San Francisco
Whole Person Care
California Medi-Cal 2020 Waiver Initiative

Update April 3, 2018
Health Commission
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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

Co-Lead: Department of Public Health
- Department of Aging and Adult Services
- Emergency Medical Services
- Community Based Organizations
- SF Health Plan & Anthem BC
- Private Hospitals

Housing
- Co-Lead: Department of Homelessness and Supportive Housing
- Community Based Organizations

Health

Benefits
- Department of Human Services

Whole Person Care
## WPC Performance Goals / Metrics

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

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

Whole Person Care
2017 - Homeless Served - 14,377

- 3,655 Observed Homeless - Source: HSH/StrtMedShelter Health (ytd 28%)
- 3,971 Self-Reported Homeless - Source: All Oth DPH Programs (ytd 47%)
- 6,751 Source is both Observed & Self-Reported (ytd 25%)

By SF Medi-Cal Status

- 6,166 Total with SF-Medi-Cal (WPC Enrollees) (57%)
- 8,211 Total without SF-Medi-Cal (not WPC Enrollees) (43%)
2017 Outreach and Engagement Services (Shelter, Navigation Centers, Sobering Center Nights)

$851,602 Under-Produced Unbillable

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

Finding:
- Auto-renew process requires individual file annual taxes

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

Finding:
- Myths and confusion abound with providers

Implement Benefits Navigators Pilot
Advocate for Legislative Changes
Streamline Hospital and Behavioral Health Process
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
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.

As a provider, I understand how the system prioritizes clients into housing and into care. It’s fair and flexible.

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.

As a client, if I go into the hospital, my care team is notified and they reach out to help.

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

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

Existence of system gaps and/or insufficient capacity.

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

Successful, innovative, and compassionate services.
# San Francisco’s Ecosystem of Care

## Care Coordination (CARE COORD)

### Medical
- Ambulance
- Emergency Room
- Inpatient
- Urgent Care Clinics

### Mental Health
- PES
- Inpatient
- Acute Diversion
- Mobile / Westside Crisis
- Dore Urgent Care

### Substance Use Disorder
- Sobering Center
- Medical Detox
- Social Detox

### Housing
- Street
- Vehicle
- Encampment
- Resource Center
- Emergency Shelter

### Social
- Incarceration
- No Benefits
- No Work
- No Community/Family

## Urgent and Emergent

### Medical
- Ambulance
- Emergency Room
- Inpatient
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### Mental Health
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## Transition and Stabilization

### Medical
- Medical Respite
- Shelter Health
- Street Medicine
- Jail Health

### Mental Health
- Residential Treatment
- Intensive Case Management
- Hummingbird Psych Respite
- Jail Psych

### Substance Use Disorder
- Residential Treatment

### Housing
- Shelter Services
- Navigation Centers
- Stabilization Rooms
- Transitional Housing
- Housing Navigation Services

### Social
- Benefits Navigation/Advocacy
- Cash Assistance
- Workforce Development

## Recovery and Wellness

### Medical
- Primary Care
- Specialty Care
- Board And Care
- Rehab & LT Care

### Mental Health
- Outpatient
- Case Management
- Board And Care

### Substance Use Disorder
- Outpatient/Peer
- Methadone Maint.
- Buprenorphine

### Housing
- Permanent Supportive Housing
- Cooperative Living
- Housing Stabilization Services
- Rent Subsidies

### Social
- SSI
- Employment
- Food Stamps
- Meaningful Life
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.
Questions?