



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 PY3/2018
 April 2, 2019

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

Component	Attachments
1. Narrative Report Submit to: Whole Person Care Mailbox	<input type="checkbox"/> Completed Narrative report <input type="checkbox"/> List of participant entity and/or stakeholder meetings <i>(if not written in section VIII of the narrative report template)</i>
2. Invoice Submit to: Whole Person Care Mailbox	<input type="checkbox"/> Customized invoice
3. Variant and Universal Metrics Report Submit to: SFTP Portal	<input type="checkbox"/> 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	<input type="checkbox"/> Care coordination, case management, and referral policies and procedures, which may include <i>protocols and workflows.</i> <input type="checkbox"/> Data and information sharing policies and procedures, which may include <i>MOUs, data sharing agreements, data workflows, and patient consent forms.</i> One administrative metric in addition to the Universal care coordination and data sharing metrics. Describe the metric including the purpose, methodology and results.
5. PDSA Report Submit to: Whole Person Care Mailbox	<input type="checkbox"/> Completed WPC PDSA report <input type="checkbox"/> Completed PDSA Summary Report
6. Certification of Lead Entity Deliverables Submit with associated documents to: Whole Person Care Mailbox and SFTP Portal	<input type="checkbox"/> Certification form

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

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I. REPORTING INSTRUCTIONS

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.

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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.*

In 2018, San Francisco WPC pilot continued maintained a unified commitment to meeting implementation challenges.

1. Alignment.

SF WPC has continued partnerships with 5 city departments, 2 health plans and several contracted non-profits, as well as consensus of direction and momentum through PDSA activities.

- The HSH (housing) / DPH (health) Summit helped to understand how respective departments' services should work together to serve shared clients. Historically, providers have experienced challenges that have limited our capacity to provide coordinated services and support for shared clients. This resulted in difficulty connecting clients to resources managed by other departments and staff at all levels unclear on pathways and protocols.
- HSH (housing), HSA (benefits), and DPH (health) convened an interagency data sharing workgroup with the purpose of coordinating and aligning efforts. The group brings together subject matter experts to address opportunities, challenges and barriers implementing interagency data sharing agreements.
- The Whole Person Care team, with the support of a FUSE Corps fellow, is planning an interagency alignment project to address prioritization of shared clients and to design and prototype a system of care response.

Finally, we continue to be sensitive to our stakeholders' capacity for participation in Whole Person Care strategic initiatives.

2. Reducing reliance on urgent/emergent services.

HUMS Top 100 Workgroup: In response to a directive from DPH leadership, the SF Whole Person Care (WPC) and the UCSF Evaluation team convened an interagency, multidisciplinary team to review the Department of Public Health's Top 100 HUMS (High Users of Multiple Systems) clients. Our objective was to better understand and develop care recommendations for our most vulnerable clients, and to develop

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system of care recommendations to be presented to WPC and DPH executive leadership. These recommendations will serve the Top 100 HUMS and improve care for additional high-risk individuals.

EMS-6 Base Physician Pilot: Emergency medical and psychiatric departments are used by 40% of the homeless population annually. Using a PDSA between DPH's phone-based directing physician and a high user paramedic unit, WPC aims to bring down avoidable emergency department (ED) use by creating permission guidelines allowing EMS to be redirected to another safe but less resource-intensive program.

3. Increasing knowledge.

Mortality Death prevention report: DPH Street Medicine and SF Whole Person Care reviewed homeless deaths identified from Medical Examiner reports. The report describes the characteristics of homeless individuals who died in San Francisco from 2016 – 2018, including demographics, causes and locations of death. The housing, health and social service utilization history of deceased homeless individuals was examined to identify opportunities for policy change and inform clinical practice. Unstable addresses, a lack of identification, and unreliable identifiers in administrative data have meant it is challenging for providers and researchers to track, verify, and study homeless deaths.

Primary assessment: HSH implemented the Primary Assessment to support the implementation of the Coordinated Entry (CE) System for adults experiencing homelessness. The Primary Assessment is one of several steps in the CE process. It provides a standardized and consistent method for assessing adults experiencing homelessness and identifies who will be prioritized to receive an HSH-funded housing resource.

