Behavioral Health Services System of Care

San Francisco Department of Public Health

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Hillary Kunins, MD, MPH, MS
Director of Behavioral Health Services and Mental Health SF
San Francisco Department of Public Health

City & County of San Francisco
Department of Public Health

Outline

- System of Care Overview
- Highlights of specific system elements
  1. Jail Health services
  2. Office of Coordinated Care
  3. Street Care
  4. Care Plans
  5. Intensive Outpatient Treatment
  6. Coordinated City Response
- Scenario illustrating transitions in care across system
- Successes and Key Challenges

Our Vision, Mission, and Key Strategies

Vision

For all San Franciscans to experience **mental and emotional well-being** and **participate meaningfully** in the community across lifespans and generations.

Mission

To provide **equitable**, effective substance use and mental health care and promote **behavioral health and wellness** among all San Franciscans.

Behavioral Health Services at a Glance

Largest provider of mental health and substance use prevention, early intervention, and treatment services in San Francisco. Civil service staff and contracted community partners deliver clinical services across the City.

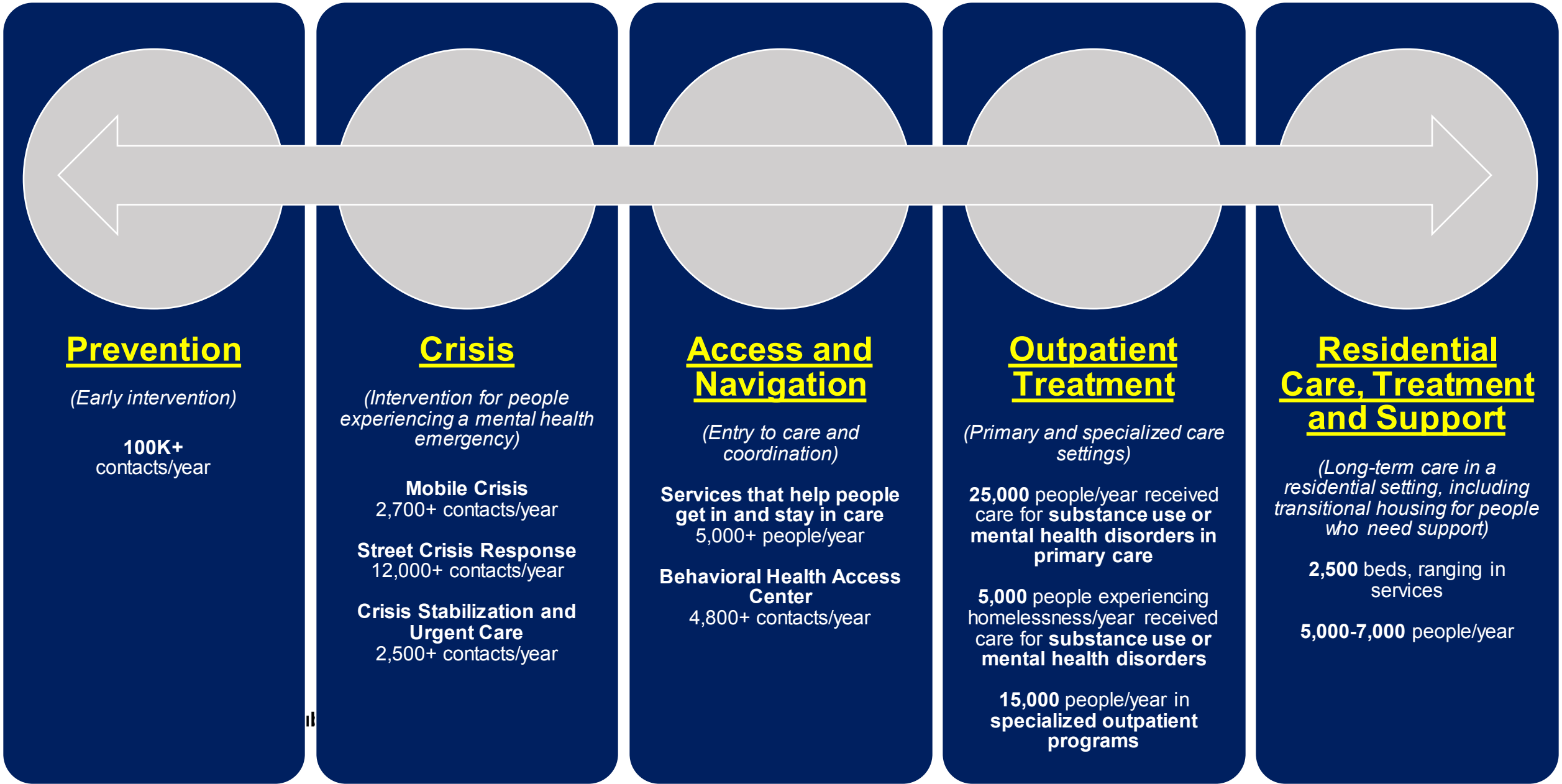
100,000+ connections to prevention, care, and treatment

