services / Outpatient Specialty Services

SUBJECT: Response to the Management Audit of the Community Health Services

This memo is in response to the recommendations pertaining to the Community Health Services (CHS) management audit conducted by the Board of Supervisors' Management Auditors during FY2022. The Community Health Services enjoyed working with the audit team and appreciates the opportunity to provide a response to these recommendations.

SECTION 1: Reporting on Patient Referrals and Access

Recommendation

The Ambulatory Outpatient Specialty, Community Health and Administrative Services Director should:

1.1 Direct the Ambulatory Care Quality, Education, Standards & Utilization Management Director, Regulatory and Analysis Director, and Health Center manager to add and report methodology for calculating retention in HIV medical care to ensure clarity and consistency in reporting. (Priority 2)

1.2 Direct the Health Center manager to implement quantifiable and measurable "measures of success" in FY 2022–23 Operational Priorities. (Priority 2)

The Board of Supervisors Health and Hospital Committee chair should:

1.3 Request annual reports from the Ambulatory Outpatient Specialty, Community Health and Administrative Services, Director on patient access to the specialty clinics, including (i) appointment no show rates by clinic, and retention in HIV medical care; and (ii) strategies to improve patient access. (Priority 2)

ACHS Response

1.1 **Partially agree**
With regard to retention in care reporting, the two percentages reported with differences were pulled at different times which impacted the result. For the Ambulatory Care Quality report, the percent quoted was year to date data. The yearly audit report was based on calendar year. In the past few months, the Retention in Care Report has moved into an automated reporting format and does no longer rely on manual sourcing. It is built based on the most recent HRSA definition. Using this new reporting tool, our CY 2021 rate shows at 84.1%, which is favorable based on the National average of 82%.

For the past 5 years, we have used uniform data reporting across all specialties (including infectious diseases) to ensure timely triage and access to care.
The report entitled "HHS_E-consult_referral_TAT Summary [101245]" provides the following four metrics for every referral:

- Time taken to triage the referral
- Time taken to obtain insurance authorization
- Time taken to contact the patient and offer and appointment
- Time taken for the patient to be seen in clinic

For Quarter 1 of 2022, the median time for providers to triage a referral to infectious diseases was less than 1 day (22. 9 hours). The standard is < 72 hours (for non-urgent referrals), so the infectious disease clinic is meeting this metric with ease.

In addition, 93% all referrals triaged to be seen within 21 days were seen within 21 days. The standard is > 90%, so the infectious disease clinic is also meeting this metric. This information is available in the report entitled "HHS E-Consult Non-Urgent Compliance Report [101337]".

As far as ease of appointment is concerned, all clinics have implemented proactive scheduling where clinic staff call patients as soon as a referral is received, triaged, and authorized. The amount of time taken to make this call, as well as the outcome of the proactive practice, is recorded in HealthLink as a discrete entry and available for reporting and review. For example, in Q12022, the median time taken to make the first phone call to the patient was 1.7 days (this includes weekends and holidays). In addition to this quantitative information, any patients who are having trouble in scheduling an appointment are encouraged to contact customer service, which logs and follows up on all complaints. The managers are included in these communications.

All these reports are available in HealthLink for managers and others to review.

1.2 **Agree**
We agree that measures submitted as part of quality oversight must be quantifiable and measurable and will strive to ensure ongoing that this is the case.

1.3 **Agree**
Reports may be provided as requested.

SECTION 2: Social Worker Workflow Inefficiencies

Recommendations**:**

The Ambulatory Outpatient Specialty, Community Health and Administrative Services Director should:

2.1 Work with Technology Services and Solutions Department staff to facilitate approval of the HealthLink build request in 2022 to allow tracking of patient referrals to social workers and referral outcomes, including referrals to case management coordination provided by The Health Trust or other future community provider. (Priority 2)

2.2 Direct TB Clinic and Partners in AIDS Care and Education Clinic managers to work with the medical and psychiatric social workers, SCVMC's director of social work, and the ambulatory medical social work manager to develop service-specific clinical competencies that would further define (a) Social worker roles and expectations; (b) referral timelines and documentation of referral outcomes; and (c) criteria and procedures for referring TB Clinic patients to the social workers. (Priority 2)

2.3 Direct the TB Clinic manager to develop a policy for conducting regular patient chart audits. (Priority 2)

ACHS Response

2.1 **Agree**
Although it is not a standard to track internal referrals between providers and onsite MSW staff team members, this team has requested the associated HealthLink build, and it is in a priority queue that is regularly reviewed by Ambulatory leadership and the TSS teams.

