City and County of San Francisco

Whole Person Care Pilot

Application to the

California Department of Health Care Services

Re-submitted September 19, 2016

SECTION 1: WPC LEAD ENTITY AND PARTICIPATING ENTITY INFORMATION

1.1 Whole Person Care Pilot Lead Entity and Contact Person (STC 117.b.i)

Organization Name	San Francisco Department of Public Health (SFDPH), which includes Zuckerberg San Francisco General Hospital
Type of Entity	Designated Public Hospital
Contact Person	Barbara A. Garcia
Contact Person Title	Director of Health
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Add'l Contact Person Title	Deputy Director of Health
Add'l Contact Person Telephone	415.554.2769
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1.2 Participating Entities

Required Organizations	Organization Name	Contact name and title	Entity description and role in WPC
1. Medical Managed care plan	San Francisco Health Plan (SFHP)	Sumi Sousa, Officer, Policy Development & Coverage Programs	The San Francisco Health Plan is the public, not for profit Medi-Cal managed care plan for the City and County of San Francisco and currently enrolls 86% of the city's Medi-Cal managed care members. SFHP was created by the City and County of San Francisco and is governed by a 19 member board made up of SFHP members, providers, labor and representatives from the Mayor's Office and Board of Supervisors. SFHP is committed to improving the quality of life for the people of San Francisco and the providers who serve them. The San Francisco Department of Public Health is the largest provider of care for SFHP's Medi-Cal members, with over 40% assigned to their primary care clinics or where San Francisco General Hospital is their designated hospital. Under the WPC Pilot, SFHP will be a data-sharing partner as well as a member of the Steering Committee. SFHP will provide WPC pilot partners with all relevant member information, including utilization data and access to PreManage Community, an information exchange that provides real-time alerts to primary care providers from hospitals and an editable, interactive care plan. SFHP will also ensure that its participation in the

			WPC Pilot is aligned and coordinated with SFHN's work on PRIME and SFHP's upcoming Health Homes pilot. Other WPC care partners will provide relevant information back to SFHP so that there is no duplication but instead, a more efficient, effective care delivery system.
2. MediCal Managed Care plan	Anthem Blue Cross Partnership Plan	Joel Gray, Executive Director, CA Medicaid North	Anthem Blue Cross has more than 25 years of experience administering Medicaid and state-sponsored programs in California, during which they have developed long-term, collaborative partnerships with the State and many counties. Anthem currently provides services to over 1.2 million Medicaid members throughout California. Services are provided on a foundation of accountability and responsibility to members with a person-first philosophy, which includes focusing on the many social and physical determinants of health that impact the Medicaid population. Under the WPC Pilot, Anthem will be a data-sharing partner as well as a member of the Steering Committee. Anthem will participate in WPC Pilot planning activities, identification and engagement of members, and coordination efforts. Data will be exchanged bi-directionally between Anthem and the WPC Partners to ensure eligible members are referred to programs that best meet their needs without duplication of services. They will additionally share health outcome and utilization data for purposes of program evaluation.
3. Health Services Agency/Department	San Francisco Department of Public Health (SFDPH)	Colleen Chawla, Deputy Director of Health/Director of Policy and Planning	The San Francisco Department of Public Health (SFDPH) is the lead entity and health care anchor for San Francisco's WPC Pilot. The Mission of SFDPH is to protect and promote the health of all San Franciscans. SFDPH strives to achieve its mission through the work of two main branches – the Population Health Division and the San Francisco Health Network (SFHN). With a broad community focus, the Population Health Division provides the core public health services for the City and County of San Francisco, such as health protection and promotion, disease and injury prevention, disaster preparedness and response, disease surveillance and monitoring, and environmental health services. SFHN is the City's only complete system of care and has locations throughout the city, including Zuckerberg San Francisco General Hospital Medical Center, Laguna Honda Hospital and

			Rehabilitation Center, over 15 primary care health centers, and a comprehensive range of substance abuse and mental health services. As the City's safety net system, SFHN serves more than 100,000 people every year through its clinics and hospitals and serves the largest percentage of the city's Medi-Cal beneficiaries and uninsured. Under the WPC Pilot, SFDPH will be the lead entity, a data sharing partner, a Steering Committee co-chair, and a service provider. As the lead entity responsible for coordinating the WPC Pilot, SFDPH will provide project management, submit all reports, convene meetings, monitor services, and develop, implement and monitor the budget. SFDPH will work with its WPC Pilot partners to develop policies and procedures related to the pilot. SFDPH will provide primary care and behavioral health services through SFHN, and ensure that the WPC Pilot aligns with other efforts, including PRIME, Health Homes, and the Drug Medi-Cal Organized Delivery System. SFDPH maintains the Coordinated Case Management System database, which centralizes essential health, behavioral health, and social information on homeless adults accessing public healthcare services. Relevant CCMS data will be shared with other WPC Partners that will likewise share their client data with SFDPH to provide a real-time, actionable whole person profile.
4. Specialty Mental Health Agency/Department	San Francisco Health Network (SFHN) Behavioral Health Services (BHS)	Marcellina Ogbu, Acting Director, Behavioral Health Services	San Francisco Behavioral Health Services (BHS) is a part of SFDPH's health care delivery system, the San Francisco Health Network (SFHN). BHS operates the County Mental Health Plan, Jail Behavioral Health Services, and provides San Franciscans with a robust array of services to address mental health and substance use disorder treatment needs. The full range of specialty behavioral health services is provided by a culturally diverse network of community behavioral health programs, clinics and private psychiatrists, psychologists, and therapists. Treatment services include: early intervention/prevention, outpatient treatment (including integrated medical and behavioral health services), residential treatment, and crisis programs. Services are integrated, trauma informed, culturally competent, and based in principles of recovery and wellness. Treatment sites are located throughout San Francisco and

			services are available to residents who receive Medi-Cal benefits, are San Francisco Health Plan members, or other San Francisco residents with limited resources. Under the WPC Pilot, SFHN BHS will be a provider of mental health and substance use disorder services as well as a data sharing partner (to the extent allowed by law). A significant number among San Francisco's homeless population have behavioral health challenges. SFHN BHS and the Mental Health Plan provide a multitude of services that will benefit the WPC pilot target population, including placement, hospitalization/stabilization, and outpatient services. BHS operates a Behavioral Health Access Program that will serve as an entry point for individuals with mental illness, and appropriately prioritize WPC Pilot clients into lower levels of care. BHS will also be integral in guiding the creation of the Behavioral Health Navigation Center.
5. Public Agency	Department of Homelessness and Supportive Housing (DHSH)	Sam Dodge, Deputy Director for External Affairs	The consolidated Department on Homelessness and Supportive Housing (SFDHSH) launches as the newest City and County of San Francisco (CCSF) agency on July 1, 2016. With the singular focus on addressing homelessness in San Francisco, it is made up of essential homeless serving programs that traditionally existed in other departments across city government. SFDHSH's services range from homelessness prevention and street outreach, to shelter, to supportive housing. By moving these programs under one roof, DHSH will increase coordination and improve services through an integrated *Navigation System* that will match people with the right housing interventions based on their specific needs. Under the WPC Pilot, SFDHSH will be a data sharing partner, a Steering Committee co-chair, and a service provider. As the CCSF agency tasked with serving and housing the homeless, SFDHSH will work with its WPC partners to build the communications, data and technology infrastructures needed to create the Multi-Agency Care Coordination System, while ensuring consistency and alignment with SFDHSH's development of coordinated entry for housing placement. SFDHSH has been deeply involved in the planning for WPC and will be integral in the implementation of the initiative.

6. Public Agency	Human Services Agency	Susie Smith, Deputy Director, Policy & Planning	The Human Services Agency (HSA) comprises three City and County of San Francisco departments: the Department of Human Services, the Department of Aging and Adult Services, and the Office of Early Care and Education. HSA serves as the state-mandated county public social services agency, providing public assistance to low income children and families, single adults, the disabled, and seniors in San Francisco. HSA provides cash assistance, food and nutritional support, health insurance, employment training, child care subsidies, in home care, among other services. In addition, HSA provides services and support to children, seniors, and dependent adults. Until the recent creation of a new department exclusively focused on homelessness and supportive housing, HSA also administered the City's homeless and supportive housing services and brings significant expertise in homeless services. Under the WPC Pilot, HSA will be a data sharing partner, a Steering Committee member, and a service provider. HSA will ensure that participants in the WPC Pilot receive all of the public benefits for which they are eligible, as well as help connect clients who enter through its service doors to other city resources. HSA will help WPC Pilot participants enroll and remain in: Medi-Cal, CalFresh (SNAP), CalWORKS (TANF), and the County Adult Assistance Programs (CAAP), which provides short-term cash aid and social services to very low-income San Franciscans with no dependent children who are not eligible for other cash assistance programs. CAAP also helps low-income, able-bodied adults access employment and training opportunities through the Personal Assisted Employment Services program. For elderly and disabled adults, the program provides additional cash aid and assistance in applying for Supplemental Security Income.
7. Public Agency	San Francisco Department of Aging and Adult Services (DAAS)	Melissa McGee, Acting Deputy Director	San Francisco's Department of Aging and Adult Services (DAAS) plans, coordinates, and advocates for community-based services for older adults and adults with disabilities. The mission of DAAS is to assist older adults and adults with disabilities, and their families, to maximize self-sufficiency, safety, health and independence so that they can remain living in the community for as long as possible and maintain the highest quality of

			life. DAAS coordinates an integrated, comprehensive range of social, mental health, and long-term care services that fosters independence and self-reliance. Under the WPC Pilot, DAAS will be a data sharing partner, a Steering Committee member, and a service provider. DAAS has been integrally involved in the planning and development of the WPC Pilot and is highly invested in the development of IT-infrastructure that will enable coordination of services and sharing of data throughout city and community programs. The WPC pilot will further enhance and enable DAAS to provide wraparound services through case management and coordination for older individuals who enter the program via community providers.
8. Community Partner	Institute on Aging (IOA)	Dustin Harper, Vice President of Community Living	The Institute on Aging (IOA) is one of Northern California's largest community-based nonprofits providing comprehensive health, social, and psychological services for seniors and adults with disabilities and chronic illness. IOA's mission is to enhance the quality of life for adults as they age by enabling them to maintain their health, well-being, independence, and participation in the community. IOA develops and provides innovative programs in physical health, mental health, social services, education, and research. Their patient population is highly diverse across race and ethnicity, primary language, gender, socioeconomic status, and psychiatric diagnosis. IOA offers 24 programs and services that reach over 8,000 unduplicated individuals each year across the Bay Area. IOA holds home care, community clinic, and adult day program licenses, and provides social, recreational, mental health, educational, care management, home care, fiduciary, and community support services. Since 2007, IOA has worked with DAAS to administer the Community Living Fund, which funds home and community-based services, or combination of goods and services, that help individuals who are currently, or at risk of being, institutionalized. The program targets some of California's highest utilizers and uses a two-pronged approach: (1) coordinated case management and (2) purchase of services. Under the WPC Pilot, IOA will be a data sharing partner, a Steering Committee member, and a