~21,000 people using Behavioral Health Services in FY 22-23 (Mental Health & Substance Use Disorder)

Top 5 Most Frequent Primary Diagnoses

- Depressive/Mood Disorders
- Substance Use Related Disorders
- Schizophrenic/Psychotic Disorders
- PTSD/“Severe” Stress Reaction
- Anxiety Disorders

Range of Behavioral Health Care Services



Prevention

(Early intervention)

100K+
contacts/year

Crisis

(Intervention for people experiencing a mental health emergency)

Mobile Crisis
2,700+ contacts/year

Street Crisis Response
12,000+ contacts/year

Crisis Stabilization and Urgent Care
2,500+ contacts/year

Access and Navigation

(Entry to care and coordination)

Services that help people get in and stay in care
5,000+ people/year

Behavioral Health Access Center
4,800+ contacts/year

Outpatient Treatment

(Primary and specialized care settings)

25,000 people/year received care for **substance use or mental health disorders in primary care**

5,000 people experiencing homelessness/year received care for **substance use or mental health disorders**

15,000 people/year in **specialized outpatient programs**

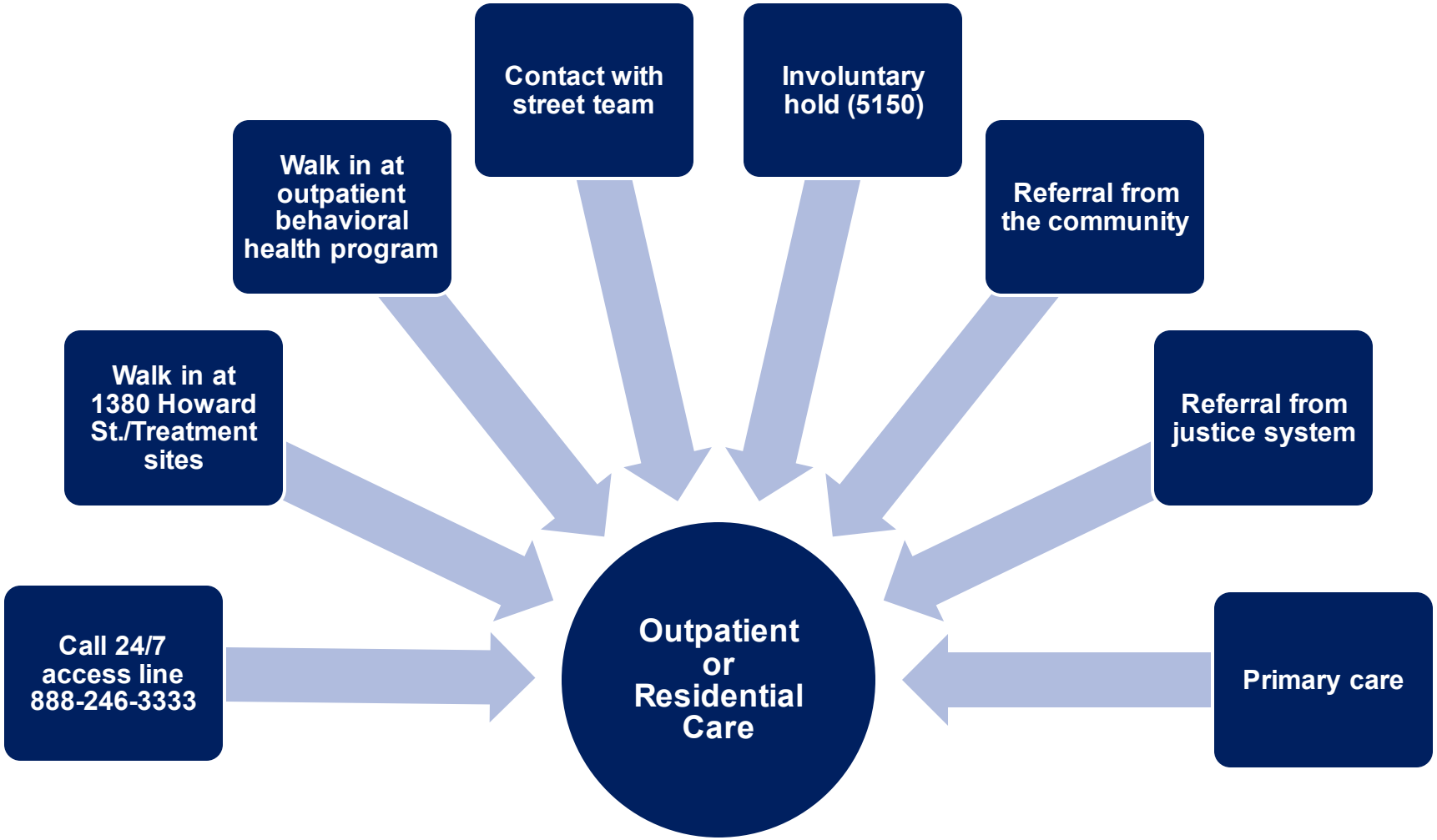
Residential Care, Treatment and Support

(Long-term care in a residential setting, including transitional housing for people who need support)

