San Francisco
Annual Narrative Report 2020
April 30, 2021

REPORTING CHECKLIST

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

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

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

I. REPORTING INSTRUCTIONS

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

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

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

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

II. PROGRAM STATUS OVERVIEW

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.

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

SF WPC continues to collaborate across five city departments -- health (DPH), social services (HSA), homelessness and supported housing (HSH), fire (SFFD), police (SFPD), and mayor's office; as well as two county Medi-Cal health plans (SF Health Plan and Anthem Blue Cross); and several contracted community-based organizations.

During PY5, the year of the COVID-19 pandemic, SFWPC continued to make progress and reach milestones of its WPC goals.

A) City-wide care coordination teams' model intervention may become the new standard. It has been tested for subsets of SMI and High Utilizers.

B) Data sharing infrastructure progressed on two fronts, formalized data exchange agreements under HIPPA and data exchange technology using DPH . Do you EHR and its Compass Rose coordinated care module.

C) The innovative programs (Street Medicine and Shelter Health plus the homeless to housing sequence of CE assessment, housing CM, placement, and supportive services) proved their value and were essential component of the COVID-19 response.

In new activities, the SF WPC team contributed to the county-wide COVID-19 response.

A) Some staff were deployed to COVID Command Center activities.

B) Remaining staff provided daily reports from the CCMS database while other staff dispersed PPE and implemented vaccination protocols.

C) The WPC-CCMS test environment for integrated data gained city-wide acknowledgement for its quick response. By reporting daily on persons

experiencing homelessness (PEH) combined with knowledge of their health vulnerability indicators, it facilitated care coordination and placement into protective settings (primarily Shelter-In-Place & Investigation and Quarantine sites).

Some activities were paused. Stakeholder meetings were delayed until the fall when there was capacity to organize and facilitate, as well as availability of members.

2. **Increasing coordination and appropriate access to care**

WPC targeted clinical projects have proven effective at increasing access to care.

-Street Medicine continued its work in the Shelter-in-Place hotels, in addition to maintaining its usual work of providing basic care and coordination for homeless individuals encountered during outreach.

-Shelter Health provides basic primary care, and for WPC it provides care referrals, coordination, and establishes a health record for everyone not connected to health care. COVID-19 has made this more imperative.

-Benefits eligibility workers aim to increase enrollment in county general assistance, CalFresh, and Medi-Cal. Most staff were deployed to COVID-19 duties. They will return in PY6 to focus on Medi-Cal coverage at Shelter-In-Place locations.

-Buprenorphine treatment and methadone referrals were made to opiate addicts engaged on the street, mitigating behavior that could significantly increase risk of acquiring or spreading COVID-19.

-Care Coordinators for Shared Priority SMI clients continued to meet weekly to enable access to health and housing for this highly vulnerable population who have historically been unable to help themselves.

-EMS6, its Base Hospital Medical Doctor, and its alliance with community health and housing providers continued to operate and divert its clients from the hospital.

3. **Reducing inappropriate emergency and inpatient utilization**

SFWPC has been successful at reducing avoidable ED utilization (AMB) and inpatient stays (IPU) for all enrollees in each of the four consecutive years of WPC!

PDSA #1 and #2 are studying the Shared Priority SMI clients and the EMS6 High Utilizers to pinpoint factors related to successful interventions.

4. **Improving data collecting and sharing**

Data collection plans moved forward. External sources and internal paper and spreadsheet sources are in process or have completed the move into Epic EHR.

Data sharing governance experienced some delays due to staff being deployed as disaster service workers in response to the COVID-19 emergency.

5. **Achieving quality and administrative improvement benchmarks**

The benchmark goal is 100% accuracy and transparency for reporting deliverables. Quality assurance reports developed in previous years help meet the expectation and ensure the detection of missing or duplicated data.

6. **Increasing access to housing and supportive services**

The pathway from street to home developed and supported by WPC resources continues to be successful!

