

# **A Case Study of the City and County of San Francisco's Integrated Intake Unit**

## ***Recommendations for Marin County***

**ANA P. BAGTAS**

### **EXECUTIVE SUMMARY**

In 2007, Marin County's Department of Health and Human Services integrated its aging and adult social services programs. The Division of Aging and Adult Services was formed. The division continues to evolve, and developing a centralized intake and screening system has been identified as a next step in this process.

This paper explores the feasibility of implementing an integrated intake system in Marin County. The primary program model studied for this paper was the City and County of San Francisco's Integrated Intake Unit. Sonoma County's experience implementing a centralized intake process was also investigated. Recommendations for Marin County's

consideration in the development of an integrated intake system are as follows:

- Demonstrate the value and contributions of the program to the agency
- Celebrate the successes of the integrated intake team
- Avoid staff burnout and recruit unit employees based on "fit" for the program
- Establish methods to capture meaningful data that inform staff and management
- Explore the use of volunteers in the integrated intake unit
- Develop a formal training program for intake unit staff and volunteers

---

**Ana P. Bagtas, Programs Coordinator,  
Marin County Department of Health & Human Services**



# A Case Study of the City and County of San Francisco's Integrated Intake Unit

## *Recommendations for Marin County*

ANA P. BAGTAS

### **Introduction**

The Division of Aging and Adult Services was established in 2007 as a result of a restructuring within the County of Marin's Department of Health and Human Services. Prior to this event, this office was named the Division of Aging, dedicated to administering services for older adults and responsible for planning and coordinating the Area Agency on Aging in Marin County. Programs included in the integrated Division of Aging and Adult Services are Adult Protective Services, Area Agency on Aging, In-Home Supportive Services, Long-Term Care Ombudsman, Medical Case Management, Public Guardian, and Veterans Services.

Three years after the restructuring of adult and older adult programs in Marin County, centralizing the intake of programs within the Division of Aging and Adult Services was identified as a necessary next step. This paper explores the feasibility of developing and implementing an integrated intake system in Marin County. The Integrated Intake Unit of the City and County of San Francisco's Department of Aging and Adult Services was studied as a model to guide Marin in this process.

### **A Case Study of the City and County of San Francisco's Integrated Intake Unit**

The City and County of San Francisco's Department of Aging and Adult Services (SF DAAS) developed the Integrated Intake Unit in 2008 to fill the gaps in older adults,' disabled persons,' and family caregivers' access to services. The establishment of the Community Living Fund (CLF), charged with providing comprehensive case management and purchase of services to assist residents in moving out of institu-

tions and into community living, also prompted the creation of a centralized intake system. The idea is to create a central phone number for clients to call and receive a variety of services offered in San Francisco. A uniform tool to assess clients will be used to help maintain the quality of data and care plans. The ten resource centers that were running throughout the City were merged into one collaborative entity. Programs included in SF DAAS' Integrated Intake Unit are Adult Protective Services, Community Living Fund, Information and Assistance, Home-Delivered Meals, In-Home Supportive Services, and Veterans Services. The unit relies on community partners such as 211, 311, Aging and Disability Resource Centers, Community Living Fund service agencies, and meal providers to promote the program and reach clients.

**Resources and Inputs** The Integrated Intake Unit includes 13 full-time equivalent staff and a number of auxiliary and part-time employees. Existing job classifications and available resources were utilized, keeping the cost of launching the project to a minimum. No financial resources were dedicated towards the development of the Integrated Intake Unit. According to the unit's manager, net savings were actually realized due to the ability of licensed clinical social workers and those who are working towards licensure to time study and claim Skilled Professional Medical Personnel and County Services Block Grant—HR for APS and CLF intakes. Utilizing available technology further kept costs down. With the exception of APS and IHSS, data management for the Integrated Intake Unit is handled by RTZ, an existing vendor. Phone systems already in place throughout city and county offices are utilized in the unit.

