SAN FRANCISCO WHOLE PERSON CARE

Stakeholder Discovery: Findings, Insights and Recommendations

SF WPC Evaluation and Service Design Teams
December 2018

UNIQUE OPPORTUNITY PRESENTED BY WHOLE PERSON CARE

Historically, the organizational structure of city departments, the lack of policies and procedures to facilitate coordination, and the disincentives for interagency collaboration have resulted in systems of care that are fragmented and difficult to navigate for our shared clients.

The Whole Person Care Pilot provides a unique opportunity for action, as it enables agencies that provide health, housing and benefit services to work together in a human-centered fashion.

Funding, technology, legal authority and leadership are, for the first time, aligned to support a Whole Person Care approach for departments to work together through data sharing and improved care coordination.

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OBJECTIVES

Conducted in-person, qualitative interviews and participatory design activities with key stakeholders and partners across City departments, agencies and disciplines:

- To **gauge awareness** of the WPC pilot, objectives, and deliverables
- To better understand **what is currently working and what is not** for adults experiencing homelessness – especially our most vulnerable – with regards to care coordination and data sharing
- To **identify opportunities for success and potential risks** facing the WPC pilot

Discovery Approach / Overview
STAKEHOLDER INTERVIEWS

To understand the perspective of key stakeholders and partners across City departments, agencies and disciplines:

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Barry Zevin
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Tanida Maselli
Josh Bamberger
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System of Care

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WHAT WE HEARD, INSIGHTS, RECOMMENDATIONS

System of Care

System of Care / Insight 1

NEED TO OPERATE IN AN INTEGRATED WAY

Silos and episodic care models contribute to the lack of collaboration and coordination. As a result, providers and clients experience barriers providing, connecting with, and receiving care.

Providers want access to cross-agency, comprehensive, actionable health and social services data that will enable care coordination. They often don't have these data or the ability to access these services (but both may exist).

Connecting clients to services can be dependent on a provider's knowledge of the system or personal relationships.

There is a lack of communication between episodic care providers, services, and organizations.

> *The strength and weakness of SF is that there is so many CBOs. Consequently, they are fragmented.*
>
> *Different systems are all working for the same patient population, so how do we connect those systems? For example, allowing someone from a non-DPH organization to access CCMS.*
>
> *We need better bridges between the two departments (HSH and DPH).*
>
> *We need to operationalize the personal relationships that exist between departments.*

System of Care / Insight 2

NEED FOR A MORE COORDINATED DELIVERY SYSTEM

The delivery system requires anticipatory planning, has limited co-located care, and is uncoordinated, which results in negative experiences for patients and providers.

Episodic, fragmented care doesn't work for our most vulnerable clients.

There is a lack of care coordination—or someone responsible for a client as they move through the system of care.

Having staff with medical expertise (RNs) in shelters provides an alternative to calling 911.

Patients are perceived as "not wanting" care or housing, and can be "dismissed" from programs, leaving no option aside from EDs.

> *How do we get the system so that everyone experiencing homelessness has "no wrong door" and can get matched to appropriate housing and supports, stabilized in housing/right level of care?*
>
> *Most of the folks are not getting regular mental health treatment, but it can be hard to tell around substance use because of protections by 42 CFR.*
>
> *People who have alcohol use disorder are at highest risk for early death. There needs to be alignment across departments to serve their complex health, housing, and social needs.*

System of Care / Insight 3
NEED FOR SHARED PRIORITIES

Across departments, agencies, and services there is a lack of alignment on how to define, identify, and prioritize the Whole Person Care population.

There is no shared acuity score for prioritizing clients across the system. HSH's coordinated entry, HSA's benefits programs, DPH's case conferences, and the Mayor's office employ different ways of identifying and prioritizing clients.

Outside of HSH, there is no clear homeless indicator across systems. Homelessness isn't consistently identified or documented.

Improved communication would enable providers across the system of care to better serve clients, connect them to the right next service, and reduce potential duplication of work.

