

SAN FRANCISCO WHOLE PERSON CARE

Stakeholder Update

October 19, 2018
WPC Stakeholders
101 Grove, Room 220 and WebEx



AGENDA

- 1. Introductions**
- 2. WPC Status Updates**
- 3. WPC Project Highlights**
- 4. Q&A**
- 5. Next Meetings**

WHOLE PERSON CARE PILOT

San Francisco seeks to improve outcomes for **adults experiencing homelessness** through care coordination around physical health, mental health, substance use and social services, as well as information sharing solutions aimed at coordinating communication and data sharing.

WPC is a Medi-Cal waiver program and an interagency effort to establish a comprehensive, seamless and **human-centered** system of care that improves health outcomes and supports the goal of making homelessness rare, brief, and one-time.

Target Population

Adults who are homeless, with a focus on the most vulnerable

Estimated WPC population on Medi-Cal to be served from 2017–2020: 17,000

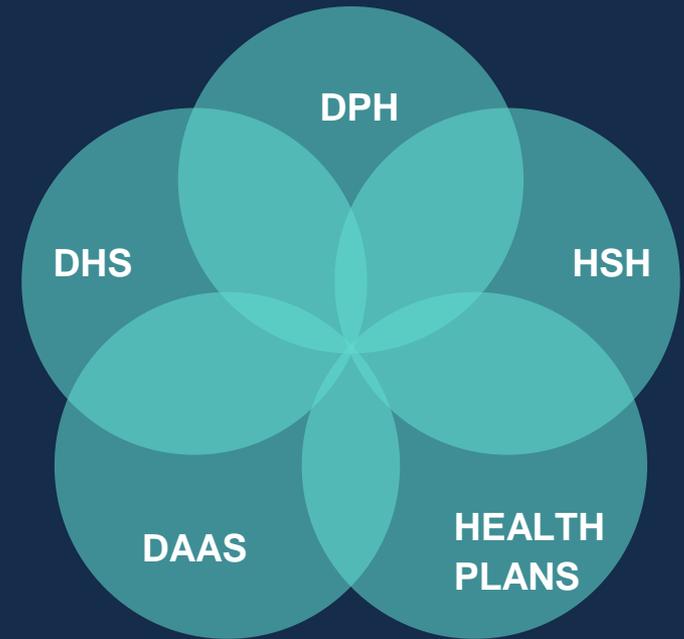
VISION AND APPROACH

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

**“Whole Person Care is about
the system doing the back flips
so the client doesn’t have to.”**

MARIA X MARTINEZ

Director of San Francisco Whole Person Care



WPC DISCOVERY HIGHLIGHTS

- Need for a more holistic, accountable, coordinated citywide delivery system for our shared clients.
- Integrated data plays an essential role in integrated care delivery.
- Integrated data is required to evaluate and improve.
- Sustainability of Whole Person Care requires alignment and support of city leaders.

Whole Person Care

CURRENT PROJECTS

INTERAGENCY CARE COORDINATION	INTERAGENCY DATA SHARING	SERVICES (Current & Future)	BENEFITS	GOVERNANCE
Risk Stratification	Case Management	Street Medicine & Shelter Health	Housing & Disability Advocacy Program	Data Governance
Universal Assessment	Data Sharing and Integration	HSH Navigation Centers	SSI Advocacy	Interagency Policies & Procedures
Client Action Plan	WPC Platform	HSH Encampment Resolution Team (ERT)	Benefits Enrollment	WPC Evaluation
Case Conferencing		HSH Access Points/ Resource Center		WPC Reporting
StreetCare app		HSH Housing Navigation and Stabilization Services		WPC Enrollment and Utilization
Top 100 HUMS		Interagency Health Resource Center		
Death Review				

Interagency Project Highlights

“We need to adapt and evolve our services to meet the clients where they are in order to address the systemic issue of homelessness. This Pilot allows us to target clients who go unnoticed, but are in high need of social services.”

TUQUAN

*Hot Benefits Navigator,
Next Door Shelter*



Need



Ask Veronique

Room 103

Monday, Wednesday, Thursday: 7am-5:30pm

Tuesday: 6am-4:30pm

Take One

Need Food stamps
Medical, General
Assistance?