HSH completed the Assessment Blitz for adults experiencing homelessness; the Blitz occurred from August 6th through October 31st. As of November 1st, over 3,700 adults were assessed, which exceeded our goal of 2,000, thanks to the tremendous efforts of our partners and HSH staff.

DPH continues to partner with HSH to collect client data to inform system of care response and improvement, interagency coordination, and resource allocation decisions. New protocols permit transfer of data into standardized formats for state reporting.

CCMS utilization: Whole Person Care continues to increase the adoption rate and usage of integrated data by providing appropriate access to CCMS client records and training for why and how to use integrated data.

RideAlong StreetCare App: The WPC team facilitated conversations between DPH's IT procurement division and RideAlong, a developer and vendor of "StreetCare" — a mobile, responsive web application that allows street-based health workers to view and document relevant information for shared clients. Throughout the process we

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encountered significant challenges due to complex IT and contracting requirements and extended timelines. In the end, we were not able to contract with RideAlong but integrated our learnings into the 2019 RFP for the Interagency Care Management platform.

4. Improving benchmarks.

SF WPC defines administrative quality and improvement as having documented and uniform procedures.

SF WPC has successfully implemented promotional hand-outs, user guides for integrated data, and procedures for documenting PDSA activities including the many discovery and design activities.

5. Increasing access.

San Francisco has made great strides in 2018 by opening additional Navigation Centers as models for engaging long-term homeless individuals with barriers to utilizing the traditional shelter system and accessing care to drive outcome improvements. These low threshold facilities provide access to services and staff from multiple City agencies, as well as partner community-based organizations, affording opportunities to connect our clients with benefits and a chance to exit into stable housing.

The Bayshore Navigation Center opened in September 2018, followed by the Bryant Street Navigation Center in October 2018 (the second and third Navigation centers opened in 2018 respectively - see additional details in “Incentives”). Additionally, the City expanded housing navigation services.

The WPC pilot has provided an opportunity to define and identify needs of homeless adults. Our objective is to design and implement a system of care that ensures 100% of adults experiencing homelessness are appropriately assessed for housing, health, and benefits. In 2018, HSH began providing Resource Center services including “Problem Solving” to help individuals try to identify available safe options for a place to stay (at least short term) outside of the-homeless response system and to provide linkage to benefits and services.

6. Improving health outcomes.

Interagency Care Planning and Coordination: Access to integrated health and social data via the CCMS Whole Person Care Summary has increased with outreach, training, and small scale pilots to validate information needs of providers. Additionally, the WPC team has partnered with care coordination groups across DPH to input “Client Action Plans” into the WPC Summary. The “Action Plan” pilot in CCMS documents agreed upon next steps from case conferences and who to contact for

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information or updates. “Action Plans” reduce duplication of efforts and improve coordination between services.

The pilot has helped the team to identify system gaps and opportunities for improving care coordination. Providers across the city continue to be challenged by the lack of capacity in appropriate resources and services to meet the needs of our target population.

Buprenorphine Program Communication: Whole Person Care partnered with the Street Medicine team and Fuseproject through Civic Bridge, a program that pairs government organizations with private sector design and technology specialists, to design and develop communication and training materials. The project resulted in a website designed for health care providers and entities interested in implementing a Buprenorphine program in their community. The goal of the materials is to share learnings and increase access to medication assisted treatment for substance use.

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III. ENROLLMENT AND UTILIZATION DATA

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

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

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

Item	Month 1	Month 2	Month 3	Month 4	Month 5	Month 6	Unduplicated Total
Unduplicated Enrollees	547	359	393	380	375	358	2413

Item	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12	Annual Unduplicated Total
Unduplicated Enrollees	349	453	519	603	291	251	4879

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

Costs and Aggregate Utilization for Quarters 1 and 2							
FFS	Month 1	Month 2	Month 3	Month 4	Month 5	Month 6	Total
Dual Dx Residential Cost	\$52,500.00	\$23,100.00	\$39,600.00	\$42,900.00	\$-	\$-	\$158,100.00
Dual Dx Utilization	175	77	132	143	-	-	527
SUD Residential	\$65,800.00	\$87,920.00	\$89,320.00	\$85,400.00	\$-	\$-	\$328,440.00