People experiencing homelessness continue to be able to be assessed for coordinated entry (CE) regardless of the door they enter through to move toward Housing Referral Status, and then housing navigation services if eligible.

Temporary housing in short-term shelters and longer-term Navigation Centers remained impacted by COVID-19 primarily due to the need to observe social distancing practices.

7. **Improving health outcomes for the WPC population**

SF WPC is ever trying to innovate and improve health outcomes for people experiencing homelessness using metrics, dashboards, and clinical feedback to learn more about the population and positively impact health outcomes,

The innovations that are expected to have the greatest impact on health outcomes are being studied in the PDSAs.

Additionally, the homeless death study to understand the causes of homeless deaths and plan for death prevention initiatives culminated in journal publication.

III. ENROLLMENT AND UTILIZATION DATA

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
Unduplicated Enrollees	**398**	**335**	**280**	**148**	**173**	**170**	**1505**

Item	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12	Annual Unduplicated Total
Unduplicated Enrollees	204	200	208	239	211	208	2775

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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.*

Costs and Aggregate Utilization for Quarters 1 and 2

FFS	Month 1	Month 2	Month 3	Month 4	Month 5	Month 6	Total
FFS 1 Dual Dx Residential Cost	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Dual Dx Utilization	0	0	0	0	0	0	0
FFS 2 SUD Residential	$ -	$ -	$ -	$ -	$ -	$ -	$ -
SUD Residential Utilization	0	0	0	0	0	0	0
FF3 Medical and Psych Respites Residential	$ 305,444.45	$ 296,441.03	$ 289,050.16	$ 248,601.95	$196,059.59	$ 224,279.27	$ 1,559,876.45
Medical and Psych Respites Utilization	2,273	2,206	2,151	1,850	1,459	1,669	11,608
FF4 Resource Center Services	$ 32,589.85	$ 35,923.85	$ 28,005.60	$ 18,253.65	$ 23,421.35	$ 26,338.60	$ 164,532.90
Resource Center Services Utilization	391	431	336	219	281	316	1,974
FFS 5 Coordinated Entry Expansion	$ 119,253.12	$ 98,824.32	$ 80,438.40	$ 38,814.72	$ 48,263.04	$ 61,286.40	$ 446,880.00

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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
Coordinated Entry Expansion Utilization	467	387	315	152	189	240	1,750
FF6 Encampment	$ 4,127.76	$ 2,063.88	$ 582.12	$ -	*	*	$ 7,250.04
Encampment Utilization	78	39	11	-	*	*	137
FF7 Engagement	$ 538,656.30	$ 509,467.14	$ 513,660.42	$ 406,715.40	$471,563.82	$ 565,896.24	$ 3,005,959.32
Engagement Utilization	32,885	31,103	31,359	24,830	28,789	34,548	183,514

Costs and Aggregate Utilization for Quarters 3 and 4

FFS	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12	Total
FFS 1 Dual Dx Residential Cost	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Dual Dx Utilization	0	0	0	0	0	0	0
FFS 2 SUD Residential	$ -	$ -	$ -	$ -	$ -	$ -	$ -
SUD Residential Utilization	0	0	0	0	0	0	0
FFS 3 Medical and Psych Respites Residential	$ 223,204.24	$ 205,734.91	$208,422.50	$ 236,239.04	$ 212,185.12	$ 205,063.01	$2,850,725.27

