Mental Health Service Center

Options and Cost Analysis

CITY & COUNTY OF SAN FRANCISCO

Office of the Controller
City Performance Unit

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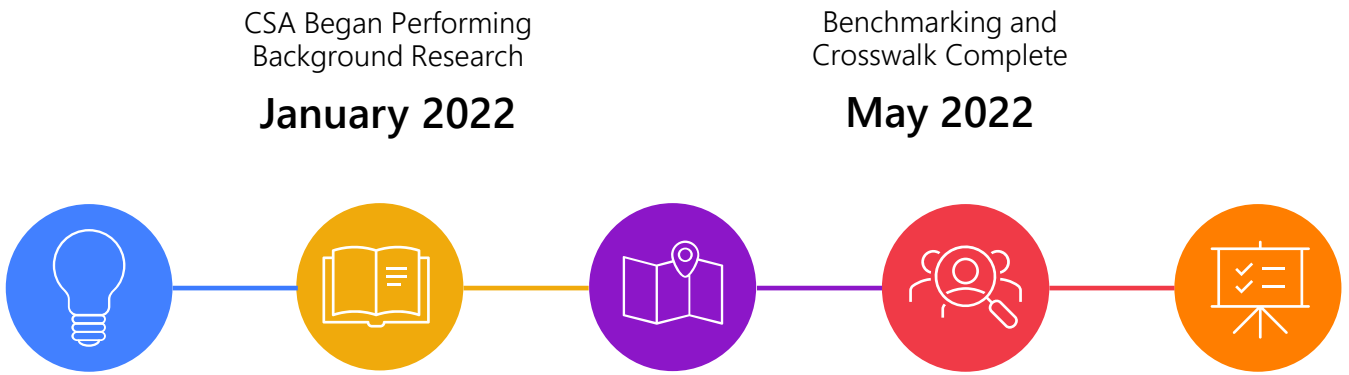
09.30.2022

Project Purpose

In December 2019 San Francisco adopted the Mental Health San Francisco (MHSF) legislation, mandating reforms to the City's behavioral health services, including creation of a 24-hour, 7 day-a-week Mental Health Service Center (MHSC). The City Performance unit of the Controller's Office was asked by Department of Public Health (DPH) to research and develop an initial set of options to begin planning of the MHSC. The project sponsors anticipated the work of this project would provide MHSF stakeholders with the options and information needed to hold a robust discussion and potentially reach alignment on the MHSC's implementation direction.

Timeline



Project Deliverables

Deliverables outlined in project plan

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

IWG Presentations and Input

IWG Engagement

- Mar 22 IWG meeting on introduction to project, current state of MHSC implementation, proposed IWG engagement and discussion
- May 18 Discussion Group on Benchmarking results and Crosswalk of Services draft
- May 24 IWG meeting on MHSC legislative requirements, Benchmarking results, Crosswalk of Services draft, and discussion
- June 23 Discussion Group on updated Crosswalk and the proposed Options
- June 28 IWG meeting on Crosswalk, preliminary Options review, and discussion
- Aug 23 IWG meeting on final Options and Cost Analysis, with discussion

MHSC Legislative Requirements

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

1. Assessment of Immediate Need

Assess a patient's need for immediate medical treatment; refer as necessary and appropriate.

2. Pharmacy Services

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

3. Transportation

To off-site treatment programs.
From jail and Zuckerberg San Francisco General Hospital (ZSFGH).

4. Psychiatric Assessment, Diagnosis, Case Management, and Treatment

Provide onsite consultations, diagnosis and/or referral, create a treatment plan, prescribe medications, and assign case management/care.

5. Mental Health Urgent Care

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

6. Drug Sobering Center (opened)

Clinical support and beds at appropriate level of care for individuals experiencing psychosis due to drug use.
*Center must coordinate services with MHSC but does not need to be housed in the same building.

Benchmarking

Methodology

Project team met with 6 jurisdictions to discuss health programs similar to the MHSC

- Santa Clara County
- Los Angeles County
- Riverside County
- Orange County
- New York City
- Multnomah County

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 in other 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.

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

Crisis Stabilization Unit (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 they supported the idea of having a full pharmacy.

Crosswalk of Existing Services

Methodology

Project team met with subject matter experts and conducted research to:

1) Identify potential programs that could be modified or scaled up to meet the MHSC requirements.
2) Explore the extent to which the current or planned Behavioral Health Services (BHS) in San Francisco are meeting the MHSC requirements per the MHSF legislation.