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Costs and Aggregate Utilization for Quarters 1 and 2							
FFS	Month 1	Month 2	Month 3	Month 4	Month 5	Month 6	Total
SUD Residential Utilization	470	628	638	610	-	-	2,346
Medical and Psych Respites Residential	\$270,102.66	\$245,511.22	\$280,046.74	\$254,380.26	\$252,767.71	\$261,233.62	\$1,564,042.21
Medical and Psych Respites Utilization	2,010	1,827	2,084	1,893	1,881	1,944	11,639
Resource Center Services	\$-	\$-	\$-	\$-	\$-	\$-	\$-
Resource Center Services Utilization	-	-	-	-	-	-	-
Coordinated Entry Expansion	\$6,894.72	\$7,405.44	\$10,469.76	\$7,916.16	\$8,171.52	\$14,555.52	\$55,413.12
Coordinated Entry Expansion Utilization	27	29	41	31	32	57	217
Encampment	\$2,116.80	\$2,963.52	\$529.20	\$1,534.68	\$1,270.08	\$1,323.00	\$9,737.28

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Costs and Aggregate Utilization for Quarters 1 and 2							
FFS	Month 1	Month 2	Month 3	Month 4	Month 5	Month 6	Total
Encampment Utilization	40	56	10	29	24	25	184
Engagement	\$500,032 .26	\$453,889 .80	\$495,544 .14	\$482,669 .46	\$494,70 8.76	\$461,22 8.04	\$2,888,072. 46
Engagement Utilization	30,527	27,710	30,253	29,467	30,202	28,158	176,317

Costs and Aggregate Utilization for Quarters 3 and 4							
FFS	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12	Annual Total
Dual Dx Residential Cost	\$-	\$-	\$-	\$-	\$-	\$-	\$158,100.00
Dual Dx Utilization	-	-	-	-	-	-	527
SUD Residential	\$-	\$-	\$-	\$-	\$-	\$-	\$328,440.00
SUD Residential Utilization	-	-	-	-	-	-	2,346
Medical and Psych Respites Residential	\$281,928 .05	\$281,659 .29	\$285,959 .43	\$294,290 .96	\$273,73 0.90	\$255,18 6.54	\$3,236,797.3 8
Medical and Psych Respites Utilization	2,098	2,096	2,128	2,190	2,037	1,899	24,087
Resource Center Services	\$-	\$-	\$-	\$-	\$11,085. 55	\$22,004. 40	\$33,089.95
Resource Center	-	-	-	-	133	264	397

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Costs and Aggregate Utilization for Quarters 3 and 4							
FFS	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12	Annual Total
Services Utilization							
Coordinated Entry Expansion	\$9,959.04	\$200,968.32	\$209,905.92	\$239,527.68	\$47,752.32	\$34,984.32	\$798,510.72
Coordinated Entry Expansion Utilization	39	787	822	938	187	137	3,127
Encampment	\$2,857.68	\$1,111.32	\$529.20	\$1,217.16	\$687.96	\$423.36	\$16,563.96
Encampment Utilization	54	21	10	23	13	8	313
Engagement	\$486,076.50	\$476,920.08	\$463,930.74	\$478,918.44	\$484,700.58	\$505,077.30	\$5,783,696.10
Engagement Utilization	29,675	29,116	28,323	29,238	29,591	30,835	353,095

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

Amount Claimed								
PMPM	Rate	Month 1	Month 2	Month 3	Month 4	Month 5	Month 6	Total
Enhanced Care Coordination	\$314.94	\$275,570.96	\$247,856.39	\$274,626.14	\$241,872.57	\$233,999.11	\$231,794.54	\$1,505,719.71
Care Coordination Utilization		875	787	872	768	743	736	4,781
Enhanced Housing Transition Services	\$348.23	\$29,947.78	\$28,554.86	\$16,018.58	\$10,098.67	\$9,053.98	\$4,178.76	\$97,852.63

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Amount Claimed								
Enhanced Housing Transition Service Utilization	0	86	82	46	29	26	12	281
Housing & Tenancy Stabilization Services	\$422.16	\$219,523.20	\$230,921.52	\$252,029.52	\$279,469.92	\$301,000.08	\$332,239.92	\$1,615,184.16
Housing & Tenancy Stabilization Utilization	0	520	547	597	662	713	787	3,826

