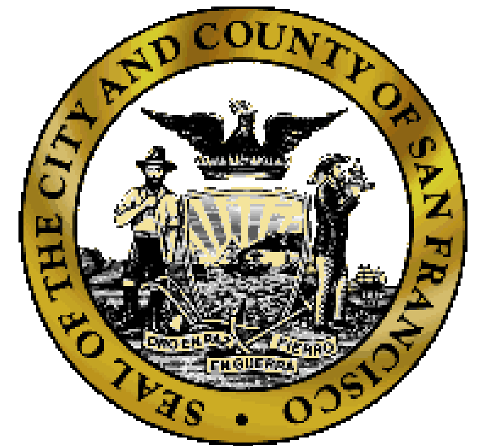
San Francisco Whole Person Care

California Medi-Cal 2020 Waiver Initiative



Update April 3, 2018

Health Commission

Maria X Martinez, Director Whole Person Care

Barry Zevin, MD, Medical Director Street Medicine & Shelter Health

- San Francisco’s WPC
- Getting and Keeping Homeless People on Medi-Cal
- Approach to IT Solution
- Target Population
- Approach to System of Care Transformation

WHOLE PERSON CARE AWARD – SAN FRANCISCO

FUNDING

$18M New

$18M Match

Thru Dec 2020

TWO-PRONGED INNOVATION APPROACH

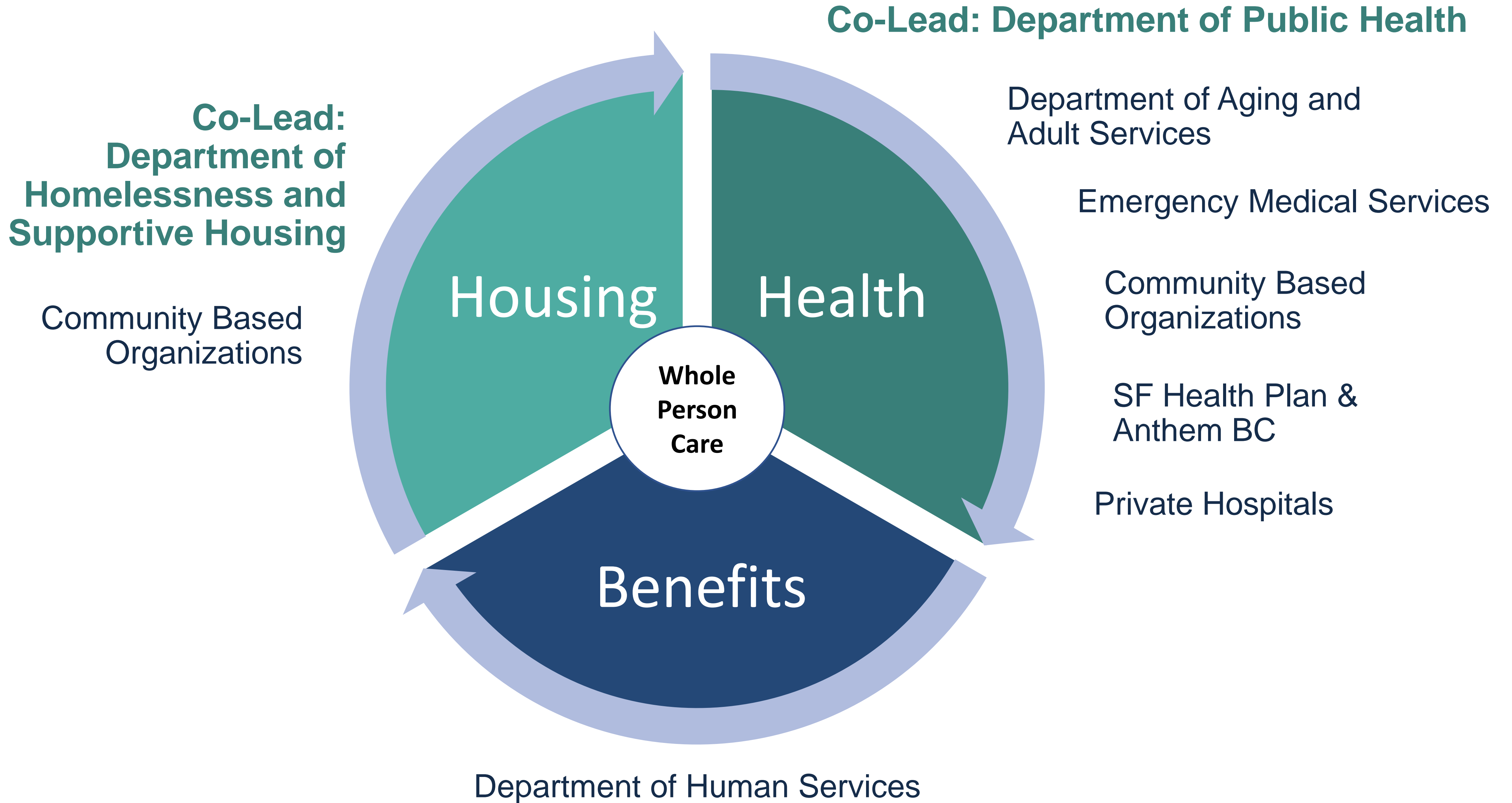
Services / Care Coordination

& Tech Solutions

TARGET POPULATION

Homeless Single Adults

WHOLE PERSON CARE A MULTI-AGENCY EFFORT

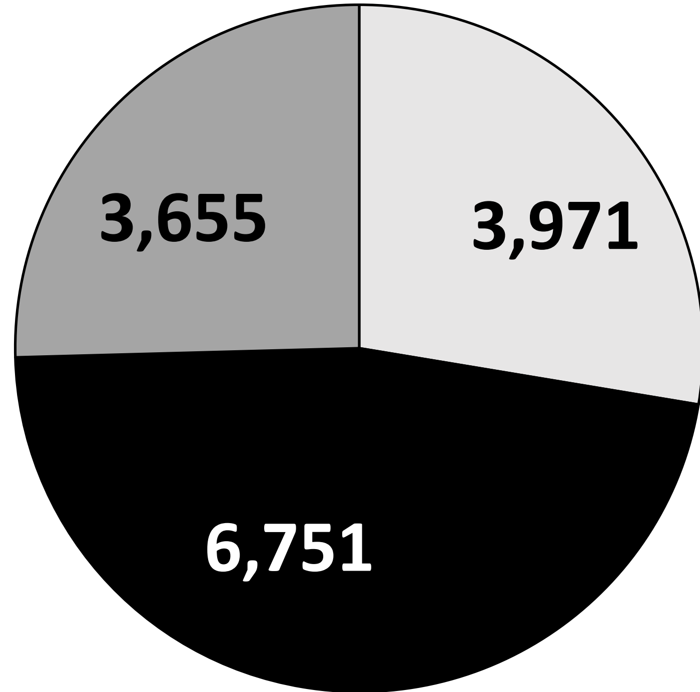


WPC
Performance Goals / Metrics

HEALTH OUTCOMES	HOUSING OUTCOMES
1. Reduce Emergency Department Utilization 2. Reduce Inpatient Hospital Utilization 3. Increase follow-up after hospitalization for Mental Illness 4. Increase initiation and engagement in Substance Use Disorder treatment 5. Increase care plan accessible by team w/in 30 days of enrollment and annually 6. Increase TB clearance 7. Decrease 30 day Readmissions 8. Decrease Jail Recidivism 9. Increase Suicide Risk Assessment	1. Reduce/resolve Encampment days 2. Reduce time from encampment response (first encounter/touch) to placement 3. Increase referrals and engagement for housing services 4. Increase assessments for coordinated entry into permanent housing 5. Increase transition of high-need individuals from a permanent housing referral into placement 6. Increase reaching 6-month milestone in their permanent housing placements

