Whole Person Care
Interagency Shared Priority Launch

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SFHN Whole Person Integrated Care

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Health Commission – October 15, 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

Department of Aging and Adult Services (DAAS)

Fire Department Emergency Medical Services (SFFD EMS)

WHOLE PERSON CARE DELIVERABLES BY DECEMBER 2020

Interagency Prioritization Method

Interagency System Response

- Interagency “Shared Priority” Launch
- SFHN Whole Person Integrated Care

Interagency Data Sharing

Interagency Shared Priority Launch

An in-depth analysis of public health data identified about **4,000 (1 in 5) 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

Interagency Prioritization Method

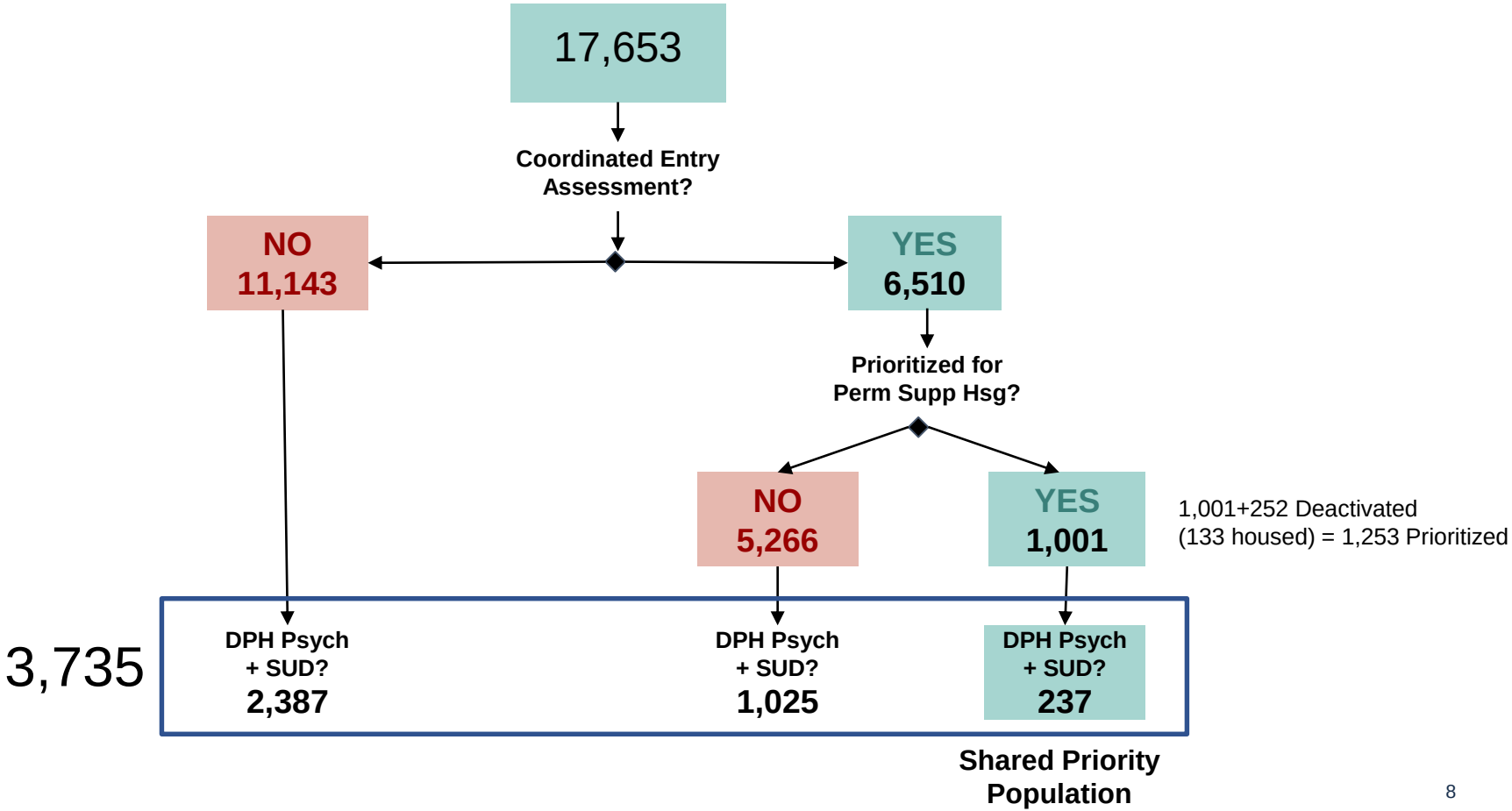
✓ ACCOMPLISHMENTS:

- 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)



Interagency System Response

✓ **ACCOMPLISHMENTS:**

- Interagency Summit prioritized next steps in August 2018.
- Conducted planning workshops in Spring of 2019 to implement “Shared Priority” population.
- Implemented Provider Workgroup and System Response Team in September 2019.
- Designed and implemented “High Intensity Care Team” with SFFD EMS, DPH, and HSH.
- Shared Priority launched

WORKS IN PROGRESS:

- Launch of Shared Priority” system response (evaluation due Feb 2020)
- Planning and development of Homeless Health Resource Center (move in Fall 2021)

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

Purpose is to support teams and manage project deadlines

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

Purpose is to unjam doors, address system barreirs/gaps, assure shared principles are incorporated

Proposed Pilot Participants (handout only)

Project Team

Anton Bland (MH Reform)

Diana Oliva-Aroche (DPH)

Dara Papo/Anthony Federico (HSH)

Robin Candler (BHS)

Maria X Martinez (WPC)

Caroline Cawley, WPC Evaluation Team (UCSF)

Provider Workgroup

Barry Zevin (Street Medicine)

Simon Pang EMS6 (SFFD)

Mark Mazza/Kendra Leingang (HSH)

Sean Taylor / Sherry Williams (Care Coordinator)

Robin Candler (BHS)

Tanya Mehra (Jail Health)

Cindy Ward (HSA)

Holly Aversano (ESC)

System Response Team

Irene Sung, (BHS)

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 (DAAS)

Luis Calderon (Transitions)

Mark Leary (UCSF BH)

Susie Smith (HSA)

Roles and Responsibilities (handout only)

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 typical 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.

Provider Workgroup

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 Workgroup. 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

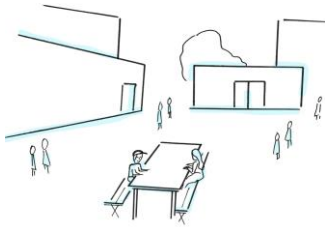
Case Conference → Street-to-Home Plan

3

PES → Care Team Coordination

4

Hummingbird → Residential Treatment



5

Navigation Center → Home

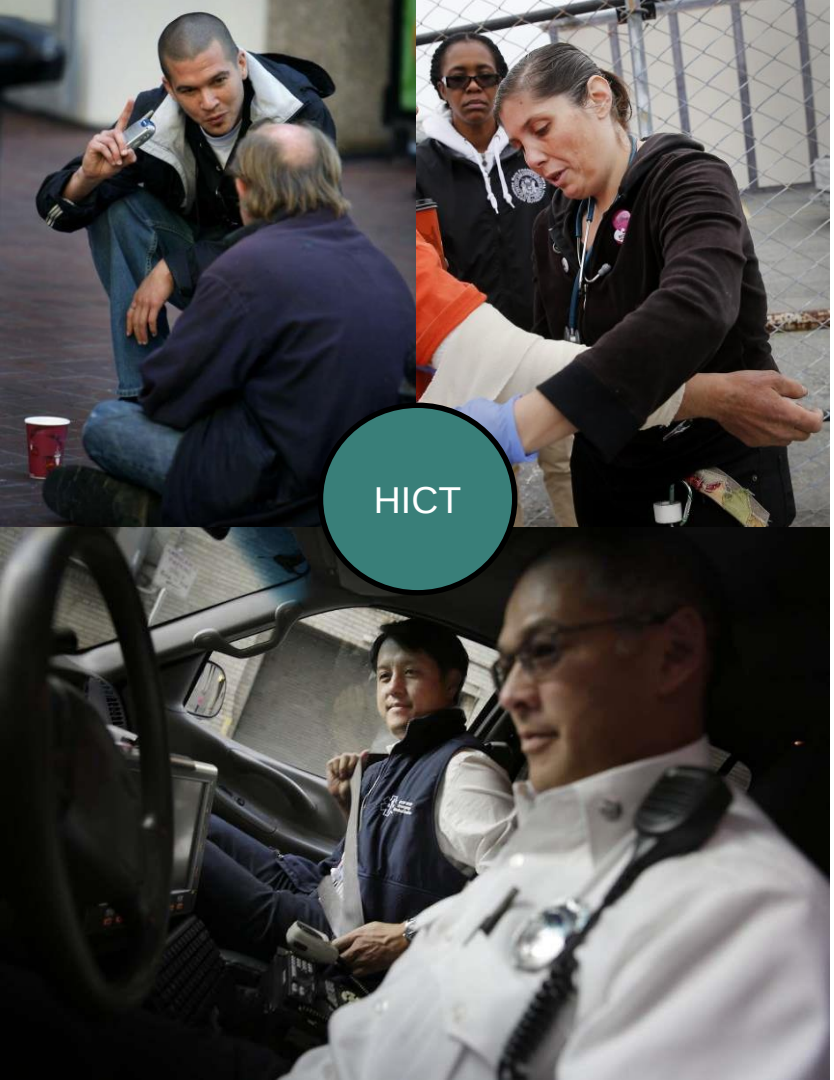
What's different?

