San Francisco Whole Person Care

California Medi-Cal 2020 Waiver Initiative

February 2, 2018

COIT Budget & Performance Subcommittee

SF WHOLE PERSON CARE

- Background: What is it?
- Targeted Population in SF: Who is it for?
- SF’s Approach to Whole Person Care
- SF’s Approach to Technology Solution
  - Current State
  - Future Solution
  - Interim Solution

State of California
Department of Health Care Services

Background

WHOLE PERSON CARE

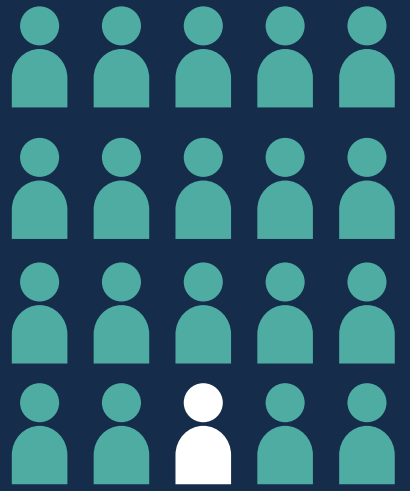
Target Population

Vulnerable Medi-Cal beneficiaries who are high utilizers of multiple health care systems who continue to have poor outcomes

The care for just

5%

of Medi-Cal enrollees accounts for



OVER

50%

of total Medi-Cal spending

WHOLE PERSON CARE

Purpose of Waiver

Increase Integration

among county agencies, health plans, and providers and develop infrastructure to ensure sustainability in the long term.

Increase Coordination

and appropriate access to care for the most vulnerable Medi-Cal beneficiaries.

Reduce Inappropriate Utilization

of emergency and hospital care.

Improve Data Collection

and sharing to support strategic sustainable program improvements.

Improve Quality

by achieving targeted quality and administrative improvement benchmarks.

Improve Health Outcomes

and pay for improvements in health status rather than for services provided.

City and County of San Francisco
Whole Person Care

SF's Targeted Population

WHOLE PERSON CARE AWARD – SAN FRANCISCO

FUNDING

$36.1 M Annual
$18M New / $18M Match
Thru Dec 2020

TWO-PRONGED INNOVATION APPROACH

Services / Care Coordination
& Technology Solutions

TARGET POPULATION

Homeless
Single Adults

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

Total Homeless Adults Served by DPH Annually

11,107

Estimated 7k additional

Risk Stratification Methodology:

HUMS – 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

WHOLE PERSON CARE **TARGET POPULATION**

Risk Category	Homeless Population (FY1617) with DPH record	Total Adults	Total Urgent/ Emergent Costs
		11,107	**$169M**
Severe	High user AND Long-term Homeless		
High	High user, NOT Long-term Homeless		
	Long-term Homeless, NOT High User		
Elevated	NOT Long-term Homeless, NOT High User		

WHOLE PERSON CARE **TARGET POPULATION**

Risk Category	Homeless Population (FY1617) with DPH record	Total Adults	Total Urgent/ Emergent Costs
		11,107	**$169M**
Severe	High user AND Long-term Homeless	**12%**	**74%**
High	High user, NOT Long-term Homeless		
	Long-term Homeless, NOT High User	**27%**	**10%**
Elevated	NOT Long-term Homeless, NOT High User	**61%**	**16%**

WHOLE PERSON CARE TARGET POPULATION BY DISORDERS

Risk Category	Homeless Population (FY1617) with DPH record	Serious Medical	Psych	Drug/ Alcohol	All 3
		48%	**58%**	**63%**	**31%**
Severe	High user AND Long-term Homeless				
High	High user, NOT Long-term Homeless				
	Long-term Homeless, NOT High User				
Elevated	NOT Long-term Homeless, NOT High User				