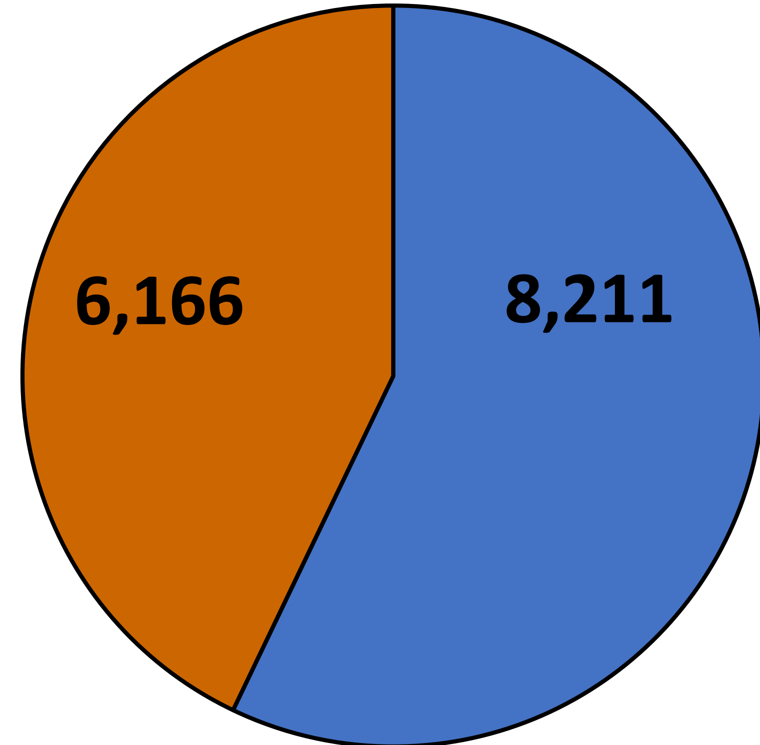
REPORT ON PROGRESS
1. Increase care coordination, case management, and referral infrastructure 2. Increase data sharing 3. Develop Universal Assessment Tool

