MHSF Office of Coordinated Care Recommendations (Initial Work)

First Discussion Group participants (11/22/21): Chair Monique LeSarre, Kara Chien, Vitka Eisen, Andrea Salinas

Foundational Resources for Recommendation Development

Mental Health SF Administrative code:

Mental Health San Francisco (MHSF), created through legislation (File No. 191148), identifies an Office of Coordinated Care on Page 12, lines 24-25 & Page 13 1-6: (2) Part Two: Establishment of the Office of Coordinated Care.

The 25 Department shall operate an Office of Coordinated Care to oversee the seamless delivery of mental health care and substance use services across the City's behavioral health systems, and to ensure that Mental Health SF is accountable and proactive in how it delivers care. The Office of Coordinated Care shall seek to ensure that services are provided to Mental Health SF participants in the most efficient and cost-effective way and shall minimize unnecessary bureaucracy. The Office of 5 Coordinated Care shall be staffed by City employees. The Office of Coordinated Care shall perform 6 the following functions (summarized below):

A. *Real-time Inventory of Program and Service Availability.*
B. *Case Management and Navigation Services to Ensure a Continuum of Care*
C. *Coordination with Psychiatric Emergency Services and Jail Health Services*
D. *Data Collection*
E. *Authorized Disclosures*
F. *Marketing and Community Outreach.*

IWG meeting discussions August-October 2021: see recordings on IWG website

IWG meeting recommendation brainstorm on November 9, 2021: During the November meeting, the IWG brainstormed potential recommendations for the Office of Coordinated Care (see November meeting minutes)

Principles group applied to all recommendations (from the draft IWG principles)

For each recommendation, ask, "does this recommendation…"

1. Reflect evidence and/or community based best practices, data, research, and a comprehensive needs assessment.
2. Prioritize mental health and/or substance use services for people in crisis.
3. Provide timely and easy access to mental health and substance use treatment (low barriers to services).
4. Create welcoming, nonjudgmental, and equity- driven treatment programs/spaces where all individuals are treated with dignity and respect.
5. Utilize a harm reduction approach in all services. (*Harm reduction is a public health philosophy, which promotes methods of reducing the physical, social, emotional, and economic harms associated with drug and alcohol use and other harmful behaviors on individuals and their community. Mental Health SF shall treat all consumers with dignity and compassion, and shall*

provide care without judgment, coercion, discrimination, or a requirement that clients consumers stop engaging in specific behaviors as a precondition to receiving care.)
6. Maintain an adequate level of free and low-cost medical substance use services and residential treatment slots, commensurate with the demand for such services.
7. Facilitate the integration of mental health and substance use services to ensure that individuals experience treatment as one seamless and completely coordinated system of care, organized around their individual needs.

Discussion Group Recommendations

Overarching care-standards that need to considered in all the recommendations suggested in this document:

- Coordinated care recommendations need to address both physical and virtual environments
- Recommendations need to consider accessibility beyond what various health insurance covers
- All recommendations address the need for greater care coordination to identify and prevent clients from falling into "gaps" in their healing process before becoming stable.
- Transition periods between care providers should be covered, no one is discarded without a care plan.

1-One case manager for one client across systems and agencies

Currently there are too many entities (probation, hospital, mental care, and so on) that do not communicate well with each other. We recommend someone overseeing all of the entities by following the client from touchpoint to touchpoint to coordinate their care. This role is not another case management project, but a connector role of mapping and oversight to keep track of people and their progress. This case manager role will convene team meetings by bringing together all people engaged in their client's healing to facilitate a collaborative decision-making effort in navigation and accountability for the services provided and the treatment results. This organized collaborative effort does not take the place of the community work provided by different agencies and entities, it just links them together. This can enhance accountability and provide oversight to make sure treatment is being delivered as one person is touching upon multiple systems for each client.

This case manager will have ROI clearance and need to bean equitably compensated city employee or staff from the community, keeping in mind that it is a lot of work to coordinate higher level care and there is a need for case-load balancing.

2-OCC oversight on communication and the need to find optimal technology for a communication process that works across the system AND central record keeping database

Communication can break down between programs and agencies and there needs to be easier and more dependable ways for systems of care to communicate with each other. We recommend the identification and use of an optimal communication tool that works beyond systems of care and can link multiple agencies and programs.

The optimal communication tool will also include a central record-keeping database

This recommendation is particularly important for the placement and transition of clients. There are many instances where communication breakdowns lead to gaps between programs as clients move into "next phases" of their treatment program. For example, a client could complete the detox program from Health Right 360, and then have to wait for placement in next agency along the path to stabilization, and this "gap" could cause them to relapse. A communication tool across the system of care could enable more fluid transitions through fluid communications that can highlight more than one option or plan for placement and transition.

3-OCC should create a continuum of care process throughout the care system

People get released from a program because they are no longer classified as acute. The become subacute (can drink and eat on their own) and are let go before they have a place to go and are dumped back on the street.

No person should be discharged from care without a safe-landing of appropriate care.

Funding for this continuum of care needs to be secured:

- Prop C
- Insurance
- Call for State Senators Scott Wiener to introduce a state-wide legislation supporting the principle of not discarding anyone before their health is stabilized.

4-A balanced load of 8 cases is recommended for linkage teams

A balanced case-load would allow for the level of care necessary. Overburdened case managers do not want to take new cases and this adds to the gaps in care especially during transitions and placement.

A decrease in case-loads makes systems of care work, and hiring retention rates could improve.

A balanced case-load is also necessary for outpatient care.

5-Enhancing case management systems that are already working and effective

- Focus units
- Lower cases per worker
- Peer escorts
- Open more and build upon Peer Centers and Drop in Centers to connect people to care