May 24, 2022

Mental Health San Francisco

Implementation Working Group

San Francisco
Department of Public Health

harder + co | community research

Call to Order/Roll Call

Scott Arai and Shon Buford’s last IWG meeting!

And also a big thank you to Philip Jones!

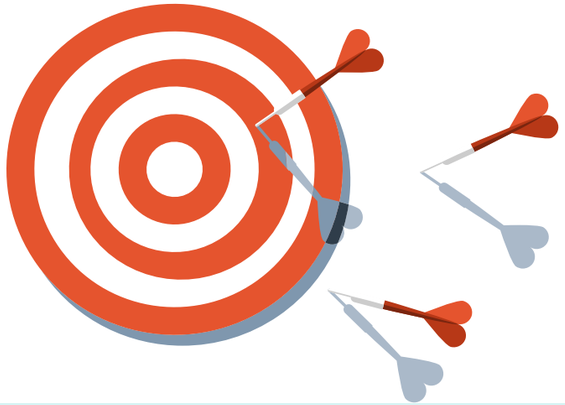
Vote to
Excuse Absent Member(s)

Decision Rule:

- Simply majority, by roll call

Meeting Goals

1. Receive brief monthly Director's update
2. Receive an update and provide feedback on the Minna Project
3. Discuss and potentially vote on Crisis Stabilization Unit recs
4. Receive an update from the Controller's Office on the Mental Health Service Center Options Analysis and provide feedback
5. Receive an update on the Street Crisis Response Team



All materials can be found on the MHSF IWG website at: https://www.sfdph.org/dph/comupg/knowlcol/mentalhlth/Implementation.asp

Reminder: Mental Health SF Domains

Marlo Simmons

Dr Angelica Almeida

Kathleen Silk

April Sloan

Mental Health SF Domains

- **Office of Coordinated Care**
  - Case Management and Navigation
  - Overall Care Coordination
  - Marketing / Community Outreach
  - Inventory of Programs and Services
- **Street Crisis Response Team**
  - Pilot Phase
  - Ongoing Implementation
- **Mental Health Service Center**
  - Centralized Access
  - Pharmacy Services
  - Transportation
- **New Beds and Facilities*** (Mental Health and Substance Use Treatment Expansion)
  - Expanding Existing Models
  - Drug Sobering Center
  - Crisis Unit
  - TAY

Eme Garcia

Yoonjung Kim

Max Rocha

Dan Kaplan

Jamila Wilson

Mike Wylie

Data and IT Systems | HR Hiring and Pipeline | Equity | Analytics and Evaluation

9:10 AM - 9:15 AM

Discussion Item #1

Remote Meeting Update

All materials can be found on the MHSF IWG website at:
https://www.sfdph.org/dph/comupg/knowlcol/mentalhlth/Implementation.asp

State and Local Requirements

RESOLVED, as follows:

1. the State of California and the City remain in a state of emergency due to the COVID-19 pandemic. At this meeting, the IWG has considered the circumstances of the state of emergency.

2. As described above, because of the COVID-19 pandemic, conducting meetings of this body and its discussion groups in person would present imminent risks to the safety of attendees, and the state of emergency continues to directly impact the ability of members to meet safely in person

Public Comment for Discussion Item #1

Remote Meeting Update

Steps:

- Call (415) 655-0001
- Enter access code 2491 802 4812
- Press ‘#’ and then ‘#’ again

Vote on Discussion Item #1

Remote Meeting “Findings”

Decision Rule:

- Simply majority, by roll call

9:15 AM - 9:25 AM

Discussion Item #2

Approve Meeting Minutes

All materials can be found on the MHSF IWG website at:
https://www.sfdph.org/dph/comupg/knowlcol/mentalhlth/Implementation.asp

Public Comment for Discussion Item #2

Approve Meeting Minutes

Steps:

- Call (415) 655-0001
- Enter access code 2491 802 4812
- Press ‘#’ and then ‘#’ again

Vote on Discussion Item #2

Approve Meeting Minutes

Decision Rule:

- Simply majority, by roll call

9:25 AM - 9:30 AM

Discussion Item #3

MHSF Director's Update

Marlo Simmons

All materials can be found on the MHSF IWG website at:
https://www.sfdph.org/dph/comupg/knowlcol/mentalhlth/Implementation.asp

Public Comment for Discussion Item #3

MHSF Director’s Update

Steps:

- Call (415) 655-0001
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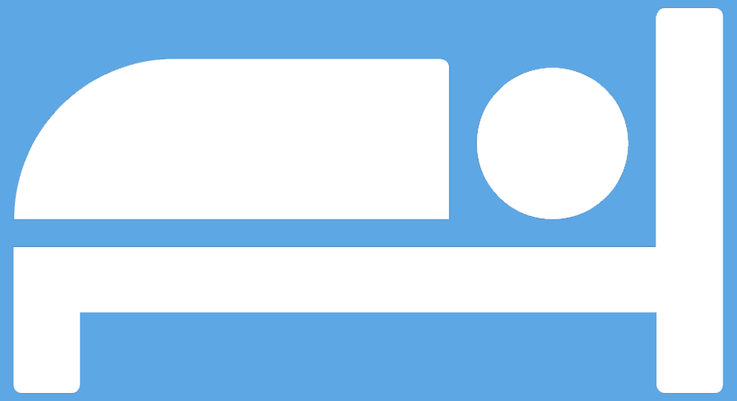
- Press ‘#’ and then ‘#’ again

9:30-10:20

Discussion Item #4

New Beds and Facilities: Minna Project Update & Feedback



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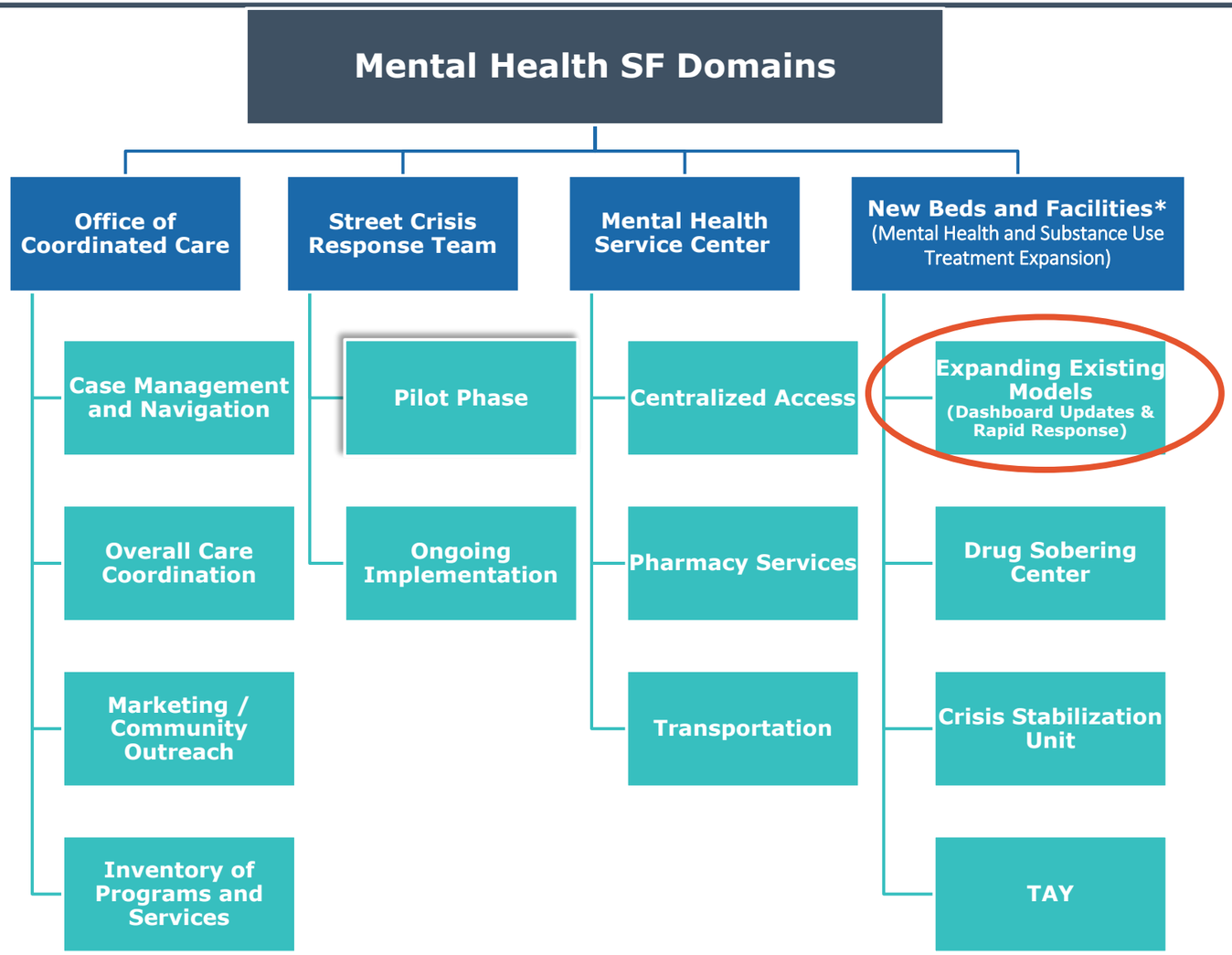
Reminder: Mental Health SF Domains



Yoonjung Kim

Max Rocha

Data and IT Systems | HR Hiring and Pipeline | Equity | Analytics and Evaluation

A Different Process: Rapid Response

- Dashboard updated to include **Minna Project**
- Rapid nature of project required similar response from IWG
  - DPH met with members of IWG to develop understanding
  - Participating IWG members provided feedback of how to hone presentation to focus IWG feedback
  - IWG members gave initial feedback to DPH, to be summarized after DPH presentation

DPH Behavioral Health Residential Treatment Expansion Dashboard*

DPH Behavioral Health Residential Treatment Expansion

The San Francisco Department of Public Health (DPH) is increasing residential treatment and care services by approximately 400 overnight treatment spaces, or beds. The expansion effort is guided by the 2020 DPH Behavioral Health Bed Optimization Report, Mental Health SF legislation, and with input from stakeholders. The goal is to offer high quality, timely, easily accessible, coordinated, and recovery-oriented care delivered in the least restrictive setting.

