State of California - Health and Human Services Agency

Department of Health Care Services

Whole Person Care

Lead Entity Mid-Year or Annual Narrative Report

Reporting Checklist

San Francisco

Annual Report PY2

4/2/2018

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

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

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

I. REPORTING INSTRUCTIONS

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

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

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

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

II. PROGRAM STATUS OVERVIEW

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

At the end of PY2 (2017) San Francisco has faced challenges, experienced success, and learned lessons.

1. Increasing integration among county agencies, health plans, providers, and other entities. These activities have been time consuming but rewarding. A) The monthly Steering Committee was comprised of all WPC partners, i.e., SF City departments, Health Plans, and community providers. This group was successful as a communication platform. B) A quarterly Executive Steering Committee was formed to focus on interdepartmental logistics that will transform care coordination for the homeless population. It is comprised of senior executives of Public Health (DPH), Homelessness and Supportive Housing (HSH), Human Services (HSA), Aging and Adult Services (DAAS), the Controller's Office, and the Mayor's Office. This group has been successful in identifying the ancillary resources available, the procedures required for change implementation, and the limitations.

2. Increasing coordination and appropriate access to care. The SF WPC believes that increasing access to Medi-Cal insurance will facilitate increased access to care. WPC partnered with Fjord design consultancy, HSA, and HSH on an 8-week project to map the Medi-Cal enrollment experience and identify and prioritize ways to improve it. The design team conducted over 40 qualitative interviews at 8 locations. The successes were interagency collaboration, WPC publicity, a field guide of resources for staff, and the development of a Benefits Navigators planned pilot to become a PDSA intervention.

3. Reducing inappropriate emergency and inpatient utilization. These PDSA activities have been slower to implement than anticipated in part because it has been difficult to scale down the project to a target population, care team, and intervention that can be easily measured and compared to others.

4. Improving data collection and sharing. The challenge here stems from the size and number of SF departments and procedures that must be included. The early successes have been to establish relationships among the City departments that meet legal standards, the agreement to use an existing technology platform and

database as interim, and the hiring of consultant Gartner Inc. to document needs, explore vendors, and inform WPC of the direction an RFP should take when published later in 2018.

5. Achieve quality and administrative improvement benchmarks. The combination of the metrics measurements and PDSA activities show that the WPC is on target with expectations and can meet them in upcoming review periods.

6. Increasing access to housing and supportive services. This is a priority for SF and the reason homeless adults comprise the WPC target population. SF believes stable and safe housing is strongly associated with improved health outcomes. The WPC partner, the Homeless and Supportive Housing Department, initiated the foundational work for a continuum of services to move from street/encampment, to shelter and resources centers, to system-wide assessment, to appropriate level of care in permanent supportive or independent housing, to housing transition services, and finally housing stabilization support.

Improving health outcomes for the WPC population. Related to the quality metrics these activities are also on target. The SF WPC pilot project supports the Institute for Healthcare Improvement “Triple Aim” -- to improve health and healthcare experiences while reducing costs.

III. ENROLLMENT AND UTILIZATION DATA

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

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

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

Item	Month 1	Month 2	Month 3	Month 4	Month 5	Month 6	Unduplicated Total
Unduplicated Enrollees	2,151	776	750	600	573	569	*

Item	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12	Annual Unduplicated Total
Unduplicated Enrollees	569	512	428	487	448	348	8,211

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

FFS	**Costs and Aggregate Utilization for Quarters 1 and 2**						
	Month 1	Month 2	Month 3	Month 4	Month 5	Month 6	Total
Dual Dx Residential $300	$600	$7,5000	$20,400	$32,700	$69,300	$69,000	$199,800
Utilization 1	2	25	68	109	231	231	666
SUD Residential $140	$5,320	$0	$16,100	$59,640	$112,000	$135,940	$329,000
Utilization 2	38	0	115	426	800	971	2,350

Medical Respite Residential $134.38	$94,065.60	$95,275.02	$113,550.62	$123,225.94	$126,719.80	$128,197.98	$681,034.96
Utilization 3	700	709	845	917	943	954	5,068
Coordinated Entry Expansion							
Utilization 4	0	0	0	0	0	0	0
Encampment Response Expansion Services							
Utilization 5	0	0	0	0	0	0	0

