SAN FRANCISCO WHOLE PERSON CARE

Stakeholder Update: Discovery Summary

SF WPC Evaluation and Service Design Teams
11/16/18

AGENDA

1. Introductions
2. Discovery Summary
3. Q&A
4. Next Meetings

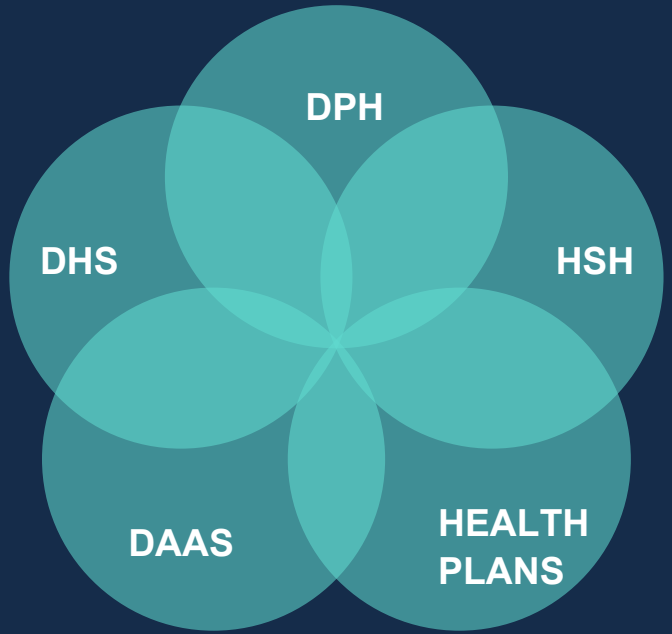
WHOLE PERSON CARE VISION AND APPROACH

Innovations in Services

- A structure (people and policies) to care for the highest risk and highest utilizing clients across the City's ecosystem of services

Innovations in Technology

- A platform to share comprehensive, integrated data that provides context for all our shared clients



Shared Governance

KEY QUESTIONS

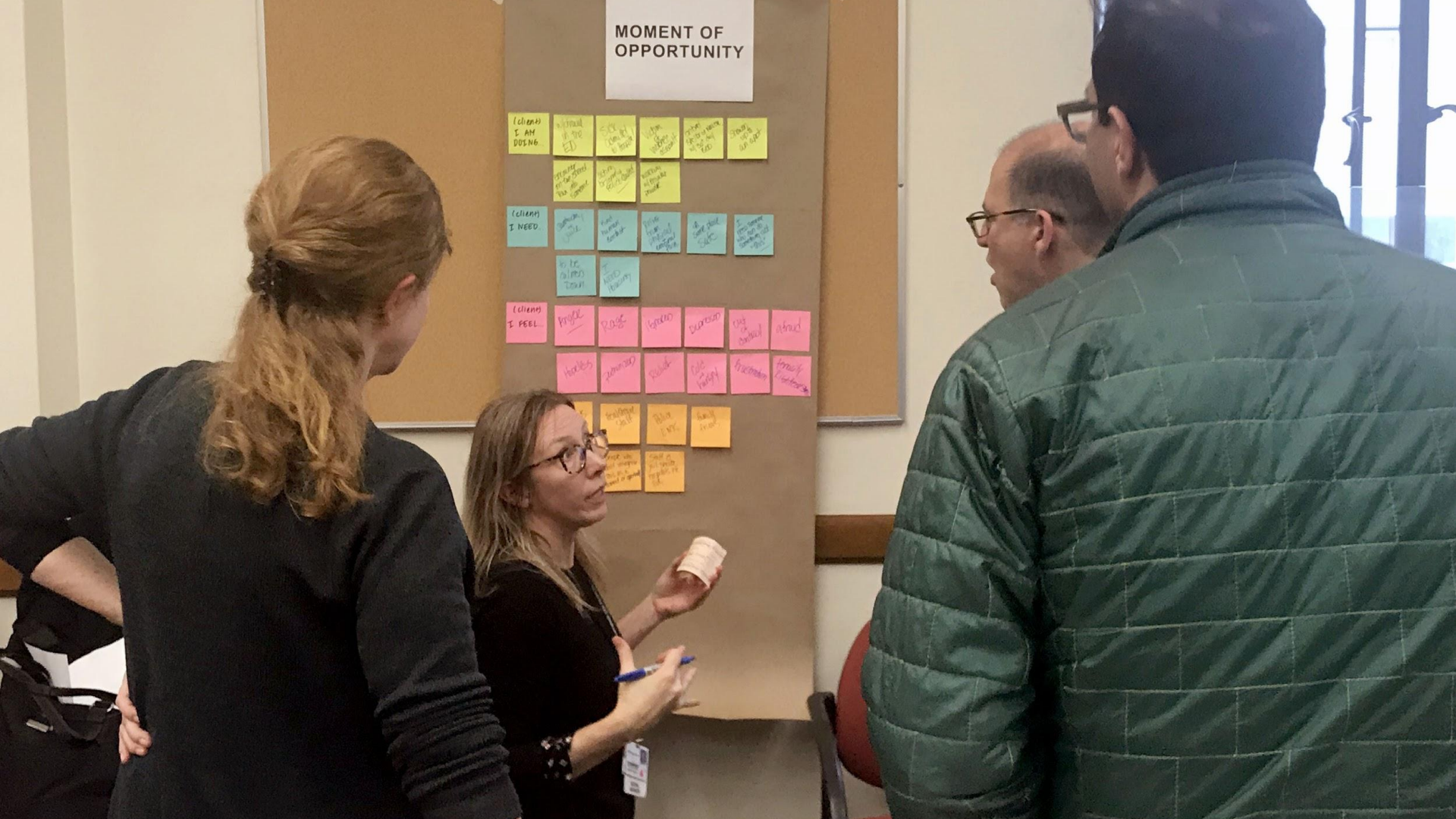
What will be our greatest opportunity for impact?

