SAN FRANCISCO WHOLE PERSON CARE

Interagency Prioritization Workshops 1 + 2

Report Out
Whole Person Care facilitated a series of workshops with representatives from DPH, HSH, HSA, and SFHP to **build a vision** and **design a process** for a homeless system of care response to interagency prioritization.

**Workshop 1** focused on identifying and prioritizing shared values for an interagency process and envisioning the future experience of clients, staff, and community members.

**Workshop 2** focused on designing the future process for interagency prioritization, identifying opportunities to pilot, and developing in-depth proposals.

Pilots proposals focused on the HSOC prioritization response, tele-consults, and a protocol to check data and establish a shared data set.

Next steps will include presenting workshop outcomes to DPH and HSH leadership and refining pilot proposals to align with current interagency efforts.
Our Approach

To design, develop, and validate an interagency prioritization process for shared clients experiencing homelessness, Whole Person Care facilitated a series of workshops to answer the following questions.

What are our shared values?
How will the homeless system of care respond differently?
Who is our target population?
How will we know we have made a difference?

What methods will we use to identify and prioritize?
What will be the process for engaging, assessing, prioritizing and placing individuals?
What governance structure is needed?

What interventions can be tested in the short term?
Who needs to be involved?
What resources are needed?
How will we track and measure success?
Workshop 1 and 2 Scope

Workshop 1 and 2 focused on building a vision, designing a future state process, and identifying pilot opportunities for interagency prioritization for shared clients. The project did not focus on designing a prioritization tool (or formula) or redesigning service pathways.

In Scope

- Creating a shared vision
- Designing a future state process
- Identifying pilot opportunities

Out of scope

- Designing tools
- Finalizing a formula for prioritization
- Defining pathways for how we refer & place
Whole Person Domains of Risk and Strength

The team reviewed an initial list of domains to kick-start the future state mapping exercise and prompt discussion about information valuable to the interagency prioritization process.
## Adults Experiencing Homelessness

The team reviewed the list of potential services to be considered for interagency prioritization for shared clients.

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<tr>
<th>DEPT</th>
<th>PERSPECTIVE</th>
<th>SCARCE RESOURCES AND SERVICES</th>
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<tbody>
<tr>
<td>DAAS</td>
<td>Older People, Adults with Disabilities, and Veterans</td>
<td>LPS Conservatorship (mental health), Public Guardian (dementia/cognitive impairment), In-Home Supportive Services, Adult Protective Services, Representative Payee program, Community Living Fund, CVSO (County Veteran Service Office)</td>
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<tr>
<td>DPH</td>
<td>Health</td>
<td>Residential Detox&lt;br&gt;Residential Treatment: MH, Dual Dx &amp; Substance Use Disorder&lt;br&gt;Intensive Case Management&lt;br&gt;Custodial SNF, Locked Sub-Acute, RCF (Dementia)&lt;br&gt;Medical and Psych Respite&lt;br&gt;Stabilization Rooms</td>
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<td>HSA</td>
<td>Adults eligible for CAAP, Medi-Cal, or Snap</td>
<td>Benefits Navigation</td>
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<tr>
<td>HSH</td>
<td>Housing and Street Outreach</td>
<td>Permanent Supportive Housing Stabilization Rooms</td>
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Workshop 1
Building the Vision
Recap
The case for change starts with a vision.
A shared vision paints a clear and aspirational picture of the future. It serves to encourage and align teams around an ideal and future state allowing multiple pathways for implementation.
Design what we will do differently, together

To build a vision for an interagency homeless system of care response the team discussed current state challenges and designed for the client pathway, keeping the end in mind.

Homeless System of Care Response

**ACCESS**
Determine how clients come into our system.

**ASSESS**
Define the information and characteristics collected and reviewed.

**PRIORITIZE**
Use agreed-upon criteria necessary to prioritize clients.

**REFER + PLACE**
Determine resources and services needed and understand system gaps.
Interagency Prioritization Process Shared Values

Values serve as the foundation for a vision and a touchstone for evaluating potential solutions. The team identified and prioritized values for an interagency homeless system of care response to prioritization.