FFS	**Costs and Aggregate Utilization for Quarters 3 and 4**						
	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12	Total
Dual Dx Residential $300	$54,000	$80,700	$51,600	$57,300	$50,100	$84,300	$577,800
Utilization 1	180	269	172	191	167	281	1,926
SUD Residential $140	$110,180	$85,260	$73,080	$89,600	$79,800	$63,700	$830,620
Utilization 2	787	609	522	640	570	455	5,933
Medical Respite Residential $134.38	$129,944.91	$144,054.75	$159,374.01	$180,202.82	$199,150.32	$219,307.23	$1,713,069
Utilization 3	967	1,072	1,186	1,341	1,482	1,632	12,748
Coordinated Entry Expansion	$16,598.40	$19,152	$8,171.52	$7,916.16	$8,937.60	$6,128.64	$66,904.32
Utilization 4	65	75	32	31	35	24	262
Encampment Response Expansion Services	$54,000	$80,700	$51,600	$57,300	$50,100	$84,300	$577,800
Utilization 5	0	0	0	0	0	0	0

Whole Person Care

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

PMPM		**Amount Claimed**						
	Rate	Month 1	Month 2	Month 3	Month 4	Month 5	Month 6	Total
Engagement	$246.27	$363,252.04	$344,535.33	$360,543.04	$354,632.50	$346,505.51	$351,677.23	$2,121,145.65
MM Counts 1		1,475	1,399	1,464	1,440	1,407	1,428	8,613
Enhanced Coordinated Care	$314.9	$112,118.64	$133,849.50	$167,233.14	$173,217.00	$163,453.86	$162,823.98	$912,696.12
MM Counts 2		356	425	531	550	519	517	2,898
Enhanced Housing Transition Services	$348.23	0	0	0	0	0	0	0
MM Counts 3		0	0	0	0	0	0	0
Housing and Tenancy Stabilization Services	$422.16	0	0	0	0	0	0	0
MM Counts 4		0	0	0	0	0	0	0

PMPM		**Amount Claimed**						
	Rate	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12	Total
Engagement	$246.27	$358,572.86	$364,483.40	$347,736.87	$335,176.97	$330,251.52	$312,027.35	$4,169,394.63
MM Counts 1		1,456	1,480	1,412	1,361	1,341	1,267	16,930
Enhanced Coordinated Care	$314.9	$166,918.20	$185,814.60	$249,432.48	$209,120.16	$221,717.76	$253,841.64	$4,627,098.48
MM Counts 2		530	590	792	664	704	806	6,984

Enhanced Housing Transition Services	$348.23	$3,482.30	$6,616.37	$8,705.75	$*	$4,526.99	$5,919.91	$*
MM Counts 3		10	19	25	*	13	17	*
Housing and Tenancy Stabilization Services	$422.16	$17,730.72	$16,464.24	$9,709.68	$9,287.52	$8,443.20	$13,931.28	$75,566.64
MM Counts 4		42	39	23	22	20	33	179

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

The Homeless and Supportive Housing Department was able to initiate the foundational work for the WPC expansion services, however, the ramp-up in clients using the services was slower than expected. This is partly explained by delays in hiring full staff.

SF exceeded its service projections in 2017 for the "Additional 90 days of Substance Use Disorder Treatment in SUD Residential Treatment" FFS and the Medical Respite Services FFS. As SF was unable to meet its projections in other FFS categories for 2017, we have budget savings that can be used to make up for this difference.

IV. NARRATIVE – Administrative Infrastructure

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

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

Delayed hiring and purchases are a consequence of the mismatch between WPC calendar year and SF fiscal year budgeting. When the Round 1 application was approved in November 2016, it was immediately out of sync with local budgeting. The result was delayed hiring and contracting.