WHOLE PERSON CARE TARGET POPULATION BY DISORDERS

Risk Category	Homeless Population (FY1617) with DPH record	Serious Medical	Psych	Drug/ Alcohol	All 3
		48%	**58%**	**63%**	**31%**
Severe	High user AND Long-term Homeless	90%	89%	96%	**78%**
High	High user, NOT Long-term Homeless	75%	83%	91%	57%
	Long-term Homeless, NOT High User	63%	72%	79%	44%
Elevated	NOT Long-term Homeless, NOT High User	35%	46%	51%	18%

WHOLE PERSON CARE TARGET POPULATION BY OTHER FACTORS

Risk Category	Homeless Population (FY1617) with DPH record	Chronic High User
		2%
Severe	High user AND Long-term Homeless	**23%**
High	High user, NOT Long-term Homeless	6%
	Long-term Homeless, NOT High User	2%
Elevated	NOT Long-term Homeless, NOT High User	0%

WHOLE PERSON CARE TARGET POPULATION BY OTHER FACTORS

Risk Category	Homeless Population (FY1617) with DPH record	Chronic High User	Jail Episode
		2%	**25%**
Severe	High user AND Long-term Homeless	23%	38%
High	High user, NOT Long-term Homeless	6%	29%
	Long-term Homeless, NOT High User	2%	32%
Elevated	NOT Long-term Homeless, NOT High User	0%	21%

WHOLE PERSON CARE TARGET POPULATION BY OTHER FACTORS

Risk Category	Homeless Population (FY1617) with DPH record	Chronic High User	Jail Episode	African American
		2%	**25%**	**31%**
Severe	High user AND Long-term Homeless	23%	38%	40%
High	High user, NOT Long-term Homeless	6%	29%	23%
	Long-term Homeless, NOT High User	2%	32%	46%
Elevated	NOT Long-term Homeless, NOT High User	0%	21%	25%

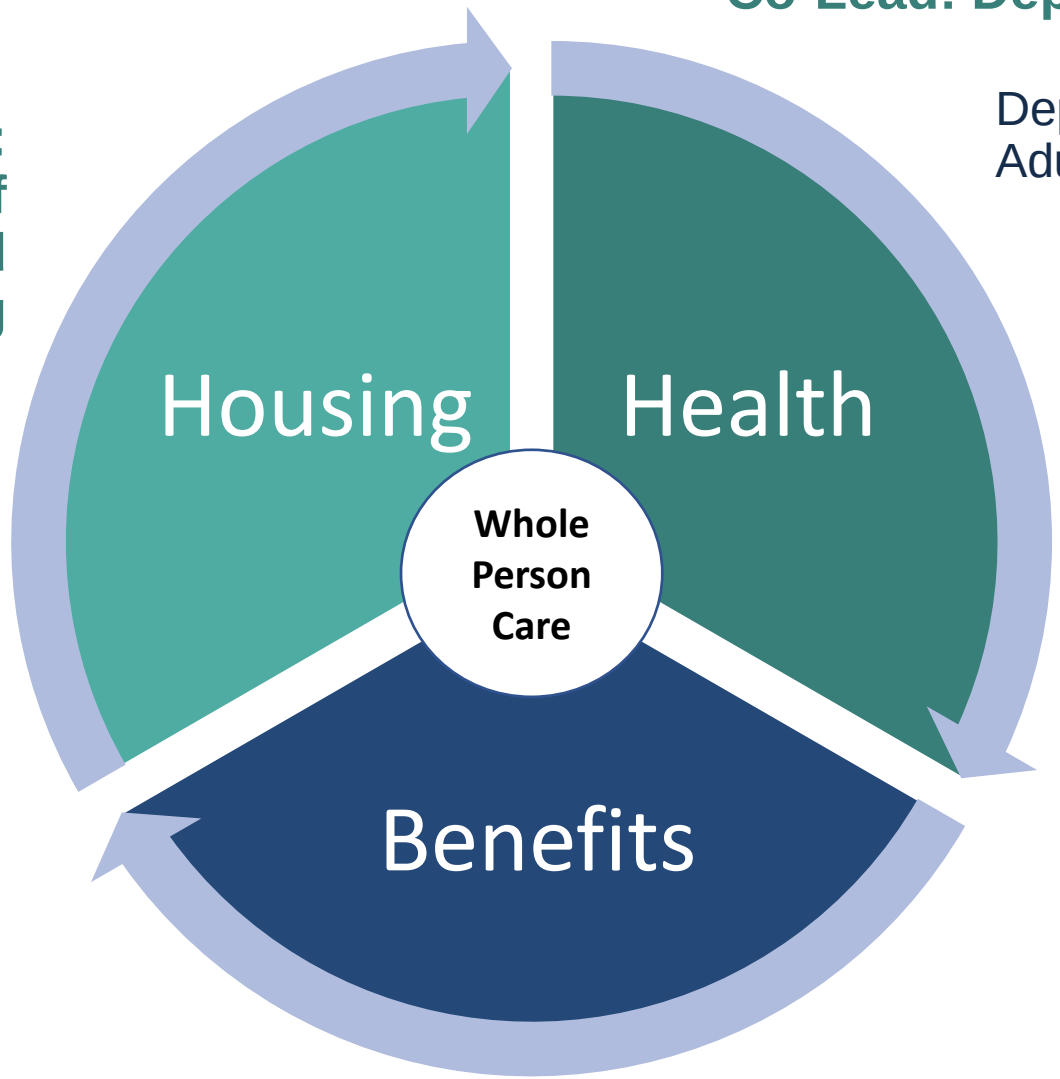
San Francisco's Approach to Whole Person Care

