Recommendations from the San Francisco Department of Public Health Community Programs Stakeholder Engagement Process August 2008 – May 2009

May 15, 2009



Table of Contents

Introduction	2
Workgroup 1: Integrating Primary Care and Behavioral Health	7
Workgroup 2: Coordinating Care	14
Workgroup 3: Managing Beds	19
Workgroup 4: Increasing Health Equity	23
Workgroup 5: Supporting Children, Youth, and Families	29
Workgroup 6: Community Based Organizations	36
List of Participants	41
Sources	46
Glossary of Acronyms	49
Appendices	51

Photographs of the Stakeholder Engagement Process



Introduction

Background and Overview

Community-based health services in San Francisco have been hit particularly hard by the current economic climate. In the fall of 2008, the San Francisco Department of Public Health (DPH) began facing budget reductions. Since then, City departments including the Community Programs Division, which encompasses Community-Oriented Primary Care, Community Behavioral Health Services, Maternal and Child Health, Housing and Urban Health, Health Promotion and Prevention, HIV Health Services, and HIV Prevention, have been asked to propose additional budget reductions. With the knowledge that these reductions would require significant changes in its structure and services, Community Programs made it a priority to engage with affected organizations and communities in responding to the Division's financial situation. In August 2008, Community Programs initiated a participatory planning process aimed at generating, evaluating, and building consensus for ideas that will help DPH identify and recommend system of care improvements, revenue enhancements, and cost reductions, while preserving the Department's values of engaging community, reducing disparities, and promoting prevention. A broad range of representatives from civil service, the Service Employees International Union (SEIU), community based organization (CBO) leadership, DPH and other City department staff were invited to join what came to be called the *Stakeholder Engagement Process*, the initial results of which are presented in this report.

Goals of the Stakeholder Engagement Process

- Plan for a new community-based public health system that will improve outcomes and increase efficiencies in six priority areas;
- Support Community Programs' principles of community engagement and involvement;
- Obtain input to inform Community Programs reorganization and guide service system changes.

Preserving Community Programs' Goals and Values

From the start of this process, Community Programs wanted to ensure that decisions in response to budget reductions were driven by the Division's overall goals of providing high quality, accessible, culturally and linguistically competent health services; connecting every uninsured San Franciscan to a primary care home; providing comprehensive, coordinated care; and serving clients in the least restrictive environment possible. Community Programs also took steps to confirm that its goals were aligned with the principles articulated by the Health Commission and the Human Services Network.

Healthy San Francisco. Beginning in 2006, the City of San Francisco embarked on the development of a universal health care access program, *Healthy San Francisco*, designed to guarantee that all uninsured individuals have access to a primary care home. This policy direction was incorporated in the stakeholder engagement process.

Partnering with CBOs. Community Programs is dedicated to strengthening the partnership between DPH and community-based organizations. CBOs are vital to the service system; Community Programs has 300 contracts with 161 unique agencies, and close to 60 percent of the Division's work is contracted to nonprofits.



Decision making. Decisions will not be driven solely by cost savings, but also by maintaining a focus on Community Programs' mission and core values. The interest is in identifying opportunities for long-term savings, rather than building a system based on crisis.

Health Commission Principles

Community Programs took steps to ensure that the goals of the Stakeholder Engagement process were aligned with the *Health Commission Principles to Guide Budget Reductions*. As articulated by the Health Commission, it is necessary to set budget priorities in order to preserve a commitment to improving the health of all San Franciscans and to provide the highest quality of services in all neighborhoods of the City.

The budget principles that were adopted by the Health Commission are organized into five key areas. Please see Attachment A for a complete list and additional details on the Health Commission principles.

- **Revenue.** Maximize revenue increases and minimize cuts to leveraged services.
- **Vulnerable populations.** Minimize the impact of cuts on vulnerable populations and prioritize services for lowest income, more severe illness, health disparities, and homeless populations.
- Core functions. Focus on the Department's core functions (assure a primary care home; provide emergency care; and protect the public's health through education and disease control) and address the four priority goals outlined in the revised DPH Strategic Plan.
- Primary Care teams. Ensure (a) primary care providers coordinate specialty care services to minimize duplication and ensure equity of service delivery; and, (b) primary care teams use multidisciplinary approaches for severely mentally ill persons.
- Service reductions. Engage in a strategic approach to service reductions, including: identifying high priority services; mitigating impact of service cuts; and taking into account availability and capacity of community provided services, among other key factors.

Engagement Process

Community Programs was committed to engaging stakeholders in an inclusive and participatory planning process that was transparent and well-organized, and that built on recent planning, assessment, and policy work. Due to the rapid timeline for financial changes in Community Programs, some immediate decisions had to be made by the Division Director in the fall of 2008. A group of stakeholders was convened in August 2008 to receive budget updates and provide input.

In February 2009, Community Programs expanded on this process by inviting additional stakeholders to participate in a series of planning meetings that allowed stakeholders to give input in the form of recommendations that would inform the reorganization of the Community Programs Division and the development of future Community Programs Requests for Proposals (RFPs). DPH engaged Harder+Company Community Research, a consulting firm specializing in research and planning for the social sector, to facilitate this process. This project received project management and financial support through the City Services Auditor Division, Controller's Office.



Policy Initiative Workgroups

Early in the planning process, Community Programs staff and key stakeholders identified six policy initiative workgroups in response to the need to make changes to the service system given the budget reductions. The selection of workgroups focused on finding efficiencies within the context of an integrated system that values prevention, cultural and linguistic competency, primary care homes, integrated services, and community-based service delivery. Some groups explicitly focused on finding efficiencies, while others focused on how to maintain a commitment to families, prevention, integrated services, and cultural competence in the face of reduced resources.

Planning Structure and Roles

The planning process involved the following groups and roles:

- Stakeholder Group. The Stakeholder Group received monthly budget and data updates and contributed to emerging recommendations from workgroups. As the planning process continues, the Stakeholder Group may conduct specific activities such as reviewing data, giving feedback on a recovery policy, and other tasks as identified.
- **Project Leaders.** Project Leaders were representatives from DPH and Community Based Organizations with expertise in the content areas of each of the six policy initiative workgroups. They gave direction to the workgroups, provided input on the process, refined the goals and membership of workgroups, and led the development of workgroup recommendations.
- Workgroups. Workgroups were responsible for developing draft recommendations and comprised members of the larger Stakeholder Group as well as additional representatives who were invited to join the meetings. The charge of the workgroups was to engage in comprehensive discussion about the implementation and implications of policy changes. To promote involvement in the workgroups, at the initial meetings members were asked to identify other colleagues who should be brought to the table.

Meetings and Timeline

- In August 2008, Community Programs convened the Stakeholder Group.
- Additional planning meetings were held in December 2008 and January 2009 to define policy initiatives and identify additional stakeholders to be invited to the Stakeholder Group and Workgroups.
- Four monthly community planning meetings from February to May 2009 were held with the Stakeholder Group and Workgroups. Workgroups scheduled additional outside meetings in between the monthly community meetings.
- Project Leaders and DPH staff met during this time to monitor the planning process and the development of recommendations.
- Final recommendations were developed by May 15, 2009 for review by Community Programs.

In numbers...

- There were **164** participants from DPH civil service, CBO leadership, SEIU, HSA, and the community.
- Participants spent approximately 100 hours attending more than 46 meetings



Summary of Recommendations

Each workgroup developed a set of priority recommendations, which are detailed in this report. The following chart summarizes the key recommendations from the six policy initiative workgroups.

Workgroup	Recommendations
1. Integrating Primary Care and Behavioral Health	 Ensure that all clients/patients are assigned a primary care provider. Designate either primary care clinics or community behavioral health settings as health care homes depending on the immediate, ongoing, and changing needs of clients/patients. Consider a "menu of integration models," whereby providers have the flexibility to select elements for implementation specific to the needs of their clients/patients. Address essential components during the next phase of implementation planning, including: administrative structure and leadership; physical facilities; workforce development and training; safety; and staffing/relationship management.
2. Care Coordination	 Provide care in a coordinated fashion for all DPH clients and patients. Formal care coordination should be prioritized for clients who are not equipped to coordinate their own care, are involved in multiple systems, and have multiple needs. Ensure a more organized team and client-centered approach to care coordination to reduce costs and improve health outcomes for clients. Ensure that clients and patients do not fall through the cracks or use unnecessarily duplicative services by outlining a framework for a coordinated care system and providing for shared data and communication tools.
3. Managing Beds	 IMD Subgroup Move clients to less restrictive settings by identifying clients ready to step down to a lower level of care, which will create more efficiencies and reduce costs. Support efforts to minimize length of stay; explore alternatives to Institutions for Mental Diseases (IMDs); find exit models that provide supportive housing outside of substance triggering environments; and strengthen connections to the IMD community. Substance Abuse Subgroup Expand the existing behavioral health authorization and utilization review process to include residential substance abuse treatment programs. Ensure joint responsibility for coordination, transition, and emergency episode response among Behavioral Health Access Center, Placement Unit, and client's case manager.
4. Increasing Health Equity	Maintain prevention and public health functions as a core component of new initiatives, services and system
5. Supporting Children, Youth and Families	 Serve families in an integrated manner by preserving the primary relationship with the client (child, youth, family, TAY). Build the capacity of existing entry points (hubs) to follow children, youth, and families across the system of care to ensure optimal outcomes. Collaborate with the Mayor's Interagency Council to improve coordination across all systems of care serving children, youth, and families with complex needs. Commit resources to prevent Transitional Age Youth from falling through the cracks.
6. Community Based Organizations	 Recognize and respect nonprofit self-determination and governance while supporting efforts to evaluate a continuum of strategic restructuring opportunities. Support proactive capacity development of organizations in order to preserve accessible and culturally based service delivery. Continue to engage contractors in efforts to streamline contracting and improve contractor assessment practices.



Cross-Cutting Themes

The following key themes emerged across workgroups.

- **Care coordination**. Care coordination is key to ensuring the streamlining of care and preventing duplication of services. Ensuring a coordinated approach to care will reduce costs and improve health outcomes for clients.
- **Revenue maximization/cost saving**. All workgroups noted the importance of revenue maximization and cost saving, while maintaining a focus on the core values of Community Programs.
- → **Data sharing**. Data sharing among providers is essential to ensuring coordinated care and optimal health outcomes for clients. A common database would address the duplicative forms and paperwork that multiple providers complete on the same client and would allow clients to be tracked so they do not fall through the cracks.
- Cultural and linguistic competence. Cultural and linguistic competency should be reflected in the development and implementation of programs and services delivered by the department and contractors. Culturally and linguistically competent services should encompass all aspects of age, gender, sexual orientation, language, religious beliefs, place of origin, cultural background and ethnicity. DPH should provide capacity building and technical assistance to contractors to increase their capacity in these areas.
- **Community capacity**. Smaller organizations that play an important role serving diverse communities often struggle with capacity issues and could be adversely impacted by the recession. DPH should support capacity development for these organizations.
- → Parity and equity in standards and accountability. To meet contract requirements, nonprofits must demonstrate continued effectiveness through established performance measures. Services provided by the City are not necessarily held to the same standards, and there should be a civil service commitment to a corresponding level of accountability.

Next Steps

Throughout this process, stakeholders provided input in the form of recommendations to inform (a) the reorganization of the Community Programs Division; and, (b) the development of future Community Programs Requests for Proposals (RFPs). Community Programs will use these recommendations that emerged from the process to help modify existing services within civil service and to inform structural changes for all RFPs. In addition, this recommendations document will serve as a Strategic Plan for Community Programs future planning efforts.



Workgroup participants engaging in discussion



Workgroup 1: Integrating Primary Care and Behavioral Health

Workgroup Leaders: Kavoos Bassiri (CEO of RAMS, representing the Association of SF Mental Health Contractors); Bob Cabaj, MD (Director, CBHS, SFDPH); Lisa Golden, MD (Medical Director, Ocean Park Health Center, DPH); Dick Hodgson (Vice President of Policy and Planning, San Francisco Community Clinic Consortium).

Overview

Integrating primary care and behavioral health care is central to the transformation of the San Francisco public health system of care. Community Programs identified the need to improve care at the interface of physical health, mental health, and substance use, which would result in increased efficiencies, improved health outcomes for clients, and –ultimately– cost reductions and revenue maximization. San Francisco launched its first pilot projects in 2005 and has implemented local approaches to integration. The current economic climate served as a catalyst to identify the *Integration of Behavioral Health and Primary Care* workgroup as one of six priority initiatives designed to engage community stakeholders in developing preliminary recommendations to guide implementation and next steps.

In its beginning stages, the following goals guided the development of the group's workplan and initial discussions:

- Ensure that behavioral health clients have primary care homes.
- Increase the ability to manage behavioral health needs in primary care clinics.

The following key questions also framed the workgroup's discussions:

- How do we ensure that behavioral health clients have primary care homes?
- How can we ensure that clients in primary care homes are connected to behavioral health services?
- Where should primary care services occur for severely mentally ill (SMI) clients, clients with severe and persistent substance abuse issues (SA), and children/youth with severe emotional disorders (SED)?
- What clinical, structural, or financial mechanisms would be helpful, feasible, and beneficial to integrate primary care and behavioral health in San Francisco?

Since 2005, DPH Community Programs has piloted several Behavioral Health and Primary Care integration models. The workgroup agreed to begin its work by building on the lessons learned from these local models. As such, workgroup members reviewed 12 San Francisco clinics, each of which has integrated primary care and behavioral health services uniquely along a continuum, from co-located primary care and behavioral health services to episodic consultations. Core elements of each model were identified and compiled, including the services provided, populations served, information/communication systems, and strengths and challenges of each model (see *Attachment 1.1: Integrated Clinic Models* in Appendices section of this document).



Fundamental Concepts for Integration

Client-Centered Health Care Home. The workgroup also discussed extensively the concept of a client-centered health care home where primary care and behavioral health services interface and other support services are coordinated to provide optimum, seamless care for clients/patients. At the core of the group's discussions is the idea that either primary care clinics or community behavioral health agencies should be allowed to serve as a health care home depending on the immediate, ongoing, and changing needs of the client/patient. For example, workgroup members acknowledged that clients/patients with severe mental illness might be more effectively served in a behavioral health setting/agency while it may be necessary to select a primary care clinic as the health care home for a client/patient with chronic health issues.

Therefore, workgroup discussions around local integration models and health care homes involved two important implications for the DPH's policy direction in supporting integration. These provide the basis for the workgroup's set of recommendations outlined below.

- All health care homes assure that clients/patients are linked to a regular primary care physician.
- Behavioral health clinics and primary care clinics can be designated as a health care home.

Menu of Integration Models. In reviewing the local integration models, the workgroup reinforced the principle that no single model is the "correct" model by which all primary care and behavioral health integration in San Francisco must occur. Workgroup members agreed that a single model of integration would not effectively meet the diverse needs of the city's population. Rather, the group developed the concept of a "menu of integration models" whereby providers have the flexibility to select elements for implementation specific to the needs of their clients/patients. Furthermore, integration elements that support team based care can be defined as clinical mechanisms for collaboration supported by detailed operational plans. This approach is consistent with DPH's core value of client-centered services and its policy that "any door is the right door".

Essential Integrated Care Components. Realizing the goal of assigning all clients a health care home will be determined by the supply of health care homes as well as the capacity of the service system to provide comprehensive and coordinated care, the workgroup identified essential components of system capacity which must be addressed during the next phase of implementation planning. Those components include:

- Administrative structure and leadership. This includes senior leader support, quality assurance, seamless back office support, defining lines of reporting and supervision, clarifying lines of supervision for interdisciplinary teams of primary care, and behavioral health practitioners.
- Physical facilities. Co-located services should be able to accommodate the type of services being delivered. Facilities should have adequate physical space for increased client volume and appropriate work space for teams. In addition to this, adequate physical space for increased client volume and providing appropriate work space for teams is required.
- Workforce Development and Training. Workforce development and training should address cultural shifts, change management, and cross training. The integration of behavioral health and primary care requires a cultural shift for providers. In order to address the inevitable tensions, provider training is essential, particularly to learn about each other's practice cultures. DPH should develop mechanisms to address cultural differences and increase understanding between providers of



behavioral health and primary care. Workforce development and cross-training should be supported as a way to bridge these differences and facilitate a positive cultural shift.

- Safety. This includes safety within the facility, staff resources, and capacity such as client waiting room management (e.g., flexible hours, waiting time for appointments).
- **Staffing/Relationship Management.** This includes curbside consultation, staff meetings, case conferencing, and supervision.

Guiding Principles

In developing its recommendations, the group also adopted the following guiding principles:

- The system of care should be seamless for clients and patients;
- There should be information sharing and effective communication in order to support improved outcomes for clients;
- Interdisciplinary teams should work together to actively collaborate, cooperate and ensure the coordination of care;
- The Department should prioritize client-centered care;
- The system of care needs to generate revenue, and be cost effective and population based; and
- The system of care should match staff capacity to client/population needs.
- System level and client level outcomes should be defined to help assess the effectiveness of integrated care and measure client health outcomes.

Recommendations

Workgroup members acknowledged that the rapid timeline is being driven by the urgency of the fiscal crisis which requires making decisions about the allocation of scarce resources. Despite the economic driver, the group emphasized the need to propose core elements of an ideal integrated system of care. The group acknowledged that the public policy implications of prioritization in the current economic environment could result in a severely rationed system of primary care and behavioral health services. Nonetheless, the group agreed that the following recommendations suggest a foundation on which to build integrated models of primary and behavioral health care in San Francisco.