For much of 2017, the program operated on a skeleton staffing model, mostly borrowed from other departments. Fortunately, Maria X Martinez was able to be re-assigned as WPC Director in late 2016, along with Fidez Bituin as a half-time administrative assistant. We were able to hire Kiersten Robertson as a full time Operations Manager in November 2017 who is responsible for overseeing all communications with and reporting to the state, in addition to managing day to day operations of the pilot, include contracts and budgets. We plan to hire an epidemiologist in early 2018 to support the contracted evaluators. Because of personnel resource restrictions in the City and County of SF, we are unable to hire a WPC quality improvement analyst, but are able to use borrowed staff to fulfill these responsibilities.

New WPC administrative staff are expected to join HSH and HSA in the first quarter of 2018. The Round 2 expansion application was also out of sync with city/county fiscal budget since it was not approved until June 2017, and therefore HSH also experienced a delayed ramp-up of staff hires, as well as longer purchasing time for mobile hardware and software, and an inability to provide training. These delays are expected to be resolved during 2018, though the discordance of annual versus fiscal budgeting will continue to present challenges.

V. NARRATIVE – Delivery Infrastructure

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

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

Highlights and Updates of the five key areas identified during the mid-year report:

1) Along with our consulting partner, Gartner, the WPC Information Technology team has met with executive stakeholders across City and County of San Francisco (CCSF). In addition, they met with IT leaders within DPH to better understand their technology infrastructure. Through these discussions we secured support and commitment to address interagency data sharing as one of the top two IT priorities for DPH.
2) The Mayor's Office recognizes the many missed opportunities from silo'ed departments not being able to share information, and as such has an initiative to establish multiple agencies within the City and County as Covered Entity and we are beginning to establish guidelines. Making use of this effort, WPC is streamlining the MOU/BAA that is immediately necessary.
3) Department of Public Health (DPH) is the WPC LE and the owner of the current system used for sharing data related to WPC. DPH-IT has established a secure method for all to access this info. Modern tools have made this possible without adding license and support costs through technologies of WebConnect and Duo.
4) As we have explained through the rollover request of the IT budget, DPH spent 2017 completing a thorough analysis of the technology that CCSF will require to build and sustain an interagency data sharing infrastructure. At the same time, we are challenged with meeting deliverables and improving outcomes. While the final architecture is being formed, we are making use of current systems in new ways. We are making interim modifications that inform our future state and improve our ability to help staff and clients.
5) WPC reimbursements are one way to highlight return on investment (ROI) for innovating in service and technology. The latter coupled with current research on social determinants of health is a powerful incentive to manage this change now across CCSF. The WPC director, Maria X Martinez, has been instrumental in explaining this across partners. She has given dozens of presentations to various stakeholders within the City and County, regionally and nationally; and this has been having meaningful impact.

San Francisco continues to rely on its pioneering, in-house developed Coordinated Case Management System (CCMS) an integrated data system. Staffing for this work continues to be the greatest issue. In December 2017, we hired a Business Analyst to

help with CCMS and early in 2018 we aim to hire an Information Steward to provide further support to CCMS. These persons are key in making use of existing DPH-IT technologies and defining the future state.

We also hired a Chief Service Designer in September 2017 to ensure our team takes a holistic approach to understanding, planning for, and implementing human-centered services and systems (rather than services that are billing-, disorder- and/or facility-centered). As an initial step, she conducted qualitative interviews with key stakeholders across CCSF to understand their goals, concerns, and insights about the Whole Person Care program. Based on key insights, the team developed a framework for organizing, prioritizing, and assigning project work. We engaged core partners and worked with external consultants to identify opportunities for improvement and plan for 2018 initiatives.

The delivery infrastructure was enhanced through the expansion (round 2) application. HSH worked on creating the infrastructure necessary for the universal assessment that will be used for both Coordinated Entry and across other systems. This process included identifying the questions that would be used, testing them to ensure that they did not include bias, as well as the technological aspects of HSH's ONE computer system buildout. The creation of these universal assessment questions is a key aspect of WPC and of the alignment of client prioritization across the three departments participating in San Francisco's WPC initiative.
Additionally, HSH hired a Business Analyst to support the ONE system development in July 2017.