2,500 beds, ranging in services

5,000-7,000 people/year

How People Can Get Into Behavioral Health Care



Where DPH is Delivering Behavioral Health Care

DPH Primary Care Clinics with Behavioral Health Services

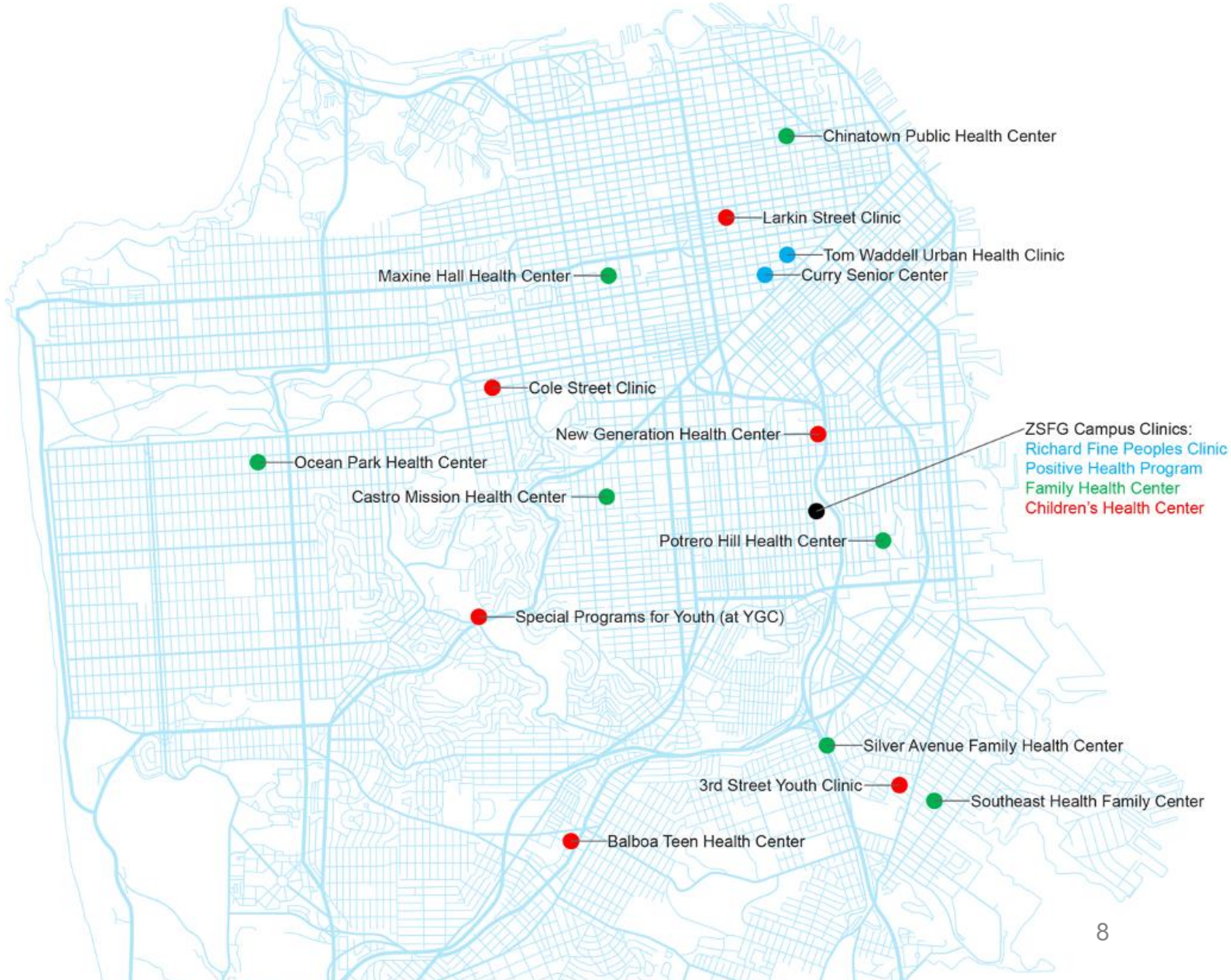
Of all people served in primary care approximately half receive care for behavioral health conditions.

Served FY21-22

25,000 people treated in DPH primary care clinics for mental health and substance use issues.