> *Having a single meeting with representatives from all relevant agencies in one room would be very useful.*
>
> *It's hard to know what or who is the priority.*
>
> *I want to know what to do when they show up in my clinic. Who's responsible?*
>
> *We do not have reliable data on which of our clients are homeless.*
>
> *We need to stop thinking about clients as yours or mine. We need to develop a shared client mentality.*

System of Care / Insight 4

NEED TO REALIGN RESOURCES

The right resources—staff, services, and funds—aren't always accessible in the right place at the right time. There may be a need to develop new services or redistribute existing staff and resources to meet needs.

Resources are not always available due to cost, timing, do not exist, lack of awareness, or service restrictions.

Consistently lacking appropriate resources can lead to provider fatigue.

There are a disproportionate amount of resources devoted to urgent / emergent medical care compared to recovery and wellness.

Providers need tools to provide better outcomes: knowledge of what can be done for patients related to addiction, shelter and jail.

> *A success of WPC would be realizing how to better coordinate existing resources rather than adding a bunch of new resources.*

> *People with the least training tend to be left to work with the most acute patients.*

> *Our department [HSH] has nowhere near the level of resources needed….there is a lack of case management or housing navigation roles that reach across different programs. In the shelter system, there is limited case management.*

System of Care / Insight 5

NEED FOR MORE STEP-DOWN AND STEP-UP HOUSING OPTIONS

Supportive housing and step-down services are working well but there is a lack of appropriate options as clients move towards stabilization, recovery, and wellness.

Low-barrier services like navigation centers, medical respite, Hummingbird, and medical staff in shelters are working (we think). More evaluation of current options is needed.

San Francisco needs more low-income and permanent supportive housing to meet the need.

Many people that get stuck in the wrong level of care are individuals who are homeless.

Lack of capacity of step-down or step-up options hinders the ability to improve flow through the system.

"Supportive housing is working well. We're now trying to move people with lower needs to housing with less/no services to free up spots.

PSH inventory: Over 7000 existing housing units, 7000 people experiencing homeless and 5% turnover.

We think Hummingbird has let ED feel more comfortable about discharging patients. We think all of these services work well, but there is nowhere for clients to go at the other end!

At the end of treatment, all we have to offer is a stabilization room, not conducive to recovery.

System of Care / Insight 6

NEEDS TO IMPROVE ACCESS TO BENEFITS

Individuals that are homeless face unique challenges enrolling in and renewing benefits. Multiple efforts are underway to simplify and streamline the process for individuals who are homeless.

Many clients are not on Medi-Cal or other benefits for which they qualify due to lack of an address, lack of knowledge about eligibility, etc.

Individuals who are homeless experience a high level of Medi-Cal churn.

Medi-Cal enrollment is complicated by time needed to complete out of county transfers and other processes.

Access to mental health and substance use services can be limited by a client's ability to enroll in and maintain Medi-Cal.

> *We are placing eligibility workers in navigation centers – enrolling individuals in Medi-Cal and other services simultaneously.*
>
> *We are facilitating applications via website (some programs don't require face-to-face appointment) – partnership with non-profit agencies to help patients apply.*
>
> *We are cross training HOT case managers on how to enroll people in benefits. How is it working in shelters vs. navigation centers?*

System of Care / Recommendations

NEED TO OPERATE IN AN INTEGRATED WAY

1/ Facilitate connections across services by providing integrated data, transportation between services, staffing, and financing that promote collaboration, coordination, and communication, including with consortium clinics.

Projects: WPC IT Solution, Data Sharing Policies & Procedures, Care Coordination Policies & Procedures

2/ Operationalize a technology platform to facilitate citywide community care plans or action plans as a way to connect care teams and better serve clients.

Projects: WPC IT Solution, Community Care Plan

NEED FOR A MORE COORDINATED DELIVERY SYSTEM

3/ Develop a care coordination approach to support and assign responsibility for vulnerable clients over time, including those who aren't yet ready, or don't see what's available as relevant or desirable, or who have been kicked out of programs. Do away with idea that there are service-resistant clients.