1. Assign all clients a primary care provider.

All behavioral health clinics serving as a health care home for clients will have a process in place for ensuring connection to a primary care provider. Linking all clients to a primary care provider allows clients who are seriously mentally ill to maintain a primary relationship with their behavioral health provider. The system of care should ensure that all clients/patients have a primary care provider while supporting client choice and flexibility to determine their health care home (i.e. whether the health care home is a primary care clinic or behavioral health setting/agency). Each client will have an ongoing relationship with a primary care provider to provide continuous, comprehensive care. When the health care home is a primary care site, the primary care provider will also provide first contact and lead the team who collectively take responsibility for the ongoing care of the client.



2. Establish a clear definition of health care homes as either a primary care clinic or a behavioral health setting/agency. A designated health care home assures clients/patients access to both primary care and behavioral health services. Designated health care homes must meet a core set of criteria.

DPH should provide a definition of a health care home to ensure a common understanding throughout the provider community. A health care home can be designated as either a primary care clinic or behavioral health clinic based on a shared decision making process that considers client choice and needs. Clients ultimately have the right and choice to determine which health care site will serve as his/her health home. However, the provider may guide clients towards a behavioral health or primary care site depending on the client's immediate and ongoing needs. The designated health care home must provide continuity of care and be responsible for the determination of client needs and linkage to services.

A review of existing medical home definitions in the literature resulted in the identification of the following core criteria that must be met for all health care homes:

- Capacity for care coordination and case management
- Ability to bill for client services and manage revenue
- Capacity to evaluate clients holistically (mental health, physical health, legal, etc.)
- Connection to specialty care
- Availability of technology and information systems support
- Provides the majority of care for client

For primary care and/or behavioral health community based organizations that do not meet the criteria for health care homes, DPH should provide capacity building resources and technical assistance to develop and increase their capacity to serve as a health care home. Additionally, DPH should develop accountability and performance measures for all agencies serving as health care homes.

As clients' needs change, the health care home designation may transition from a primary care arena to behavioral health and vice versa, based on the predominant current needs of the client. Mechanisms need to be in place to ensure seamless transition back and forth between mental health and primary care to accommodate the appropriate level of care for the client.

3. Guarantee that all clients within a health care home have access to care coordination.

- Care must be coordinated across the complex health care system no matter where the client entry point into services is. Care coordination is key to ensuring clients receive appropriate care.
- Care coordination is crucial to streamline care and prevent duplication of services or addition of unnecessary services.
- A clear procedure must be defined for selecting the care coordinator.
- The assignment of the care coordinator triggers navigation of the system.

<u>Definition from Workgroup 2:</u> Identification of the care coordinator. The coordinator emerges as a lead from the team of providers already caring for the client and is someone who already has an existing relationship and direct knowledge of the client to understand his/her needs. Other factors to consider in identifying the care coordinator include client choice and having the capacity to take on the role of the lead coordinator.



4. Develop protocols and procedures for record keeping and information and data sharing, and provide communication and training for all DPH and affiliated primary care and behavioral health providers working within integrated models of care settings.

Communication between primary care and behavioral health systems is key to fostering communication between providers, which in turn will facilitate collaboration. There are two aspects to enhancing communication between primary care and behavioral health:

- Develop a shared electronic health record. In order to facilitate communication among providers, DPH should explore the possibility of a common electronic database, or an electronic portal through which providers can access different client databases (i.e. "data warehouse"). DPH should also ensure that providers input common client data elements on a regular basis. An electronic health record holds particular promise in facilitating integration since it increases the opportunities for primary care and mental health providers to share medical records. The use of health information technology has been cited in several studies as capitalizing on the use of an electronic health record to support on and off site communication among providers. Electronic registries have been shown to be a cost effective and efficient method of client/patient managements, as well as a tool for preventing clients from falling through the cracks. Currently, primary care and behavioral health services maintain separate client databases: the primary care system uses the Lifetime Clinical Record (LCR), while the behavioral health system is developing an electronic record using Clinician's Gateway.
- Ensure that clear policies for information sharing are developed and that opportunities for training are provided. While DPH has developed a policy matrix for sharing protected health information for treatment services, further clarification of sharing patient information between and among treatment providers is warranted (See DPH Privacy Policy Matrix Sharing Protected Health Information for Treatment Purposes). It will be essential to make sure that the electronic system that is developed follows all federal and state laws. A protocol should include clarification on Health Insurance Portability and Accountability Act (HIPAA) regulations and definition of common data elements that can be used across agencies. Finally, DPH should integrate training and information into existing systems reviews including the Annual Review and the yearly Health Stream Review mandated by HIPAA. Within integrated models training for DPH and affiliates working must include addressing the needs of special populations (population subsets).
- 5. Ensure that culturally and linguistically competent services are maintained within an integrated model of care.

First, culturally and linguistically competent services should be linked to health care homes and encompass all aspects of age, gender, sexual orientation, language, religious beliefs, place of origin, cultural background and ethnicity. Second, as the criteria for health care homes are implemented, certain CBOs and nonprofit organizations may not have the capacity to meet the criteria. Many of these CBOs and nonprofit organizations provide important services to diverse populations in the city. To ensure that these services are maintained, DPH should develop mechanisms that support coordination and collaboration between agencies. Additionally, DPH should provide capacity building resources and technical assistance to increase their capacity to serve as health care homes (See Recommendation 1).



6. Develop financing strategies that support revenue maximization and address existing barriers to financing behavioral health services in primary care settings as well as primary care providers in behavioral health settings/agencies.

One of the major challenges to integrated care is funding. Care coordination and management, central activities to the functioning of integrated care models, are difficult to bill for and collect reimbursement. The health care and behavioral health systems have historically operated different funding and reimbursement mechanisms. Billing and accounting systems should be initiated that allow for billing across disciplines and payment for services associated with coordination of care among the multi-disciplinary team. DPH should pursue two tracks: 1) addressing current barriers with creative solutions and 2) advocating changes to federal and state structural barriers to financing strategies.

Based on their experiences with the continuum of integration models, the workgroup identified the following specific examples of financial barriers to implementation that will need to be addressed.

- Different billing rules for FQHC and Short-Doyle/Medi-Cal. The primary challenge to billing for services is the difference in rules for Federally Qualified Health Center (FQHC) and Short-Doyle/Medi-Cal billing. A possible solution to address this hurdle is to create a table of billing rule (e.g., who can bill, what can be billed, how many times per day, etc.) put together by experts in FQHC and Short-Doyle/Medi-Cal service billing.
- "Opening" patients in Short-Doyle system. Prior to billing Short-Doyle, patients need to be "opened" in the Short-Doyle system. This requires extensive documentation, as well as Utilization Review requirements.
- Need for "certified" Short-Doyle sites. Patients seen under Short-Doyle must be opened at a "certified" site, and records must be stored at that certified site. This regulation makes satellite treatment within primary care challenging.
- "Medical Necessity" criteria for Short-Doyle. Limits to the "Medical Necessity" criteria to bill under Short-Doyle may not align with Primary Care consultation and treatment needs. This means that patients may need to have a certain severity of illness prior to being authorized.
- Diagnostic requirements for billing. Certain Behavioral Health diagnoses frequently seen in Primary Care may not qualify for treatment under Short-Doyle. Examples of such diagnoses include dementia, delirium, autism, developmental delay, any symptom secondary to a medical/neurologic problem, and any symptom secondary to a substance use disorder.
- **FQHC billing limits.** The limit on frequency of billable visits to FQHC is lower than what is frequently necessary for appropriate behavioral health care. In addition to this, there are also limits on same day visits, which is a frequent practice in behavioral health care.
- Clinics do not currently meet regulations for both Medi-Cal and FQHC certification. Currently, primary care clinics are not Medi-Cal certified and behavioral health clinics do not meet FQHC regulations. In order to overcome this challenge, there should be movement toward certifying all primary care and behavioral health clinics so that they meet regulations for both revenue streams. An additional strategy could be to use the base site to bill through and bill as a "field visit."
- Opening a BIS chart for primary care and behavioral health consults. An additional challenge to billing is that it is often impractical to open a billing and information system (BIS) chart when primary care wants to consult with behavioral health on a case. Potential solutions to address this barrier



include: (1) Use the table of billing rule to see if behavioral health FQHC billing can be done; (2) Create a new charting system that complies with both FQHC and Short-Doyle/Medi-Cal billing so billing can occur in either for any client/patient; and (3) Bill indirect services until it is determined that the client/patient will meet medical necessity for behavioral health services (lower reimbursement).



Participants engaging in discussion at the Integrating Primary Care and Behavioral Health Workgroup

Workgroup 2: Coordinating Care

Workgroup Leaders: Edwin Batongbacal (Director, DPH CBHS Adult and Older Adult Systems of Care); Grant Colfax (Director, DPH HIV Prevention Section, representing the HIV Prevention Planning Council); David Fariello (Division Director, SFGH Citywide Case Management Community Focus-UCSF); Brenda Storey (Director, Mission Neighborhood Health Center, representing Community Clinic Consortium members).

Overview

Representatives from DPH, CBOs and the Human Services Agency (HSA) came together to outline a system of coordinated care for vulnerable populations in San Francisco. The intent of the *Coordinating Care* workgroup was to identify methods to improve health outcomes and reduce costs by ensuring a more organized approach to care. Coordination may not be needed for individuals who are able to negotiate multiple service lines on their own and have no desire to be "coordinated"; however, the practice of care management may be needed on a number of levels:

- Clients who need only one type of service from DPH (e.g., mental health services). Coordination is needed when clients move from one modality to another and when they move in and out of acute levels of mental health care.
- Coordination is needed when those same clients need to be engaged in other types of DPH services and are not able to negotiate that on their own.
- Coordination is needed when clients are users of multiple systems, but primarily urgent/emergent services; that is, they are not stabilized in any one area. There are levels of complexity of these types of clients some are the high users of multiple systems (HUMS) and there is another tier of those who are on their way to being HUMS.

Care coordination should be the goal for all clients engaged in the DPH safety net. The goal of this workgroup was to focus on those clients who are not equipped to coordinate their own care and who are users of multiple urgent/emergent services. By orchestrating a coordinated system of care for this tier of clients, it is expected that other levels of coordination would benefit as well.

As such, the workgroup undertook the task of outlining the framework for a system that would ensure that clients do not "fall through the cracks" or use unnecessarily duplicative services as they move through multiple systems in San Francisco. The *Coordinating Care* workgroup focused on defining key components of a coordinated system of care for individuals who use urgent and emergent services across multiple systems.

The workgroup identified these overall goals for a coordinated system of care:

- Ensure access to and engagement in services for clients
- Reduce acuity and recidivism for clients



Guiding Principles

The following guiding principles of a coordinated system of care direct the recommendations for coordinated care:

- Client-centered and recovery-based
- Data-based
- Outcomes driven
- Evidence/logic based
- Shared accountability and success

Recommendations

Overall, the *Coordinating Care* workgroup recommends that DPH implement a Coordinated Care system to serve individuals who are involved in multiple systems and have multiple needs. It is expected that this coordinated system will result in meeting the goal of improved health outcomes and reduced costs by ensuring a more organized approach to care in San Francisco. The *Coordinating Care* workgroup has identified the following five priority recommendations for DPH that outline the framework for the coordinated system of care.

1. Further define criteria of users of multiple systems who are at high risk, then identify and engage individuals who meet criteria for orchestrated Coordinated Care.

Engagement in multiple service systems results in an array of service providers who oftentimes do not have a whole picture of the client and are unaware of other services that the client is receiving. This often leads to duplication of efforts and even conflicting overall treatment goals for the client.

Individuals who utilize urgent and emergent care services across multiple systems should receive coordinated care. These clients are those who are the next tier below the HUMS, but who may become HUMS clients if left unattended. Clients in the coordinated system of care could include, for example, those with substance abuse and medical issues, and HIV-positive dual diagnosed individuals, but no Psychiatric Emergency Services (PES) or in-patient service use, or individuals with mental health and medical issues but no substance abuse. By coordinating care for these high users, it is expected that recommendations will trickle down to low service using clients, thereby creating a more organized care system for all individuals who engage in services.

There are three primary ways to identify clients who should enter into Coordinated Care:

- 1. Central administration should cross-check service utilization data to identify clients. The Coordinated Case Management System (CCMS) includes this data on high users.
- 2. Screening at the front end when a client enters services.
- 3. Agency-identified clients. In certain cases, providers may identify clients who should receive coordinated care through this system.



Once identified, these clients would trigger a specific response that would then open up a higher level of wraparound services for the individual. It is critical that the coordinated system of care is supported by infrastructure that will support this system and ensure that clients are able to access needed services.

2. Assign a care coordinator to each of these clients to identify and work with other members of the Coordinated Care Team.

Clients who engage in multiple systems of care are often assigned multiple case managers, but there is no identified "lead" with a holistic view of the client. A lead care coordinator would thus be able to ensure that clients do not get lost when switching between systems and would also hold a comprehensive picture of the client's strengths and needs.

Once a client enters into the Coordinated Care system, a care coordinator should be designated and assigned to oversee the care and treatment of the client.

- Identification of the care coordinator. The care coordinator should emerge as a lead from the team of providers already caring for the client. This individual should be someone who already has an existing relationship with the client and direct knowledge and understanding of the client's needs. Client choice is an important factor to consider in identifying the care coordinator. In addition to this, the provider should have the capacity to take on the role of lead coordinator. In cases where the designation of the care coordinator is not clear, the Behavioral Health Access Center (BHAC) may be able to serve as an arbitrator to help decide the care coordinator.
- Function of the care coordinator. A care coordinator is an individual who is dedicated to ensuring that the client receives organized and seamless care across multiple providers and systems. The care coordinator should be responsible for linking clients across all systems in order to eliminate duplication of effort and unite different services. This person holds an understanding the overall system of services in which the client is engaged. Importantly, the care coordinator is responsible for overseeing the joint care plan and ensuring that providers are working together toward common outcomes for the client. In some cases, the coordinator also creates the treatment team and identifies other providers that should be at the table in order to stabilize the client.

In order to successfully serve clients, care coordinators should be paired with someone at the system level with authority (e.g., BHAC, Placement) to authorize services for these high using clients.

3. Develop a joint care plan based upon an assessment of the client's risks and strengths, using the various domains of recovery.

The array of providers who may be caring for a high using client often do not know the treatment goals of other providers also serving the client. A joint care plan will ensure that all providers are working toward a common goal across the multiple service systems.

A joint care plan serves as a "master plan" for clients in Coordinated Care. This care plan can be electronic, which would be easily accessible by the team of providers and would serve as a cost-effective communication channel. Overall, the coordinated care plan should be simple and user friendly for providers.



The joint care plan is not intended to replace any one provider's treatment plan; rather, it aims to highlight the client's treatment plan(s) and address urgent issues while supporting and sustaining the client's strengths. One of the goals of coordinated care is to have some agreement, to repeat assessments and have shared information, and to reduce the need to duplicate assessments as clients navigate the different systems of care. In order to be consistent with client-centered and recovery-based care, the care plan should address the client's self-identified goals.

The framework for the joint care plan should be based on the Domains of Risk & Strength (DORS). Categories include the following: (1) physical health, (2) mental health, (3) substance abuse, (4) housing, (5) financial, (6) legal, (7) personal safety, (8) skills, (9) social support, and (10) meaningful role. These domains capture a holistic picture of client strengths and identified needs.

4. Utilize a shared database and communication system for coordinating, monitoring, and collecting profiles, services, and outcomes to facilitate information sharing and communication among service providers.

Clients who engage in multiple systems of care are served by multiple providers who often do not communicate. This lack of communication results in duplication of efforts and disorganized care for the client.

Information sharing and communication between service providers is vital to the success of a coordinated system of care. Communication ensures that all providers have up-to-date and accurate information about the client, and shared information will allow for input into the joint care plan. As a result, this will enable providers to work together to reach the identified goals in the joint care plan.

In order to facilitate communication among providers, a common database should be used. This common database would address the duplicative forms and paperwork that multiple providers complete on the same client, thereby decreasing both provider time and costs. Using an electronic system, client referrals should also be tracked in order to see that a client does not "fall through the cracks" and to ensure that they follow-through. This database should be shared among providers from substance abuse, behavioral health, primary care, and CBOs.

5. Design Coordinated Care to be outcome-driven and to address common individual- and system-level barriers and successes.

Designation of desired outcomes is necessary to monitor if the Coordinated Care system is in fact serving to benefit the client. These outcomes will measure the effectiveness of the system and identify areas for improvement in order to better meet clients' needs.

In order to determine if the Coordinated Care system benefitted the client, the following five primary outcomes for clients engaged in the Coordinated Care system are proposed:

- 1. Connection to a primary care provider
- 2. Decreased use of urgent/emergent services
- 3. Positive movement through stages of recovery
- 4. Improved client perception of quality of life and self-confidence/resiliency



5. Improved living situation (e.g., attains and maintains permanent housing)

These outcomes point to the overall goals of access and engagement in services, as well as reducing acuity and recidivism. As such, these client-level outcomes aim to measure the health *and* recovery of an individual engaged in the Coordinated Care system and should be monitored system-wide. In addition to these client-level outcomes, this coordinated system of care further aims to affect these system-level outcomes:

- 1. Decreased duplication of effort
- 2. Awareness and communication between service providers
- 3. Provider satisfaction

Although not designated here, a standardized tool should be used to measure each of these outcomes.