KEY — May 5, 2022

Project Phases and Status: Complete; In process; Planned

Δ MHSF legislation

1 Program design; 2 Regulatory assessment; 3 Facility selection; 4 Out for bid/contracting; 5 Community outreach & City approvals; 6 Permit & construction

Goal 30	Open 2021 — **Hummingbird - Valencia** — Status Serving clients — Open — *28 beds currently available*	Psychiatric respite facility to serve people experiencing homelessness from the Mission and Castro
Goal 20 Est. Beds	Open 2020 — **Managed Alcohol Program** — Status Permanent location and additional funding will expand the program from 10 beds to 20 beds — Open — *10 beds currently available*	Pilot | Medical supervision for people with chronic alcohol dependency
Goal 30 Beds	Open 2021 — **12-month Rehabilitative Board and Care** — Status Serving clients — Open — *Client placement varies*	Pilot | Out-of-county supervised living and treatment for people with chronic mental health illness and/or coming from locked facilities
Goal 31 Est. Beds	Open 2021 — **Mental Health Rehabilitation Beds** (aka LSAT) — Status Serving clients — Open — *Client placement varies*	Out-of-county psychosocial rehabilitation for people who are conserved in a locked setting
Goal 13 Est. Beds	Open 2022 — **Psychiatric Skilled Nursing Facilities** (aka PSNF) — Status Serving clients — Open — *Client placement varies*	Out-of-county secure 24-hour medical care for people with chronic mental health conditions
Goal 69 Est. Beds	Open 2022 — **Residential Care Facility** Δ (aka Board and Care) — Status Serving clients — Open — *23 beds currently available*	Supervised residential program for individuals with mental health issues who require assistance with activities of daily living.
Goal 75 Est. Beds	Open 2022 — **Minna Project** (aka Dual Diagnosis Transitional Care for People With Justice Involvement) — Status Serving clients — Open — *12 beds currently available*	Transitional care for people in contact with the criminal justice system with a dual diagnosis of mental health and/or substance use issue
Goal 20 Est. Beds	Opening Spring 2022 — **SOMA RISE** Δ (aka Drug Sobering Center) — Status Completing construction — 1 2 3 4 5 6	Pilot | 24-7 program for people experiencing homelessness with drug intoxication, providing short term stays and linkage to services
Goal 6 Est. Beds	Opening 2022 — **Cooperative Living for Mental Health** Δ — Status Accepting applications — 1 2 3 4	Communal living for people with chronic mental health and/or substance use Additional $11M to stabilize leased properties available through MOHCD
Goal 16 Est. Beds	Opening 2023 — **Crisis Diversion Facility** Δ — Status Program design in development — 1 2 3	Short-term, urgent care intervention as an alternative to hospital care
Goal 30 Est. Beds	Opening 2023 — **Enhanced Dual Diagnosis** Δ — Status Contracting in process — 1 2 3	Transitional medically enhanced care for people with a dual diagnosis of mental health and substance use issues
Goal 10 Est. Beds	Opening 2023 — **Transitional Age Youth (TAY) Residential Treatment** Δ — Status Program design in development — 1	Supervised treatment for young adults with serious mental health and/or substance use issues
Goal 70 Est. Beds	Opening 2023 — **Residential Step-down - SUD** Δ — Status Active negotiations to acquire a building — 1	Long-term sober living environment for clients coming out of residential care programs

*https://sf.gov/residential-care-and-treatment

PRESENTATION OUTLINE

- Background
- Systems Gaps
- Program Overview and Models
  - Purpose
  - Program Scope
  - Site Overview
  - On-site Supportive Services
- Community Engagement
- Data and Evaluation
- Questions

BACKGROUND

- Many people in California prisons/jails have significant mental health needs
  - CA prison inmates: 15% of men and 30% of women have SMI
  - San Francisco county jail: 15% inmates treated for mental illness
- More than 50% of clients who are receiving services from Community Assessment & Services Center (CASC) have serious mental illness (SMI)
  - Case manage 320 clients - 170 with SMI
  - And of those with SMI, 50% are also chronically homeless

APD'S REENTRY DIVISION

- Design and implement a portfolio of reentry and rehabilitative services
- Operate15 transitional housing programs (345 units)
- Housing Data FY 20/21
  - 611 justice involved adults housed
  - Reduced homelessness by 77,111 days
  - 140 participants placed in permanent or stable housing

SERVICE GAPS

- Long wait to access permanent housing
- Challenges in accessing residential treatment programs
  - Moderate to long wait to access dual diagnosis programs
  - Highly structured programs that require compliance with state regulations
- High demand for more low-threshold programs for people
  - May not be interested or ready for a structured program

PURPOSE

San Francisco Department of Public Health and Adult Probation Department are working in partnership to provide transitional living for justice-involved clients with behavioral health needs, focusing on providing wrap-around services for dually diagnosed clients.

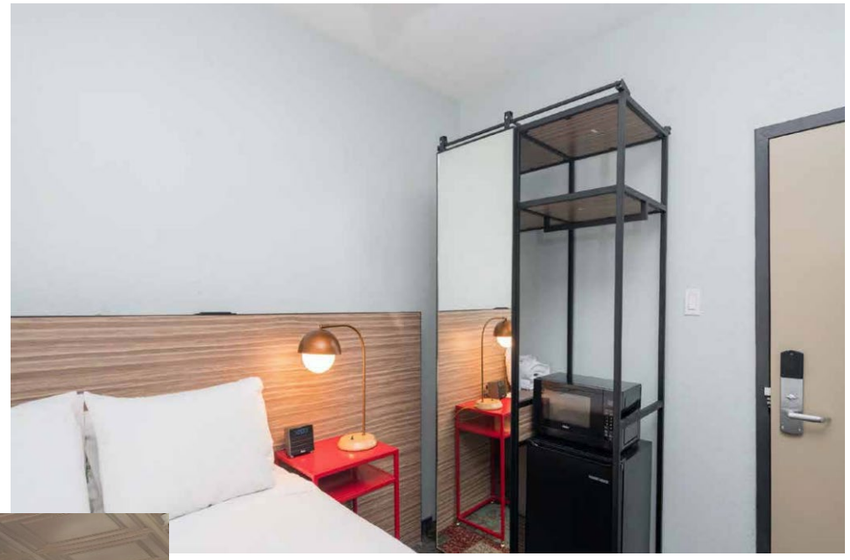
PROGRAM SCOPE

- **Goal:** Improve quality of life and enhance recovery for clients with justice-involvement and mental illness and/or substance use disorder
  - Improve behavioral health of clients with justice involvement
  - Reduce repeated encounters with the justice system
  - Reduce homelessness
  - Increase transitional housing and treatment opportunities for people coming out of jail
  - Equity at the forefront of the program

OVERVIEW OF THE SITE

- Located at 509 Minna Street, San Francisco
- Used to be a commercial hotel; master leasing the property
- Newly remodeled

OVERVIEW OF THE SITE



- 75 units with private baths
- Treatment space
- Commercial kitchen and laundry facility
- Two dining rooms

ON-SITE SUPPORTIVE SERVICES

INDIVIDUALIZED SUPPORT SERVICES PROVIDED ON SITE IS THE KEY COMPONENT

DPH Clinical Services

- Clinical services
  - Clinical assessment and review
  - Case management
  - On-site specialty MH outpatient services
  - Medication management
  - Individual therapy
  - Group therapy

APD Supportive Services

- Property management
- Reentry case management services
- Program coordination, referrals and intakes
- On-site 12-step and support group
- Peer support

DYNAMIC PARTNERSHIP

- Department of Public Health – funding and clinical oversight
  - UCSF Citywide Case Management Services
- Adult Probation Department – transitional housing and case management
  - Westside Community Services

REFERRALS

- Accept referrals from: jail, BH Court, Parole/Probation Office, Pre-Trial Diversion, residential behavioral health programs, outpatient behavioral health services, hospitals, etc.
  - Prioritize clients currently in the forensic system (jail, BH court, etc.)
  - Receive clients graduated from a mental health residential treatment program who need ongoing support and stabilization
  - Receive clients waiting for placement at a mental health residential treatment program
  - Spanish monolingual clients
- Referrals can be made via the CASC website: https://www.reentrysf.org/minna (under construction)

ELIGIBILITY

- Eligibility Criteria:
  - Experiencing homelessness
  - SF resident
  - History of justice involvement
  - Mental illness and/or substance use disorder
  - Independent in activities of daily living
- Expected average length of stay: about 1 year

HIGHLIGHTS

- Ribbon cutting ceremony is scheduled for June 9th, 2022.
- Phasing in of client admission through to October, starting May 2022.
- The Minna Hotel is budgeted under Proposition C (OCOH)
  to receive approximately $4.7 million annual operating funds, which includes master lease and on-site supportive services.

COMMUNITY ENGAGEMENT PLAN:

PARTNERING TO ENHANCE CARE

- Positive feedback from the neighborhood:
  - The local neighborhood community has been notified of the intent to situate the Minna Hotel as a community resource.

- Various stakeholders, including the BH court judges and staff, pre-trial diversion, jail and other partners, will be reached out in order to receive their inputs.

- Equity-related interviews or focus-group at CASC will be conducted to hear diverse voices from clients with SMI and/or SUD who have justice-involved history.

DATA AND EVALUATION

- The Minna Project will perform annual evaluations on
  - Client benefit and satisfaction
  - Transitions and connections to other services
  - Racial equity
- Metrics will be aligned with other MHSF Key Performance Indicators, including measures of
  - Increase in linkage to housing
  - Reduction in jail time
  - Reduction in repeated encounters with the justice system
  - Increase in treatment opportunity
- We will also aim to measure impact across racial and ethnic groups to monitor how this program advances equity.

KEY QUESTIONS FOR CONSIDERATION

- What are key principles or design elements for the clinical services to consider/incorporate?

- Additional ideas to further support racial equity?

- What do you think are the priority measurable outcomes for behavioral health services?

Discussion Group Conv

Key Points Discussed

- Low threshold program
- Do not need to go through probation to have access
- Prioritizes Spanish-speaking/monolingual consumers (gap in service)
- Community engagement plan under way to hear from diverse voices who have justice involved history/suffering from mental illness/substance use
- A drug free site, but recognizes there will be drug use and people will be supported regardless
- Citywide patient services (Medi-Cal billing contractor)
- Client can stay from a month to as long as 2 years
- This will not be part of OCC - will be part of residential system of care
- Referral process managed by Westside, with DPH clinic review on a regular basis.