Projects: Care Coordination Policies & Procedures, Citywide consideration

4/ At times, solutions to problems rely on high-level "favors" or personal relationships: operationalize a clear prioritization process.

Projects: WPC IT Solution, DPH/HSH Summit, Care Coordination Policies & Procedures

System of Care / Recommendations

5/ Assure co-located care whenever possible that includes medical, mental health, substance use, HSH access point services, benefits, etc.

Projects: Benefits Navigator Shelter Pilot, Health Resource Center, Care Coordination Policies & Procedures

NEED FOR SHARED PRIORITIES AND CLIENTS

6/ Develop protocols allowing staff to operate across agencies and serve as accountable care coordinators that follow the patient—in the health care system and the community—regardless of funding source and episodic fluctuations of more or less intensive levels of care.

Projects: Top 100 HUMS, Universal Assessment, Community Care Plan, Data Sharing Policies & Procedures, Citywide consideration

7/ Better characterize HUMS and pre-HUMS population to ensure that their needs are being addressed throughout the continuum. Consider allocation of staff, resources, etc. to serve HUMS patients.

Projects: Top 100 HUMS, Citywide consideration

8/ Use shared, interagency data to create mutually-agreed-upon priority clients to coordinate service delivery. Review how people are ranked in the HSH priority system compared to lists based on high utilization or medical vulnerability and vice versa.

Projects: WPC IT Solution, Data Sharing Policies & Procedures, Top 100 HUMS, Universal Assessment

9/ Provide accessible view of “client flow” through the system of care (e.g., visual dashboard).

Projects: Data Sharing Policies & Procedures, Citywide consideration

System of Care / Recommendations

NEED TO REALIGN RESOURCES

9/ Codify policy that “any door is the right door” to allow the right service to come to the right patient at the right time—in housing settings, acute medical settings, ambulatory medical and mental health settings, jail, etc.

Projects: Care Coordination Policies & Procedures

10/ Develop new resources (e.g. the Health Resource Center) designed specifically to address the needs of the WPC population.

Projects: Health Resource Center

NEED FOR MORE STEP-DOWN AND HOUSING OPTIONS

11/ Prioritize flexible housing funds, “any door is the right door” access points, and services that can retain people in housing.

Projects: Citywide consideration

NEED TO IMPROVE ACCESS TO BENEFITS

12/ Ensure those who are eligible are enrolled in Medi-Cal and other benefits (CAAP, SNAP, etc.) by streamlining and simplifying enrollment processes. Work with HSA to prevent individuals from churning off when their coverage is due to expire.

Projects: WPC IT Solution, Care Coordination Policies & Procedures

System of Care
HUMS JOURNEY MAP

The Top 100 HUMS (High Utilizers of Multiple Systems) journey map tells the story of a prototypical individual experiencing chronic homelessness in San Francisco. The map is a snapshot of client and system actions, the services and departments involved across the journey, as well as, pain points and opportunities for improvement.

The map brings together the perspective of urgent/emergent providers and quantitative data analysis of the top 100 HUMS utilization in 2017-18.

Taking a human-centered service design approach highlights how systemic barriers impact our shared clients over time.

WHOLE PERSON CARE

TOP 100 HUMS JOURNEY MAP

The journey map tells the story of a prototypical high utilizer of multiple systems experiencing homelessness in San Francisco. The map depicts client and system "actions", the involvement of services and departments over time, and client painpoints. Taking a human-centered service design approach highlights how systemic barriers impact our shared clients over time.

SCENARIO

John is a 50-year-old male who lives outdoors and has experienced homelessness in San Francisco for more than 13 years. He has polysubstance use disorder and experiences substance-induced psychosis. John has hepatitis C and may have cognitive impairment but has never been formally evaluated.

He frequently visits the emergency department (90 times this year) and had two medical inpatient stays for serious infections. John visited PES 10 times last year, usually due to his methamphetamine use, and was placed on 5150 involuntary holds for grave disability several times. He spent 20 nights at the sobering center and tried going to detox once but left after several days.