Operating Hours

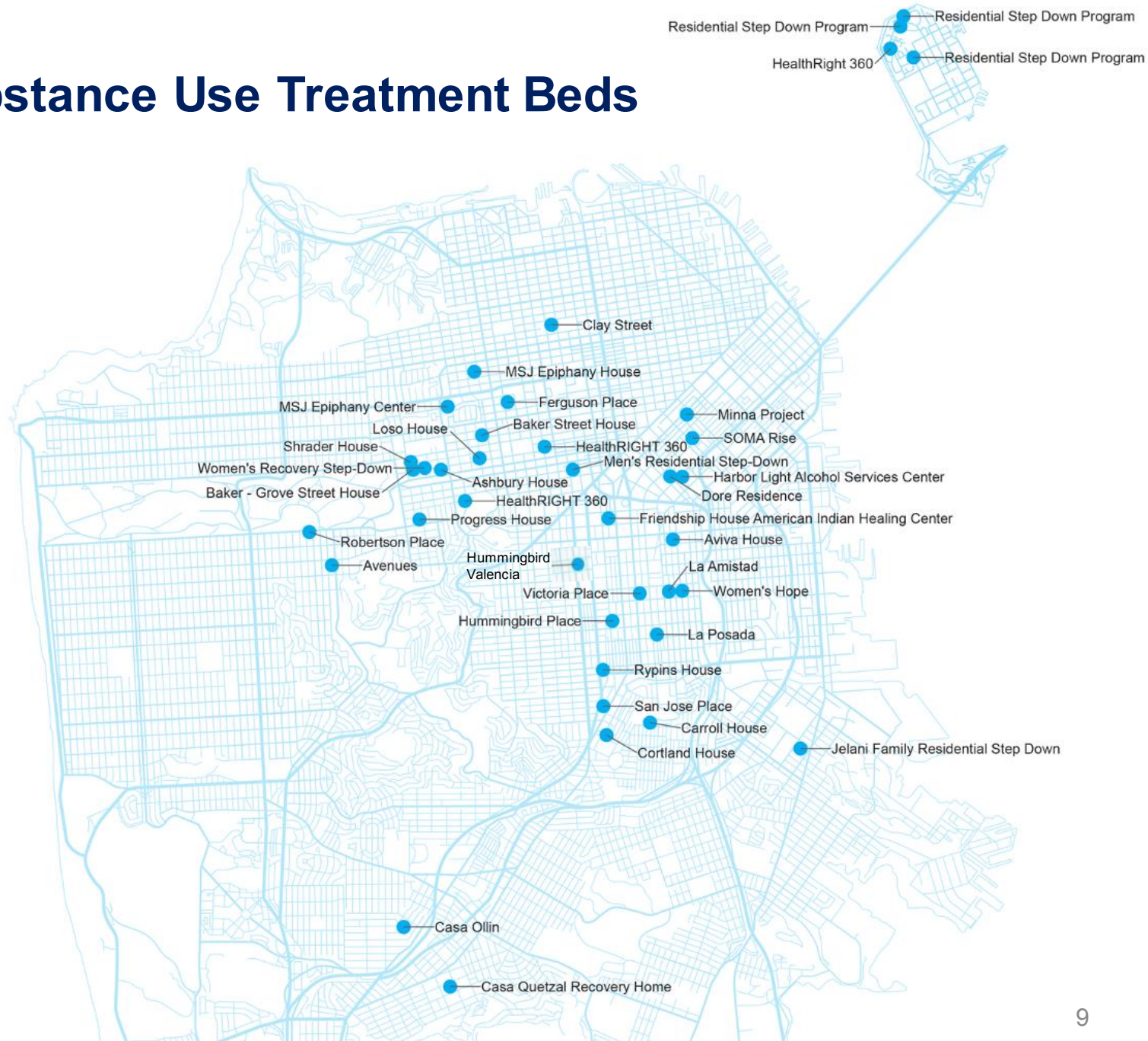
Generally 8am-5pm, Monday-Friday, with extended weekend and evening hours at some locations.



- Primary Care for adults only
- Primary Care for adults, children, families
- Community Health Programs for Youth