IWG Principles

IWG recommendations and feedback consider:

1. Evidence and/or community based best practices
2. Prioritize mental health and/or substance use services for people in crisis.
3. Provide timely and easy access to mental health and substance use treatment (low barriers to services).
4. Ensure welcoming, nonjudgmental, and equity- driven treatment programs/spaces
5. Use a harm reduction approach
6. Ensure adequate level of free and low-cost medical substance use services and residential treatment slots
7. Integrate mental health and substance use services
8. Ensure workers associated with the project are paid a parity wage with public employees
9. Continuum of services

Minna Project Feedback

Share screen for virtual white board

(white board results will be posted in meeting minutes)

Public Comment for Discussion Item #4

Minna Project Update & Feedback

Steps:

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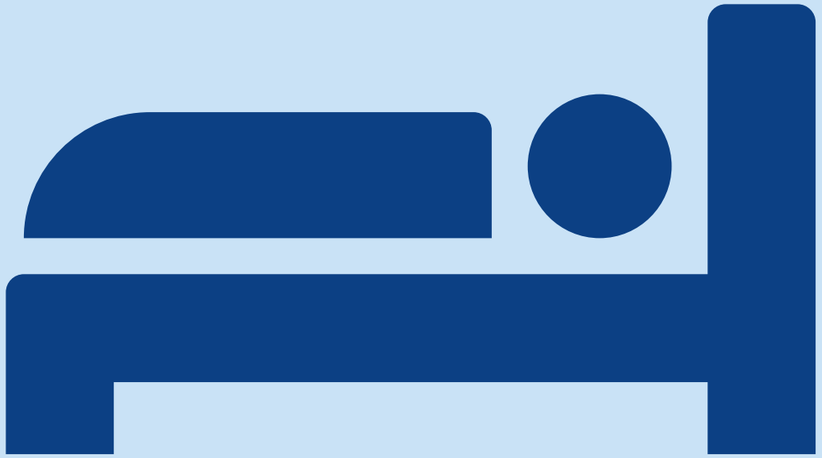
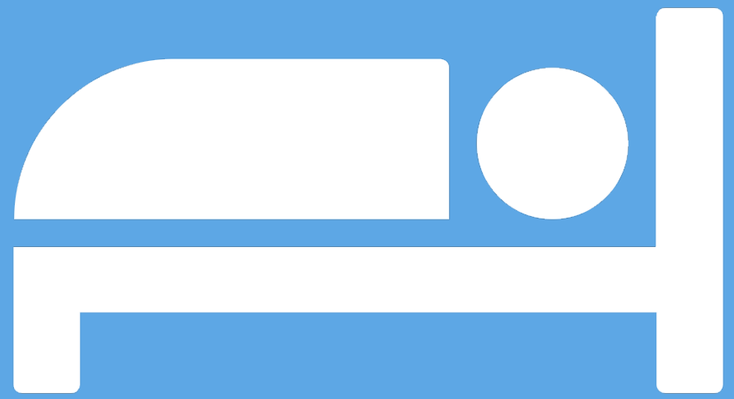
- Press ‘#’ and then ‘#’ again



10:20-11:15

Discussion Item #5

New Beds and Facilities: Crisis Stabilization Unit Recommendations



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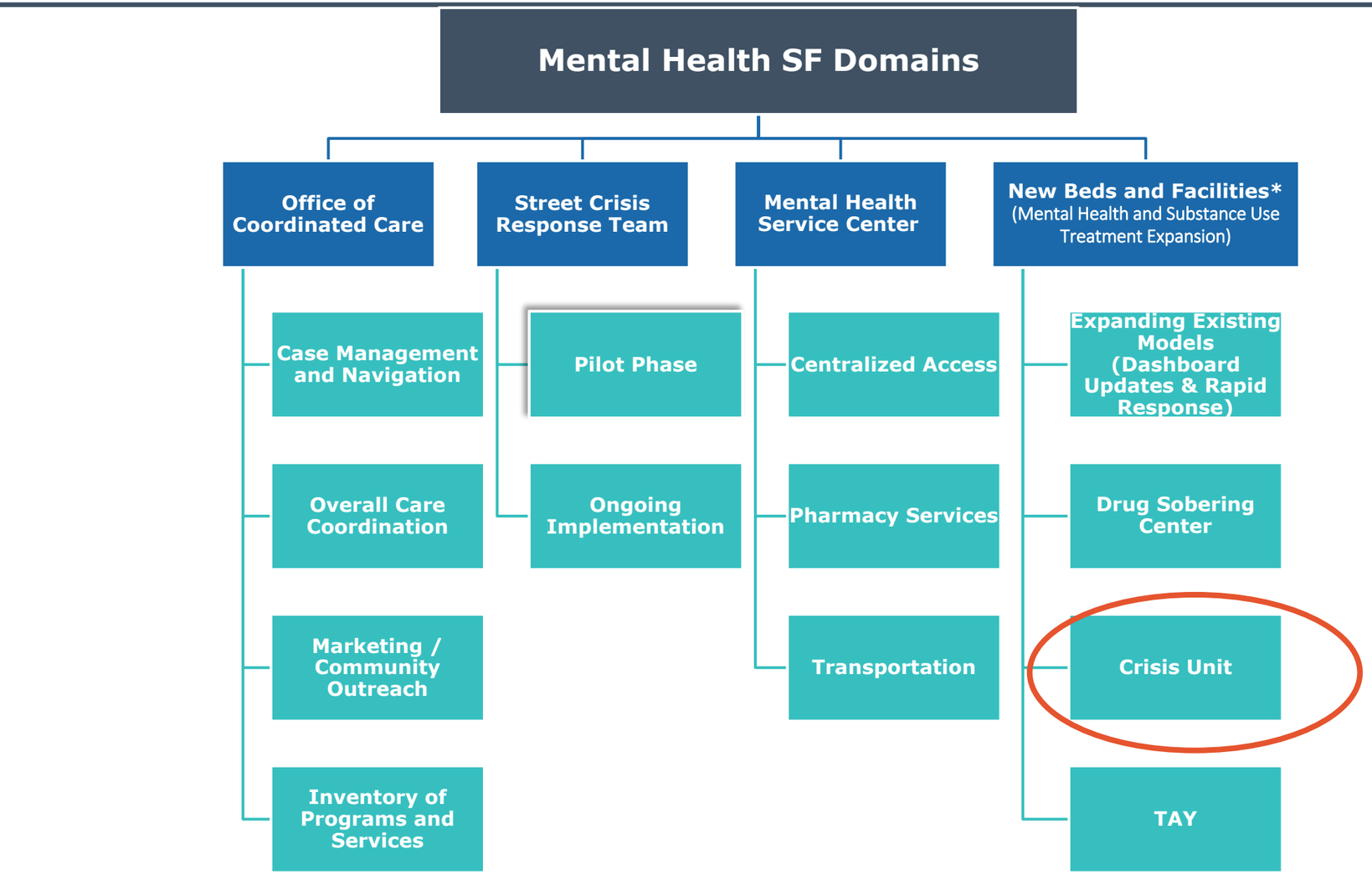
Reminder: Mental Health SF Domains



Eme Garcia

Data and IT Systems | HR Hiring and Pipeline | Equity | Analytics and Evaluation

Reminder of the Recommendation Roadmap

You are here!

September 28-October 26*
IWG receives background and discusses

November 9*
IWG engages in white board session to source recommendation ideas

December
Discussion Group crafts recommendations

January 25*
IWG reviews Discussion Group's work

March-May
Discussion Group refines recommendation wording

May 24 *
Review recommendations and vote

Conflict of Interest key
- = step out
- = be vigilant
- = all can participate

* Occurs during monthly IWG public meetings

Discussion Groups Key Takeaways

Takeaways specific to CSU

- The CSU has a **sustainability plan**, informed by data on how long people stay and Medi-Cal reimbursement rates
- The unit is **cost effective at 8 or 16 individuals** due to staffing ratios

Takeaways larger than CSU

- Need to **map the continuum of care**- both to ID gaps AND ensure effective referrals and supports (connection to OCC discussion group?)
- Need advocacy for underlying issues (e.g., housing, Medi-Cal reimbursements)

Crisis Diversion Unit Recommendations

Share screen

of recommendations

Crisis Stabilization Unit Recommendations

What is your level of agreement with the current Crisis Stabilization Unit Recommendations?

Public Comment for Discussion Item #5

New Beds and Facilities: Crisis Stabilization Unit Recommendations

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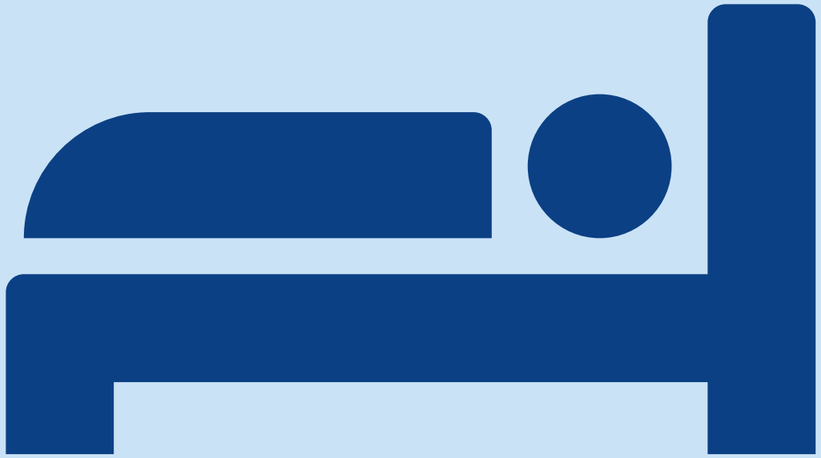
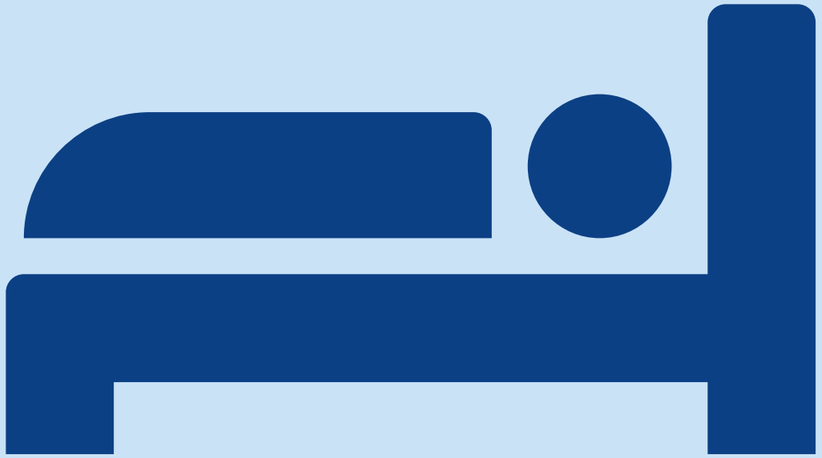


Vote on Discussion Item #5

New Beds and Facilities: Crisis Stabilization Unit Recommendations

Decision Rule:

