Whole Person Care
Interagency Shared Priority Project

Maria X Martinez
Director Whole Person Care
Barry Zevin, MD
Director Street Medicine and Shelter Health

December 3, 2019
Partnership

(Co-Lead) Department of Public Health (DPH) and Community Partners
(Co-Lead) Department of Homelessness and Supportive Housing (HSH) and Community Partners
Department of Human Services Agency (DHS)
UCSF Evaluation Team
Department of Disability and Aging Services (DDAS)
Fire Department Emergency Medical Services (SFFD EMS)
WHOLE PERSON CARE DELIVERABLES BY DECEMBER 2020

Interagency Prioritization Method

Interagency System Response

Interagency Data Sharing
An in-depth analysis of public health data identified **3,735** (1 in 5 of the 12-month total 17,638 unique individuals experiencing homelessness) who have a history of co-occurring psychoses and substance use disorders…

- **80%** used urgent/emergent care services in FY1819
  - 223 individuals used over 24 services

- **95%** have a history of alcohol use disorder
  - 65% utilized the ED but only 6% utilized the Sobering Center

- **35%** identify as Black/African American
  - Blacks outnumber Whites in this population

- **74%** have a serious medical condition
  - 12% HIV/AIDS
  - 65% CHF
  - 35% Hypertension
  - 4% Renal Failure

- **40%** are 50+ years of age
  - The average age of death for homeless adults is 51
  - 113 individuals are 18-24 years of age

- **22%** had involuntary psychiatric holds
  - 3% are currently conserved
  - 11% are currently assigned an intensive case manager

- **28%** had at least one county jail interaction in FY1819
  - The average number of incarcerations is 2.3

- **40%** have cycled in and out of homelessness for more than 13 years
  - 29 died in FY1819
2017 Discovery 400 individuals
2018 DPH / HSH Retreat
2019 Build a Vision & Design the process
WHOLE PERSON CARE DELIVERABLES

Interagency Prioritization Method

✅ ACCOMPLISHMENTS:
- HSH (Dept of Homelessness and Supportive Housing) completed over 6,000 Coordinated Entry assessments in FY1819 and prioritized 1,001
- DPH endorsed HSH’s Coordinated Entry prioritization methodology
- HSH endorsed DPH’s ranking methodology to prioritize those with co-occurring histories of psychoses diagnoses and substance use disorders

❌ WORKS IN PROGRESS:
- Individuals with histories of psychoses under-represented in Coordinated Entry pools:
  - assessed, but not prioritized
  - not yet assessed
Adults Experiencing Homelessness Served by DPH and/or HSH in FY1819 (as of 7/31/19)

Coordinated Entry Assessment?

NO 11,143

YES 6,510

Prioritized for Perm Supp Hsg?

NO 5,266

YES 1,001

Shared Priority Population

DPH Psych + SUD

2,387

1,025

237

3,735
Our Shared Principles

- Prioritization process is **fair, equitable, and transparent**
- **Pathway is clear** to necessary resources and services
- Response is trauma-informed, culturally-competent, and **adaptable** to the unique needs of individuals
- For clients and staff, process is **hopeful** and reinforces belief that positive change is possible
- Process is built and success is measured with a **racial equity lens**
- Success and accountability are **shared** across agencies
Shared Priority Approach

Interagency PROJECT TEAM
Purpose is to support teams and manage project deadlines

Interagency PROVIDER WORKGROUP
Purpose is to triage, improve pathways, identify barriers, and generate ideas

Interagency SYSTEM RESPONSE TEAM
Purpose is to unjam doors, address system barriers/gaps, assure shared principles are incorporated

Care Coordinator, CMs, Housing Navigators, High Intensity Care Team and System Providers
Team Members

Project Team
Anton Bland (MH Reform)
Diana Oliva-Aroche (DPH)
Dara Papo, Anthony Federico & Megan Owens (HSH)
Angelica Almeida (BHS)
Maria X Martinez (WPC)
Cindy Ward (HSA)
Caroline Cawley, (UCSF Eval)

Provider Team
Barry Zevin (Street Medicine)
Simon Pang (EMS 6 SFFD)
Mark Mazza & Kendra Leingang (HSH)
Shawn Taylor & Sherry Williams
(Care Coordinators, Street Medicine)
Robin Candler (BHS)
Holly Aversano (ESC)