WHOLE PERSON CARE **A MULTI-AGENCY EFFORT**

Co-Lead: Department of Public Health

Co-Lead: Department of Homelessness and Supportive Housing

Community Based Organizations



Department of Aging and Adult Services

Emergency Medical Services

Community Based Organizations

SF Health Plan & Anthem BC

Private Hospitals

Department of Human Services

Whole person, Whole story

Physical Health	Mental Health	Substance Use	Living Situation	Finances
				
Legal	**Safety**	**Skills**	**Support**	**Meaning-ful Role**
				

WPC
Deliverables

	Current State
Data Sharing	5+ separate systems
Risk Assessment Tool	Service / Disorder / Facility Based
Shared Care Plans	Multiple Single System
Communiques & Alerts	Care Team Members Unknown
System of Care	Service / Disorder / Facility Based

WPC Deliverables

	Current State	By 2020	Quotes from the Future
Data Sharing	5+ separate systems	Integrated Interagency Data System	*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	Service / Disorder / Facility Based	Multi-Agency Multi-Disciplinary Tool	*As a provider, I understand how the system prioritizes clients into housing and into care. It's fair and flexible.*
Shared Care Plans	Multiple Single System	Integrated and Shared 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	Care Team Members Unknown	Technology and Tools	*As a client, if I go into the hospital, my care team is notified and they reach out to help.*
System of Care	Service / Disorder / Facility Based	Implemented Human Centered SOC	*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 Homeless 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	I I **- Placement** **- Behavioral Health Access Center** **- Treatment Access Program** **- ICM (Sydney Lam)** I I	• Residential Treatment • Intensive Case Management • Hummingbird Psych Respite • Jail Psych	• Outpatient • Case Management • Board And Care
SUBSTANCE ABUSE	• Sobering Center • Medical Detox • Social Detox		• Residential Treatment	• Outpatient/Peer • Methadone Maint. • Buprenorphine
HOUSING	• Street • Vehicle • Encampment • Resource Centers	• Shelter • Navigation Centers • Stabilization Rooms • Transitional Housing	I I **Coordinated Entry** I I	• Permanent Supportive Housing • Cooperative Living • Case Management • Rent Subsidies
SOCIAL	• Incarceration • No Benefits • No Work • No Community/Family	• Benefits Navigation/Advocacy • Cash Assistance • Workforce Development		• SSI • Employment • Food Stamps • Meaningful Life

We adopt a **“whatever it takes”** approach and are relentless in questioning the status quo to make the changes necessary to improve the outcomes of our most vulnerable homeless residents.