These five recommendations outline the framework for what a Coordinated Care system would look like in San Francisco. The workgroup recognizes that further details for each of these elements remain to be determined, but these recommendations present the building blocks for developing a more organized and coordinated approach to care. A visual representation of Coordinated Care is presented in the Appendices section of this document under the heading *Attachment 2.1: Coordinated Care System*.



Participants provided input on workgroup recommendations through post-it cards during an interactive poster session



Workgroup 3: Managing Beds

Workgroup Leaders: Steve Fields (Executive Director, Progress Foundation, representing the Human Services Network); Barbara Garcia (Director, DPH Community Programs); Alice Gleghorn (Deputy Director, CBHS, SFDPH); Kelly Hiramoto (Deputy Director, DPH Director of Placement).

Overview

Residential treatment is one of the most expensive services offered by Community Behavioral Health Services (CBHS) for both mental health and substance abuse clients. The *Managing Beds* workgroup was identified by Community Programs with the goal of managing high costs and client needs through overseeing admissions and discharge for residential treatment. The *Managing Beds* workgroup focused on adult residential substance abuse treatment programs and inpatient psychiatric facilities (IMDs, or Institutions for Mental Disease¹). Given that the substance abuse and mental health systems offer different levels of care, the *Managing Beds* workgroup split into two subgroups: the *Substance Abuse subgroup* and the *IMD Client Assessment subgroup*. Background and recommendations are presented separately for each subgroup².

Substance Abuse Subgroup

Placement for residential substance abuse treatment is not currently managed in a centralized manner as is treatment for mental illness. The goal of Community Programs is to improve the substance abuse system of services by centrally managing admissions and discharge, which would increase access and appropriate placement for clients and result in cost savings for the department. The Substance Abuse subgroup of the workgroup was charged with addressing the following issues: 1) High Utilizers of Multiple Systems (HUMS) are the highest need clients who access DPH's most expensive services; 2) after completion of a residential program, substance abuse clients are not regularly placed into the next appropriate level of care upon discharge, making them more likely to continue accessing residential substance abuse treatment services; 3) there is no centralized access to DPH-funded substance abuse beds, and identifying open beds is time consuming and not always prioritized by client need; and 4) historically, substance abuse programs have had different program admission/exclusion criteria by agency, and not by system of care.

With these issues in mind, the Substance Abuse subgroup identified the following three goals to guide the development of recommendations:

- To manage high costs and client needs, DPH will manage access to residential beds (admissions and discharge) in collaboration with community partners & CBOs
- Ensure that all clients are at the least restrictive, most appropriate level of care
- Ensure commitment to recovery, resiliency, and wellness throughout services

² Note: These recommendations do not apply to children/youth residential treatment.



¹ An Institution for Mental Diseases (IMD) is defined as a hospital, nursing facility, or other institution that is primarily engaged in providing diagnosis, treatment, or care of people with serious mental illness.

In addition, the subgroup used the following <u>key questions</u> in the beginning stages to frame initial conversations:

- Are clients in the right level of care? If not, what level of care should they be in and where?
- What resources are needed to transition people to the appropriate level of care?
- How do we ensure that all clients are at the least restrictive, most appropriate level of care?
- What should be the criteria for admissions and discharge?
- How do we obtain input from community partners into the DPH structure for management of beds?

Overview

The Substance Abuse subgroup engaged in detailed discussions about rolling out the restructured system for the management of residential substance abuse treatment beds. In addition to identifying an overarching policy recommendation and key components, one of the most important elements of the discussion was the identification of key issues that DPH should consider for implementation of the new system (presented on the following page). The workgroup also developed draft standardized admissions criteria. A visual of the overarching policy recommendation of this workgroup is presented in the Appendices section of this document under the heading: *Attachment 3.1*; a visual of the standardized criteria is under *Attachment 3.2*.

Recommendations

The restructuring of the substance abuse bed management system involves one overarching policy recommendation, as well as a number of primary components.

1. Expand the existing authorization and utilization review process to include residential substance treatment programs.

A number of barriers currently exist that impede DPH's ability to provide efficient access to and management of residential substance abuse treatment services. These include:

- 1. HUMS, who represent the highest need clients for substance abuse services, are not regularly provided appropriate placement because they are often difficult to manage.
- 2. Many substance abuse clients do not receive appropriate placement into housing and/or further care upon discharge, making them more likely to relapse and continue accessing residential substance abuse treatment services.
- 3. There is no centralized access to DPH-funded beds/slots, and identifying them is time consuming and not always prioritized by client need.
- 4. Substance abuse programs have different program admission/exclusion criteria.

Therefore, workgroup participants agreed that DPH should centralize access to and management of beds in residential substance abuse treatment programs.



Specifically, consider the following primary components of this expanded authorization and utilization review system:

- Implement centralized management of substance abuse beds by Community Programs Placement Unit;
- Implement Utilization Review (UR) of all substance abuse beds;
- Ensure that the Behavioral Health Access Center (BHAC) coordinates with the Placement Unit and the client's case manager for admission, transition between placements, medication, and response to emergency episodes;
- Create standardized criteria for eligibility and procedures for admission and discharge;
- Create a prioritized referral and placement process for all DPH-purchased Substance Abuse beds;
- Ensure that BHAC and the Placement Unit have joint responsibility for coordination among agencies for placement and discharge;
- Reduce duplication of case management;
- Ensure substance abuse clients are connected to primary care and/or behavioral health;
- Implement census data system.

Key Issues for Consideration

The Substance Abuse subgroup identified the following key issues that DPH should consider when expanding the existing authorization and utilization review process for residential substance treatment programs. More detail regarding the key issues can be found in the Appendices section of this document under heading: *Attachment 3.3.*

- 1. Importance of substance abuse provider involvement and input in admission and discharge
- 2. Clarification of placement process
- 3. Challenges to implementing standardized intake, admissions and discharge
- 4. Issues faced by specific populations
- 5. Challenges resulting from multiple access points to the substance abuse system
- 6. Ensuring placement or housing upon discharge
- 7. Ensuring placement for high priority clients
- 8. Ensuring one case manager per client
- 9. Ensuring connection to primary care/behavioral health
- 10. Implementation of census data system
- 11. Clarification about substance abuse bed funding



IMD Client Assessment Subgroup

Overview

DPH currently pays for approximately 230 clients in 10 IMD facilities. The task of the Institution for Mental Disease (IMD) Client Assessment subgroup was to conduct a clinical assessment of all clients currently residing in IMDs to identify clients that could step down to a lower, more appropriate level of care. Moving clients to less restrictive settings, as appropriate, will improve client outcomes and reduce costs for DPH.

The IMD Client Assessment subgroup of the workgroup identified the following <u>objective</u> to guide the development of recommendations:

Move clients to least restrictive setting by identifying clients ready to step down to a lower level of care and identify destinations that are ready to accept them to lower the IMD census.

Assessment Progress

- 6 out of 10 IMD facilities were assessed. This represents 83 percent of all IMD beds and 202 clients.
- The group agreed to defer assessment at the remaining facilities since they were high level of care Skilled Nursing Facilities (SNF) or Traumatic Brain Injury (TBI)/neurobehavioral/high assault populations.
- 4 clients were identified as able to step down now.
- It was confirmed that the clients currently at IMDs were appropriately placed.

Recommendations

- 1. Support continued efforts to assure the least restrictive level of care and minimize Length of Stay (LOS).
- 2. Explore opportunities for diversion to community programs before sending clients to IMD and consider system changes for a different type of facility in the community if indicated.
- 3. To reduce isolation, strengthen community connections within the IMD structure via groups and interviews/meetings with community program representatives and Intensive Care Managers.
- 4. For IMD clients needing supportive housing, find exit models that provide this service outside of the Tenderloin or other high substance triggering environments.



Workgroup 4: Increasing Health Equity

Workgroup Leaders: Ginger Smyly (Deputy Director, DPH Prevention); Doreen Der-McLeod (Executive Director, Cameron House / representing the Asian & Pacific Islander Health Parity Coalition).

Health Inequities are systemic, avoidable, unfair and unjust differences in health status in the distribution of disease and illness across population group, and mortality rates. They are sustained over time and generations and beyond the control of individuals.

Health disparities are evident differences that exist across different social groups in a society (Peter, 2000). Among all inequalities there exist a subset of disparities that are avoidable and therefore unfair or inequitable (Louisville Metro Center for Health Equity).

Overview

Current and anticipated budget deficits make it challenging to provide essential programs and services as less resources are available. However, these trying times can be an opportunity for DPH to shift the paradigm from primarily providing palliative or curative services, to more effectively address health inequities in services, programs and policies. Such a shift will require systemic changes in how we prioritize and plan services, the methods advanced, and the distribution of resources.

DPH convened the *Increasing Health Equity* policy initiative workgroup to make recommendations that would inform the reorganization of Community Programs and development of future RFPs. The workgroup consisted of representatives from DPH, as well as clinicians and representatives from CBOs in San Francisco.

The goals of the *Increasing Health Equity* workgroup were to:

- Reduce and/or eliminate health disparities among the San Francisco population
- Continue to ensure cultural and linguistic competency of the San Francisco Department of Public Health services which represents the cultural perspective of vulnerable communities
- Ensure that public health functions of prevention and health promotion are maintained

Discussions in the *Increasing Health Equity* workgroup centered on refocusing DPH's Community Programs to include strategies with an emphasis on addressing health inequities systematically, which would lead to improved health outcomes for priority populations. This would result in an RFP process that is reflective of internally-practiced DPH strategies. Over the course of the discussion, the workgroup came up with the following <u>revised goals</u>, which were used to frame the recommendations:

- Reduce and eliminate health disparities.
- Use population specific evidence about disproportionately adverse outcomes or poor access to care to make decisions regarding services, programs and contracts.
- Protect and improve the health of the most at-risk populations (i.e., who are disproportionately affected by health disparity) as services are cut.



- Identify, prioritize and address the social determinants of health to eliminate or reduce health disparities.
- Maintain a culturally competent workforce for the populations served.
- Ensure access to services that meet the linguistic, cultural, and neighborhood needs of vulnerable populations.
- Maintain, improve and enhance public health functions to prevent disease and promote health.

Guiding Principles

These conversations resulted in the following <u>principles</u>:

- Implement prevention and health promotion interventions across a wide spectrum (in the medical setting, in communities and in societal institutions).
- Reduce health disparities through policies, programs, and services that address root causes of health disparities, specifically social determinants of health and inequities.
- Demonstrate principles of community engagement and participation.

Integrating other sources and recommendations

The workgroup incorporated recommendations from the following sources:

- DPH Prevention Strategic Plan: 2004-2008 Five-Year Plan
- Asian and Pacific Islander Health Parity Coalition recommendations
- Chicano/Latino/Indigenous Health Equity and Social Justice Planning Group recommendations
- African American Leadership Group recommendations
- African American Health Workgroup
- Alcohol Workgroup Health Equity Leadership Team
- Communities of Opportunity Business Plan
- Mental Health Services Act (Prevention and Early Intervention Plan)
- Mental Health Services Act (Community Services and Supports Plan)
- San Francisco City and County Violence Prevention Plan

Recommendations

The *Increasing Health Equity* workgroup proposed the following recommendations to reduce and/or eliminate health disparities and health inequities and achieve better health for all San Franciscans. These recommendations may have multiple sub-recommendations or "action steps." In some cases the action steps may overlap into other recommendation areas. Some recommendations may pertain to DPH's structure and systems while others pertain to RFP and services, thus pointing to the interdependence of work to address health inequity and health disparities.



1. <u>Public Health, Health Promotion and Prevention</u>. Promote and maintain prevention and public health functions related to reducing and eliminating health disparities and health inequities by ensuring that prevention is a core component of new program initiatives, services, and part of the overall design where appropriate across the department and contractors.

We recognize that "people cannot achieve their fullest health potential unless they are able to take control of those things which determine their health," (World Health Organization). One of the aims of Public Health is to create environments that are conducive to healthy choices and that reduce differences in current health status among populations.

Sub-recommendations for DPH System Changes:

- Establish a baseline of services for at-risk and vulnerable populations.
- Develop and implement Public Health Vital Signs in clinical settings (primary care, substance abuse and mental health treatment).
- Develop and implement Public Health Vital Signs in community settings (African American identified cultural, social, community and faith institutions, etc.).
- Screen and refer for depression/Post Traumatic Stress Disorder (PTSD) in all clinical settings.
- Screen and refer for alcohol use as a "Public Health Vital Sign" in clinical settings.
- Increase education and public awareness programs on health practices, prevention, and access to support health services.
- Practice-based evidence should be given high value and the effectiveness of programs and initiatives should always be evaluated.
- Provide opportunities to build capacity among civil service employees/sections and community partners to address health disparities and health inequities (or using the spectrum of prevention or the Bay Area Regional Health Inequities Initiative [BARHII] framework).

Sub-recommendations for RFPs:

- Include a technical assistance and training initiative to support and build community partners' capacity to address alcohol related and other problems (or using the spectrum of prevention or the BARHII framework).
- Include an initiative to improve African American cardiovascular health through interventions along the continuum of the medical model through the socio-environmental factors (or using the spectrum of prevention or the BARHII framework).
- Include contractor compliance or implementation of Public Health Vital Signs screening and referrals (tobacco, alcohol use, trauma, PTSD, etc.).
- Include a menu of selected health disparity/health inequity issues, population outcome objectives, and strategies/methods to be addressed by contractors.
- 2. <u>Data</u>. Systematically collect, analyze and report on health disparities and inequities, by ethnic/cultural, age, neighborhood and other relevant groupings in order to plan and prioritize funding, and evaluate services, projects and contracts.



Systemized and effective data collection strategies are part of the 10 essential core functions of Public Health (monitor health; diagnose and investigate; inform, educate, empower; mobilize community partnerships; develop policies; enforce laws; link to/provide care; assure competent workforce; and, evaluate). Data enables Public Health departments to: 1) identify community health problems by monitoring health status 2) evaluate the effectiveness, accessibility, and quality of population-based health services, and 3) conduct research to develop innovative solutions to health problems.

Sub-recommendations for DPH System Changes:

- Communities should be engaged as much as possible in the development, collection and analysis of health data. Findings should be shared with all stakeholders in user-friendly formats that encourage understanding and action.
- An easily accessible, centralized source of data should be created and an annual or periodic report on health outcomes/status, access to care and health equity in San Francisco should be produced.
- Data collection tools and efforts should capture the diversity of San Francisco neighborhoods and populations including smaller and/or emerging groups. Whenever feasible, disaggregate health data into specific ethnic and cultural sub-groups, especially among Asian/Pacific Islanders and Chicano/Latino/Indigenous groups. Analysis should also be conducted by neighborhood, age group, or other factors beyond cultural, place of origin and language. Finally, periodically map services by neighborhood as a planning tool.
- Data should inform each stage of intervention development and should guide decisions about funding and priority setting.
- Conduct further assessment of the health needs of Indigenous immigrant communities in San Francisco.
- Practice-based evidence should be given high value and the effectiveness of programs and initiatives should always be evaluated.

Sub-recommendations for RFPs:

- Include opportunities to conduct qualitative and quantitative neighborhood or population specific needs assessments, particularly of emerging populations.
- 3. <u>Cultural Humility / Cultural Competence</u>. Ensure cultural humility and cultural competency are reflected in the application, development and implementation of programs and services delivered by the department and contractors.

The San Francisco Department of Public Health is committed to developing and maintaining health services that are culturally competent, consumer-guided, and community-based. Cultural competence is an essential requirement for health care providers to provide effective services to our diverse populations (DPH Cultural & Linguistic Competency Policy). Cultural humility is characterized by an ongoing reflection and learning from the populations we serve.

Sub-recommendations for DPH System Changes:

Review recommendations of external/internal groups, as well as integrating the knowledge of community leaders and partners.



- Reach out to community leaders and CBOs to include them in the processes of planning and delivery of services.
- Preserve bi-lingual and bi-cultural Full Time Equivalents (FTEs), including temporarily vacant
 positions, to encourage access to services by limited-English Asian and Pacific Islander populations
 and other mono-lingual populations.
- Practice-based evidence should be given high value and the effectiveness of programs and initiatives should always be evaluated.

Sub-recommendations for RFPs:

- Include how contactors will engage community in the processes of planning and delivery of services.
- Include opportunities for contractors to identify and adopt effective community/grassroots practices, such as *Promotores*, lay health workers, reexamination of signs and symptoms, etc. (evidence-based practice vs. practice-based evidence).
- Include opportunities to address health disparities through a holistic approach as defined by the culture of the population being served.
- Include opportunities to support efforts to create and sustain a workforce of Indigenous service providers.
- Ensure that contractors promote/preserve bi-lingual and bi-cultural staff to encourage access to services by limited English populations.
- 4. <u>Building Community Capacity</u>. Build the capacity of community and grassroots organizations to address the health issues of emerging populations and other affected populations by providing training opportunities and technical assistance.

Community and grassroots organizations deliver cultural and linguistically competent services in diverse communities. Increasing capacity empowers these organizations to plan and implement effective programs that can improve the health status of local residents and create a healthier community.

