



CITY AND COUNTY OF SAN FRANCISCO DEPARTMENT OF PUBLIC HEALTH

# HOUSING AND HOMELESS REPORT 2005-2007



*Building Healthy Communities*

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## Overview

The San Francisco Department of Public Health (DPH) is pleased to present its Housing and Homeless Report to the Health Commission. DPH has engaged in many exciting and innovative initiatives since its last report in 2004, and it continues to lead the city and country in its response to housing and homeless issues.

DPH's practice of "meeting people where they are" and doing whatever it takes to raise the health status of all populations continues to guide the Department's work. Toward that end, DPH actively collaborates with community partners, other government agencies, and consumers to develop more effective ways to improve the wellbeing of those struggling with multiple challenges such as poverty, unstable housing, mental illness, substance abuse, trauma, and violence. While these conditions confront many clients daily, DPH's primary challenge remains that of overcoming traditional barriers and delivering integrated and empowering services that improve people's lives.

DPH's overall strategy can be summarized as:

- Collaboration: Working with the community, nonprofit organizations, and other government agencies to improve and integrate healthcare and housing services for all populations.
- Prevention: Affording all San Franciscans access to the care and services they need to improve their health outcomes and wellbeing and stay off the streets.
- Housing First: Prioritizing access to stable housing for the currently homeless.
- Integrated Support Services: Coordinating DPH systems of care to ensure that all persons have access to the individualized support they need to improve their health status and secure and retain housing.

Please note that this report does not attempt to list every DPH-affiliated homeless service; rather, it highlights the more notable developments that have occurred over the last two years and points out several important issues and policy areas DPH must address in the future.

# HOUSING AS HEALTH CARE



*The Department of Public Health – Housing and Urban Health (DPH-HUH) strives to improve the health and wellbeing of homeless persons while reducing the costly over-utilization of emergency services. DPH-HUH achieves this aim through a continuum of housing options designed to “meet people where they are.” Permanent supportive housing allows formerly homeless persons to live independently with access to on-site services designed to help them stabilize their health and maintain housing; transitional and stabilization units provide shorter-term housing options to homeless persons as they progress along the housing continuum.*

**Housing Collaborations: Department of Public Health – Housing and Urban Health**

**Permanent Supportive Housing – Direct Access to Housing**

The Department of Public Health-Housing and Urban Health (DPH-HUH) strives to end homelessness in San Francisco through the expansion of its Direct Access to Housing (DAH) program. Established in 1998, DAH provides permanent, service-enriched housing to extremely low-income homeless people / persons at-risk of homelessness—most of whom have concurrent mental health, substance use, and chronic medical issues. DAH currently houses approximately 850 formerly homeless persons across 20 sites—an expansion of 259 units since the release of the *2004 DPH Homeless and Housing Services Report*.

**Table 1: Current DAH Inventory**

Start Date	Building Name	Total Units	DAH Units	DAH Population	Additional Information
1999	Pacific Bay Inn	75	75	Homeless adults with special needs	Master leased
1999	Windsor	92	92	Homeless adults with special needs	Master leased
2000	Le Nain	86	86	Homeless seniors (55+) w/ special needs	Master leased
2001	Broderick Residential Care Facility (RCF)	33	33	Persons exiting institutions with mental health and/or physical health needs requiring licensed facility	Master leased RCF
2003	Star	54	54	Homeless adults with special needs	Master leased
2003	Camelot	55	55	Homeless adults with special needs	Master leased
2004	CCR	204	60	Homeless seniors (55+)	Block of units, existing affordable housing
2004	West	104	40	Homeless seniors (55+)	Block of units, new construction
2004	Empress	89	89	Chronically homeless adults with special needs*	Master leased
2005	Folsom/Dore	98	40	Chronically homeless adults with special needs*	Block of units, new affordable housing construction
2005	Plaza	106	106	Homeless adults with special needs	Studio units, new construction
2006	Mission Creek Senior Community	139	51	Frail homeless seniors (62+)	One bedroom units, new construction
2006	DAH for Chronic Alcoholics (6 sites)	Varies	62	Chronically homeless adults with a disabling addiction to alcohol*	Blocks of units, existing affordable housing
2007	DAH Prop. 63 Program (2 sites)	Varies	20**	Severely mentally ill adults who are homeless or at-risk of homelessness	Blocks of units, existing affordable housing
<b>TOTAL</b>	<b>--</b>	<b>1135+</b>	<b>863</b>	<b>--</b>	

\* "Chronically homeless" as defined by the U.S. Department of Housing and Urban Development.

\*\* This number will increase by five units in Fall 2007. These units will be designated for senior clients referred via the DAH Prop. 63 Program; the housing site has yet to be designated.

By 2010, DAH will expand to house close to 500 additional tenants across nine new sites as indicated in the table below.

