



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



San Francisco  
 PY4 2019 Annual Narrative Report  
 Revised 7/17/2020

**REPORTING CHECKLIST**

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

<b>Component</b>	<b>Attachments</b>
<b>1. Narrative Report</b> <b>Submit to:</b> Whole Person Care Mailbox	<ul style="list-style-type: none"> <li>Completed Narrative report</li> <li>List of participant entity and/or stakeholder meetings (<i>if not written in section VIII of the narrative report template</i>)</li> </ul>
<b>2. Invoice</b> <b>Submit to:</b> Whole Person Care Mailbox	<ul style="list-style-type: none"> <li>Customized invoice</li> </ul>
<b>3. Variant and Universal Metrics Report</b> <b>Submit to:</b> SFTP Portal	<ul style="list-style-type: none"> <li>Completed Variant and Universal metrics report</li> </ul>
<b>4. Administrative Metrics Reporting</b> <b>(This section is for those administrative metrics not reported in #3 above - the Variant and Universal Metrics Report.)</b>  <b>Note: If a Policy and Procedures document has been previously submitted and accepted, you do not need to resubmit unless it has been modified.</b>  <b>Submit to:</b> Whole Person Care Mailbox	<ul style="list-style-type: none"> <li>Care coordination, case management, and referral policies and procedures, which may include <i>protocols and workflows.</i>)</li> <li>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.</li> </ul>
<b>5. PDSA Report</b> <b>Submit to:</b> Whole Person Care Mailbox	<ul style="list-style-type: none"> <li>Completed WPC PDSA report</li> <li>Completed PDSA Summary Report</li> </ul>
<b>6. Certification of Lead Entity Deliverables</b> <b>Submit with associated documents to:</b> Whole Person Care Mailbox and SFTP Portal	<ul style="list-style-type: none"> <li>Certification form</li> </ul>

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

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## I. REPORTING INSTRUCTIONS

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

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

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

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

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## II. PROGRAM STATUS OVERVIEW

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*Instructions: 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.*

Please limit responses to 500 words. If additional information is needed, please contact your assigned Analyst.

At year's end PY4, SFWPC had maintained focus on three main areas: city-wide care coordination, city-wide data sharing infrastructure, and specialized clinical initiatives to blend care coordination, data-sharing, and health outcome ideas.

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

The SF WPC stakeholders remain. SF has continued partnerships with five city departments -- health (DPH), social services (HSA), homelessness and supported housing (HSH), fire (SFFD), police (SFPD), and mayor's office. Additionally, there are two county Medi-Cal health plans (SF Health Plan and Anthem Blue Cross), and several contracted non-profits.

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- Stakeholders plan to meet monthly to share updates and lessons. Three monthly meetings had to be delayed and rescheduled due to schedule conflicts.
  - Interagency workshops met to agree on a citywide prioritization process for housing and treatment services. Coordinated Entry (CE) assessment is being implemented to reach more individuals throughout HSH programs.
  - Other interagency data sharing, privacy, and security workgroups meet regularly to pursue unified policies and procedures that meet city-wide standards. The City Attorney's Office is included in these activities.
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### 2. Increasing coordination and appropriate access to care

Interagency care coordination is increased by the CE housing prioritization tool. It uses social determinants and health scores to stratify access to limited permanent supportive housing. City-wide high user pilot projects have begun with a focus on transitional care while waiting for housing placement.

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Access to care continues to be facilitated by targeted clinical projects described previously.

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- Additions to benefits eligibility workers aim to increase enrollment in county general assistance, CalFresh, and Medi-Cal.
  - Shelter Health works to establish a health record for everyone not connected to health care and provide basic primary care and care referrals.
  - Street Medicine also enrolls and provides basic care and coordination for homeless individuals met during outreach.
  - Buprenorphine treatment and methadone referrals are made to opiate addicts engaged on the street.
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### 3. Reducing inappropriate emergency and inpatient utilization

Regarding avoidable ED utilization,

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- PDSA #1 (EMS6 and Base Hospital Medical Doctor) continues to add more patients and improve data collection. Preliminary results were positive and led to expansion of the concept to blend with the City's High Intensity Care Team. Conceptualizing the variables to be tracked and measured became one of WPC's high priority innovations.
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Regarding inpatient utilization, PDSA #2 is monitoring All Cause Hospital Readmissions. Although the rate for WPC enrollees (homeless adults on SF Medi-Cal) is higher than the rate for non-homeless hospital patients, the overall hospital readmit rate is decreasing. How to explain this improvement is not evident and competing priorities have made this discussion item less imperative.

### 4. Improving data collecting and sharing

Data collection steadily improves from sources previously described: HSH and electronic ONE System, Street Medicine/Shelter Health, Hummingbird Psychiatric Respite.

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- DPH primary care data moved into Epic as planned beginning in Aug 2019.
  - As a result of the move, systems that previously had been disparate moved into Epic, however only partially at the onset, requiring the remapping of pathways and workflows. Specifically, with PES, so existing workflow came to an end and was not adequately replaced, so data entry came to a halt, which was not well communicated, creating some challenges with invoicing.
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Data sharing continued its activities.