			service provider. IOA will provide services that increase the quality of life for WPC clients through enhanced care delivery and the provision of services that foster independence.
9. Community Partner	HealthRIGHT 360 (HR360)	Vitka Eisen, CEO	HealthRIGHT 360 (HR360) is a non-profit 501(c)3 organization that in 2011 combined the legacy of the nation's first free medical clinic (Haight Ashbury Free Clinic, founded in San Francisco, 1967) and the expertise of a leading behavioral health organization (Walden House, founded in San Francisco, 1969) into a comprehensive, integrated Federally Qualified Health Center. The agency has grown in recent years following a series of visionary mergers across California that anticipated the whole-person-health and integration aims of healthcare reform. Today in San Francisco, HR360 operates four primary care health centers and over twenty behavioral health programs that are specialized to address the needs of specific sub-populations (including women with children, individuals at high risk of HIV/AIDS, seriously mentally ill offenders, and transgender individuals), and they provide full-spectrum, integrated care to low-income, homeless, and/or justice-involved adults, children, and families. HR360 also specializes in providing substance use treatment services. An overwhelming number of homeless adults suffer from substance use disorders. HR360 will integrate substance use disorder treatment services across the WPC Pilot programming aimed at improving health outcomes for people experiencing homelessness. Under the WPC Pilot, HR360 will be a data sharing partner, a Steering Committee member, and a service provider.
10. Community Partner	Baker Places	Jonathon Vernick, Executive Director	Baker Places is a San Francisco community based agency established in 1968 to provide transitional residential treatment services as an alternative to long term care in state hospitals. Today Baker operates 9 treatment programs scattered throughout the City that focus on individuals with mental health, substance abuse and HIV/AIDS related issues. It operates the only medically managed Detox in the state and its programs offer a continuum of care from acute and transitional licensed, residential treatment services as well as supported housing with case management.

			Many among the population served by Baker have had episodes of homelessness in their recent past. Baker Places will provide an enhanced continuum of care to the WPC Pilot participants, including extended residential treatment stays for the participants until they are connected to appropriate supportive housing and wrap around services. Under the WPC Pilot, Baker Places will be a data sharing partner, a Steering Committee member, and a service provider.

1.3 Letters of Participation and Support (see attached)

SECTION 2: GENERAL INFORMATION AND TARGET POPULATION

Section 2.1 Geographic Area, Community and Target Population Needs

Overview

Homelessness continues to be an intractable problem in the City and County of San Francisco. Despite spending $160 million dollars per year in homelessness-related urgent healthcare costs, outcomes for San Francisco's homeless population have remained relatively unchanged over the past decade. A deep look into San Francisco's system of care reveals a strong and wide foundation of services and robust data about the homeless population, but also a siloed and uncoordinated service delivery structure with limited capacity to share information. Building upon the system's strengths to overcome these barriers, San Francisco's Whole Person Care Pilot program (WPC Pilot) comprises two key elements: Innovations in Infrastructure and Innovations in Service.

San Francisco Whole Person Care Pilot	**Innovations in Infrastructure**	The **Multi-Agency Care Coordination System** (MACCS) will: ○ Establish a **data sharing platform** that can be used as both a real-time care management tool that links information across agencies and disciplines and an integrated data system for analysis and monitoring; ○ Develop and implement a multi-agency **universal assessment tool** to evaluate the needs of each homeless San Franciscan; ○ Use data to strengthen **care coordination** by stratifying the population based on risk and prioritizing those with the greatest needs for the deepest interventions; ○ Provide a **foundation for a citywide Navigation System**, which aligns shelter and housing resources and creates system-wide priorities and data to match people in need with the right housing intervention.

	Innovations in Service	Focusing on homeless adults in San Francisco who rely on the public healthcare safety net, innovative **service interventions** will: o **Maximize use of existing services**; and o Create new services that **fill identified gaps**, largely in the area of behavioral health.
	Budget	$23.1 million/year

Strong Service Foundation

The San Francisco Department of Public Health (SFDPH), which operates San Francisco's public healthcare delivery system, is the designated lead entity for the WPC Pilot. Operationally, this responsibility will be shared by SFDPH and the San Francisco Department of Homelessness and Supportive Housing (SFDHSH). Together, these two departments represent the strong service foundation upon which this application builds.

SFDPH operates San Francisco's only complete healthcare delivery system. As the public healthcare safety net, SFDPH serves more than 100,000 people annually through its network of 15 primary care clinics, two hospitals, and a wide array of behavioral healthcare (mental health and substance use disorder treatment). SFDPH serves the largest proportion of San Francisco Medi-Cal beneficiaries and uninsured. SFDHSH brings together under one roof the multitude of homeless services including outreach, shelter, support services, and permanent supportive housing.

Robust Data

Several data sources provide a picture of San Francisco's homeless population. The 2015 bi-annual point-in-time survey (which enumerates sheltered and unsheltered homeless individuals seen in one night) counted approximately 6,500 homeless individuals, a number that has remained relatively steady since 2005. In 2015, 18% of homeless individuals surveyed cited alcohol or drug use as the primary cause of homelessness, second only to a lost job.

SFDPH's pioneering Coordinated Care Management System (CCMS) database provides important information about homeless adults accessing public healthcare services. CCMS centralizes essential health, behavioral, and social information into a "whole person" profile. The CCMS database currently consists of 61,000 unique individuals who were at one time known to be homeless and received at least one SFDPH service dating back to fiscal year 1997-98. CCMS data reveal, among many things, that this population has high rates of substance use disorders, mental illness, and serious medical conditions, or any combination thereof, and use urgent and emergent services at a high rate.

Timing is Right to Make Meaningful Change

San Francisco is at a critical juncture to make the most of the WPC Pilot. All of the ingredients for success on ending homelessness for thousands of San Franciscans are converging at this

time and it will require cooperation like never before. In December 2015, San Francisco Mayor Edwin Lee announced the creation of SFDHSH, which launches on the same day this application is due. Among other things, SFDHSH is charged with developing a new Homeless Management Information System (HMIS) that provides coordinated entry into San Francisco's homeless shelter and housing programs; MAACS will support and complement this work to address homeless health and service needs. Through the WPC Pilot, San Francisco seeks to build a strong collaborative infrastructure to better integrate our homeless services and programs across agencies. In addition, San Francisco lawmakers will be placing a sales tax measure on the November 2016 ballot to provide stable funding for homeless and mental health services.

In addition to the significant opportunities for change in San Francisco's homeless services, the WPC Pilot leverages other health improvement efforts to ensure maximum impact and minimum duplication of services. The WPC Pilot proposal has been designed to complement San Francisco's planning for and participation in the PRIME, Drug Medi-Cal, and Health Homes programs. To ensure coordination and avoid overlap with the Health Homes program, the MACCS data-sharing infrastructure to be developed under the WPC Pilot will be linked to the information technology tool being used by San Francisco's Medi-Cal managed care plans for that program. The alignment of these opportunities places San Francisco in a key position to create a foundation for sustainable success that can support communication and coordination across the delivery system beyond the conclusion of the pilot, and provide a model that can be replicated for success in other jurisdictions.

Developed with Key Partners

To plan for San Francisco's WPC Pilot, SFDPH convened several San Francisco city departments – the incoming staff of SFDHSH, the Human Services Agency, the Department of Aging and Adult Services (a division of the Human Services Agency), and the Mayor's Office. Non-city agencies engaged in discussions included both of San Francisco's Medi-Cal managed care plans and several community-based organizations, including HealthRIGHT 360, Baker Places, and the Institute on Aging. We met regularly in the 45 days leading up to the due date of this application to together design the interventions that will have the most significant impact on the target population.

Section 2.2 Communication Plan

San Francisco is in the unique position of launching its new Department on Homelessness and Supportive Housing on the same day that this application is due. The strategic planning process for the new department will be critical for WPC implementation and will inform the WPC Pilot's Plan-Do-Study-Act (PDSA) cycles. As the new SFDHSH takes shape, the WPC Pilot infrastructure will evolve into a **shared governance model, with SFDPH and SFDHSH sharing leadership.**

At the WPC Pilot outset, a memorandum of understanding (MOU) will be developed that defines and outlines roles, expectations, service integration, deliverables, data sharing, funds flow, patient flow, and terms of participation for all involved entities. The MOU will ensure frequent and clear communication, and mutual understanding among the participating organizations regarding roles, responsibilities, and commitments required for successful pilot implementation. Multiple individuals and committees will be involved in developing and sharing communications among the WPC Pilot participants, as described below.

A dedicated Program Director will be hired as the main contact and the day-to-day operations lead for the WPC Pilot. The Program Director will work directly with care coordinators, partner organizations, and community groups. The Program Director will have responsibility for overall program monitoring and management, providing for partner training in policies and protocols, including the PDSA process, and ensuring compliance with WPC Pilot requirements. The Program Director will be accountable to the WPC Steering Committee co-chairs.

A **WPC Steering Committee will be established to provide policy-level oversight of the WPC Pilot.** Co-chaired by SFDPH and SFDHSH, the WPC Steering Committee will meet monthly and comprise executive-level representatives with decision-making authority on behalf of each of the partner organizations, which include the community based organizations, Medi-Cal managed care plans, and other city departments working on WPC. They will provide strategic guidance, review and approve policies, and direct service, clinical, operational and information technology integration. Members of the Steering Committee will represent the WPC Pilot in public forums. Finally, the Steering Committee will help identify trends across the pilot that may provide for improvement through PDSA, and resolve strategic and policy barriers that arise from the WPC Operations Committee.

A **WPC Operations Committee will be established to oversee the seamless delivery of care to participants and smooth communication** across the direct services teams in the partner organizations. Accountable to the WPC Steering Committee, the WPC Operations Committee will meet twice-monthly and comprise service providers, clinical staff, consumers, and other partners. It will have purview over functional elements of the WPC Pilot through a series of subcommittees (these may include performance improvement, budget, patient care, information technology, data sharing, and others). Importantly, the WPC Operations Committee will be responsible for performance improvement through PDSA cycles.

The **WPC Program Director will be responsible for managing two key communications tools**: a twice-monthly WPC Pilot Program update, supplemented by emails as needed, to connect the Steering Committee, the Operations Committee, and its subcommittees; and a monthly program update to communicate to outside stakeholders, program participants, and the community at large. The WPC Pilot will leverage its partners' communications platforms (e.g., newsletters, websites) to broaden its communications reach.

