Results-Based Accountability Framework for CCSF Shared Priority Pilot

Results: The conditions of well-being we want for our children, families and the community
- Provide stable housing and case management services
- Decrease utilization of urgent and emergent services (PES, ED, DORE, Sobering Center)
- Increase in stabilization services (enrollment in MAT, residential treatment, outpatient treatment)
- Improvement in quality of life for clients

Indicators: How we measure these conditions?

a) Data sources
- Housing enrollment records (ONE system – HSH)
- Health care utilization data (CCMS)
- Adult Needs and Strengths Assessment (ANSA) ratings (Avatar)
- HSA benefits enrollment data
- Pilot care coordinator records/dashboard

b) Data points

<table>
<thead>
<tr>
<th>Data points</th>
<th>Source</th>
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<tbody>
<tr>
<td>Medi-Cal, SSI, CAAP, CalFresh enrollment</td>
<td>HSA benefits enrollment data (HSA to share aggregate statistics at baseline and at pilot completion)</td>
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<tr>
<td></td>
<td>CCMS (Medi-Cal)</td>
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<td>Enrollment in intensive case management, or other appropriate form of case management</td>
<td>CCMS – listed ICM or CM program</td>
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<td>Level of active engagement with case management services (e.g., at minimum, weekly visits for ICM, monthly for non-ICM)</td>
<td>CCMS – CM service encounters</td>
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<td>Permanent supportive housing placement and length of stable tenancy</td>
<td>ONE – System *should also be available in CCMS (encounters with HSH stabilization services)</td>
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<td>Navigation Center stays, in preparation for housing placement</td>
<td>CCMS (Nav center stays, encounters with HSH navigation services)</td>
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<tr>
<td>Long-term residential facility placement (e.g., locked facility, Board and Care)</td>
<td>CCMS (for some facilities – Laguna Honda)</td>
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<tr>
<td>Use of acute services before and after pilot: ED, medical inpatient (stays and days), urgent care, PES, psych inpatient (stays and days), Dore, detox and sobering center</td>
<td>Pilot Care Coordinator</td>
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<tr>
<td>Use of primary care</td>
<td>CCMS – outpatient medical data extract</td>
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<tr>
<td>Use of rehabilitation services</td>
<td>CCMS – SUD service data extract</td>
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<tr>
<td>Use of Medication Assisted Treatment (MAT)</td>
<td>CCMS – SUD service data extract (Methadone visits) CBHS Pharmacy? (David Pating)</td>
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<td>Use of non-urgent mental health resources (e.g., outpatient MH services, Hummingbird)</td>
<td>CCMS – MH service data extract CCMS – Hummingbird intake</td>
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<tr>
<td>Mortality</td>
<td>Medical Examiner reports CCMS – State death registry feed</td>
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<tr>
<td>Number of clients who could not be located during pilot period (start vs. end)</td>
<td>Pilot care coordinator dashboard CCMS – lack of service encounters</td>
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<tr>
<td>5150s</td>
<td>CCMS – PES 5150s in utilization report</td>
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<tr>
<td>Encounters with the criminal justice system - Jail health days</td>
<td>CCMS - JHS encounters</td>
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<tr>
<td>Presence of care plans in Epic, EDie, CCMS - Inclusion of contact details for pilot care coordinator, ECS housing navigation, EMS6</td>
<td>Epic, EDie, CCMS (track roll-out of standard care plan).</td>
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<tr>
<td>Completed assessments and improvements on ANSA action items</td>
<td>Avatar</td>
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<tr>
<td>Priority clients per case manager, barriers to client success identified by case managers</td>
<td>Responses to case manager letters/survey</td>
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<tr>
<td>Contacts between pilot case coordinator and members of patient care team (e.g., ICM, housing navigator)</td>
<td>Pilot care coordinator dashboard</td>
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<tr>
<td>Agency engagement in pilot process</td>
<td>Implementation, Triage and Systems Response team meeting minutes (attendance by agency)</td>
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<tr>
<td>Perceptions of interagency communication and collaboration</td>
<td>Pre/post survey of Implementation, Triage and Systems Response team members</td>
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<tr>
<td>Detailed tracking of touch points and interagency communication/responses for 10 patients (journey map)</td>
<td>CCMS (care encounters) Pilot care coordination dashboard (communication points)</td>
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**Baselines:** *What the measures show about where we’ve been and where we’re headed.*

