Whole Person Care
Interagency Shared Priority Launch
Maria X Martinez
Director Whole Person Care

SFHN Whole Person Integrated Care
Hali Hammer, MD
Director Ambulatory Care, SFHN

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)

Department of Aging and Adult Services (DAAS)

UCSF

Fire Department Emergency Medical Services (SFFD EMS)
WHOLE PERSON CARE DELIVERABLES BY DECEMBER 2020

Interagency Prioritization Method

Interagency System Response

Interagency Data Sharing

Interagency “Shared Priority” Launch

SFHN Whole Person Integrated Care
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)

Coordinated Entry Assessment?

17,653

NO 11,143

YES 6,510

Prioritized for Perm Supp Hsg?

NO 5,266

YES 1,001

DPH Psych + SUD? 2,387

DPH Psych + SUD? 1,025

DPH Psych + SUD? 237

3,735

1,001+252 Deactivated (133 housed) = 1,253 Prioritized

Shared Priority Population
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

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
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

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<th>IDENTIFY</th>
<th>ENGAGE</th>
<th>PRIORITIZE</th>
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<tr>
<td>1. Prioritize via Coordinated Entry Assessment</td>
<td>• Activate Alerts</td>
<td>1. Develop “Street-to-Home” plans</td>
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<td>2. Rank based upon DPH health conditions</td>
<td>• Appoint Single Care Coordinator</td>
<td>2. Prioritize:</td>
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<td>As needed, appoint:</td>
<td>• Housing</td>
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<td></td>
<td>• HSH Housing Navigator</td>
<td>• Treatment slots</td>
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<td>• Case Manager</td>
<td>• In-home support</td>
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<td>• “High Intensity Care Team” first responders</td>
<td>• Benefits</td>
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<td>(handout only)</td>
<td><strong>Assertive Community Treatment (ACT) model</strong>&lt;br&gt;Marshall M, Lockwood A. Assertive community treatment for people with severe mental disorders. Cochrane Database of Systematic Reviews 1998, Issue 2.</td>
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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

Transitions clinical programs:
- Street Medicine
- Shelter Health

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

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

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

Location:
NOW: 50 Ivy
2021: 1064 Mission
PLUS offsites, shelters, and street
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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