Sub-recommendations for DPH System Changes:

- Review recommendations of external/internal groups and integrate the knowledge of community leaders and partners.
- Provide opportunities and technical assistance to community and grassroots organizations and groups to build their capacity to address the health issues of emerging populations (training, etc.)
- Develop and/or adapt approaches to addressing social determinants of health (per above) including coalition building and advocacy for equity in health care access and services, other areas of inequity, public policies, etc.
- Reach out to community leaders and CBOs to include them in the processes of planning and delivery
 of services.

Sub-recommendations for RFPs:

Include how contractors will engage community in the processes of planning and delivery of services.



- Include opportunities for contractors to identify and adopt effective community/grassroots practices such as Promotores, lay health workers, reexamination of signs and symptoms, etc. (evidence-based practice vs. practice-based evidence).
- Include opportunities to address health services and health disparities through a holistic approach as defined by the culture of the population being served.
- Include opportunities to support efforts to create and sustain a workforce of Indigenous service providers.
- Include opportunities and support for contractors to engage, support and provide technical assistance to smaller CBOs and grassroots groups advocating for the needs of emerging populations.
- Ensure that contractors promote/preserve bi-lingual and bi-cultural staff to encourage access to services by limited English populations.
- 5. <u>Social Determinants of Health</u>. Identify, prioritize, and address the social determinants of health to eliminate or reduce health disparities and health inequities across the department and contractors.

The social determinants of health are societal conditions that contribute to differences in health outcomes of different populations. Social determinants include: political, social, and economic institutions and systems, and neighborhood and workplace social and physical conditions (Source: Social Environment and Health).

Sub-recommendations for DPH System Changes:

- Identify broad based societal factors that result in health disparities or health inequities such as: historical trauma and injustices, discrimination, racism, lack of educational and career opportunities, un- and underemployment, wage levels and working conditions, inadequate housing, inadequate family supports such as quality parenting support and child care, social isolation and lack of social support, poor access to healthy food, overabundance of environmental health hazards, etc. Refer to the BARHII framework and the Health Equity Leadership Team (HELT) action plans.
- Develop and adapt approaches to addressing social determinants of health (per above) including coalition building and advocacy for equity in health care access and services, other areas of inequity, public policies, etc.
- Disseminate information on social and other determinants of health to DPH programs for use in program development, data collection, and work with communities.

Sub-recommendations for RFPs:

• Include efforts addressing social determinants of health related to health disparities and a menu of approaches that contractors can adopt to address these social determinants of health along a continuum (primary to tertiary prevention, and upstream to downstream determinants interventions), and in relation to identified community or population assets and social and organizational network arrangements.

The Appendices section of this report includes a Sample Menus of Objectives and Social Determinants of Health developed by the workgroup. See Attachment 4.1.



Workgroup 5: Supporting Children, Youth, and Families

Workgroup Leaders: Germán Walteros (Associate Director, Instituto Familiar de La Raza); Marlo Simmons (Adolescent Health Coordinator, SFDPH and Department of Children, Youth, and Their Families); Sai-Ling Chan-Sew (Director, SFDPH CBHS Child, Youth, and Family System of Care).

Overview

As part of its commitment to promoting recovery and health for families, communities, and individuals, DPH convened the *Supporting Children*, *Youth*, *and Families* policy initiative workgroup. The workgroup consisted of representatives from DPH and CBOs in San Francisco serving children, youth and families. Although the current economic climate poses important challenges, both DPH representatives and community based providers were committed to preserve and prioritize serving families through a culturally and linguistically competent, outcomes based, family-driven, youth-guided system of care that emphasizes recovery and resiliency.

In its beginning stages, the workgroup used the following key questions to frame initial conversations:

- How do we stabilize and support families through health and wellness promotion, as well as trauma and injury prevention?
- How do we address and prioritize the needs of the most vulnerable families?
- How do we serve families in an integrated manner, as opposed to serving children/youth and their parents/caretakers separately?

These conversations resulted in the following <u>vision</u>: *Children*, *youth and families are physically and mentally healthy*.

Guiding Principles

- Services must be family and youth centered, culturally and linguistically competent, and age appropriate;
- Services should meet children, youth, and families where they are, both in terms of physical points of entry, as well as their level of readiness for services;
- Services should help ensure that children, youth, and families are in stable living conditions, including disconnected youth and young adults;
- Services should be coordinated to avoid fragmentation and duplication across all agencies serving children, youth, families, and Transitional Age Youth (TAY), including Primary Care, HIV, Maternal and Child Health, and other health care systems;
- Services should be parent-guided, youth-driven, and strengths-based; and
- Families are defined both in traditional and non-traditional terms (e.g., self-defined support system for TAY).



Integrating the work of Mayor Newsom's IAC

As the work of the group progressed, Kimberly Wicoff, Director of the Mayor's Interagency Council (IAC) joined the group and introduced the group to the recommendations of the three following initiatives:

- Communities of Opportunity (COO)
- Violence Prevention Plan (VPP)
- Transitional Youth Task Force (TYTF)

Kimberly also introduced the group to the priorities the IAC has identified as central to its effort to coordinate inter-departmental efforts on the three initiatives by focusing on the following recommendations:

- All children are safe and flourishing at home;
- All youth graduate high school ready for their next step;
- Young adults and adults have living wage employment; and,
- All families and individuals have safe, healthy housing

The workgroup reviewed and discussed the four IAC priorities and the primary role of DPH, and agreed that most recommendations from the workgroup fit into the goal "All children are safe and flourishing at home," which formed the basis for the workgroup's guiding principle to ensure that children, youth, and families are in stable living conditions.

Priority Populations

The workgroup identified groups of high-need, priority populations which, even if broader in scope, are highly aligned with the target populations identified through the three initiatives represented by the Interagency Council. Therefore, each of the recommendations includes strategies that address these populations.

Workgroup Priority Populations and Risk Indicators

Children in stressed families

Children, youth, and families in and around public housing developments; Families isolated from access to the system of care (i.e. not currently accessing services, or unaware/unwilling to access available services); Trauma exposed children, youth, and families; Children and youth experiencing parental behavioral health issues, neglect, and abuse.

Families with children involved in multiple systems

Juvenile Justice; Foster Care; Mental Health; Special Education.

Transitional Age Youth (Most At-Risk)

Young unmarried parents; High school drop-outs; Homeless youth; Youth with a disability or other special need; Emancipated (or soon will be) youth out of public systems (juvenile justice, foster care, special education and mental health).

IAC Target Populations

- Public housing residents
- Multi-system involved families
- Previously incarcerated youth and adults
- CalWorks families
- Public housing residents
- Multi-system involved families
- Previously incarcerated youth and adults
- CalWorks families
- Transitional Age Youth



Recommendations

The *Supporting Children, Youth, and Families* workgroup believes that the following recommendations, if implemented, would result in long-term improvements to the System of Care and to improved health outcomes for children, youth, and families in San Francisco.

1. Collaborate to improve coordination and prioritization in care planning across systems of care to reduce institutionalization/group care and support families living in natural communities, particularly for children, youth, and families who have complex needs and/or are served by multiple systems.

High-need children, youth, and families who are in crisis and/or involved in multiple systems require coordinated services that meet their immediate and long-term needs. Serving these high-need populations effectively and efficiently entails coordination across systems through a systems-level strategy that reaches clients in crisis to help them (A) move seamlessly across systems, and (B) transition to a less restrictive level of care. In this regard, collaboration with the Mayor's Interagency Council and other partners is crucial. When systems collaborate effectively with one another, children, youth, and their families are able to access wraparound, crisis stabilizing services that are culturally and linguistically appropriate, and that provide them the skills and abilities to manage their behaviors and prevent placement at higher levels of care. In addition, it is especially important to ensure coordination of care for families when one or both parents are in jail. These stabilization efforts are important to ensure that children, youth, and families are able to stay in, or return to, stable living conditions in their families or communities. Please see *Attachment 5.1* in the Appendices Section for a visual that depicts a workgroup-created "Care Coordination Model for Multi-System Involved Children, Youth, and Families with Complex Needs."

- Ensure providers receive proper training. DPH should ensure that case managers and other direct service providers are properly trained to help support the goals set forth above (cultural and linguistic competence, skills-building, least restrictive care, return to home/stable living conditions), especially for children, youth, and families with dual diagnoses and those needing crisis stabilization services. In addition, it is important to provide training to direct service providers in adult systems so that they can appropriately serve Transitional Age Youth. Proper training in these areas helps meet clients where they are at, where they want to be, and may help prevent the need for higher levels of care.
- Support the adoption of city-wide case management general guidelines as reference points to ensure consistent practice (intensive, moderate, etc.). To provide a more uniform understanding of what case management services entail, DPH should explore the adoption of city-wide case management standards (developed by the Department of Children, Youth and their Families DCYF) as reference points or general guidelines for providing consistent case management services to families. DPH should compare the DCYF guidelines with Medi-Cal reimbursement guidelines for case management services.
- Train supervisors to support implementation and to address structural barriers to reforms. In addition to direct service providers, it is important that supervisors also receive support and training to help facilitate implementation of these recommendations. In addition to ensuring buy-in and increased understanding of new policies and procedures, properly trained supervisors can better support their staff to meet the needs of high-need clients.



- Expand access to services for families by assessing how Medi-Cal can help pay for family services. The current billing system creates barriers for providing services to families as a whole. Care providers in adult systems often find that the clients they serve also have needs for their young children or adolescents/youth, and find it hard to assess those needs, serve the whole family, and/or provide appropriate referrals. DPH should explore billing Medi-Cal for family services.
- 2. Partner with the Mayor's Interagency Council (IAC) to develop a coordinated system of services for children, youth, and families that supports multiple "hubs," ensures that one "Care Coordinator" is identified and maintains a primary relationship with the client, and helps sustain smooth transitions across the continuum of care.

One of the major road blocks for families in San Francisco, and for the Children, Youth, and Families system of services and supports, are fragmented and duplicative services. Too often, families deal with a number of different providers, resulting in conflicting expectations. Furthermore, providing services in this manner often results in duplication of efforts and inefficient use of resources. Workgroup participants called for a system that ensures that the needs of the parent (adult) are addressed and coordinated in conjunction with the care of the children/family, and for further collaboration and support for and from the Mayor's Interagency Council. Please see *Attachment 5.2* in the Appendices section of this document for a workgroup-created "*Model of Services and Supports for Children, Youth, and Families*"

- Partner with the IAC to develop and pilot a coordinated system of services with the following components:
 - Multiple "hubs". There are multiple entry points into the system of services for Children, Youth, and Families. These entry points include public housing, schools, community centers and family resource centers, primary care clinics, child care, and other community based multi-service centers. These entry points could serve as service "hubs" for families, with family and youth choice about where they access services. In addition, these hubs should be properly trained and have adequate staff capacity.
 - A "Care Coordinator" is identified and maintains a primary relationship with the client. One of the key components of a coordinated system of services is ensuring that clients have one "Care Coordinator" rather than multiple uncoordinated providers. When families, children, and youth have a primary relationship in the Children, Youth, and Families service system, client service utilization, data sharing, and communication are smoother, resulting in improved infrastructure. The "Care Coordinator" also facilitates a family-centered, team decision-making process, which ensures that families are involved in all decisions related to their care planning. DPH should be involved and commit resources for the development of this model including the necessary data and communication components.
 - Sustain smooth transitions across the continuum of care. Families access services across the continuum of care, from prevention and health promotion to intervention and higher levels of treatment. It is important that, as clients transition into higher (or lower) levels of care, they are supported to avoid letting them fall through the cracks. This includes reaching families "before they fail" or before they are even in crisis. DPH should make a commitment to improved communication within the children's system and across systems serving families.



- Draft Model for Pilot. Workgroup participants identified key elements of a coordinated system of services that might address the needs and assets of families in San Francisco. Elements included: access, engagement, service appropriateness (service delivery), linkages, and outcomes. The result was a draft model of services and supports that is highly aligned with current models and work occurring through the Mayor's Interagency Council. The workgroup sees this model as one tool for conceptualizing coordination for client-level services and supports provided to Children, Youth, and Families.
- 3. Fund activities that ensure children, youth, and families needing behavioral health support are identified and receive early intervention services before they need higher levels of care or experience other negative outcomes.

There are a number of factors that lead to unstable living conditions for children, youth, and families. Mental health and substance abuse concerns rank high among these factors, and may result in abuse/neglect or involvement in other systems, such as child welfare or criminal justice. In order to reach families "before they fail" and before they need higher levels of care or experience other negative outcomes, it is critical to identify and provide early intervention services for children, youth, and families needing mental health support. Two important steps toward achieving these goals are (1) providing provider training in the facilitation of family-guided interagency care planning and coordination meetings, and (2) creating better cross-system and cross-agency tracking of linkage and connectivity to appropriate services for the child/youth/family.

- Expand the availability of mental health consultation services. Each of the entry points identified in the previous recommendation (public housing, schools, primary care, child care, community centers) afford a unique opportunity to identify and reach families needing mental health support by providing behavioral health screenings. Care providers at each of these entry points need to be well-equipped, so training, observation, and coaching are very important, in addition to brief intervention work with families, and referrals and support linking. DPH should help support the delivery of and training for mental health consultations at each of these entry points.
- Support outreach and engagement activities. DPH should support outreach and engagement activities to target populations who may be at higher-risk for experiencing adverse behavioral health outcomes. Some of these populations have been prioritized by the City's IAC (public housing residents, multi-system involved families, previously incarcerated youth and adults, CalWorks families, and Transitional Age Youth). DPH should support these efforts to provide outreach and engagement to populations experiencing mental health and/or substance abuse by meeting people "where they are", both geographically and in their level of readiness for services.
- Train providers serving adults to assess the needs of the whole family. Providers serving adults have a unique opportunity to assess the needs of their clients' children and youth. For instance, a provider working with a client experiencing mental health and/or substance abuse issues is uniquely positioned to assess if there are kids or youth at home or in their care, and to coordinate care or refer the family for services. It is important to note that adult providers should not, per se, be required to serve the family of their adult clients, but rather assess the presence and needs of children and youth in their care.
- Provide parent education and skills-building services for children 0-5 and their families. DPH should continue to support parent education services and skills-building programming targeted to



children ages 0 to 5 and their parents/caretakers. Reaching families and caretakers who have young children helps identify and support families earlier on.

4. Create incentives for the adult and child systems to work together to support and ensure optimal outcomes for Transitional Age Youth.

Transitional Age Youth (TAY), and their families/connections, receiving services from the Children's system may not be ready for transition to the Adult system. Likewise, the Adult system may not be ready for TAY transitioning from the Children's system. Communication and transition planning are of critical importance to prevent TAY falling through the cracks, and to ensure optimal outcomes for this population. As defined by the Transitional Age Youth Task Force (TYTF), TAY most at-risk include: young, unmarried parents, high school dropouts, homeless youth, youth who have a disability or other special need, emancipated (or soon to be) youth, and youth out of public systems (juvenile/adult criminal justice, foster care, special education and mental health).

- Commit resources from the Adult Service system for TAY services. TAY are more likely to be uninsured and have higher needs for primary care and behavioral health services, resulting in higher costs for the Children's system. Therefore, DPH should carve out resources from the Adult service system specifically for TAY services.
- **Develop transition planning.** To ensure a smooth transition for TAY (and prevent them from being dropped), the Adult system should prioritize referrals from the Children's system for TAY. In addition, services for TAY should be enhanced by providing training for Adult providers to work with TAY. Finally, providers from both systems working with TAY should meet as youth prepare to transition so that they have a coordinated transition plan. *This recommendation action step emerges from and is supported by the TYTF plan.*
- Support residential treatment for TAY. DPH should help build the continuum of housing opportunities and maximize leveraging opportunities in housing for TAY. In addition, DPH should follow-through in their involvement with the Mayor's Housing Plan and continue to support a predetermined number of housing units. For instance, some workgroup participants suggested that current adult residential treatment programs that may be closed could instead be converted to TAY facilities. This recommendation action step emerges from and is supported by the TYTF plan and the Housing plan.
- Address the needs of young families. Transitional Age Youth who are young parents have specific needs for themselves and for their young children. In this sense, they may be multi-systems involved and have higher needs for primary and reproductive care, life skills, housing, as well as employment and education services. DPH should assertively mandate the systems involved to work together to address these needs.
- Expand gender-specific services. A key strategy for improving service delivery, particularly for youth, is to provide gender specific services. Often, because of the stage of youth development, vulnerable youth need specific and specialized services that are best delivered in settings and program designs that are tailored along gender lines. DPH should allocate resources for programs that provide gender-specific, as well as culturally- and age-appropriate, services to high-risk youth in San Francisco. Critical services include comprehensive sex education in the schools, specifically for youth who may end up HIV+ and engage in CARE services.



5. Focus on community violence, intimate partner violence, child abuse, and trauma as significant public health issues for children, youth, and families in San Francisco.

Community violence, intimate partner violence, child abuse, and other forms of trauma have a significant impact on the well-being of many children, youth, and families in San Francisco. In this sense, community-based violence and trauma recovery services are very important to help address the repercussions from violence that many families face.