2,500 Mental Health and Substance Use Treatment Beds

Out of County
~450 beds



55 Specialized Outpatient Mental Health and Substance Use Treatment Sites

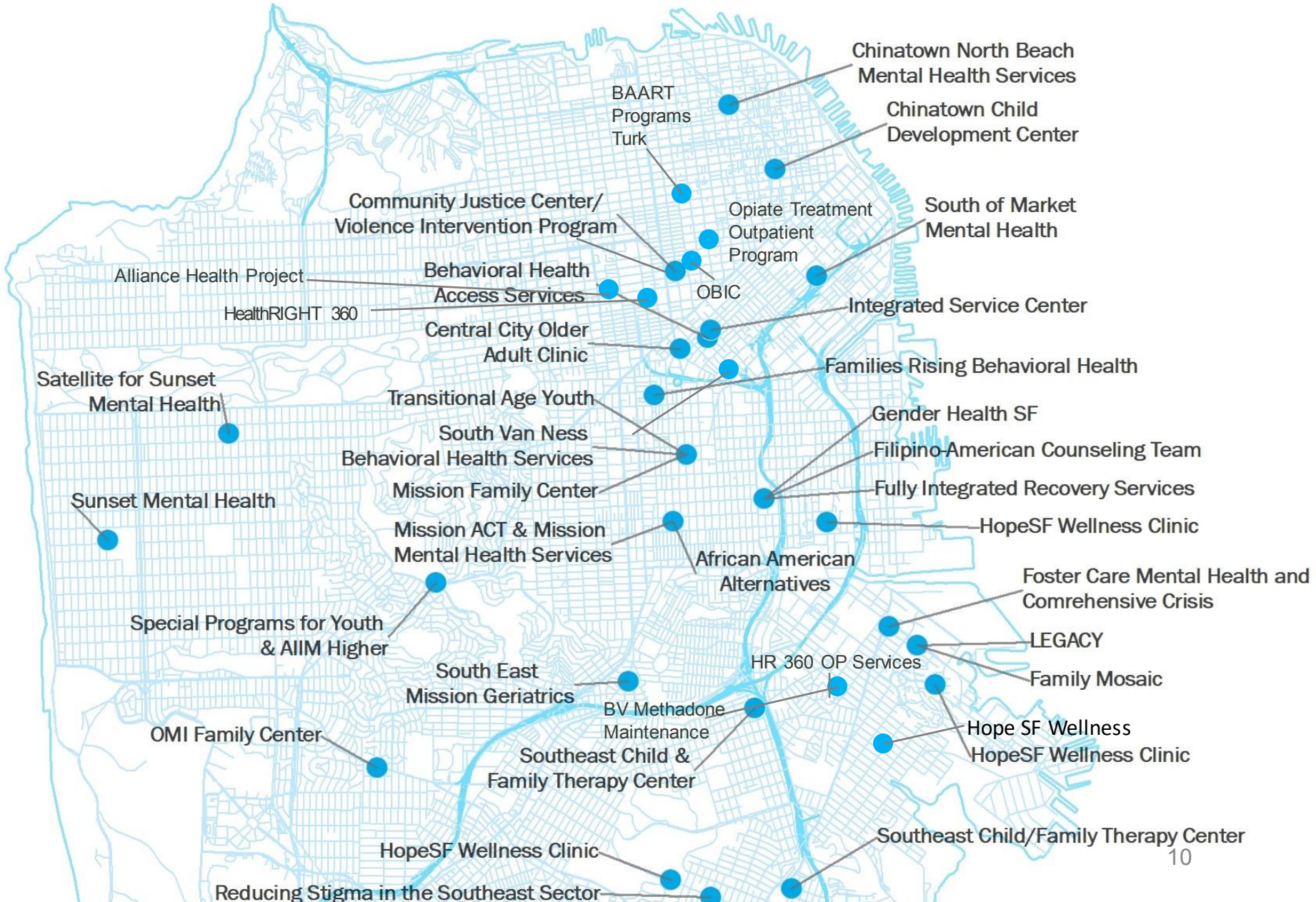
Most people accessing specialty services are treated in outpatient settings.

Served FY21-22
15,000 people

Operating Hours
9am-5pm
Monday-Friday

Open evenings and/or weekends:

- Buprenorphine Induction Clinic
- Behavioral Health Access Center
- BAART Programs.



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Behavioral Health Care in SF County Jails

Services in Jail

- All people are screened for behavioral health needs during intake
- People who have a behavioral health need are offered substance use counseling, medications for addiction treatment, mental health care, referral to services upon reentry, and more
- Jail Behavioral Health staff include health workers, behavioral health clinicians, and psychiatrists

Connections to Care Upon Release

- Office of Coordinated Care and Jail Health Services coordinate care for people with complex behavioral health needs to ensure there are no gaps in care
  - Office of Coordinated Care provides case management, a care plan, and connections to on-going care
  - Jail Health Services works with Behavioral Health Services and Sheriff for residential placement

Transformative Changes are Coming

- Transition to SFHN shared client health record via Epic allows for centralized access to outpatient and intensive outpatient care
- CalAIM will allow jails to bill for Medi-Cal services provided 90-days prior to release

Reentry Planning

7000+ people were released from jail last year
50% of people in custody leave within **72 hours**

- **Strategies vary** depending on length of stay and ability to initiate treatment while in custody
- **Close collaboration** with criminal justice and community partners
  - *Sheriff, Probation, Pre-Trial Diversion, Public Defender, DA, Behavioral Health Services, & others*
- Focuses on **continuity of care** and setting individuals up **for successful reintegration** into the community
- **Full spectrum of services** are available to support individuals at release
  - *Range from providing discharge medications and transportation to initiation of a conservatorship and placement in a locked psychiatric facility*
- Vast majority of complex **discharge plans are done through treatment courts** where Reentry staffs two courts (Mental Health Diversion Court and Behavioral Health Court)
- **Connect to treatment** (mental health disorder, substance use disorder, and physical health) is done in partnership with multiple stakeholders
  - *Jail Health Services **initiates referrals** and provides **warm hand-offs***

Improving Access and Care Coordination for San Franciscans

The Office of Coordinated Care (OCC) manages behavioral health central access points, provides case management, care oversight, and care planning.