San Francisco's Approach to IT Solution

FRONT END

People, processes, and systems that create the end-to-end service experience for clients, providers, and partners.

Panel Management

What are the needs, expectations, and motivations of providers and clinic directors when preparing to care for clients?

PROVIDER, DIRECTOR

Population Health

What are the needs, expectations, and motivations of administrators and researchers when using vulnerable populations data?

ADMINISTRATION, RESEARCHER

Point of Service

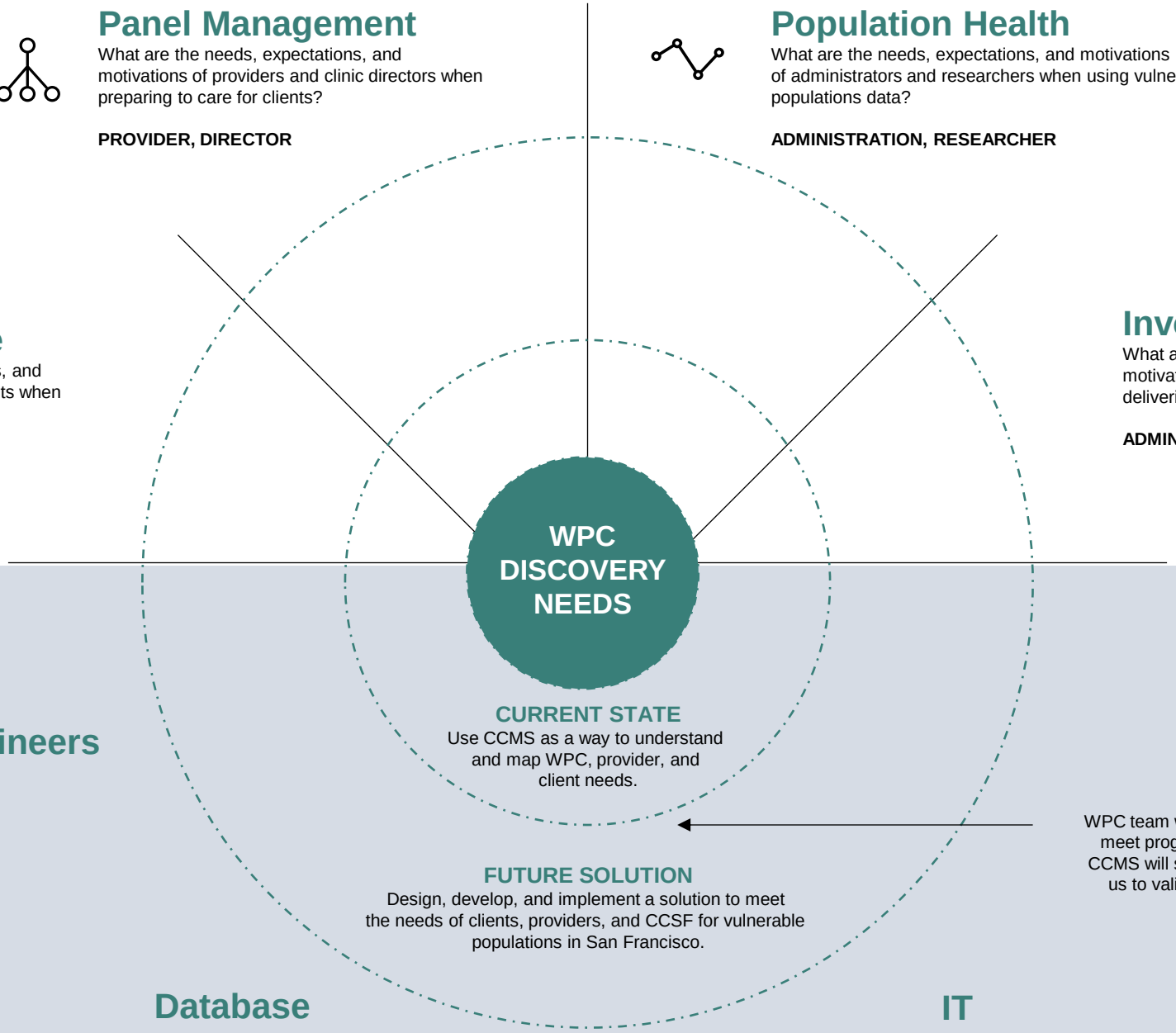
What are the needs, expectations, and motivations of providers and clients when delivering or receiving care?