Providers describe John as easy to anger and difficult to engage. Over time he cycles through services throughout the system of care. He is tenacious and has learned how to survive on the streets but has a hard time following through with a plan or making it to appointments.

IDENTIFIED BARRIERS

- **Services are designed for episodic care**
- **Medical, mental, and social services operate in silos and lack systems for collaboration**
- **Clients fall through the cracks in times of transition**
- **Clients and providers experience difficulties connecting to services**
- **There is a need for low-barrier options to meet clients where they are**
- **The system of care can be re-traumatizing for clients**

SERVICE EPISODES

130

Average number of urgent/emergent service visits for the top 100 HUMS during 2017-18. By service:

Emergency Department: 89
Inpatient stays: 3.8
Urgent Care: 2.1
PES: 7.9
Psych inpatient: .3
Dore: 1.5
Medical Detox: .6
Social Detox: .08
Sobering Center: 24.6

The path to stabilization and wellness is not linear. Clients cycle through urgent/emergent, transitional, and stabilization services. Meeting a client where they are requires recognizing where they are in the process and responding appropriately.

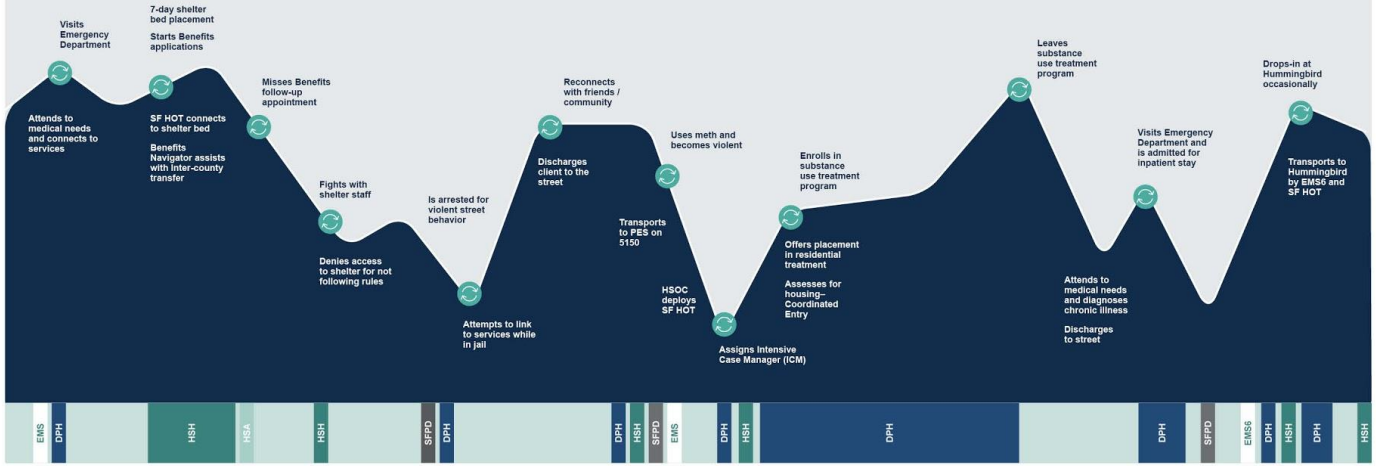
MOMENT OF OPPORTUNITY
"I need help."

POINT OF ENGAGEMENT
"I want help."

LOOSELY CONNECTED
"I don't know where to go for help."

STABILIZATION
"I know where to go and how to get help."

DESTABILIZATION
"I'm not ready. What I need you don't have."



99%
Of the top 100 HUMS in 2017-18 visited the emergency room.
Average visits: 89
Maximum visits: 341

51%
Have been homeless for more than ten years.
99 of the top 100 HUMS have a history of homelessness

42%
Receive Supplemental Security Income (SSI).

40%
Of the top 100 HUMS had at least one county jail interaction in 2017-18.

50%
Had either a 5150 or a 5250 (involuntary psychiatric holds).
16 of the top 100 HUMS meet criteria for SB 1045

42%
Went to the Sobering center or Detox.
91% had a history of drug or alcohol abuse

17%
Are actively engaged with DPH case management or Intensive Case Management (ICM).

