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

Data points	Source
Medi-Cal, SSI, CAAP, CalFresh enrollment	HSA benefits enrollment data (HSA to share aggregate statistics at baseline and at pilot completion) CCMS (Medi-Cal)
Enrollment in intensive case management, or other appropriate form of case management	CCMS – listed ICM or CM program
Level of active engagement with case management services (e.g., at minimum, weekly visits for ICM, monthly for non-ICM)	CCMS – CM service encounters
Permanent supportive housing placement and length of stable tenancy	ONE – System *should also be available in CCMS (encounters with HSH stabilization services)
Navigation Center stays, in preparation for housing placement	CCMS (Nav center stays, encounters with HSH navigation services)
Long-term residential facility placement (e.g., locked facility, Board and Care)	CCMS (for some facilities – Laguna Honda)

	Pilot Care Coordinator
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	CCMS urgent/emergent utilization reports
Use of primary care	CCMS – outpatient medical data extract
Use of rehabilitation services	CCMS – SUD service data extract
Use of Medication Assisted Treatment (MAT)	CCMS – SUD service data extract (Methadone visits) CBHS Pharmacy? (David Pating)
Use of non-urgent mental health resources (e.g., outpatient MH services, Hummingbird)	CCMS – MH service data extract CCMS – Hummingbird intake
Mortality	Medical Examiner reports CCMS – State death registry feed
Number of clients who could not be located during pilot period (start vs. end)	Pilot care coordinator dashboard CCMS – lack of service encounters
5150s	CCMS – PES 5150s in utilization report
Encounters with the criminal justice system - Jail health days	CCMS - JHS encounters
Presence of care plans in Epic, EDie, CCMS - Inclusion of contact details for pilot care coordinator, ECS housing navigation, EMS6	Epic, EDie, CCMS (track roll-out of standard care plan).
Completed assessments and improvements on ANSA action items	Avatar
Priority clients per case manager, barriers to client success identified by case managers	Responses to case manager letters/survey
Contacts between pilot case coordinator and members of patient care team (e.g., ICM, housing navigator)	Pilot care coordinator dashboard
Agency engagement in pilot process	Implementation, Triage and Systems Response team meeting minutes (attendance by agency)
Perceptions of interagency communication and collaboration	Pre/post survey of Implementation, Triage and Systems Response team members
Detailed tracking of touch points and interagency communication/responses for 10 patients (journey map)	CCMS (care encounters) Pilot care coordination dashboard (communication points)

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	Quality
Effort	**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	**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	