**Table 2: DAH Pipeline Projects**

Start Date	Building Name	Total Units	DAH Units	DAH Population	Additional Information
Summer 2007	TBD	--	5	Severely mentally ill senior adults referred through the DAH Prop. 63 Program	Location TBD
November 2007	Providence Senior Housing Development	50	5	Frail homeless seniors (62+)	New construction, all one bedroom units
January 2008	Parkview Terrace (Parcel A)	101	20	Chronically homeless seniors	New construction
Summer 2008	18 <sup>th</sup> and Alabama	151	11	Chronically homeless seniors	New construction
Summer 2008	990 Polk	110	50	Chronically homeless seniors	New construction
April 2009	9 <sup>th</sup> and Jessie Senior Housing	107	26	Chronically homeless seniors	New construction
2009	1500 Page Street Residential Facility	45+	45+	Homeless adults leaving institutions who have mental health and/or physical health needs that require a licensed facility	Licensed RCF owned and operated by AgeSong collaboration; totally renovated
2009/10	Parcel C (Golden Gate & Franklin)	100	20	Chronically homeless seniors	New construction
2009/10	Central YMCA	174	174	Chronically homeless adults	Rehabilitated site will house Housing and Urban Health Clinic
January 2010	Central Freeway Parcel G	120	120	Chronically homeless adults	New construction
<b>TOTAL</b>	<b>9 New Programs</b>	<b>958+</b>	<b>476+</b>	<b>--</b>	<b>--</b>

Below are six summaries of notable DAH sites that have recently opened or are in the development phase. Several sites mark DAH's expansion beyond the Tenderloin to other San Francisco neighborhoods like Mission Bay.

Direct Access to Housing at Mission Creek Senior Community

Mission Creek Senior Community, a new mixed-use development owned and operated by Mercy Housing California, opened in March 2006. Mission Creek offers 139 one-bedroom apartments to San Francisco's seniors including 51 seniors to be served by DAH. These DAH tenants are

very low-income residents (20% of median income) who are physically disabled or frail and homeless or at-risk of becoming homeless. All heads of household are 62 or older.

DAH tenants receive comprehensive services onsite. An Adult Day Health Care (ADHC) program



provides nursing, physical and occupational therapy, social work, and more. Mercy Housing also provides tenant support services to DAH seniors. A Behavioral Health Specialist offers tenant support services, intensive case management, and one-on-one behavioral health support regardless of whether DAH tenants participate in ADHC. All staff work collaboratively to offer weekly psychosocial educational support groups that range from general

support, stroke survivor support, diabetes, smoking cessation, and a recovery group.

DAH housing at Mission Creek, coupled with appropriate supportive services, provides a stable living environment in which residents can address the underlying causes of homelessness, ranging from physical or mental disability to chronic medical conditions. As a result of the DAH program, residents have been able to achieve housing stability, improved health, reduced use of acute and emergency services, increased incomes, and engagement in vocational programs.

#### Direct Access to Housing for Chronic Alcoholics

Launched in August 2006, the DAH Program for Chronic Alcoholics is a two-year initiative funded by the U.S. Department of Housing and Urban Development (HUD). The program provides 62 units of permanent supportive housing across six sites to chronically homeless persons with disabling, long-term alcohol addictions.<sup>1</sup>

At initial contact clients:

- Were homeless and on the street, and
- Had been homeless for at least 365 days of the last five years, and
- Had no history of transitional or permanent housing in the last five years, and
- Were living in an emergency shelter or other place not meant for human habitation (e.g., street, abandoned building, car, etc.).

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<sup>1</sup> HUH contracted with the following nonprofit housing providers to supply 62 units of permanent housing to the DAH Program for Chronic Alcoholics: Chinatown Community Development Center (William Penn Hotel), Community Awareness and Treatment Services (Eddy St. Apartments), St. Vincent de Paul Society of San Francisco (Arlington Hotel), and the Tenants and Owners Development Corporation (Bayanihan House, Hotel Isabel, and Knox Hotel).

Despite challenges facing the program's target population, the DAH Program for Chronic Alcoholics achieved several positive outcomes during its first six months of operation. For example:

- The DAH Program for Chronic Alcoholics placed 62 eligible applicants in permanent supportive housing. This exceeded DPH-HUH's original goal of placing 50 clients in housing within the initial six months of operation.
- All DAH tenants (62/62 currently) remained engaged in intensive case management after placement. This exceeded DPH-HUH's original goal of keeping at least 95% of tenants continuously engaged in services.
- Eighty-three percent of tenants (10/12 original program tenants = 83%) were housed for the entire six-month period.<sup>2</sup>
- Seventeen persons (17/62=27%) were identified as high users of emergency medical services (EMS). Of those:
  - 65% (11/17) reduced their EMS use by 100% as indicated by comparisons of post-housing behavior to baseline usage pre-move-in.
  - 12% (2/17) reduced EMS use by 95%.
  - 6% (1/17) reduced EMS use by 90%.
  - 6% (1/17) reduced EMS use by 50%.