PROVIDER, CLIENT

Invoicing

What are the needs, expectations, and motivations of providers and clients when delivering or receiving care?

ADMINISTRATION, FINANCE



WPC DISCOVERY TEAMS

- SERVICE
- TECH
- EVAL
- STIR

CURRENT STATE

Use CCMS as a way to understand and map WPC, provider, and client needs.

FUTURE SOLUTION

Design, develop, and implement a solution to meet the needs of clients, providers, and CCSF for vulnerable populations in San Francisco.

INTERIM SOLUTION

WPC team will prioritize the evolution of CCMS to meet program requirements in the short term. CCMS will serve as a working prototype allowing us to validate potential solutions and inform the future solution.

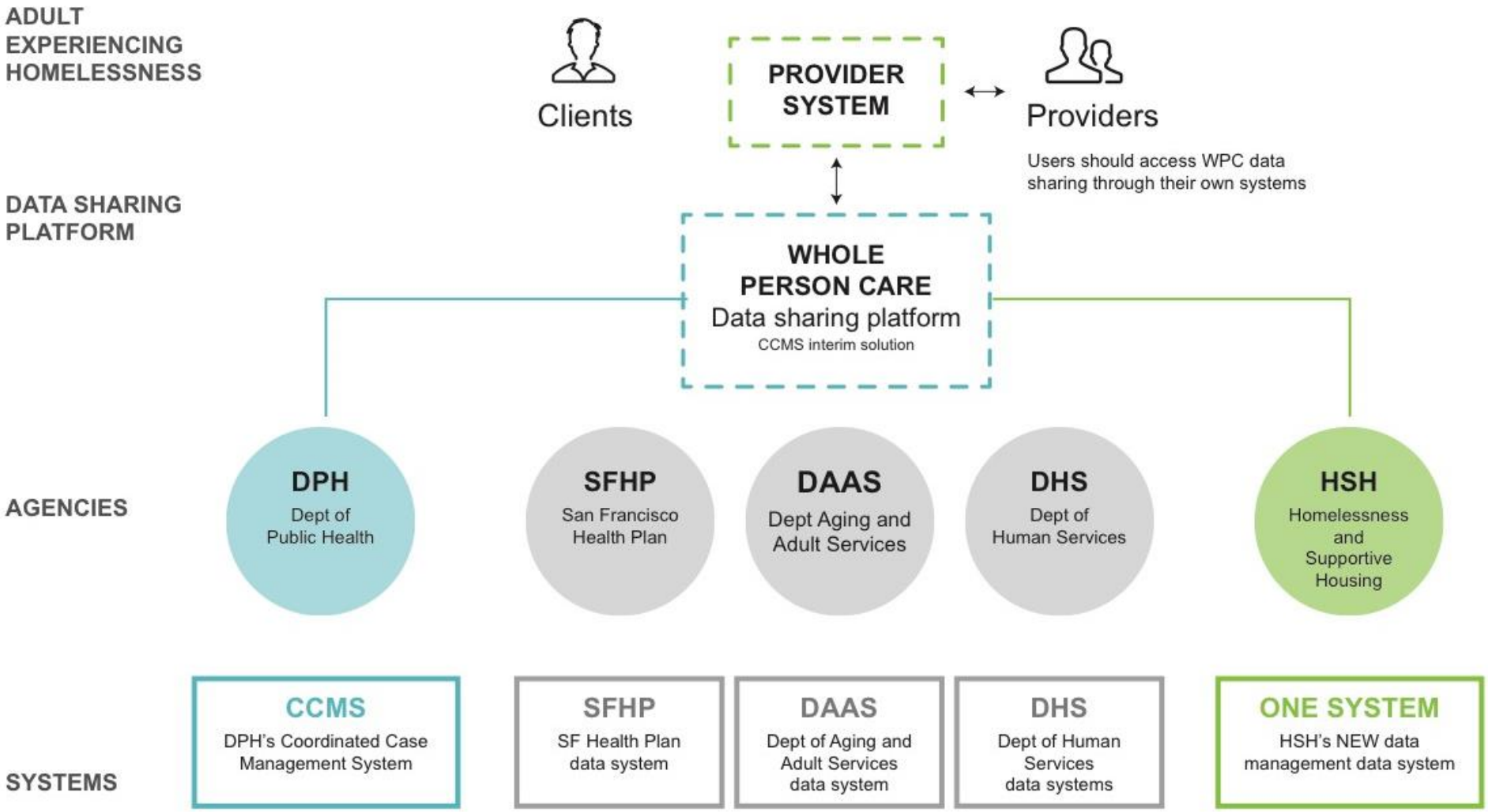
Engineers

Database Admins

IT Leadership

BACK END

Data, systems, policies, and governance that enable and support service delivery.


ADULT EXPERIENCING HOMELESSNESS
Clients
PROVIDER SYSTEM
Providers
Users should access WPC data sharing through their own systems