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- Interagency MOU development is ongoing, as is data governance policy development.
- The City Attorney with whom WPC had a positive working relationship and was integral to moving forward citywide data sharing agreements resigned from her position, setting us back in time.
- Multiple agencies came together to make recommendations to CCSF for a Central Data Integrity Officer, but there was no further momentum by CCSF to create a position, without which there is increased difficulty sharing data across siloed agencies.
- The WPC Patient Summary with integrated health and social determinants by individual clients continues to expand. Training and user guides are available.

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## 5. Achieving quality and administrative improvement benchmarks

The benchmark for reporting deliverables is 100% accuracy and transparency. Quality improvement reports help the process.

- Service data checks to prevent missing or double counting have become more automated and less time-consuming for staff.

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## 6. Increasing access to housing and supportive services

The process of moving from experiencing homelessness into housing continue successfully as designed earlier.

- Coordinated Entry (CE) process begins with a Primary Assessment, a self-reported interview. HSH has now assessed 7,000+ individuals through CE. The score standardizes eligibility for receiving limited HSH housing resources. CE access points have also been launched for transitional aged youth (TAY).
- Post assessment, "Priority Status" qualifies an individual for case management to locate housing.
- Problem Solving attempts to identify solutions to the individual's episode of homelessness without entering the homeless response system.
- Everyone moving into permanent supportive housing (PSH) is offered supportive services at a level matched to their needs.
- The perennial challenge remains that San Francisco does not have enough housing stock.

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## 7. Improving health outcomes

SF WPC uses metrics, PDSAs, and specialized clinical interventions to learn more about improving health outcomes.

- The greatest impact on health outcomes is expected to evolve from pilot projects for homeless high users of emergency services. The city-wide high

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intensity care teams that may merge are Healthy Streets Operations Center (HSOC), Top 100 High Users of Multiple Systems (HUMS), High priority Coordinated Entry (CE) list, and EMS-6 of the SF Fire Department.

- The buprenorphine project expansion and its website reduce disease transmission and provide long-term solutions to keep opiate addicts out of the ED.
  - Additionally, WPC Medical Director Barry Zevin conducts death reviews to understand the causes of homeless deaths and plan for death prevention initiatives.
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### III. ENROLLMENT AND UTILIZATION DATA

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*Instructions: 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
<b>Unduplicated Enrollees</b>	515	370	319	405	411	356	2,376

Item	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12	Annual Unduplicated Total
<b>Unduplicated Enrollees</b>	382	566	449	362	321	273	4,729

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*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.*

<b>Costs and Aggregate Utilization for Quarters 1 and 2</b>							
<b>FFS</b>	Month 1	Month 2	Month 3	Month 4	Month 5	Month 6	Total
<b>Dual Dx Residential</b>	0	0	0	0	0	0	0
<b>Dual Dx Utilization</b>	0	0	0	0	0	0	0
<b>SUD Residential</b>	0	0	0	0	0	0	0
<b>SUD Residential Utilization</b>	0	0	0	0	0	0	0
<b>Medical and Psych Respite Residential</b>	\$ 275,343.46	\$274,940.32	\$ 325,332.60	\$ 315,791.67	\$ 330,976.54	\$ 278,165.42	\$1,800,550.01
<b>Medical and Psych Respite Utilization</b>	2,049	2,046	2,421	2,350	2,463	2,070	13,399
<b>Resource Center Services</b>	\$ 32,256.45	\$ 28,255.65	\$ 32,089.75	\$ 41,091.55	\$ 38,841.10	\$ 40,258.05	\$ 212,792.55
<b>Resource Center Services Utilization</b>	387	339	385	493	466	483	2,553



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<b>Coordinated Entry Expansion</b>	\$ 64,606.08	\$ 59,498.88	\$ 66,648.96	\$ 107,506.56	\$ 115,678.08	\$ 126,913.92	\$ 540,852.48
<b>Coordinated Entry Expansion Utilization</b>	253	233	261	421	453	497	2,118
<b>Encampment</b>	\$ 5,503.68	\$ 3,704.40	\$ 2,857.68	\$ 4,180.68	\$ 4,762.80	\$ 2,540.16	\$ 23,549.40
<b>Encampment Utilization</b>	104	70	54	79	90	48	445
<b>Engagement</b>	\$ 548,091.18	\$ 505,666.98	\$ 560,114.10	\$ 539,491.68	\$ 551,137.86	\$ 519,180.48	\$ 3,223,682.28
<b>Engagement Utilization</b>	33,461	30,871	34,195	32,936	33,647	31,696	196,806

### Costs and Aggregate Utilization for Quarters 3 and 4

<b>FFS</b>	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12	Annual Total
<b>Dual Dx Residential</b>							
<b>Dual Dx Utilization</b>							
<b>SUD Residential</b>							
<b>SUD Residential Utilization</b>							
<b>Medical and Psych</b>	\$301,816.20	\$274,940.32	\$307,325.76	\$306,788.24	\$334,470.41	\$320,629.32	<b>\$3,646,520.27</b>