- Simply majority, by roll call




5 Minute Break

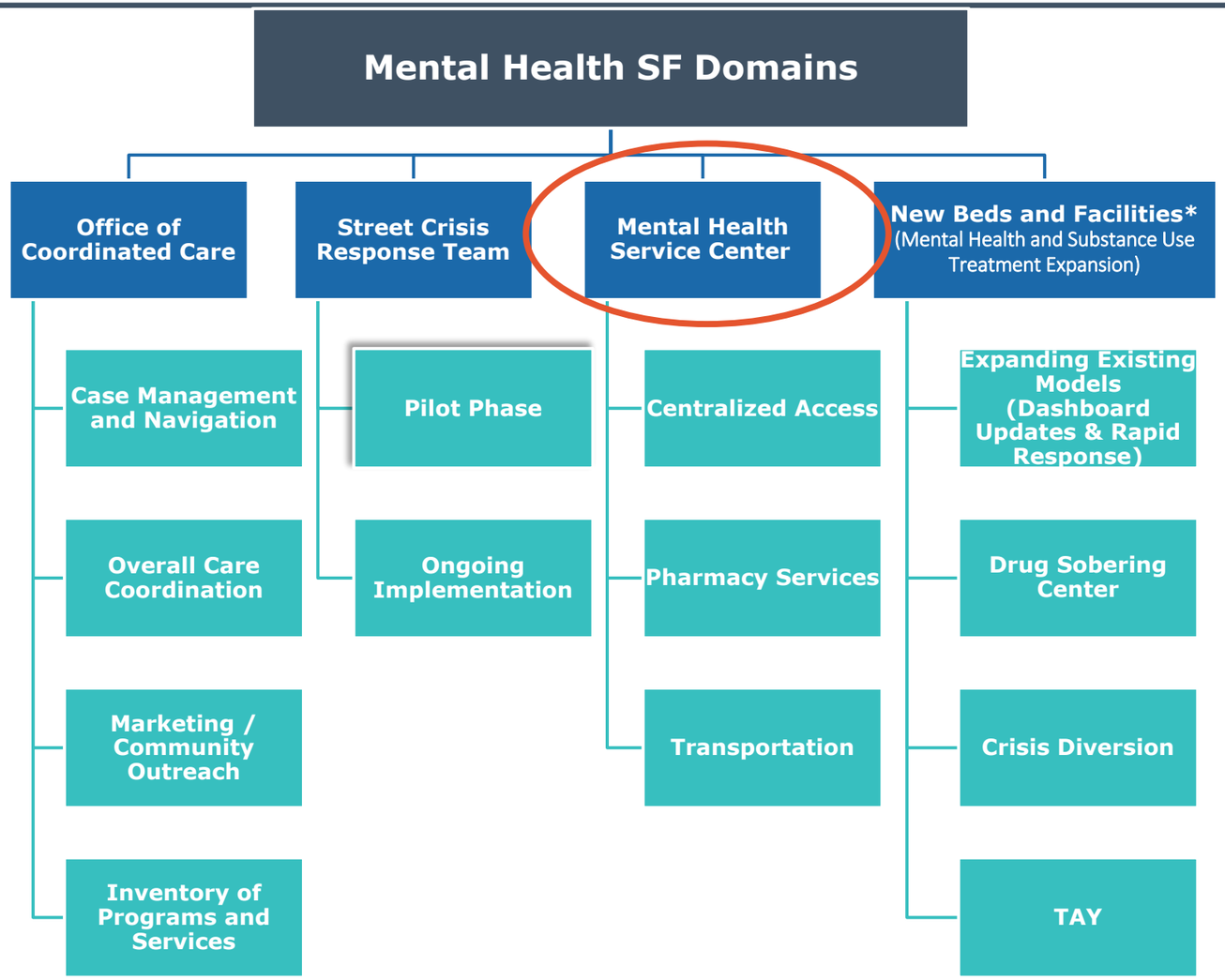
11:20 - 12:25 PM

Discussion Item #6

Mental Health Service Center: CON Options Analysis Briefing and Feedback

All materials can be found on the MHSF IWG website at:
https://www.sfdph.org/dph/comupg/knowlcol/mentalhlth/Implementation.asp

Reminder: Mental Health SF Domains



Mike Wylie

Jamila Wilson

Dan Kaplan

Data and IT Systems | HR Hiring and Pipeline | Equity | Analytics and Evaluation

Mental Health Service Center

Update #2: Benchmarking + Service Crosswalk

CITY & COUNTY OF SAN FRANCISCO

Office of the Controller
City Performance Unit

Mike Wylie | Dan Kaplan | Jamila Wilson

05.24.2022

Agenda

Background

Service Center Benchmarking

Discussion

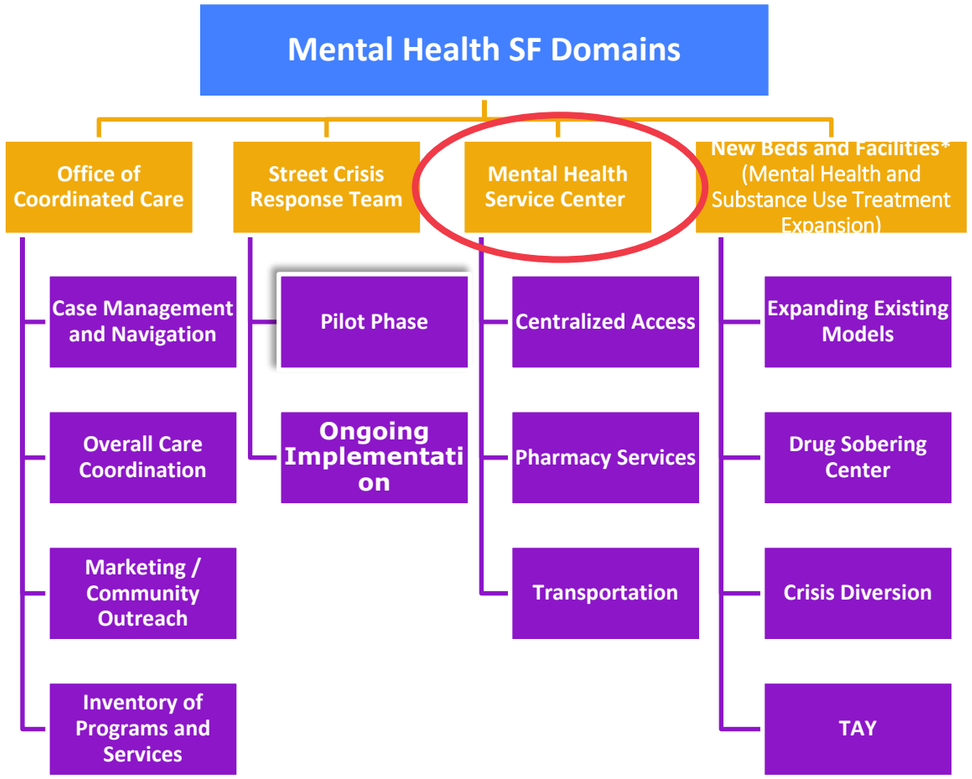
Crosswalk of Services

Jamboard Exercise
Discussion

Overview of Mental Health Service Center (MHSC)

What is the MHSC? What does the legislation require?

Reminder: Mental Health SF Domains



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Deliverables and Timeline

Planned Deliverables

- **Crosswalk of Existing Services** -- Identify current services, remaining gaps compared to the legislation.
- **Benchmarking** – Research several other 24/7 service models, including program structure, demand, and key lessons learned.
- *Equity Assessment* – Work with DPH's equity leads to ensure appropriate criteria are considered in the analysis.
- *Interviews with MHSF Stakeholders* – Share findings and solicit feedback on the analysis.
- *Options + Cost Analysis* – Provide three options for a MHSC roll-out, from a standalone to a virtual center approach. Provide cost estimates for each.
- *Project Summary* – Summarize project work in a Powerpoint deck.

Planned Delivery Date = June 30

MHSC Legislative Requirements

The MHSF legislation specifies the Service Center provide 6 key services.

Assessment of Immediate Need
Assess a patient's need for immediate medical treatment refer as necessary and appropriate.

Psychiatric Assessment, Diagnosis, Case Management, and Treatment
Provide onsite consultations, diagnosis and/or referral, create a treatment plan, prescribe medications, and assign case mgmt./care.

Pharmacy Services
Stock and provide mental health + substance use medications at a reasonable cost 7 days a week.

MH Urgent Care
Clinical intervention for those experiencing escalating psychiatric crisis and require rapid engagement, assessment, and intervention.

Transportation
To other service sites.
From Jail and ZSFGH.

Drug Sobering Center
Clinical support and beds at appropriate level of care for individuals experiencing psychosis due to drug use.

Benchmarking

How do other jurisdictions provide 24/7 entry to behavioral health services?
Is there overlap with the proposed MHSC?

Methodology

Project team met with 6 jurisdictions.

Comparable Health Systems

- California Association of Public Hospitals Lists 12 counties with public hospitals
- County Behavioral Health Directors Association recommendations
- Out-of-state jurisdictions with known comparable systems
- Total = 12 municipalities

Desk Research into 24/7 Services

- Team conducted a web review of mental health programs similar to MHSC at municipalities.
- Identified 6 municipalities with MHSC-like programs.

Interviewed Jurisdictions

Interviewed 3 types of roles:

- County Behavioral Health Directors
- Directors of Call-Centers
- Directors of Drop-in Services

Also spoke with 1 vendor.

Santa Clara County

Population = 1.9m
PIT Count = 9,706
Area = 1,304 sq mi

Operates a 24/7 call center and a drop-in urgent care.

Call Center—BHS Call Center

- **County-operated.**
- *Services Provided—* Operates individual call lines for mental health and substance use. Both lines provide initial screenings, counseling, and referrals.
- *Staffing—*Skilled screeners conduct initial screenings for both lines. Clinicians take mental health crisis calls and certified counselors take substance use calls.

Drop-In Services—Urgent Care

- **County-operated.**
- *Services Provided*— Psychiatric evaluation, diagnosis and treatment. Brief medication management, referral to services and community resources, phone consultations with clinical staff.
- *Staffing—*Clinical staff, Licensed Practitioners of the Healing Arts (LPHA's), and doctors. Languages spoken: English, Mandarin, Spanish, Korean, Farsi, Vietnamese

New York City

Population = 8.8m
PIT Count = 78,604
Area = 306 sq mi

Operates 24/7 virtual model offering call/text/chat services.

Call Center—NYC Well

- **Vendor-operated.**
- *Services Provided—*Crisis counseling, information and referrals to services, and suicide prevention. Translation service to provide care in 200+ languages. All communications are anonymous unless client is being referred to care. Referrals can be made to a particular clinic, mobile crisis teams, or a number of nonprofit providers. Dispatch of mobile crisis teams occurs from 8am-8pm for individual care in the home.
- *Staffing—* Counselors and peer support staff
- *Origins—* Grew out of a suicide prevention hotline. Plans to evolve with the introduction of 9-8-8

Multnomah County

Pop = 803,377
PIT Count = 4,015
Area = 466 sq mi

Operates a call center (24/7) and walk-in clinic (extended hours).

Call Center—BH Crisis Intervention Line

- **County-operated.**
- *Services Provided*—Needs assessment of individual, referral to Cascadia health services or alternative resources.

Drop-In Services—Cascadia Health and Planned Resource Center

- **Vendor-operated.**
- *Services Provided*—Cascadia Health provides mental health, addiction recovery, primary care resources. They operate Multnomah's urgent walk-in clinic with counseling services, access to prescriptions, and referrals. Cascadia mobile crisis teams are utilized for direct care.
- *Next Steps*— Opening a multi-story Behavioral Health Resource Center Fall 2022. Contracted Staff. Non-crisis space with basic care services (laundry, showers, etc.) and connection to resources, housing and mental health services. Partially funded through local bonds.

Los Angeles County

Population = 9.8m
PIT Count = 56,257
Area = 4,753 sq mi

Operates a call center and 7 drop-in urgent care centers. (both 24/7)

Call Center—ACCESS Center

- **County-operated.**
- *Staffing*--Clinical and non-clinical staff with crisis and referral skillsets; licensed clinical supervisor.
- *Origins*—In operation since 1980s; now merging with 9-8-8 line.

Drop-In Services—Urgent Care Centers

- **Vendor-operated.**
- *Services Provided*--Crisis intervention, linkage, housing connections, and therapeutic transportation. Clients can stay for up to 24 hours.
- *Staffing*--Psychiatrists, nurse practitioners, licensed case workers, peer support staff, nurses to administer medications, and certain specialists (housing or case manager).
- *Origins*--First center opened in 2003; most have been open for <5 years.