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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
Medical and Psych Respites Utilization	1,661	1,531	1,551	1,758	1,579	1,526	21,214
FFS 4 Resource Center Services	$ 28,172.30	$ 27,172.10	$ 28,255.65	$ 32,756.55	$ 34,173.50	$ 42,591.85	$ 357,654.85
Resource Center Services Utilization	338	326	339	393	410	511	4,291
FFS 5 Coordinated Entry Expansion	$ 75,075.84	$ 73,032.96	$ 86,567.04	$ 100,356.48	$ 175,176.96	$ 206,841.60	$1,163,930.88
Coordinated Entry Expansion Utilization	294	286	339	393	686	810	4,558
Encampment	*	*	$ 1,905.12	$ 8,202.60	$ 1,640.52	$ 2,275.56	$ 21,485.52
Encampment Utilization	*	*	36	155	31	43	406
Engagement	$ 672,317.10	$ 724,520.16	$770,498.82	$ 842,259.60	$ 863,111.34	$ 898,950.78	$7,777,617.12
Engagement Utilization	41,045	44,232	47,039	51,420	52,693	54,881	474,824

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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 for Quarters 1 and 2**

PMPM	Rate	Month 1	Month 2	Month 3	Month 4	Month 5	Month 6	Total
PMPM	Rate	Month 1	Month 2	Month 3	Month 4	Month 5	Month 6	Total
PMPM1	-	-	-	-	-	-	-	-
MM Counts 1	-	-	-	-	-	-	-	-
PMPM2 Enhanced Care Coordination	$ 314.94	$ 211,323.56	$ 223,291.21	$ 256,044.79	$ 132,903.94	$ 107,393.94	$ 125,030.48	$ 1,055,987.91
Care Coordination Utilization		671	709	813	422	341	397	3,353
PMPM3 Enhanced Housing Transition Services	$ 348.23	$ 97,504.40	$ 129,541.56	$ 146,604.83	$ 94,370.33	$ 82,878.74	$ 96,807.94	$ 647,707.80
Enhanced Housing Transition Svcs Utilz		280	372	421	271	238	278	1,860
PMPM4 Housing and Tenancy Stabilization Services	$ 422.16	$ 783,951.12	$ 805,903.44	$ 837,143.28	$ 863,739.36	$882,314.40	$ 894,134.88	$ 5,067,186.48
Housing and Tenancy Stabilization Utilization		1,857	1,909	1,983	2,046	2,090	2,118	12,003
PMPM5 High Intensity HUMS Care Team	$1,060.04	$ 254,410.04	$ 265,010.46	$ 273,490.80	$ 313,772.39	$296,811.72	$ 286,211.30	$ 1,689,706.70

PMPM5 High Intensity HUMS Care Team		240	250	258	296	280	270	1594

Amount Claimed for Quarters 3 and 4

PMPM	Rate	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12	Total
PMPM #1	-	-	-	-	-	-	-	-
MM Counts 1	-	-	-	-	-	-	-	-
Enhanced Care Coordination	$ 314.94	$ 128,179.86	$ 136,368.26	$128,809.74	$ 209,433.93	$ 153,374.92	$ 108,968.63	$ 1,921,123.24
Care Coordination Utilization		407	433	409	665	487	346	6,100
Enhanced Housing Transition Services	$ 348.23	$ 133,023.86	$ 141,033.15	$164,364.56	$ 153,569.43	$ 174,115.00	$ 256,993.74	$ 1,670,807.54
Enhanced Housing Transition Svcs Utilz		382	405	472	441	500	738	4,798
Housing and Tenancy Stabilization Services	$ 422.16	$ 907,221.84	$ 920,730.96	$935,084.40	$ 938,461.68	$ 949,015.68	$ 957,458.88	$10,675,159.92
Housing and Tenancy Stabilization Utilization		2,149	2,181	2,215	2,223	2,248	2,268	25,287

PMPM5 High Intensity HUMS Care Team	$1,060.04	$ 288,331.38	$ 297,871.76	$307,412.13	$ 293,631.59	$ 281,971.13	$ 294,691.63	$ 3,453,616.32
PMPM5 High Intensity HUMS Care Team		272	281	290	277	266	278	3,258

IV. NARRATIVE – Administrative Infrastructure

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
SF WPC experienced significant staffing changes halfway into PY5. Maria X Martinez, WPC Director, long-time member of SFDPH executive team and frequently honored SF resident, [REDACTED]. Amber Reed, SF WPC Chief Service Designer, became the SF WPC Acting Director. Dara Papo left her post as HSH WPC Manager to become Director of Whole Person Integrated Care with DPH. WPIC is the newest division of the San Francisco Health Network Ambulatory Care department. WPC and CCMS Data Analyst, Allison Lee, took a leave of absence from her position to work in the COVID Command Center.