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<b>Respite Residential</b>							
<b>Medical and Psych Respite Utilization</b>	2,246	2,046	2,287	2,283	2,489	2,386	<b>27,136</b>
<b>Resource Center Services</b>	\$51,593.65	\$50,093.35	\$ 50,176.70	\$39,591.25	\$37,257.45	\$32,923.25	<b>\$474,428.20</b>
<b>Resource Center Services Utilization</b>	619	601	602	475	447	395	<b>5,692</b>
<b>Coordinated Entry Expansion</b>	\$155,769.60	\$131,765.76	\$137,383.68	\$101,122.56	\$ 76,097.28	\$73,288.32	<b>\$1,216,279.68</b>
<b>Coordinated Entry Expansion Utilization</b>	610	516	538	396	298	287	<b>4,763</b>
<b>Encampment</b>	\$ 3,122.28	\$1,323.00	\$ 3,598.56	\$ 2,804.76	\$ 1,375.92	\$ 2,010.96	<b>\$ 37,784.88</b>
<b>Encampment Utilization</b>	59	25	68	53	26	38	<b>714</b>
<b>Engagement</b>	\$534,708.72	\$534,299.22	\$523,914.30	\$544,749.66	\$517,837.32	\$529,434.36	<b>\$6,408,625.86</b>
<b>Engagement Utilization</b>	32,644	32,619	31,985	33,257	31,614	32,322	<b>391,247</b>

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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*

Amount Claimed								
PMPM	Rate	Month 1	Month 2	Month 3	Month 4	Month 5	Month 6	Total
<b>PMPM 2 Enhanced Care Coordinatio n</b>	\$314.94	\$ 288,798.36	\$346,747.0 0	\$317,142.8 0	\$277,775.5 2	\$245,021.9 5	\$249,746.0 2	\$1,725,231. 66
<b>PMPM 2 Enhanced Care Coordinatio n Utilization</b>		917	1,101	1,007	882	778	793	5,478
<b>PMPM 3Enhanced Housing Transition Services</b>	\$348.23	\$ 18,107.96	\$35,867.69	\$68,949.54	\$ 76,610.60	\$ 61,288.48	\$ 79,048.21	\$ 339,872.48
<b>PMPM 3Enhanced Housing Transition Svc Utilz</b>		52	103	198	220	176	227	976
<b>PMPM 4 Housing and Tenancy</b>	\$422.16	\$497,726.6 4	\$511,235.7 6	\$527,277.8 4	\$540,364.8 0	\$561,472.8 0	\$584,691.6 0	\$3,222,769. 44

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<b>Stabilization Services</b>								
<b>PMPM 4 Housing and Tenancy Stabilization Utilization</b>		1,179	1,211	1,249	1,280	1,330	1,385	7,634
<b>PMPM5 High Intensity HUMS Care Team</b>	\$1,060.04	\$50,882.01	\$51,942.05	\$26,501.05	\$38,161.51	\$40,281.59	\$38,161.51	\$245,929.71
<b>PMPM5 High Intensity HUMS Care Team</b>		48	49	25	36	38	36	232

<b>Amount Claimed</b>								
<b>PMPM</b>	Rate	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12	Total
PMPM 2 Enhanced Care Coordination	\$314.94	\$291,002.93	\$220,141.83	\$192,427.26	\$238,093.31	\$206,599.48	\$217,622.32	\$3,091,118.79
Enhanced Care Coordination Utilization		924	699	611	756	656	691	9,815

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PMPM3Enhanced Housing Transition Services	\$348.23	\$96,111.48	\$127,103.95	\$115,960.59	\$158,096.42	\$144,863.68	\$137,550.85	\$1,119,559.45
PMPM3 Enhanced Housing Transition Svcs Utilz		276	365	333	454	416	395	3,215
PMPM4 Housing and Tenancy Stabilization Services	\$422.16	\$605,799.60	\$618,042.24	\$628,174.08	\$648,859.92	\$661,524.72	\$679,677.60	\$7,064,847.60
PMPM4 Housing and Tenancy Stabilization Utilization		1,435	1,464	1,488	1,537	1,567	1,610	16,735
PMPM5 High Intensity HUMS Care Team	\$1,060.04	\$30,741.21	\$28,621.13	\$16,960.67	\$230,029.08	\$248,049.79	\$227,909.00	\$1,028,240.59
PMPM5 High Intensity HUMS Care Team		29	27	16	217	234	215	970

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

The Jul-Dec totals were adjusted in the invoice to account for updates to the Jan-Jun data.  
FFS1 and FFS2 were discontinued in 2018 and \$ merged into other services.

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## IV. NARRATIVE – Administrative Infrastructure

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*Instructions: 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. Please limit your responses to 500 words.*

### **WPC Staff**

In Q3 and Q4, no updates or changes to WPC staff, aside from the fellow completing her fellowship in September.