Access & Navigation – Information, screening, referral and direct connection to behavioral health care

- **Behavioral Health Access Line (BHAL):** 24/7 state-mandated/regulated call center
- **Behavioral Health Access Center (BHAC):** Walk-in center, open 7 days/week, for access to behavioral health services

CARE Coordination – Systematic and focused services for priority populations needing engagement and connections to care.

- **Priority populations include**:
  - People leaving hospital: inpatient, ED, PES (including 5150s)
  - People with crisis contacts (including SCRT)
  - People leaving jail
    People who are experiencing homelessness
  - People with high utilization of multiple systems and high behavioral health needs
  - People in HSH system: shelters, navigation centers, permanent supportive housing

Street Response is a Part of Our System of Care

Neighborhood-based Behavioral Health Care (BEST Neighborhoods)

Provide behavioral health assessments and regular engagement for high-priority, unhoused people with serious behavioral health conditions and complex needs. Work closely with other street teams (including SCRT follow up) and City departments.

Overdose Response Follow-up (POET)

Emergency response for people experiencing an overdose in the community. Within 72 hours of overdose event, the Post Overdose Engagement Team outreaches to engage individual into treatment and/or teach skills to prevent future overdoses.

Street Medicine

Street-based health care teams served over **3,000** people experiencing homelessness in FY22-23.

Care Plans for People with Behavioral Health Challenges: Key System Function

The aim of a **care plan** is to **outline achievable care, treatment, and recovery goals**. Plans are **tailored to the individual** and **developed by a mental health professional**.

Care plans often involve **multi-disciplinary coordination** across outpatient clinics, intensive outpatient, emergency services, follow up teams (i.e.: BEST neighborhoods), conservatorship, etc. and include:

- Behavioral health challenge or diagnosis
- Recommended care and treatment
- Goals for care and treatment
- Important milestones

Intensive Outpatient Programs Provide Integrated Treatment and Case Management

~1300* adults were served in Intensive Outpatient Programs

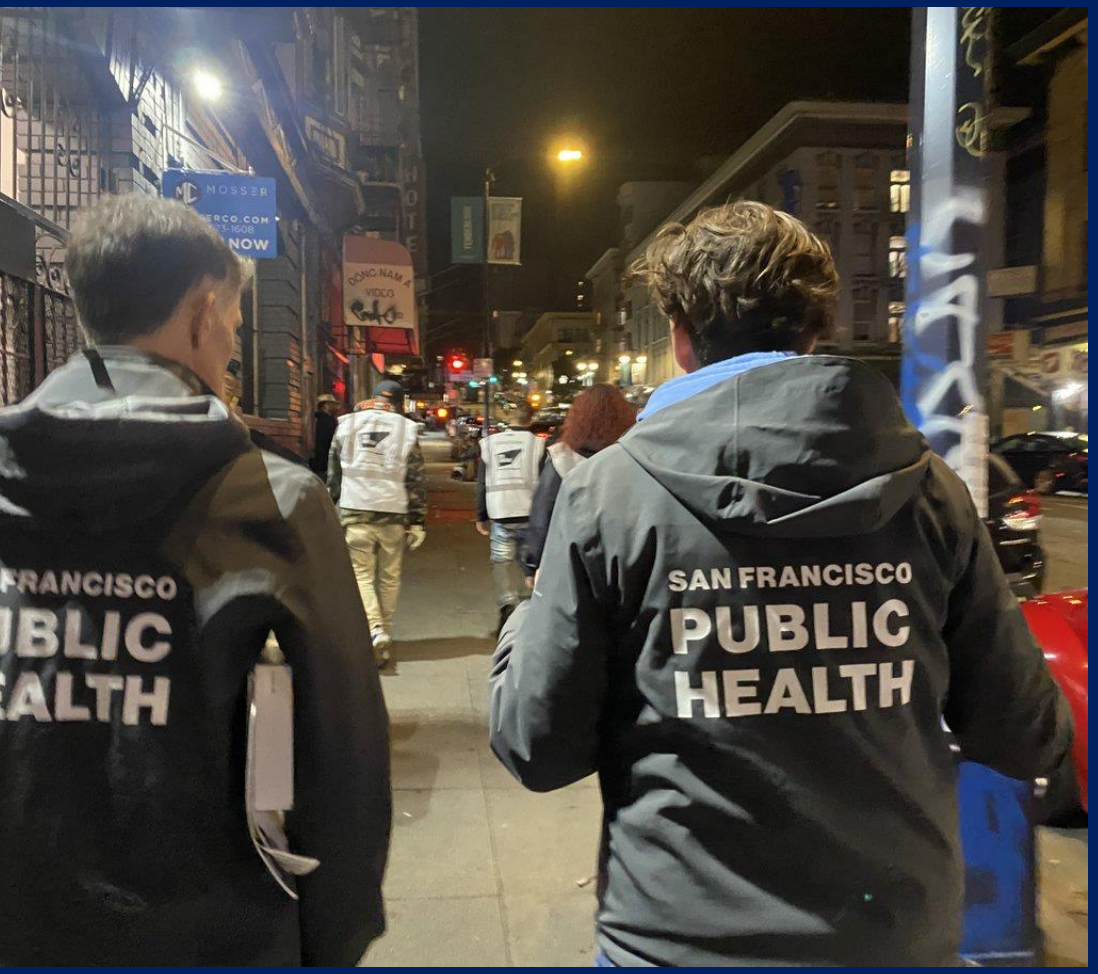
An **Intensive Outpatient Program** (also known as Intensive Case Management) consists of a **multidisciplinary treatment team** (social worker, psychiatrist, health worker, nurse.) that **provides team-based care for people with complex mental health and substance use needs**.