Section 2.3 Target Population

San Francisco's WPC Pilot will focus on **homeless adults who rely on public healthcare services provided by SFDPH.** In FY 2014-15, SFDPH's CCMS data repository identified

9,975 such individuals. Approximately 6,700 of these individuals would be Medi-Cal beneficiaries eligible to participate in the WPC Pilot – 5,000 are known Medi-Cal enrollees and an additional 1,700 are Medi-Cal eligible and will become enrolled through the pilot. While CCMS data show that a higher proportion would likely be Medi-Cal eligible, given the challenges facing this population, it is likely that not all Medi-Cal eligible individuals will actually enroll in Medi-Cal.

CCMS tracks information across multiple domains, including physical and behavioral health and living situation, and integrates information from multiple systems, including SFDPH's electronic medical record, ambulance transports, jail health services, sobering center, medical respite, behavioral health programs, homeless outreach, and homeless shelters. **Of the 9,975 individuals who experienced homelessness during FY14-15** and accessed care at SFDPH:

- More than half have been treated for serious mental health disorders;
- Nearly 60% had a history of drug or alcohol abuse;
- Nearly half have been treated for serious medical conditions;
- A third are tri-morbid and have been treated for all three of the above conditions;
- One-third have been continuously or intermittently homeless for longer than a decade (up from 9% in 2007); and
- Many are aging on the streets (the number of individuals age 60 or older increased 30%, from 856 in 2007 to 1,103 last year).

CCMS additionally has the capability to stratify the population on a range of factors to help prioritize sub-populations for targeted intervention. The WPC Pilot proposes to implement the risk stratification methodology depicted in the table below.

Severe Risk	Top 5% of users of urgent/emergent services AND Homeless > 10 years	570	5.7%
High Risk	Top 5% of users of urgent/emergent services AND Homeless ≤ 10 years	754	7.6%
	Homeless > 10 years (not in top 5%)	2,702	27.1%
Elevated Risk	Homeless (not in top 5% and homeless ≤ 10 years)	5,949	59.6%
TOTAL	**Homeless and rely on public healthcare services provided by SFDPH** (FY1415)	**9,975**	**100%**

The methodology is based upon a number of historical factors, including the span of time the individual has experienced homelessness, which might be continuous or sporadic. Presenting conditions might also elevate a client's risk stratification. Other risk factors are the individual's use of urgent/emergent services, and use of multiple healthcare systems. Urgent/emergent services are monitored by systems of care using service counts as follows:

- Medical System: Inpatient days, ED visits, Urgent Care visits, Medical Respite days, ambulance transports

- Mental Health System: Inpatient days, Psych Emergency visits, Crisis Intervention encounters, Acute Diversion days, Urgent Care visits
- Substance Abuse System: Sobering Center visits, Medical Detox days and Social Detox days

This risk stratification methodology will be studied and refined throughout the WPC Pilot, with particular attention paid to the Elevated Risk category to evaluate other stratifications based on vulnerability (e.g., youth, elderly, women) to determine whether movement into higher risk categories can be prevented.

The intensity of interventions will be based upon stratified risk: The most intensive interventions will focus on the 1,324 patients who are also very high users of urgent/emergent services.

Identification of the Target Population

Given San Francisco's significant focus on homelessness and the timing and alignment of multiple initiatives and priorities to serve this population, WPC Pilot partners agreed early on to focus on San Francisco's homeless population. To refine the focus, city agencies – SFDHSH, SFDPH, the Department of Aging and Adult Services, the Human Services Agency, and the Mayor's Office – convened city partners – both Medi-Cal managed care plans, as well as community-based organizations, HealthRIGHT 360, Baker Places, and Institute on Aging. We also had separate conversations with non-profit hospital leaders. Representatives from each of these organizations met several times over the last 45 days to review data and share experience and knowledge.

The group reviewed data from a number of sources, including CCMS, San Francisco's bi-annual point-in-time homeless surveys, the homeless services audits performed by the San Francisco Controller's office and the San Francisco's Budget and Legislative Analyst, and other relevant sources. The group agreed that **every homeless adult will be assessed and have a health record, and that risk stratification will direct intensive resources to those with the highest need. "Severe" and "High Risk" Homeless** (high users of urgent/emergent services and/or those who have experienced over ten years of homelessness) **experience twice the rate of serious health disorders and three times premature mortality than the general homeless population**.

SECTION 3: SERVICES, INTERVENTIONS, CARE COORDINATION, AND DATA SHARING

Section 3.1 Services, Interventions, and Care Coordination

Overview

The WPC Pilot proposal incorporates lessons learned from San Francisco's Navigation Center. The first Navigation Center, opened in March 2015, provides a range of on-site services for the adult homeless population. The Center has co-located services for healthcare and entitlement benefits, connects people with social services and long-term housing, or helps reconnect them with loved ones. To date, over 80% of clients had positive exits, including: 216 reconnections with family; 152 placements in supportive housing; 16 placements into stabilization units; and four placements into residential treatment. This new Navigation Center approach to homelessness provided the lessons that are the foundation of this proposal:

- need for a universal assessment to ensure that the right clients are placed into the right services at the right time;
- need for real-time client data to make the best decisions for a highly mobile and often hard-to-reach population; and
- need for improved care coordination to enable clients to obtain the services they need precisely when they are ready.

By creating a system that invests in **innovations in infrastructure and service**, the WPC Pilot will improve the lives of people experiencing homelessness in San Francisco.

Innovations in Infrastructure

The WPC Pilot invests in MACCS, which comprises a data-sharing platform, a multi-agency universal assessment tool, and enhanced care coordination capabilities.

Data Sharing Platform

The MACCS data and care coordination hub centralizes critical data on homeless adults accessing SFDPH's public healthcare services. It is at the core of San Francisco's WPC Pilot. Medical, behavioral, emergency, and social service data will be integrated into one interactive platform, which will be accessible to service providers (in compliance with all privacy laws) in real-time to help them make critical decisions for their patients and clients. The vision for MACCS is described in detail in Section 3.2.

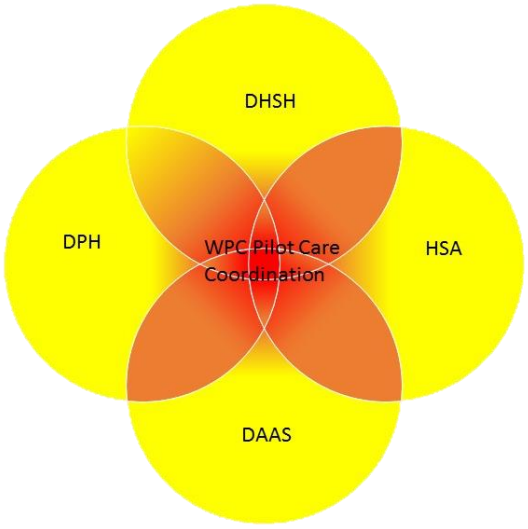
Universal Assessment Tool

MACCS also incorporates the development of a standardized multi-agency assessment tool that will be used to evaluate the needs of all homeless individuals seeking services in San Francisco. Pulling from historical information known about the client and real-time interviewing, the universal assessment will measure client acuity across multiple domains (e.g., health, length of homelessness) and stratify individuals into risk categories that will guide the intensity of interventions.

Care Coordination

San Francisco has a range of existing case management programs at SFDPH, SFDHSH, the Human Services Agency, the Department of Aging and Adult Services, and others to help clients navigate services. However, as in other parts of our system, they are siloed and do not communicate well or regularly. Using the power of data and standard assessment, MACCS will bolster the case management infrastructure by centralizing tracking of care coordination activities for WPC Pilot participants and prioritizing those with the highest risk stratifications for the most intensive interventions (see Figure 1).

Figure 1: Care Coordination Model



The WPC Pilot will employ centralized care coordinators reporting to the Program Director. These care coordinators will collaborate with the client's primary case managers to develop a Community Care Plan. Focusing on the highest risk patients, the WPC Care Coordination Team will additionally:

- Remove barriers to facilitate timely connections to needed services, which may include medical care, conservatorship, intensive case management, mental health and substance abuse residential treatment;
- Ensure other providers are alerted to the client's elevated status;
- Dispatch outreach workers to locate individuals in the streets or pickup wherever they present; and
- Provide transitional or bridge case management services and continuously monitor the client until they are fully engaged in care.

As the elements of MACCS advance in their development, the WPC care team will have increased access to accurate and comprehensive information to connect clients with appropriate services in a timely manner.

Foundation for a Citywide Navigation System

The data-sharing platform, the universal assessment tool, and the risk-stratified care coordination model are key elements not only of MACCS, but also of SFDHSH's broader Navigation System. While MACCS focuses on homeless San Franciscans with high healthcare needs, the Navigation System focuses on all homeless San Franciscans. Because a significant proportion of the homeless population has high healthcare needs, investments in MACCS will become the foundation for the broader Navigation System infrastructure. With the new SFDHSH launching today, MACCS helps set the stage for true interdepartmental collaboration to improve health and housing outcomes for homeless San Franciscans. Figure 2 depicts the data infrastructure for the Navigation System.