Moreover, infrastructure work occurred in preparation for the new Navigational Centers that will be opening. To ensure accessibility to WPC enrollees, Navigation Centers are located in a variety of locations across San Francisco, which requires extensive relationship building with local businesses and neighborhood groups in the planning phases of these projects. Business and neighborhood groups who had previously spoken out against existing Navigation Centers prior to opening in their neighborhoods now help advocate for the opening of new centers – since these existing centers opening, neighbors have witnessed the significant return on investment and neighborhood improvement that has resulted. HSH has also worked on standardizing the policies and procedures for the Local Operating Subsidy Program (LOSP), which will ensure consistency across the supportive housing providers that will be housing and working with WPC enrollees. The LOSP policy and procedure manual was intended for distribution during this reporting period, however due to delays with department/commission review, it is now anticipated to be finalized and distributed in early 2018.

VI. NARRATIVE – Incentive Payments

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

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

San Francisco opened two additional Navigation Centers in 2017. In addition to the Central Waterfront Navigation Center, which opened on May 25th, the Van Ness Navigation Center opened on July 6th. It is operated by contractor St. Vincent de Paul, with additional services provided by Downtown Streets (work experience), and Brilliant Corners (housing placement). This navigation center has 120 beds. Payment earned by CCSF for $50,000.

SFDPH and WPC provided guidance and support to two programs of community-based organizations to help them become Drug Medi-Cal certified: Baker Places, Inc. (for medically-supported detoxification in a licensed and certified substance use residential treatment program) and HealthRight 360, Inc. (for socially-supported detoxification in a licensed and certified substance use residential treatment program), however certification is still pending and expects to be granted in 2018. Payment not earned yet; incentive payments rolled over to 2018.

Building upon the foundation laid in the first part of 2017, San Francisco developed a universal assessment tool based on the health and housing requirements established by the federal government's Homeless Management Information System. Additionally, the CCMS WPC Summary has been made available to all members of the treatment team and includes risk factors based upon service and diagnostic information that have been identified in CCMS's source systems. Both have been implemented and are in process of being normalized. Payment earned by CCSF for $325,000.

VII. NARRATIVE – Pay for Outcome

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

At mid-year 2017, San Francisco reported on two metrics -- reduce ED utilization and reduce Inpatient utilization -- that appear in Pay for Outcome in the WPC pilot project.

For the annual 2017 metric reporting, all pilot projects were given an extension of the due date. Metrics will be reported on 5/31/18. However, SF WPC has completed preliminary calculation of metrics. Results show Pay for Outcome metric "Other (Variant) Outcome: Housing Care Coordination" is 100% and predicted to remain at that level for the duration of the WPC pilot, making improvement impossible. Therefore, SF WPC appreciates the opportunity to remove that metric from the Pay for Outcome category and replace it with "Other Variant: Housing Services." We anticipate that results for "Other Variant: Housing Services" have room for improvement. This is all assuming that the metric definitions are not changed in a way that impacts our calculations.

We anticipate being able to report on all metrics. The calculation methods specified in the Metrics Technical Specifications manual will be used. As noted mid-year, some methods differ from SF's typical methodology, therefore SF will convert to align with the new specifications.

Baseline information reporting is based on the 2016 data of WPC enrollees beginning Jan 2017 through June 2018. The goal for 2017 is to maintain baseline. A reduction of 5% annually over baseline is the local goal beginning in PY3 (2018).

The target population of SF homeless persons can be challenging to engage and serve. At this time SF is unable to predict its performance over time but will continue to implement a strategy of improved care coordination and data sharing to determine if those interventions can help SF meet the targeted goals. We are, however, optimistic that we will be able to maintain baseline in 2017 and therefore we prospectively invoiced for the associated outcomes in the annual report.

VIII. STAKEHOLDER ENGAGEMENT

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

2017 was devoted to planning for, forming, and cultivating partner relationships and support for Whole Person Care initiatives. Key stakeholders across departments were identified and engaged through discovery interviews, committee meeting, and human-centered design working sessions. Key activities focused on understanding barriers and prioritizing opportunities for getting and keeping individuals on Medi-Cal and conducting multidisciplinary meetings to collaborate on issues relevant to Whole Person Care.