### **Evaluation**

The WPC Evaluation team continued to support data and analytics initiatives in 2019, including improvements to data categorizations in CCMS. The team developed an evaluation framework for the Shared Priority project, and generated bi-weekly dashboards of key outcome metrics for stakeholders. In November 2019, they published a peer-reviewed article in Health Affairs titled “Frequent Emergency Department Users: Focusing Solely on Medical Utilization Misses the Whole Person.”

### **Training**

In partnership with DPH and community based partners, HSH is creating a San Francisco specific on-line training about best practices to work with people experiencing homelessness. In 2019, an in-person version of this training was provided to both DPH and HSH staff and work is underway to create an interactive on-line version of the training (e.g. creating storyboard and sourcing videos). In 2019, HSH contracted with the Harm Reduction Coalition to provide two trainings on de-escalation for the homeless response system (HRS) and 3 training on harm reduction. All were well received by participants. The training funds are being mostly implemented in PY5 as part of codifying the work and processes that were created through WPC. Many aspects of the Homeless Response System (Coordinated Entry and Problem Solving) have only been launched in the past 18 months. Aspects of launching other training initiatives were slowed down by both the city’s procurement process and lack of capacity of HRS providers to take the lead on implementing training initiatives. HSH is finalizing an RFQ to identify providers who can both quickly project manage aspects of the training landscape and turn existing content into web-based modules.

To also support of these initiatives in 2019, SF HSH secured the services of a part-time consultant to help implement the training landscape. Aiesha Davies Consulting helped schedule trainings and organized the Training workshop at the HSH Provider conference, in which providers had the opportunity to prioritize training topics for implementation in 2020.

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HSH vetted two on-line training platforms but determined that neither provided a sustainable way to effectively train the homeless response system workforce, which is planned to be reassessed and accomplished in 2020.

Consulting firm, HTA, provided project management support to develop and manage several training initiatives designed to improve the capacity of social service and health care providers in San Francisco to meet the needs of clients who are homeless, transitional age youth (TAY) and/or are experiencing behavioral health challenges. HSH is developing and coordinating the delivery of training (Behavioral Health 101) for homeless response providers (e.g. HOT, glide, supported housing program staff).

### **Travel**

Staff traveled to the semi-annual learning collaborative in Sacramento in September.

### **Tablets/Computers**

Tablets and Computers purchased were necessary aspects of the Coordinated Entry Expansion and were used to allow street outreach staff to complete street and field-based coordinated entry assessments and for staff to more efficiently work in field-based setting.



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## IV. NARRATIVE – Delivery Infrastructure

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*Instructions: 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. Please limit your responses to 500 words.*

### **MACCS**

San Francisco spent the first half of 2019 publishing an RFP to develop an enterprise interagency coordinated care system (formerly known as MACCS - multi-agency care coordination system). Simultaneously, DPH was preparing to migrate its EHR vendor from Cerner to Epic, which went live in August 2019. Key champions of the WPC technology solution - including the Chief Technology Officer and the Director of Health - unexpectedly and suddenly left the Department. Ultimately, management predecessors determined that it would be better to invest further in Epic than attempt to set up a novel data system with a different vendor.

This unexpected shift resulted in the redistribution of MACCS dollars to leveraging the capabilities of Epic and expanding SF's existing data sharing infrastructure (CCMS) to be able to better bridge to Epic. For example, Epic immediately allows us to make integrated data more accessible, but the data must be relevant to the new initiatives developed under this pilot. Shared Priority is an example of a project in which two agencies - DPH and HSH – worked together to address a population with common urgency. This project makes use of both systems and allows us to experience the technology modifications as PDSA with real-world outcomes.

In the absence of the enterprise interagency coordinated care system, the HSH ONE system functionality needed to be enhanced to data share with DPH's Epic system. The ONE System enables San Francisco's Homeless Response System to meet all federal reporting requirements with a single client system of record. Additionally, an external consultant was hired to perform a comprehensive Health Check of the project, a Fit-for-Purpose assessment of the system and a Project Roadmap.

### **IT Achievements**

#### **Source System Workflow**

Fifteen years of preparation work is complete except for a few elusive details that were anticipated from beginning. Examples include: obtaining ICD-10 codes for death certificates, re-mapping data elements changed by Epic implementation, adding new data elements recently identified, and automating all data input so staff upload and

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download is no longer needed. The next and final step in process is confirming with the future Epic platform that it is able to receive everything from CCMS test environment. Staff meetings to sign-off on this aspect have begun.

### ***Data Warehouse Interface***

The CCMS data warehouse, while adding additional data sources over the years, has not been systematically inspected and cleaned up, so we had plenty of opportunity to improve the data in preparation for transitioning to a new data warehouse.

The following have been standardized and categorized for integration into our next data platform:

- Medical data from Invision, Epic, California Vital Record Death Registry, and the San Francisco Health Plan
- Behavioral health data from the Avatar Mental Health and Substance Abuse data warehouse, the SF Fire Department, and Psych Respite
- Social data from the Homeless Management Information System, shelter records, Navigation Centers, Medi-Cal Eligibility Determination System, and Jail Management Information Systems

Critical CCMS reports have been identified, and their methodologies defined. Duplicative or unneeded reports have been eliminated. This will aid in transitioning all CCMS reports to the future vendor.