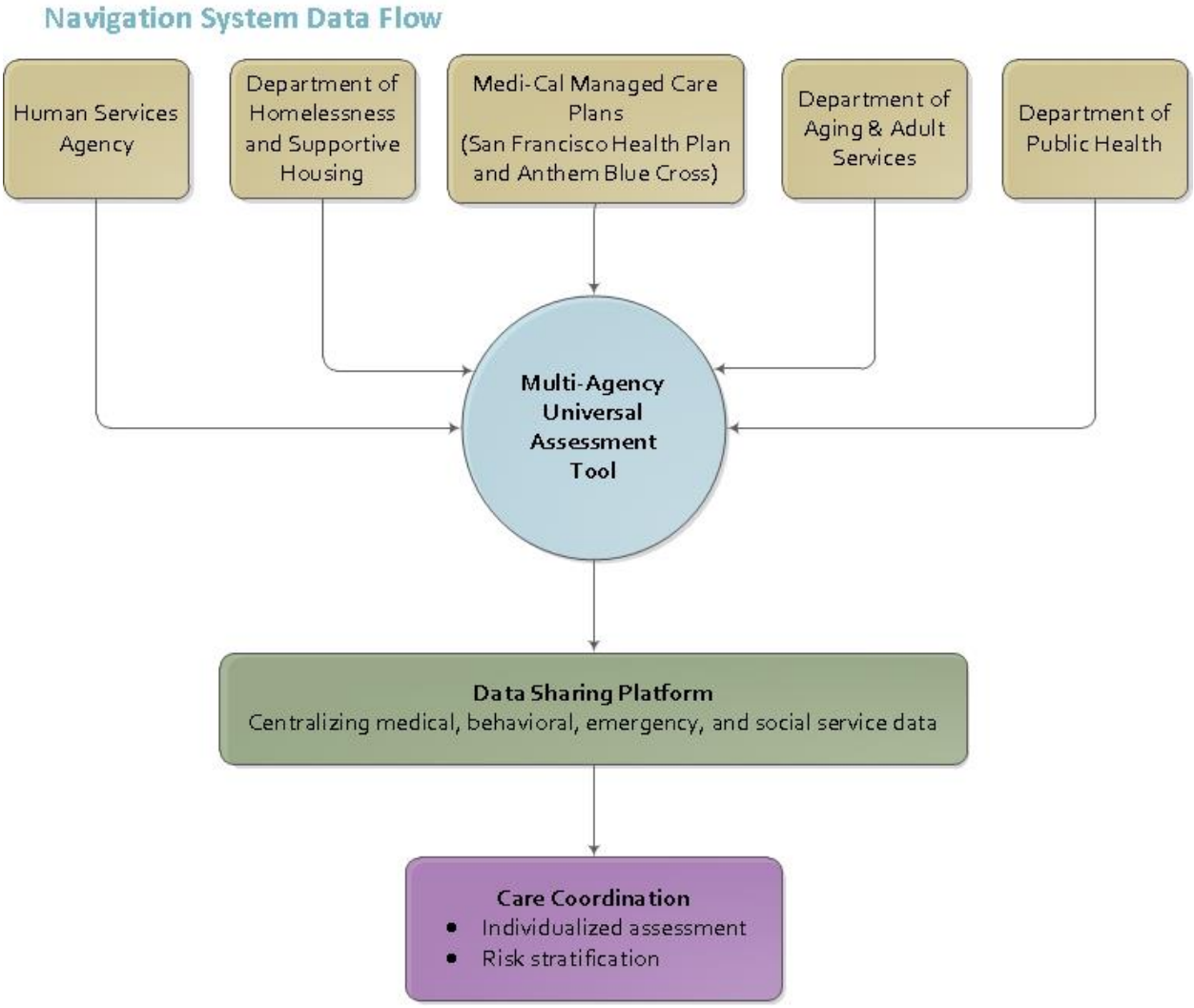


Figure 2: Shared MACCS/Navigation System Infrastructure

Innovations in Service

Existing Services

The full continuum of existing health, social, and housing services available to homeless San Franciscans through SFDHSH, SFDPH, and the Human Services Agency will be leveraged to support individuals enrolled in the WPC Pilot. Broadly, these services include:

- Screening for and enrollment into Medi-Cal and other public benefits;
- Comprehensive medical, behavioral health, and social services;
- SF Homeless Outreach Team, which works in small teams to outreach to homeless individuals on the street to provide case management, medical care, and linkage to housing and services;
- Homeless services and housing supports; and
- Case management

Services to Fill Identified Gaps

In addition to these established services, the WPC Pilot proposes supplementary services to fill identified gaps in care. Those additional services are detailed below.

Navigation Centers

Building upon our success, the WPC Pilot will support the expansion of the Navigation Center model by providing for six Navigation Centers over the next two years, including one dedicated to serving individuals with persistent behavioral health challenges. The first Navigation Center, operated under contract by Episcopal Community Services, created a model for engaging with long-term homeless individuals with barriers to utilizing the traditional shelter system. The Navigation Center brings together services and staff from multiple City agencies and non-profit partners to streamline the processes by which homeless individuals connect to benefits and exit into stable housing.

Expanding Medical Respite

The WPC Pilot proposes to expand San Francisco's existing Medical Respite shelter to provide medical and psychosocial care for those whose needs cannot be safely met in a regular shelter setting. A recent assessment of shelter residents found that over 53% had a psychological condition, nearly 50% had a medical condition that contributes to early mortality, and almost 60% have used urgent/emergent services. The Medical Respite expansion would be an alternative to hospital emergency departments as well as a destination for hospital discharges, providing a period of recovery and stability for individuals who would otherwise be on the street.

5150 Wraparound Project

CCMS data show that individuals in the WPC Pilot identified as Severe and High Risk use psychiatric emergency services at SFDPH's Zuckerberg San Francisco General Hospital an average of 3.3 times a year. The 5150 Wraparound Project seeks to break this cycle. Working with the five largest hospital emergency departments, operated by SFDPH, Sutter Health, and Dignity Health, peer navigators or health workers will arrive on-site at hospital emergency departments to escort patients to the discharge destination and provide a warm handoff. Employing peers who can support the individual's decision to enter into care or shelter will increase the likelihood that the person will remain engaged. Additionally, the Project will leverage the expertise of HealthRIGHT 360 to streamline access to substance use disorder services for this population.

Integrating Substance Use Disorder Services into Primary Care and Mental Health Clinics

One-third of the WPC Pilot target population has been diagnosed with medical, psychiatric, and substance use conditions. To increase integration and coordination of care across these disciplines, this WPC Pilot proposes to embed alcohol and drug counselors in SFDPH primary care and mental health clinics that serve a high proportion of the WPC Pilot population. Alcohol

and drug counselors will accept warm handoffs, provide counseling, and coordinate with the client's primary care team.

Building Capacity to Expand Detoxification Services

The rate of alcohol and drug dependency among the Severe Risk WPC population is more than 90%. SFDPH currently supports residential detoxification programs at HealthRIGHT 360 and Baker Places and nearly half of the top 5% users of urgent/emergent services access them. While residential detox services will become reimbursable under the Drug Medi-Cal Organized Delivery System, significant investments are required to prepare these programs to meet staffing, documentation, and audit requirements. This WPC Pilot proposes to build the infrastructure needed to sustain these programs under Drug Medi-Cal.

Extension of Residential Substance Use Disorder Treatment

Drug Medi-Cal provides for residential treatment in 30-day increments up to a total of 90 days. However, 90 days is not always sufficient for high utilizers with long-term substance use disorders, and many dually- or triply-diagnosed clients in the WPC Pilot may require 12 weeks or more just to stabilize from co-occurring medical or mental health conditions. An extended stay, authorized individually on an as-needed basis, would address substance use disorder treatment in meaningful way and ensure that a client's mental and physical needs are addressed to maximize success upon discharge.

Reducing Institutional Care for Homeless Seniors

To address the aging homeless population, the Institute on Aging will provide intensive transitional care management services to enable discharge or prevent institutional care for homeless seniors who would otherwise be "housed" in long-term care facilities due to their complex medical conditions. This program leverages the existing infrastructure and resources of San Francisco's Community Living Fund, which couples care management with the purchase of needed goods and services.

Section 3.2 Data Sharing

Coordinated care among San Francisco's numerous homeless services providers is hindered by a decentralized data infrastructure. Regulatory, privacy, and service mandates require each agency to maintain program-specific documentation systems. Additionally, none of the current applications has the interoperability to exchange information to provide a 360-degree view of the client either in real-time or retrospectively, nor the functionalities to facilitate seamless communication and care coordination across agencies.

Sustainable Infrastructure for Information Exchange

MACCS is the core of the WPC Pilot and one cornerstone of the technology solution for SFDHSH's broader Navigation System that will enable San Francisco to serve its homeless clients holistically. Among the goals of the new SFDHSH is to create an information technology platform that integrates medical, behavioral, and social data with housing information. This data

would be accessible to the greatest extent allowable under privacy laws to providers of health and homeless services, anytime, anywhere, and on any device.

The MACCS infrastructure will explore the opportunity to harness the power and security of the cloud, as well as mobile technologies to deliver a comprehensive, real-time view of each client's health and social data to develop an interagency shared community care plan and alert members of the client's care team of key events. The WPC Pilot will explore partnering with a technology innovator, such as Salesforce and its Health Cloud, a client relationship platform that can aggregate multiple datasets and streamline care coordination for clients. Together, the WPC Pilot partners will:

- Identify the initial use case;
- Define input and output data for care planning and coordination;
- Determine source system configuration and architectural design;
- Determine directionality of the data between systems;
- Determine the timeliness of the data; and
- Create a data model and information governance structure.

Integrating Information from Multiple Sources

The WPC Pilot will integrate multiple information systems and data sources through MACCS in order to promote collaborative planning and care coordination for the WPC target population:

- Coordinated Care Management System (CCMS) – Centralized repository of data from 15 data sets providing a "whole person" profile comprising 20 years of essential medical mental, and substance abuse health histories and social information on our vulnerable populations served by SFDPH;
- Homeless Management Information System (HMIS) – to be implemented by October 2017, the system of record providing coordinated entry to all SFDHSH homeless services;
- Enterprise Electronic Health Record (EHR) – to be implemented by late 2018, a unified electronic health record integrating data on medical, behavioral, substance use, and correctional health services provided by SFDPH;
- Multiple Human Service Agency (HSA) Information Systems – various data systems that track eligibility for public assistance and In-Home Supportive Services; and
- Emergency Department Information Exchange (EDIE) – a web-based communication technology that enables intra- and inter-emergency department communication and is used for the Health Homes program by San Francisco's Medi-Cal managed care plans, San Francisco Health Plan and Anthem Blue Cross.

Strong Data and Information Sharing Governance

Significant data security, privacy, compliance and ownership concerns must be addressed to ensure both client rights and organizational liabilities are fully protected. An early critical success activity will be to convene each partner's respective information technology, legal and compliance teams and to tightly project manage that group to assure the WPC Steering

Committee can reach agreement and execute contracts or memoranda of understanding (MOUs) on data sharing and governance.

Managing Potential Implementation Challenges

Forces that may negatively impact project scope, schedule, cost, and outcome include: legal and regulatory restrictions; data sharing constraints; technical delays; low user adoption; poor accountability to outcomes; and competing organizational priorities. To mitigate these potential barriers, the Operation's Committee's data sharing subcommittee will be integrated into the WPC Pilot governance structure. This monthly forum will involve high-level leaders from each partner agency and will use an executive visual dashboard to summarize and present status updates to build project-wide accountability.

Implementation Timeline

Pilot Year	Activities
2016	• Establish MACCS Program Management Office • Secure contract for HMIS vendor solution • Implement EDIE • Begin analysis of available datasets, user needs, and measures of success • Develop workplan, governance structures and working committees
2017	• Install and implement HMIS • Secure contracts for relevant technology solutions • Sign MOUs for data sharing and care coordination accountability
2018	• Install and implement SFDPH enterprise EHR • Complete system configuration and data integration for CCMS, HMIS, HSA systems, and EDIE • Design, build and test workflow processes, and decision support
2019	• Complete system configuration and data integration of EHR • Validate and refine care team workflow processes and decision support algorithm • Implement population health analytics to target client segments for specific interventions • Initiate program evaluation and impact assessment
2020	• Complete program evaluation

SECTION 4: PERFORMANCE MEASURES, DATA COLLECTION, QUALITY IMPROVEMENT AND ONGOING MONITORING

4.1 Performance Measures

Members of the WPC Pilot target population will experience two interventions: 1) a connected electronic infrastructure for care coordination (the Multi-Agency Care Coordination System – MACCS), and 2) augmentation of certain services with a move toward value-based care models. The result is a homeless single adult living on the streets or in the shelters of SF can experience treatment access opportunities coming faster and closing gaps that previously required the individual to travel around the city for services and tell their personal history many times. A Medi-Cal eligible beneficiary with worsening disease conditions and escalating treatment costs is most likely to notice the difference.