Amount Claimed								
PMPM	Rate	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12	Annual Total
Enhanced Care Coordination	\$314.94	\$217,307.38	\$239,668.00	\$237,778.37	\$293,837.37	\$216,992.45	\$216,047.63	\$2,927,665.85
Care Coordination Utilization	0	690	761	756	933	689	686	9,296
Enhanced Housing Transition Services	\$348.23	\$20,893.80	\$12,884.51	\$7,661.06	\$12,536.28	\$22,286.72	\$19,152.65	\$193,267.65
Enhanced Housing Transition Service Utilization	0	60	37	22	36	64	55	555
Housing and Tenancy Stabilization Services	\$422.16	\$356,725.20	\$389,231.52	\$406,117.92	\$426,803.76	\$439,046.40	\$442,423.68	\$4,119,437.28
Housing and Tenancy Stabilization Utilization	0	857	933	979	1030	1061	1072	9,758

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

Service utilization changed for the first half of 2018. This was the result of removing FFS1 and FFS2 to ensure there was no duplicate invoicing with the Medi-Cal Organized Delivery System Waiver affecting SUD services.

HSH adult Coordinated Expansion Services began in August, 2018. Resource Center services began in November, 2018.

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IV. NARRATIVE – Administrative Infrastructure

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

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

The WPC administrative team was fully staffed by mid-2018, enabling more comprehensive support of WPC services and projects.

In October 2018, the WPC team attended the DHCS WPC in-person meeting in Riverside, CA. San Francisco's team shared learnings and insights from a "Benefits Navigator Pilot," which initiated benefits enrollment and advocacy in shelters, a Medi-Cal Enrollment service design deep-dive with Fjord Consulting, and a discussion on the overlap of Health Homes and Whole Person Care.

Members of the Whole Person Care team attended a Harm Reduction Coalition in **October, 2018**. This multidisciplinary conference focused on improving health related outcomes for individuals using drugs and alcohol and provided an overview of best practices from around the country. The learnings were directly helpful in informing HSH strategies and pilot program development.

HSH held a city-wide provider training on December 7, 2018 that was attended by over 95 participants from 57 organizations. The training focus was on how people will access the homeless resource system, primary of which is the WPC-funded coordinated entry process, utilizing the first iteration of a universal assessment tool. A link to the presentation can be located: <http://hsh.sfgov.org/research-reports/2018-provider-conference/>

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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.

Choosing and implementing a major technology platform is a long and arduous process in city government, which is why they are rarely removed. And even when replaced, the path of least resistance is using the same vendor. SF WPC desired a broad marketplace search to find the best commercially available product. To manage this kind of RFP, the scope of the solution had to be contained; the assumption being that once the base requirements were established, it will be possible to add agencies as their data becomes available. Knowing the Current State and Future Vision, allows us to build incremental solutions even before the platform is available. We are using program funds to set the foundation with key pieces like Data Warehouse and Enterprise Unique ID.

As we continue to rely on CCMS, funds are spent to shore up its foundation and maintain its longevity. Internal resources are limited with personnel using their expertise to build features and functionality. Therefore, we chose to outsource regular upkeep for security compliance on the hardware.

The WPC team partnered with case conferences and programs across agencies to develop an action plan for providers accessing the CCMS WPC Summary page. As CCMS was increasing its user base, account clean-up was accomplished to maintain the security and protection of confidential client information. Finally, CCMS trainings were provided to 81 total staff members spanning nine different programs.

Two staff members funded through the delivery infrastructure moved on from SF WPC in the second half of 2018, thus leaving their positions vacant. One of these positions was modified into a contract-funded service design fellow, who started in October 2018 (see details below), and the other was transferred into a Integrated Data Analyst (1824), which will be hired in early 2019. The latter position is a permanent civil servant who will continue to support the work of WPC beyond 2020.

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Whole Person Care began a partnership with FUSE Corps to host an executive-level fellow for one year starting October 1, 2018. The fellow has helped to identify strategic, technological, and service delivery improvements that can help advance the vision of Whole Person Care: a comprehensive, seamless and human-centric system of care in which the most vulnerable individuals receive the services they need, with the ultimate goal of making homelessness rare, brief and one-time.