DATA SHARING PLATFORM
WHOLE PERSON CARE
Data sharing platform
CCMS interim solution
AGENCIES
DPH
Dept of Public Health
SFHP
San Francisco Health Plan
DAAS
Dept Aging and Adult Services
DHS
Dept of Human Services
HSH
Homelessness and Supportive Housing
SYSTEMS
CCMS
DPH's Coordinated Case Management System
SFHP
SF Health Plan data system
DAAS
Dept of Aging and Adult Services data system
DHS
Dept of Human Services data systems
ONE SYSTEM
HSH's NEW data management data system

WHOLE PERSON CARE

The purpose of Whole Person Care is to improve health outcomes for San Francisco's most vulnerable populations through an interagency and human-centered approach to service and care coordination.

Current Situation…

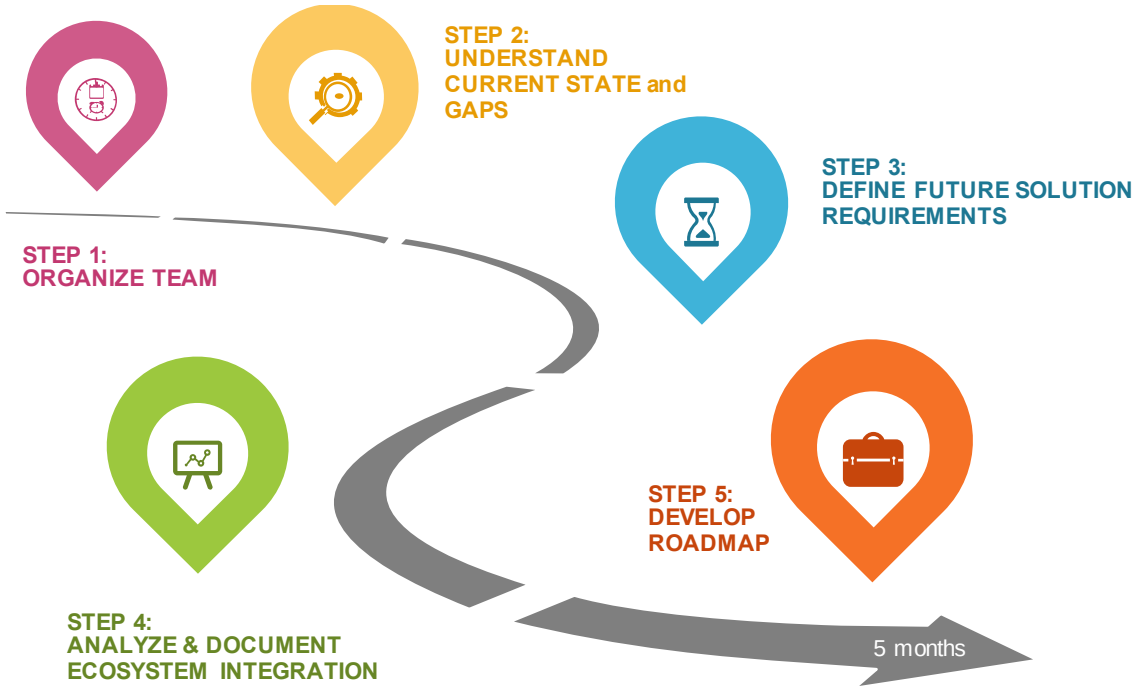
- Multiple systems that don't talk
- Disconnected and duplicate client registrations
- Service gaps / lack of coordination
- Data flow and quality challenges
- Difficult to access data