### ***Execute Data Sharing Agreements***

Internal and external data sharing agreements are in place, with the following system partners:

- Medical: Epic (Internal), CA Vital Records Death Registry(Internal), San Francisco Health Plan (External)
- Behavioral: Avatar Mental Health and Substance Use Data Warehouse (Internal), San Francisco Fire Department (External), Psych Respite (Internal)
- Social Determinants of Health: Homeless Management Information System (shelter data, Navigation Centers, Homeless Response Services (External), Medi-Cal Eligibility Data System (External), Jail Management Information System (Internal)

### ***De-duplicate Patients***

Record linking and deduplication occurred successfully throughout 2019 within the CCMS test environment. Auto-merging criteria were created and implemented for each source system feeding into CCMS test environment. Manual merging was done according to logic rules in situations where records were similar but not meeting auto-merge algorithm criteria (e.g., 100% match on first name, last 4 of SSN, and 80% match on last name due to "Jr." being concatenated into last name within record).

### ***Coordinated Care Management Go Live***

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This incentive is complete. All data sources can be viewed by authorized care coordination staff. Ongoing adjustments to the page design in CCMS test environment are expected. The final design that will appear in Epic is determined by Epic parameters.

## ***Coordinated Care Management Usage***

More than 50% of identified case management programs utilized the Whole Person Care Summary within the CCMS test environment within 2019. Specifically, the Whole Person Care Summary was used by staff within the DPH AOT, UCSF CityWide Linkage, UCSF CityWide AOT, EMS6, SFHOT, ECS Coordinated Entry, and SFHP case management programs.

## ***Data Sharing External Access***

External staff at HSH can access SFDPH CareLink, DPH's simplified version of the Epic EHR available to our partners.

While SFFD's SFDPH CareLink accounts have been created, and required trainings completed, access has not yet been achieved due to DPH's internal Epic priorities taking precedence. Access will be completed in 2020.

## ***Data Sharing Internal Access***

Internal DPH staff using SFDPH's Epic or Avatar EHRs are now able to access the CCMS WPC Summary using a link within these systems. Accessing the WPC Summary requires no sign-in and utilizes the user's credentials from the source EHR to validate their access.

## ***Communicate Risk Alerts***

Alerts have been successfully created and displayed within the Whole Person Care Summary (CCMS test environment) and are visible to DPH internal staff accessing Epic and Avatar EHRs via single sign-on. Alerts also viewable within Epic and Avatar directly. Alerts are as follows:

- Shared Priority Alert: identifies client as a Shared Priority client of DPH and our partner agency, HSH, which prioritizes them for housing and health services. Contains contact information for Care Coordinator.
- HUMS Alert: Identifies client as a High User of Multiple Systems, a complex client with complex needs, and directs user to care team members.
- Housing, HSH Priority CAAP: Identifies client as prioritized for HSH housing placement via CAAP criteria. Provides contact information for Housing Placement Navigator.
- Housing, HSH Priority: Identifies client as eligible for HSH housing placement via CAAP criteria. Provides contact information for Housing Placement Navigator.
- Case Management alert, EMS-6, Citywide, LEAD programs: Identifies client as receiving services from program listed, provides contact information.

## ***Communicate Care Plans for High Risk Patients***

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Individualized care plans were developed for the 237 Shared Priority clients. Care plan information is available in 4 unique sources (CCMS, ONE, Avatar, and Epic). EMS prioritized clients have been identified, care plans have been developed, and pathways for obtaining information have been added to CCMS.

### ***Epic Customization***

Most of the programs that transitioned from CCMS data entry into Epic data entry provided documentation for the customization in 2019. Medical Respite is one program that did not, but will in 2020. In order to transition Sobering Center and Street Medicine/Shelter Health to Epic, they had to work with Epic implementers to customize the interfaces to adequately capture their workflow needs.

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## V. NARRATIVE – Incentive Payments

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*Instructions: 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. Please limit your responses to 500 words.*

### **Open Navigation Centers (4 units @ \$500,000 each)**

San Francisco opened or expanded all four budgeted Navigation Centers in 2019:

1. *Civic Center (10/2019)* added 20 beds, which required structural rehabilitation of a previously unused portion of the site that had not been up-to-code. The Civic Center has all private rooms which makes this a valuable resource for individuals who have difficulties in congregate settings. Like all other Navigation Centers, it houses individuals who are in the process of being navigated to supportive housing and allows “partners, possessions and pets.”
2. *Division Circle (8/2019)* added 60 beds by constructing a second “sprung” geodesic dome structure within the footprint of the site. Division Circle is centrally located to many services as well as having robust staff and programming occurring on site including benefits eligibility workers. This expansion greatly increased the ability for individuals to be indoors and remain connected to services while being navigated to supportive housing. Like all other Navigation Centers, it houses individuals who are in the process of being navigated to supportive housing and allows “partners, possessions and pets.”
3. *Upper Yard/Vehicle Triage Center (12/2019)* opened with 30 vehicle parking spaces for overnight parking. Upper Yard is SF’s first “Navigation Center” for individuals currently living in vehicles. It provides a valuable resource for individuals who are being navigated to supportive housing and who have difficulties in congregate settings.
4. *Embarcadero Navigation Center (12/30/19)* opened with 200 beds (despite a lawsuit from neighbors that delayed the site’s opening until the end of 2019). Embarcadero Navigation Center both houses individuals who are being navigated to supportive housing and has some short-term beds which allow street outreach to support people to stabilize indoors while being connected to coordinated entry or other next step services. This site is in a minimally-service-rich area and so provided an important resource to diversify the locations of Navigation Centers. Like all other Navigation Centers, it allows “partners, possessions and pets.”