System Response Team
Irene Sung & Angelica Almeida (BHS)
Anton Bland (MH Reform)
Barry Zevin (Street Medicine)
Claire Horton (ZSFG UCSF)
Dara Papo & Mecca Cannariato (HSH)
Hali Hammer (PC)
Jack Chase & Hemal Kanzaria (ZSFG Social Medicine)
Jill Nielsen (DDAS)
Luis Calderon (Transitions)
Mark Leary (UCSF BH)
Susie Smith (HSA)
Deb Borne (Transitions)
Lisa Pratt (Jail Health)
Clement Yeh (EMS)
Dedria Black (HSH)
Roles and Responsibilities

Project Team
Team attends problem-solving sessions to see where the pilot stands and ensure timelines and results are being met as described in the Pilot Charter.

They typically deal with issues the team cannot fix due to access hierarchy and scrutinize pilot processes that are not yet having the desired effect.

They are ultimately responsible for the Pilot project deliverables and may be required to conduct analyses and oversee implementation and evaluation.

Provider Team
Team reviews the Shared Priority List and categorizes the system response or next steps based upon the individual’s known/unknown status and history and in coordination with the individual’s care team.

They are ultimately responsible for triaging the 237 individuals and recommending and initiating a system response. This team will identify the most vulnerable, intractable, and difficult to appropriately serve with our current response system and refer systems issues to the System Response Team.

System Response Team
Team reviews the system barriers referred from the Provider Team. They are ultimately responsible for problem-solving for those who are the most vulnerable, intractable, and difficult to appropriately serve with our current response system, and to help prioritize their access to scarce resources.

Team also identifies barriers to our shared client’s stability and gaps in the health and homelessness response systems - including utilizing a racial equity lens and the shared principles - thereby generating recommendations for future resources and policy revisions.
Shared Priority Goal:

Health, Housing, and Human Services will adopt a “whatever it takes” approach to place our most vulnerable clients experiencing homelessness into housing or other safe settings.
Street-to-Home

1. 311 → HSOC → Street Outreach Team

2. Case Conference → Street-to-Home Plan

3. PES → Care Team Coordination

4. Hummingbird → Residential Treatment

5. Navigation Center → Home
What’s different?
We’re taking a population-focused, interagency approach that builds on evidence-based practices to

<table>
<thead>
<tr>
<th>IDENTIFY</th>
<th>ENGAGE</th>
<th>PRIORITIZE</th>
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</table>
| 1. Prioritize via Coordinated Entry Assessment | ● Activate Alerts  
   ● Appoint Single Care Coordinator | 1. Develop “Street-to-Home” plans |
| 2. Rank based upon DPH health conditions | As needed, appoint:  
   ● HSH Housing Navigator  
   ● Case Manager  
   ● “High Intensity Care Team” first responders | 2. Prioritize:  
   • Housing  
   • Treatment slots  
   • In-home support  
   • Benefits |
We’re taking a population-focused, interagency approach that builds on evidence-based practices to

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<tbody>
<tr>
<td><strong>Population Lens: Data to Identify</strong></td>
<td><strong>Care Coordination</strong></td>
<td><strong>Housing First</strong></td>
</tr>
<tr>
<td>Larimer ME, Malone DK, Garner MD, et al. Health care and public service use and costs before and after provision of housing for chronically homeless persons with severe alcohol problems. JAMA 2009;301:1349-1357</td>
<td><strong>Connecting with Hard-to-Reach Individuals</strong></td>
<td><strong>Housing, Benefits, and Health: Combination Approaches</strong></td>
</tr>
</tbody>
</table>
Alert!
This individual is a Shared Priority client and is high priority for housing, health, and human services. Contact High Intensity Care Team at 415-816-6739 / fireems6@sfgov.org to coordinate next steps/discharge planning.
Performance Measures - Shared Priority

Outcome Metrics

- Successful placement into housing or other safe setting
- Improved quality of life scores
  Adult Needs and Strengths Assessment (ANSA)
- Reduced avoidable use of Urgent/Emergent Services
- Increased engagement in behavioral health treatment services
- Increased enrollment in benefits
  ( Medi-Cal, SSI, CAAP, CalFresh)

Evaluation

- Did the pilot align with the shared principles?
- Did we improve staff experience of interagency collaboration?
- Was the pilot methodology effective?
- Are we clear on the resources that will be needed to sustain effort?
Living Situation

