SFDPH Community Programs

Stakeholder Engagement Process

Recommendations At A Glance

May 2009

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community research

Overview and Purpose

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.

Beginning 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, and DPH and other City department staff were invited to join what came to be called the *Stakeholder Engagement Process*.

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, 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 to provide 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.

From the start, 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.

Recommendations

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 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 the core values of Community Programs in the face of reduced resources.

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

Cross-Cutting Themes

Each workgroup developed a set of priority recommendations, which are summarized in this document and detailed in the full report. 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.

The following sections provide a summary of the goals, guiding principles, and recommendations from each of the six policy initiative workgroups.

Workgroup 1: Integrating Primary Care and Behavioral Health

The Community Programs Division 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.

Fundamental Concepts for Integration

Client-Centered Health Care Home. The system of care must ensure that all clients/patients are assigned to a health care home. A client-centered health care home is where primary care and behavioral health services interface and other support services are coordinated to provide optimum, seamless care for clients/patients. Either primary care clinics or community behavioral health settings/agencies can be designated as a health care home depending on the immediate, ongoing, and changing needs of the client/patient.

Menu of Integration Models. Implementation of integration strategies should consider a "menu of integration models," whereby providers have the flexibility to select elements for implementation specific to the needs of their clients/patients.

Essential Integrated Care Components. Essential components of system capacity that must be addressed during the next phase of implementation planning include: Administrative structure and leadership; Physical facilities; Workforce Development and Training; Safety; and Staffing/Relationship Management

Guiding Principles

- The system of care should be seamless for clients and patients;
- There should be information sharing and effective communication 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;
- The system of care should match staff capacity to client/population needs; and
- System level and client level outcomes should be defined to help assess the effectiveness of integrated care and measure client health outcomes.

Recommendations

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. 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. 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.**

   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. 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.

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.
   - Ensure that clear policies for information sharing are developed and that opportunities for training are provided.

5. **Ensure that culturally and linguistically competent services are maintained within an integrated model of care.**

   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. DPH should provide capacity building and technical assistance to increase their capacity to serve as health care homes.

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.**

   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.

Workgroup 2: Coordinating Care

*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. 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.*

Guiding Principles

- 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.

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.**

   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 High Users of Multiple Systems (HUMS), but who may become HUMS clients if left unattended. 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 wrap around services for the individual.

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

   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. Factors to consider in identifying the care coordinator include client choice, as well as the individual having the capacity to take on the role of the lead 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 is responsible for overseeing the joint care plan and ensuring that providers are working together toward common outcomes for the client.

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

   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. 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. The framework for the joint care plan should be based on the Domains of Risk & Strength (DORS): (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.**

   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.

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

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

Workgroup 3: Managing Beds

*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 Disease[1]). 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 subgroup**.* [2]

Substance Abuse Subgroup

The group began by identifying a number of barriers that currently impede DPH's ability to provide efficient access to and management of residential substance abuse treatment services. These include:

- HUMS (High Users of Multiple Systems), who represent the highest need clients for substance abuse services, are not regularly provided appropriate placement because they are often difficult to manage.
- After completion of a residential program, 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.
- There is no centralized access to DPH-funded beds/slots, and identifying them is time consuming and not always prioritized by client need.

[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.

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

- Historically, substance abuse programs have had different program admission/exclusion criteria by agency, and not by system of care.

Recommendations

1. *Overarching Policy Recommendation*: Expand the existing authorization and utilization review process to include residential substance 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 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.

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.

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.

Draft admissions criteria for residential substance abuse treatment programs were also developed collaboratively by CBHS, BHAC and workgroup members.

IMD Subgroup

DPH currently pays for approximately 230 clients in 10 IMD facilities. The task of the 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.

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

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 the San Francisco Department of Public Health (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 for services, the methods advanced and in the distribution of resources.

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 San Francisco Department of Public Health services which represents the cultural perspective of vulnerable communities; and
- Ensure that public health functions of prevention and health promotion are maintained.

Over the course of the discussion process the workgroup came up with the following aims 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

- 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.

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:

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.

2. **<u>Data</u>. Systematically collect, analyze and report on health disparities and inequities, by ethnic/cultural, age, neighborhood and other relevant groupings as a guide for the planning, setting of funding priorities, and evaluation of 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.

3. **<u>Cultural Humility</u>[3] /<u>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.

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.

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).

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.

Workgroup 5: Supporting Children, Youth, and Families

*The San Francisco Department of Public Health (DPH) convened the **Supporting Children, Youth, and Families** workgroup to make recommendations that would inform the reorganization of Community Programs in ways that preserve the Department's commitment to children, youth, and families. The workgroup developed recommendations for inclusive supports that address the needs of priority populations and high-risk children, youth, and families in San Francisco.*

Guiding Principles

- Services must be family and youth centered, culturally and linguistically competent, and age appropriate;

[3] The concept of cultural humility has been proposed as a more suitable goal than cultural competence, as it focuses on the process of intercultural exchange, paying explicit attention to clarifying the service provider's values and beliefs through self-reflection and self-critique.

- 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 (e.g., self-defined support system for TAY) terms.

Recommendations

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.

   - Ensure providers receive proper training.
   - Support the adoption of city-wide case management general guidelines as reference points to ensure consistent practice (intensive, moderate, etc.).
   - Train supervisors to support implementation and to address structural barriers to reforms.
   - Expand access to services for families by assessing how Medi-Cal can help pay 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.

   - Partner with the IAC to develop and pilot a coordinated system of services with the following components: multiple "hubs"; a "Care Coordinator" is identified and maintains a primary relationship with the client; sustain smooth transitions across the continuum of care.
   - Draft Model for Pilot.

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.

- Expand the availability of mental health consultation services.
- Support outreach and engagement activities.
- Train providers serving adults to assess the needs of the whole family.
- Provide parent education and skills-building services for children 0-5 and their families.

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.

   - Commit resources from the Adult Service system for TAY services.
   - Develop transition planning.
   - Support residential treatment for TAY.
   - Address the needs of young families.
   - Expand gender-specific 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.
   - Expand the availability of trauma screening and training to Family Resource Centers and schools (including high school wellness centers).
   - Increase the capacity of providers to identify risk factors earlier.

Workgroup 6: Community Based Organizations

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. Recognizing the importance of nonprofits to City service delivery, the San Francisco Department of Public Health charged the ***Community Based Organization (CBO)*** *workgroup with developing recommendations in the face of these challenges.*

Guiding Principles

- 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

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.
   - Take into account pros and cons of restructuring options.
   - Minimize community disruption.
   - DPH and nonprofits should partner in solicitation of private support.
   - Collaborate with nonprofits to reduce health care costs.

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.
   - Take into account prior performance.
   - Improve assessment of cultural competence.
   - Promote nonprofit reserves.

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. 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.
   - Target capacity-building appropriately.
   - Assess nonprofit capacity needs.
   - Identify new resources.

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 departments should continue to engage contractors in redesign and implementation.

   - Facilitate more timely payment.
   - Continue to engage in City streamlining efforts.
   - Assess indirect cost rate caps.
   - Solicit stakeholder input regarding the new Business Office.

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.

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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.

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