Ask Veronique how
Room 103
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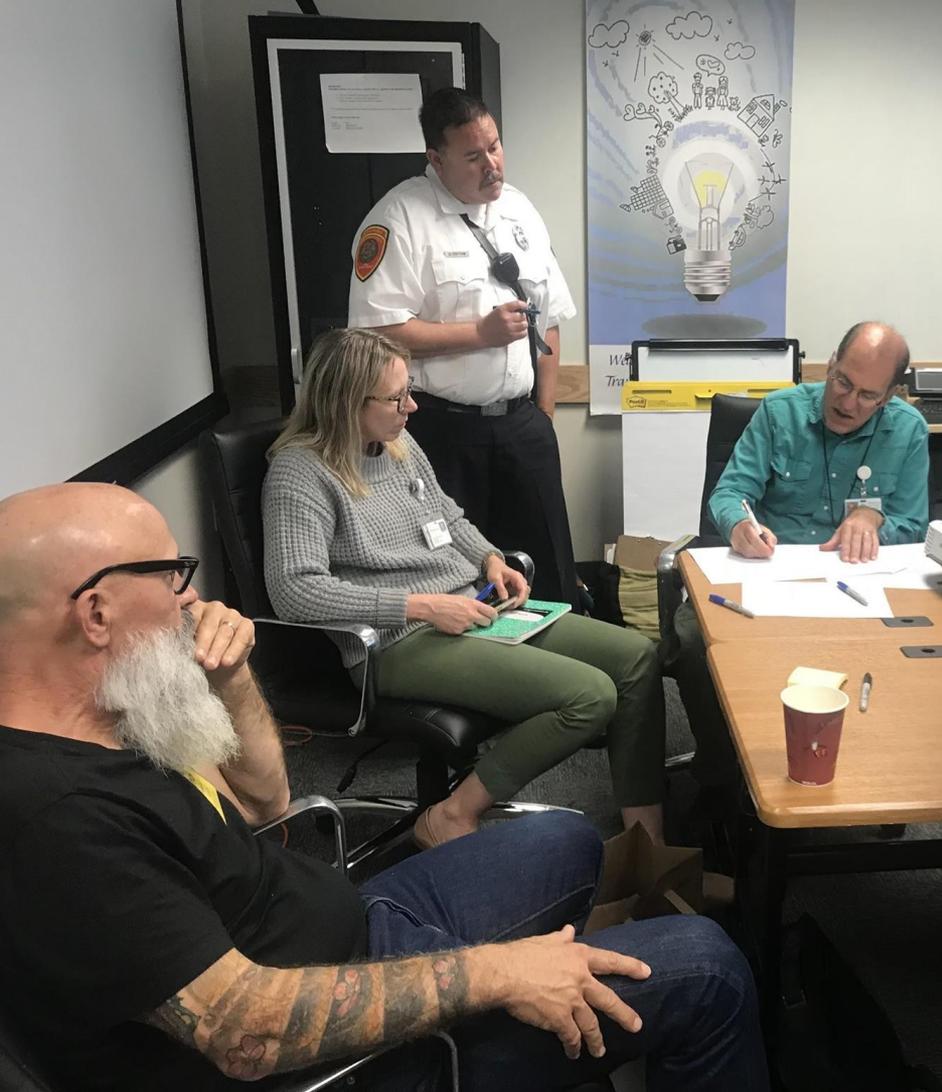
Benefits Navigator Pilot

34% of homeless shelter clients are not enrolled in Medi-Cal.

Goal: Station HOT navigators in 2 shelters to offer onsite benefits assistance for Medi-Cal, CAAP, and CalFresh—meeting clients where they are.

Next steps:

- Assess how pilot can inform benefits navigation in other settings.
- Explore potential for scaling.
- Use data to inform policy priorities.



Top 100 HUMS

On average, the top 100 HUMS use urgent/emergent services **130 times per year, costing over \$194,000 each.**

Goal: Evaluate service utilization and outcomes for the top 100 highest utilizers of multiple systems to develop system improvement recommendations.

Next steps:

- Present finalized care and system recommendations to leadership.
- Pilot actionable interventions.
- Design and validate WPC deliverables.