<table>
<thead>
<tr>
<th>Unknown</th>
<th>Not Sheltered</th>
<th>Temporarily Sheltered</th>
<th>Housed</th>
</tr>
</thead>
<tbody>
<tr>
<td>45</td>
<td>79</td>
<td>68</td>
<td>32</td>
</tr>
<tr>
<td>-3</td>
<td>-10</td>
<td>+10</td>
<td>+1</td>
</tr>
</tbody>
</table>

- No service utilized in 30 days
- Service utilized/contact in last 30 days
- Nav/Shelter/ Stabilization Room
- Treatment/ Respite
- HSH Permanent Supportive Housing
- Board & Care, RCF/E, Self Resolved

Engagement

<table>
<thead>
<tr>
<th>Outreach</th>
<th>Housing Navigator</th>
<th>Case Management</th>
<th>Assigned Housing Unit</th>
</tr>
</thead>
<tbody>
<tr>
<td>19</td>
<td>191</td>
<td>55</td>
<td>26</td>
</tr>
<tr>
<td>+0</td>
<td>+0</td>
<td>+3</td>
<td>+12</td>
</tr>
</tbody>
</table>

- High Intensity Care Team
- Assigned HSH Navigator
- Outpatient Case Management
- Intensive Case Management
- Awaiting PSH move-in

Housing Process

<table>
<thead>
<tr>
<th>Inpatient</th>
<th>Sobering Center</th>
<th>ED</th>
<th>PES</th>
<th>Jail</th>
</tr>
</thead>
<tbody>
<tr>
<td>6</td>
<td>3</td>
<td>14</td>
<td>19</td>
<td>5150</td>
</tr>
<tr>
<td>+5</td>
<td>+1</td>
<td>-5</td>
<td>-0</td>
<td>-0</td>
</tr>
</tbody>
</table>

- 1 stay starting Nov 6 - Nov 19
- 14 visits Nov 6 - Nov 19

Benefits

<table>
<thead>
<tr>
<th>CAAP</th>
<th>SSI</th>
<th>Medi-Cal</th>
<th>CalFresh</th>
</tr>
</thead>
<tbody>
<tr>
<td>84</td>
<td>25</td>
<td>47</td>
<td>150</td>
</tr>
<tr>
<td>-0</td>
<td>+6</td>
<td>-0</td>
<td>-0</td>
</tr>
</tbody>
</table>

- Enrolled
- Enrolled in SSI
- Advocacy
- Enrolled

Population
237 individuals
5 deceased
5 housed
1 lost housing
33 currently

Case Managed
42 start
84 currently

Urgent/Emergent Services

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<th>Sobering Center</th>
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</thead>
<tbody>
<tr>
<td>14</td>
<td>6</td>
<td>3</td>
</tr>
<tr>
<td>-5</td>
<td>+5</td>
<td>+1</td>
</tr>
</tbody>
</table>

- 25 visits Nov 6 - Nov 19
- 1 stay starting Nov 6 - Nov 19
- 14 visits Nov 6 - Nov 19

PES
19
-0

- Patients had 33 visits July 2019

Jail
0

- 5 stays starting Nov 6 - Nov 19

- July 2019

- +2

- +0

- -0

- July 2019

- +6

- +0

- -0

- In and out of county

- Enrolled

- July 2019

- +3

- +1

- +12

- Awaiting PSH move-in

- July 2019

- +0

- -0

- July 2019

- +2

- 5 stays starting Nov 6 - Nov 19

- +6

- +0

- -0

- In and out of county

- Enrolled

- +3

- +1

- +12

- Awaiting PSH move-in

- July 2019

- +2

- 5 stays starting Nov 6 - Nov 19

- +6

- +0

- -0

- In and out of county

- Enrolled

- +3

- +1

- +12

- Awaiting PSH move-in

- July 2019

- +2

- 5 stays starting Nov 6 - Nov 19

- +6

- +0

- -0

- In and out of county

- Enrolled

- +3

- +1

- +12

- Awaiting PSH move-in

- July 2019

- +2

- 5 stays starting Nov 6 - Nov 19

- +6

- +0

- -0

- In and out of county

- Enrolled

- +3

- +1

- +12
ZSFG services utilized between Jul 1 – Nov 22, 2019

72 clients had 274 ED visits
16 clients had 32 medical inpatient stays
8 clients had 12 psych inpatient stays
61 clients had 148 ZSFG clinic visits

*Since Epic Go Live we are having issues with PES data in CCMS.*
Questions?

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