- Support Crisis Response Networks or similar models. These networks provide case management, street outreach, and crisis response interventions to address community, school, and home-based violence in specific neighborhoods. DPH should continue to support Crisis Response Networks and/or similar models to address violence in the communities most impacted by violence and trauma.
- Expand the availability of trauma screening and training to Family Resource Centers and schools (including high school wellness centers). In addition to reaching targeted neighborhoods, violence and trauma prevention strategies should also target underserved communities where domestic violence may be not reported or made known. With this in mind, DPH should expand the available of trauma screening and training to community based entry points, such as Family Resource Centers and schools.
- Increase the capacity of providers to identify risk factors earlier. Many families experiencing intimate partner violence/domestic violence and other forms of trauma access services through the mental health system. DPH should provide training for providers to help them implement family-focused best practices for earlier identification of risk factors related to violence and trauma. DPH could also help institutionalize sustainability by creating a training track around violence and trauma to train as many providers as possible.



Participants engaging in discussion at the Supporting Children, Youth, and Families Workgroup



Workgroup 6: Community Based Organizations

Workgroup Leaders: Sherilyn Adams (Executive Director, Larkin Street Youth Services, representing the Human Services Network); Brett Andrews (Executive Director, Positive Resource Center, representing the HIV/AIDS Provider Network); Jacob Moody (Executive Director, Bayview Hunters Point Foundation for Community Improvement, representing the African American Health Leadership Group).

Overview

The City's current budget situation poses serious risks to San Francisco's nonprofit sector, as nonprofits will likely experience substantial losses of City funding in the coming years. Contract reductions will challenge nonprofits to find new funding sources and more cost-effective methods of service delivery. Some nonprofits will face threats to their sustainability in the face of declining funding from government, foundations, and individual donors associated with the recession. Alongside risks to nonprofits come risks to community members who benefit from City-funded services provided by nonprofits.

Recognizing the importance of nonprofits to City service delivery, DPH charged the *Community Based Organizations (CBOs)* workgroup with developing recommendations in the face of these challenges. The workgroup used the following <u>key questions</u> to frame its initial conversations:

- What are the unique contributions of CBOs to the delivery of city-funded services?
- What mechanisms for increasing efficiencies among CBOs would be feasible and beneficial, given the critical role of CBOs in the Community Programs service system?
- What are the parameters (principles, guidelines, and criteria) for determining opportunities for mergers, consolidations, and streamlining?
- How can DPH streamline the contracting process to gain greater efficiencies?

Nonprofits are essential to DPH's ability to achieve its mission which calls for ensuring equal access to all; providing quality, comprehensive, culturally-proficient health services; and preventing disease and injury. The workgroup identified the following competitive strengths offered by nonprofits with respect to delivery of Cityfunded services to the community.

- Nonprofits deliver high quality services. Nonprofits are recognized by the City, other funders, and the community for high quality service delivery. Community-based organizations offer the ability to provide linguistically and culturally competent and peer-based services to new and under-served communities. Nonprofits are often geographically located in the communities they serve, making them more in touch with community needs. Some nonprofits are able to approach service delivery in a more holistic manner given that they are less constrained by mandates and eligibility issues than government agencies. Community members are often more trusting of the service provider if that provider is community- rather than government-based. Nonprofits also bring sector expertise in specific content areas and have greater flexibility than the City to innovate and develop best practices.
- Nonprofits are flexible and responsive to community needs. Nonprofits are known for being nimble and dynamic. Community members often find it easier and more comfortable to access services that are



community-based. Nonprofits can respond promptly to changes in community needs and offer the ability to scale up new services quickly. Nonprofits experience fewer constraints than the City and are free to think beyond mandated services, populations, and funding streams. Nonprofits also play an important advocacy role and can influence policy in ways that City staff cannot.

- Nonprofits leverage an array of resources. Most nonprofits leverage an array of outside funding sources including foundation grants, individual donor contributions, and non-local government funds. Many are also able to leverage a substantial volunteer base. This base includes board members that bring external strengths, energy, diversity, and expertise beyond the nonprofit sector and local region. These relationships enable nonprofits to tap into a variety of funding sources, often resulting in augmentation of and enhancements to City-funded service delivery.
- Nonprofits are highly accountable to client outcomes. Because nonprofits are responsible to multiple funding sources, they must demonstrate continued effectiveness through established performance measures in order to remain competitive for sustained government and private funding. They also have explicit accountability for the delivery of cultural and linguistically competent care through the City contracting process. Services provided by the City are not necessarily held to the same standards. Community stakeholders believe there should be a civil service commitment to a corresponding level of accountability.
- Nonprofits promote economic development. According to the recent University of San Francisco (USF) study, San Francisco nonprofits make an important contribution to our local economy. They represent nearly eight percent of local wages as well as \$8.6 billion in expenditures. Nonprofits also play an important workforce development role, making entry-level jobs available to low- and middle-income residents, many of whom go on to higher-paying government jobs.

Guiding Principles

Recognizing the critical role CBOs play in the Community Programs service system, the group developed the following guiding principles for development of recommendations:

- DPH should prioritize the availability and quality of services for priority populations impacted by health disparities within current cost constraints.
- Nonprofits are a crucial partner in the delivery of City-funded and other services for populations most affected by health disparities.
- Nonprofit governance and self-determination should be recognized and respected in the current environment.
- DPH has a responsibility to engage community stakeholders in the budget and policy making process.

Recommendations

Workgroup members recognize that the following recommendations do not represent all nonprofits that contract with DPH and encourages DPH to gather feedback from all of its contractors. Nevertheless, the group believes the following recommendations will help DPH maintain the strengths of its community-based service delivery network.



1. Support and foster community-driven strategic restructuring efforts that maximize service availability and quality for priority populations.

The current economic environment is compelling many nonprofits to evaluate various strategic restructuring options (i.e., mergers, management service organizations, fiscal sponsorship, etc.) as a way to ensure survival and maintain service delivery. Existing literature suggests that restructuring is most successful when efforts are driven by internal governance and leadership, and not by external pressure from outside funders. DPH should be aware of the power it wields in this regard and look for ways to foster and support community-driven restructuring efforts by providing access to relevant resources and tools. It should also focus on supporting efforts that sustain vital services, improve care for clients, and address health disparities.

- Assist nonprofits to explore restructuring. DPH should provide resources for organizations exploring or undergoing restructuring in the form of planning and implementation grants, capacity-building support, and Board/Executive Director training. The Department should also proactively identify strategic restructuring opportunities and partners where there is potential to reduce costs and improve service effectiveness.
- Take into account pros and cons of restructuring options. A range of models for nonprofit consolidation exists, each with its own set of advantages, disadvantages, and costs depending on individual circumstances. DPH should use the attached matrix developed by the workgroup as guidance for identifying how to play a constructive role in such efforts.
- Minimize community disruption. DPH should take a lead role in minimizing service disruption to the community in cases of nonprofit closure and during the transitional period before and after the fall RFP(s) cycle. The Department should also be mindful of potential unintended consequences restructuring may have with respect to leveraging of state, federal, and private resources.
- **DPH and nonprofits should partner in solicitation of private support.** Collaborate with the philanthropic sector to build resources to support nonprofit strategic restructuring.
- Collaborate with nonprofits to reduce health care costs. DPH should explore the feasibility of brokering health care coverage for nonprofit contractors.
- 2. Improve contractor assessment practices to ensure that DPH is funding high-performing, competent, and fiscally strong nonprofits.

DPH must fund strategically in these challenging times in order to preserve and sustain services for priority populations. Minimizing under-performance, poor contractor outcomes, and risks associated with potential financial instability of nonprofit contractors is crucial in the face of diminishing resources. While organizations may have strong program goals and models, they must also have the organizational, financial, and management infrastructure to adequately support their work.

• Fund organizations with strong fiscal and organizational capacity. The proposal review process should integrate assessment of critical areas nonprofits must address to ensure financial stability and sustainable operations, including governance, management and personnel, funding diversification, etc. DPH should review and identify appropriate assessment tools for this purpose.



- Take into account prior performance. DPH should review prior program performance in its assessment of nonprofit applicants. This includes assessment of program outcomes as evidenced by accurate and reliable data as well as measures such as generation of targeted revenues for Medi-Cal eligible providers.
- Improve assessment of cultural competence. It is widely recognized that cultural competence (inclusive of ethnicity, age, disability types, etc.) is critical to service delivery effectiveness. Too often, assessment of provider competence is based on assertions and subjective judgments, rather than a more intentional and explicit process. DPH should review and identify appropriate assessment tools for this purpose.
- Promote nonprofit reserves. DPH should use the RFP process to encourage nonprofits to have at least two months of unencumbered operating revenue held in reserve. DPH should require nonprofits that do not meet this criterion to have a plan in place to meet it within three years.

3. Support capacity development of organizations providing key services in priority neighborhoods.

San Franciscans value accessible (i.e., neighborhood-based) and culturally-based service delivery. These characteristics are key to serving populations most affected by health disparities. There is concern that smaller organizations that play an important role serving communities affected by disparity often struggle with capacity issues and could be adversely impacted by the recession. These organizations face challenges raising funds to support their efforts as they often lack an expansive donor base. DPH should support capacity development for these organizations in cases where a lack of other effective service options exists. Capacity-building assistance should be proactive, rather than introduced after a problem has become out of hand.

- Provide access to both professional and peer-based support. DPH should provide nonprofits access to a pool of professional consultant hours for one-on-one assistance. In addition, the Department should promote peer-based mentoring models, where mature, stable nonprofits mentor newer, smaller organizations. Capacity building support should address areas such as succession planning, governance, fundraising, fiscal issues, city contracting, data/management information system (MIS), and leadership development.
- Target capacity-building appropriately. DPH should develop a clear method of prioritizing organizations for capacity-building assistance. Ideally, all community-based organizations would have access to such assistance. However, given constraints of the current budget environment, priority should be given to organizations serving priority neighborhood and populations and that have demonstrated capacity needs. Improved prioritization will require DPH to clarify priority populations and neighborhoods and to distinguish between organizations that can benefit from such assistance and others that should be encouraged to consider strategic restructuring.
- Assess nonprofit capacity needs. DPH should require nonprofits to complete self-assessments
 regarding programmatic and organizational capacity as part of an effective targeting process.
- Identify new resources. DPH should identify and develop new resources to support nonprofit capacity-building, including philanthropic and federal dollars. Currently, the Department does not have the resources to dedicate to intensive capacity-building efforts.



4. Continue to streamline and improve the nonprofit contracting process.

Several improvements in DPH contracting with nonprofits have been made in recent years. However, room for improvement remains with respect to ensuring timely payment and articulating and improving the methodology for setting indirect cost rates. As DPH restructures contract development, technical assistance, and compliance, the Department should continue to engage contractors in redesign and implementation. In addition, opportunities exist with respect to increasing efficiencies through the use of the DPH's shared database.

- **Facilitate more timely payment.** Given the financial pressure on nonprofit organizations in today's economic environment, it is now more important than ever to ensure contracts are certified and nonprofits are paid in a more timely manner.
- **Continue to engage in City streamlining efforts.** DPH should continue to work on streamlining nonprofit contracts in liaison with the Nonprofit Contracting Task Force.
- Assess indirect cost rate caps. There is concern that current indirect cost rate caps are below the costs of doing business by nonprofits. DPH should explore the adequacy of City indirect cost rate caps relative to the true cost of nonprofit administration. As part of this work, the City should clarify the methodology for setting indirect cost caps, create flexibility in the rate depending on agency size and partnership structures, and explore the process used by the federal government to set allowable reimbursement rates.
- Solicit stakeholder input regarding the new Business Office. DPH should convene and facilitate a contractors' committee to advise on design and implementation of the new Business Office.

The workgroup reviewed a number of resources during the recommendations development process, which provide information about nonprofit strategic restructuring (i.e., mergers, consolidations, management service organizations, etc.) and current challenges facing the sector. This information may be found in both the *Sources* section of this report for *Workgroup 6* and in the Appendices section under *Attachment 6.1*.



Participants engaging in discussion at the Community Based Organizations Workgroup



List of Participants

Stakeholder Engagement Process³

Jason Adamek, San Francisco Department of Aging and Adult Services

Sherilyn Adams, Human Services Network, Larkin Street Youth Services (6, Project Leader)

Brett Andrews, Positive Resource Center, HIV/AIDS Provider Network (6, Project Leader)

Margot Antonetty, DPH Housing and Urban Health (2, S)

Jaime Arcila, Service Employees International Union 1021 (S)

Phil Arnold, Human Services Agency (2, S)

Joshua Bamberger, DPH Housing and Urban Health (3)

Kavoos Bassiri, Richmond Area Multi-Services, Inc.; Association of SF Mental Health Contractors (1, Project Leader)

Edwin Batongbacal, DPH Community Behavioral Health Services (2, Project Leader)

Michael Baxter, DPH (1)

Richard Beal, Haight-Ashbury Free Clinics, Inc. (3)

Bob Bennett, Family Services Agency (2, S)

Ken Berrick, Seneca Children's Services (5)

Alisa Birgy, Progress Foundation Ashbury House (5)

Deborah Borne, Tom Waddell Health Center (2)

Twila Brown, DPH Maternal, Child and Adolescent Health (S)

Gayle Burns, HIV Prevention Planning Council (S)

Bob Cabaj, DPH Community Behavioral Health Services (1, Project Leader)

Ramon Calubaquib, API Health Parity Coalition, Japanese Community Youth Council (6)

Debra Camarillo, The Latino Commission (3)

Mary Ellen Carroll, Controller's Office (1, 3, 6, S)

Phil Castiglione, DPH Behavioral Health Access Center (3)

Jenny Chacon, DPH (4, S)

Sai-Ling Chan-Sew, DPH (5, Project Leader)

Aaron Chapman, DPH Community Behavioral Health Services (1)

Mark Cloutier, San Francisco AIDS Foundation

Grant Colfax, DPH HIV Prevention Section (2, Project Leader)

Robyn Collins, Baker Places (3)

Gregg Cross, Service Employees International Union 1021 (1)

Doreen Der-McLeod, Cameron House, Asian and Pacific Islander Health Parity Coalition (4, Project Leader)

Michael Drennan, DPH Community Oriented Primary Care (S)

³ Alphabetical by last name. In parenthesis, workgroup membership is indicated by workgroup number and Stakeholder Group membership is indicated by an "S".



Toby Eastman, Larkin Street Youth Services (5)

John Eckstrom, Haight Ashbury Free Clinics Inc. (1, 6)

Ben Eiland, Haight Ashbury Free Clinics, Inc. (S)

Duane Einhorn, DPH (6, S)

Ken Epstein, Edgewood Children's Center (5)

David Fariello, DPH San Francisco Citywide Case Management (2, Project Leader)

Stephen Fields, Asian American Recovery Services

Steve Fields, Progress Foundation, Human Services Network (3, Project Leader)

Bruce Fisher, Huckleberry Youth Programs (5)

Louise Foo, Conard House (3)

Deirdra Forte Wilson, M.D., DPH (4)

Jenny Friedenbach, Coalition on Homelessness (S)

Barbara Garcia, DPH Community Programs (3, Project Leader)

Estela Garcia, Chicano Latino Indígena Health Equity and Social Justice Planning Group, Instituto Familiar de la Raza (4, 6, S)

Mark Ghaly, Southeast Health Center (5)

Al Gilbert, Family Service Agency of San Francisco (6)

Alice Gleghorn, DPH Community Behavioral Health Services (3, Project Leader)

Margaret Gold, Jelani, Inc. (3)

Lisa Golden, DPH Ocean Park Health Center (1, Project Leader)

Cynthia A. Gómez, Health Equity Institute at San Francisco State University (4)

Isela Gonzalez, HIV Prevention Planning Council, Jail Health Services, Forensic AIDS Project (6, S)

Dean Goodwin, DPH Health Services (S)

Janet Goy, Community Awareness and Treatment Services (CATS) (3)

John Gressman, Community Clinics Consortium (S)

Roma Guy, Prevention Council (S)

Cindy Gyori, Hyde Street Community Services (1)

Steve Harlow, New Leaf Services (S)

James Harris, Service Employees International Union (1, S)

Richard Heasley, Conard House (1)

David Hersh, DPH Community Behavioral Health Services (3)

Kelly Hiramoto, DPH Long Term Care (3, Project Leader)

Dick Hodgson, Community Clinics (1, Project Leader)

Johnson Hor, Substance Abuse Contractors (S)

Ekeoma Igboegwu, DPH Community Oriented Primary Care (1)

James Illig, San Francisco Health Commission (1, S)

Carletta Jackson-Lane, Sojourner Truth Foster Family Service Agency (5)

Gralyn Jacques, Haight-Ashbury Free Clinics, Inc. (6)

Nelson Jim, DPH Community Behavioral Health Services (1, S)



Richard Jimenez, Walden House (6, S)

Lisa Johnson M.D., DPH Community Oriented Primary Care (4)

Dan Karasic, University of California, San Francisco (1)

Mo Kashmiri, Labor Representative (S)

Brian Katcher, DPH Community Health Promotion and Prevention (4)

Masae Kawamura M.D., DPH (4)

Joanne Keatley, Center of Excellence for Transgender HIV Prevention, University of California, San Francisco

LaVaughn Kellum-King, San Francisco Mental Health Board (5)

Lani Kent, Controller's Office (3, 6, S)

Judith Klein, DPH, California Commission on Aging (1)

Sidney Lam, DPH Community Behavioral Health Services, Adult and Older Adult Services (2)

Perry Lang, African American Health Leadership Group; Black Coalition on AIDS (4, S)

Laurie Lenrow, DPH (1)

Jeff Leong, AB75 Project (S)

Terye Lewis, Black Coalition on AIDS

Rod Libbey, Walden House (3)

Shelagh Little, Consultant

Wylie Liu, California Pacific Medical Center, Asian and Pacific Islander Health Parity Coalition (4, S)

Michelle Long, DPH (6, S)

Wilma Louie, Director, Chinatown/North Beach Mental Health Services (2, S)

David Lown, San Francisco Community Clinic Consortium; Saint Anthony Free Medical Clinic (1)

Jimmy Loyce, African-American Health Leadership Group, Black Coalition on AIDS (6, S)

Steve Manley, HIV Health Services Planning Council (S)

Pierre-Joseph Marie-Rose, DPH (5)

Sue Marshall, Haight-Ashbury Free Clinics, Inc.