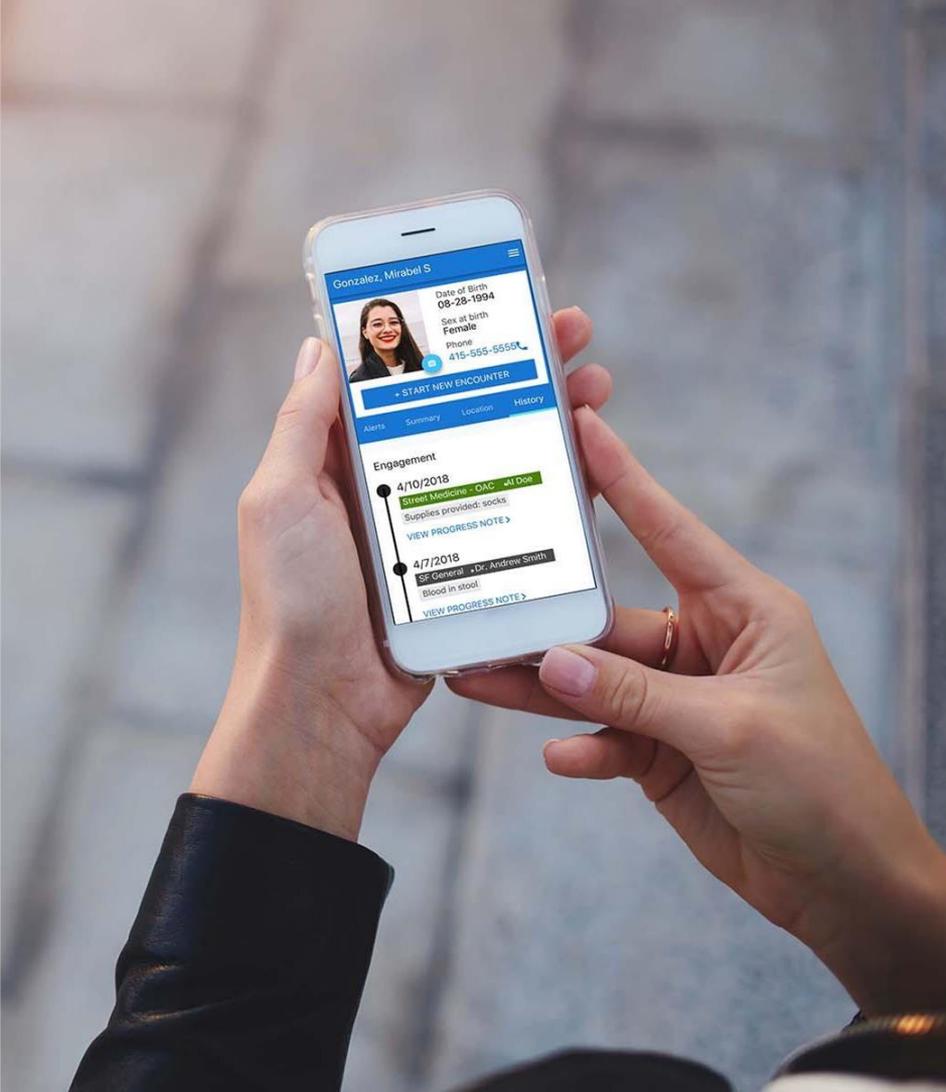
Coordinated Entry

Over **3,000** Adult Coordinated Entry Assessments completed during the initial blitz.

Goal: Match clients to priority housing resources based on length of time homeless and vulnerability.

Next steps:

- Continue ongoing assessments.
- Compare assessment data with HUMS, CCMS, HDAP sources
- Start matching priority status individuals to supportive housing beginning November 2018.



StreetCare App

160 (a growing number) outreach workers provide street-based services.

Goal: Enhance client engagement and care coordination for our shared clients through mobile device data sharing.

Next steps:

- Develop and pilot app through DPH marketplace tech store.
- Continue to prepare CCMS to enable integration with the StreetCare app.
- Expand to meet the needs of other outreach teams.

Questions?

Topics for future WPC stakeholder updates:

- WPC IT Platform
- Data Sharing
- Governance Structure
- Care Coordination
- Top 100 HUMS
- Coordinated Entry into Hsg
- Benefits Pilot
- Sustainability past 2020
- WPC Evaluation
- WPC Metrics
- Health Resource Center
- HSH Resource Center
- ...
- ...

Thank you!