2.2 **Partially agree**
All social workers, regardless of location assigned, have clear overarching expectations and report to the Director of Social Work and the Ambulatory MSW Manager who is an experienced MSW able to support specific competencies related to associated teams. The description is more general, but the site-specific orientation and the assigned work areas is completed by that associated MSW leader CHS Director will work with the MSW Director to ensure orientation tools are developed and implemented that indicate specific workflow and competencies for assigned staff.

VHC Lenzen/TB does not have an MSW on site, but the patients who come in for this TB care are generally referred from a Primary Care Provider (PCP), who would most appropriately identify the need and referral to MSW and PSW which is the community standard rather than referral from TB Specialty team. We agree that there is a need to develop a clear process for those patients who may need an MSW or PSW referral where referral to these resources from a PCP has not occurred or were a PCP may not be identified.

2.3 **Partially agree**
We will evaluate intake screening tools and develop regular chart audits for this. Currently chart audits are conducted annually.

SECTION 3: Case Management Referral Inefficiencies

Recommendations

The Santa Clara Valley Medical Center chief executive officer should:

3.1 Delegate responsibility for the Memorandum of Understanding with The Health Trust, for services to Partners in AIDS Care and Education (PACE) Clinic patients, to the Public Health Department and incorporate Memorandum of Understanding requirements into the Interagency Agreement between the Public Health Department and the PACE Clinic. (Priority 2)

The Ambulatory Outpatient Specialty, Community Health and Administrative Services, director should:

3.2 Document a centralized referral policy to formally clarify the role of themedical social worker as the facilitator of referrals to The Health Trustor future contractor, to be included as a medical social worker required clinical competency developed in conjunction with Santa Clara Valley Medical Center social worker leadership (see Recommendation 2.2 on page 32). (Priority 2)

3.3 Develop an updated referral policy, in collaboration with the Partners in AIDS Care and Education (PACE) Clinic medical social worker, for PACE Clinic patients in need of support services through the Health Trust or future contractor, who were not initially referred by Public Health Department staff, to be referred to the Public Health Department who can then facilitate a referral. (Priority 2)

ACHS Response

3.1 **Agree**
Discussion and evaluation of recommendations will occur with CEO regarding opportunities to make this change with collaboration with Public Health Department.

3.2 **Agree**
Agree to review the workflow and concur that there is potential for this with the MSW team and the Public Health Department.

3.3 **Agree**

Agree to review and update policy accordingly.

SECTION 4: Limited Hours of Community Health Services Clinics

Recommendations**:**

The Ambulatory Outpatient Specialty, Community Health and Administrative Services, Director should:

4.1 Work with the HIV Commission and Public Health Department to evaluate the need for TB Clinic and Partners in AIDS Care and Education Clinic evening hours. (Priority 2)

4.2 Work to establish additional Partners in AIDS Care and Education Clinic provider time to deliver specialized HIV care services with support from existing primary care facilities in south County. (Priority 2)

4.3 Continue to actively engage with the HIV Commission and with the Facilities and Fleet Department to identify a new location that fulfills boththe accessibility needs and clinical needs of Partners in AIDS Care and Education Clinic patients. (Priority 2)

ACHS Response

4.1 **Disagree**
There is currently no access issue as timely appointments in both urgent, initial consult, and follow up categories meet all associated compliance requirements and enable patients access to a multidisciplinary team.

PACE clinic – Despite having a very small patient base compared to all Primary Care teams, does maintain an evening clinic. Patients require of this team require a multifaceted approach that during a visit, patients have access to a medical provider, nursing staff, MSW, PSW, pharmacist, and community workers in particular. To fully implement beyond one evening a week clinic schedule, it would be difficult to sustain due to the full staffing complement required to meet the needs of a very small patient volume.