The remaining 12% (2/17) reduced EMS use by 20%; chronic conditions related to their alcoholism required such care.

DPH-HUH attributes the success of the program to pre-existing linkages between tenants and intensive case management providers such as the McMillan Intensive Case Management Team and the San Francisco Homeless Outreach Team.<sup>3</sup> Intensive case managers provide ongoing support to the chronic alcoholic DAH tenants ranging from one-on-one counseling and alcohol/substance abuse treatment to

#### **DAH for Chronic Alcoholics: Case Study**

The McMillan Intensive Case Management (ICM) Team first encountered Mr. M, a chronic inebriate with concurrent substance use and mental health issues, when he entered medical detox at the age of 34. Requesting help, Mr. M suffered from debilitating depression and anxiety, which medication did little to abate. Mr. M lacked income and had a long history of unstable housing and homelessness.

McMillan, though ultimately successful in connecting Mr. M to Social Security Income, had difficulty stabilizing the client in housing given his chronic alcoholism and decompensating health; Mr. M had to be hospitalized close to death on several occasions. Though referred to residential substance abuse treatment and emergency stabilization several times, Mr. M was unable to retain housing despite the support of intensive case management services; Mr. M was psychiatrically hospitalized several times because of depression and suicidal ideation that would not subside.

After cycling through the system several times, the McMillan ICM Team placed Mr. M in permanent supportive housing through the DAH Program for Chronic Alcoholics. Mr. M remains stably housed through the program and continues to receive ICM services from the McMillan Team. Mr. M just celebrated his first year anniversary of sobriety, which he attributes both to housing and ICM services received from McMillan. He "gives back" by serving as a part-time volunteer in the community.

<sup>2</sup> Exits: One tenant died due to complications related to his long-term alcohol addiction. The other required treatment in a residential rehab setting; the stability and intensive case management he received through the DAH program enabled providers to get him admitted to a rehab program appropriate for his needs.

<sup>3</sup> While several teams provide intensive case management services to DAH tenants, McMillan acts as the primary "gatekeeper" to the program, controlling the flow of applications for housing and ensuring that all DAH tenants receive an appropriate level of intensive case management tailored to their needs.

linking clients to primary medical care. Given the program's success in terms of tenant outcomes and cost-effectiveness, DPH-HUH is working with HUD to expand the DAH Program for Chronic Alcoholics.

### DAH Prop. 63 Program

The DAH Prop. 63 Program, which began in March 2007, will provide 25 units of permanent supportive housing to seriously mentally ill persons under the State's *Mental Health Services Act*.<sup>4</sup> Clients are referred to the program via four Full Service Partnerships (FSPs) selected through a competitive process administered by DPH - Community Behavioral Health Services:

- University of California, San Francisco – Citywide Case Management Forensics
- Family Service Agency – Adult Division
- Family Service Agency – Senior Division
- Hyde Street Community Services

FSPs have pre-existing intensive case management relationships with all clients who are referred to the DAH Prop. 63 Program. These relationships continue throughout clients' DAH tenancy and are complemented by additional support services available at the housing site as provided by the building owner / operator. DPH-HUH partners with the FSPs, on-site support services staff, and property management to ensure that DAH Prop. 63 Program tenants have access to the wraparound support they need to improve their health outcomes and succeed in independent housing.

#### **DAH Prop. 63 Program Innovation**

To better prepare clients for placement in permanent housing, DPH-HUH instituted a stabilization component to the DAH Prop. 63 Program. Living in stabilization units prior to entering permanent housing allows clients to adjust to independent living supported by intensive case management. Successful stabilization also demonstrates to Property Management that Prop. 63 clients can thrive in a community-based setting, increasing the likelihood that Prop. 63 clients are accepted into permanent housing.

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<sup>4</sup> DPH-HUH has contracted with the Tenderloin Neighborhood Development Corporation to provide 20 units of permanent supportive housing at the Dalt and Ritz Hotels. Five additional units will be available to senior FSP clients as of Summer 2007; the senior housing site has yet to be determined.

### Parkview Terrace

Parkview Terrace is a new affordable senior housing community currently under construction. Scheduled to open January 2008, the development is a partnership between DPH-HUH; AF



Parkview Terrace

Evans Development, Inc.; Chinatown Community Development Center, Inc.; and the San Francisco Redevelopment Agency.