Evaluation
The WPC Evaluation team continued to support data and analytics initiatives, e.g., the Shared Priority project by generating bi-weekly dashboards of key outcome metrics. It also identified subgroups eligible for special projects and interventions, such as HSH's "scattered site" housing program.

Additionally, Evaluation team members presented WPC related work to stakeholder groups, served on multiple panels, and published articles.

Training
As the COVID-19 pandemic continued, training resources continued to be diverted to training for Disaster Service Workers and non-profit staff at Shelter-In-Place COVID-19 housing sites. The focus was on overdose prevention, de-escalation, and secondary trauma.

Tablets, Software and Support
SF WPC procured mobile devices for health workers and nurses who are apart of roving clinical teams to facilitate engagement with people living on the streets, in shelters, and in Navigation Centers/SIP sites. Additionally, desktop cameras and compatible headsets were purchased for BHS staff to better engage with their mobile staff and clients virtually face-to-face.

IV. NARRATIVE – Delivery Infrastructure

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.

ONE System Infrastructure ($328,889.32)
The WPC partnership continues to refine how data is automatically and securely transferred from the Department of Homelessness and Supportive Housing (HSH) into SFDPH Epic in preparation for phasing out the CCMS test environment.

HSH started work on the Unit Level Housing Inventory project with Bitfocus in August, 2020. To date, out of the 7 modules that make up the entire project, the project team completed two (Funding Source Management & Building Management) and is on track to complete two more (Unit Configuration Type Management & Unit Management) by the end of April, 2021. The building of the 7 modules is scheduled to complete by September, 2021. However, the migration of building and unit inventory as well as client data are expected to be done sometime in the spring of 2022.

Additionally, as part of our effort to expand the number of housing units into the ONE System, the HSH PMO team migrated the entire Direct Access to Housing portfolio (around 65 programs) from DPH's CCMS into the ONE System.

Coordinated Care Management tool
Epic's coordinated care management (CCM – and now called "Compass Rose") module is customizable with certain limitations. Several key stakeholders held WebEx conference calls with Epic and WPC to determine customization needs.

Source System Workflow and Data Integration
Mapping is a detailed process of looking item by item at the way data sources previously in the CCMS test environment will transfer into Epic. This is a more detailed process than originally imagined. The final sign-off ensured smooth transition in time for the Nov 9th, 2020, "Go Live" date. CCMS continues to provide the WPC reporting.

Community Partnership Software IT Achievement (AKA IT Secure Transfer of Data) ($250,000)

The SF response to Covid-19 pandemic beginning in Jan 2020 included reconfiguring program locations serving WPC enrollees to promote social distancing, adding new locations to maintain overall capacity, and expanding an existing City contract with RTZ (locally based Emeryville company specializing in quick custom healthcare database development) to manage the data for the new locations. This affected WPC enrollees engaged in FFS3 (Medical Respite and Hummingbird Respite) and FFS7 (shelters and Navigation Centers) and adds a new data source for WPC reports. Integrated data on COVID-19 vulnerable individuals, available only from WPC, has become instrumental in shaping SF's pandemic response. This supports mapping the data collected by RTZ and securely transferring it into DPH's Covid-19 server for use in WPC reports.

Epic data integration and Epic Care Management Module
Work with Epic progressed on several fronts:

Epic Customization ($100,000)
The Sobering Center, Street Medicine and Shelter Health, and Medical Respite programs all have worked with SF's EHR, Epic to customize their workflow processes for data entry. Payment was already received for Sobering Center and Street Medicine customization.