We're taking a population-focused, interagency approach that builds on evidence-based practices to

IDENTIFY	ENGAGE	PRIORITIZE
1. Prioritize via Coordinated Entry Assessment 2. Rank based upon DPH health conditions	• Activate Alerts • Appoint Single Care Coordinator As needed, appoint: • HSH Housing Navigator • Case Manager • "High Intensity Care Team" first responders	1. Develop "Street-to-Home" plans 2. Prioritize: • Housing • Treatment slots • In-home support • Benefits

We're taking a population-focused, interagency approach that builds on evidence-based practices to

IDENTIFY	ENGAGE	PRIORITIZE
Population Lens: Data to Identify Target Population 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 **Evaluating Interventions** Kertesz SG, Baggett TP, O'Connell JJ, Buck DS, Kushel MB. Permanent Supportive Housing for Homeless People — Reframing the Debate. New England Journal of Medicine. 2016; 375:2115-2117. (handout only)	**Care Coordination** Raven MC, Kushel M, Ko MJ, Penko J, Bindman AB. The effectiveness of emergency department visit reduction programs: a systematic review. Annals Emergency Medicine. 2016;68(4):467-83. **Connecting with Hard-to-Reach Individuals** Borne D, Tryon J, Rajabiun S, Fox J, de Groot A, Gunhouse-Vigil A. Mobile Multidisciplinary HIV Medical Care for Hard-to-Reach Individuals Experiencing Homelessness in San Francisco. AJPH 108(S7);S528-S530. **Assertive Community Treatment (ACT) model** Marshall M, Lockwood A. Assertive community treatment for people with severe mental disorders. Cochrane Database of Systematic Reviews 1998, Issue 2.	**Housing First** Tsemberis S, Eisenberg RF. Pathways to Housing: Supported Housing for Street-Dwelling Homeless Individuals With Psychiatric Disabilities. Psychiatric Services. 2000;51(4);487-493. **Housing, Benefits, and Health: Combination Approaches** Burt MR, Wilkins C, Mauch D. Medicaid and permanent supportive housing for chronically homeless individuals: literature synthesis and environmental scan. Washington, DC: Office of Disability, Aging and Long-Term Care Policy, Office of the Assistant Secretary for Planning and Evaluation, Department of Health and Human Services, 2011



First Response
High Intensity Care Team
(EMS6, Street Medicine & SFHOT)

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?

Whole Person Integrated Care

SAN FRANCISCO HEALTH NETWORK

Why Whole Person *Integrated* Care?

- Historically, different place-based clinical services were developed to fill perceived gaps without an overall population-based strategy
- Disparate and mostly siloed programs serving the same population
- Documentation on different systems, preventing accurate data collection and coordination of care
- Variation in clinical models and approaches to care for a complex and vulnerable population

Whole Person Care provides the programmatic foundation (start-up budget, service designer, data and analytics) needed to ground our work to integrate clinical services

Whole Person Integrated Care

Integrating Transitions clinical teams and Tom Waddell Integrated Medical Services

Location:

NOW: 50 Ivy

2021: 1064 Mission

PLUS offsites, shelters, and street

Integrated Behavioral Health:

- Consolidated program staff: Psychiatrists, Psych. NPs, BH Clinicians
- Psychiatric NP and Psychiatrist liaisons to specialty BH Services
- Psychiatry consultation for Urgent Care, Respite, Sobering, and Street Med

Primary Care Programs:

- TW Urgent Care
- TW episodic care sites
- Medical Respite and Sobering Center
- DAH Nursing
- TW Dental: homeless and HIV/Ryan White services

Transitions clinical programs::

- Street Medicine
- Shelter Health

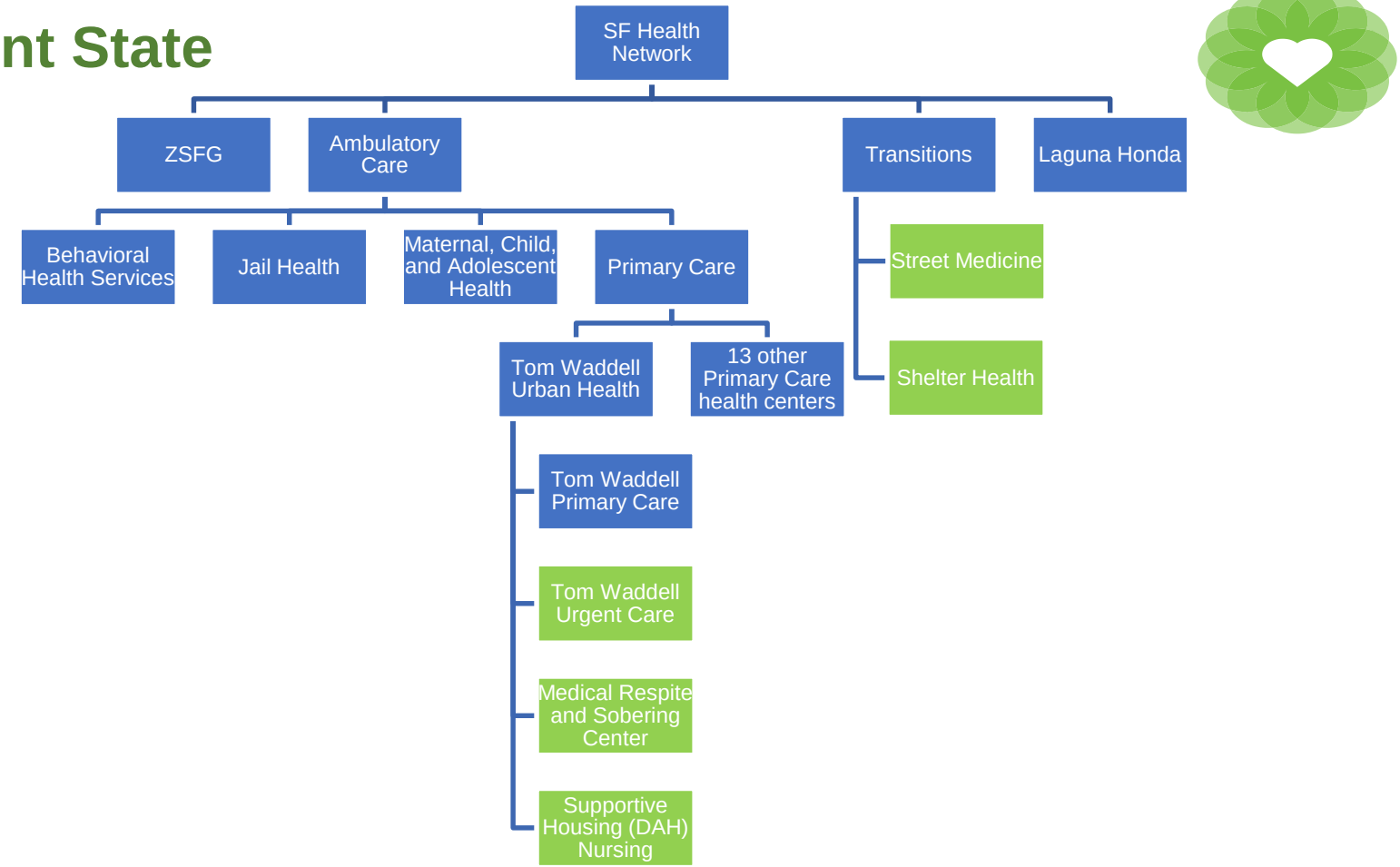
Clinical supervision and operational oversight:

- Primary Care (operational and clinical), WPIC, and Ambulatory Care (programmatic)
- Billing, EHR, budget, privileging and credentialing, clinical protocols, supply ordering => PC discipline directors (ie CMO, Director of Nursing, COO, PC Patient Access Unit)

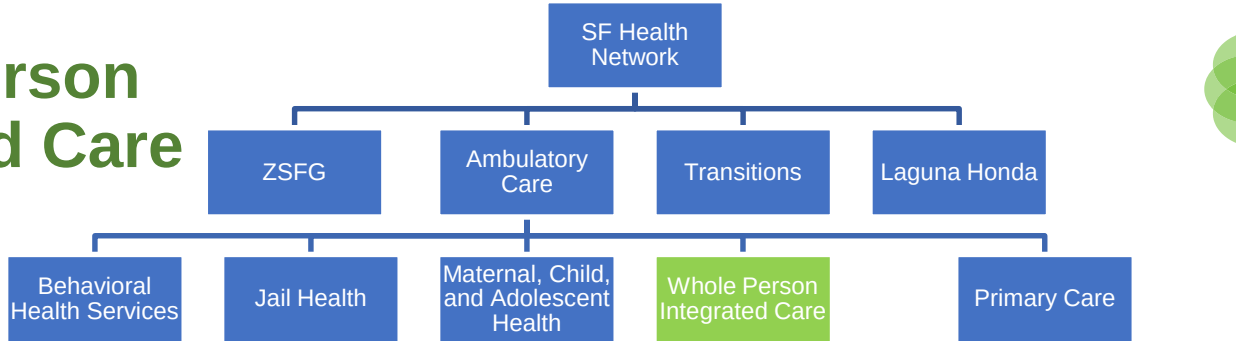
Programmatic foundation:

- Whole Person Care coordinated approach to highest user/highest risk subset of clients served (using Shared Priority list)
- Transitional Primary Care
- Specialty mental health and SUD treatment within a transitional Primary Care model

Current State

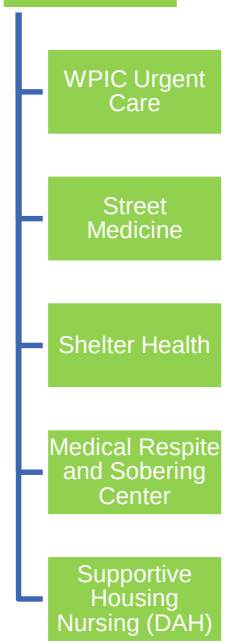


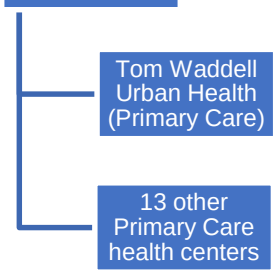
Whole Person Integrated Care



Whole Person Integrated Care

- Target patient population: people experiencing homelessness
- Coordinated care
- Specialized staff working across practice settings
- Integrated, human-centered approach to care
- Open access to health services, housing and benefits assistance
- Outreach and engagement
- All documentation in Epic





Whole Person Integrated Care (WPIC): Timeline

- **Early 2018**: beginning of collaboration with Mayor's Office of Housing and Community Development (MOHCD), Homelessness and Supportive Housing (HSH), Mercy Housing, Episcopal Community Services on vision for a Whole Person Care clinical hub in conjunction with new housing for formerly homeless adults
- **Spring, 2018**: user group (staff) meetings re: design of new clinical space (1064 Mission)
- **August, 2019**: announcement of WPIC integration and reorganization of clinical services for people experiencing homelessness by Director Colfax
- **August, 2019**: meetings of managers of different programs re: clinical oversight of new discipline groups
- **September, 2019**: announcement and beginning of coordination of care work on Shared Priority population
- **October, 2019**: planned meetings with impacted program staff re: plan for integration of services and supervisory changes
- **November, 2019**: Street Medicine and Shelter Health Medical Director Barry Zevin will assume medical oversight of Tom Waddell Urgent Care
- **January, 2020**: projected hiring of Director of WPIC
- **Fall, 2021:** projected opening of new Homeless Health Resource Center

Questions?

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