Maria X. Martinez, DPH Community Programs (2, S)

Norman Mathis, Jelani Inc (3)

Josephine McCreary, DPH (1)

James L. McGhee, Mental Health Board (6)

Carol McGruder, Prevention Planning Council (S)

Maryanne Mock, DPH (1, S)

Catherine Moller Spaulding, Controller's Office (6, S)

Mark Molnar, HIV Health Services Planning Council (1, S)

Jacob Moody, African-American Health Leadership Group, Bayview Hunter's Point Foundation (6, Project Leader)

Sister Estela Morales, Epiphany Center (3)

Charlie Morimoto, DPH Community Programs (1, S)

Craig Murdock, DPH Behavioral Health Access Center (3)

Orlando Naka, Friendship House

Larry Nelson, Walden House (2)



Lori Norcia, DPH (1)

Marcellina Ogbu, DPH (1, S)

Susan Okada, Asian American Recovery Services (3)

Anne Okubo, DPH Administration (S)

Maureen O'Neil, DPH (1)

Tracey Packer, DPH HIV Prevention Services (4, S)

Rajesh Parekh, SF FIRST (2, S)

Ana Perez, Central American Resource Center, Chicano/Latino/Indígena Health Equity and Social Justice Planning Group (S)

Genny Price, Huckleberry Youth Programs (5)

Vickie Proctor, Ozanam Center (3)

Randy Reiter, DPH Epidemiology

Alberto Rendon, Chicano/Latino/Indígena Health Equity and Social Justice Planning Group (S)

Perry Rhodes, HIV Planning Group (S)

Daniel Rizik-Baer, Bayview Hunter's Point Foundation

Max Rocha, Department of Children, Youth, and their Families (5)

Criss Romero, Service Employees International Union 1021 (S)

Nancy Rubin, Edgewood Children's Center (5)

Toni Rucker, DPH Community Behavioral Health Services

Michelle Ruggels, DPH Operations (S)

Martha Ryan, Homeless Prenatal (6)

Bob Rybicki, Westside Community Services (6)

Michelle Schurig, Controller's Office (1, 3, 6, S)

Christina Shea, Richmond Area Multi-Services, Inc (5)

Deborah Sherwood, DPH Community Behavioral Health Services (2, S)

April Silas, Homeless Children's Network

Marlo Simmons, DPH, Department of Children, Youth and their Families (5, Project Leader)

Nakari Small, DPH (1)

Mike Smith, HIV/AIDS Providers Network, AIDS Emergency Fund (6, S)

Ginger Smyly, DPH Prevention (4, Project Leader)

Jorge Solis, SF FIRST (2)

Peg Stevenson, Controller's Office

James Stillwell, DPH (1, S)

Brenda Storey, Mission Neighborhood Health Center, Community Clinics Consortium (2, Project Leader)

Irene Sung, DPH (1, S)

Laura Thomas, HIV Health Services Planning Council (4, S)

Steven Tierney, San Francisco Health Commission

Lance Toma, Asian Pacific Islander Wellness Center (6)

Marc Trotz, DPH Housing and Urban Health (3, S)



Lilian Uwuseba, Epiphany Center (3)

Jorge Vega, Huckleberry Youth Programs

Jonathan Vernick, Baker Places (3)

Germán Walteros, Instituto Familiar de La Raza (5, Project Leader)

Sarah Wan, Community Youth Center (2)

Mary Ann Warren, San Francisco Department of Aging and Adult Services (3)

Ed Warshauer, Service Employees International Union 1021

Kimberly Wicoff, Mayor's Office of Communities of Opportunity (2, 5)

Denise Williams, Walden House (3, S)

Barbara Wismer, Tom Waddell Health Center, DPH Primary Care Clinics (S)

Jessica Wolin, Health Equity Institute, San Francisco State University (4)

David Yonemoto, Asian American Recovery Services (3)

Judy Young, Vietnamese Youth Development Center; Asian and Pacific Islander Health Parity Coalition (4)

Albert Yu, Chinatown Public Health Center, DPH Primary Care Clinics (1, S)

Tiffany Yu, San Francisco Public Conservator Office (3)

Barry Zevin, Tom Waddell Health Center (1)

Harder+Company Staff

Michelle Magee

Clare Nolan

Nayeli Cerpas

Janise Kim

Raúl Martínez

Alison Hamburg

Nicole Peterson

Aimee Crisostomo

Alejandra Portillo



Sources

Workgroup 1: Integrating Primary Care and Behavioral Health

American Academy of Family Physicians (AAFP), American Academy of Pediatrics (AAP), American College of Physicians (ACP), American Osteopathic Association (AOA). Joint Principles of the Patient-Centered Medical Home. March 2007.

Butler M, Kane RL, McAlpine D, Kathol, RG, Fu SS, Hagedorn H, Wilt TJ. (2008) Integration of Mental Health/Substance Abuse and Primary Care No. 173 (Prepared by the Minnesota Evidence-based Practice Center under Contract No. 290-02-0009.) AHRQ Publication No. 09-E003. Rockville, MD. Agency for Healthcare Research and Quality. October 2008.

http://www.ahrq.gov/downloads/pub/evidence/pdf/mhsapc/mhsapc.pdf

California Primary Care, Mental Health, and Substance Use Services Integration Policy Initiative. Vision, Principles and Collaborative Care Continuum. March 24, 2009.

Mauer, Barbara. (2008) Behavioral Health / Primary Care Integration and The Person-Centered Healthcare Home, October 2008. MCPP Healthcare Consulting and The National Council for Community Behavioral Healthcare.

Mauer, Barbara. (2006) Behavioral Health/Primary Care Integration: The Four Quadrant Model and Evidence-Based Practices (Revised February 2006). MCPP Healthcare Consulting and The National Council for Community Behavioral Healthcare.

Schuffman, Dorn. (2009) Bringing Primary Care & Behavioral Health Together: The Missouri Integration Initiative. The Behavioral Health & Social Service Industry Analyst, May 2008, 20:2, 8-9; retrieved on February 27, 2009 from www.openminds.com/circlehome/eprint/2008/050108/050108/htm

San Francisco Department of Public Health. Primary Care and Behavioral Health Integration Protocol, March 2005 (Draft)

Summary of Integration Issues based on SF First/TWHC Pilot

Summary from SF First Integration Pilot Meeting; March 18, 2009.

The National Council for Community Behavioral Healthcare. Medical Homes and People with Mental Illness. www.thenationalcouncil.org/cs/public policy/medical homes issue brief.

Workgroup 2: Coordinating Care

San Francisco Department of Public Health; Data on High Users of Multiple Systems.



Workgroup 3: Managing Beds

San Francisco Department of Public Health, Community Behavioral Health Services. Committee on Efficient Access to and Management of Behavioral Health Treatment; February 5, 2009.

San Francisco Department of Public Health, Community Behavioral Health Services. Centralized Opiate Program Evaluation; Intake Packet.

San Francisco Department of Public Health, Placement Task Force. Current Levels of DPH Community Placement for Single Adults, Revised 2006.

Workgroup 4: Health Equity

Aragón, Tomás J.; Lichtensztajn, Daphne Y. Lichtensztajn; Katcher, Brian S.; Reiter, Randy; Katz, Mitchell H.. "Calculating Expected Years of Life Lost for Assessing Local Ethnic Disparities in Causes of Premature Death."

Farmer, Paul E.; Nizeye, Bruce; Stulac, Sara; Keshavjee, Salmaan. "Structural Violence and Clinical Medicine."

HIV Prevention Planning Council. "2004 San Francisco HIV Prevention Plan." http://sfhiv.org/files/plan 2004/2004 SF HIV Prevention Plan.pdf

Office of Disease Prevention and Health Promotion; US Department of Health and Human Services. "Healthy People 2020."

San Francisco Department of Public Health. "African American Health in San Francisco."

Tervalon, M. and Murray-Garcia, J. "Cultural humility versus cultural competence: a critical distinction in defining physician training outcomes in multicultural education." Journal of Health Care for the Poor and Underserved. 9(2), 117-125, 1998.

Workgroup 5: Supporting Children, Youth and Families

San Francisco Adolescent Health Working Group. (2009) "A Snapshot of Youth Health and Wellness." In partnership with the Department of Children, Youth, and Their Families and the Department of Public Health: Maternal, Child and Adolescent Health Section.

San Francisco Department of Public Health. "Community Behavioral Health Services Child, Youth, and Families System of Care Annual Report," July 1 2007to June 30, 2008. Research, Evaluation, and Quality Management: October, 2008.

San Francisco Mayor's Office Communities of Opportunity Business Plan. "Pilot Phase Business Plan 2006-2010" and "COO 2.0 Business Plan Update, 2008."



San Francisco Mayor's Office Transitional Youth Task Force. (2007) "Disconnected Youth in San Francisco: A Roadmap to Improve the Life Changes of San Francisco's Most Vulnerable Young Adults."

San Francisco Mayor's Office Violence Prevention Plan. (2007) "Emphasizing Coordination, Accountability, and Outcomes."

Workgroup 6: Community Based Organizations

Cortez, Alexander; Foster, William; and Smith Milway, Katie. (2009) Nonprofit M&A: More than a Tool for Tough Times. *The Bridgespan Group*, 2009.

Available at: http://www.bridgespan.org/uploadedFiles/Homepage/Articles/Mergers and Acquisitions/091702-Nonprofit%20Mergers%20and%20Acquisitions.pdf

Cortez, Alexander; Foster, William; and Smith Milway, Katie. (2008) Mergers Can Be a Tool for Charities in Tough Times. Chronicle of Philanthropy, December 11, 2008.

Available at: http://philanthropy.com/financial crisis/

La Piana, David and Kohm, Amelia. (2003) In Search of Strategic Solutions: A Funder's Briefing on Nonprofit Strategic Restructuring. Grantmakers for Effective Organizations, 2003.

Available at: http://www.lapiana.org/downloads/InSearchofStrategicSolutions.pdf

La Piana, David. (2000) Nonprofit Mergers: Is Your Organization Ready for the Road? *Amherst H. Wilder Foundation*, 2000.

Available at: http://www.tgci.com/magazine/Nonprofit%20Mergers-%20Ready.pdf

Silverman, Carol; Martinez, Arleda; Rogers, Jamie; Waddell, Gene; and Morin-Calderon, Lina. (2009) San Francisco's Nonprofit Sector: Contributions, Diversity, Challenges. *University of San Francisco Institute for Nonprofit Organization Management*, 2009.

Available at: http://www.usfca.edu/inom/INOM SF Nonprofit Report.pdf

Social Entrepreneurs, Inc. (2004) Nonprofit Mergers: A Primer for Nonprofit Leadership. Available at: http://socialent.aztech-cs.com/resources/articles/pdfs/nonprofitmergers.pdf

The Bridgespan Group. (2008) Managing in Tough Times: Seven Steps.

Available at: http://www.bridgespan.org/LearningCenter/ResourceDetail.aspx?id=2638



Glossary of Acronyms⁴

ADL. Activities of daily living.

BARHII. Bay Area Regional Health Inequities Initiative.

BHAC. Behavioral Health Access Center.

BIS. CBHS's electronic billing and information system, also known as Insyst.

CalWORKs. California Work Opportunity and Responsibility to Kids.

CBHS. Community Behavioral Health Services, a section within the San Francisco Department of Public Health.

CBO. Community Based Organization.

COO. Communities of Opportunity, Mayoral Initiative.

COPE. Centralized Opiate Placement Evaluation.

DCYF. Department of Children, Youth and their Families.

DPH. Department of Public Health.

FQHC. Federally Qualified Health Center.

HIPAA. Health Information Portability and Accountability Act. This 1996 act is a federal regulation that provides protections for consumers in group health insurance plans. HIPAA prevents health plans from excluding health coverage of pre-existing conditions and discriminating on the basis of health status. In addition, it created regulations governing transactions, privacy, security, and the sharing of a client's protected health information (PHI).

HSA. Human Services Agency.

HUH. Housing and Urban Health.

HUMS. High Utilizers of Multiple Systems.

IAC. Mayor's Interagency Council.

IEP. Individual Education Plan used in schools for children receiving CBHS services.

InSyst. CBHS's electronic billing and information system, also known as the BIS billing system.

IMD. Institution for Mental Diseases, commonly known as an "L-Facility." Subacute nursing care facility for clients with severe and chronic psychiatric disorders who need longer term, locked institutional care.

LCR. Lifetime Clinical Record.

LOS. Length of stay.

MHSA. Mental Health Services Act or Prop 63. Proposition 63 is a statewide initiative that provides mental health treatment, prevention and early intervention, education and training to Californians affected by mental illness. It is funded by a 1% tax on individuals who earn more than \$1 million per year.

MSO. Management Service Organization.

⁴ Many terms in this glossary are taken from the San Francisco Department of Public Health Community Behavioral Health Services Organizational Provider Manual, updated December 2008.



PES. Psychiatric Emergency Services, located at San Francisco General Hospital. This is a crisis stabilization facility for primarily involuntary clients needing intensive intervention for stabilization. Clients are treated at PES for up to 23 hours.

PTSD. Post traumatic stress disorder.

RFP. Request for proposals.

SA. Substance Abuse.

SD/MC. Short-Doyle Medi-Cal.

SED. Seriously Emotionally Disturbed: Now called ED, this is a designation of a type of special education special day class, e.g., self-contained class through the San Francisco Unified School District.

TAY. Transitional Age Youth.

TYTF. Transitional Age Youth Task Force.

UR. Utilization Review; a process whereby a client's level and duration of care is evaluated over time.

VPP. Violence Prevention Plan, Mayoral Initiative.



Participants engaging in discussion at the Coordinating Care Workgroup

Appendices

Attachment A: Health Commission Principles

Health Commission Principles to Guide Budget Reductions Adopted February 17, 2009

PREAMBLE

The Department of Public Health is committed to improving the health of all San Franciscans. In order to accomplish this goal, the Department funds programs inside DPH and in communities across the city. These partnerships enable us to provide the highest quality health services in all neighborhoods of the City. In order to accomplish these goals in challenging fiscal times, it is necessary to set budget priorities. The priorities and polices that govern health funding in San Francisco require the active involvement of the Health Commission, the Health Department staff, community partners, the Mayor, the Board of Supervisors and the public. The policies and budget assumptions for 2009-2010 are:

- The Health Department operates, and plans to rebuild, an acute care hospital and trauma center, and must meet all regulatory requirements in order to do so.
- The Health Department operates, and is currently rebuilding, a long-term care facility, and must meet all regulatory requirements in order to do so.
- The Department has a County and State mandated role to control the spread of communicable illness, including tuberculosis, sexually transmitted diseases, HIV/AIDS. These activities must be adequately funded to fulfill this role.
- Healthy San Francisco is a citywide priority, and the Health Department operates a primary care network that is critical to the success of Healthy San Francisco.
- The Health Department depends on successful partnerships with community based organizations.
- The Health Department is committed to community-based alternatives to institutional and long-term care.
- A number of Health Department budget allocations are used to draw down State and Federal funds
- The Department is developing measures and outcomes for all programs that it operates and funds
- Cultural and linguistic competency is integral to effective service delivery by both cityoperated and contracted services.

Given the above budget assumptions, which must be adequately funded, the budget principles that are adopted by the Health Commission will be applied to the remaining portion of the budget.

Revenue

- The Department shall develop a budget to include revenue increases to the maximum extent possible.
- The Department shall ensure that fee-based programs will have fees set to recover costs, and those programs that are financially self-sustaining will be exempt from cuts (e.g., immunization clinic, outpatient dialysis), although cost reductions within them can be considered.
- The Department will minimize cuts to leveraged services whose General Funds draw down MediCal, state and federal funding, grants, etc.



 Any reduction in the General Fund will be presented in the context of other revenues, including grants, for the identified services.

Vulnerable Populations

- 5. In proposing cuts the Department will minimize the impact on vulnerable populations. We define vulnerable populations as low income persons with the following characteristics:
 - Lowest Income: Prioritize services for the very poor over services for the poor.
 - More Severe Illness: Prioritize services for those with serious illness over those with moderate illness.
 - Health Disparities: Prioritize services addressing populations with known disparities over programs serving the general population.
 - Homeless: Prioritize services for the homeless over the housed.
- Given that most clients we serve fit at least one of these characteristics, clients fitting multiple categories would be judged to be more vulnerable than other persons.
- The Department will identify those vulnerable persons most likely from history or condition to need institutional care, and maintain community-based services and support for those persons to avoid higher-end costs.