### **Open Resource Center (1 unit @ \$500,000, 1 unit rolled over)**

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The Transitional Aged Youth (TAY) Resource Center/Access Point opened on April 1, 2019 and is located at 134 Golden Gate Ave in San Francisco. In response to community feedback obtained through the Youth component of the Strategic Framework, this Resource Center targets transitional aged youth and is currently open Monday-Friday from 10am-2pm. The Resource Center provides engagement, problem solving, referral to resources, showers, hygiene supplies, connections to employment, benefits, and health care services and Coordinated Entry services, and is staffed by Larkin Street Youth Services. The Resource Center will continue post December 2020 through a combination of other funding sources. SF WPC earns \$500,000 for opening the TAY Resource Center.

### **Future Capacity Building Incentives based on PDSA**

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

1. *Health Fairs* (6 X \$50,000)

Responsive, street-based services that meet the needs of individuals experiencing homelessness where they are, the monthly health fairs have been an effective means of increasing access to medical care for individuals experiencing homelessness. Facilitated by a collaborative of partners across City departments and CBOs, Health Fairs focus on overlapping vulnerabilities of San Franciscans at risk for both HIV and hepatitis C.

- July 16 @ Napoleon between Evans and 280 in the Bayview
- August 20 @ Pier 27 in D3
- September 17 in collaboration with Glide Harm Reduction Services and San Francisco AIDS Foundation Syringe Access Services @ McKinnon, Barneveld and Loomis in the Bayview
- October 15 partnering with Lava Mae's PCV @ the library in Civic Center
- November 19 in collaboration with Glide Harm Reduction Services and San Francisco AIDS Foundation Syringe Access Services @ Jerold and Rankin
- December 17 @ 14th & Trainor

2. *Interagency Workgroup Read-out* (paid \$40,000 @ midyear)

3. *Homeless Systems of Care Improvement*

a. *Continuation and evaluation of ERT expansion* (1 unit @ \$100,000)

HSH successfully launched its first Vehicular Triage Center with spaces for 30 vehicles, amenities (toilets/showers) and 24/7 staffing in 2019. HSH is in the process of completing the final report of the (HUD unsheltered Technical Assistance) analysis of the ERT program model and completed the implementation and planning for the Vehicular Encampment Resolution Team;

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both of which were critical for the successful launch of the 2019 V-ERT program.

b. *Training* (1 unit @\$100,000)

Homeless Outreach Team leadership 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. HSH scaled up staff supervision and management support and trainings (e.g., annual privacy training) were modified to support the needs of street outreach workers.

### High Intensity HUMS Care Team Start-up Incentive (\$80,000)

1. *Case conferences*

Case conferences occur every week on Thursdays to produce pre-hospital action plans for people on the Shared Priority List, which EMS-6 coordinates by including all members of the patients care team within and outside of DPH. These are highly structured meetings that summarize challenges and strengths of patient, organize action items, and support coordinated treatment planning. Each meeting is closed with Likert scale rating that EMS-6 tracks.

Additional interagency case conferences take place (1-5 times per month) as needed to focus care, and support community partners in caring for shared patients.

2. *Engagement plans, alerts and notes in data systems*

Each of the three components of EMS-6 have their own systems for documentation. The **fire department** has an end of watch report. **Street Medicine** does an end-of-shift summary report that is sent daily to teams to ensure continuity of care and follow up, and each encounter is documented in EPIC with approximately 15-20 patients per week. Alerts are commonly placed in CCMS, EDIE, and EPIC. **SFHOT** charts in HSH's One System.

Team members communicate extensively with each other and in their prospective systems. Additionally, they communicate and follow up on treatment planning with other agencies via email, calls and messaging through EPIC.

### Bed Management Database (\$600,000)

In 2019 the San Francisco Department of Public Health (DPH) identified an immediate need for a robust, real-time, bed availability system that tracks the supply of behavioral health treatment beds. There was no single "source of truth" for the number of beds available across the behavioral health system of care at a given point in time. The lack

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of real-time inventory data can create barriers for clients who seek services, for providers who wish to refer clients, and for DPH in its understanding of bed investment needs and bottlenecks in the system of care. Implementing a system that allows for a daily report of residential treatment bed vacancies can benefit potential clients, their advocates and health care providers.