Data Sharing External Access
SFDPH CareLink, the simplified version of the Epic EHR became available to external partners. This is especially significant for SFFD whose staff were also granted access to the Emergency Department Information Exchange. EDIE is the HIE that can view emergency department visits outside of the San Francisco Health Network, the service delivery arm of SFDPH.

V. NARRATIVE – Incentive Payments

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.

SFWPC is pleased that most incentives were achieved. Some activities had to be diverted to other efforts due to spacing precautions needed during COVID-19 pandemic.

Open Navigation Centers (2 units @ $500,000 each)
SF existing shelters and Navigation Centers had to reduce capacity to ensure 6-feet of space between beds. Additionally, a safe space for tents was needed for unsheltered WPC clients whose age or medical conditions put them at increased risk for severe illness from COVID-19. As a result, San Francisco opened 22 Shelter in Place (SIP) sites that operate in much the same way that Navigation Centers do. Additionally, Safe Parking sites were opened to provide a safe place for clients who live in their vehicles. Clients are still able to bring their partners, possessions and pets, and are receiving continuity of CM services plus on-site healthcare and security. The Department of Homelessness and Supportive House (HSH) is exploring long-term lease and/or purchase of Shelter-In-Place sites to prevent returning vulnerable individuals to the street for the duration of the COVID-19 pandemic. This incentive is paid to the City and County of San Francisco and supports the work of several agencies and departments within the system.

Open Behavioral Health Respite ($500,000)
SF opened one BH Respite in the first half of 2020 and due to COV delays will not open the 2nd one originally slated to open in 2020 until late 2021. However, SF is offering respite services at one of its SIP sites. This incentive is paid to the City and County of San Francisco and supports the work of several agencies and departments within the system.

CalAIM Sustainability ($635,000)
Work on preparing for CalAIM was put on hold in SF in Spring 2020 in order to prioritize response to the COVID-19 pandemic, a decision that was further substantiated when DHCS put CalAIM on hold. Once meetings re-commenced with MCPs in fall 2020, focus shifted to developing a roadmap. SFHP is providing consulting services to SF Health Network to strategize for the transition to CalAIM. This incentive is paid to the City and County of San Francisco and supports the work of several agencies and departments within the system.

VI. NARRATIVE – Pay for Outcome

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 10 Pay for Outcome metrics. Five were met based on data that was collected by SF County.

SF is pleased with the success of AMB and IPU. Both ED and hospital utilization have shown downward trends since first measured in PY1. FUH success is not tied to a particular intervention but to general emphasis on care management post mental health hospitalization. Success in Housing Care Management is tied to WPC expanded services and increased access to staff. Success in encampment resolution is tied to increased access to Shelter-In-Place Covid-19 housing sites.

Lack of success in health outcome IET, i.e., placement in SUD treatment, may be due to difficulty capturing the data from the database. TB Clearance rate is less than expected because program enrollment is not requiring it. Supportive housing placement after referral is at 100%, its maximum, and can no longer show increases. The percentage of persons assessed for housing using a Coordinated Entry tool has been stable but did not meet the 5% increase threshold. Finally, All Cause Readmission to a hospital within 30 days of previous discharge did not meet its 5% reduction threshold for unknown reasons.