Core Functions

- 8. In proposing cuts, the Department will focus on its core functions:
 - to assure a primary care home for every uninsured and underinsured person, and maintain the
 physical and behavioral healthcare safety net for low-income, vulnerable populations,
 - to provide emergency care for accidents and diseases that are life-threatening,
 - to protect the public's health through education and infectious disease control.
- The revised DPH Strategic Plan now incorporates the four priority Community Benefit Partnership
 goals into the plan: Access to Care, Communicable Disease Control, Chronic Care Management,
 and Violence Prevention. DPH and our community partners must work together to address these
 priorities.

Primary Care Teams

- 10. In the near future, valuable services such as housing, skilled nursing care, diagnostics, medical specialty care, and home health care should be treated as specialty care; that is, the need for the care should be defined by the interaction between the primary care provider and the patient. Use of these resources should be coordinated by the primary providers, thereby minimizing duplication and ensuring equity of service delivery.
- 11. In the near future, primary care teams for severely mentally ill persons should include multidisciplinary approaches to manage chronic conditions and promote recovery and wellness in community settings.

Service Reductions

12. The Department will identify those services of the highest priority where no cuts will be recommended and those services of moderate priority where some cuts can be recommended.



- 13. The Department will continue to fulfill its legally mandated functions, although we may recommend cuts to fulfill this mandate at lower expenses.
- 14. When making service cuts, the Department will try to mitigate them by substituting a less expensive level of service for the same population, or look for opportunities to provide a similar service at a lower cost
- 15. In proposing cuts, the Department will take into account the availability and capacity of other providers in the community who can offer the same or alternative services for the same population.
- 16. Budget cuts should directly address the need in today's economy for efficiency of scale, so the Department will identify savings from service efficiencies and coordination, consolidation of functions and structures, and administrative streamlining.
- 17. Budget principles and reductions will apply equally to providers of identified services, regardless of whether they are operated by city or contract staff.
- 18. In proposing cuts, the Department will consider the ease or difficulty of growing services back when there is additional funding.

Budget Approval Process

In proposing budget cuts or funding restorations, the following questions should be answered by staff in the presentation to the Commission and the public:

- <u>Priorities and Principles Review</u> How do these reductions (and/or restorations) relate specifically to the priorities and principles set by the Health Commission and the Director for improving the health of all San Franciscans. (What are the impacts of this budget action on those strategic priorities; are they congruent with stated priorities?)
- <u>Effectiveness review</u> What are the effectiveness and efficiency evaluations for the programs
 proposed for reductions or restorations as compared with other similar programs. (How effective
 and efficient is this program in meeting the goals referred to above, stipulated in RFPs and
 contracts, etc.)
- Systematic review How might these services be provided by other partners (public, private, non-profit) in our community.



Attachment 1.1: Integrated Clinic Models

Clinic	Key Elements	Core Populations	Staffing/ Relationship Management	Funding	Strengths	Challenges	Information Systems	Case Conferencing
FULLY INTEG 1. Balboa Teen Health Center	MH & SU outpatient programs Primary care Reproductive health services Health education	Youth 12-19 (and their families, to a limited extent)	Leadership team (MD & MSW) with common vision Culture based on population needs 12 staff, 3-5 interns Medical: FT NP, RN, medical asst., MD 8 hrs/wk BH: 3 FT MFTs Health Ed: PT MPH, FT asst. Admin: 2.5 FT front/back office	Multiple sources School-based center – will see everyone (not based on funding)	200+ BH referrals ~800 medical UDC Personal touch Clients assessed through HEADSS format initiated by whichever discipline sees youth first Access through multiple doors	Billing Need for multiple languages/cultural piece	Single interdisciplinary chart (paper) Curbside consults happen frequently Weekly staff meetings (check-in & client reviews)	Monthly
2. Ward 86	Medical clinic first, strong MH presence Evidence-based clinic Formally connected to MH orgs (CSP, UCSF) Referrals to Chronic Care HIV/AIDS Multidisciplinary Program (CCHAMP)	HIV-centered, diverse population	2 Psychiatrists 5 FT Social workers	No Short-Doyle Medi-Cal			Electronic charting system (HERO) User-friendly Sequential order All notes are accessible	Joint case conferences Share info. w/ Women's Center, primary care, CCHAMP



Clinic K	Key Elements	Core Populations	Staffing/ Relationship Management	Funding	Strengths	Challenges	Information Systems	Case Conferencing
Outpatient Clinic (TOPC) Direction Clies care on- Sub serv MH Hot enti assi Inte man Inte spee In-s betv	1. (Note: 10.1947)	Central City Continually assessing needs of community (e.g., significant Arab speaking/Muslim population in TL	 17 on staff – psychiatrists, NPs, psychologists, social workers, MFTs, licensed psychiatric technicians, & peer counselors Hyde St. Full Service Partnership Team – 4 intensive CMs to high-risk pop. Housing & Entitlements specialist All staff trained in assessment of substance use issues, Stages of Change, and motivational interviewing Positive relationship between MD and TOPC staff 	• Multiple	 Holistic approach to clients Multidisciplinary staff "One-stop-shopping" model Both partners can bill for services (TOPC staff can bill for MH; MD can bill for primary care services as a satellite of TW) 	• Lack of resources (e.g., ½ day per week does not fill high need for co-located primary care – appts. fully booked several weeks in advance)	Link to CBHS Insyst system and MD can link to DPH system – each system is separate with limited access, but can be shared with release of info. Clients sign release of information so TOPC staff can work collaboratively with MD	Informal but regular Case conferences scheduled as needed for intensive client review



Clinic Key	y Elements Core Populat	ions Staffing/ Relationship Management	Funding	Strengths	Challenges	Information Systems	Case Conferencing
Broderick) (boar perma comm housi MH Media provia (reguland to referration care a hospined by the provia care a hospined by the provia care a hospined by the prima provia case in Linka Vocata rehab Daily reside Media Food	nunity based ing cal services ded on-site lar assessment riage on-site; rals to primary and italization as ed) client has a ary care der management age with titional bilitation activities for ents cation mgmt. • Dual and trip! • Some monolir API Community Programs Place Team Team activities for ents cation mgmt.	MH and Nurse manager Clinical coordinator Office manager Psychiatrist, MH professionals, psychiatric nurses, CNAs, acupuncturist Residential program	Medi-Cal CBHS and HUH contracts Resident's rental fees	Multilingual Interdisciplinary	Limited budget Lack of electronic records Not having a single primary care provider to serve all RAMS residents Mgmt. of serious medical conditions w/ limited staff and increased need for specialty care	Single interdisciplinary chart (paper)	Three daily shift reports Weekly clinic meeting to review client status and needs

Clinic	Key Elements	Core Populations	Staffing/ Relationship Management	Funding	Strengths	Challenges	Information Systems	Case Conferencing
5. Haight- Ashbury Free Clinics	Primary care Substance use tx. Services MH services Intensive case mgmt.	Diverse population (homeless, working poor, persons living with HIV)		90% state and local General Funds Medi-Cal	"Any door is the right door" philosophy Integrated clinic space includes exam rooms, group mtg. rooms, individual counseling rooms, and 12 detox beds Case manager helps clients navigate through services; referrals made in person (Clients are walked from office to office) Long term staff and volunteers	Different service cultures Billing	Shared treatment plans (psychiatry signs off on all tx. Plans for all patients w/ MH and SU concerns)	Curbside consults Weekly team meetings
6. Castro- Mission Health Center	Services provided on- site: Psychotherapy Psychiatry Case Management Substance Abuse counseling Clinical consultation to physicians, nurses, and other providers		Bilingual MH team (psychiatrists, CSW, MFTs, medical SW, certified substance abuse counselor, student interns		Staff have specialized training in providing culturally and linguistically appropriate services			



Clinic	Key Elements	Core Populations	Staffing/ Relationship Management	Funding	Strengths	Challenges	Information Systems	Case Conferencing
7. Special Programs for Youth (SPY)	NPs complete HEADSS assessment for all detained youth BH staff provide screening, assessment, intervention and treatment Meeting with judges	Youth detained at Juvenile Justice Center & Log Cabin Ranch Youth referred to Community Assessment & Referral Center.	MD, NP, RNs, MEA, Psychiatrist, Clinical psychologist, MSW/MFT, program coordinator		BH outcomes improved	Increased daily census Reduction in BH staff Barriers to linkages to CBHS clinics for youth upon release	Single chart PC enters into LCR and psychiatrists have access to it BH staff enter services into BIS	Collaborative meetings with JPD, SFUSD, and HAS daily As needed case conferencing
8. Housing and Urban Health	Primary care & psych services for formerly homeless residents living in city funded permanent supportive housing (on-site clinic) Also "bedside care" (home visits) PC and BH for residents in 54 buildings in the city Cross-disciplinary model	Residents of HUH housing New patients enter generally enter system through PC provider	NP, PA provide PC 4 psychiatrists & 2 psych. NP provide MH services Providers work across discipline	• FQHC	Weekly cross- training Revenue-generating Billable MH services		Lifetime Clinic Record charting	Consultation as necessary Weekly staff meetings w/ both PC and BH staff 2x/month - crosstrainings including case presentations clinic staff has regular consults with CMs at housing sites

Clinic	Key Elements	Core Populations	Staffing/ Relationship Management	Funding	Strengths	Challenges	Information Systems	Case Conferencing
CO-LOCATED	CLINICS	7						
1. Mission Mental Health	MH & SU outpatient programs Primary care services available through psychiatric/medical NP Programs: Mission Integrated Service Center, Mission Assertive Community Treatment, & Alternatives Program (primary care referrals received from all three) Partner relationship w/ Mission Council (substance use program)	Adults age 18-60 w/severe mental illness Latino and Spanish-speaking Alternatives Program focuses on AA men leaving IMD facilities	NP, psychiatrists, LCSW, MFT, psychologists, and support staff NP reports to SFGH Family Medical Clinic (clinical medicine); Mission Clinic medical director (clinical psychiatry); and program director (administrative)	Short-Doyle, Medi-Cal Medicare General Fund	Language and culturally appropriate care for Spanish- speaking and AA men	Billing Lack of integration for lab services (PC vs. BH)	Single interdisciplinary chart PC charting in primary care section of BH record Clinician's Gateway for progress notes and billing	Weekly staff mtgs. Monthly medical staff mtgs. Curbside consults



Clinic	Key Elements	Core Populations	Staffing/ Relationship Management	Funding	Strengths	Challenges	Information Systems	Case Conferencing
2. Family Mosaic Model	BH model Intensive CM program Comprehensive service for youth and their families	Diverse pop. 3-18 years	On-site PHN 18 Family advocates/case managers 3 clinical supervisors 1 clinical psychologist 1 psychiatrist PHN close relationship with PC (St. Lukes, SFGH, CPMC and other PC providers)		on-site PHN FMP clinic located in Bayview District	Client pop. "fallen through the cracks"; highest risk PHN culture shift	Clinician's Gateway	PHN does regular health education and training w/ staff Weekly RISK meetings Open door policy
3. SOMMHS (SOMA)	BH focused w/ MH and SU outpatient programs ISC, FACT, SF FIRST Team PC services avl. onsite at SOMA clinic through TWHC 100-140 pt. capacity for PC at SOMA	Adults ages 18-60 Focus pops. include Filipino/Tagalog speaking, and homeless mentally ill	Psychiatrist, psych. NP, SW, psychologists Coordination btwn TWHC and SOMA staff occurs at nursing/NP level PC referrals initiated from all programs		Language and culturally appropriate 900+ active BH clients 200+ intensive BH patients SF FIRST Capacity for 100-140 PC patients	Lack of integration for lab services and re: pharmacy benefit	Separate paper charting Separate info. systems (LCR vs. Clinician's Gateway)	Weekly staff meetings for BH staff PC providers do not participate in SOMMHS staff mtgs. Monthly med. mtgs. Need for case conf. recognized, but not yet implemented Curbside consults

Clinic	Key Elements	Core Populations	Staffing/ Relationship Management	Funding	Strengths	Challenges	Information Systems	Case Conferencing			
MOBILE CLIN	MOBILE CLINICS										
1. Primary Care Interface Program	Mobile team consists of Child Psychiatrist and licensed MFT Provide comprehensive psychiatric and psychosocial assessments, triage, and/or brief tx to children and families w/in CHN Primary Care clinics (direct access to psychiatric services at clinics) Comprehensive f/u of referred clients Also provides inservice trainings on BH topics for clinicians and staff	Children ages 1-17 and their families	MFT Child psychiatrist	When patient/family requires more than one or two brief sessions, services are billed	Bilingual MFT Timely, mobile, flexible completion of assessments ("Treatment drop- off" is avoided) Continuing follow through on tx. Recommendations		Clinicians Gateway	Regular communication with referring MDs about tx. progress			



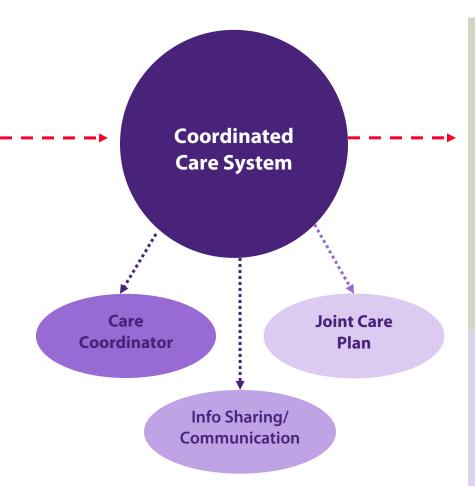
Attachment 2.1: Coordinated Care System

Overall Goals:

- Ensure access to and engagement in services for clients.
 Reduce acuity and recidivism for clients.

Protocol for Identifying Clients

- Identify clients already in the system by having central administration cross check data.
- Screening at the front end when a client enters services (multiple points of entry). The screening tool should be based on the outcome indicators.
- Agency-identified clients.



Outcomes

Individual Level

- Connection to primary care provider
- Decreased dependence on urgent/emergent services
- Positive movement through stages of recovery
- Improved client perception of his/her quality of life and selfconfidence/resiliency
- Improved living situation

System Level

- Decreased duplication of services
- Awareness and communication between service providers
- Benefit to providers



Attachment 3.1: Overarching Policy Recommendation

SFDPH Community Programs Managing Beds Workgroup – Substance Abuse Subgroup

Overarching Policy Recommendation: Expand existing authorization and utilization review process to include residential substance abuse treatment programs.

Primary components:

- Implement centralized management of substance abuse beds by Community Programs Placement Unit;
- Implement Utilization Review (UR) of all substance abuse beds;
- Ensure that the Behavioral Health Access Center (BHAC) coordinates with the Placement Unit and the client's case manager for admission, transition between placements, medication, and response to emergency episodes;
- Create standardized criteria for eligibility and procedures for admission and discharge;
- Create a prioritized referral and placement process for all DPH-purchased SA beds;
- Ensure that BHAC and the Placement Unit have joint responsibility for coordination among agencies for placement and discharge;
- Reduce duplication of case management;
- Ensure substance abuse clients are connected to primary care and/or behavioral health;
- Implement census data system.

1. Importance of	2. Clarification of	3. Challenges to	4. Issues faced by	5. Challenges resulting	6. Ensuring placement or
substance abuse provider	placement process	implementing	specific populations	from multiple access	housing upon discharge
involvement and input		standardized intake,		points to the substance	
in admission and		admissions and		abuse system	
discharge		discharge			
7. Ensuring placement	8. Ensuring one case	9. Ensuring connection	10. Implementation of	11. Clarification about	
7. Ensuring placement for high priority clients	8. Ensuring one case manager per client	9. Ensuring connection to primary	10. Implementation of census data system	11. Clarification about substance abuse bed	
<u> </u>	· · · · · · · · · · · · · · · · · · ·	· · · · · · · · · · · · · · · · · · ·	*		
<u> </u>	· · · · · · · · · · · · · · · · · · ·	to primary	*	substance abuse bed	

Key issues to consider

Attachment 3.2: Draft Standardized Admissions Criteria

Community Behavioral Health Services

Standardized Admission Criteria for Residential Substance Abuse Treatment

Background

Purpose:

- 1. Reduce barriers to accessing care.
- 2. Reduce confusion/ambiguity around admission criteria by developing a consistent set of inclusion/exclusion criteria across programs.
- 3. Assure referral is to appropriate level of care.

Related Issues

- 1. How exactly will "straight-up" residential Mental Health beds fit into this initiative?
- 2. Development of a Standardized Intake Packet that will reflect Admission Criteria and meet appropriate Federal and State requirements. This will also include a patient information section so patients understand what will be expected of them.
- 3. Development of an Assessment/Admission Process.
 - a. BHAC staff will perform the majority of assessments.
 - b. Other points of access.
 - c. Close coordination between BHAC and the Placement Unit.
 - d. Role of the accepting program.
- 4. Development of a Patient Prioritization Scheme.

Inclusion/Exclusion Criteria - Admission (Inclusion) Criteria

- 1. Client must be a San Francisco resident (meet residency criteria).
- 2. For an adult bed, the client must be 18 or older, or be an emancipated minor.
- 3. For Substance Use/Dual Diagnosis beds, the client must have an active or recent history of a substance use disorder.
- 4. For Residential Medical Detox, the client must be at risk for a significant withdrawal syndrome from alcohol, benzodiazepines, other sedatives, or opioids. If the client is currently evidencing severe withdrawal symptoms, he/she should be brought to the nearest Emergency Room.
- 5. Any psychiatric or medical conditions should be sufficiently stable so that the client can be managed safely, as well as benefit from the program.
- 6. Patients should have at least a two-week supply of medication or a one-week supply plus a prescription upon program entry.