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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.

Navigation Centers

San Francisco anticipated opening four Navigation Centers in 2018, and ultimately opened three during the course of the year, though has expectations of opening four additional Navigation Centers in 2019. San Francisco earned \$1,000,000.00.

The Bayshore Navigation Center (opened September 2018) was developed from an empty industrial warehouse and a two-story office building at 125 Bayshore Blvd in Bayview-Hunters Point. It consists of 128 beds, community/dining space, restrooms/showers, client laundry, storage for guests' belongings, outdoor space and office space for staff, case management, and medical and benefits services.

The Bryant Navigation Center (opened October 2018 at 680 Bryant Street) consists of a complex of modular trailer buildings that serve as dormitories, restrooms, showers, laundry, community room and offices to serve approximately 84 clients experiencing homelessness with similar services as those provided at SF's existing Navigation Centers.

Resource Center

HSH had identified plans to open a resource center in 2018 but after receiving feedback from the community opted to modify the approach laid out in the original proposal. The community requested that the resource center provide greater accessibility for people experiencing homelessness by expanding services to more than one location, resulting in a commitment to establish multiple smaller sites as opposed to one center in 2019. Adults being served will receive the same scope of services originally outlined, but extended to four additional Access Points, facilitated through the mobile Access Point team. Additionally, HSH is planning to open up a 24/7 Resource Center in 2019 to serve Transitional Aged Youth.

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Homeless Health Resource Center

The Homeless Health Resource Center opening has been delayed until 2019. DPH spent 2018 carefully strategizing the integration of three historically independently functioning programs: Street Medicine, Shelter Health, and the Tom Waddell Urgent Care Center. This integration process requires capacity building across the department, which in and of itself takes time, but was further delayed due to leadership changes in 2018. The culmination of weaving these three independent entities will be the Homeless Health Resource Center.

Medical and Social Detox to become Drug Medi-Cal Certified

During 2018, Baker Places and HR360 worked toward readiness for Drug Medi-Cal certification and assembling staff to handle billing. The licensing process was completed by both organizations but billing details have not yet been implemented.

Capacity Building PDSA

As part of the evaluation and PDSA processes, SF WPC identified several capacity building projects that support the whole person goal to make compelling contributions to improving the system of care for homeless clients:

1. Health Fairs (11X\$50,000): San Francisco conducted 11 pop-up health fairs throughout the City in 2018. Multiple agencies (including SFHSH, SFDPH Population Health, HealthRight 360, Glide, LINCS, UCSF, DPH Street Medicine, San Francisco Aids Foundation and LavaMae) partnered together to provide street-based access to health services for individuals experiencing homelessness. Services were aimed at being non-intrusive, welcoming, and friendly in a harm reduction fashion.
2. Interagency Summit and Workgroups (\$40,000): In 2018, DPH and HSH planned, conducted, and synthesized learnings from a one-day interagency summit designed to better understand barriers and opportunities for communication and collaboration. Stakeholders and subject matter experts discussed agency missions, goals, challenges and possible solutions. As a result, the formation of 4 distinct working groups to address prioritized focus areas and projects has been recommended. These focus areas include: Shared Client Communication, Linkages and Client Navigation, Staff Resource Development, and Prioritization Criteria.
3. Homeless Systems of Care Improvements (2X\$100,000):
 - a. HSH took the learnings from ERT and modified policies and protocols to include outreach to individuals living in vehicles. The resulting vehicular Encampment Resolution Team (V-ERT) provides a safe transitional location for high need individuals who are being navigated to other arrangements. A needs assessment for individuals living in vehicles resulted in the planning of a 2019 launch of a “vehicular engagement center.”

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- b. HSH leadership who support the Homeless Outreach Team took learnings and best practices from the Harm Reduction Coalition conference and the National Alliance to End Homelessness (NAEH) conference regarding ways to reduce vicarious trauma among street outreach workers and 1) instituted additional staff supervision and management support and 2) modified trainings (e.g., annual privacy training) to meet the specific needs of street outreach workers.

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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.