The public-facing website, FindTreatmentSF.org, went live for public use in December 2019. It displays the daily availability of some 500 substance use treatment beds in San Francisco. The information displayed has proven to be invaluable for its intended audiences: clients, referring health care providers, and DPH staff. The data provided through the website has been used for internal process improvement efforts to decrease vacancies and increase referrals to treatment. A similar mental health residential treatment resource is currently used for internal quality improvement projects and should become public in the future.

**Open community Psych Respite (Hummingbird)**  
Rolled Over



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## VI. NARRATIVE – Pay for Outcome

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*Instructions: 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. Please limit your responses to 500 words.*

San Francisco WPC has ten Pay for Outcome metrics. Three were met based on data collected by SF County and comparative data from DHCS. While San Francisco’s data indicated ACR was met, DHCS’s data did not confirm this, although a decrease is still evident.

Success in health outcomes for AMB and IPU may be due to random variation in the Enrollee population. Newer enrollees appear to be younger and healthier than enrollees at the beginning of pilot project. Success in Housing Care Management is clearly tied to increased access to staff due to WPC expanded services and some of the opportunities they offer.

Lack of success in health outcomes FUH and IET may be due to different procedures in Avatar database. TB Clearance rate is less than expected because a smaller percentage of Enrollees access the programs that require it. Encampment Resolution is taking longer due to the increased complexity of transitioning the remaining persons who are less well suited to limited available housing options.

SF Budget # (Tech Spec Manual #)	Name	Method	PY3 result	PY4 result	Change	Metric Met or Not Met
U1 (2.1)	Ambulatory Care (AMB), Reduce ED Utilz	per 1000 member months	274	202.9	>5% decr	Met
U2 (2.2)	Inpatient Utilization - General Hosp Acute Care (IPU)	per total member months	47	40.98	>5% decr	Met

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U3 (2.3)	Follow-up after Hosp for Mental Illness (FUH) - 7d, 30d	% of MH Inpt disch	61 73	58.44 69.84	no incr	Not Met
U4 (2.4)	Initiation & Engagem ent of Alcohol & Drug Trmt (IET) - 14d, 30d	% of persons with new AOD diag	37 33	33.24 29.15	no incr	Not Met
V2 (3.1.1)	All Cause Readmissi ons (ACR)	% of hosp stays	29.6	23.91*per DHCS	<5% decr* per DHCS	Not Met
Other6 (3.2.2)	Housing Services	% Enrollees received Housing CM	3.6	10.00	>5% incr	Met
Other2 (3.2.3)	Supportiv e Housing (Placeme nt after referral)	% Enrollees placed in housing after Housing CM referral	100	100	<5% incr	Not Met
Other1	TB Clearance	% Enrollees with TB clearance	26.3	23.67	no incr	Not Met
Other3	Encampm ent Resolutio n	# of days from Encampment engagement to temp housing	18.59	33.76	no decr	Not Met
Other5	Common Assessme nt with new assmt tool	% Enrollees assessed by housing assmt tool	23	22.70	no incr	Not Met

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## VII. STAKEHOLDER ENGAGEMENT

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*Instructions: 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. An attachment to this report is also acceptable, please note below if this option is being used. 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, and DAAS continued meeting monthly to provide guidance on planning and implementation processes necessary to accomplish SF WPC goals.

### **MONTHLY SF WPC STAKEHOLDERS MEETING**

The Whole Person Care team facilitates monthly presentations (with a live-online option, which has significantly increased attendance) led by subject matter experts on WPC related projects. The meetings enable WPC stakeholders to remain apprised of progress made around interagency care coordination and data sharing to better serve shared clients. This ensures alignment of Whole Person Care initiatives and supports the citywide commitment to work differently to improve the system of care for people experiencing homelessness.

1. Street-Based Care: A Collaborative Approach, Deb Borne, Paul Harkin, Eileen Loughran, July 19, 2020
2. Tipping Point Community on Findings from the Chronic Homelessness Initiative, Nina Catalano, September 17
3. CCSF Shared Priority Pilot, Mara X Martinez, Barry Zevin, October 18, 2020

### **EVALUATION TEAM MEETINGS**

The Whole Person Care Evaluation team facilitates in person meetings twice monthly with members of the Whole Person Care team. These meetings are an opportunity for the Evaluation team to update the group on ongoing evaluation projects, present the results of data analysis and solicit guidance from the WPC team. The meetings are also an opportunity for researchers and providers interested in partnering with the WPC team to introduce themselves and share proposals for collaboration or data sharing.

### **SHARED PRIORITY PROJECT**

To support the implementation of the Shared Priority Project, 3 workgroups were convened during the second half of 2019.