4.2 **Partially Agree**
We agree additional South County presence may be desirable moving forward, but due to the complexity of care needs of this patient population that require significant care team presence, the need to ascertain space and again be able to replicate the many clinical and complementary aspects of this highly specialized work team to ensure equitable care is provided in a separate location. This will definitely be evaluated. We currently do run PACE Clinic monthly at VHC Gilroy.

4.3 **Agree**
Agree and we are actively pursuing options at present.

SECTION 5: Website Inaccuracies

Recommendations**:**

The Ambulatory Outpatient Specialty, Community Health and Administrative Services Director should:

5.1 Work with the Technology Services Solutions Department to (a) provide hours and days of Partners in AIDS Care and Education Clinic services at Valley Health Center Gilroy, and hours and days of TB (latent) Clinic services on Valley Health Center Gilroy, Valley Health Center Tully, and Valley Health Center Milpitas webpages, and future webpages as applicable; and (b) provide information on available services on the dedicated TB Clinic and Refugee Clinic webpages. (Priority 1)

5.2 Consult with the Public Health Department on creating designated webpages for the Infectious Disease and STI Clinics. (Priority 2)

ACHS Response: Agree

5.1 **Agree**
We agree and plan to move forward to update associated pages and information which will further assist the community to access care with us.

5.2 **Agree**
Agree to improve collaboration on developing this component.

SECTION 6: ARIES Data Entry Delays

Recommendations**:**

The Ambulatory Outpatient Specialty, Community Health and Administrative Services Director should:

6.1 Discuss with Technology Services and Solutions the feasibility of digitizing the Clinic's paper-based patient services form for patients to submit electronically, using their personal device or a Clinic tablet, to eliminate a portion of the manual data entry process. (Priority 1)

The Technology Services and Solutions Department should:

6.2 Provide a report to the Board of Supervisors regarding the prioritization of the build interface between Valley Medical Center's electronic health records system, HealthLink, and the State's AIDS Regional Information and Evaluation System (ARIES) which would automate large portions of patient information data entry into ARIES, as to comply with Ryan White Program timeline requirements. (Priority 1)

6.3 Continue to work with the PACE Clinic on the build interface between Valley Medical Center's electronic health records system, HealthLink, and the State's AIDS Regional Information and Evaluation System. (Priority 1)

ACHS Response **Agree**

6.1 **Partially Agree**
Concur and clinic manager and director have been in discussions with TSS on continued efforts to further decrease in manual entry and explore possible options to automate the data upload and this continues to be a collaborative effort. Prior efforts made by the Clinic, TSS, and SCVMC Analytics have already resulted in significant reduction in manual data entry by multiple providers and clinic staff, which improved timely and accurate reporting.

6.2 **Agree**
We will provide updates on prioritization as requested.

6.3 **Agree**
There are continued discussions on the ARIES build interface and the TSS team are aware of its priority. We will ensure this is addressed and provide updates.

County of Santa Clara
Technology Services and Solutions
150 W. Tasman Drive | San Jose, California 95134 | (408) 918-7127

DATE: June 28, 2022
TO: Board of Supervisors
FROM: Khalid Turk, Chief Healthcare Technology Officer
SUBJECT: Response to Recommendations in the Management Audit of the Office of Community Health Services

This memo contains a response to the management auditor's recommendation that the Santa Clara County Technology Services (TSS) Department:

> "*6.1 Provide a report to the Board of Supervisors regarding the prioritization of the build interface between Valley Medical Center's electronic health records system, HealthLink, and the State's AIDS Regional Information and Evaluation System (ARIES) which would automate large portions of patient information data entry into ARIES, as to comply with Ryan White Program timeline requirements. (Priority 1)*"
>
> and
>
> "*6.2 Continue to work with the PACE Clinic on the build interface between Valley Medical Center's electronic health records system, HealthLink, and the State's AIDS Regional Information and Evaluation System. (Priority 1)*"

TSS agrees with the above recommendations.