The WPC Pilot partners will be reimbursed for these achievements and activities according to performance measures that emphasize planning and implementation in pilot years 1 and 2, then completion and refinement in years 3, 4, and 5. The WPC Pilot Attachment MM is the guiding document throughout all performance measures.

1) Universal Metrics

Universal health outcome measures #1-5 apply to the impact being made by service delivery interventions. They are the shared responsibility of partners having contact with homeless individuals. Payment for reporting refers to tracking and reporting the health outcome measures in a standardized timely manner and is requested for all five. Payment for improved outcomes is attached to the first four. Partners will receive payment if standardized reporting shows measurable improvement over time. The relative amounts of compensation will shift over the course of the pilot to emphasize outcome improvement more than standardized reporting.

Universal metric #6 requires an administrative organizational structure that is the responsibility of SFDPH as the lead partner. This metric will be reported, but no payment is attached. Each of the WPC partners will contribute to developing contracts, MOUs, scope of practice, and policy and procedure documents that will govern the WPC Pilot. Each partner will have contracts or MOU documents specifying participation.

Universal metric #7 requires the planning and implementation of a shared data structure. This metric will be reported, but no payment is attached. All partners will contribute via regular meetings to the planning and decisions regarding infrastructure technology.

2) Variant Metrics

Variant metrics 1-4 emphasize that this WPC Pilot wants to create a health and social record for every homeless individual and connect them to the resources they need to maintain their health and well-being and the community's wellness as well.

Variant 5 measures the commitment to ensuring individuals have the support services they need to stay in their chosen housing. No one benefits if homeless individuals cycle in and out of housing.

Outcome metric 6 protects everyone from communicable diseases.

Reporting and evaluation will follow the WPC Pilot Attachment GG throughout the pilot period. Data transmission to SFDPH will be electronic as the preferred method. Initially health and social input will arrive through CCMS, and shelter and housing placement will transmit via HSA. The Navigation Centers will use alternative reporting initially. As the pilot progresses and infrastructure is completed, all data will be retrieved from the new system.

4.1.a Universal Metrics

☑ Health Outcomes Measures

☑ Administrative Measures

Universal metric	PY1	PY2	PY3	PY4	PY5	Participating entities
U1. Emergency Department Utilization HEDIS	Baseline: (count adult users of medical ED, visits per adult user)	Maintain baseline	Reduce by 2% from previous year	Reduce by 2% from previous year	Reduce by 2% from previous year	DPH
U2. Inpatient Hospital Utilization HEDIS	Baseline: (count adult users, # days per user)	Maintain baseline	Reduce by 2% from previous year	Reduce by 2% from previous year	Reduce by 2% from previous year	DPH
U3. Follow up after hospitalization for Mental Illness HEDIS	Baseline: (% inpatient patients receiving follow-up)	Maintain baseline	Increase by 2% from previous year	Increase by 2% from previous year	Increase by 2% from previous year	DPH Behavioral Health Services
U4. Initiation and engagement in alcohol and other drug dependence treatment HEDIS	Baseline: expected: pts using residential AOD detoxification	Maintain baseline	Increase by 2% from previous year	Increase by 2% from previous year	Increase by 2% from previous year	DPH Behavioral Health Services Baker Places HR360
U5. Proportion of beneficiaries in MH follow-up treatment with care plan accessible by entire team w/in 30 days of	Baseline: Pts receiving follow-up treatment post psy ED and Inpt who have care plans	Maintain baseline	Increase by 2% from previous year	Increase by 2% from previous year	Increase by 2% from previous year	DPH DHSH HSA DAAS/IOA Baker Places HR360

Universal metric	PY1	PY2	PY3	PY4	PY5	Participating entities
enrollment and anniversary in program						
U6. Care coordination, case management, and referral infrastructure	Baseline: examine needs for written documentation	Develop contracts, MOUs, scope of responsibilities, care coordination	Update	Update	Update	DPH DHSH HSA DAAS Baker Places HR360
U7. Data and information sharing infrastructure as measured by documentation of policies and procedures for all entities that provide care coordination, case management monitoring, strategic improvements.	Baseline: examine needs for written documentation	Develop contracts, MOUs, scope of responsibilities, care coordination	Update	Update	Update	DPH DHSH HSA DAAS/IOA Baker Places HR360 SF Health Plan Anthem BC

4.1.b Variant Metrics

Variant Metric	PY1	PY2	PY3	PY4	PY5	Participating entities
1. Completion of Universal Assessment Tool with homeless individuals	Baseline: counts completion of assessments	Maintain baseline	Increase by 2% from previous year	Increase by 2% from previous year	Increase by 2% from previous year	
2. Health Outcomes: 30 day All Cause Readmissions	Baseline: count of hospital readmission w/in 30 previous discharge	Maintain baseline	Reduce by 2% from previous year	Reduce by 2% from previous year	Reduce by 2% from previous year	
3. Health Outcomes:	Baseline: count of persons and jail	Maintain baseline	Reduce by 2% from	Reduce by 2% from	Reduce by 2% from	

Variant Metric	PY1	PY2	PY3	PY4	PY5	Participating entities
Decrease Jail Recidivism	days over time period		previous year	previous year	previous year	
4. Health Outcomes: Suicide Risk Assessment Required for Pilots w/ SMI Target Population	Baseline: count of suicide assessments in PES and Psy Inpt	Maintain baseline	Increase by 2% from previous year	Increase by 2% from previous year	Increase by 2% from previous year	
5. Housing: Permanent Housing	Baseline: in CCMS and HSA database of persons leaving housing placement	Maintain baseline	Reduce by 2% from previous year	Reduce by 2% from previous year	Reduce by 2% from previous year	

Outcome Metric	PY1	PY2	PY3	PY4	PY5	Participating entities
6. Obtain TB clearance in preparation for next treatment placement	Baseline – In CHANGES shelter database and CCMS	Maintain baseline	Increase by 2% from previous year	Increase by 2% from previous year	Increase by 2% from previous year	

Section 4.2 Data Analysis, Reporting and Quality Improvement

Data Analysis, reporting and quality improvement will be conducted in the SFDPH performance framework consisting of three pillars: **mindset, skillset, and toolset**. The Mindset pillar creates a learning organization, whereby problem solving and the use of data for improvement is cultivated. The second pillar, Skillset, focuses on the development of internal capacity and staff aptitude to improve on inefficiencies and challenges in the workplace. Lastly, the Toolset pillar recognizes that in order to improve, we need to leverage technology, data systems, registries, and analytics, together with the first two pillars to be successful.

Data Analysis/Reporting (toolset)

Essential to measuring the impact of the WPC Pilot, MACCS will support data collection, risk stratification, analysis, and reporting. An **information technology (IT) subcommittee of the Operations Committee will be responsible for mapping the elements of each measure** to MACCS. Subcommittee members will create a standardized data dictionary and nomenclature

for the documentation of key performance and process measures. This process will create a uniform language from which to report and discuss data. SFDPH has already created a data validation process and procedure to ensure the accuracy of the data capture and will incorporate these protocols into the development of the MACCS. Automated monitoring systems will be created to alert IT staff and assess completeness of data transfer between systems.

Once the data warehouse is created, an electronic performance dashboard, consisting of key driver and process metrics, will be produced; it will have the ability to drill down to the agency, and navigation center level. Regular data flow will allow for the availability of timely, actionable dashboards. Patient level registry lists will identify from the universal assessment tool, gaps in care. **Data can be analyzed to assess a variety of concerns, including identifying patients at highest risk, those who have fallen out of care, and those who are not engaging.**

Performance measures will be posted electronically on a shared platform or pushed out for front line staff, workgroups, and executive sponsors to discuss.

Taking a population health approach, patient lists will also be generated to identify patients (still assuring confidentiality) who are missing key services from the universal assessment tool and community treatment plan. Local agencies and navigation centers can proactively outreach to patients to link them to much needed services.

While each participating entity in the WPC Pilot will be responsible for data submission, SFDPH will take ultimate responsibility for reporting of data on the metrics.

Coaching and Review Process (Mindset)

The **Operations and Steering Committees will review the dashboard and performance measures regularly** to ensure that agencies and navigation centers are staying on track. Using a standardized report out format, executive sponsors and champions will be asked clarifying questions and coached towards improvement. Real case scenarios where system or bureaucratic issues impede health and housing goals will be presented and discussed. General themes, trends and case reviews from among the different agencies, along with common barriers, will be escalated to the Steering Committee for resolution.

The participating agencies and their teams are expected to also review their metrics regularly, using the data to inform new interventions, and to decide on whether to adopt, adapt or abandon current interventions. Failures will prompt learnings and those teams who are not able to achieve milestones, will be directed to devise alternative performance improvement plans (PIP). Additionally targeted coaching in quality improvement principles and tools (e.g., process mapping, root cause analysis, and rapid cycling PDSA) will address performance issues.

In an effort to create a culture of quality, WPC pilot teams will incorporate performance improvement discussions into regularly occurring staff meetings and huddles, creating a performance improvement mindset in all staff.

Quality Improvement (PDSA) Process (Skillset)

The foundation for this three pillared framework is the Model for Improvement and the PDSA. Consistent with this model, is:

- The setting of an AIM statement: what are we trying to accomplish?

- The development of performance measures: how do we know that a change is an improvement?
- The execution of countermeasures: what changes can we make that will result in an improvement

SFDPH has a robust, 11-month Quality Improvement Learning Academy that trains teams of staff in problem solving skills, the use of data for improvement, rapid PDSA cycling, and change management.

WPC pilot teams will be taught the fundamental quality improvement principles and how to apply them to the proposed interventions. WPC Pilot workgroups and champions will meet regularly to create local performance improvement goals, develop project milestones and project plans (PLAN). Interventions will be scoped to allow for small steps of change, and rapid cycling (DO). Monthly review of the project plans and dashboard performance measures between executive sponsors and champions will ensure that proposed interventions are analyzed (STUDY), on track, and that barriers encountered are dealt with in a timely manner (ADJUST). Lastly, interventions and countermeasures will be evaluated based on a number of factors, including, sustainability, value added outcomes, resources required, simplicity of design, and return on investment. These factors will determine whether the solutions need additional refinement, are ready for spread, or should be terminated.