To align with the goals above the crosswalk was conducted in two ways:

1) Program Specific Crosswalk(s)

In line with legislative intent to develop a single location for services, we compared the MHSC legislation to specific BHS programs, including:

- Behavioral Health Access Center (BHAC)
- Crisis Stabilization Unit (CSU)
- Dore Urgent Care Clinic (DUCC)
- Tenderloin Linkage Center (TLC)

2) System Wide Crosswalk

Compared each service called for by the MHSC legislation to relevant, current or in progress BHS Services, including:

- Behavioral Health Access Center
- Crisis Stabilization Unit
- Dore Urgent Care Clinic
- Office of Coordinated Care (OCC)
- Street Crisis Response Teams (SCRT)
- SOMA Rise

System-Wide Crosswalk

MHSC Requirement	Existing Programs				In Progress		Total
	BHAC	DUCC	SCRT	SOMA Rise	CSU	OCC	
Assessment of Immediate Need	●	●	●	●	●	◐	●
Psychiatric Assessment, Diagnosis, and Treatment*	●	◐	○	○	●	○	●
Case Management*	○	○	○	○	○	●	●
Pharmacy Services	◐	◐	○	○	◐	○	◐
Mental Health Urgent Care*	◐	●	◐	○	●	○	●
Transportation	○	○	◐	◐	◐	◐	◐
Drug Sobering Center	◐	○	○	●	●	○	●

*These are MHSC requirements the IWG identified as remaining service area gaps

This table crosswalks existing and in progress programs in the Behavioral Health system of care with the legislative requirements of the Mental Health Service Center. It shows where service needs are being met or where support is needed.

Do BHS Programs Meet MHSC Requirements?	
Meets	●
Partially Meets	◐
Does Not Meet	○

09.30.2022

Equity Framework

Equity Framework

Background:

The City Performance team created a framework to outline key equity considerations for the implementation of the MHSC. The framework utilizes existing MHSF and BHS equity principles and goals to inform a set of equity criteria considered in the subsequent options analysis.

The four equity criteria considered in the options analysis are:

- **Priority Populations.** Examine how the MHSC fits with current DPH/BHS equity goals.
- **Culturally Congruent Services.** Evaluate the degree to which an option may align with a healthcare recipient's preferred cultural values, beliefs, worldview, and practices.
- **Workforce Diversity.** Evaluate whether an option may present opportunities to hire workers with lived experience, multilingual skills, and ensure hiring practices are equitable.
- **Location and Access.** Evaluate whether service center(s) location aligns with DPH's equity goals, including geographic proximity and accessible transportation services for priority populations.

Controller's Options Analysis

Controller's Options Analysis

The Controller’s Office developed three options for a MHSC roll-out: a standalone, a multi-location or a virtual center approach. The analysis for each option addresses several topic areas from general descriptions to feasibility and caveats.

The following is addressed for each of the options:

- Summary of Services Offered and Staffing
- Equity Considerations
- Cost Estimates (staffing, operating, facility costs, totals)
- Facility Availability and Timing
- Transportation
- Caveats

Option 1—Stand-Alone Center

Deliver services required by the MHSF Legislation in one new location. All services outlined in the MHSF legislation will be offered, except for a Drug Sobering Center which has opened in its own building.

- **Services Offered**—Assessment & Diagnosis, Urgent Care, Pharmacy, Case Management, Treatment Planning, Transportation.
- **Staffing**—24/7 civil service staffing. Includes moving current BHAC to the new location with its staff augmented to cover additional shifts and new service areas.
- **Equity Considerations** —
  - **Cultural Congruency**: Difficult to have multiple cultural presentations with one location.
  - **Workforce Diversity**: May contribute to already scarce staffing between civil service and CBOs. CBOs seen as more connected to underserved communities. Benefits are that civil service positions could provide career opportunities and higher wages to individuals if hired from the community.
  - **Location and Access**: A central site might not be close to underserved communities; will require clients to travel outside their neighborhood and more transportation options and access. A benefit to a central site is it may reduce complexity of travel once there.
  - **Priority Population**: Some high need populations may be served well at one location; but for total needs across the city and serving hard-to-reach clients, decentralized sites serve diverse needs/populations.