The ARIES system only accepts manual XML file uploads through their website. TSS is currently working on building the necessary data capture elements in HealthLink, and this effort is scheduled to be completed by December 2022. The next step will be for the HHS Analytics & Reporting team to extract the necessary data per the state requirements for the HHS Clinical Operations team to upload to the ARIES system.

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SANTA CLARA VALLEY MEDICAL CENTER Hospital & Clinics
O'CONNOR HOSPITAL A COMMUNITY HOSPITAL
ST. LOUISE REGIONAL HOSPITAL A COMMUNITY HOSPITAL

Hospitals and Clinics Administration

DATE: June 16, 2022

TO: Board of Supervisors' Management Audit Division

FROM: Paul E. Lorenz
DocuSigned by: Paul Lorenz 47ECF3A78343489...
SCVMC Chief Executive Officer

SUBJECT: Response to the Management Audit of the Community Health Services

This memo is in response to the Community Health Services (CHS) management audit conducted by the Board of Supervisors' Management Auditors during FY2022.

SECTION 3: Case Management Referral Inefficiencies

The Santa Clara Valley Medical Center chief executive officer should:

3.1 Delegate responsibility for the Memorandum of Understanding with The Health Trust, for services to Partners in AIDS Care and Education (PACE) Clinic patients, to the Public Health Department and incorporate Memorandum of Understanding requirements into the Interagency Agreement between the Public Health Department and the PACE Clinic. (Priority 2)

The Ambulatory Outpatient Specialty, Community Health and Administrative Services, director should:

3.2 Document a centralized referral policy to formally clarify the role of themedical social worker as the facilitator of referrals to The Health Trust or future contractor, to be included as a medical social worker requiredclinical competency developed in conjunction with Santa Clara Valley Medical Center social worker leadership (see Recommendation 2.2 on page 32). (Priority 2)

3.3 Develop an updated referral policy, in collaboration with the Partners inAIDS Care and Education (PACE) Clinic medical social worker, for PACE Clinic patients in need of support services through The Health Trust or future contractor, who were not initially referred by Public Health Department staff, to be referred to the Public Health Department who canthen facilitate a referral. (Priority 2)

SCVMC agrees with Section 3 recommendations.

3.1 Discussion and evaluation of recommendations will occur with CEO regarding opportunities to make this change with collaboration with Public Health Department.

3.2 Agree to review the workflow and concur that there is potential for this with the MSW team and the Public Health Department.

3.3 Agree to review and update policy accordingly.

County of Santa Clara Health System
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SCVMC Community Health Services Accomplishments 2021

I. Ambulatory Outpatient Clinics

COVID-19 Challenges and Responses

1. Ensuring continuity of care and providing access to services in a safe environment for our patients amid COVID-19 restrictions and limited physical clinic spaces

   Responses:
   Implemented workflow changes, physical space improvements and modifications, and adopted new technology to offer innovative ways to provide access and engage patients in care
   - Face to face appointments and virtual appointments were staggered to allow for social distancing in a tight space. Face to face appointments did not exceed number of available clinic rooms for any time slot. A virtual waiting room was created to queue patients outside of the main clinic space and complete part of their intake process through additional features built into MyHealthOnline.
   - Social distancing markers and maximum occupancy placed all throughout clinic as reminders for staff and patients
   - The clinic was one of the first of ambulatory clinics to implement and pilot the Enhanced Video Visit project in cooperation with the TSS, to offer alternative options to face to face clinic appointments
   - Providers in shared offices were allocated their own private space to aid with telehealth appointments and maintain social distancing and patient privacy
   - Staff, provider workspaces and exam rooms set up with video and audio computer hardware accessories to support virtual (video) visits. Secured additional HRSA Ryan White Grant funding to purchase needed equipment for telehealth (laptops, desks, etc.)
   - The nursing, senior HSR and outreach team reached out to patients to create accounts and educate patients on how to use MyHealthOnline

2. Reaching out, connecting with, and supporting and finding solutions for patients to address new problems brought about by COVID-19 restrictions and lockdown, such as social isolation (for a group already experiencing stigma), anxiety, depression and the devastating economic effects of job loss and the increasing need for food and housing assistance.

