SAN FRANCISCO

Whole Person Care

Health Commission Update

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August 18, 2020
OUTLINE

San Francisco Whole Person Care Overview
Innovations in Data Sharing Technology
Innovations in Care Coordination Services
Sustainability: Beyond 2020 Waiver
Innovations in Technology

- A platform to share comprehensive, integrated data that provides context for all our shared clients

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
WHOLE PERSON CARE OPPORTUNITY

CLIENT visits Emergency Department

PROVIDER attends to medical needs and connects to services

7-day shelter bed placement

SF HOT connects to shelter bed

Benefits Navigator assists with interstate transfer

Misses Benefits follow-up appointment

Attends to medical needs and diagnoses chronic illness

Fights with shelter staff

Discharges client to the street

Denies access to shelter for not following rules

Attempts to link to services while in jail

Uses meth and becomes violent

Is arrested for violent street behavior

Transported to PES on 5150

HSOC deploys SF HOT

Assigns Intensive Case Manager (ICM)

Accepts placement in residential treatment

Assesses for housing

Coordinated Entry

Leaves substance use treatment program

Visits Emergency Department and is admitted for inpatient stay

Attends to medical needs and diagnoses chronic illness

Drops-in at Hummingbird occasionally

Transports to Hummingbird by EMS and SF HOT
Accomplishments

- Identified client, provider, and department requirements for a data sharing solution to support interagency care coordination across the City.
- Partnering with DPH IT to select and plan for the implementation of Epic’s Care Coordination Management (CCM) toolset.

In Progress

- Transition integrated health, housing and social data to Epic.
- Install and launch DPH’s Epic care coordination tools for Whole Person Integrated Care (WPIC) programs.
- Expand access to CareLink to non-dph partners working with WPIC clients.
- Implement data sharing agreements and protocols.
Example

- Leverage integrated data to identify individuals at higher-risk for COVID-19 complications for placement in alternative housing settings.
- Provide information to inform policy and planning decisions (for example Project Room Key funds for implementation).
- Produce a daily census for frontline providers and staff enabling targeted outreach and linkage to health, housing and social services in alternative settings (like SIPs and I/Q sites).
- Track, aggregate and report on coordinated models of care in SIPs.

People Experiencing Homelessness (PEH)
(flagged in CCMS in last 12 months)

- 30% Higher-risk
- TOTAL=15,211

PEH: Unsheltered
(Homeless outdoors or not otherwise specified)

- 22% Higher-risk
- TOTAL=8,129

PEH: Sheltered
(Homeless shelter system, treatment, hotel room)

- 40% Higher-risk
- TOTAL=7,082
INNOVATIONS IN CARE COORDINATION SERVICES

Shared Priority Project

Accomplishments

● Launched the Shared Priority project adopting a “whatever it takes” approach to place SF’s most vulnerable clients experiencing homelessness into housing or other safe settings.

● Convened a “system response” committee to identify and problem-solve system barriers and delivered bi-weekly project dashboard to monitor progress.

In Progress

● The Shared Priority care coordination team continues to meet weekly to identify, engage, and prioritize vulnerable clients for health, housing and social services.

● The use of integrated data to target interventions and identify hard to link individuals.

● Monitoring of the Share Priority cohort for future evaluation and the development of systems recommendations.
**Shared Priority Bi-Weekly Dashboard**

**8-11-2020**

**Population**
237 individuals
6 no service util/SP contact since start of project
13 deceased

**Case Managed**
56 start
119 currently

**Housed**
6 start
3 lost housing
126 currently
LPS Conserved
3 currently

**Living Situation**

<table>
<thead>
<tr>
<th>Situation</th>
<th>Unknown</th>
<th>Not Sheltered</th>
<th>Temporarily Sheltered</th>
<th>Housed</th>
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<tr>
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<td>30</td>
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<td>38</td>
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<td>-2</td>
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<td>Description</td>
<td>No service util in 30 days</td>
<td>Service util/contact in last 30 days</td>
<td>Nav/Shelter/Stab Room/SIP Hotels</td>
<td>HSH PSH, Scattered Site/Flex Pool, Sec 8</td>
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<td>Description</td>
<td>Treatment/Respite</td>
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<td>Board &amp; Care, Left SF, Self Resolved</td>
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**Engagement**

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<tr>
<th>Service</th>
<th>Case Management</th>
<th>Housing Navigation</th>
<th>Assigned Housing Unit</th>
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<td>Description</td>
<td>Outpatient Case Management</td>
<td>HSH Housing Svcs Oct 19 - July 31</td>
<td>Awaiting PSH move in</td>
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<td>Description</td>
<td>Citywide Linkage ICM</td>
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<td>Description</td>
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**Housing Process**

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**Benefits**

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<tr>
<th>Benefit</th>
<th>CAAP</th>
<th>SSI</th>
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<th>CalFresh</th>
<th>IHSS</th>
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<td>+0</td>
<td>+0</td>
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<tr>
<td>Description</td>
<td>Enrolled in SSI</td>
<td>Advocacy</td>
<td>In and out of county</td>
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<td>Enrolled</td>
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Example

- Learnings from Whole Person Care have informed the model of care for Shelter In Place hotels (SIPs) and outreach work with unsheltered people experiencing homelessness.

- Implemented large-scale medical and nursing services within HSH/HSA established SIPs.

- Relied on available WPC data to identify and locate clients who were vulnerable quickly.

- Established relationships with partner agencies and organizations provide were foundational to working together efficiently and effectively.
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.
Future of SF Whole Person Care

WAIVER

- DHCS is pushing to extend the 1115 Waiver for WPC through 2021. CalAIM implementation is delayed (expected Jan 2022).

SERVICE DELIVERY

- Whole Person Integrated Care (WPIC) is on track to open our new health resource center on Stevenson Street in November 2021.
- Merging Urgent Care and Street Medicine’s Open Access Clinic was accelerated by COVID-19 response
- High Intensity Care Team collaboration has been expanded and accelerated during this time and will continue to serve shared clients

TECHNOLOGY

- Transition of integrated data and reporting from CCMS to an Epic environment
- Shared Priority serves as a model for citywide care coordination as we implement Epic’s Coordinated Care Management toolset
- Expand access to Epic CareLink for care coordination teams and street-based providers across the city
SUSTAINABILITY

Future of Whole Person Care

Ambulatory Care

Whole Person Integrated Care

Medical Director
SSHUC
Street Medicine
Shelter Health
Urgent Care

Medical Director
MRSC & Supportive Housing
Medical Respite and Sobering
PSH Nursing
Transitions Care Coordination

Director
Whole Person Care
Whole Person Care
Questions?
Thank you to all our WPC partners!

Department of Public Health (DPH)
Department of Homelessness and Supportive Housing (HSH)
Department of Human Services (DHS)
Department of Aging and Adult Services (DAS)
Fire Department Emergency Medical Services (SFFD EMS)