STEERING COMMITTEE

Key stakeholders and leaders met up to once a month to provide feedback and direction on SF's approach to Whole Person Care service design projects and IT initiatives. These meetings enabled us to shape our engagement with our IT partner and vendor, Gartner.

8/3/2017

Reviewed work with Fjord and Benefits Navigators pilot. Discussion on future state.

10/5/2017

Overview of HSH's strategic plan presented. "Quotes from the future" exercise to elicit perspective on how providers, management and clients would respond if asked about their experience in the future state.

12/7/2017

Presented WPC roadmap and work plan. Overview of journey mapping. Status update on benefit navigator's pilot. Discussion of how to more effectively use Steering Committee meetings, frequency of meeting and who should be members.

EXECUTIVE STEERING COMMITTEE

Executive leadership from DPH, HSH, DAAS, HSA and the Mayor's office met quarterly to receive updates from the Whole Person Care team about ongoing initiatives and budget adjustments. The group provided invaluable insights and guidance in how to accomplish Whole person Care goals and objectives.

8/09/2017 10-11:30 AM
Presentation on WPC background, target population, budget, and services. Discussed WPC pain points and mitigation efforts regarding Medi-Cal eligibility of homeless adults receiving services in SF, care coordination PMPM, and unspent WPC $. Initial conversations started on WPC sustainability.

11/13/2017
Provided overview of human centered design. Continued the conversation about getting and keeping people on Medi-Cal. Discussed SSI advocacy. Reported on HSH strategic framework.

CORE PLANNING COMMITTEE

A small team of critical leadership from DPH, HSH, DAAS, HSA and the Mayor's office met monthly to provide guidance on planning and implementation processes that contributed the success of SF WPC goals. We like to think of this group as the "getting stuff done" group.

Meets monthly for 1 hour (typically in advance of Steering meeting)

HUMS MEETING

Delegates from the WPC team attended monthly meetings with care providers from across CCSF and partner organizations to better understand pain points and

opportunities for improving care coordination and information sharing about individuals who are homeless as they navigate the system of care.

Meets 3rd Thursdays of the month for 1.5 hours

COMPLEX CARE MANAGEMENT

Delegates from the WPC team attended monthly meetings with care providers and administrators serving complex care management challenges. We partnered with the multidisciplinary group to discuss care plans, referrals, potential data sharing solutions, and a methodology for identifying Whole Person Care enrollees.

Meets 3rd Thursdays of the month for 1.5 hours

IX. PROGRAM ACTIVITIES

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

(1) The Whole Person Care team designed and implemented enhancements to the "WPC Patient Summary" screen within CCMS, SF WPC's existing data sharing application. Furthermore, for the first time, new users outside of DPH's firewalls were enabled to access CCMS, increasing our ability to grow our user base. This also enabled more providers access to critical information, improving their ability to provide the right care at the right time.

(2) We engaged the High Users of Multiple Systems (HUMS) provider group to elicit feedback and generate ideas about system-wide care coordination barriers and opportunities. Design thinking activities ensured the process was participatory and human centered.

We identified, hired, and on-boarded a Chief Service Designer, an IT project manager and a business analyst to support design and development projects. Their first product was to outline the San Francisco "Ecosystem of Care" which outlined urgent/emergent services (wherein most homeless people remain), transitional services, and wellness/recovery services in all system domains (Medical, Mental Health, Substance Use, Housing, and Benefits). These additional staff allows us to take on high impact projects and be in better positioned to meet aggressive deadlines.

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

(1) In 2017 our team encountered challenges identifying care coordinators who serve the SF Whole Person Care target population. Provider information and functionality capabilities in CCMS didn't allow for care coordinator registration or tracking. Additionally, many of the care providers work in external systems and bill for their services through programs other than Whole Person Care.