Orange County

Population = 3.2m
PIT Count = 6,860
Area = 948 sq mi

Operates a 24/7 in-person care center. Minimal drop-ins, with most clients sourced from law-enforcement drop-offs.

In-Person Services—BeWell OC

- **Public, private, and CBO partnership.**
- *Services Provided*--Substance Use Disorder Unit, Drug Sobering Center, Crisis Stabilization Unit, Crisis and Substance Abuse Residential Services.
- *Staffing*—Licensed clinicians, nursing, CRP, alcohol and drug counselors, mental health providers, and physical health providers.
- *Origins*—Initiated by a coalition concerned public and private sector experts, as well as faith-based hospitals.
- *Next Seps*—Expanding to a 100+ acre site focused on TAY and families.

Riverside County

Population = 2.5m
PIT Count = 2,884
Area = 7,303 sq mi

Operates a call-center and 3 drop-in urgent care centers. (both 24/7)

Call Center—CARES Line

- **County-operated.**
- *Services Provided*—Behavioral health screenings and referrals. System-wide beds tracked in real-time and can be assigned during the call.
- *Staffing*—Licensed CTs, drug and alcohol counselors, paraprofessional case managers, counselors, and peer mentors. In-person during the day, remote at night.

In-Person Services—Mental Health Urgent Care Centers

- **Vendor-operated.**
- *Services Provided--*Immediate crisis intervention support, medication services, and linkage to other services and benefits. Clients sourced via drop-ins, crisis response teams, and law enforcement.
- *Staffing—*Mental health providers, nurse practitioners, and peer staff with lived experiences. Fluent in English and Spanish.

Key Lessons from Benchmarking

Common themes emerged from the 6 jurisdictions interviewed.

24/7 Models are Common
Many different counties offer some form of a drop-in center, be it virtual, brick-and-mortar, or some combination of the two.

Marketing is Key
Lack of marketing can cause confusion about what the center is, while too much marketing can increase demand to the point that staff are overburdened.

Funding
Most programs rely heavily on MediCal; private-insurance reimbursements can be a challenge to secure.

Demand Fluctuates
Demand generally remains strong from 4am to 11pm. Can increase overnight demand through law-enforcement or crisis team drop-offs.

Staffing
CSU-mandated staffing ratios can be a challenge to meet and bilingual staff with specific credentials can also be hard to find. Peer support staff is common and valuable.

None Have Pharmacies
Many offer limited medications, though supported the idea of having a pharmacy.

What stood out to you?

Do other jurisdiction's mix or model of services match that of SF's MHSF goals?
Are there elements of other jurisdictions SF should incorporate into the MHSC?

Crosswalk of Services - Draft

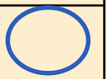
To what extent is San Francisco currently meeting the Service Center requirements in the legislation?
Where are there potential opportunities to scale programs?

Two Ways to Conduct a Crosswalk

Program-Specific Crosswalk(s)
More in-line with the Legislation's intent to develop a convenient one-stop shop for services, we compare the MHSC legislation to specific BHS programs:

- CDU/CSU
- BHAC
- Dore Urgent Care Center
- Tenderloin Linkage Center

System-Wide Crosswalk
Compare each service called out for by the MHSC legislation to the City's landscape of BHS programs.

Do BHS Programs Meet MHSC Requirements?	
Meets	
Partially Meets	
Does Not Meet	

Crisis Diversion/Stabilization Unit

Envisioned program has closest operating model to MHSC legislation.

MHSC Requirement	Addressed?	How it Satisfies MHSC Reqt
Assessment of Immediate Need	●	Assessed by care team upon entry
Psychiatric Assessment, Diagnosis, Case Mgmt, and Treatment	◐	Will receive full MH, SUD, and Medical assessment, diagnosis, and crisis management treatment
Pharmacy Services	◐	Medications administered onsite, but not dispensed
MH Urgent Care	●	Original basis for CDU
Transportation	◐	Accompanied transit to next point of treatment, but not from Jail or ZSFGH
Drug Sobering Center	●	Can initiate treatment for drug-induced psychosis

Behavioral Health Access Center

Not as comprehensive as the MHSC, nor does it operate 24/7.

MHSC Requirement	Addressed?	How it Satisfies MHSC Reqt
Assessment of Immediate Need		Centralized access point for low to high-barrier needs
Psychiatric Assessment, Diagnosis, Case Mgmt, and Treatment		Consultations with licensed healthcare professionals (including psychiatry); only initial treatment planning
Pharmacy Services		Medications administered onsite, hours recently extended
MH Urgent Care		Clinicians onsite to assess and refer treatment
Transportation		Not available through BHAC
Drug Sobering Center		Provides referrals, but is not a sobering center

Dore Urgent Care Clinic (DUCC)

A non-institutional alternative to acute psychiatric care.

MHSC Requirement	Addressed?	How it Satisfies MHSC Reqt
Assessment of Immediate Need		Assessed upon entry
Psychiatric Assessment, Diagnosis, Case Mgmt, and Treatment		Provides assessment and triage. Clients can receive care up to 23 hours; case management not provided
Pharmacy Services		Does not stock a pharmacy. Medications administered on site
MH Urgent Care		Original intention of DUCC
Transportation		Coordinates but does not provide transportation to and from the clinic
Drug Sobering Center		Provides low acuity services, but is not a sobering center

Tenderloin Center (TLC)

A less clinical and behavioral health-focused site than the MHSC.

MHSC Requirement	Addressed?	How it Satisfies MHSC Reqt
Assessment of Immediate Need		Voluntary referrals available, but not core focus of Center
Psychiatric Assessment, Diagnosis, Case Mgmt, and Treatment		Teams of clinicians and specialists not available onsite to develop treatment plans
Pharmacy Services		Does not stock a pharmacy
MH Urgent Care		Not an urgent care facility
Transportation		Transport services <u>from</u> the center to other sites, no transport <u>to</u> the center
Drug Sobering Center		Offers safe space for substance use, but does not have a medical focus

System-wide View

MHSC Requirement	Existing Programs				In-Development		
	BHAC	TLC	DUCC	SCRT	CDU/CSU	SOMA Rise	OCC
Assessment of Immediate Need	●	◑	●	●	●	●	◑
Psychiatric Assessment, Diagnosis, Case Mgmt, and Treatment	◑	○	◑	○	◑	○	◑
Pharmacy Services	◑	○	◑	○	◑	○	○
Mental Health Urgent Care	◑	○	●	◑	●	○	○
Transportation	○	●	○	◑	◑	◑	○
Drug Sobering Center	◑	◑	○	○	●	●	○

Jamboard Activity

What of the organization or elements of the crosswalk need revision?
Are any key programs missing from the system-wide view?

Mental Health Service Center Feedback

Share screen for virtual white board

(white board results will be posted in meeting minutes)

System-wide vs. Program view

What are the pros and cons of these different approaches?
Which programs are the best candidates for expansion?

Options Analysis @ June 28th Meeting

Interviews with IWG volunteers and BHS SMEs will continue to inform options analysis.

CON will prepare three options for the MHSC.

01 **Stand-Alone Center**

- A full-service MHSC facility staffed and otherwise depicted in the MHSC portion of the legislation.

02 **Multi-Location Center**

- Meeting the MHSC goals listed in the legislation through a combination of several service locations and centers.

03 **Virtual Center**

- Offering services called for in legislation through a distributed/ decentralized system.

Public Comment for Discussion Item #6

Mental Health Service Center: CON Options Analysis Briefing and Feedback

Steps:

- Call (415) 655-0001
- Enter access code 2491 802 4812
- Press ‘#’ and then ‘#’ again

12:25 - 12:55

Discussion Item #7

Street Crisis Response Team Update

All materials can be found on the MHSF IWG website at:
https://www.sfdph.org/dph/comupg/knowlcol/mentalhlth/Implementation.asp

Reminder: Mental Health SF Domains

Dr Angelica Almeida

Kathleen Silk

April Sloan

Mental Health SF Domains

- **Office of Coordinated Care**
  - Case Management and Navigation
  - Overall Care Coordination
  - Marketing / Community Outreach
  - Inventory of Programs and Services
- **Street Crisis Response Team**
  - Pilot Phase
  - Ongoing Implementation
- **Mental Health Service Center**
  - Centralized Access
  - Pharmacy Services
  - Transportation
- **New Beds and Facilities*** (Mental Health and Substance Use Treatment Expansion)
  - Expanding Existing Models (Dashboard Updates & Rapid Response)
  - Drug Sobering Center
  - Crisis Diversion
  - TAY

Data and IT Systems | HR Hiring and Pipeline | Equity | Analytics and Evaluation

STREET CRISIS RESPONSE TEAM GOAL AND STRATEGIES

Goal: Provide rapid, trauma-informed response to calls for service to people experiencing crisis in public spaces in order to reduce law enforcement encounters and unnecessary emergency room use.

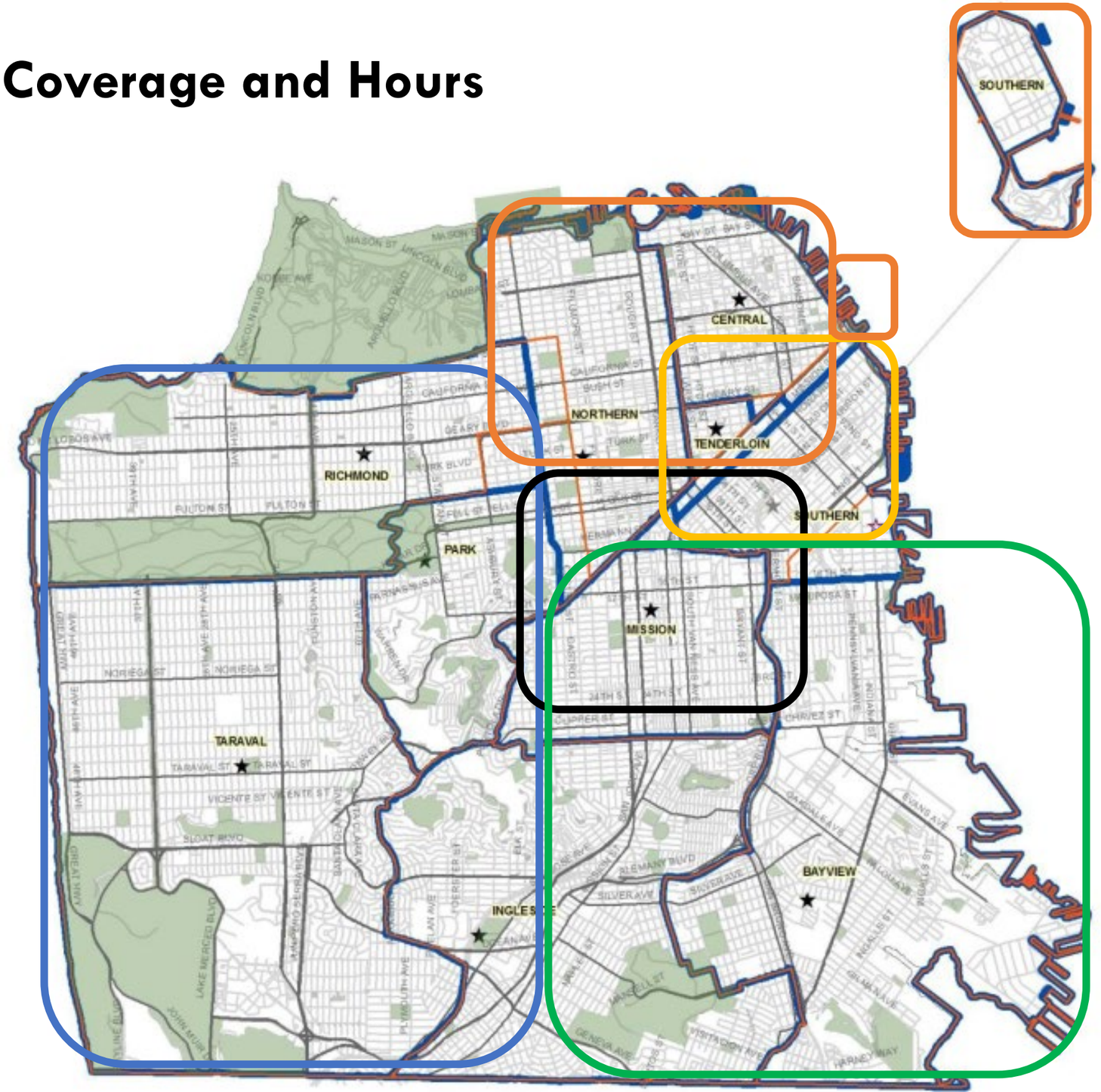
1. Identify 9-1-1 calls that will receive behavioral health and medical response rather than law enforcement response.

