Breaking the Cycle: Innovate on PSH Care Model Briefing

Homeless Oversight Committee

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Brief Introductions

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Where we are today

A COMPLEX DELIVERY SYSTEM ACROSS HSH & DPH

San Francisco's PSH system operates with a wide range of care models across multiple service providers, funding streams, and oversight structures, creating variability in service delivery and expectations.

GROWING COMPLEX RESIDENT CARE NEEDS

Resident physical and behavioral health needs have increased in complexity, yet the PSH system has not been comprehensively evaluated to ensure that services, staffing models, and resources consistently match resident needs.

Where we want to go

PSH system of care design, including the "right" bed mix aligned to the health and social needs of residents.

Standardized care model tiers with corresponding outcomes, including transition to higher and lower levels of support, rate structures & reimbursement strategies

Governance & Operating Framework between HSH and DPH to design, implement, and manage the PSH system of care

Care Model Innovation Analysis Plan

Deliverable: Actionable recommendations to improve outcomes for PSH residents through care model redesign aligned with social and health needs.

Define Outcomes	Establish what success looks like for PSH residents
Assess Acuity & Risk	Analyze available data to segment current PSH tenants by care needs
Catalog Services	Inventory and tier existing PSH services to understand current capacity and variation across sites
Identify Gaps	Compare needs with service capacity to produce system-level recommendations for innovation

Workstream #1: Aligning on Resident & System Outcomes

Status: In progress

PSH Resident Groups & Desired Outcomes

Archetype	Description	Desired Client Goals	Desired System Goals
Exceeds Current / Typical PSH Capacity	Residents whose short- or long-term substance use, behavioral health, cognitive capacity, and/or physical health barriers or needs surpass what current PSH can safely and sustainably support.	1. Transition to the *right level of care to meet clinical needs* (e.g., LSAT, SNF, or newly designed enhanced PSH level) 2. Maintain stable placement 3. Stabilize health conditions to the degree possible 4. Reduce premature mortality, with a focus on overdose as the most significant cause	1. Improve building stability 2. Reduce use of emergency services (ER, EMS, jail) 3. Improve overall system flow by moving clients to higher levels of care outside of PSH when indicated 4. Rehabilitation with care that may lead to transition from higher level of care to core PSH
CORE PSH Residents	Residents who are formerly homeless, extremely low income, and have chronic substance use, mental, and/or physical health conditions that are manageable with ongoing PSH-level supports.	1. Stabilization in housing 2. Stabilization in health and overall wellness (rehabilitation) 3. Stabilization in community engagement 4. Transition up or down in care level as needs evolve. 5. Reduce premature mortality, with a focus on overdose as the most significant cause	1. Improve building stability 2. Reduce use of emergency services (ER, EMS, jail) 3. Improve system flow by increasing the number of residents who successfully stabilize and transition toward greater independence, reducing costs related to turnover, property impacts, and intensive service delivery. 4. Stronger connection into mainstream benefits. 5. Reintegration into community and positive social connections (faith based, employment, family, etc.)
Lower Needs Residents	Residents who are stably housed and who no longer need intensive services	1. Transition toward independence — either economic (via employment or long-term affordability supports) or temporary/tapering of stabilization supports 2. Viable pathways out of PSH to transition to independence	1. Increase system flow by freeing up higher-support PSH units for residents with greater needs. 2. Stronger connection into mainstream benefits. 3. Reintegration into community and positive social connections (faith based, employment, family, etc) 4. Pathways out must mirror what is accessible in PSH

Assessing Acuity & Risk of PSH Tenants

KEY FINDING

Administrative data alone cannot support a top-down redesign of the PSH portfolio or reliably define the "right" bed mix.

Views created using HEDIS measures + SMI identification give some directional information

01 Assess Existing Administrative Data

Evaluate data from HSH, DPH, LEMSA, and HSA to determine whether these sources can estimate the number and proportion of PSH clients requiring a higher level of care than currently available.

02 Fill Gaps with Qualitative Data

Identify clients who may be overlooked when relying solely on administrative data. Use qualitative data collection to surface needs that quantitative sources cannot capture.

03 Explore a Tenant Status Assessment

Investigate implementation of a recurring status assessment tool to regularly understand tenant stability and support dynamic, ongoing monitoring of the PSH population.