Client Experience

- Process is fair, equitable, and transparent
- Pathway is clear to resources and services
- Response system is trauma-informed, culturally-competent, and adaptable to the unique needs of individuals
- Process is hopeful and reinforces belief that positive change is possible

System

- Process and results are an interagency collaboration
- Leaders are committed to the vision and process
- Process is built and success is measured with a racial equity lens
- Clients and staff are included in the process and provide authentic input
- Results are clear, measurable and show value
The team worked in small groups to draft statements that captured the “From” (current state) and “To” (where we want to go) for different stages of the interagency response to prioritization process for shared clients.
Access + Assess
The initial stage where clients come into our system and information and characteristics are collected and reviewed.

FROM
There are disparities in certain populations in terms of access to services and assessments, and even once assessed these people are still not prioritized.

We don’t use relevant, available data, in a way that improves, our ability to assess client’s situation or condition which results in missed opportunities, inefficiency, and inequality.

TO
There are no longer disparities in access and assessment completion and results based on race, language, disability, sexual orientation, gender, identity, age and cognitive functioning.

CCSF data is deployed in a way that improves accuracy and equity of assessments and thereby increases access to people experiencing homelessness.
Prioritize
The stage of the process where defined criteria are used for prioritizing clients.

FROM
Lack of shared prioritization criteria (HSH Coordinated Entry, multiple DPH lists, HSOC, and Mayor’s Office) AND multiple competing prioritization pools creates confusion.

Different access to information, office based services and unclear authority to share information (PHI).

TO
Prioritization done by clear assessment protocol criteria that key stakeholders are aware of and aligned with regular analysis occurs to study system impact and fidelity.

Real time field-based assessment using mobile access to shared databases that allows integration of existing assessments.
Refer + Place
The final stage where clients are matched with resources and services needed.

FROM

- Services are not available when a client is ready, no treatment on demand or where they are and there is no (or few) low barrier services.
- Most vulnerable clients require support to bridge gaps between episodic care - even when clients are not ready to engage.
- Disproportionate representation of African American, Transgender, non Binary, and LGBQ who experience homelessness do not have relevant responsive system of care - and continue to be traumatized.

TO

- Services are available when and where clients are ready for them. Services accommodate for cognitive impairment, addiction, and med/psych/social complexity.
- Once prioritized, clients have an advocate and care manager and support to maintain a level of stabilization.
- Availability of culturally relevant, responsive system of care (program model, staff, awareness) for African American, Transgender, non Binary, and LGBQ.
Target Population Characteristics

The team identified populations that would benefit from an interagency prioritization process. The goal was not to prioritize “vulnerable” populations but to understand where we can start.

Who is being failed by the system?

- People who are poor self-reporters of their own life
- Inability to self-care
- Chronic chaotic substance use
- African Americans
- Transgender individuals
- People that chronically don’t get along with others
- People who decline or unable to use offered available services, housing, and shelter
Measures of Success

The team identified areas where improvement could be measured. Further refinement is necessary to determine appropriate metrics.

● **Potential Measures**
  ○ 100% of people experiencing homelessness have a completed assessment for services, benefits, and housing
  ○ Assessments are measurably connected to services, benefits, and housing
  ○ Zero disparity in outcome of assessment measurement/relative prioritization (includes disparity decrease in completion of assessment)
  ○ Decrease in repeated use of urgent/emergent services
  ○ Decrease in time from first recognized as homeless to intervention

● **Success would be...**
  ○ Decrease in unsheltered individuals experiencing homelessness; including most vulnerable
  ○ Appropriate & timely interventions
  ○ *Placeholder/draft*: Engagement in “meaningful” activity
  ○ *Suggested*: Interagency alignment on “meaningful engagement” in services

● **Necessary for success...**
  ○ Shared data to measure, implement, data/performance
  ○ Awareness of protocols
Agencies want to work together for the benefit of providing better client care.