(2) San Francisco's WPC program aims to serve as the "connective tissue" between a wide variety of urgent emergent, transitional care, and recovery and wellness services. Systems and services operate in silos and are difficult to navigate for clients and providers. Hand-offs and referrals are often not followed through and people fall through the cracks. Bringing administrators and care providers together, in alignment, to identify policies and procedures that allow for consistent care coordination is an ongoing challenge and goal.
(3) Effectively capturing and tracking complex care coordination encounters by a wide range of providers posed technical and administrative challenges. Manually

completing paper encounter forms added to the documenting tasks of busy care providers. The delivery, collection, safe transport, digitization, and storage of physical encounter forms containing PHI required a sizable investment of staff time and resources. Inconsistent data entry and a manual data ingestion processes limited our ability to leverage all the data that had been collected.

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

(1) Access to the Whole Person Care Patient Summary from the CCMS system is being marketed to end users, training and orientation conducted, and web connect software supported to enable connections across the DPH firewall.

(2) Benefits information from the MEDS system now displays on the Whole Person Care Patient Summary screen, adding value for end users by giving them access to information they requested.

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

(1) San Francisco is engaged in a project to have its multiple agencies become a hybrid covered entity to allow data sharing across the city. Once complete, this status will greatly benefit creating new data sharing arrangements for Whole Person Care. However, a challenge is that the city attorney has not signed the draft policy agreements.

(2) San Francisco Department of Public Health is implementing two new technology platforms that will greatly benefit Whole Person Care data sharing: an Epic electronic health record (eHR), and a vendor supplied eMPI (enterprise master person index). These are high priorities for DPH, and although the WPC interagency data-sharing platform is the DPH's second priority, it can be difficult to get access to expertise/resources to facilitate interim data sharing.

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

(1) We applied to a city initiative entitled Startup in Residence (StIR) providing us the opportunity to develop a mobile application to collect data from street encounters with homeless clients. This process has highlighted many of issues we will face is designing a broader infrastructure. In the true spirit of continuous improvement, it is helpful to work through it with a smaller scope first.

(2) We are experimenting with options for improving the data collection from paper into electronically retrievable sources. The immediate value is for display through WPC Patient Summary view in CCMS.

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

(1) WPC affords us the opportunity to collect data not previously attempted. Collecting this information is a major change in the silo habits of staff working with clients. The policy and process are slow to develop even though there is dollar value through this pilot. And we want the mechanism to exist after 2020 so staff is not learning and then re-learning. In 2018 we will hire a Coordinator of Integrated Care to develop protocols, clinical care paths, core competencies, etc. to assure practice changes as technology enables us to share information and coordinate care across silos.

(2) CCSF system of care is very fractured so difficult to pinpoint a single area for improvement. And difficult to recognize small improvements in one area having impact to another. We are capturing new pieces of information to demonstrate value going forward. We rely on anecdotal evidence and assumptions for before the pilot began.

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

We categorize success in two ways: improving population health and meeting pilot deliverables. The list below shows some of the concerns that have arisen in the course of the first operational year of the WPC pilot.

<u>Conflict between calendar year and fiscal year budgeting</u>. In SF, the WPC funding was allocated into county baseline budgets, which placed it in the fiscal year (July-June) contracting period and made it impossible to hire staff or access funds until

approximately three months post the start of the fiscal year due to budgetary policy stipulating that no new employees may be hired until September of the fiscal year. SF will face similar constraints due to rollover budget approval at the beginning of April 2018. With such a delays, staffing adequately to meet the work needs is difficult.

Start-up period not adequate. As SF projects what it wants to accomplish at the end of 2020, it's evident that every month of time is essential. The delays caused by not being able to hire, slow contracting processes, delaying implementation may affect the end results. SF recognized the need for a ramp-up period and therefore spent much of PY2 in start-up mode. Taking this time has enabled us to thoughtfully consider how to impact meaningful change in the community. The downside is that the change process will have to happen faster to keep up with the encroaching pilot end date.

Care Coordination may not be the solution if care doesn't exist. Whole Person Care addresses care coordination, but it does not address the fact that health and benefit services within large systems of care are not the right fit for the homeless person. Rather than disjointed services, the service that is needed might not exist at all, e.g., it is not a matter of coordinated care, but rather developing relevant services. As a result, high use of urgent emergent services may be less driven by coordination than it is by service gaps. This requires high level policy change, with added complexity and time. We are exploring how to address system issues as we case conference the top 100 users of urgent / emergent services in San Francisco.