SFWPC reports on ten Pay-for-Outcome metrics annually. For reference, a SFWPC enrollee is a single adult experiencing homelessness who is on Medi-Cal with SF County of Responsibility.

SFWPC appreciates the change allowing metrics to be compared to the previous year instead of to the baseline. SF experienced a problem measuring performance relative to the 2016 baseline year. Specifically, from the 18-month (Jan 2017-June 2018) baseline cohort, only 75% had data in the 2016 baseline year. That sample was not representative of the ongoing cohort. Baseline cohort was healthier in the year prior to enrollment than they were at time of enrollment during PY2 and PY3.

#11 Met: Reduction of ED utilization in PY3 was achieved relative to PY2 using DHCS. ED utilization procedure is number of visits by the target population to medical and psychiatric ED units, one per day, not followed by an inpatient transfer, occurring during M/C enrollment divided by member months. PY2 was 460 per 1000 member months, and PY3 dropped to 352 per 1000 exceeding a 5% threshold. Compared to SF's data, the trend was similar as PY2 359 ED utilization dropped to 274 in PY3.

#12 Met: Reduction of Hospital Inpatient discharges for PY3 was met relative to previous year using DHCS data. The metric procedure is number of medical and psychiatric unit discharges during months of M/C enrollment divided by member months. PY2 was 55 per 1000 member months, and PY3 is 45. Compared to SF's data, the trend was similar as PY2 55 inpatient utilization dropped to 47 in PY3.

#13 Met: Improvement in Follow-up after psychiatric hospitalization for PY3 was met compared to PY2 using DHCS data. At 7 days post hospitalization, the enrollment based on DHCS data of outpatient treatment was 4% in PY2, and 12% in PY3. At 30 days, the corresponding results were 11%, and 28%. Improvement exceeded the 5% threshold. However, compared to SF's data, the improvement over previous year was a negative 6.15% (7days) and negative 2.67% (30 days).

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#14B Not Met: Improvement in initiation and engagement in treatment after initial SUD diagnosis was NOT met compared to PY2. Using SF's data, new episodes in SUD treatment programs those who had next episode within 14 days following first diagnosis were 41% in PY2, and 37% in PY3. For those who were engaged with 3 or more services within 30 days, the corresponding results were 38%, and 33%. Neither measure increased initiation or engagement by 5%.

#10 Not Met: Reduction in All Cause hospital readmissions for PY3 was not reduced compared to PY2 using DHCS data. Metric looks at enrollees with 3 months of Medi-Cal enrollment prior to hospital discharge and 1 month post, and it measures number of readmissions to medical and psychiatric hospital within 30 days of previous discharge. Results are .25% readmit rate in PY2, and .55% PY3, i.e., no reduction. However, compared to SF's data, rates trended differently as PY2 32% readmission rate decreased to 30% in PY3.

#16 Not Met: Increase in obtaining TB clearance for PY3 was not increased compared to PY2. It's measured as number of enrollees with known TB clearance compared to all enrollees. Results are 38% in PY2, and 26% in PY3.

#16 Not Met: Reduction in number of days to leave encampment was not met in PY3. It's measured as days between first outreach contact in street encampment and transfer to shelter (days not percentages). Results were 8.4 days in PY2 (the baseline year) and 18.6 days in PY3.

#16 Met: Increase in number of enrollees assessed by Common Assessment for the Homeless tool was met in PY3 compared to PY2 (the baseline year). Results were 0% enrollees in PY2 and 23% in PY3.

#8 Met: Increase in persons receiving Housing Services to obtain housing was met in PY3 compared to PY2 (the baseline year). Results were 1% in PY2 and 4% in PY3.

#9 Met: Increase in Supportive Housing (placements) was met in PY3 compared to PY2 (the baseline year). Results were 4% in PY2 and 6% in PY3.

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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.

CORE PLANNING COMMITTEE

A small team of critical leadership from DPH, HSH, HSA met monthly throughout 2018 to discuss guidance on planning and implementation processes that will contribute to accomplishing SF WPC goals.

SF WPC STAKEHOLDERS

The Whole Person Care team conducts monthly stakeholder meetings to share progress in moving toward interagency care coordination and interagency data sharing to better serve shared clients. The meetings provide an opportunity for stakeholders to stay updated on WPC projects, engage subject matter experts from their organizations, ensure alignment of Whole Person Care initiatives, and support the a citywide commitment to working differently to improve the system of care for people experiencing homelessness.

