MHSF Office of Coordinated Care Recommendations (Approved 3.22.22)

Foundational Resources for Recommendation Development

Mental Health SF Administrative code:

Mental Health San Francisco (MHSF), created through legislation (File No. 191148), identifies an Office of Coordinated Care on Page 12, lines 24-25 & Page 13 1-6: (2) Part Two: Establishment of the Office of Coordinated Care.

The 25 Department shall operate an Office of Coordinated Care to oversee the seamless delivery of mental health care and substance use services across the City's behavioral health systems, and to ensure that Mental Health SF is accountable and proactive in how it delivers care. The Office of Coordinated Care shall seek to ensure that services are provided to Mental Health SF participants in the most efficient and cost-effective way and shall minimize unnecessary bureaucracy. The Office of 5 Coordinated Care shall be staffed by City employees. The Office of Coordinated Care shall perform 6 the following functions (summarized below):

- A. *Real-time Inventory of Program and Service Availability.*
- B. *Case Management and Navigation Services to Ensure a Continuum of Care*
- C. *Coordination with Psychiatric Emergency Services and Jail Health Services*
- D. *Data Collection*
- E. *Authorized Disclosures*
- F. *Marketing and Community Outreach.*

Office of Coordinated Care Background: see [IWG meeting PowerPoints](#) August-October 2021.

Discussion Group Recommendations

Overarching care-standards that need to be considered in all the recommendations suggested in this document:

- OCC should coordinate policy and advocacy efforts focused on
  - Acquiring and/or leveraging funds to support initiatives beyond Prop C, and
  - Addressing caps on service such as 23-hour limits on certain urgent or emergent care services expanding
- Coordinated care recommendations need to address both physical and virtual environments
- Recommendations need to consider accessibility beyond what various health insurance covers
- All recommendations must address the need for greater care coordination to identify and prevent clients from falling into "gaps" in their healing process before becoming stable.
- Transition periods between care providers should be covered; no one is discharged without a care plan.
- The OCC should develop a visual care coordination systems map that identifies systemic gaps. This map should be dynamic, reflecting changes/improvements/ongoing gaps areas.
- The OCC should be empowered to drive care coordination across multiple SF systems, including, but not limited to: DPH, hospitals, HSH, HSA, BHS, APD, SFPD, SFFD, and DEM, and including supporting the benefits entitlement process and rapid access to services.

- OCC should develop a comprehensive community outreach and education plan to help engage the community in improving ongoing service development by introducing harm reduction principles, trauma informed therapy treatment, and client-centered and culturally responsive services.

1-One care coordinator for one client across systems (DPH, BHS, HSA, HSH, etc.)

Currently there are too many entities (see above) that do not communicate well with each other. The OCC should be charged with following clients from touchpoint to touchpoint to coordinate care. This role is not another case management project, but a **connector** role of mapping and oversight to keep track of people and their progress. This connector/care coordinator role will convene team meetings by bringing together all people engaged in their client's healing to facilitate a collaborative decision-making effort, and to support navigation and accountability for the services provided and the treatment results. This organized collaborative effort does not take the place of the community work provided by different agencies and organizations; rather, it links them together. This can enhance accountability and provide oversight to make sure treatment is being delivered as one client is touching upon multiple systems.

The OCC should have the authority to convene care coordination efforts across each of the city departments.

The OCC should be responsible for establishing after-hours response for emergency care coordination.

The connector/care coordinator function should enable ROI consent

Staff must be equitably compensated city employees or staff from community -based organizations.

2-OCC oversight on communication and the need to find optimal technology for a communication process that works across the system AND central record keeping database

Communication can break down between programs and agencies and there needs to be easier and more dependable ways for systems of care to communicate with each other. We recommend the identification and use of an optimal communication tool that works beyond systems of care and can link multiple agencies and programs.

The optimal communication tool will also include a central record-keeping database.

This recommendation is particularly important for the placement and transition of clients. There are many instances where communication breakdowns lead to gaps between programs as clients move into "next phases" of their care plan. A communication tool across the system of care could enable more fluid transitions through fluid communications that can highlight more than one option or plan for placement and transition.

In addition to electronic communication, the work group recommends regular team meetings across the systems of care, including DEM, HSA, HSH, DPH, and CBOs. For example, a monthly working group that works on reflecting and updating practices and ensuring accountability.

3-OCC should create a continuum of care process throughout the care system

Individuals get released from PES or other acute crisis services because they are no longer classified as acute. They become subacute (can drink and eat on their own) and are discharged without connection to a next level of care.

No person should be discharged from care without a safe-landing and appropriate care coordination including but not limited to housing.

Funding for this continuum of care (including housing) needs to be secured:

- Prop C
- Managed care plan
  - DPH should work with SF Health Plan to report out on leveraging ECM and community supports.

4- Target case load ratios for the care coordinators should be based on client acuity and intensity

- 8 to 10 for high acuity
- 11 to 15 for moderate
- 16 to 30 for stable

5-Enhancing case management systems that are already working and effective

- Support focus units (cultural, language, gender orientation, justice-involved)
- Utilize peer navigators/support services
- Include coordinated transport system as part of the OCC responsibility
- Open more and build upon Peer Centers and Drop in Centers to connect people to care

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