2. Deliver therapeutic de-escalation and medically appropriate response to person in crisis through multi-disciplinary team (paramedic + behavioral health clinician + peer).

3. Provide appropriate linkages and follow up care for people in crisis, including mental health care, substance use treatment, and social services.

Current Coverage and Hours

Region	Hours	Launch Date
Tenderloin	0900-2100	Launched 11/30/2020
Mission/ Castro	0700-1900	Launched 2/1/2021
Bayview	1100-2300	Launched 4/5/2021
Waterfront / Chinatown /North Beach	0700-1900	Launched 5/10/21
Park/ Richmond/ Sunset	0600-1800	Launched 6/14/21



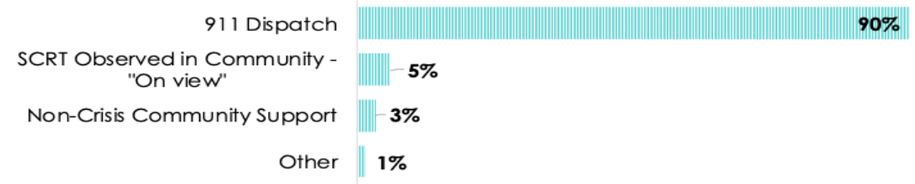
DATA – APRIL & CUMULATIVE

Crisis Calls Handled by SCRT	April	Cumulative*
	735	9,260

800-B Calls that Received SCRT Response**	April	Cumulative
	60%	47%

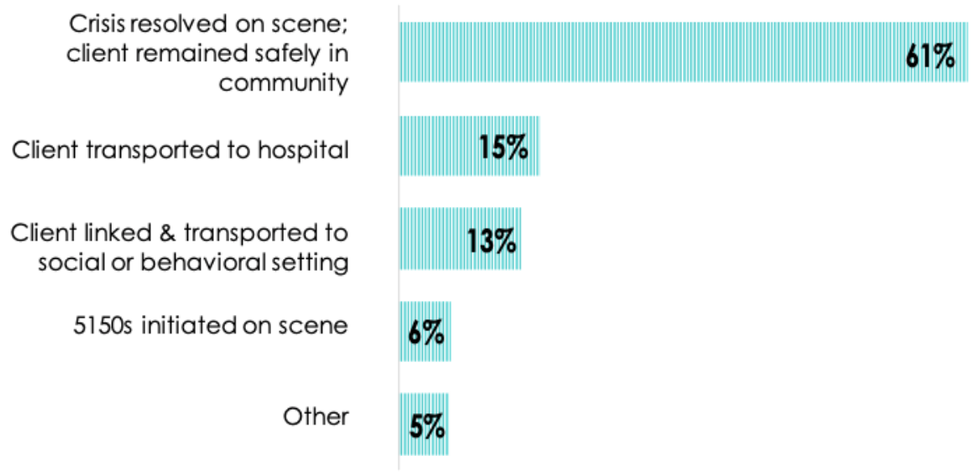
Average Response Time	April	Cumulative
	17 min	16 min

Referral Source: Cumulative



Client Engagements	April	Cumulative
	278	4,525

Engagement Outcomes: Cumulative



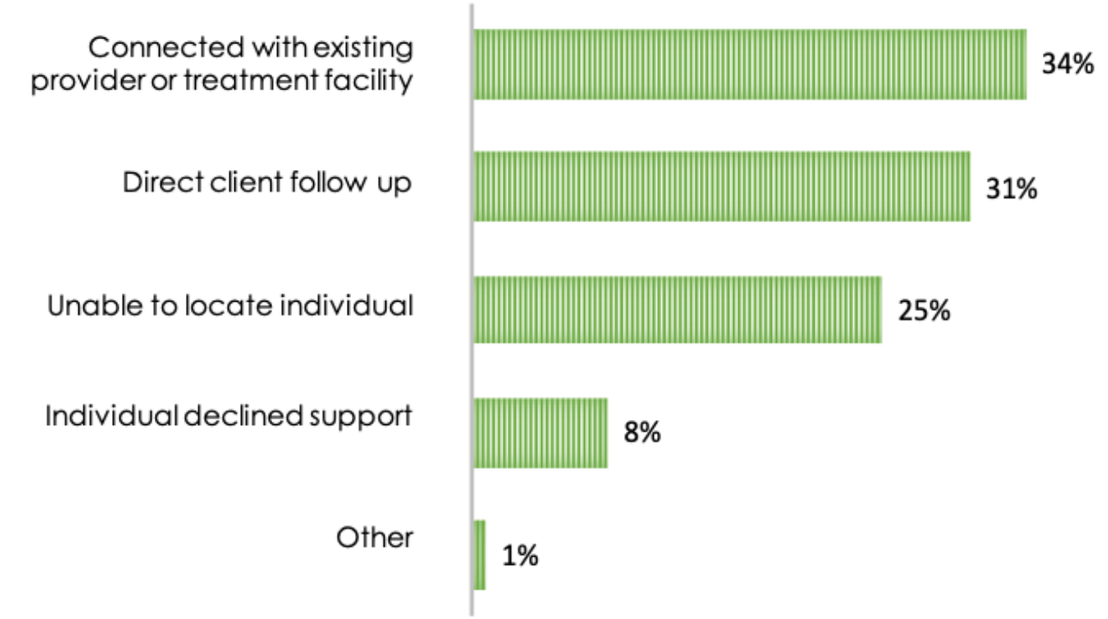
**A single client engagement may result in multiple outcomes.*

DATA – APRIL & CUMULATIVE

Office of Coordinated Care Follow Up Rate

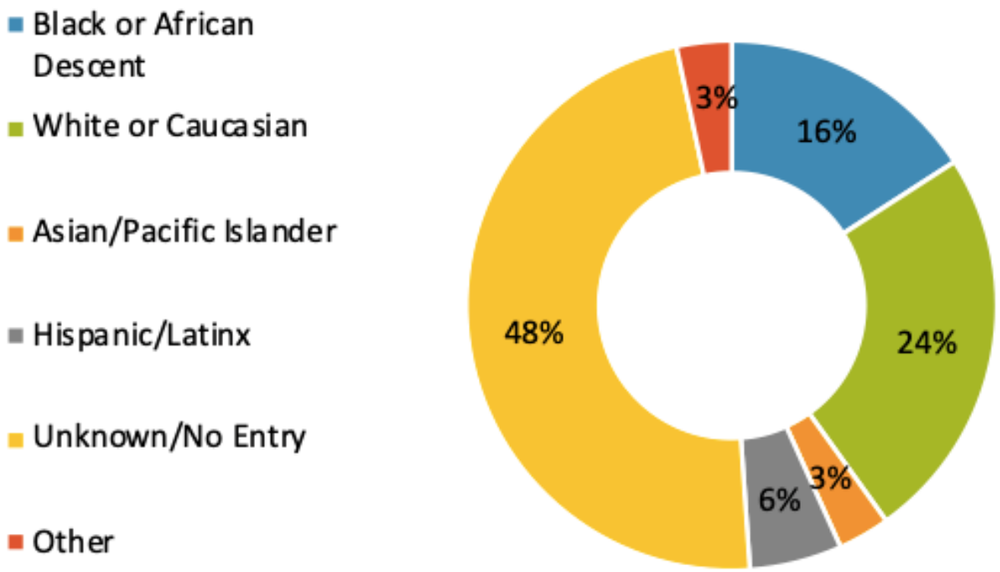
April	*Cumulative
78%	49%

Connections to Care: Cumulative

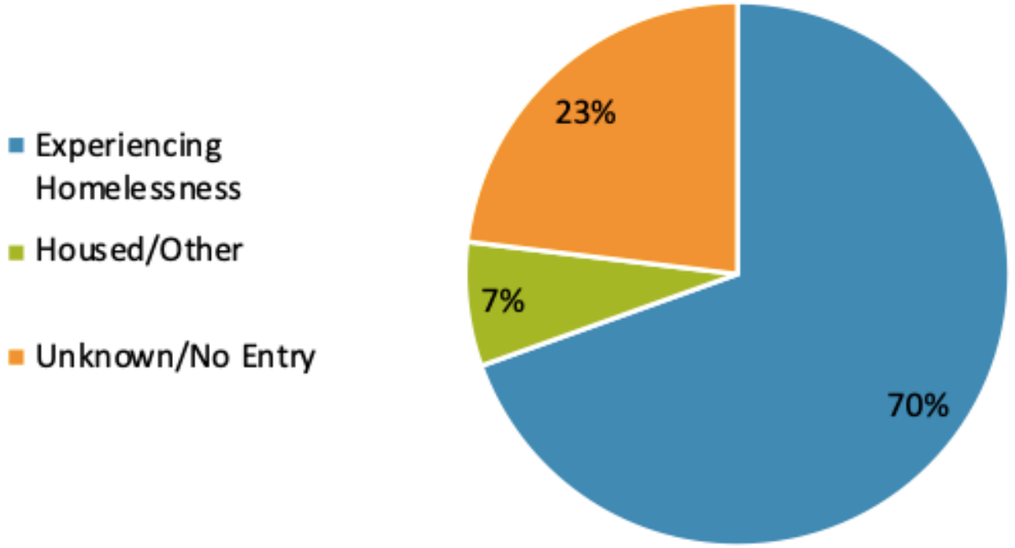


DEMOGRAPHIC DATA – CUMULATIVE

Race & Ethnicity



Living Situation



UPCOMING MILESTONES

- SCRT's 7th Team will launch Summer 2022!
- SCRT's switch from police dispatch to EMD (Emergency Medical Dispatch) is scheduled for Summer 2022. This transition helps achieve SCRT's goal of eliminating police response to behavioral health calls.
- The Office of Coordinated Care (OCC) now provides support 7 days a week. The team includes behavioral health clinicians and health workers dedicated to follow up and care coordination for SCRT clients.
- The teams continue to focus on equity in their work. All staff participate in twice yearly equity surveys. Data are reviewed by leadership and shared with staff. These data will help inform upcoming equity trainings for staff and management teams. SCRT continues to prioritize equity when hiring and onboarding new staff.