SF Budget # (Tech Spec Manual #)	Name	Method	PY4 result	PY5 result	Change	Metric Met or Not Met
U1 (2.1)	Ambulatory Care (AMB), Reduce ED Utilz	per 1000 member months	202.9	159.3	>5% decr	Met
U2 (2.2)	Inpatient Utilization - General Hosp	per total member months	40.98	37.71	>5% decr	Met

	Acute Care (IPU)					
U3 (2.3)	Follow-up after Hosp for Mental Illness (FUH) - 7d, 30d	% of MH Inpt disch	58.44% 69.84%	62.66% 73.55%	>5% incr	Met
U4 (2.4)	Initiation & Engagement of Alcohol & Drug Trmt (IET) - 14d, 30d	% of persons with new AOD diag	33.24% 29.15%	31.50% 27.15%	no incr	Not Met
V2 (3.1.1)	All Cause Readmissions (ACR)	% of hosp stays	*23.91* per DHCS*	*26.94% per SF*	<5% decr*	Not Met
Other6 (3.2.2)	Housing Services	% Enrollees received Housing CM	10.00	18.87%	>5% incr	Met
Other2 (3.2.3)	Supportive Housing (Placement after referral)	% Enrollees placed in housing after Housing CM referral	100%	100%	<5% incr	Met
Other1	TB Clearance	% Enrollees with TB clearance	23.67%	10.64%	no incr	Not Met
Other3	Encampment Resolution	# of days from Encampment engagement to temp housing	33.76d	17.09d	>5% decr	Met
Other5	Common Assessment with new assmt tool	% Enrollees assessed by housing assmt tool	22.70%	22.00%	no incr	Not Met

VII. STAKEHOLDER ENGAGEMENT

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 held monthly meetings to provide guidance on planning and implementation activities necessary to accomplish SF WPC goals. Upon emerging from COVID-19 response, the core planning group restarted meeting in Q3 2020.

MONTHLY SF WPC STAKEHOLDERS MEETING
The WPC staff team has facilitated monthly presentations to its stakeholders led by subject matter experts on WPC related projects. The meetings enable WPC stakeholders to become educated regarding progress and to offer feedback during the discussion periods. The result strengthens support for the multi-agency commitment to "work differently" at all stages of the system of care for people experiencing homelessness.

WPC was one of the first city programs to offer a virtual online meeting forum, an option which increased attendance. After being placed on hold due to interruptions by COVID-19, these meetings were reinstated in the fall of 2020.

EVALUATION TEAM MEETINGS
The WPC Evaluation team meetings were re-instated in Q4 2020 after a pause as clinical members of the SF WPC Evaluation team played key roles in COVID-19 response leadership. These meetings provide an opportunity for the Evaluation team to update ongoing evaluation projects, present results of data analysis, solicit guidance from the WPC team and discuss collaboration.

MANAGED CARE PLAN CALAIM PLANNIGN MEETINGS
Monthly meetings with Anthem were established to begin conversations about CalAIM.

INTERNAL (SF DPH) CALAIM PLANNING
Work on preparing for CalAIM re-commenced in late fall 2020. SFHP provided SFHN with contracted consulting services to help DPH establish a CalAIM roadmap and transition plan. The consultants held interviews with many subject matter experts to inform a report on CalAIM readiness and roadmap that would be delivered in early 2021.

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

The CE and ONE joint committee continued to meet regularly, although postponed some meetings during the initial COVID-19 shelter in place. 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/

SHARED PRIORITY PROJECT and HIGH-INTENSITY CARE TEAM (HICT)

These two clinical activities were established by SF WPC with assistance of stakeholders and the Evaluation team. They meet weekly for case conferences and their work continued and expanded throughout 2020 as these services remained critical during SIP.

VIII. PROGRAM ACTIVITIES

Care Coordination

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

- SF WPC proposed to build an IT infrastructure that made city-wide care coordination possible. PY5 2020 saw the realization of that proposal. DPH IT began installation of Epic's Care Coordination Management toolset (CCM) which went live in Nov.

- The WPC team maintained important care coordination tools, e.g., the original WPC Patient Summary with alerts visible in Epic, Avatar, HSH ONE System. The CE housing priority algorithm was refined by UCSF/Marc Benioff homeless initiative.

- The clinical pilot projects of High Intensity Care Team and Shared Priority came together under a newly approved PMPM5 beginning Oct 2019. They met weekly through 2020 with measurable successes for their participants.