   Responses:
   Expanded outreach efforts for timely, in-depth assessment and identification of patient needs to enable them to address new challenges resulting from the pandemic to maintaining their health and well-being
   - Clinic staff and providers assess needs and refer patients in need of housing and food assistance to the Medical Social Worker (MSW) and Whole Person Care (WPC) coordinator to help obtain immediate support and connect them with available community resources.
   - Provided grocery gift cards for patients in dire need of food assistance through additional funding secured from a HRSA Ryan White COVID-19 Cares Act grant
   - The WPC Coordinator arranged transportation assistance for patients to go to their appointments, including COVI19 testing and vaccine appointments

- The clinic Health education Specialist Created a reference / resource manual for patients for all available resources in the county, such as the latest COVID-19 information / precautions, testing, treatment, food, housing, transportation, behavioral health support and other county resources.
- Announcement during daily huddles on any available or new country resources on critical needs such food assistance and housing during daily morning virtual clinic staff huddles
- Patients experiencing issues with social isolation and depression were immediately referred to the PACE Behavioral Health Team comprised of psychiatrists and Licensed Clinical Social Workers (LCSWs)
- Clinic Community Outreach Specialists delivered medications to patients who were homeless, transient or could not come out to the Pharmacy to pick up their prescriptions
- Face to face appointments made available throughout the pandemic at providers' discretion
- PACE Clinic worked with the Primary Care Behavioral Health Team to create and pilot a Virtual Group Therapy service to offer mental health support for select patients

3. Maintaining team morale, close / seamless coordination of patient care and staff teaching / training opportunities given COVID-19 restrictions - social distancing measures and remote work arrangements for some staff.

   Responses:
   - Staff meetings and morning huddles were converted to a virtual platform in 2020. Staff and providers were set up with headsets and cameras in offices and for remote work
   - TB / Refugee continued staff development sessions during monthly virtual staff meetings. A brand new PACE/ID lecture series piloted virtually. MDs, fellows, and the Pharmacy team presented current and new developments in HIV & ID care. Individually wrapped lunches were provided to encourage participation.
   - In 2020, a virtual staff retreat was organized to encourage staff to connect and have fun via MS Teams. In 2021, we were able to safely return to an in-person format for both teams.
   - Continued the clinics' tradition of celebrating holidays through COVID-19 safe activities (can be done whole socially distancing) such as holiday ornament contest and individually wrapped treats and/or meals.

PACE and general Infectious Disease Clinics Accomplishments:

1. Increased viral suppression rates in 2021 94% compared to 91% in 2020. Percentage of patients who got their labs drawn and had an undetected HIV viral load. Latest RW viral suppression rate was 89.4%.
2. Retention in care rates increased at 89% for 2021 compared to 84% in 2020. This is the percentage of patients who had a medical visit with MD, NP, or Pharmacist in a calendar year.

3. Continued to provide services despite challenges brough on by the pandemic. Increased medical visits by 16% in 2021, compared to 2020.
4. One of the first of ambulatory clinics to implement Video visits during the pandemic. Video visits, along with tele-visits continue to be options for patients to readily access healthcare. Webcams and iPad were installed and provided for the clinic for virtual appointments.
5. Piloted virtual group therapy session. We saw the need to provide this service to our patients especially during unprecedented times and piloted virtual group therapy session in the clinic. This was offered in Spanish and English. Patients were provided with technical assistance and the IPAD and space to join the virtual group if needed.
6. Promoted COVID vaccines through proactive patient outreach. High COVID-19 vaccination rates among PACE patients of up to 78% within a few months of the EUA availability of the vaccine.
7. Increased outreach efforts during the pandemic including HIV medication delivery to patients who were homeless, transient, or fearful of leaving their homes due to the pandemic.
8. Enhanced assessment for critical resource needs and additional support to help patients access these resources. E.g., Transportation - bus tokens, taxi vouchers etc. to come to their clinic appointments, COVID-19 testing or to receive their COVID-19 vaccine
9. Expanded access to RAPID ART- newly diagnosed patients receive their HIV medication within 72 hours. Service was maintained throughout the pandemic and present time.
10. Expanded PrEP services to a small, stable panel to provide wrap around care for partner services and patients at high risk for contracting HIV
11. Introduction of new longer acting, injectable anti-retroviral HIV medications for eligible patients. Cabenuva monthly injections were made available to patients, and they were able to receive their monthly injections at the PACE clinic.
12. Resumed community outreach and awareness efforts, e.g., World AIDS Day events, Post Street Jubilee, Silicon Valley Pride event
13. Focused on reconnecting and maintaining team morale amid the high stress situations resulting from the pandemic. Resumed in-person staff retreats, holiday celebrations, lunch lecture series while maintaining appropriate IP measures.
14. Increased focus on Intense Case Management efforts – a multidisciplinary team meets quarterly or more to manage patients who have detectable viral load. The team identifies solutions and activities to improve patients' engagement in care, with very good results. We started in 2019 with 150 patients on the list and now are currently managing 60 patients on the list.