SF Whole Person Care (WPC) Pilot

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Partners

**Department of Public Health
Homelessness and Supportive Housing**

Department of Human Services

Department of Aging and Adult Services

SF Health Plan

Community agencies

Whole Person Care funds

New and expanded health services:

- Expansion of our Street Outreach, Street Medicine and Shelter Health teams
- Expansion of our Encampment Resolution team
- Psych Respite (Hummingbird)
- Expansion of Medical Respite
- Expansion of residential treatment days
- Shelters, Navigation Center and Sobering Center
- Benefits Navigator Pilot in shelters
- Creation of a fully-integrated comprehensive Homeless Health Resource Center

Housing resources:

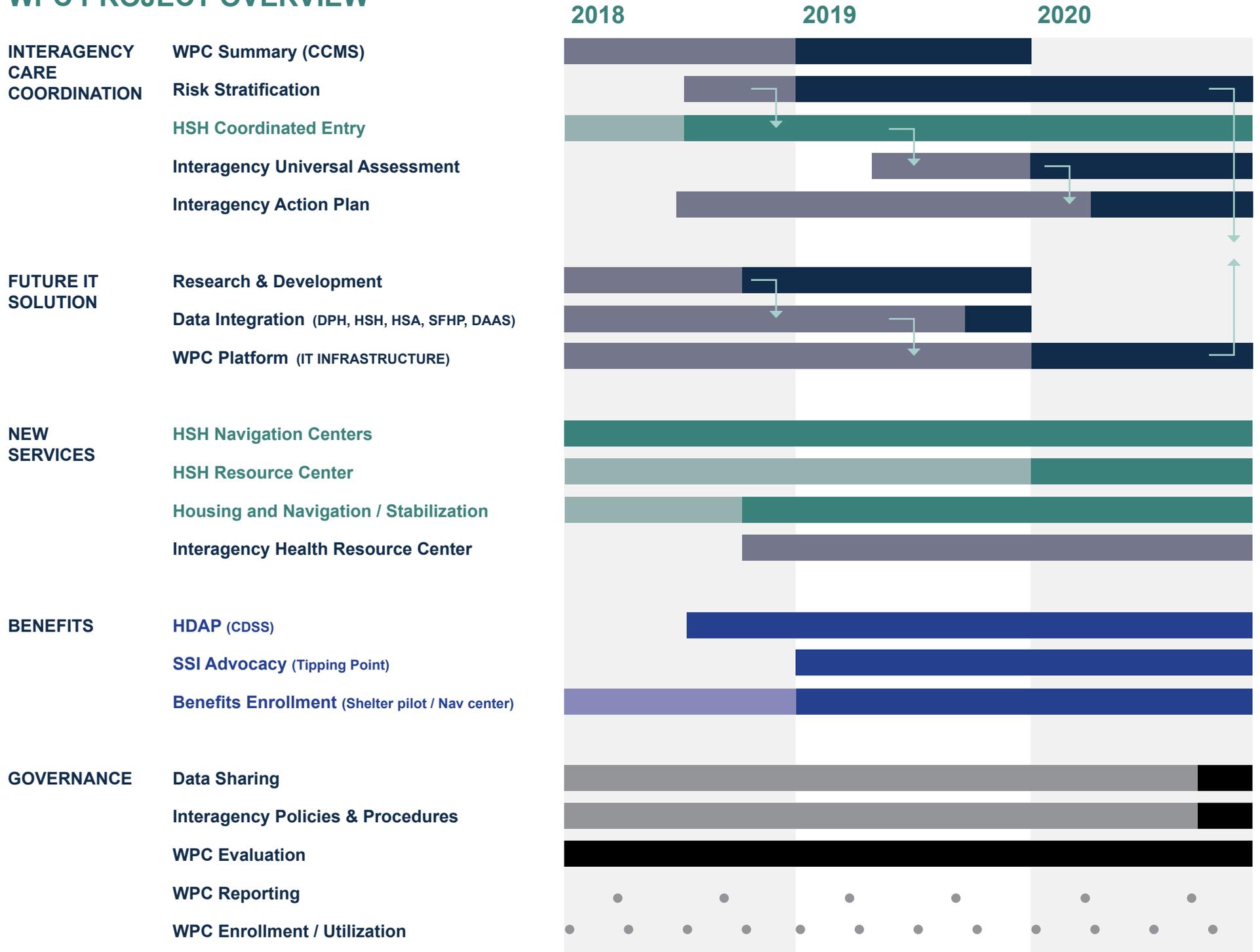
- HSH access centers
- Housing coordination and navigation services
- Housing stabilization services

Improved knowledge sharing:

- **Universal Assessment Tool** Standard citywide questions to help determine risk and rising risk
- **Shared Community-wide Care Plan** Solution to share key client information and care plan between providers
- **Alerts and Communication** between members of the care team
- **Panel and Caseload Management tools**

“ Whole Person Care is about the system doing the back flips so the client doesn’t have to.” — DIRECTOR OF SF WHOLE PERSON CARE

WPC PROJECT OVERVIEW



WPC PROJECT DESCRIPTIONS

Interagency Care Coordination

WPC Summary (CCMS) An accessible view of a client's integrated health, housing and benefits information relevant to care coordination and linkages to services.