EMERGENCY MEDICAL DISPATCH (EMD)

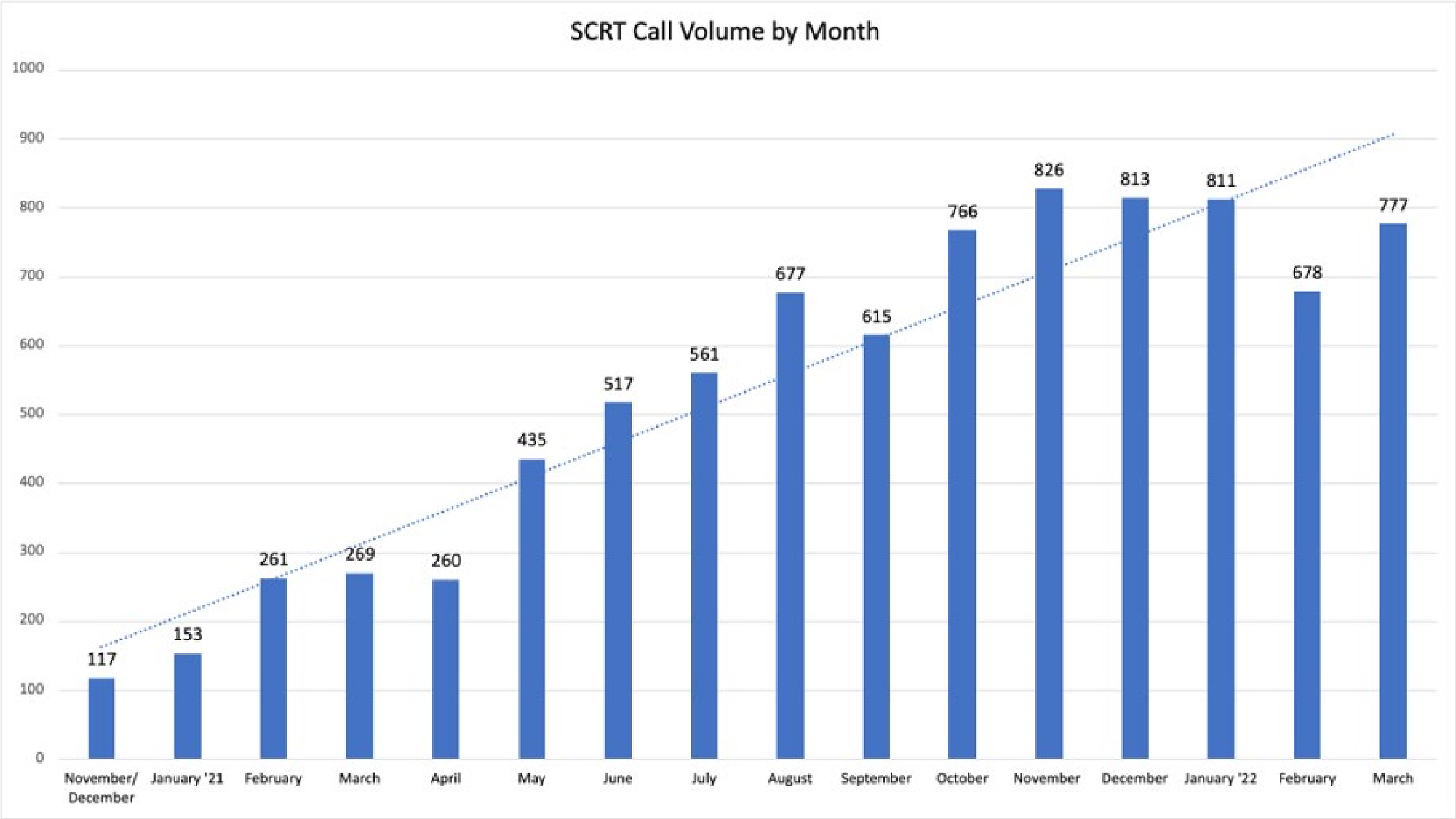
- EMD stands for Emergency Medical Dispatch. This is the dispatch procedure used by EMS and will not change the types of calls SCRT is responding to. SCRT is currently using police dispatch and the switch will aid in removing police response to behavioral health calls.
- SCRT and EMS will take over an estimated 11,000 calls/year (this is subject to change and has shown signs of increasing in recent months and includes calls that are already handled).
- This is part of fulfilling SCRT's larger role in SF crisis response.
- There is an anticipated increase in call volume including the potential for indoor calls (80% of calls are anticipated to remain outdoors). Examples of indoor calls include shelters, indoor public spaces such as malls, SROs, and private residences.
- SCRT will be co-responding with ambulances for some calls.
- Teams will continue to have a geographic focus, but also dynamically dispatch to the closest available team.

EMD PREPARATION & TRAINING

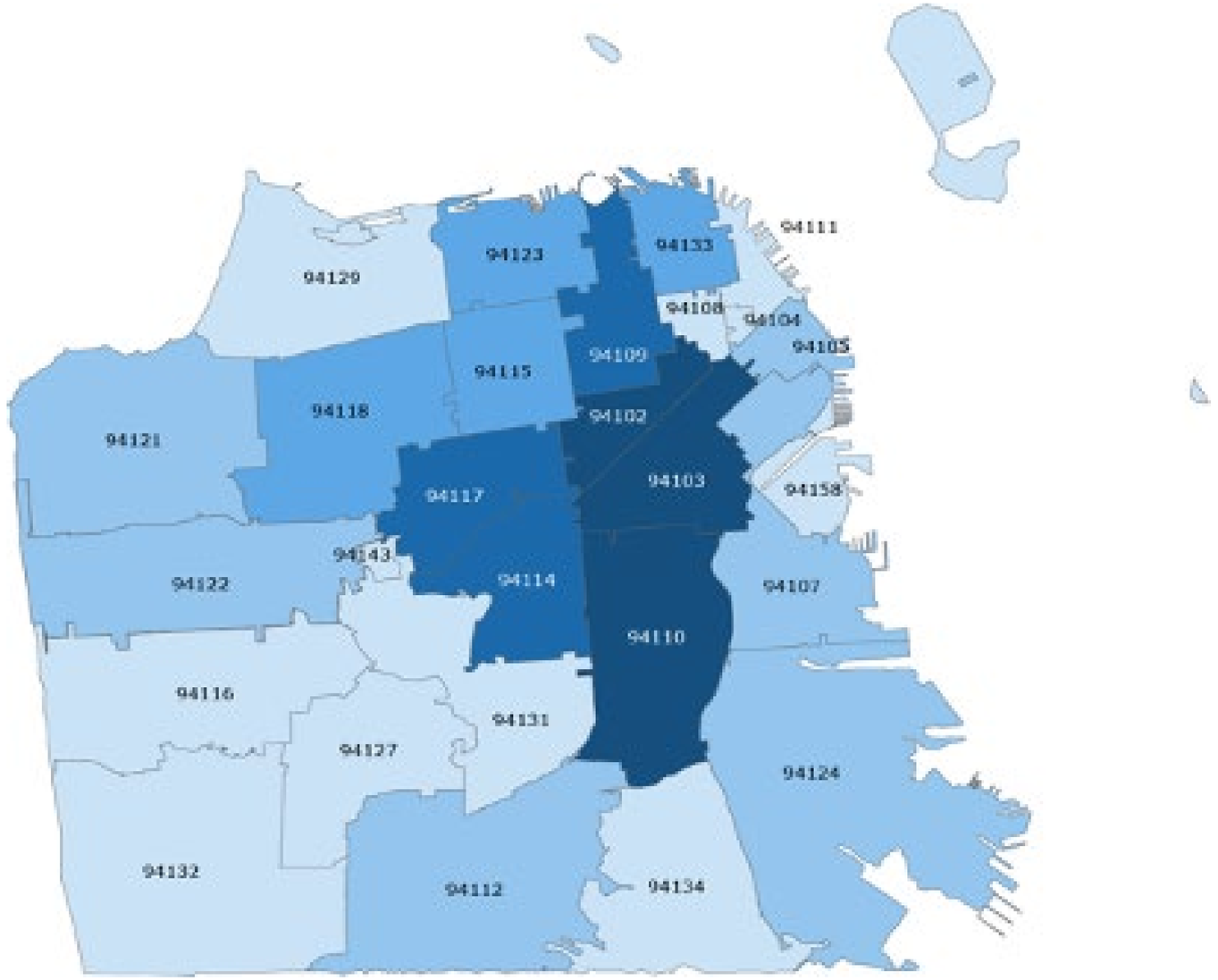
- Teams began training at the end of 2021 (this was then postponed due to a delay in move to EMD) and continued trainings this month in anticipation of the EMD transition this summer, which has been communicated with front line staff
- Trainings include both didactic and experiential learning. Some topics include:
  - General EMD Introduction
  - Situational and Spatial Awareness
  - Team Safety
  - Advanced De-escalation Strategies
  - Responding Indoors & Working with Families
  - Case Scenario Guidelines
  - EMD Call Codes and Dispatch Changes
  - Vignettes & Case Scenarios

CALL VOLUME

- SCRT is responding to around 60% of 800B calls
- The last year has seen an almost 50% increase in call volume
  - If volume had stayed the same as previous years, SCRT would be handling almost 90% of 800B calls
  - Based on national data, each SCRT team is anticipating responding to 5-8 calls per shift, allowing 7 teams to handle and estimated 13,000-20,000 calls a year
- The transition to EMD dispatch (Summer 2022) will result in all 800B calls being removed from police dispatch. These calls will be handled by SCRT or an ambulance.