Workstream #3: Catalogue Current PSH Services

Status: In progress

Level 1

Light/As-Needed Services

~500 /3%

Target population
Lower-needs residents who have already stabilized in PSH

Key features
- Case management available but used as-needed
- No/limited on-site services or community-building
- Typically better amenities / larger units than standard SRO
- Similar to BMR/Section 8 units, plus light-touch services

🏢 **Site-based**

🔑 **Tenant-based**

~275 beds   **~225 beds**

Example: The Abigail Housing Ladder; Compass Family SSHP Housing Ladder

Level 2

Core Service Package

~13,000 beds/80%

Target population
Core PSH

Key features
- Regular meetings with case managers (1:14 – 1:25 ratio) to connect with wraparound services
- Community-building or community-integration support
- Varying levels of low-barrier services coordinated at the building level (e.g food, childcare, employment specialist)

🏢 **Site-based**

🔑 **Tenant-based**

~9,000 beds   **~ 4,000 beds**

Example: The Vincent CAAP Housing; Flexible Housing Subsidy Pool, City Gardens
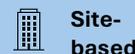
Level 3

More health-related support on-site

~2,000 beds/10%

Target population
Core PSH to Core + (higher acuity)

Key features
- Typically 1:25 case management ratio
- Community-building support
- More health-related interventions for higher-acuity clients available and integrated on-site (such as nursing and specialty MH)

🏢 **Site-based**

~2,000 beds

Example: Le Nain, 990 Polk, the Margo, 600 7th Street

Level 4

Intensive supports at client or building level

~500 beds / 3%

Target population
Exceeds Current / Typical PSH Capacity

Key features
- Multidisciplinary teams that closely coordinate care
- Often includes physical and behavioral health support, clinical case management, and home health aides
- Can be at the building-level (e.g. Cardea Health/Enhanced Care PSH) or at client-level (e.g. Full Service Partnership)

🏢 **Site-based**

~500 beds

Example: Kelly Cullen Community/Cardea Health and Full Service Partnerships

Workstream #4: Identify Gaps Initial Ideas

Status: In progress

Illustrative Resident Groups, Gaps & Solutions

Resident Group	Example Profile	Key Gaps Identified	Illustrative Improvements
Exceeds Typical PSH Capacity	Tenant with advanced dementia cycling between PSH, ED, and streets	• Barriers to higher-level placement • Limited enhanced PSH models • Financing gaps for complex care	• Structured placement pathways • Case conferencing for high-acuity tenants • Right-sized enhanced PSH models • Flexible stabilization funding
Core PSH Residents	Tenant with SMI and/or substance use disorder who can remain housed with intensive support	• Inconsistent service models • Lack of early stabilization workflows • Limited financing for higher-acuity support	• Tiered care ladder (ECM → ICM → ACT) • Strengthened roving BH models • Standardized assessments & transfer triggers
Lower-Need Residents	Tenant stable in housing but limited by income or benefit barriers	• No systematic step-down process • Limited move-on pathways	• Formal step-down identification • Employment & subsidy referrals • Barrier-removal supports

Governance Structure & Operating Framework

Status: In progress

Governance Structure & Operational Framework

What we mean by Governance Structure: ⟷ What we mean by Operational Framework:

What we mean by Governance Structure:

- Staffing expectations
- Roles/Responsibility
- Joint Decision making
- Accountability
- Service framework/menu of services for "Core PSH"
- Contracts
- Financing
- Data/Reporting
- Performance
- Policy Alignment
- Safety

What we mean by Operational Framework:

- Shared intake/transition/exit process
- Organizational principles
- Shared Workflows
- Uniformed interpretation and application of policy
- Standardized Safety protocols
- Case Conferencing
- MOUs/shared agreements

Next Steps

What are the immediate Next Steps?

Resident Group	Next Steps	Targeted Timeline
Exceeds Typical PSH	• Pilot exploration for hard to serve high acuity clients • PSH Accuity Analysis • Pre-placement Case Conference	• March 2026 • In progress • TBD
Core PSH	• Governance Structure & Operational Framework Working Sessions kick off • PSH Service Delivery Framework • Multiyear Procurement Plan Design PSH Design Sprints	• April 2026 • April 2026 • TBD
Low Acuity	• Iterating on mainstream benefits proposal	• Ongoing

Questions ?