Option 1—Stand-Alone Center – Continued

- **Cost Estimate**—
  - Staffing: $20.3 M
  - Operating costs: $2.3 M
  - Facility cost: Range of $660k- $1.6M to lease (annual), $10M-$31.3M to purchase (one-time). *Based on Sq. Ft. range of 20,000-25,000.*
  - Total (Lease): $23.3M to $24.2M
  - Total (Purchase): $32.6M to $53.9M
- **Facility Availability and Timing**—Very dependent on the real estate market, locations available, and building conditions. 1.5-3 years are typical for acquiring and moving to a new site, state licensing, and community input. Pharmacy licensing for a new location could take 2-3 years, or up to 4 years if including licensure for methadone.
- **Transportation**—Site would include a shuttle providing transportation *from* the MHSC to offsite treatment programs as well as *to* MHSC clients exiting SF County Jail and ZSFG Psychiatric Emergency Services (PES) unit, as per the legislation.

Option 1—Stand-Alone Center – Continued

Caveats and Feedback—

- For over 2 years DPH and City Real Estate have been searching for suitable buildings that could house all the MHSC components but have been unsuccessful.
- It may be hard to find a suitable site with the exact square footage needed for the stand-alone service center. Would likely be housed in a larger site with upper-level office space for other uses.
- Based on benchmarking and SME feedback on feasibility concerns, this stand-alone option would not have a 24/7 full pharmacy. This option would include additional staff that could prescribe medications at all hours and have a stock of medications available to dispense on-site when the BHS pharmacy is not open.

Option 2—Multi-Location Center

Deliver required MHSC services through several programs and locations already in operation (including BHAC, DUCC, CSU, OCC, SOMA Rise) and one new urgent care center.

- **Services Offered**—Assessment & Diagnosis, Urgent Care, Pharmacy, Case Management, Treatment Planning, Transportation, Drug Sobering Center.
- **Staffing**—Mixed CBO/civil service staffing. Existing sites would need to staff additional shifts to provide 24/7 operations. OCC would need additional case management staff to assist with care coordination between sites. A new urgent care clinic in the community is included in this option.
- **Equity Considerations**—
  - **Cultural Congruency**: Services located in local communities tend to be more culturally congruent and hire diverse staff via community providers.
  - **Location and Access**: Multiple locations support diverse cultural presentations and can benefit focus populations in their neighborhoods. However, multiple locations will require adequate transportation access. Current programs are primarily located in SOMA and Tenderloin. This option could consider an additional site in high-need areas like the Southeast or Mission.
  - **Workforce Development:** Impact of this option is mixed/unclear as to reducing wage pressures faced by nonprofit contractors. May provide more opportunity for services by community agencies, but without the resources to close wage differences this option may reinforce existing workforce inequity.

Option 2—Multi-Location Center - Continued

- **Cost Estimate**—
  - Staffing: $12.2M.
  - Operating costs: $1.8M
  - Facility cost: New urgent care: Range of $154k-$446k to lease (annual) and $2.6M-$9M to purchase (one-time).
    Based on a Sq. Ft. range of 4,680-7,200.
  - Total (Lease): $14.2M to $14.4M
  - Total (Purchase): $16.6M to $23.0M
- **Facility Availability and Timing**—For an additional urgent care site, the timeline will be 1-3 years. This is subject to the real estate market (which varies by region), acquiring and moving to a new site, state licensing, and community input. Hiring additional staff at existing sites would take approximately 1 year.
- **Transportation**—A new CBO-operated shuttle would ensure transportation from ZSFG PES and SF County Jail to relevant sites, as well as provide transportation between MHSC programs. Option 2 would also utilize OCC's Bridge Engagement Services Team and the SOMA Rise Shuttle to coordinate transportation to care and between sites.

Option 2—Multi-Location Center – Continued

Caveats and Feedback—

- Option 2 would not include a 24-hour pharmacy. This option would include additional staff that could prescribe medications at all hours.
- This model accounts for one additional urgent care clinic; more satellite options could be considered in future phasing and pending need.
- The OCC is not yet fully operational; its effective implementation will be critical to coordinating services in this option.
- Effective transportation, including coordination with other transportation services like the SOMA Rise shuttle, will be critical in this option.
- More provider education and public-facing marketing is needed for both clients and staff to experience the MHSC as a unified system (not included in cost estimate). This includes enhanced publicizing of BHAC as a central access point, internally and externally.
- BHAC enhancement of client experience and coordination of services may be hindered or not feasible at the currently leased building.
- Improved data systems are needed to allow for real-time inventory across the BHS landscape.

Option 3—Virtual Center

Streamline existing mental health call lines into one intake line similar to the approach being pursued in New York City. Replicate extensive phone/text/chat system while building off work already underway by the 9-8-8 Workgroup ("Call SF").