70%
Are known to the Department of Homelessness and Supportive Housing.
22 have been in DAH housing (ever), 12 are in DAH housing

67%
Of the top 100 HUMS were in the top 1% in the previous year.

Over $19 mil
Estimated cost of urgent/ emergent services for the top 100 HUMS in 2017-18.

Data Considerations

Data Considerations

Data Sharing Considerations / Insight 1

DATA QUALITY

Across agencies, many stakeholders report struggling with issues of data quality and availability.

Data that already exist may be incomplete or inaccurate (duplicates, errors, missing indicators or encounters).

Stakeholders across all agencies report struggling with important data quality issues.

> *Missing even basic data from the street medicine team encounters.*
>
> *The ED is one of the largest sources of data quality issues and duplicate encounters.*
>
> *CCMS is reliant on source data systems. When you identify patients with over 365 sobering center days per year, or patients who have died but subsequently have a ED visit, this suggest data quality issues.*

Data Sharing Considerations / Insight 2

DATA GOVERNANCE

Methods of data collection and storage vary widely, even within individual agencies. A unified, formal approach to an interagency data system governance would improve data access and utilization.

There is no clear approach to data governance, across agencies and health systems.

Several stakeholders expressed wariness about who would own the WPC platform and integrated data, how the data would be used, and for what purpose.

Opportunities to improve data accessibility, usability, and integrity exist across agencies.

> *If we have a shared database, who will own the data? Who will be given access to the data? Who will determine what questions can be asked?*
>
> *DPH does not have a formal approach to data governance.*
>
> *How data is entered, stored, and used varies greatly, ranging from handwritten sheets to excel spreadsheets to functional databases. There is no standardization in data collection and use.*

Data Sharing Considerations / Insight 3

DATA ACCESSIBILITY

Data accessibility is recognized as a priority but questions remain about potential restrictions on data sharing.

Improving data accessibility for clients, providers, and administrators is a recognized priority.

Data sharing between DPH, DHS, DAAS and HSH is recognized by all agency leaders as important, though each agency may have potential restrictions on data sharing.

42 CFR part 2 [legislation regarding confidentiality of substance use treatment] is a large barrier to sharing data for high-risk patients.

> *Bi-directional data sharing is important for both departments, and the need goes beyond just WPC program enablement. Data sharing with DPH would amplify the ability to share services.*
>
> *There are concerns related to DHS's ability to share Medi-Cal client data for purposes other than Medi-Cal eligibility.*
>
> *We need to have knowledge sharing across departments because sometimes clients are lost to follow-up when they transition between services.*

Data Sharing Considerations / Insight 4

DATA INTEGRATION

Integrated data plays an important role in integrated care delivery. To get the most out of integrated data, a client action plan and the appropriate resources also need to be in place.

There is a general openness to data integration across agencies.

HSA and DPH already have some experience with data integration, within their own departments.

While there is support for data integration, it remains unclear how such data will be leveraged.

> *If you want integrated services, you need integrated data. We would need a sustained and cooperative county council to help merge multiple data sources.*
>
> *Data integration alone is insufficient. There also needs to be time and personnel allotted to use the data and run reports so that integrated data are useful.*
>
> *We were apprehensive about taking on Whole Person Care because at the heart of it is data sharing. Can we crack this nut?*

Data Sharing Considerations / Insight 5

DATA USE FOR IMPROVEMENT, EVALUATION

Standard reporting processes and shared metrics would allow program managers to evaluate interagency work and drive system improvements.

Existing data is not consistently being used for systems improvement or program evaluation.

There is inconsistency across agencies in leveraging data or tracking metrics.

There are no standardized data processes, (e.g., no standard approach for data collection, entry, application) including for use in evaluation and reporting.

There is a focus on “doing” but less attention paid to “studying and adjusting.”