SCRT Call Volume by Month
1000
900
800
700
600
500
400
300
200
100
0
117
153
261
269
260
435
517
561
677
615
766
826
813
811
678
777
November/ December
January '21
February
March
April
May
June
July
August
September
October
November
December
January '22
February
March

HEAT MAP (JANUARY – MARCH)



Legend	
	10% or more of calls
	7 - 9% of calls
	4 - 6% of calls
	2 - 3% of calls
	1% of calls or less

Zip code	Neighborhood
94103	SOMA
94110	Mission
94102	Tenderloin/Civic Center
94109	Polk Gulch/Nob Hill
94114	Upper Castro
94117	Haight Ashbury

HARDER CO. YEAR ONE EVALUATION

- SCRT responses are primarily reaching unique individuals. Eighty-one percent of SCRT clients have had a single SCRT encounter

- Team member skills and the SCRT approach are well positioned to meet the presenting health needs of clients

- The SCRT provides a host of psychological supports and educational resources for clients, ensuring they are safe and secure before planning for future service interventions

Ultimate Client Dispositions

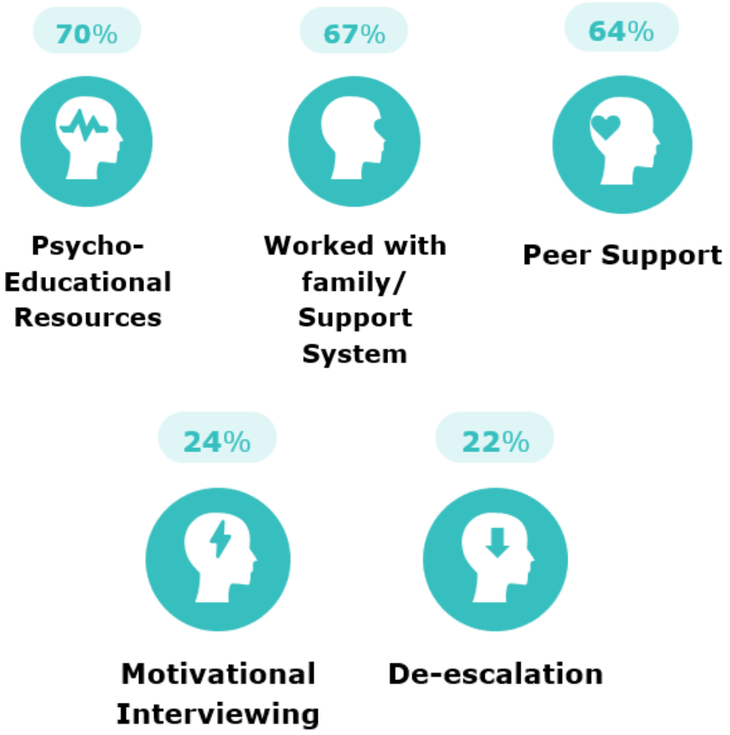
Disposition	Percent
Remain in community	59%
Non-ambulance transport to resources	14%
Ambulance transport	15%
Walked away after brief encounter	11%
Declined transport against medical advice	1%

** Most clients are not transported to medical facilities, but are either transported by SCRT to resources in the community (e.g. Hummingbird, DORE, congregate shelter, shelter in place hotel, SF Sobering center) or remain safely in the community where they receive direct resources.*

Direct SCRT Interventions

Intervention	Percent
Provided psychoeducation/resources	70%
Worked with family/support system	68%
Provided peer support	65%
Motivational interviewing	26%
Used de-escalation techniques	24%
Coordinated care with providers	23%
Other intervention[22]	30%
Supported coping skills	16%
Made safety plan	13%

For those who remain in the community:

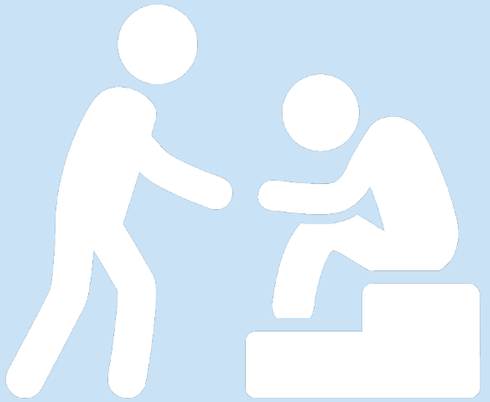


Public Comment for Discussion Item #7

Street Crisis Response Team Update

Steps:

- Call (415) 655-0001
- Enter access code 2491 802 4812
- Press ‘#’ and then ‘#’ again



Public Comment for

Any other matter within the jurisdiction of the Implementation Working Group not on the agenda

Steps:

- Call (415) 655-0001
- Enter access code 2491 802 4812
- Press ‘#’ and then ‘#’ again

Anticipated IWG Meeting Topics 2022

Topic Area	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
IWG Domains												
Street Crisis Response Team					U				U			
New Beds & Facilities (NB&F): Drug Sobering Center						U				U		
NB&F: Crisis Unit	D	D		D	D				U			
NB&F: Transitional Aged Youth (TAY)			D	D		D					U	
NB&F: Expansion of Existing Models					D	U					U	
Office of Coordinated Care (OCC)	D	D	D					U	U	U	U	
Mental Health Service Center (MHSC)			U		U	U	U		D	D		
Analytics & Evaluation	U						U				U	
Deliverable: IWG Annual Progress Report										★		
Deliverable: IWG Implementation Report												★
Other Intersecting Departments/Projects/Briefings												
CON: Citywide Street Outreach Briefing (SCRT, SFHOT, SORT, etc.)		U										
HSH: Housing Briefing		U										
DPH MHSF Budget Update							U					

D=Design U=Update

Housekeeping

- Next Meeting Date and Time
  - 4th Tuesday of the month 9:00AM-1:00PM
  - **June 28, 2022**
- Volunteer to be part of the TAY Discussion Group!
- Meeting Minutes Procedures
  - https://www.sfdph.org/dph/comupg/knowlcol/mentalhlth/Implementation.asp
  - Draft minutes in the next two weeks
  - Approved meeting minutes will be posted
- MHSF IWG e-mail address for public input: MentalHealthSFIWG@sfgov.org

Adjourn

Member Meeting Attendance (per Bylaws)

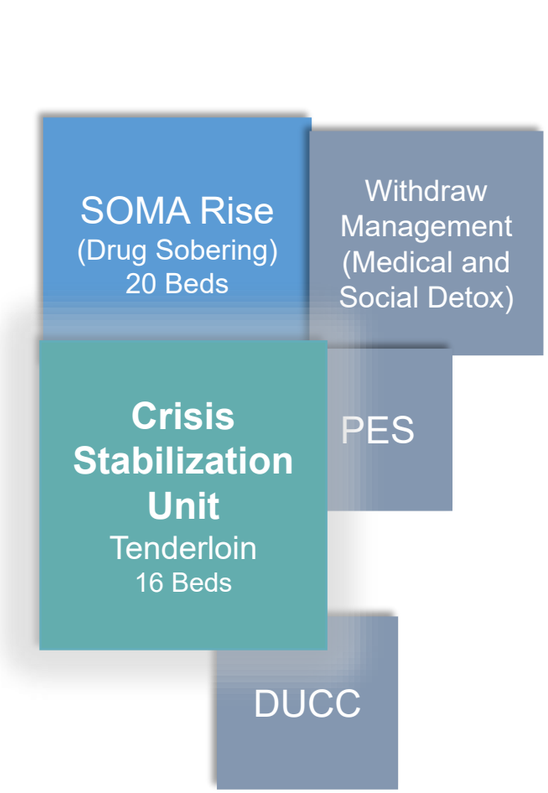
Member Absences

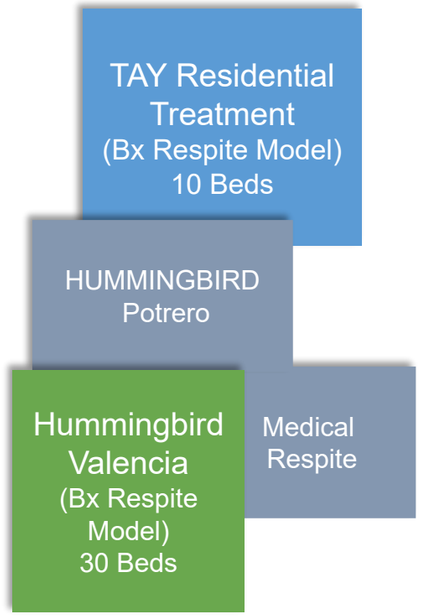
*Any member who **misses three regular meetings** of the Working Group **within a 12- month period without the express approval** of the Working Group at or before each missed meeting will be deemed to have **resigned** from the Working Group ten days **after the third unapproved absence.***

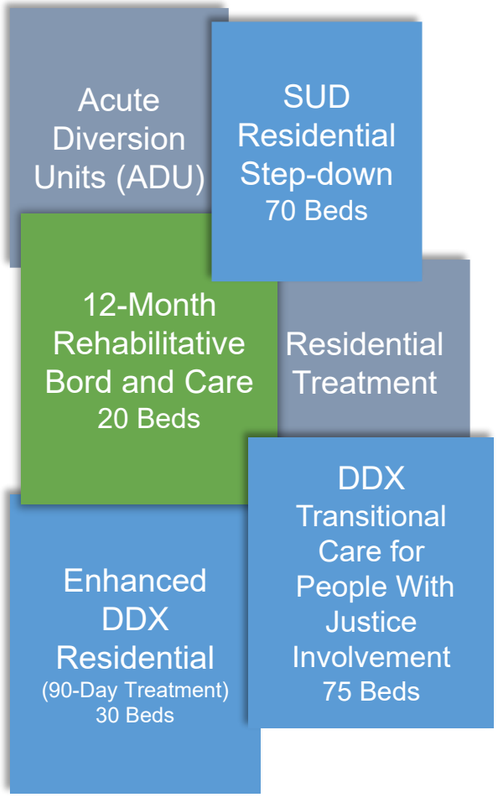
Excused Absences

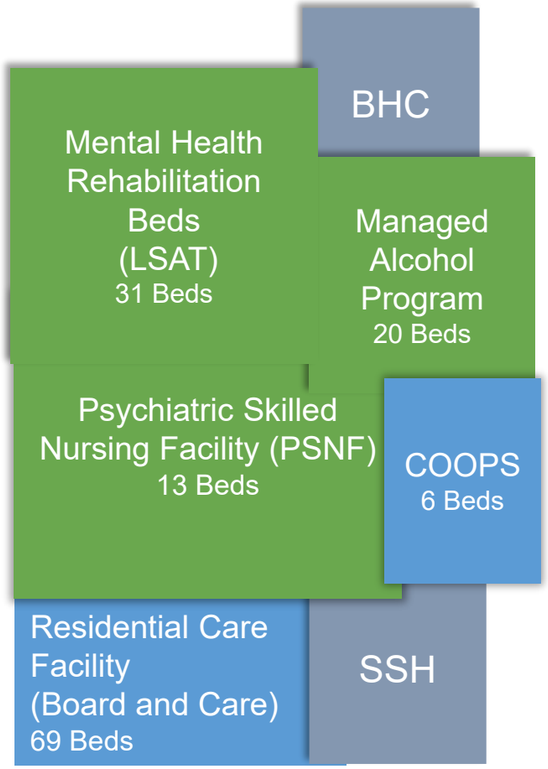
*The Working Group may **vote to excuse an absent member** from a Working Group meeting. If the Working Group does not take such a vote at the meeting or at a previous meeting, then the minutes shall note that the absence is unexcused.*

DPH Bed Continuum of Care









Short-Term Care

- Emergency and urgent care
- Low barrier
- Immediate
- No authorization required
- Walk-ins accepted

Respite Care

- Safe environments
- Low barrier
- Encourage treatment

Transitional Care

- Planned therapeutic and treatment services
- Skill building

Long-Term Care

- Specialized support
- Safe environments to support stabilization

Open | In Development | Existing Services