Valley Health Center Lenzen (TB/Refugee Health Clinic) Accomplishments:

1. Continued to provide clinic services despite challenges brought on by the pandemic. The clinics remained open and did not close or reduce any services throughout the pandemic and continued to see patients in-person and via telehealth options as

needed. The clinic continued to accept all referrals for active TB, LTBI, Class B screening, positive TST referrals from primary care and Employee Health Department, as well as serve all newly arrived refugees, asylees and SIV holders.

2. The TB Clinic continued to provide 100% in person access to new TB consults, active TB cases and Refugee arrivals.
3. Along with PACE & ID, the TB/Refugee Clinic was one of the first of ambulatory clinics to implement Video visits during the pandemic. Video visits, along with tele-visits continue to be options for patients to readily access healthcare. Webcams and iPad were installed and provided for the clinic for virtual appointments.
4. Provided virtual options for active TB patients on Direct Observed Therapy. Coordinated with PHD Pharmacy on DOT medications management and delivery.
5. Increased outreach efforts during the pandemic including more thorough assessment of other critical resource needs. E.g., transportation, housing, food assistance, COVID-19 testing and vaccinations.
6. Introduced COVID-19 testing for staff in the clinic to avoid travel to other hospital sites.
7. Provided COVID-19 testing to patients report symptoms and are scheduled for in person provider visit.
8. Assisted patients to schedule COVID-19 testing and Vaccination appointment at different SCC sites.
9. Promoted COVID vaccines through proactive patient outreach and coordination with the PHD Travel IZ Clinic, resulting in high rates of vaccination among TB & Refugee patient populations.
10. In collaboration with AACI introduced telehealth CST (Center for Survivors of Torture) mental health assessment and counselling appointments for Refugee clinic.
11. Successful completion of the Refugee Health Assessment site survey and its first fully virtual format in 2021. The program was cited as one of the best in the state.

<u>Meeting the needs at the start of the Afghan Evacuee Surge Q4 2021</u>

To meet the surge of projected arrivals for the fiscal year, our program is working hard to rapidly increase our service capacity and patient access to achieve the program goals and time frame as mandated by the Office of Refugee Health and CDPH.

- Adding up to 4x the number of medical provider clinics for Refugee health assessment services
- Immediately assessed the staffing need and requested for more positions.
- Cross training of TB Clinic staff - advanced practice providers, nurses and PHAs on the refugee health assessment process and requirements
- Hiring additional support staff (Community Worker and Health Services Representative) for intake and care coordination
- Collaboration with various internal and external partners to facilitate access to pediatric healthcare, vaccinations (including COVID-19) and mental health services
- Continue to maintain close working relationship with resettlement agencies.
- Provided COVID-19 education, assist with COVID-19 testing and vaccination appointments.