- 237 clients in pilot who are prioritized for housing, suffering from psychoses and substance use disorder (alcohol and/or drug)
- Average duration of homelessness = 11 years
- Race/ethnicity
  - 38% African American / Black
  - 33% White
  - 10% Latino/a
- Gender
  - 67% male
  - 27% female
  - 2% transgender
- Age
  - Average age = 45
- # Medi-Cal, SSI, CAAP, CalFresh enrollment at start of pilot
- 30 clients have intensive case managers
- 85 clients have other mental health service (includes fee for service psychiatrist)
- 8 clients were placed in permanent supportive housing before start of pilot
- 54 clients are in a Navigation Center, in preparation for housing placement
- In the fiscal year preceding pilot start date (FY1819):
  - 29 clients (12%) were Top 1% HUMS
  - 142 (60%) were in the Top 5% for at least one prior year.
  - 30 (13%) have been in the Top 5% for at least five of the last ten years.
  - Average HUMS score=13 visits/stays per year (median = 4, range 0 – 359)
    - 39 (17%) clients had no urgent/emergent utilization
  - 163 (69%) clients used the ED (average=6 visits per year)
    - 49 (21%) had 10+ ED visits per year
  - 69 (29%) clients used PES (average=1 visit per year)
  - 26 (11%) clients used the sobering center (average=13 visits per year)
  - Use of rehab services
  - Use of non-urgent mental health resources (outpatient MH services, Hummingbird)
  - 41 (17%) clients had at least one 5150
  - 83 (35%) clients had at least one jail stay
- 3 clients are currently conserved; 14 clients have some history of conservatorship.
- 3 deaths prior to pilot start
- 35 clients need to be located (whereabouts unknown/lack of contact)
• # who already have care plans in any system (e.g., EDie, CCMS, Epic)
• 75% of clients have at least one completed ANSA (ever)
• 50% of clients have a completed ANSA in the last 12 months.

Turning the curve: *What success looks like if we do better than the baseline.*
• Individuals are placed in stable setting (PSH or other care facility) and retained
• Individuals are enrolled in benefits

Strategies: *What works to improve these conditions?*
• Interagency case triage and intensive care planning
• Individualized street-to-home plans
• Systems level identification of barriers and problem solving
• Evidence-based models (e.g., Housing First, Care coordination)
• High intensity mobile care team
### Performance Measures

#### Quantity

**How Much We Do?**
- # Clients triaged by team (237)
- # of clients located
- # of street to home plans made and entered into data systems
- # of care plans that include assessment/plan for both health and housing
- # enrolled in benefits (Medi-Cal, SSI, etc.)
- # enrolled in case management
- # engaged with care team
- # of clients placed in navigation centers
- # of clients placed in residential treatment
- # of clients housed
- # of clients receiving MAT
- # of clients using outpatient mental health resources
- # of clients with completed ANSA

#### Quality

**How Well We Do It?**
- # days to stabilization/housing from outreach
- Level of housing retention
- Time from entering Nav Center to housing placement
- Pilot team feedback: survey of participants on Systems Response, Triage and Implementation teams (pre/post)
- Number of clients per case manager at baseline and after pilot
- Timeliness of response (from ECS, from case managers, from system response team)
- Contacts between pilot care coordinator and members of client care team
- Number of agencies present at each team meeting (implementation, triage and system response)
- Appropriateness of pilot outcome metrics
- Journey maps of system/agency touchpoints and system/agency communication for 10 example patients

#### Effect

**Is Anyone Better Off?** *What quantity/quality of change for the better did we produce?*
- Decrease in utilization of urgent and emergent services
- Increased use of outpatient mental health resources
- Increased number of clients indoors (permanent supportive housing, residential treatment) and retained there
- Increase in case management enrollment and engagement
- Improvement on ANSA action items (DPH benchmark – improved score on 30% of items per patient).
- Improved perception of interagency collaboration and communication (based on pre/post survey of pilot team members)
- Improved understanding of the effectiveness and appropriateness of shared priority population interventions