Intensive Outpatient teams aim to stabilize people, improve their health outcomes, and equip them with the tools necessary to move them from a crisis to stability and routine care.

- Provide mental health and substance use treatment.
- Support people to access and maintain benefits (health care, food, housing, etc.),
- Case managers meet with people weekly, or as often as is needed. If someone is in acute distress, they may be seen daily.

*FY22-23

Coordinated Response with City Agencies and Community Organizations



Aims to **increase stability** and **connections** to **care**. DPH takes lead on providing behavioral and physical health care and case management.

- Daily and weekly coordination with **SFPD**, **DEM**, **SFFD, HSA**, and **HSH** on street engagement and response, including case management for high-priority individuals.

- Collaborate with **SFFD** on follow up for people seen by **SCRT** and **POET** teams and linkage to care.

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Scenario 1: About Gerald

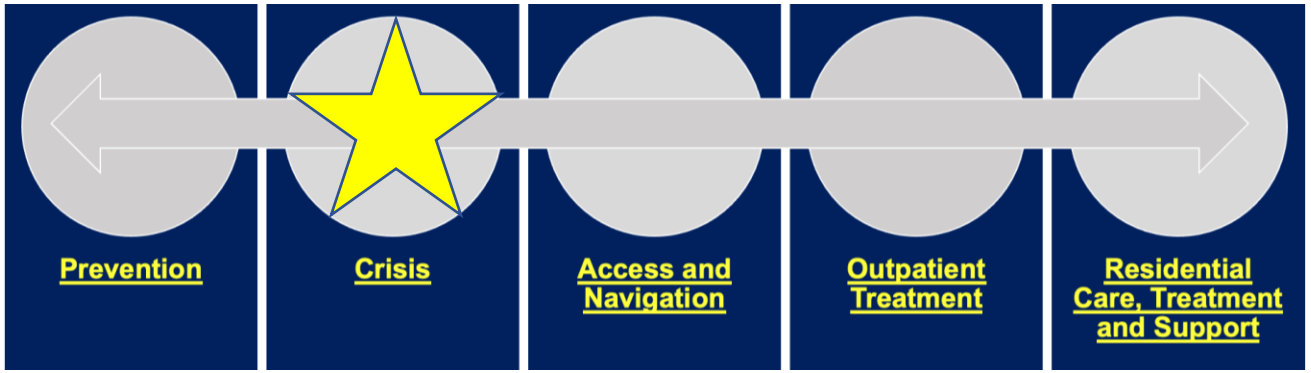
- Male
- 57-year-old
- Bipolar disorder
- Uses methamphetamine
- Currently unengaged in treatment
- Unhoused or marginally housed for the last 15 years
- Previously engaged in mental health treatment but only for a short period of time
- History of emergency department visits
- Has cancer but is not regularly receiving physical health care

Scenario: Crisis Encounter to Care Coordination

SCRT encounters Gerald after he is observed in distress on the street. SCRT assesses and transports Gerald to Dore Urgent Care and makes a referral to Office of Coordinated Care (OCC) for follow up.

Upon receiving the referral, an OCC case manager meets with him at Dore Urgent Care. The case manager reviews Gerald's health history to better understand his behavioral health needs and learns that Gerald stopped using his psychiatric medication because he didn't like how it made him feel.

Gerald informs the case manager that a close family member recently passed away, which is contributing to his distress. He declines behavioral health care but agrees to receive help to find a navigation bed.