PSDA FUND

This WPC Pilot incorporates the Plan-Do-Study-Act (PDSA) process throughout the service interventions as well as the care coordination models proposed here. The oversight and governance model we have put in place for this pilot as well as the rich data infrastructure that we are developing provide the necessary elements for the PDSA improvement process. We are also proposing the establishment of a PDSA Fund that to allow us to test responses to identified needs. This fund, which would be administered by the San Francisco Public Health Foundation, would be flexible and quickly accessible to enable the WPC Pilot to conduct small-scale tests of change. Those with promise could be brought to scale, and, as needed, addressed through the program modification process. Examples of the types of expenditures that might be covered by the PDSA Fund could include pay for performance program, implementation of high value activities such as home visits, transportation, Daytime activities, and patient incentives.

Section 4.3 Participant Entity Monitoring

Through meetings and case conferencing, SFDPH plans to closely monitor the WPC Pilot services provided (both in terms of quantitative data collection/analysis/reporting and more informal feedback provided by partners and clients). **The program director in conjunction with SFDPH's Quality Improvement unit will be responsible for developing the Quality Plan**. They will manage the WPC Pilot quality and improvement activities. These activities include coordinating transfers when needed, trouble shooting care coordination challenges, audits, monitoring data quality, client flow, and client experience. The director and the various subcommittees will regularly monitor the data collected and submitted by participating entities toward the various metrics. They will troubleshoot problems, engage in PDSA cycle to address these problems, and provide on-going trainings. A health care analyst is budgeted whose responsibility includes monitoring, training, and evaluation/audits. The MOU will include standardized policies and procedures (developed and approved by the Steering and Operations Committees) for clinical practice and services, care coordination, contract terms, and obligations. The terms will define deliverables, service delivery, submission of reports, program

targets, data quality and timeliness standards, conflict resolution processes, technical assistance, and termination if the terms are not met. If problems of non-performance by any partners arise, efforts will be made to develop corrective action plans to assist the organization in recalibrating its course. If the problem seems insurmountable, SFDPH will consult with DHCS.

SECTION 5: FINANCING

5.1 Financing Structure

Intake and Oversight of Funds. SFDPH will provide financial management and oversight for the WPC program. Financial reporting and decision-making will be incorporated into the proposed governance structure for the WPC pilot described in the Communications Section above. DPH will receive and distribute the funding to partner agencies. Funds will be managed under DPH and the City and County of San Francisco's accounting practices, policies and regulations. Oversight and tracking of federal funds is extensive and includes the DPH Chief Financial Officer, Health Commission, City Controller's Office, Mayor's Budget Office and Board of Supervisors. DPH has existing contractual agreements, MOUs, and other formal financial relationships with each of the partner entities that will be leveraged and modified to administer, distribute, and track pilot funding. These agreements will be used to formalize payment processes and to ensure funds are sufficient to provide reimbursement for provided services by setting clear payment maximums and establishing the conditions under which payments will be distributed.

Infrastructure Payment Distribution: The proposal includes payments to the Department of Public Health for staffing to oversee the program and develop and administer governance structure. In addition, funding is requested for creation of delivery infrastructure for the Navigation System in the newly created Department of Homelessness and Supportive Housing. The application also includes a substantial information technology program, administered by DPH, to create IT infrastructure linking data between currently detached systems and enable shared data access and coordination across multiple agencies.

Service and Intervention Payment Distribution:

Department of Homelessness and Supportive Housing (DHSH). Operationalizing Navigation Centers is a critical component of the City's strategy to improve outcomes for the target population. The City has a goal of having six navigation centers open within the next two years. Because of the critical role of these centers, the proposal includes one-time incentive payments to DHSH upon the opening of each center. Once the centers are open and operating, the pilot includes per-member-per-month (PMPM) funding for homeless Medi-Cal beneficiaries to cover the cost of operation of the navigation centers, delivered by DPH to DHSH. The PMPM payment allows flexibility and creates an incentive to manage costs creatively.

Department of Public Health (DPH). In addition to DPH's role in project oversight (in close collaboration with DHSH), the pilot proposes a per-member-per month (PMPM) payment for medical respite service expansion and for a new program to provide navigation resources to Medi-Cal clients as they are released back into the community from Psych Emergency Services. Both of these programs will be critical to keeping clients engaged in services and preventing avoidable hospital readmissions for high-utilizers. The PMPM payment structure will allow for flexibility and adaptability of these services over time.

Human Services Agency (HSA) and Department of Aging and Adult Services (DAAS). HSA and DAAS will provide care coordination services for subsets of the target population. Payments to these agencies are proposed to be made on a fee-for-service basis to leverage existing financial structures. DAAS will also subcontract with the Institute on Aging for care coordination services, using the existing fee-for-service model for administrative efficiency. These agencies will be eligible to receive incentive payments based on outcome measurements.

Baker Places and HealthRight360. The two community-based, not for profit behavioral health providers will receive fee-for-service payments for residential substance use services, with added incentive payments based on outcomes. These outcome-based payments will also be used as a pilot to explore moving behavioral health services toward value-based payments.

San Francisco Health Plan (SFHP) and Anthem Blue Cross (ABC). The County's two Medi-Cal health plans will receive infrastructure funds needed to produce and manage utilization data among Medi-Cal beneficiaries needed to establish baselines and measure outcomes under the pilot. The plans will also assist in integrating EDI system data into the MACCS platform.

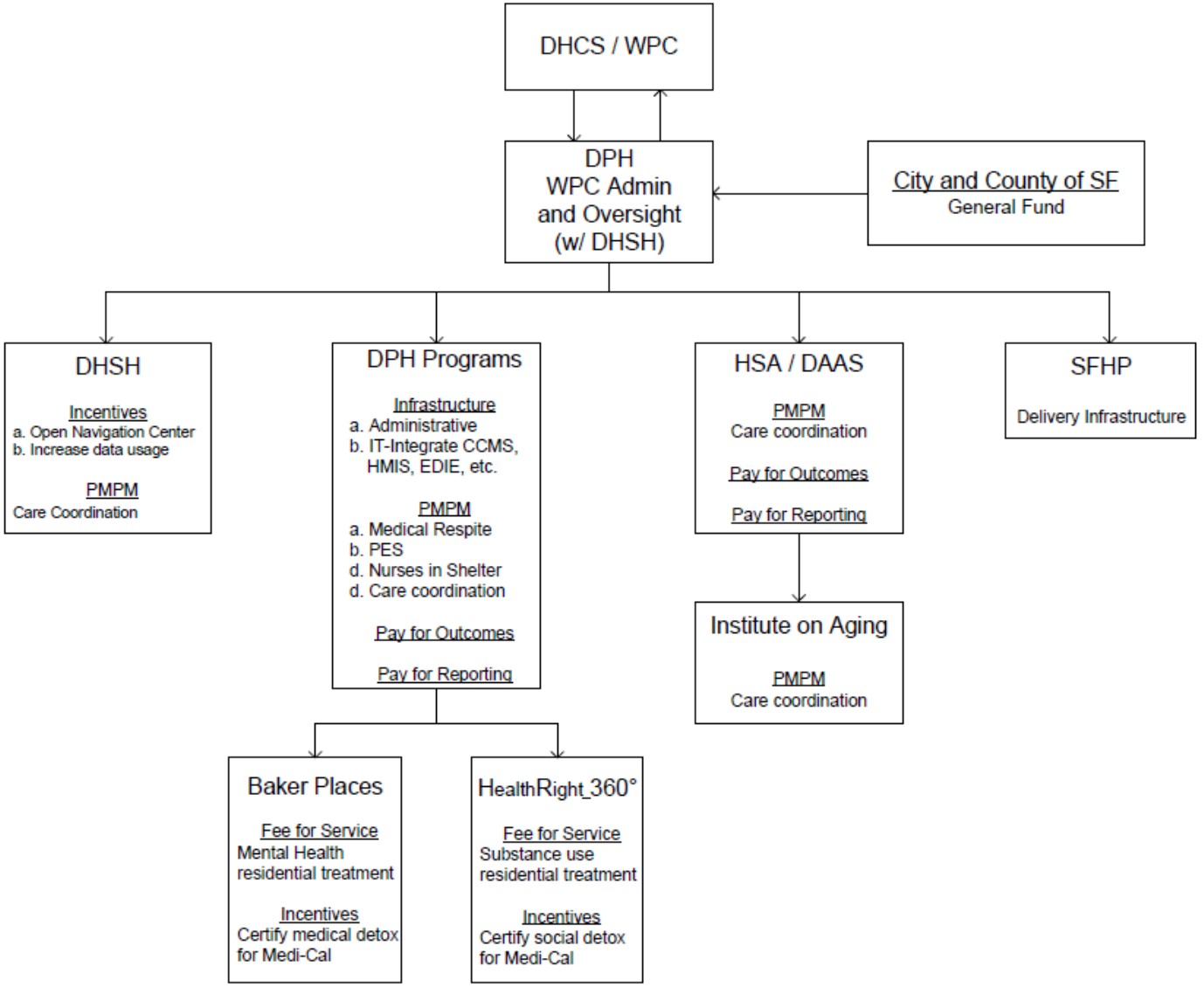
Payments Based on Incentives, Outcomes, and Reporting. An overarching goal of the pilot is to establish permanent operational and management practices across agencies that are consistent with value based payments. It is expected that every participating partner will have the opportunity to earn payments for their roles in achieving outcome targets. During the first year of the pilot, the partnering entities will engage in a planning process to define how outcome-based payments for successful performance of the pilot will be distributed among agencies, and formalize the arrangements through contract and MOU provisions. Each subsequent year this model will be re-evaluated using a PDSA process.

Timelines for Payments. Infrastructure, pay-for-outcome, and pay-for-reporting payments will be expended and then the County will receive federal reimbursement. Fee-for-service payments will be paid through the City's regular periodic invoicing process, although the contracted payment schedule may be structured to coincide with the timing of the federal payments. Per-member-per month payments will be made quarterly using payment estimates, then reconciled to actuals at the end of the year once final reporting is available. All payment schedules will be established between DPH and partner agencies through contracts, MOUs, and work order agreements.

Alignment with Other Funding Sources. The proposed WPC pilot has been strategically designed to operate in close coordination with other major funding initiatives planned over the next five years. Application development was led by the City's 1115 Waiver Integration Team, which is coordinating San Francisco's strategy for implementing PRIME, GPP, Drug Medi-Cal Waiver, and Health Homes. In June 2016, San Francisco voters passed Proposition A, a $350 million General Obligation bond including funds to improve county health and homeless service facilities, improving capital infrastructure needed to drive outcome improvements for the target population. The Mayor's proposed budget introduced on June 1, 2016 includes $221 million in funding for the new Department of Homelessness and Supportive Housing, and a proposed sales tax for the November, 2016 ballot that will provide nearly $50 million per year for homeless services. The WPC pilot will be closely coordinated and managed with each of these initiatives to maximize patient outcomes.