Interagency prioritization is a priority and needs to be addressed.

The scope of an interagency process is clearly understood.

There is a sense of trust among agencies when designing new processes.

There are clear measurements for success around an interagency prioritization process.

Workshop 1 Team Barometer
A pulse check survey was taken at the start and end of the workshop to gauge initial understanding of the project and workshop impact. The team learned there are many considerations to building this process and was aligned that we can do it.
Workshop 2
Designing the Process
Interagency Prioritization: Future State Process

The team worked in small groups to draft a Street Outreach process to reflect where the interagency process *should be within 3 years* to align with the shared values and outcome measures generated in Workshop 1.
Ari lives outdoors and has experienced homelessness in San Francisco for many years. Over time Ari has cycled through the homeless and health systems of care.

Ari lives with HIV and has a traceable viral load, trouble recounting medical and personal history, a hard time following through with a plan or making it to appointments. Ari often refuses offers of services and has received denial of services due to verbal confrontations.

Providers experience frustration because current services or criteria do not meet Ari’s needs.

Attributes:
- Polysubstance use disorder and substance induced psychosis
- May have cognitive impairment
- Chronic medical illness
Designing the Future State Process

Each small group began by aligning on a Street Outreach process that reflected where the Interagency Prioritization process could be in 3 years.
Highlighting Areas for Pilot Opportunities

Small group discussions highlighted areas along the future state process map that could be used to identify future and actionable pilots (designed in 3 weeks and tested in 3 months).
Identifying the Information Flow

Further discussions highlighted what information was available (or needed) for the Street Outreach future state process map.
Pilot Opportunities

Once the small groups aligned on a future state process flow, each group worked to identify actionable pilots that could be designed within 3 weeks and tested within 3 months. The greater group decided on 3 pilots to present to stakeholders.
Brainstorming Potential Pilots
Each small group combined generated a list of 14 potential pilots for the Interagency prioritization process.
Pilot Opportunities
Each small group then selected the top three pilots to share. From this list the greater group selected three pilots to present to stakeholders.

- Tele consult (8 votes)
- Real-time shared data system (3 votes)
- Every client has a shared action plan (created with client) (5 votes)
- Collaborate with HSOC to pilot wraparound service using data (12 votes)
- ID point person to see client through next steps (3 votes)
- Protocol to check available data systems (6 votes)
Top 3 Pilot Opportunities

The greater group aligned on three actionable pilots to share with the greater stakeholder group and used the exercise to identify needed program involvement, resources, and success criteria for each pilot.

- **HSOC Prioritization Response**
  Utilize existing HSOC structure to collect, assess, and deploy shared resources for highest identified clients.

- **Tele-consults**
  Real time on demand consultation with client in front of you. The more answers right there, the better the outcome likely to be. Expand client “network”; Consult for authorization; Reconnect the client back to services.

- **Protocol to Check Data + Establish a Shared Data Set**
  One system integration POC; Improve information provided to clients/patients; Maximize the utilization of data we have; Target assessments by what’s needed; Use data instead of expensive assessment.
Team Barometer
Agencies are aligned in where the interagency prioritization process should be in the short and long term.

Actionable pilots to advance the future state process for interagency prioritization have been clearly identified.

The scope of an interagency prioritization process is clearly understood.

There is a sense of trust among agencies when designing new processes.

There are clear measurements for success around an interagency prioritization process.

Workshop 2 Team Barometer

The pulse survey taken before and after the workshop showed an increase in alignment, trust, and a greater understanding of scope and measurements for the Interagency Prioritization project.

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What’s Next

- Executive Leadership will be updated to provide feedback and align on next steps.
Thank you!