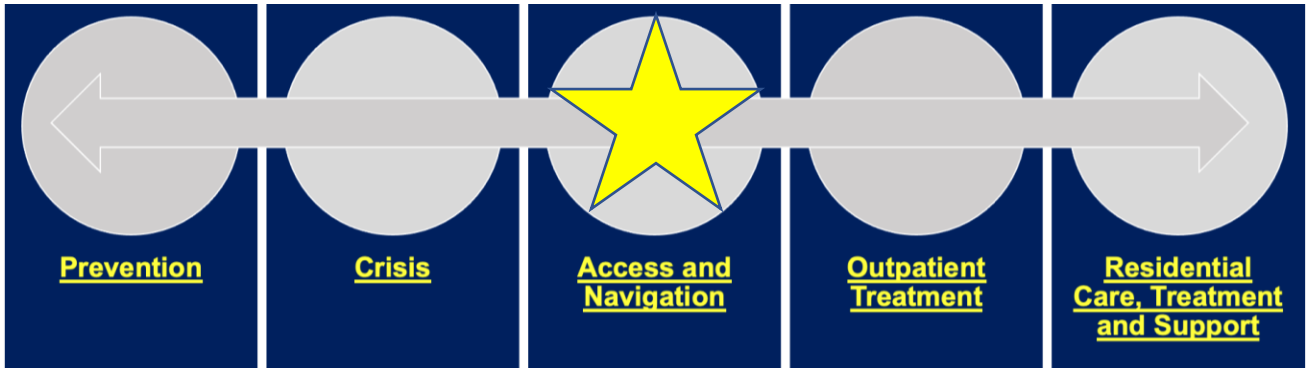
Scenario: Care Plan and Coordination

After visiting the navigation center with Gerald, the case manager offers to meet with him daily. Gerald agrees to meet twice a week and declines mental health care.

Finally, he agrees to develop a care plan with the case manager. He expresses that securing housing is his first priority, and that he is interested in receiving physical health care.

Although, he declines mental health care and says he's not ready to make a change in his drug use, which he says makes him feel better. He does agree to continue discussing mental health and substance use as a part of his care plan.

The case manager accompanies Gerald to a Coordinated Entry access point so he can be assessed for permanent supportive housing. The case manager also works with him to re-engage with his physical health providers.

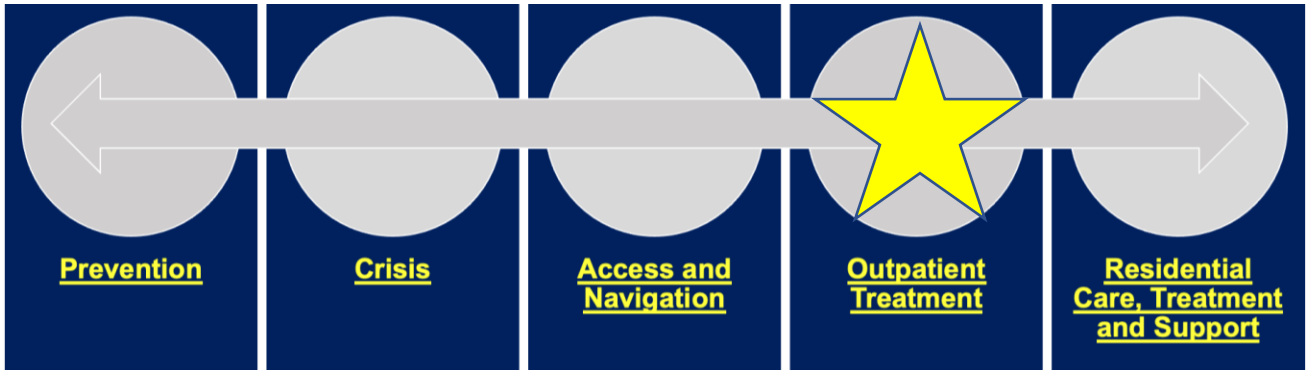


Scenario: Progress and Outcome

Throughout the seven months that the case manager engages with Gerald, progress is slowed when Gerald disappears for days or expresses a lack of willingness to engage. However, the case manager's persistent, regular engagement supports Gerald's continued interest in obtaining supportive housing, and increased interest in receiving cancer treatment.

Gerald is successfully placed in permanent supportive housing and begins treatment for cancer. Once housed, Gerald tells the case manager that he would like to enter a mental health treatment program.

The case manager connects Gerald to an Intensive Outpatient Program where a multi-disciplinary team reviews his care plan, communicates with OCC, and implements the plan. An Intensive Outpatient Program case manager takes over and begins to meet with Gerald at least twice a week.



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Mental Health San Francisco Successes

- Established Office of Coordinated Care services to **ensure successful transitions** through care and treatment as well as keeping **people with complex needs** connected to care.
- Launched BEST Neighborhoods behavioral health care team to regularly engage with **high-priority unhoused people** with **serious behavioral health conditions**.
- Increased residential care and treatment by **350 beds**.
- **Expanded assessment** and **treatment** including hours of operation for the walk-in treatment center, pharmacy, OBIC, and Opioid Treatment Programs.
- **$1.8M** added to existing **intensive outpatient** and **stabilization providers** to support filling critical vacancies, ensure competitive salaries, and increasing staffing.

Key Challenges and Impacts to Service Delivery

- Workforce **recruitment** and **retention**
- Acquiring **new beds** and **facilities** for care and treatment
- **Data** and **analysts**

Thank you