What will be the most challenging?

DISCOVERY METHODS

- **Workshops with providers**
- **Stakeholder interviews**
- **Quantitative analysis**

Journey Map Workshop


MOMENT OF
OPPORTUNITY

SCENARIO

John is a 50-year-old male who lives outdoors and has experienced homelessness in San Francisco for more than 13 years. 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.

Attributes:

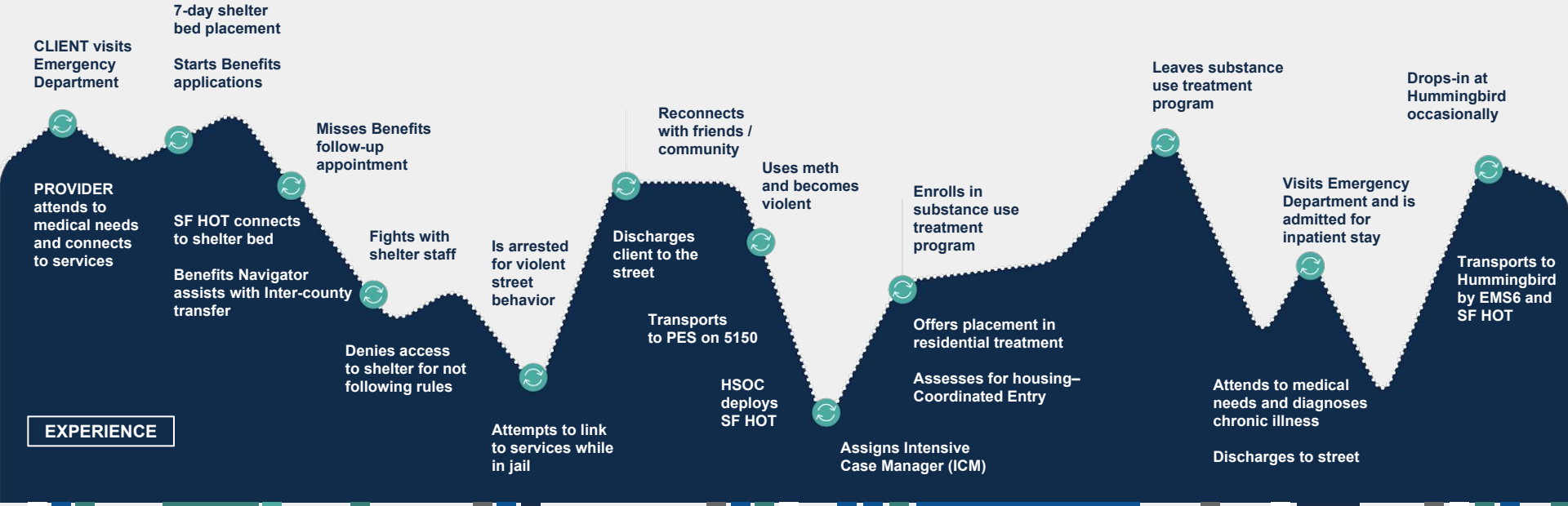
- **Polysubstance use disorder and substance-induced psychosis**
- **May have cognitive impairment**
- **Chronic illness**

Service Utilization highlights:

- **ED visits: 90**
- **PES visits: 10**
- **Sobering nights: 20**

WHOLE PERSON CARE JOURNEY MAP

TIME



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.

99%
Of the top 100 HUMS in 2017-18 visited the emergency room.

Avg: 89
Max: 341

51%
Have been homeless for more than ten years.

99 of the top 100 HUMS have a history of homelessness

5%
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.

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

$19,423,438
Total cost of urgent/emergent services for the top 100 HUMS in 2017-18.

Average cost per person: $194,234

Discovery Interviews

LEARNING GOALS

What does Whole Person Care mean to you and your organization?

What's currently working and not working when supporting the WPC population?

What are the biggest challenges with interagency care coordination and data sharing?

What is success for Whole Person Care?