Legal and logistical aspects of data systems hamper data sharing.

- The process of identifying technological systems to share data across WPC departments and community providers has had anticipated and unanticipated impediments that we are still working to identify and resolve.
- The five main source systems that will contribute to and partake in the interagency data sharing platform are in various stages of development and moving targets. Two are legacy and changing to new vendors, two are new and not yet fully implemented.
- We need to need standardize how living conditions are defined, coded, collected and reported across the multitude of agencies and programs who serve the same population. Currently this is defined inconsistently, is missing altogether, is rewritten and not historically kept, etc. We will be addressing this issue in 2018.

Housing pipeline is not sufficient to meet needs of WPC population. Permanent Supportive Housing (PSH) is the most successful housing intervention to stabilize the WPC (homeless) population. San Francisco does not have an adequate pipeline of PSH in place and WPC does not fund this critically important resource.

The guidelines about non-overlapping care between Whole Person Care and Health Homes may mean neither waiver covers the care provided. The SF WPC target

population (homeless adults) could overlap with other Waivers that are not specifically focused on care of the homeless. This issue will not only continue to divert staff time to discussions, policy development, and elaborate billing algorithms, but also it may exclude enrollees of WPC and require them to accept other care. We are concerned that the homeless will NOT seek services designed for medically-complex, if the care is not also designed for socially complex patient.

Homeless individuals don't see the importance of enrolling for Medi-Cal. The lack of follow-through on Medi-Cal enrollment was not anticipated. At least 15% of the target population has no known health insurance coverage yet resists Medi-Cal enrollment despite staff efforts to assist them. Accessing benefits is a burdensome and often complicated task that does not always have clear value for homeless individuals. We did not account for this when drafting our application so did not set aside funds to incentivize the target population to get on Medi-Cal. Additionally, as a county with a "single standard of care," anyone who seeks care regardless of benefits enrollment will receive it. The result is inability to bill for services. We dedicated much time to addressing these challenges in 2017 through our "Civic Bridge" engagement with Fjord consultants and while we are optimistic about improvements to the process as a result of the findings and recommendations that came out of the engagement, we still anticipate continued challenges with getting and keeping homeless individuals on Medi-Cal (among other benefits), particularly in the immediate future.

The Cal-MEDS database indicates some homeless individuals accessing SF services have other counties of residence or other counties of responsibility. The overlap with neighboring counties was not anticipated. To date SF is unable to assess the scope of the problem, but it is draining admin and IT staff resources away from other projects.

Lack of direct incentives for engaging the target population. The client incentives needed to encourage continued engagement is a difficult and unpredictable task. Stipends would be helpful for engagement in changing behaviors and providing "first voice" in the design and evaluation phases of WPC.

While no complex project comes without challenges, the WPC pilot has many. It also has the potential to initiate meaningful change for some of SF's most vulnerable residents. We will work through these barriers so that we can do just that.

X. PLAN-DO-STUDY-ACT

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

PDSA Summary Report:
San Francisco has documented seven PDSAs. Attached please find 2017Q3 and 2017Q4 reports for each. The status of each is as follows.

In pre-planning phase that requires hiring staff to conduct the PDSA, reviewing measurement tools, and partnering with other similar city initiatives:

- **Ambulatory Care:** Health Outcomes: Ambulatory Care – Emergency Department Visits
- **Care Coordination:** Administrative: Care coordination, case management, and referral infrastructure
- **Comprehensive Care Plan:** Administrative: Proportion of participating beneficiaries with a comprehensive care plan, accessible by the entire care team, within 30 days
- **Data:** Administrative: Data and information sharing infrastructure
- **Inpatient Utilization:** Health Outcomes: Inpatient Utilization-General Hospital/Acute Care

Completing “Plan” phase.

- **Other: Increase Medi-Cal insurance enrollment**

Currently in “Do” phase.
Other: Measuring the adoption rate of electronic data sharing information