Risk Stratification Building off of the HUMS methodology, start by analyzing the top 100, 1%, and 5% to better assess the needs of individuals and how to connect them to services.

HSH Coordinated Entry Coordinated entry is a process to connect people experiencing homelessness to the resources available in the community. A coordinated entry system assesses the needs of the people and prioritizes them for a range of types of assistance, including immediate shelter and longer-term housing-focused programs.

Interagency Universal Assessment

Leveraging HSH's primary assessment, iterate and ensure that the tool effectively identifies and prioritizes clients for health, housing, benefits, and other resources and services.

Interagency Action Plan To better understand the needs of providers and to inform the future Whole Person Care platform design, pilot an "action plan" and measure outcomes.

Future IT Solution

Data Integration Take a 3 pronged approach to data ingestion. 1) Ensure data quality and tracking for current data sources. 2) Identify new sources to be ingested in CCMS or cloud based databases. 3) Implement data sharing agreements necessary for data sharing.

WPC Platform Integrate learnings from WPC team, PDSA pilots, and Gartner discovery work into RFP(s) for a future solution. Ensure buy-in and alignment across agencies for the approach.

New Services

HSH Navigation Centers Centers provide unsheltered San Franciscans room and board while case managers work to connect them to income, public benefits, health services, shelter, and housing. Navigation Centers are different from traditional shelters in that they have few barriers to entry and intensive case management.

HSH Resource Centers Specific information pending.

Housing and Navigation / Stabilization

Housing Navigation services are focused on working with clients to: prepare a housing plan; become "document ready" to prepare a successful housing application through the acquisition of identification, income and homelessness verifications, and other required documents; access and complete housing applications and interviews; locate and obtain other supports and service linkages necessary to successfully fulfill the housing plan; and move into housing.

Interagency Health Resource Center

Iteratively design, pilot, and implement service design solutions that meet the needs of clients, staff, and the city while delivering wrap-around services to individuals experiencing homelessness.

Benefits

HDAP HDAP funding is being used to fund the Homeless Benefits Linkages Manager, a new position designed to integrate the advocacy for disability benefits across city departments and to provide up to 150 clients with access to HSA's robust SSI Advocacy Program, link them to supportive housing through a subsidy, provide case management and housing stabilization services, and plan for a successful transition from the program when SSI is awarded.

SSI Advocacy Tipping Point Community is partnering with HSA to expand SSI advocacy services for people experiencing homelessness. HSA, Tipping Point and CBO legal services providers worked together to identify the need, gaps in existing services, and potential

target populations that could be well served by the legal model of advocacy, in addition to the medical model of advocacy that HSA has successfully administered through the County Adult Assistance Program (CAAP) for many years.

Benefits Enrollment A partnership between three city departments, the SF HOT Benefits Outreach pilot outstations outreach staff at the city's largest shelters, Next Door and MSC South. Through streamlined business processes designed to lower barriers and expedite the application process for shelter guests, the pilot's goals are to increase access to medical care (through Medi-Cal enrollment), increase income (CAAP / SSI), and decrease food insecurity.

Governance

Data Sharing Work with data governance committees, city agencies, and the attorneys to identify, align on, and implement agreements and data sharing pipelines necessary for sharing data between organizations.

Interagency Policies & Procedures Form a team of Whole Person Care team members to iteratively document policies and procedures to define a citywide approach to care coordination and interagency data sharing

WPC Evaluation Work with UCSF's team of evaluators to prioritize projects that leverage their experience and expertise as researchers and providers to inform Whole Person Care deliverables and measure outcomes.

WPC Reporting Use CCMS and other accounting systems in place to report on accomplishments of the Whole Person Care program and fulfill state requirements for drawing down funds for services, metrics, and infrastructure improvements.

WPC Enrollment / Utilization Monitor and measure WPC enrollees and services utilized.