**The Intake Process** Referrals to San Francisco's Integrated Intake Unit come from the CLF program, community-based service agencies, discharge planners, and members of the public. Referents call the dedicated intake phone number, 415-355-6700, and pick from a menu of language and program choices. Referrals may also be faxed to the unit, though most intakes are done by phone. The unit's phone tree is a pronged system where tier 1 staff with program-specific expertise receive the calls first: when no tier 1 intake-takers are available, the phone system will divert calls to tier 2 employees. All intake unit staff are able to field information and referral calls. Due to the nature of calls that are received for IHSS, another layer of the phone tree system has been set-up for this program's payroll function. A provider enrollment prompt associated with the phone tree system routes questions to the same phone number that answers payroll questions. When IHSS is chosen from the initial phone tree interface, the caller is diverted to another set of telephone prompts to properly route the calls.

**Marketing and Outreach** Consolidating all program phone numbers to one access point was challenging. Marketing and outreach campaigns to promote the phone number and the central intake system included advertisement campaigns, bus billboards, community presentations, partnership with 211, and other promotional activities. All prior program phone numbers were kept for a few years and calls were automatically routed to the intake unit.

**Reports** Reports to assess the quality of services and to identify areas for improvement are generated. Reports include abandonment rates, call volume, hold time, and program-specific requests. Information and Assistance receives approximately 300 to 400 intakes per month. IHSS and APS each receive around 400 to 500 monthly reports. AT&T uses a 5% benchmark for call abandonment rates. San Francisco's Integrated Intake Unit experiences higher phone abandonment rates, around 7-8% for APS, 20% for IHSS, and 10% for other programs. Approximately 50% of abandoned calls happen before

the two-minute mark. Call abandonment as a metric will be analyzed in further detail in the discussion section.

### **Challenges, Lessons Learned, and Successes**

Several factors contributed to the success of San Francisco's Integrated Intake Unit. Staff attentiveness to time studying has been important in tracking the work that may be claimed for funding. Proximate office space arrangements fostered increased collaboration among intake staff, availed consultants with program expertise, and promoted efficiency in processing cases. Cross-training intake staff also strengthened their professional capacity.

The availability of integrated technology systems translates to better coordination of care and reduced costs. Screeners have full access to the database system or have viewing privileges to case files. Management of cases is improved by providing social workers with the ability to follow a client's care plan, to view files and notes, and to avoid duplication of assignments. The system also eliminates the need for clients to provide the same demographic and functional information for every referral, which improves customer satisfaction. The integration of intakes also enables the unit to centralize wait lists for various services, including Meals-On-Wheels and housing vacancies, allowing staff to follow-up with clients when openings become available.

The phone tree system, though efficient, has its shortcomings. With all calls going directly to the automated phone tree, the absence of a "live" person may turn people away, contributing to hang-ups and high abandonment rates. IHSS staff mentioned a significant drop in calls when the integrated intake was introduced, though they concurred that the system has significant benefits.

Dealing with change can also be difficult. Modifications in job responsibilities, roles, and expectations can be trying for some staff. Communicating with the unions and staff and involving them in the discussions from the very start were critical.

## Discussion

San Francisco's Integrated Intake Unit is relatively new and it is continuing to improve. The unit's program manager recognizes that there is no substitute for having a live person as a first interface with customers. However, the phone tree system works effectively and expediently in screening calls and routing clients to the appropriate program.

A more flexible pronged telephone system may be the next step. In this approach, staff will have a telephone log-in ID to signal the system that they are at their desk and are available to take calls. The phone tree will only kick-in when no live person is available. A concern about the pronged system is that staff and unions may not support it, as it gives the impression that employees' movements are being closely tracked. San Francisco should carefully and sensitively approach this option.

Factors contributing to the Integrated Intake Unit's high hang-up and call abandonment rates need further exploration. Readers are cautioned of evaluating the quality of the integrated intake approach based on these metrics. AT&T's 5% benchmark for abandoned calls is based on a call center model. Calls to the integrated intake unit are much different. IHSS referral calls usually last an average of 30 minutes, not to mention the amount of time workers spend on research, which prevents staff from answering other calls. The IHSS call abandonment rate is also much higher because over 50% of referrals are received by fax, and much time is spent processing these referrals off the phone. APS is in a similar situation. The program should be evaluated based on the nature of the calls and the quality of the response, rather than relying heavily on abandonment rates, which fall short of providing a full picture of the situation. Better metrics that assess the impact of a centralized intake should be established. Metrics may include successful placement of clients in appropriate programs, improvements in the quality of life of residents transitioned out of institutions, and reduced processing time of referrals.