SERVICE DESIGN & EVALUATION TEAM DISCOVERY

In PY3 and PY4, the WPC Service Design, IT and Evaluation teams engaged over 200 stakeholders to develop system and care recommendations for high users of multiple systems (HUMS). Urgent/ Emergent providers from across DPH and HSH participated in workshops to identify and prioritize opportunities for improvements in care coordination for vulnerable clients.

SOCIAL DETERMINANTS OF HEALTH COMMITTEE

The purpose of the Social Determinants of Health Committee is to work with the DPH Epic Data Governance Committee to build standardized SDoH data infrastructure for DPH, including recommended screening questions, data fields, and workflows. The Committee work will facilitate improvements in Point Of Care (POC) health delivery, panel management and population health reporting/epidemiology, prioritized by actionable implementation (e.g. food insecurity) and informed by literature, best practices and DPH needs.

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DPH/HSH RETREAT

In PY3 20+ DPH and HSH administrators and service providers participated in the interagency retreat to better understand how each department's services work together to serve shared clients and to identify opportunities for future improvement.

WAIVER IMPLEMENTATION GROUP

DPH leadership who oversee implementation of the 1115 Medicaid Waivers in San Francisco convene monthly to discuss progress and troubleshoot implementation barriers. The focus of this group in 2018 was getting and keeping people on Medi-Cal as well as sustainability for WPC (beyond 2020).

HIGH USERS OF MULTIPLE SYSTEMS MEETING

Urgent/Emergent care providers from across agencies attend the HUMS meeting on the 3rd Thursday of every month. Goals include:

- Improving the health of individuals who are in top 1% or in top 2-5% high frequency users and at high risk.
- Improving the ability of our system of care to provide care for these patients.

The group meets to bring forward HUMS cases in need of collaborative problem solving and planning.

UNIFIED COMMAND

DPH leadership meets weekly to assist in HSOC (Healthy Streets Operation Center) objectives by providing outreach and linkage to care for individuals in targeted locations. This includes supporting the efforts to house individuals who are currently homeless and living on the streets.

HIGH PRIORITY CASE REVIEW

DPH convenes an interdisciplinary group of service leaders bi-weekly, to develop and monitor "action plans" for prioritized individuals, disconnected from the system of care. The group focuses on a subset of clients that have been identified as priority by multiple agencies and works to connect them to appropriate services.

THE COORDINATED ENTRY AND ONLINE NAVIGATION and ENTRY (ONE) SYSTEM COMMITTEE

This committee meets monthly (July 9, September 10, October 15, November 6, December 4, 2018). Meetings are attended by: HSH, Local Homeless Coordinating Board members, providers, consumers, and community members. Detailed information about past and future meetings can be located at: <http://hsh.sfgov.org/lhcb/lhcb-cesone-system-committee/>

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IX. PROGRAM ACTIVITIES

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

1. In PY3, three High Priority Clinical Review pilot projects were established: Top 100 High Users of Multiple Systems, Healthy Streets Operation Center, and EMS-6 frequent callers to 911 for avoidable reasons. Each pilot includes city-wide participation; each is developing protocols for how to govern care around the city; and each has developed a care plan template with alerts to be shown in the WPC Patient Summary of CCMS.
2. The WPC Patient Summary demonstrated the value of integrated data as part of care coordination. The number of monthly active users increased from an average of 300 during 2017 to an average of 550 monthly users by the end of 2018. The integrated data includes health utilization and social determinants of health. This success concluded the PDSA “measuring adoption rate of care coordination technology.”
3. Implementation of Problem-Solving services began at the newly opened resource center. It assists adults experiencing homelessness to work on their own behalf to find creative solutions to factors related to homelessness. Housing opportunities within the SF city limits continue to be limited.

