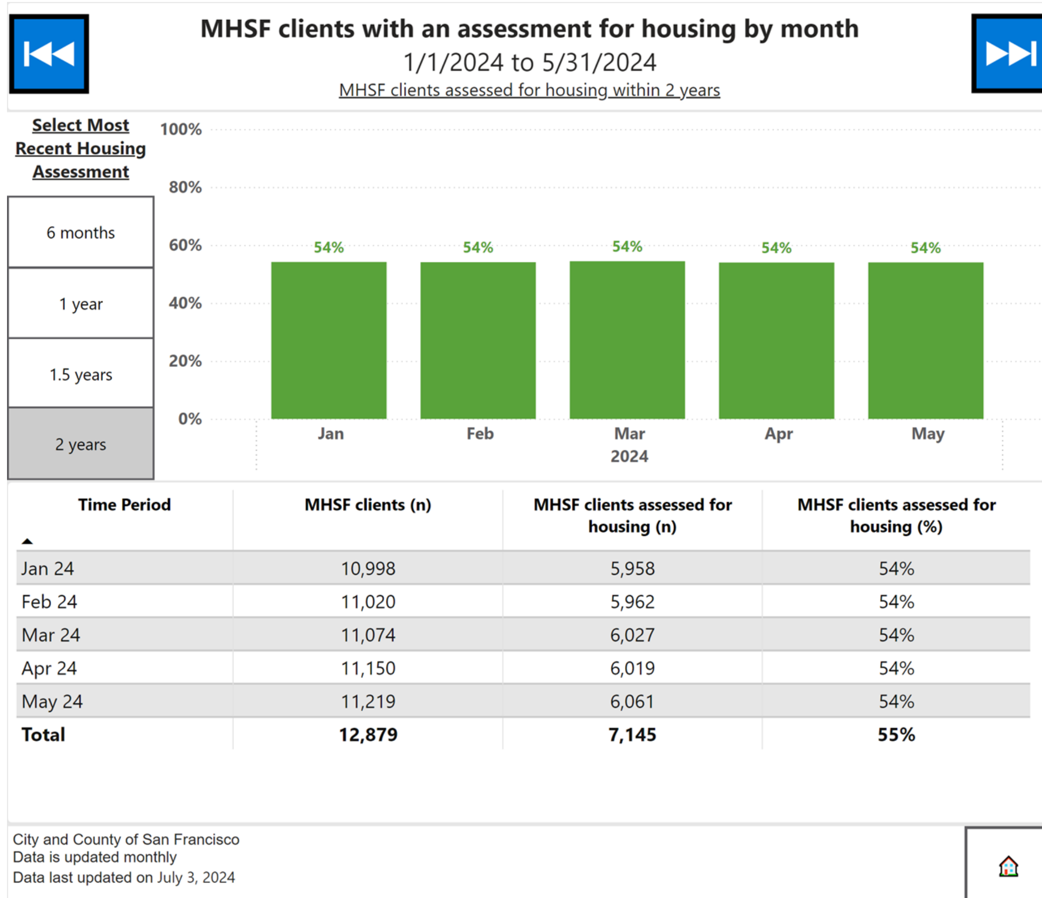
City and County
of San Francisco

Housing A3 Report Out

HSH Presentation to LHCB CE Committee 9/10/2024

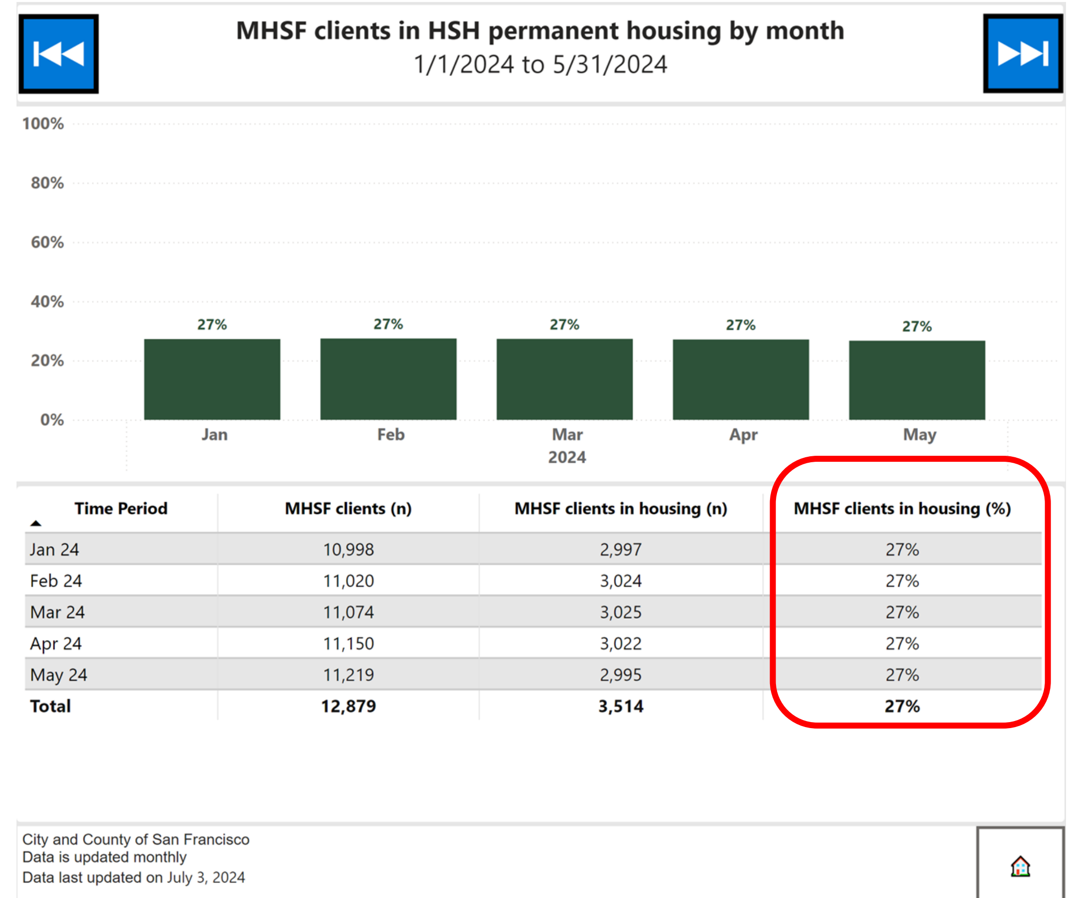
What can the health system do to help improve housing outcomes for the Mental Health SF population?

Increase the % of the MHSF population assessed for housing



Time Period	MHSF clients (n)	MHSF clients assessed for housing (n)	MHSF clients assessed for housing (%)
Jan 24	10,998	5,958	54%
Feb 24	11,020	5,962	54%
Mar 24	11,074	6,027	54%
Apr 24	11,150	6,019	54%
May 24	11,219	6,061	54%
Total	**12,879**	**7,145**	**55%**

Increase the % of the MHSF population who are placed in permanent housing



Time Period	MHSF clients (n)	MHSF clients in housing (n)	MHSF clients in housing (%)
Jan 24	10,998	2,997	27%
Feb 24	11,020	3,024	27%
Mar 24	11,074	3,025	27%
Apr 24	11,150	3,022	27%
May 24	11,219	2,995	27%
Total	**12,879**	**3,514**	**27%**

Kaizen Process - ~ 50 hours in April – May 2024

- Outline processes in detail; look for opportunities to improve
- Envision big system changes; identify themes
- **Focus on what can be done with the people in the room – steps toward the big changes**
- Use a "lean" approach > start small, test and adjust, expand, test and adjust, expand until changes are system-wide
- Participants included:
  - Frontline and leadership staff from DPH Whole Person Integrated Care and Primary Care, ZSFG, Tom Waddell, DPH Kaizen Promotion Office
  - HSH representatives from Planning, Coordinated Entry, and Housing Placement
  - Access point representatives from ECS and Dolores Street

Countermeasure 1 – Eligibility & Documentation

- Form G:Verification of Disability
  - Move the process upstream and make part of the standard work of social workers seeing patients experiencing homelessness
  - Fill out during/after patient encounter and upload into ONE
  - Hypothesis: moving this third-party process upstream will make navigation smoother and faster down the line
  - Testing: should it be for everyone or just HRS patients?