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

- The COVID-19 pandemic changed the distribution of temporary housing and the eligibility criteria to access, and also disrupted FFS-3 (Medical and Psychiatric Respite programs) and FFS-7 (shelters and Navigation Centers).

Data Sharing

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

- The difficulty of sharing data across city departments was lessened when the SF Board of Supervisors passed Ordinance 42-20 on March 3rd, 2020. The result is an amendment to the San Francisco Administrative Code. The City will now designate itself as a hybrid covered entity under the Health Insurance Portability and Accountability Act (HIPAA). Once the City Administrator's Office determines the inclusion status of various City departments ease of sharing and consistent interpretation of laws will be facilitated.

- The transition from using the CCMS test environment for integrated WPC data to using Epic technology is progressing.

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

- The biggest challenge to data sharing continues to be the lack of legal designation of WPC partner agencies under HIPAA, and whether they are

considered part of the City's covered entity, or business associates, or neither. The Board of Supervisors acted, but due to the COVID-19 outbreak, the City Administrator has not been able to release its follow-up report on the specific designation of each city department. The lesson is perseverance in face of obstacles. The report is expected by early 2021.

- Interagency data governance policies and procedures remain in draft form. These policies will be owned by the City Privacy Office, soon to be established within the City Administrator's Office. The basis for these policies will be the DPH's internal policies, which have not yet been finalized by the DPH Data Governance Committee. With COVID-19 response taking precedence, activities of the DPH Data Governance Committee have been paused.

- Interdepartmental DAAs are not yet finalized, as terms are contingent on each department's legal status under HIPAA being finalized. These agreements will be finalized when COVID-19 activities diminish and the city returns to normal business.

Data Collection

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

- WPC helped write the RFP for the Logical Data Warehouse to be used throughout DPH. This unifies data storage and server technology and will eventually make analysis of integrated data easier for population health programs like WPC.

- The value of the integrated data reports is recognized and supported by the new features being implemented in Epic. The Coordinated Care Management tool will import the same housing data as CCMS and use it as a reliable measure of client living situation.

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

- Developing methods for reporting integrated data in metrics and dashboards is a challenge. Report implementation will occur slowly. Parallel report processes will run through 2021 until all reports can be developed within Epic.

- Push-button reports in the CCMS test environment were created by an expert programmer with clinical input. Report development will now become available to several analysts with access to a data warehouse. The risk is that reports may differ because the huge amount of Epic data may be interpreted differently.

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

- SF WPC has much to be proud of. The biggest hurdle of the future is sustainability in the CalAIM model of funding.

- Another hurdle is to publicize the successes of SF WPC in ways that generate funding for continuing innovative programs and encourage their replication in other venues.

- The long-awaited completion of defining all SF city departments providing health and human services as part of a single HIPAA Covered Entity needs to be sustained in the future. It will allow data sharing when/if necessary and establish consistent definitions of privacy and security.

- Completion of the City Administrator's DAA report will allow HIPAA details to become part of contracts and MOUs.

- The perennial problem that SF does not have enough low-income housing units has no easy solution. Advocacy work continues.

- The transition from using DPH/CCMS test environment as the hub of integrated data to using Epic's Coordinated Care Management (CCM) is on schedule. Maintaining the exchange of data across city departments with the HSH ONE System for accurate housing information will be vital to usefulness of integrated data.

- Training staff about how to use Epic's many features needs to continue.

- SF WPC's often lauded director, Maria X Martinez, passed away from cancer in July 2020. She was the founder of CCMS and a tireless advocate of using integrated data and interagency communication as a foundation for a best practice called HUMS. It addressed the needs of high users of multiple systems whose troubled lives lead them to using duplicative care throughout the city or falling through the gaps in care at every location. She was one of the first voices for "Whole Person Care." She is missed, and her vision will be continued.

IX. PLAN-DO-STUDY-ACT

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

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.