5.2 Funding Diagram (see next page)

San Francisco Proposed Funding Diagram for Whole Person Care Pilot



5.3 Non-Federal Share

The non-federal share will be provided by appropriation of City and County of San Francisco General Funds to the Department of Public Health as the lead entity. The non-federal share will be appropriated and provided using the same process as other programs requiring intergovernmental transfers of the non-federal share of funds.

5.4 Non-Duplication of Payments and Allowable Use of Federal Financial Participation

San Francisco currently has a rich array of services, and believes that the core service components are in place to drive improved health outcomes at reduced cost. However, many of these services are spread across multiple agencies and entities, resulting in a system of care that is imperfectly aligned to achieve results. The target population includes very sick, very high-cost, high-utilizing individuals who periodically receive services from many agencies.

Broadly speaking, the WPC proposal will: 1) establish information technology and operational infrastructure that will facilitate coordination across systems of care, and 2) use shared financial incentives and payment structures to establish a value-based, outcome-oriented mindset to multi-agency service delivery in San Francisco. These goals are directly consistent with STC 113's criteria for WPC pilot support. While San Francisco has identified a number of strategies to achieve these goals, until the WPC pilot these actions have not been reimbursable under Medi-Cal or other federal funding.

There will be a number of processes in place to ensure federal financial participation will be received only for services provided to Medi-Cal beneficiaries and will not result in duplicative payments. The target population for the WPC proposal are the Medi-Cal eligible homeless San Franciscans who rely on the public healthcare services provided by SFDPH. The project will improve coordination of data systems across multiple agencies and organizations, including data on eligibility for Medi-Cal and other benefits. Each of the entities participating in the program has extensive experience and existing processes in place for tracking services and expenditures by insurance eligibility status to ensure compliance under federal reimbursement rules. DPH currently tracks eligibility for Medi-Cal through its electronic health record system and CCMS, and as a safety net provider has well-established processes in place to segregate services and costs based on eligibility status. DPH does not participate in the targeted case management program and DHCS will be removing San Francisco from the State Plan Amendment. Both San Francisco Health Plan and Anthem Blue Cross, the two county Medi-Cal plans, are participating in the program. HSA is the county agency designated for Medi-Cal enrollment. Data on services provided under the proposed pilot, including Medi-Cal eligibility status, will be closely tracked and reported throughout the life of the pilot. In cases where services proposed under the pilot will benefit both Medi-Cal eligible and ineligible clients, the estimated costs and reimbursement assigned to the WPC program have been pro-rated to ensure that WPC funds serve only the eligible portion of the population, with the balance assigned to City and County General Funds or other non-federal sources.

As a part of the governance structure for the pilot, participating agencies will develop a memorandum of understanding (and associated contractual language where applicable) that will include a requirement that entities receiving payment of federal funds must document eligibility status for service recipients. Where funds are provided on a fee-for-service, capitated, incentive and outcome basis, data on Medi-Cal eligibility will be required before payments are distributed to ensure federal funds are not used for services to individuals ineligible for Medi-Cal.

5.5 Funding Request

See attached

Budget Justification

San Francisco's Whole Person Care Pilot program (WPC Pilot) proposes to create a comprehensive, coordinated, and sustainable Multi-Agency Care Coordination System (MACCS) within the City and County of San Francisco to increase collaboration among, access to, and appropriate utilization of services and supports for homeless adults in San Francisco who are high utilizers of urgent and emergent care. An examination of San Francisco's system of care reveals a strong and wide foundation of services and data, but a siloed and inadequately coordinated service delivery structure that limits potential to drive patient outcome improvements.

Our proposed WPC pilot budget addresses the gaps in coordination, information technology infrastructure, and service and will allow us to provide more effective care for our homeless clients.

Administrative Infrastructure

The **Administrative Infrastructure** will oversee the entire WPC Pilot program. The Administrative team is responsible for financial management and developing and administering the governance structure. Our proposal includes 3.5 FTE of operations staff to oversee the management, operations, evaluation and quality improvement critical to the success of our whole person care pilot.

A half-time 0953 **WPC Coordinator** provides oversight of the entire project. He/she is responsible for convening partners, overall decision making, program design, operations, implementation, policy development, staff recruitment and supervision, budgeting, program monitoring and reporting, and liaison with the state, partners and other stakeholders.

The 0923 **WPC Operations Manager** (1 FTE) oversees day to day operations of the WPC Pilot, provides supervision of line staff, convenes and staffs the various steering and subcommittees, coordinates trainings, monitors deliverables, oversees data development, information and communication, and operationalizes program design and policies.

The 1406 **Administrative Support** (1 FTE) supports day-to-day office functions for the WPC team, including scheduling meetings, calendaring, preparing agendas and meeting minutes, maintaining records, ordering supplies and requisitions, preparing reports, and supporting trainings activities.

The 2119 **Quality Improvement Analyst** (1 FTE) is responsible for developing a quality plan, collecting and analyzing data, developing dashboards, designing performance improvement activities, coordinating PDSAs, guiding program monitoring, evaluation and audits, identifying training needs, coordinating trainings as appropriate, and liaising with external evaluator.

Program Evaluation: DPH will contract with UCSF to evaluate both processes and outcomes of the WPC Pilot. This is important to know what worked or did not to allow for institutionalization and spread. Our program evaluation contractor will design evaluation, develop and administer assessment tools, collect data, and prepare reports**.**

Funds allocated to program materials and supplies and contingency will be spent on computers for program staff, office supplies, training materials, and other costs associated with running the program.

Delivery System Infrastructure

To fully support the WPC Steering and Operations Committees in their efforts to coordinate care across agencies and services, we must increase our capacity in two areas. First, and foremost, is increased data and data sharing capacity through our Multi Agency Care Coordination System. Second, we must increase the capacity of our care providers in targeted areas.

Multi Agency Care Coordination System (MACCS) Data Infrastructure

Data Platform

SFDPH currently has an Oracle database, Coordinated Care Management System (CCMS) that pulls data from 15 different sources. While CCMS is in many ways a powerful tool, it is limited in its ability to integrate data from other systems, and is not universally available to providers. San Francisco proposes to develop a more robust platform on Salesforce's Health Cloud. The new platform will integrate CCMS with other critical data systems including the Homeless Information Management System (HMIS), Emergency Department Information Exchange (EDIE) and other systems into one interactive platform. This integrated system, known as MACCS, will provide a single shared source of actionable data to service providers at multiple agencies.

MACCS will enable development of a single multiagency assessment tool to develop risk stratification of patients to prioritize interventions citywide. We expect at least 200 providers will need access to this system, but we plan to review the actual needs as part of our evaluation process.

In order to support MACCS and ensure ongoing reporting capabilities, we propose the following positions:

The 1070 **IS Project Director** (.66 FTE) is the Whole Person Care IT Applications Supervisor. He/she will work collaboratively with clinical and operational leaders throughout DPH to provide whole person care application support and solutions to meet both the business and technical needs of DPH. This position plays a key role in the ongoing implementation and integration of electronic health technology in support of DPH's whole person care, regulatory, clinical and financial goals.

The 1053 **IS Business Analyst (Senior)** (.66 FTE) oversees the more difficult and complex aspects of the systems/application services development cycle, including needs analysis, cost-benefit analysis, structured systems analysis and design, feasibility analysis, technology and software assessment, telecommunications needs analysis, project planning and management, system installation, implementation and testing, conversion to production status, technical and procedural documentation, user training, and post-implementation assessment and administration. He/she is a primary IT resource for an organization with a complex system.

The 1044 **IS (Technical or Applications) Engineer – (Principal)** (.66 FTE) provides direct ongoing supervision to other IS Applications/Technical Engineers. He/she provides leadership and direction and assumes technical responsibility for completion of major projects, and serves as the top technical or applications services authority for one or more related specialties. He/she also performs and reviews complex work involving analysis, planning, designing, implementation, maintenance, troubleshooting and enhancement of complex large systems or applications services consisting of a combination that may include application operating system support, and or mainframes, mini-computers, LANS, and WANs support. Additionally, he/she serves as the lead applications operating support or database administrator for database design, migration, performance monitoring, security, troubleshooting, as well as backup and data recovery. Finally, the Principal Engineer serves as a database administrator and operating system support for applications services or technical architect and systems integrator for large complex systems.

1042 **IS (Technical or Applications) Engineer – Journey** (.66 FTE): Under general direction, this position, analyzes, plans, designs, implements, maintains, troubleshoots and enhances large complex systems, or application services consisting of a combination that may include application operating system support, database administration and/or mainframes, mini-computers, LANS, and WANs support. He/she serves as a database administrator and operating system support for applications services or technical architect and systems integrator for large complex systems.

The 1823 **Data Integrity Analyst** (.66 FTE) monitors CCMS data for duplicate records, consolidating and unmerging client records as needed, and reporting errors back to users and source systems, as well as for trends in data transfer for completeness and accuracy to assure files are being transferred as planned into CCMS and updating records. Working with IT, she/he prepares and uploads new datasets into CCMS database, and test for data integrity. She/he monitors proper linkage and functioning of the Patient Summary through DPH source systems (Avatar, eCW, Invision) and runs quality management reports at designated time intervals. Finally she/he audits user view histories and submits reports to Privacy Officers as needed.

Health Plan Reporting Infrastructure

SFHP will extract data from PreManage to integrate member data and provide identification of Health Homes participants. In order to do so, they will hire consultants to lead overall project management to establish SFHP WPC requirements, including aligning systems. On-going support of data exchange set-up and technical support will be provided internally by SFHP.

Incentive Payments

Navigation Centers

San Francisco opened its first navigation center in 2015. The Navigation Center created a model for engaging with long-term homeless individuals with barriers to utilizing the traditional shelter system and accessing care to drive outcome improvements. The Navigation Center brings together services and staff from multiple City agencies and non-profit partners to streamline the processes by which homeless individuals connect to benefits and exit into stable housing. The Center is a 24-hour, low threshold facility that allows clients to enter with their partners, possessions, and pets. In our first year of operations, we served over 450 clients. It is innovative because it is a resource center during the day and shelter at night unlike other shelters which close during the day.

We believe that this new model provides an important method of stabilizing our clients and preparing them for the next phase of housing. Additional Navigation Centers opened by the Department of Homelessness and Supportive Housing will be critical to serving our target population. To incentivize the timely opening of additional centers we are including incentive payments of $500,000 per new center. Payment is triggered when the new Navigation Centers open to clients. The lead agency will receive the payment and transfer to DHSH by established protocol. The pilot projects opening two new centers in PY2, a third in PY3, and a fourth in PY4.