- **Services Offered**—Assessment of immediate need, virtual consultations, linkages to in-person services and case management.
- **Staffing**—Would not need to build new programs, but likely need to hire additional and different staff for call center(s) and provide 24/7 shifts. Such staff projections/estimates for this model are not currently available.
- **Equity Considerations** —
  - **Priority Populations**: A consolidated line with expanded capacity to handle phone/email/text may expand initial access and reduce complexity for clients including the DPH/BHS focus populations. However, the line does not in itself provide increased access to treatment.
  - **Workforce Diversity and Cultural Congruency**: May provide opportunities for hiring from the community and adding multilingual capacity.

Option 3—Virtual Center – Continued

- **Cost Estimate**—
  - Total estimate (based on population): $3.2M
  - New Staffing, Facility, and Operating costs: N/A
- **Facility Availability and Timing**—No new program facility needed, but new call center/administrative space would be TBD. The current stakeholder coordination/implementation process for 988 and other call lines (“Call SF”) is estimated to take two years or more.
- **Transportation**—Planning for coordination of transportation services is not included in this option.

Option 3—Virtual Center – Continued

Caveats and Feedback—

- More study and analysis would be needed to accurately project this option (i.e., the NYCWell model incorporated into current Call SF plans).
- Requires improved data systems to allow for real-time inventory across the BHS landscape and to monitor for effective linkages, ongoing assessments, and warm handoffs.
- A future option to study could include scaling OCC to absorb Option 3.

Summary

The table below summarizes the estimated cost of each option and the primary sources contributing to the cost

Option 1-Stand-Alone	Option 2-Multi-Location + Urgent Care	Option 3-Virtual Center
Total (Lease): $23.3M to $24.2M **Total (Purchase): $32.6M to $53.9M**	**Total (Lease): $14.2M to $14.4M** **Total (Purchase): $16.6M to $23.0M**	**$3.2M**
The cost includes all services legislatively mandated to the MHSC, except a drug sobering center. Biggest variables are finding a suitable site and the potential costs for the facility.	The additive costs of expanded BHAC, OCC to meet the legislative goals, and a new urgent care outpatient clinic.	The estimated cost to emulate the NYC expanded call center approach but more study/analysis is needed. A local effort to staff 988 and coordinate call lines is underway ("Call SF").

IWG Input and Discussion

Additional IWG Input

Overall, IWG members expressed that Options 1 (stand-alone) and 2 (multi-location) each have benefits but also challenges. Members did not support Option 3 (virtual-only), unless it would be an additional service to Options 1 or 2.

In addition to the caveats and feedback listed within each option, the following summarizes crosscutting feedback provided by the IWG. This contains both comments by individual members and ideas supported by the group during discussion.

Consider population needs when determining service offerings. Would like to see more demand data for the different levels of care. Assess specific neighborhoods that have populations most at-risk for crisis, including who needs additional urgent care support. Further examine the need for 24/7 services and low barrier social services.

Privately-insured residents also have significant health needs. Consider how to engage private insurance companies to provide services and treatment per mental health parity laws.* While the MHSF legislation prioritizes services for those who are uninsured, on Medi-Cal, Healthy San Francisco, or experiencing homelessness, the original vision was to also include insured San Francisco residents.

*Engaging private insurance companies and advocating for San Franciscans with private health insurance will be under the purview of the Office of Private Health Insurance, which is pending development.

Additional IWG Input - Continued

Explore more facility types and options. Look into acquiring vacant office property or building a new facility for a MHSC. Consider mobile units that offer assessment, diagnosis, as well as urgent care, and can be stationed in different neighborhoods.

Build and expand existing services first before creating new ones. Be aware of existing programs that can be leveraged or scaled to meet MHSC requirements. Only create new services if there are gaps (for example, first consider expanding BHAC capacity before replicating a similar program).

Need for further wage equity analysis. Any further option modeling should consider how to close the gap between civil service and CBO staff wages.

Offer interim solutions while building out the MHSC. Recognize that all the options have a significant timeline before they can be implemented and consider interim solutions to address service gaps.

Treatment services will need to meet patient volume. Improved capacity for intake and assessment requires sufficient access to treatment.

MHSC—Options Analysis—Project Conclusion

This summary concludes the MHSC Options Analysis Project conducted by the Controller's Office. DPH leadership will next utilize this analysis and stakeholder feedback as they develop the next phase of implementation planning for the MHSC, in consultation with the Implementation Work Group and other MHSF stakeholders. Implementation of the final MHSC direction will require the identification of funding sources to support service expansion in the final design.

If you have questions about the project or this report, please contact the Controller's Office Project Team:

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