Discovery Approach / Overview
STAKEHOLDER INTERVIEWS

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

DPH
Barbara Garcia
Roland Pickens
Alice Chen
Greg Wagner
Colleen Chawla
Bill Kim
Barry Zevin
Kavoos Ghane Bassiri
Kelly Hiramoto
Anna Robert
Joseph Pace
Janet Moomaw
Pam Swedlow
Kelly Eagen
Hemal Kanzaria
Ben Liu
Margot Kushel
Hali Hammer
Amy Peterson
Aldon Mendez
Craig Murdock
Deborah Borne
Iveht Pineda
Winona Mindolovich
Albert Yu
Rajiv Praminik
Jim Genevro

HSH
Jeff Kositsky
Kerry Abbott
Dara Papo
Edmund Poon
Umeke Cannariato
Lisa Rachowicz
Megan Owens
Gigi Whitley

HSA
Susie Smith
Dan Kelly
Christine Lou
Natalie Toledo
Sahil Rahim
Vladimir Rudakov

DAAS
Cindy Kauffman
Rose Johns
Jill Nielsen
Carrie Wong
Crystal Chang

Mayor's Office
Aneeka Chaudhry
Joy Bonaguro

Controller's Office
Laura Marshall

Anthem Blue Cross
Beau Hennemann
Eric Schwimmer

SF Health Plan
Courtney Gray
Fiona Donald
Sumi Sousa
Van Wong

Other Orgs
Rachel Metz
Tanida Maselli
Josh Bamberger
Vitka Eisen

System of Care

1. Need to operate in an integrated way

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.

2. Need for a more coordinated delivery system

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?

3. Need for shared priorities

We need to stop thinking about clients as yours or mine. We need to develop a shared client mentality.

4. Need to realign resources

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

5. Need for more step-down and step-up housing options

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

6. Need to improve access to benefits

We are placing eligibility workers in navigation centers – enrolling individuals in Medi-Cal and other services simultaneously.

Data Considerations

1. Data quality

We are missing even basic data from the street medicine team encounters.

2. 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.

3. Data accessibility

We need to have knowledge sharing across departments because sometimes clients are lost to follow-up when they transition between services.

4. Data integration

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.

5. Data use for improvement, evaluation

Existing data is not being used for improvement, evaluation, or accountability.

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.

CONCLUSION

1. Discovery Report includes System of Care, Data and Sustainability recommendations based on the insights gained from stakeholder interviews.
2. Whole Person Care deliverables map onto these recommendations, including the Top 100 HUMS project, Coordinated Entry and Benefits Navigation Pilot.
3. Recommendations will also be used in process evaluation of the SF WPC pilot.

What will be our greatest opportunity for impact?

What will be the most challenging?

Thank you!

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.

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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.

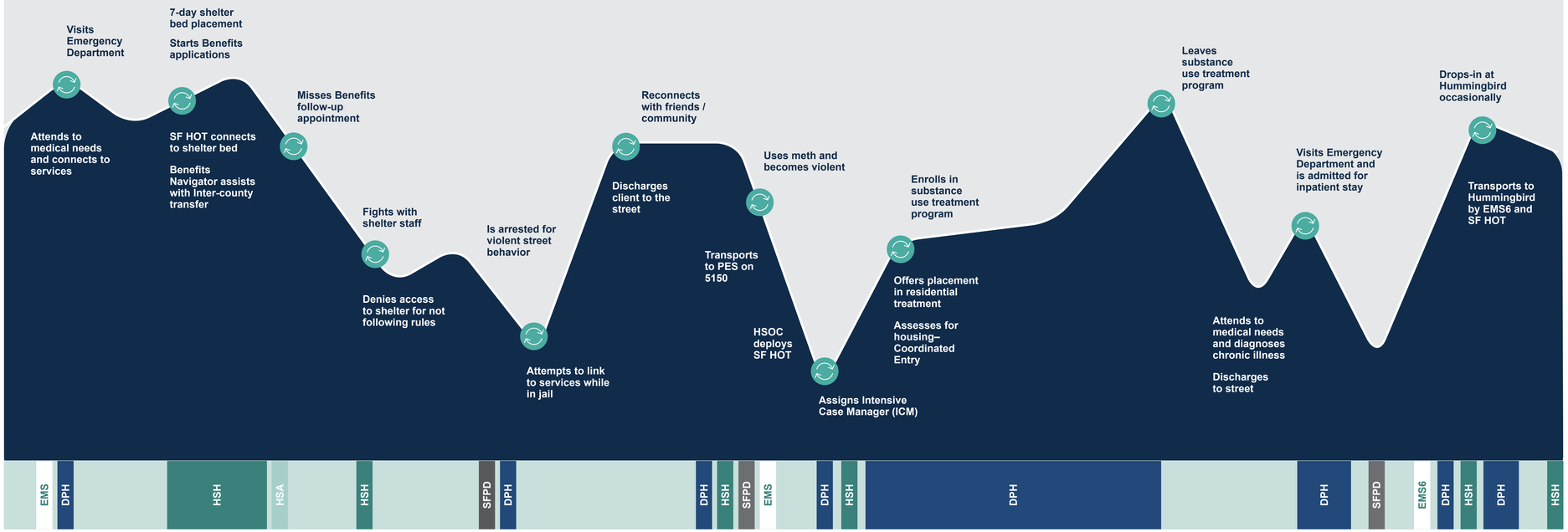
MOMENT OF OPPORTUNITY
“I need help.”

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.”



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