Capacity Building in Detox Programs

Persistent and acute substance use disorders prevents many of our clients from permanently exiting from the cycle of homelessness and housing. To incentivize two of our major community partners, HealthRIGHT 360 and Baker Places, to improve their service delivery and infrastructure, we propose an incentive payment of $400,000 each to become Drug Medi-Cal (DMC) Certified. This certification will also lead to better clinical outcomes and long term financial sustainability for these organizations. Payment is triggered when DMC certification is received and billing can begin. Payment is first received by the lead agency and then transferred into the city contracts of the down-stream non-profit organizations that will receive the incentive.

Future Capacity Building Incentive Payments

As part of our evaluation and PDSA process we will identify future goals for our downstream providers. Set-aside funding is $400K, $800K, $500K, in pilot years 3, 4, 5. We expect to use this funding for evaluating and boosting day-time activities in the Navigation Centers, for implementing medication management options in homeless shelters, and for strengthening case management follow-up for individuals newly housed in independent living situations. Payment

will be triggered by satisfactory completion of the PDSA and will go to the agency providing the service being evaluated.

Increasing Data Usage

Developing an electronic data infrastructure is only valuable if it is used by the provider community. Incentives are in place to have more computers/devices connected to the platform. These incentives for years 2, 3, 4, 5 of $50K, $40K, $30K, $20K and $350K, $280K, $210K, $140K paid to various downstream homeless providers and to DHSH respectively are intended to help them participate in the computer networking. Secondly, increasing the number of users viewing data follows the same pattern, and third increasing the number of times each user views data in course of regular work day is important and incentivized the same way. Payments decrease over time as access needs plateau. Finally, developing and completing universal assessments for all homeless persons is an activity that needs everyone's participation. Payment will be structured the same pending completion of a certain number of assessments.

Fee for Services

Some providers who have never billed DMC are having challenges meeting the staffing and documentation standards required under the DMC/ODS waiver. These funds would provide 'start up' costs for programs.

DMC/ODS residential treatment is limited to 90 days per admission, up to two admissions per year. Some of our patients may need longer or more frequent episodes of care, especially those who cannot find safe step-down housing where they can consolidate their recovery gains.

Dual Diagnosis Substance Use & Mental Health and Substance Abuse Residential Treatment are critical to stabilizing our clients with behavioral health issues. Under the new Drug Medi-Cal waiver, payments for residential treatment are limited to stays of up to 90 days. However, for some of the most complex clients in the target population, data indicates that extended stays of up to 180 days may reduce recurrence or avoidable negative health outcomes following treatment. Costs for this service were based on existing contracts and rates of $300 per day for mental health dual diagnosis and $140 a day for substance use. This will provide up to 25 targeted clients up to an additional 90 day of treatment each in both mental health dual diagnosis or substance abuse treatment.

Increases in fee-for-service payments over the four years are included to compensate for projected cost inflation over the life of the program, rather than changes in the population served. For services provided by City agencies using civil service employees, growth in fee-for-service reimbursement is included to cover wage and benefit cost increases in existing labor contracts. Where these services will be provided beyond the term of existing labor contracts, we used the projected growth rates assumed in the City and County of San Francisco's adopted 5-Year Financial Plan. For services provided by contracted partner vendors, increases in fee-for-service rates are based to negotiated increases in existing vendor contracts for similar services or, where no existing contracts are in place, based on growth rates assumed in the City and County of San Francisco's adopted 5-Year Financial Plan for contracted services.

PMPM Bundled Services

The onset of a PMPM bundle begins by being homeless in San Francisco and being enrolled in Medi-Cal managed care, Short Doyle, or Drug Medi-Cal. The expected duration of homelessness is a median of 5.8 years. Discontinuation of the PMPM bundle eligibility occurs when a person is housed for 6 months or when they are dis-enrolled and no longer a Medi-Cal beneficiary. There is no service overlap within the PMPM bundle and none with other FFS services proposed here. The acuity of health needs varies across the PMPM bundle. One quarter have primarily needs for housing and skills development or workforce re-entry. Fifteen percent have housing needs and serious health chronic conditions. They are candidates for specialty services within the bundle. Staff: Client ratio in specialty services is 1:20.

Navigation System

Our Navigation Centers, Medical Respite and Psychiatric Emergency Services are critical entry points for our population. Effective care services at these locations can engage those clients from the very beginning. Because these services are new innovations and lack an established model of fee-for-service payments, we believe a capitated model is appropriate. In addition, a PMPM structure will allow providers flexibility to use PDSA to adapt operating models to improve outcomes over time compared to a traditional payment system.

Medical respite services are currently provided through a contract between the Department of Public Health and a non-profit service provider. The costs included in the WPC budget for the expansion services are based on the existing contract in place for medical respite services, pro-rated by the proportion of beds expected to be used by the Whole Person Care population. The DPH budgets contracted services in a single line-item, so the projected total payment to the contracted provider is included here. A description of the planned services provided is included in Section 3 of the WPC application under “Innovations in Service.”

The one time cost of a van with a lift will be used to transport patients exiting Psychiatric Emergency Services. The calculated cost is two-thirds of the cost of a full price van as the van will only be used 66% of the time for the eligible Whole Person Care population. Currently, when PES patients are discharged, they receive a taxi voucher to go to their next destination, but this is no assurance that they will get to that destination and often is an issue.

San Francisco piloted the use of nurses in shelters in 2015 and experienced more than a 70% reduction in 9-1-1 calls. Given the success of the pilot, we are requesting to expand this service to additional shelters as nurses in shelters are not currently billable providers through Medi-Cal. We anticipate this program to further reduce emergency room visits and provide an enhanced level of care that is very much needed in our shelters. DPH will add 2.0 FTE registered nurses who will support clients in the shelters by providing care coordination, health assessments, immunizations, TB screening, referrals, first aid, limited wound care, training of shelter staff, liaison with Medical Respite, medication management, consultations/orders, training shelter staff, and management of minor illnesses. To maximize the services of the nurses, 2.0 FTE Health Worker IIs will also be staffed with them in the shelters.
Our calculations for our proposed rates are outlined in the subsequent PMPM Cost Analysis. Annual costs are adjusted to reflect the percentage of services that will serve the Medi-Cal

eligible population. PMPM rates are calculated by taking the total expected four year costs and dividing it by expected number of member months. This methodology allows us to create a stable rate throughout the course of the pilot. An inflation factor if 3% is then applied in the remaining three pilot years (PY).

Enhanced Care Coordination Support
We propose enhancing our care coordination team with 1.0 Clinical Lead, 1.0 FTE coordinated entry lead, 2.0 FTE case managers and 1.0 FTE outreach worker. We will also engage the Institute on Aging to provide care coordination to 54 of our most high-risk clients (54X12 = 648 member months in a program year).

The WPC Pilot will employ centralized Care Coordinators who will report to the Program Director. These care coordinators will collaborate with the client's primary case managers to develop a Community Care Plan. Focusing on the highest risk patients, the WPC Care Coordination Team will additionally:

- Remove barriers to facilitate timely connections to needed services, which may include medical care, conservatorship, intensive case management, mental health and substance abuse residential treatment;
- Ensure other providers are alerted to the client's elevated status;
- Dispatch outreach workers to locate individuals in the streets or pickup wherever they present; and
- Provide transitional or bridge case management services and continuously monitor the client until they are fully engaged in care.

As the elements of MACCS advance in their development, the WPC care team will have increased access to accurate and comprehensive information to connect clients with appropriate services in a timely manner.

Pay for Reporting and Pay for Outcomes

The payment values proposed are loosely based on the payment model under the PRIME program. The comparison to the PRIME structure provides a benchmark for reasonableness of proposed payment level, and also aligns the structure and improves administrative coordination with other efforts under the Section 1115 Waiver. Under PRIME, San Francisco may earn a maximum of $560,000 for each metric. Proposed payments per metric for reporting are $350,000 for administrative metrics and $500,000 for outcome or quality metrics. Outcome payments for quality of care metrics begin at $125,000 in PY2 and grow to $725,000 in PY4. Outcome payments for reduced utilization begin at $175,000 in PY2 and grow to $875,000 in PY5. Proposed payments also reflect the PRIME structure of transitioning over time to a higher share of pay-for-outcomes. This approach emphasizes the development of high-quality data and reporting capability at the beginning of the pilot project, then a greater focus on outcomes once data development in complete. Our justification for our metrics selection and outcomes is subsequently described.

Metrics Justification

Measure	What is measured	Why measured	Source
Universal Metrics			
U1. Emergency Department Utilization	count adult users of medical ED, visits per adult user)	Required. Target population ED visit average is 5.8.	HEDIS
U2. Inpatient Hospital Utilization	count adult users, # days per user)	Required. Target population inpatient users average 13.6 days annually. This will be converted to HEDIS methodology.	HEDIS
U3. Follow up after hospitalization for Mental Illness	% inpatient patients receiving follow-up	Required. Nearly 50% of target population suffers from mental health disorders. Metric will follow HEDIS methodology.	HEDIS
U4. Initiation and engagement of alcohol and other drug dependency	pts using residential AOD detoxification who enroll in other treatment following detox	Required. 50% target population have alcohol diagnosis. Metric will follow HEDIS methodology.	HEDIS
U5. Proportion of beneficiaries with care plan accessible by entire team w/in 30 days of enrollment and anniversary in program	Pts receiving follow-up treatment post psy ED and Inpt who have care plans	Required. Treatment plan improves care, reduces duplication and harm. Focus is on Homeless beneficiaries with Severe Risk ~ 380	Process
U6. Care coordination, case management, and referral infrastructure	Reports policies and capacity	Required. Expand policy and procedure to cover expanded population. Improves monitoring and governance	Process
U7. Data and information sharing infrastructure as measured by documentation of policies and procedures for all entities that provide care coordination, case management monitoring, strategic improvements.	Reports, policies, monitoring of operations/ Implementation, compilation and analysis information	Required. Partner agencies have baseline policies and procedures.	Process
Variant Metrics			

Measure	**What is measured**	**Why measured**	**Source**
1. Completion of Universal Assessment Tool with homeless individuals	Health assessment is part of planned universal tool. This records completion of this shared data item.	Variant. Population carries high risk for escalating health costs.	Admin
2. Health Outcomes: 30 day All Cause Readmissions	count of hospital readmission w/in 30 previous discharge	Required Variant.	Health
3. Health Outcomes: Decrease Jail Recidivism	count of persons and jail days over time period	Required Variant.	Health
4. Health Outcomes: Suicide Risk Assessment Required for Pilots w/ SMI Target Population	count of suicide assessments in PES and Psy Inpt	Required Variant.	Health
5. Housing: Permanent Housing	in CCMS and HSA database, measures number of persons who leave or remain in housing placements beyond 6 months.	Required Variant.	Housing

Outcome Metrics			
Measure	**What is measured**	**Why measured**	**Source**
TB clearance in preparation for next treatment placement	Measures number of homeless persons with TB clearance ready for next placement	Critical to transitioning to other services	Outcome