Exclusion Criteria

- 1. History of violence or threats of violence directed towards a current program staff-person(s) or resident(s).
- 2. Current active suicidal ideation with inability to "contract for safety".
- 3. Current unstable medical or psychiatric condition, which should be addressed by a medical professional on an urgent or semi-urgent basis.
- 4. For admission to residential treatment (non-detox), the client should not be at significant risk for acute withdrawal from alcohol, benzodiazepines, or opiates.
- 5. Inability to ambulate sufficiently well to negotiate program stairs, etc.
- 6. Inability to attend to activities of daily living (ADLs) without a great deal of assistance.
- 7. Clear inability or unwillingness to comply with program rules and expectations.

A client should NOT be excluded from admission:

- 1. On the basis of a **diagnosis** (for example schizophrenia). The client's functional status, not diagnosis, is the important determinant as to whether they can benefit from the program.
- 2. On the basis of **prescribed medications**, including methadone, buprenorphine, benzodiazepines, psychotropics, and opioid analgesics (pain meds). (Patients enrolled in Methadone Maintenance typically can receive up to 6 take-home doses if in residential treatment.) Prescribed marijuana (smoked) is an exception, as it would potentially jeopardize the sobriety of other residents. Prescription Marinol would be okay.
- 3. Because of outstanding **warrants** (though the patient will be encouraged to attend to these prior to placement).
- 4. Because they left or graduated from the program in the recent past.

Clients will be considered on a Case-by-Case basis for:

- 1. A history of arson.
- 2. A history of behavioral problems.

Other Issues:

- 1. If the client has "290 Status" (registered sex offender) he/she cannot be admitted to residential programs that are in the vicinity of a school etc. Programs that do not have this limitation are expected to admit these individuals.
- 2. Programs focusing on special populations (e.g., Jelani House) will have specific admission criteria that reflect this.
- 3. Individual programs may have particular expertise in certain areas (e.g., Dual Diagnosis), and this will be a consideration when determining client placement.



Attachment 3.3: Key Issues for Consideration

1. Importance of substance abuse provider involvement and input in admission and discharge

- a. Substance abuse programs should be involved in providing input into client admission and discharge. DPH should ensure collaboration among substance abuse programs, BHAC and the Placement Unit. A decision making process has already been established in the mental health system that could serve as a model.
- b. Programs and providers should have continued involvement and input as the new bed management system evolves, and programs should be involved in the evaluation of the implementation of the new system.

2. Clarification of placement process

- a. DPH should be clear with substance abuse programs about the process and criteria by which clients will be placed. DPH should clarify the roles of BHAC, the Placement Unit and the substance abuse programs in the admissions and discharge processes.
- b. Decisions regarding placement need to account for the particular areas of expertise and/or particular populations served by each substance abuse program.
- c. Concerns were raised regarding the consequences of the new authorization and utilization review process on the ability of programs to serve clients who need immediate substance abuse services. DPH should be clear about the processes by which individual programs will be able to accommodate walk-ins and referrals from community agencies.

3. Challenges to implementing standardized intake, admissions and discharge

- a. Substance abuse programs each have their own admission/exclusion criteria, making it important to identify and review criteria.
- b. DPH should collaborate with programs to look at standards around length of stay.

4. Issues faced by specific populations

- a. Particular populations face issues that may influence admission/exclusion and discharge from residential substance treatment programs.
- b. In collaboration with substance abuse programs, BHAC and the Placement Unit should work to ensure that clients are placed in programs that are culturally and linguistically appropriate.
- c. In terms of issues related to admission/exclusion and discharge, these populations need special consideration: 1) dual diagnosis clients, especially those coming from jails; 2) clients coming from detox; 3) high medical need clients; 4) methadone clients; 5) pregnant and/or parenting clients; 6) clients with neurological impairment; 7) clients with disabilities or in need of reasonable accommodations; and 8) clients who relapse and wish to re-enter residential treatment.
 - i. Dual diagnosis clients coming from jails. It is important to define a process for conducting psychiatric assessments for clients coming from jails. DPH should consider who will conduct these assessments and how they will be conducted. DPH should ensure coordination and collaboration between CBHS and the criminal justice system, including jail psychiatric services and courts.



ii. Clients coming from detox. Clients coming from detoxification programs often relapse due to being placed on waiting lists for residential treatment. It is essential that clients coming from detox receive appropriate placements in a timely manner. DPH and clients' case managers should be involved in a contingency plan if immediate placement is not possible.

5. Challenges resulting from multiple access points to the substance abuse system

a. Unlike the mental health system, there is no physical gathering place for substance abuse clients. In other words, there is no central holding place while clients are awaiting placement. Therefore, the following questions should be considered: Where are the most important access points in the substance abuse system? How long will clients have to wait for placement without a central holding place? What are the possible contingency plans if clients cannot receive immediate placement?

6. Ensuring placement or housing upon discharge

- a. DPH should not discharge a client until an exit strategy is determined.
- b. The new substance abuse placement system should work with the Housing and Urban Health Unit (HUH) to find suitable housing for clients.
- c. Currently placement upon discharge is not documented and should be in the new system.
- d. Make sure that underlying mental health needs are addressed when considering next placement.

7. Ensuring placement for high priority clients

- a. Special attention should be paid to the approximately 260 HUMS clients who are the highest need for substance abuse services.
- b. Special attention should also be paid to those clients who keep coming back to treatment. What can DPH do to ensure that clients are placed into the next level of care?

8. Ensuring one case manager per client

- a. Because of the population of HUMS that continually access the most expensive services, DPH should ensure that clients have one case manager to oversee their access to care.
- b. DPH should also work with existing case managers and fill in gaps where necessary.

9. Ensuring connection to primary care/behavioral health

a. DPH should ensure that all clients coming through the substance abuse system have access to a primary care home.

10. Implementation of census data system

a. When designing the data system for substance abuse bed management, it would be useful to add filters to tag appropriate programs for clients. For example, clients with particular disabilities or cultural/linguistic needs should be filtered to appropriate treatment programs.

11. Clarification about substance abuse bed funding

a. DPH should be clear about any changes in the bed funding process in the new system. Programs were unclear whether all beds (filled or not) will be paid for in the new system.



Attachment 4.1: Sample Menus of Objectives and Social Determinants of Health

Sample Menu of Health Outcome Objectives:

- Reduce the incidence of trauma among African Americans and other violence affected populations.
- Reduce the incidence of violent death among African American and Latino males.
- Reduce deaths due to cardiovascular disease among African American men and women.
- Reduce the impact of poverty, transportation barriers, social isolation, racism on African Americans and other "ethnic" groups subject to oppression.
- Reduce HIV infections among African Americans.
- Reduce and or prevent Hepatitis B Among Asian and Pacific Islander populations most at risk.
- Reduce the incidence of trauma among Samoans.
- Reduce the incidence of violent death among small sub-population groups such as Samoans, Cambodian and Vietnamese youth.
- Improve the graduation rates of Latino, African Americans and small sub-group populations such as Samoans, Cambodian, Laotian, Vietnamese, etc.
- Reduce the incidence of tobacco use and exposure among African Americans, Latinos, Native Americans, Asians, and Pacific Islanders.
- Establish a baseline of services in every category (Community Behavioral Health Services, HIV, Housing, etc.)
 for populations most affected use this as a formula for developing/maintaining service baselines.
- Mitigate the impact of and prevent sub-and clinical depression, particularly among high risk groups: teen, elders, people with chronic diseases, immigrants and populations with historical trauma.
- Ensure adequate family support (material, social, and psychological) in childhood, especially infancy and especially in highest-risk groups for worst disparities/outcomes.
- Reduce the impact of alcohol-related problems, including availability, marketing and sales to minors, association with violence, drugs, loitering and other poor behaviors, etc.
- Reduce the risk of contacts with the juvenile justice system for African, American, Latino, Samoan, Cambodian, Laotian and Vietnamese, etc. youth through early identification of behavioral health assessments and diagnosis.
- Increase food security in neighborhoods considered "food deserts".
- Increase consumption of fresh, nutritious foods by "at risk" populations.
- Improve management of chronic illnesses, such as diabetes, hypertension, mental health, PTSD, etc. through health promotion and self care.
- Increase opportunities and conditions for physical activity in neighborhoods.



Sample Menu of Social Determinants of Health:

A. Characterize the social determinants of health

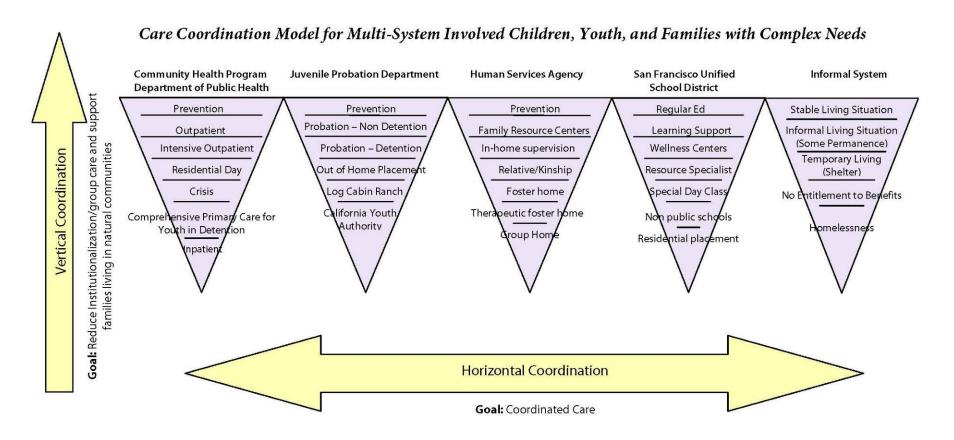
- Secure early childhood allowing safe and appropriate attachment, stimulation, development opportunities and freedom from stress.
- Discrimination/racism/oppression historical trauma and injustices.
- Community violence/community safety, unsafe streets.
- Overabundance of/readily available alcohol and tobacco products in neighborhoods.
- Lack of educational and career opportunities.
- Overabundance of environmental health hazards.
- Poverty and lack of wealth.
- Overall income inequality and levels of social hierarchies.
- Social isolation, social exclusion; social support.
- Neighborhood displacement/gentrification forced mobility and social/community disruption.
- Neighborhood related lack of essential services and amenities/urban removal (including healthy food, child care, recreation, transportation, safety).
- Availability of employment; wage levels and working hours and conditions.
- Poor quality of housing, unsafe or unaffordable housing or lack of housing.
- Opportunities for social and political participation.
- Overall chronic stress levels; stress from family, work, neighborhood; economic and health insecurity; discrimination and inequality.
- Social relations and interactions allowing development of self-esteem, empathy, and connection to others (valued member of communities).

B. Analyze how social determinants of health apply to explaining San Francisco health disparities

- To what extent do determinants listed above "explain" disparities across a population?
- How could these determinants be changed to what extent, for what populations, how?
- What is expected effect of such change on populations overall and on disparities across population groups (effectiveness of changes, interventions).
- What is the cost effectiveness of changes, interventions (cost per outcome measure change)?

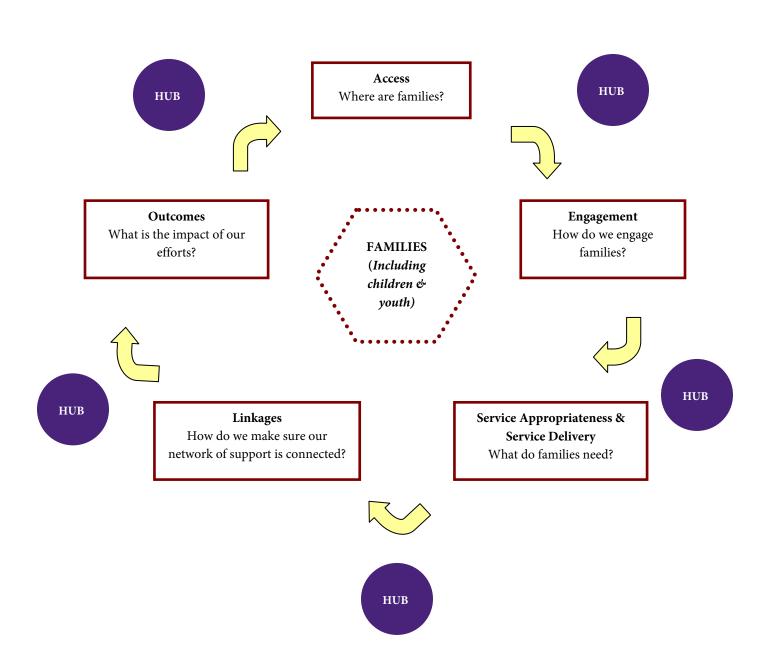


Attachment 5.1: Care Coordination Model for Children, Youth, and Families



^{*}The "Informal System" refers to an informal and parallel system of care for those isolated from access to services.

Attachment 5.2: Model of Services and Supports for Children, Youth, and Families



^{* &}quot;Hubs" (as entry points and coordinating bodies) include: public housing, schools, community centers and family resource centers, primary care clinics, child care, and other community based multi-service centers.

Attachment 6.1: Strategic Restructuring Guidance

Model	What are the benefits/pros?	What are the challenges/cons?	Potential to save costs?	Effect on services for priority populations?
Lead agency/ subcontractor ("Hub") One nonprofit (typically larger) subcontracts with another nonprofit(s); often serving common geographic area(s) or target population(s)	 Incentivizes collaboration Helps strong organizations stay strong during financial downturns Would spur some restructuring while preserving key organizations Can be catalyst for more meaningful collaboration Community has experience with this model Can leverage funding outside DPH 	 Creates key players and shuts out smaller organizations Politics of hub and subcontractor relationships Complex selection process Performance assessment can be challenging for hub Bureaucracy of contracting relationship Collaboration requires time, especially for lead Probably doesn't save money 	 Neutral in short-term (2009) Neutral in long-term (3-5 years) 	Positive or neutral
Program transfer Nonprofit divests itself completely of a specific program and turns it over to another nonprofit	 Potential quality improvement in services Preserves services for the community May save money for organization doing the transfer 	 Client population may not like the transfer Potential to lose clients Potential deleterious effect on transferer May result in layoffs May not save money Hidden costs associated with program clean up & working through confidentiality issues Requires thorough vetting process Requires DPH/funder approval 	 Neutral in short-term (2009) Neutral in long-term (3-5 years) 	 May result in loss of linguistic / cultural competency or accessibility
Administrative or "back office" consolidation Two or more nonprofits share some administration, space, and/or equipment but maintain separate programs and boards	 Can save operational costs Could improve service quality by increasing purchasing power Can point to cases where this has worked Allows providers to focus on service delivery Often a nonprofit-driven solution 	 Typically requires laying administrative staff off Creates risk for the lead organization Legal issues are a big challenge Requires stable lead agency with capacity to do this work 	 Neutral in short-term (2009) Positive cost savings in long-term (3- 5 years) 	Positive or neutral



Model	What are the benefits/pros?	What are the challenges/cons?	Potential to save costs?	Effect on services for priority populations?
Parent-subsidiary ("fiscal sponsorship") Two or more nonprofits consolidate administrative functions, policies and procedures, and some programs; one nonprofit oversees the other	 Potential cost efficiencies Enables emerging communities to develop services Organization receiving fiscal sponsorship benefits from larger infrastructure and capacity development opportunities 	 Tough for larger organizations to take on this role during hard financial times Potential legal risks May not fit with some nonprofits' mission Slow to realize cost efficiencies 	 Small positive cost savings in short-term (2009) Neutral in long-term (3-5 years) 	Positive or neutral
Management Service Organization (MSO) An independent MSO provides some or all of the administrative functions for one or more nonprofits; nonprofits pay the MSO for these services	 Can save operational costs Could be a good fit for organizations with a common mission Can get high quality services Potential to create co-operative model Can incorporate capacity building components Gain expertise MSO takes on some risk/liability 	 Typically requires laying admin staff off Outsourcing can change organizational culture Cede some decision-making power Boards may be resistant, less management power Lose institutional memory, tailored knowledge Requires significant start-up costs 	 Neutral in short-term (2009) Positive cost savings in long-term (3-5 years) 	Positive or neutral
Merger Two separate organizations completely combine programmatic, administrative and governance functions	 Potential cost efficiencies (long-term) Reduces costs for City Can bring together complementary strengths Brand can still exist from client perspective Can maintain a service at risk of going away Increase purchasing power Attractive for foundations 	 Requires major up front investment Takes a long time to realize cost efficiencies Boards can be reluctant to go this route Cultural integration is a major challenge Nonprofits reluctant Workforce reduction Post-merger integration hard Risk of skewing benefits structure Increases liability if one organization underperforming 	 Negative cost savings in short-term (2009) Positive cost savings in long-term (3-5 years) 	 May result in loss of linguistic/ cultural competency



harder - company

Harder+Company Community Research is a comprehensive social research and planning firm with offices in San Francisco, Davis, San Diego, and Los Angeles, California. Our mission is to strengthen social services, improve decision-making, and spur policy development by providing quality research, technical assistance, and strategic planning services. Since our founding in 1986, we have worked with foundations, government and nonprofits throughout California and the country. Our success results from delivering services that contribute to positive social impact in the lives of vulnerable people and communities.

harderco.com