#### **1. Interagency Shared Priority workgroup**

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Service providers and program staff met weekly to review and triage Shared Priority clients' progress from Street-to-Home. (This meeting replaced the HUMS meeting from the first half of 2019.) The team's purpose is to:

- Monitor client progress and review dashboards to identify system barriers
- Update Street-to-Home plans
- Facilitate communication and coordination
- Improve pathways and ensure appropriate linkages are made during times of transition
- Identify barriers to be addressed by the System Response team

## 2. Interagency System Response Team

Program supervisors and administrators met bi-monthly (every 2 weeks) throughout the second half of 2019 to ensure the success of the Shared Priority Project. The team's purpose is to:

- Problem-solve system barriers and gaps for shared priority clients and protect effective interventions (Example: Prioritizing access to scarce resources)
- Generate recommendations for future resources and policy revisions
- Ensure alignment with our "shared principles" for interagency prioritization

## 3. Shared Priority Implementation Team

Whole Person Care team members with the support of Behavioral Health Services, Department of Homelessness and Supportive Housing, and the Human Services Agency met weekly to:

- Ensure the successful implementation of the
- Support teams and manage project deadlines
- Document and report on project status to system leaders

## HIGH-INTENSITY CARE TEAM Implementation

The High Intensity Care Team Implementation team began meeting weekly in August 2019 to define and launch the project. They created a team charter, program overview guide for providers and client alert that can be seen by anyone in the EHR. After 2 months, this group moved to a monthly meeting model to check-in and discuss and address barriers.

## 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.

## WAIVER IMPLEMENTATION GROUP

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DPH leadership who oversee implementation of the 1115 Medicaid Waivers in San Francisco convene monthly to discuss implementation progress and troubleshoot barriers. The focus of this group for the latter part of 2019 into 2020 is sustainability for WPC through CalAIM.

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

This committee meets monthly. Meetings are attended by HSH, Local Homeless Coordinating Board members, providers, consumers, and community members. Detailed information about past and future meetings can be found at:  
<http://hsh.sfgov.org/lhcb/lhcb-cesone-system-committee/>

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## PROGRAM ACTIVITIES

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

At year's end PY4, the care coordination tools remain the same with added features. They are the WPC Patient Summary, the HSH Coordinated Entry (CE) Primary Assessment with its housing priority score, and the developing strategy for measuring success of high intensity pilot projects.

- The WPC Patient Summary extended its alerts technology to be visible in Epic, Avatar, HSH ONE System.
- The CE housing priority method and score developed by HSH is becoming widely known and discussed.
- The city-wide high intensity pilots (HUMS Top 100, HSOC, HSH Priority, and EMS-6) are came together under a newly approved PMPM5 beginning Oct 2019. Tools for measuring successful outcomes have been identified.

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

The challenges remain the same. Interagency Care Coordination Policies and Procedures have progressed but are not completed. These include:

- Multiple levels of approval required
- Where/how to preserve policies
- How to train and update staff to the agreed standards

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

At year's end PY4 there have been advances in shared data technology.

- Epic implementation for medical records went live on schedule Aug, 2019.
- Epic became the approved vendor for care coordination record management.
- The HSH new ONE System technology progressed to be the electronic database for all housing services. Data sharing by secure file transfer to DPH was established.
- WebConnect technology is helping partners external to DPH gain access to data technology managed by DPH. The number of authorized users is growing.

Meetings for shared data policies continue.

- An Interagency Data Sharing Coordinator was hired.
- SF County Health Plans are nearing final sign-off for mutual sharing with WPC.
- CCSF continues to explore the impact that AB210 would have. Approval allows multidisciplinary teams to share information if coordinating care.
- HIPAA covered entities are being reviewed by City Attorney office.

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

Data governance policies and procedures remain in draft form.

The data sharing technology of Web Connect for external users requires two step sign-on instead of a single step experienced by users within DPH systems. This creates a noticeable reduction in log-ins for data sharing platforms.

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

At year's end PY4, data collection had become electronic for all programs.

Standardized reports became more widely used for QM of enrollment, utilization, and metrics.

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

Electronic data collection from source systems still remains customized in smaller programs. The goal is to standardize data fields in preparation for transfer into EPIC.

Data reporting to meet every program's needs is an ongoing discussion.

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

SF WPC continues to face the same barriers to long-term programmatic success:

- Once city-wide technology is established, ownership and sustained maintenance of the data technology has not been determined. DPH or City/County IT are the most likely partners to have this responsibility. Funding and liability are questions.
- Collaborative interagency policies and procedures and data governance face legal and liability hurdles.
- The census count of adults experiencing homelessness in SF continues to rise as demonstrated in the 2019 Homeless Point in Time (PIT) count. Availability of housing units to meet needs for all chronically homeless individuals is not possible.
- The final challenge is to create an evidence-based practice showing multidisciplinary care coordination and data sharing improve patient outcomes. Preliminary evidence on small scale is positive.

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## VIII. PLAN-DO-STUDY-ACT

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*Instructions: 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 Attachments:

1. Reduce Emergency Department Utilization
2. Reduce Inpatient Utilization
3. Increase Care Plans
4. Increase Care Coordination
5. Data Infrastructure
6. Collection Methods

The following PDSAs are in the 'Do' phase:

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

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

- **#6 Adoption Rate:** Other: Measuring the adoption rate by clinicians of electronic data sharing information
- **#7 Increase Medi-Cal insurance enrollment:** Other
- **#8 Data Collection:** Other: Paper to electronic data entry.