> *The metrics I want are not available. There are no time-based or longitudinal metrics.*
>
> *Every DPH program should allocate resources for program evaluation.*
>
> *Existing data is not being used for improvement, evaluation, or accountability.*

Data Sharing Considerations / Recommendations

DATA QUALITY

1/ Develop a robust enterprise-wide master person index and a standard, universal, approach to defining key variables (e.g., homelessness) and data processes across systems.

Projects: WPC IT Solution, DPH IT EMPI

DATA GOVERNANCE

2/ Operationalize an Interagency Data Governance Committee that oversees the governance, accessibility, usability, integrity, and security of data across the integrated, interagency data system.

Projects: WPC Operations, Data Sharing Policies & Procedures, Citywide consideration

DATA ACCESSIBILITY

3/ Standardize how data are collected and used. It should be clear if consent is required from the client or agency, how to obtain it, and what level of access is permitted.

Projects: Data Sharing Policies & Procedures, Citywide consideration

4/ Develop role-based policies to guide which providers can access WPC data, for what purpose will data be used, and how results from analyses are disseminated in an effort to improve care.

Projects: Data Sharing Policies & Procedures, Citywide consideration

5/ Provide front-line staff with mobile devices, transportation, and access to a data platform (mobile app) that enables real-time encounter documentation that can be used for service delivery, program evaluation, and billing.

Projects: WPC IT Solution

Data Sharing Considerations / Recommendations

DATA INTEGRATION

6/ Align with EPIC data governance, while defining how existing data systems – like CCMS and EDIE – and new data opportunities with ONE and CalWin will be incorporated and shared across agencies. Assure adequate infrastructure is in place to support an interagency data sharing solution.

Projects: WPC IT Solution, Data Sharing Policies & Procedures

7/ WPC team and/or a Data Governance Committee must quickly establish the ability to share, access, and use data across systems.

Projects: WPC IT Solution, Data Sharing Policies & Procedures

DATA USE FOR IMPROVEMENT, EVALUATION

8/ Identify three to five priority process and outcome metrics from each of the core programs providing care to WPC populations.

Projects: WPC Evaluation

9/ Evaluate individual programs, who they are and are not serving and the trajectory of those patients (e.g., shelters, Medical respite, Hummingbird, etc.) to inform future planning.

Projects: Top 100 HUMS, WPC Evaluation

10/ Require agencies to utilize data for evaluation and improvement of their service delivery programs.

Projects: Data Sharing Policies & Procedures, Citywide consideration

11/ Advocate at the state level to overcome barriers to data-sharing posed by 42 CFR part 2.

Projects: Citywide consideration

Sustainability

SUSTAINABILITY OF WHOLE PERSON CARE

What we heard We need to have a plan in place in order to "flip the funding switch" when Whole Person Care is over. We need to be ready to make the transition to a different source of funds, potentially by becoming a Targeted Case Management (TCM) city.

Whole Person Care is about creating lasting collaborative relationships and facilitating coordination and knowledge sharing between departments.

Moving forward, it is essential to focus on projects that cross departments, lay the groundwork for collaboration and coordination, and identify an empowered system owner to continue the work.

Sustainability of Whole Person Care / Recommendations

SUSTAINABILITY

1/ Proactively communicate with partners and key stakeholders ensuring there is a awareness of Whole Person Care objectives, current projects, progress and achievements to date, as well as, a long term commitment to the approach.

Projects: WPC Operations

2/ Engage and inform leadership, stakeholders, and partners through regular committee meetings, work groups, and communication materials to ensure Whole Person Care deliverables are reflective of client, staff, and organizational needs.

Projects: WPC Operations

3/ Identify and grow future owner(s) of the Whole Person Care platform and service delivery approach.

Projects: WPC Operations

4/ Understand documentation standards and requirements required for Targeted Case Management (TCM) cities. Proactively design and implement systems to support the eventual transition from Whole Person Care to other funding sources.

Projects: WPC Operations, WPC IT Solution, Citywide consideration

5/ Work with city stakeholders and private donors to leverage new funding in the most effective ways possible, based on evidence.

Projects: WPC Operations, Citywide consideration

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