2017 - Homeless Served - 14,377

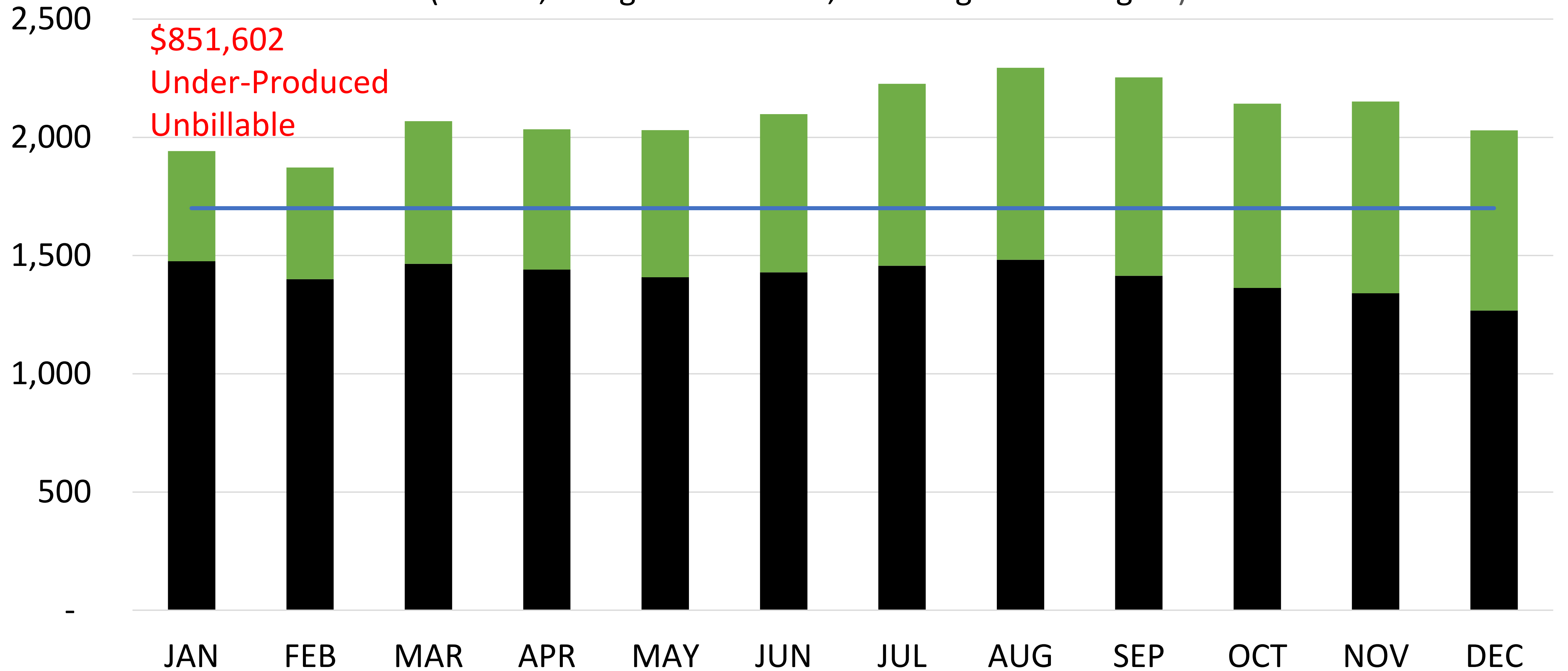


Observed Homeless - Source: HSH/StrtMedShelter Health (ytd 28%)
Self-Reported Homeless - Source: All Oth DPH Programs (ytd 47%)
Source is both Observed & Self-Reported (ytd 25%)

By SF Medi-Cal Status



Total with SF-Medi-Cal (WPC Enrollees) (57%)
Total without SF-Medi-Cal (not WPC Enrollees) (43%)


2017 Outreach and Engagement Services
(Shelter, Navigation Centers, Sobering Center Nights)
2,500
2,000
1,500
1,000
500
-
$851,602
Under-Produced
Unbillable
JAN
FEB
MAR
APR
MAY
JUN
JUL
AUG
SEP
OCT
NOV
DEC
WPC Enrollees (Homeless with SF M/C)
Homeless* No M/C or Incomplete Data
2017 Target
* Homeless in CCMS FY1516 or FY1617

Getting and Keeping People Experiencing Homelessness on Medi-Cal

FJORD SERVICE DESIGN – IMPROVING MEDI-CAL OBTAINING AND RETENTION

Finding:

- Complex process
- ID lost/stolen
- Depends on checking mail
- No incentive
- Myths/confusion

Implement Benefits Navigators Pilot

Finding:

Auto-renew process requires individual file annual taxes

Advocate for Legislative Changes

Finding:

- Temporary Medi-Cal in hospital is limited and does not auto-convert
- Inconsistent procedures within BHS

Streamline Hospital and Behavioral Health Process

Finding:

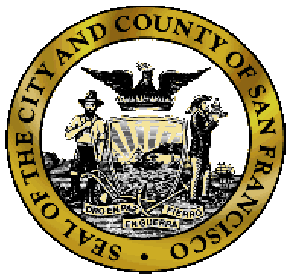
Myths and confusion abound with providers

Develop Communication Strategy (Field Guide)

Benefits Navigator Pilot

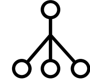
- Goal to increase Medi-Cal, General Assistance (CAAP) and Food Stamp benefits access and enrollment
- Training HOT CMs in on-line benefits application process and stationing @ Next Door and MSC South shelters
- Using targeted data to reach 90-day shelter guests not on benefits
- Testing new business processes in Human Service Agency (where interviews are required to complete enrollment)
- Utilizing Data collection + CQI to tweak service design

San Francisco's Approach to IT Solution

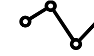


WHOLE PERSON CARE
DATA SHARING
EVOLUTION

PANEL MANAGEMENT

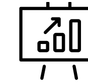


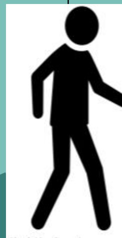
POPULATION HEALTH



POINT OF SERVICE

INVOICING





WPC Solution

FRONT END APPS

BACK END DATA

DPH (EPIC)

HOMELESS & SUPPORTIVE HOUSING DEPT (ONE)

DEPT OF AGING & ADULT SERVICES (SFGETCARE)

DEPT OF HUMAN SERVICES (CALWIN)

HEALTH PLANS (PRE-MANAGE)

CALIFORNIA (DEATH REGISTRY & MEDS)