DEPARTMENT OF HOMELESSNESS AND SUPPORTIVE HOUSING

Form G: Verification of Disability

I certify that (client name) ________________________________ has been diagnosed with one or more of the following:

- ☐ Physical, mental, or emotional impairment, including an impairment caused by alcohol or drug abuse, post-traumatic stress disorder, or brain injury, that:
  - ☐ Is expected to be long-continuing or of indefinite duration; **and**
  - ☐ Substantially impedes the individual's ability to live independently; **and**
  - ☐ Could be improved by more suitable housing.

and/or

- ☐ Developmental Disability – a severe, chronic disability that:
  - ☐ Is attributable to a mental or physical impairment or combination of mental and physical impairments; **and**
  - ☐ Is manifested before the individual attains age 22; **and**
  - ☐ Is likely to continue indefinitely; **and**
  - ☐ Results in substantial functional limitations in 3 or more of the following areas of major life activity:
    - Self-care;
    - Receptive and expressive language;
    - Learning;
    - Mobility;
    - Self-direction;
    - Capacity for independent living;
    - Economic self-sufficiency; **and**
  - ☐ Reflects the individual's need for a combination and sequence of special, interdisciplinary, or generic services; individualized supports; or other forms of assistance that are of lifelong or extended duration and are individually planned and coordinated.

and/or

- ☐ HIV/AIDS: the disease of acquired immunodeficiency syndrome (AIDS) or any condition arising from the etiologic agency for acquired immunodeficiency syndrome.

Name of Licensed/Credentialed Staff (printed): ______________________

License/Credential: ______________________

Agency Affiliation: ______________________

Signature of Licensed/Credential Staff: ______________________

Date ______________

24 CFR 578.3

Updated 5/6/2024

Countermeasure 2 – Referral and Linkage

- Expand the use of CE assessments by telephone
- Place phone calls to partner CBO Access Points to provide Coordinated Entry Assessments over the phone.
  - Specifically to reach patients who are not making it to an AP on their own
  - Reduce barriers related to mobility; build on trusting relationships
- Hypothesis: The use of phone assessments while a patient is in care will increase access to our system for people who are both 1) likely to be prioritized and 2) not making the connection to our system on their own
- Testing: Ease of the process, what capacity is needed for this to work and scale?

Countermeasure 3 – Process Clarification

1. Create an HSH 101 training focused on a social work audience
2. Increase access to ONE system by DPH social workers
3. Create an interactive training aimed at DPH social workers to better:
   - Understand the housing journey
   - Identify where patients are in the housing journey
   - Help them take the next step

- Focus on practical tools – accessing APs and problem solving, admin review, disability verification, reasonable accommodations
- Hypothesis: If health system staff know the basics of our system and are empowered to use all the tools they have available, it will reduce people getting stuck/lost in the process, as well as increase collaboration between HSH and DPH frontline staff
- Testing: with these trainings, are DPH social workers changing their workflows?

Countermeasure 4 – Interagency Communication

In-patient

- Ensure HSH is informed about the patient's location so that patients experiencing homelessness maintain access to housing services
  - **Hypothesis: Reduce instances where we lose someone in process for housing because they are at an inpatient unit**

Outpatient

- Add primary care social worker to the care team in ONE for every patient experiencing homelessness in our system
  - **Hypothesis: Increase care coordination, including a resource to help locate someone we are looking for and communicate about service needs**

While we are at it…

Category	Change
Eligibility & Documentation	• Selected HSH staff and partners (housing placement team + CE team + navigators) are getting access to EPIC to be able to better coordinate with other service providers and get documentation for chronicity of homelessness • In progress at HSH; we have a pathway established for Housing Placement and Coordinated Entry • Already in use by ECS housing navigators
Referral and linkage	• Current printed HSH resource cards will be made available at the front desks and used regularly with patients • APs have shared email addresses with DPH staff to coordinate warm handoffs/follow ups
Process confusion	• Made step by step documentation translating ONE to EPIC
Interagency communication	• Cleaned up list of services HSH sends to DPH that gets uploaded into EPIC to reduce confusion and unnecessary information • Got social workers access to ONE (and made it consistent permissions)

Metrics