Given the intake unit was created by pulling together existing job classifications from various programs, multiple job classifications currently exist. The unit manager sees an opportunity to keep classification down to no more than two. Information and Assistance is the glue that holds all of the various classifications together. Ideally, the Human Resource Department, with input from the unions, could create an Information and Assistance job class specific for the Integrated Intake Unit.

## Lessons from Sonoma County

Sonoma County provides a different insight into the administration of an integrated intake system. For nine years, Sonoma County's Aging and Adult Services department ran an integrated intake and screening system for its Adult Protective Services, In-Home Supportive Services, and Information and Referral program. The program was discontinued over two years ago, and a new intake process is currently being developed.

Several factors were cited for the breakdown of the integrated intake system in Sonoma County. Primary among them is the dramatic increase in referrals to Adult Protective Services, which created a workload imbalance. As a result, intakes were incomplete, which frustrated supervisors' ability to make good assignments for both APS and IHSS. IHSS regulations got also more complex over the years, compounding the issues and compromising the integrity of the program.

Structural issues may have also contributed to the downfall of the program in Sonoma County. The key informant interviewed for this paper referred to the job as a "burnout position." Filling vacant intake positions was very challenging. A few social workers stepped in, but none lasted for very long. Since the position also calls for a master's degree level of education, (and a Social Worker IV requirement for APS), staff felt that doing intakes was a waste of their skills. Though Sonoma recruited for this position under a new job classification, no application was received.

Sonoma County has been experimenting with alternatives to the staffing of the traditional integrated intake model. Starting in July 2011, Sonoma County will test the staffing of the intake desk on a six-month rotational schedule.

### Recommendations for Marin County

San Francisco's experience implementing an integrated intake and screening project provides Marin County with a replicable model as it pursues the development of a similar program. Lessons learned from Sonoma County should also be considered to ensure the viability of the program in Marin. Recommendations for the development and implementation of an integrated intake system in Marin County are as follows:

- 1 Demonstrate the relevance of the program to all stakeholders. This involves open and honest dialogue with staff and unions, and later, with external and internal partners. Showing the usefulness of an integrated intake system to multiple programs is important.
- 2 Take time to celebrate the gains and successes of the integrated intake team. Schedule team-building retreats, not trainings. Check-in with the team periodically to identify troublesome areas, address personnel issues, and boost staff morale.
- 3 Avoid staff burnout at all costs. A constant reminder of the value of the program and the contributions of intake staff is essential. Staff the intake unit with the right people who show genuine interest in the work and who understand its functions. If staff show interest in performing hybrid assignments that blend work in the field with the intake desk, such opportunities should be considered. Marin should also follow-up with Sonoma County to see how their rotational approach to staffing the intake unit is taking shape.
- 4 Collect meaningful data that informs management and assess progress toward program goals. Maxcess, the database used by Marin's Division of Aging and Adult Services, should be the cen-

tralized data system for the intake unit. This system should be able to generate reports. A logic model that identifies short- and long-term outcome metrics should also be developed.

- 5 Explore the use of volunteers specifically for the intake and screening functions. Retired county employees, especially those with experience in social work or social services programs, are prime candidates for this volunteer opportunity. Professional trade groups, such as the associations of nurses, social workers, and mental health clinicians, should be contacted and presented with opportunities for retired professionals within the agency.
- 6 Develop a training program for intake staff and volunteers. This is imperative in maintaining the integrity of the program and ensuring the consistency of the intake and screening process. A well-structured training curriculum will help sustain the viability of the program by buffering against the loss of institutional knowledge when there is turnover in staffing.

Overall, the author endorses the formation of an integrated intake and screening system in Marin County. Such a system increases clients' access to services, improves customer satisfaction, promotes coordination of care, and supports staff development. Doing so also demonstrates Marin's readiness to become the next county to implement an Adult Disability Resource Center (ADHC). Only a handful of counties currently operate an ADHC nationally.

### Acknowledgements

Special thanks to the following individuals of the City and County of San Francisco for their warm reception and generosity of time to help in the development of this report: Jason Adamek, Susan Garbuio, Anne Hinton, Ria Mercado, John Murray, Mario Navarro, Trent Rhorer, and Hugh Wang. My gratitude goes to my director, Nicholas Trunzo, and to BASSC liaison, Heather Ravani, for supporting my participation in this incredible program.