WPC Deliverables

Quotes from the Future

WPC Deliverables	Quotes from the Future
Data Sharing	*As a client, my case manager and doctors know me. I don't have to tell my story or fill out forms again and again.*
Risk Assessment Tool	*As a provider, I understand how the system prioritizes clients into housing and into care. It's fair and flexible.*
Shared Care Plans	*As a provider, I now know all aspects of my client's life that are impacting their situation. I have knowledge to tailor my support and am confident others will see my work.*
Communiques & Alerts	*As a client, if I go into the hospital, my care team is notified and they reach out to help.*
System of Care	*As a client, I feel taken care of. I don't have to go to so many places to get the services I need. San Francisco has a system that meets me where I am.*

San Francisco's Target Population and Approach to System of Care Transformation

WHOLE PERSON CARE TARGET POPULATION

San Francisco's integrated data system tracks homeless individuals over time

Total Homeless Adults Served by DPH Annually

11,107

Total Homeless Adults Served by HSH Annually

~15,000

Risk Stratification Methodology:

High users of urgent / emergent health services

In top 5% of urgent / emergent services in medical, psych, and substance abuse systems

Experiencing long-term homelessness

Has over 10 years of continuous or periodic homelessness

Additional Vulnerabilities

Lessons from Homeless Death Review, Homeless Pregnancy, Public Injectors / Opiate Users

WHOLE PERSON CARE TARGET POPULATION

Characteristics of HUMS

- Engages in Multiple Systems (medical, mental health, substance abuse) = fractured care
- Relies on urgent / emergent services – ED, PES, inpatient, urgent care, mobile crisis, ambulance
- Is less visible because not usually highest user of a single system
- Suffers from multiple disorders (serious medical, psych, addiction)
- Bares a higher burden of chronic diseases and premature death rates
- Is often homeless and difficult to engage

Information is siloed and difficult to share. Sharing is based on personal relationships.

Insufficient Coordination

Insufficient coordination of high-risk individuals results in gaps in care or duplication.

Service and System Limitations

Existence of system gaps and/or insufficient capacity.

Provider Excellence

Dedicated, compassionate, and caring staff go the extra mile to get work done.

Innovative Services

Successful, innovative, and compassionate services.

San Francisco's Ecosystem of Care

	Urgent and Emergent	Transition and Stabilization		Recovery and Wellness
CARE COORD	⟵	⟷	⟷	⟶
MEDICAL	• Ambulance • Emergency Room • Inpatient • Urgent Care Clinics		• **Medical Respite** • **Shelter Health** • **Street Medicine** • Jail Health	• Primary Care • Specialty Care • Board And Care • Rehab & LT Care
MENTAL HEALTH	• PES • Inpatient • Acute Diversion • Mobile / Westside Crisis • Dore Urgent Care	**- Placement** **- Behavioral Health Access Center** **- Treatment Access Program** **- ICM (Sydney Lam)**	• **Residential Treatment** • Intensive Case Management • **Hummingbird Psych Respite** • Jail Psych	• Outpatient • Case Management • Board And Care
SUBSTANCE USE DISORDER	• Sobering Center • **Medical Detox** • **Social Detox**		• **Residential Treatment**	• Outpatient/Peer • Methadone Maint. • Buprenorphine
HOUSING	• Street • Vehicle • **Encampment** • **Resource Center** • Emergency Shelter	**Coordinated Entry**	• Shelter Services • **Navigation Centers** • Stabilization Rooms • Transitional Housing • **Housing Navigation Services**	• Permanent Supportive Housing • Cooperative Living • **Housing Stabilization Services** • Rent Subsidies
SOCIAL	• Incarceration • No Benefits • No Work • No Community/Family	• **Benefits Navigation/Advocacy** • Cash Assistance • Workforce Development		• SSI • Employment • Food Stamps • Meaningful Life

SFWPC FUNDED SERVICES

WHOLE PERSON CARE JOURNEY MAPPING WORKSHOP

Care providers and subject matter experts from San Francisco's system of care convened to map the experience of a hypothetical individual who has been homeless for more than 10 years and who is difficult to engage. The workshop helped to identify and prioritize opportunities from the providers' perspective and focus on the client and provider experience.

15-20
Care Providers

Moment of Opportunity	Point of Engagement	Loosely connected	Stabilization / Engagement	De-stabilization

Questions?