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

1. While the pilot projects for city-wide care coordination teams have been successful for several individuals, the challenge to scale up to a larger population remains. Plans have been submitted to establish specialized PMPM care teams during PY4 and a resource hub for medical and social interventions by 2021.
2. Although there are now 550 monthly active users of the WPC Patient Summary, most users access the platform via a single sign-on procedure in their native electronic record system. Those accessing via double sign-on with an internet connection are much smaller in number.
3. San Francisco continues to be challenged by the fact that at the end of a client’s journey, the city lacks sufficient housing resources. Lack of affordable housing makes the Problem Solving and Homeward Bound initiatives extremely important.

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

1. In PY3, SFWPC continued to build infrastructure to support data sharing. Privacy and Data Sharing workgroups met with City and agency attorneys to sign MOUs and BAAs establishing what information would be shared, when, and with whom.
2. A WebConnect platform for authorizing individuals working off-site from DPH clinics became available to access data via the internet instead of via a VPN.
3. A prototype of an enterprise-wide master patient identifier was developed. It will be tested and refined during PY4 (2019) before roll-out to city-wide departments.
4. The external consultant completed its discovery and recommendations report for an Interagency Care Management Solution. It provides the basis for the RFP to replace the current local data sharing solution (CCMS). The CCMS integrated data Patient Summary has been crucial for WPC success to date, and is now fully recognized as the vision for future data sharing platforms.

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

1. Getting approval from multiple attorneys on issues as important as privacy and data sharing is a slow process. MOUs with the county Medi-Cal providers (SF Health Plan and Anthem Blue Cross) have been delayed as has sharing regarding the Health Homes waiver.
2. The potential partnership with RideAlong, a technology start-up company creating a mobile street application, failed to be granted a contract and is no longer a business option.

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

1. In PY3, SF standardized the procedures for incoming data used in Enrollment & Utilization and Metric reports. This involved creating new electronic templates for data input for some programs to reduce the amount of error in data entry and improve speed.
2. Internal reports were standardized to be more accessible and timely, and dashboards were refined to be more informative.
3. Quality Assurance procedures were developed to prevent errors especially any potential for double billing services.

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

1. Electronic health records are being transferred to EPIC throughout medical clinics of the SF Dept of Public Health beginning Aug 2019. Planning how the conversion will affect WPC data fields began in PY3 (2018).
2. Electronic housing records have been federally mandated to be in the ONE System at the Dept of Homelessness and Supportive Housing. Planning data collection from ONE system began in 2018.

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

We continue to face the following barriers to long-term programmatic success:

1. SF city structure has different health, social services, and housing departments with specialized contractors and differing state and federal mandates. Whole Person Care requires city departments that have historically operated in silos to initiate and authorize a collaborative infrastructure. Developing a legally robust infrastructure takes time and many levels of approval.
2. An RFP seeking a Whole Person Care interagency IT solution will be released in PY4 (2019) through the DPH. However, the most appropriate long-term "owner" of the new system has not been finalized (DPH versus citywide IT).

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3. This last challenge is vitally important to WPC staff, i.e., data sharing infrastructure and care coordination tools are only valuable if they lead to improvement in client level services. The process of identifying how technology will complete the final linkage to improve care begins in PY4.

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X. PLAN-DO-STUDY-ACT

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

List PDSA attachments

PDSA Summary Report:

San Francisco has documented seven PDSAs. Reports for each PDSA in 2018Q3 and 2018Q4 are attached. The status of each is as follows.

The following PDSAs are in the 'Planning' phase:

1. **Care Coordination:** Administrative: Care coordination, case management, and referral infrastructure.
2. **Inpatient Utilization:** Health Outcomes: Inpatient Utilization-General Hospital/Acute Care

The following PDSAs are in or entering the 'Do' phase:

1. **Data:** Administrative: Data and information sharing infrastructure.

The following PDSAs are in 'Act' phase and/or moving to 'Study' phase

1. **Comprehensive Care Plan:** Administrative: Proportion of participating beneficiaries with a comprehensive care plan, accessible by the entire care team, within 30 days.
2. **Ambulatory Care:** Health Outcomes: Ambulatory Care – Emergency Department Visits. In Act/Study phase.
3. **Data Entry:** Other: Paper to electronic data entry.

The following PDSAs have concluded, but will continue to be monitored.

1. **Adoption Rate:** Other: Measuring the adoption rate of electronic data sharing information
2. **Increase Medi-Cal insurance enrollment:** Other