Future State…

- Enhanced access to information
- Increased coordination & collaboration
- Improved data integrity
- "Next right question" prompts for client
- Flexible, human-centered tools

TECHNOLOGY SOLUTION APPROACH

Gartner will partner with CCSF to identify, define and plan for a human-centered technology solution that enables city-wide Whole Person Care and informs RFP(s) &/or modifications to current system(s) based on best practices and vendor insights.



CCMS as an interim solution enables CCSF to:

- Share data required to facilitate invoicing / reimbursement from the State
- Communicate periodic SF WPC accomplishments required by the State
- Expand access to integrated data to members of the interagency care team
- Pilot improvements in data sharing that improves point-in-time service, panel/ caseload management and population analytics
- Gain deeper insights towards the future state solution

PARTNERS (Data Systems)

Lead

- **DPH (CCMS/EPIC)**
- **HSH (ONE)**

Contribute

- DHS (CalWIN)
- DAAS (SFGetCare/IHSS)
- SFHP (PreManage)

Assist

- Gartner

THE ASK

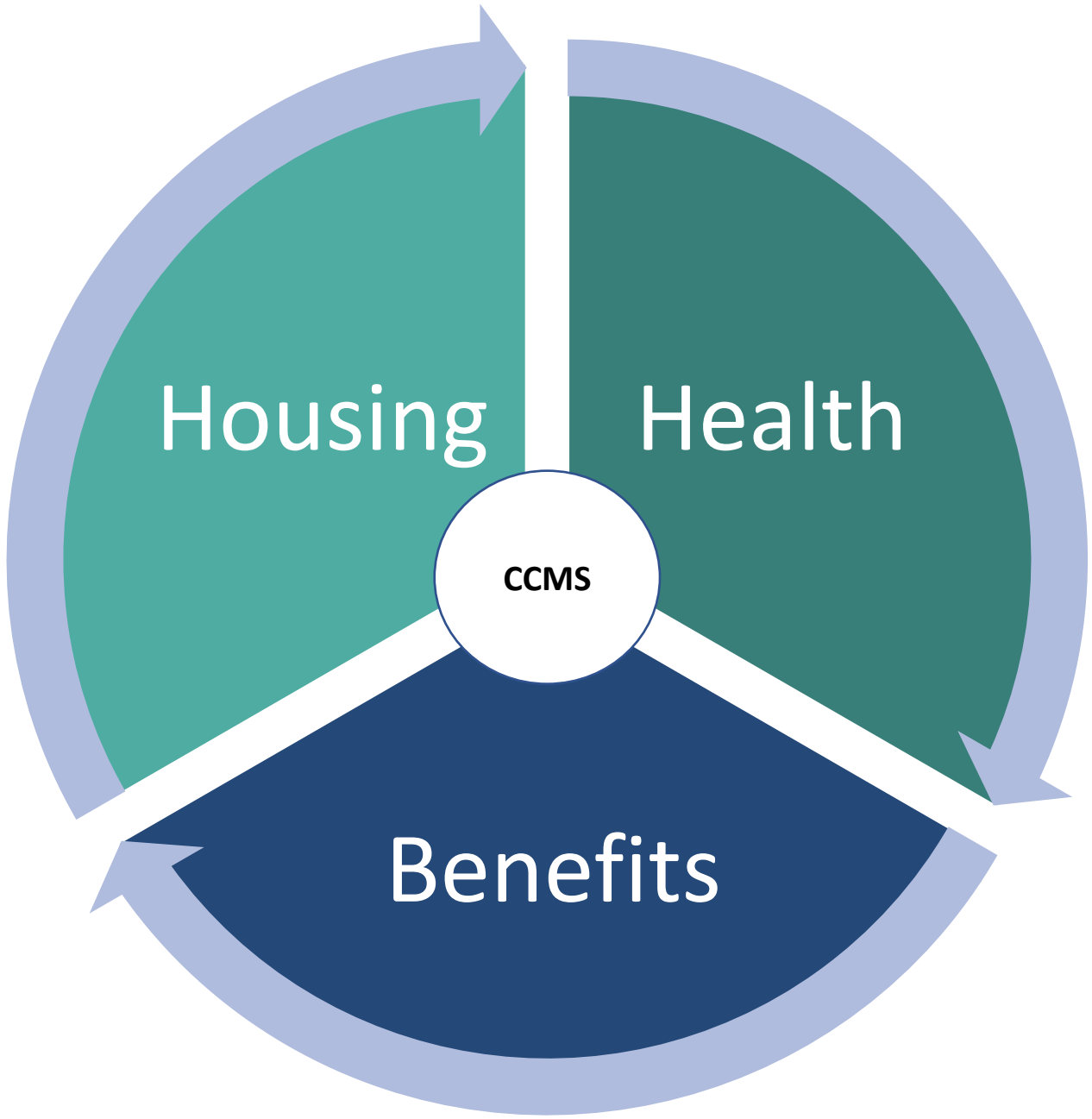
To support this effort, partners will need to:

- Dedicate staff time for interviews and insights;
- Inform the Gartner-driven analysis and planning of current and future state of WPC;
- Implement strategies that enable WPC interim and future states.

Last Updated: 01/11/2018

Coordinated Care Management System

Begun in 2005, CCMS has grown to include 20 years of bio-psycho-social histories from 15 databases for over 450,000 adult vulnerable San Franciscans



COORDINATED CARE MANAGEMENT SYSTEM (CCMS)

TRANSFER ONLY IF URGENT/ EMERGENT SERVICE

- MEDICAL
  DPH: LCR / eCW
  (Services & Diagnoses)

TRANSFER ALL RECORDS

- MENTAL HEALTH
  DPH: Avatar
  (Services & Diagnoses)
- MENTAL HEALTH
  UCSF: Psych Emergency
  (Services & Diagnoses & Notes)
- SUBSTANCE ABUSE
  DPH: Avatar
  (Services & Diagnoses)
- SHELTER
  DHS: CHANGES
  (Services & CAAP)
- SOBERING CENTER
  DPH: CCMS
  (Services & Case Notes)
- MEDICAL RESPITE
  DPH: CCMS
  (Services & Case Notes)
- JAIL HEALTH
  DPH: JIM
  (Episodes)
- SFHOT CASE MANAGEMENT
  HSH: CCMS
  (Episodes)
- DIRECT ACCESS TO HOUSING
  HSH: CCMS
  (Episodes)
- STABILIZATION ROOMS
  HSH: CCMS
  (Episodes)
- EMS AMBULANCE
  SFFD Billing
  (Transports)

TRANSFER IF MATCH

- DEATH REGISTRY
  California
  (Death Records matched)
- MEDICAL
  DPH: LCR / eCW
  (Services & Diagnoses)

MATCH & MERGE

CCMS

A PHASED APPROACH

2018

Enable **ACCESS** to information that is relevant to care (providers) and new services (clients)

2019

USE information to improve delivery of care and design of services

2020+

ITERATE and **SUSTAIN** Whole Person Care

Questions?

maria.x.martinez@sfdph.org, 415-554-2877