Staff Recognition and Awards

- Nelda David, Health Center Manager, was the recipient of Santa Clara County Employee Excellence Award Feb 2022, awarded by the Santa Clara County Board of Supervisors. She led clinical operations and the set-up of all 9 COVID-19 mass vaccination sites in Santa Clara County, which was instrumental in helping the county achieve the highest vaccination rates among large counties in the nation
- Dr. George Kent, was the recipient of 2021 Leslie Davide Burgess Lifetime Achievement Award. This award is presented annually by the County of Santa Clara Public Health Department to an individual who has demonstrated extraordinary commitment and compassion in providing education, prevention, healthcare, or support services to Santa Clara County residents who are at risk for, affected by, or living with HIV/AIDS
- The physicians in PACE/ID provided Enterprise-wide support in Infection Prevention (Dr. Supriya Narasimhan), Employee Health (Dr. Janet Kim) and COVID-19 therapeutics guidelines (Dr. Harleen Sahni, Dr. Supriya Narasimhan and Dr. Jyoti Gupta). They kept up with the changing nature of CDC and Regulatory guidance and worked with the HCC in creating policies for safe care delivery for patients and HCWs. They answered various media requests and kept the health system educated through QSMs, Town Halls and other such venues
- Dr. Michael Harbour published article on HIV- Associated wasting prevalence in the era of modern antiretroviral therapy, Journal of AIDS, Jan 2022. He presented this data at the Center of AIDS research in Miami on HIV associated Wasting.
- Omar (Jorge) Nunez, PACE Community Outreach, recipient of Legacy Award in August 2021, for his great achievement and contribution to the LGBTQ and HIV/AIDS Community, awarded by the California Legislature Assembly. Omar was featured in a documentary film on the LGBTQ movement in Silicon Valley from 1970's to present time and awarded Queer Person of Impact Award, February 2022, but Queer Silicon Valley
- PACE MDs (Dr. Manoj Ray and Dr. Carol Hu) participated in a multicenter trial on COVID-19 in HIV pts which resulted in a publication and helped to answer some of the conflicting data from other studies outside USA in HIV pts. (Characteristics, Comorbidities, and Outcomes in a Multicenter Registry of Patients with Human Immunodeficiency Virus and Coronavirus Disease 2019; Clinical Infectious Diseases, ciaa1339)
- Staff were early and enthusiastic contributors to Employee COVID-19 testing, mass vaccination clinics and patient screening. TB Clinic NPs were the primary resources of clinical support in the biggest COVID-19 mass vaccination sites in SCC and support COVID-19 clinics that provided treatment. E.g., monoclonal antibody infusions.
- Tram Pham, RN, received 2021 Nurse Excellence Award in Patient Education
- Associated Press and KPIX media coverage in recognition of the Refugee Program and vital health services provided for all newly arrived refugees into the County of Santa Clara

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Financial Support/Patient Access Services

Similarly, the Finance Support Services faced same challenges incurred during the COVID Public Health Emergency (PHE), but updated their workflows to continue to serve the community.

- My Benefits CalWIN- Initiating Medi-Cal applications went from a manual process to an automated process via BCW. This process results in higher approval rate and faster turn around time while allows staff work closely with SSA-DEBS unit.
- Improved Custody workflow - MCIEP applications are now taken SCVMC Financial Support Services. Staff streamlined workflows to improve application turn around time.
- Baby Gateway – the team streamlined application processes, improved workflows by removing unnecessary involved departments, and improved Data Match on eligible patients. The team also implemented automated Medi-Cal initiating process.
- HealthCare Access Program (HAP) - the Program provides FPL % coverage up to 649%. It offers access to affordable healthcare for all county residents effective 07/2020.
- Primary Care Access Program (PCAP) – the Program increases FPL level up to 400% from 200%. It offers PCAP coverage to SCC resident with higher FPL bracket effective 01/2022.
- MEDS-CalWIN – established an Inter-Agency agreement with SSA, which allows SCVMC enterprise financial counselors access to CalWin/ Medi-Cal Eligibility Data System (MEDS).
- Dedicated Customer Services Unit – moved to a new space that further improves staff collaboration while assists patients in a team environment from Patient Access on the front end to Patient Billing Services on the back end.
- Updated tools – the team worked with HealthLink team to improve tools such as developed several patients/accounts work queues (WQ) to capture true self-pays patients. These WQs are assigned to staff to work on and monitored on a daily basis. This development further improves the department's productivity.

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