DAH will lease 20 Parkview Terrace units to serve chronically homeless seniors. DAH tenants will be able to enjoy all Parkview Terrace amenities ranging from a large community room to a library and sun deck. The building's ground floor will provide space for a variety of community services including Northern California Presbyterian Homes and Services' Retired Senior Volunteer Program offices, offices for two social service coordinators, a hair salon, a fitness center and physical rehabilitation therapy facility.

Located one block from Opera Plaza, Parkview Terraces is conveniently located near the Performing Arts District with wide access to public transportation, restaurants, and shops.

### Central YMCA

DPH-HUH will partner with the Tenderloin Neighborhood Development Corporation (TNDC), AF Evans Development, Inc., and the Mayor's Office of Housing to renovate the Central YMCA, creating approximately 174 units of permanent supportive housing for homeless persons by 2010. Located at the intersection of Golden Gate and Leavenworth Avenues, units will include private bathrooms and kitchenettes; the historic building will also house tenant common areas and a holistic health clinic and wellness center for residents and other extremely low-income people housed in other supportive housing sites.



Central YMCA

Partners envision the Central YMCA's rehabilitation as an opportunity to bring affordable housing and health services directly to the people who most desperately need them and who often fall through the system's cracks. With a holistic approach to health care, the onsite clinic and wellness center will combine traditional and non-traditional medicine along with innovative preventive care services aimed at significantly improving the overall wellbeing and health status of tenants and community members.

The rehabilitation of the Central YMCA will be the latest in a series of building restorations along the Tenderloin's Golden Gate corridor that is updating the look of the neighborhood while

maintaining its character and affordability for residents; the renovation will also advance the City's 10-year plan to end chronic homelessness which includes the creation of 3,000 new units of permanent supportive housing by 2010. Originally built in 1910, the nine-story Central YMCA is one of the largest buildings along the Golden Gate Corridor. Continuing its long-standing commitment to the neighborhood, the YMCA plans to move to a nearby interim location while finalizing construction of its new facility on Golden Gate Avenue.

### 1500 Page Street

In 2006, DPH-HUH partnered with AgeSong, Inc. and Pacific Institute, Inc. to develop and implement the Awakenings Program at 1500 Page Street, a licensed Residential Care Facility (RCF) that, for more than 40 years, has been serving people living with mental illness. With financial support from the Mayor's Office of Housing, AgeSong purchased the building in Spring 2007. All residents have been relocated to appropriate housing in preparation for a major rehabilitation of the building.

The newly rehabilitated building will have greatly improved accessibility and will provide comfortable, modern residential care for approximately 55 people. The target population for 1500 Page includes persons otherwise hard to place due to a complex combination of behavioral and physical health issues. Awakenings will provide all residents with compassionate and integrated wraparound care including intensive case management, mental health services, substance abuse treatment, medical support, and follow-up with providers.

## **Property Management in Permanent Housing**

### Delivering Innovation in Supportive Housing

In October 2006, DPH-HUH funded a new supportive housing property management pilot called DISH (Delivering Innovation in Supportive Housing), a project of the TIDES Center. The motivation and purpose of the pilot is to explore and demonstrate a new model of "health-based" property management that provides the leadership and ongoing training/mentoring necessary to motivate personnel to provide respectful, high-quality services within a challenging environment. Through excellence in property management, DISH strives to:

- Demonstrate the healing effects of home and stable community.
- Reinforce the self-worth of persons who have not previously had access to a clean and beautiful place to live.
- Engage tenants in healthy and affirming life activities by exposing them to San Francisco's diverse artistic, cultural, and educational presence.

DISH's goals are to demonstrate measurable success in areas including:

- Increased tenant satisfaction,
- Increased staff productivity and responsiveness,
- Greater efficiency in rent collection and reporting,
- Improved building and unit appearance, and
- More effective collaboration between property management, support services, and DPH medical staff.

In less than a year of operation, DISH has achieved noticeable improvement in appearance and maintenance of DAH sites, staff morale and productivity, and increased rent collection. At this preliminary stage of analysis, it appears that property management services solely focused on the DAH network of housing is working!

## **Transitional and Stabilization Housing**

### Services to Empower Personal Success

Designed to break cycles of homelessness and incarceration, the Services to Empower Personal Success (STEPS) Program serves homeless men and women who are exiting the criminal justice system and bound for more independent lives, better health, and stable housing. In operation since July 2006, STEPS is a two-year initiative sponsored by DPH-HUH and funded by the U.S. Department of Justice.

STEPS combines transitional housing with intensive case management services to provide program participants with the support they need to develop a stable income, build savings, secure permanent housing, and access other support as needed. STEPS can accommodate 51 participants at any one time, and clients transition out of the program based on their individual goals and access to more permanent housing. STEPS serves approximately 110 persons annually, and participants remain in the program for an average of six months.

DPH-designated agencies refer clients to STEPS. These referring agencies include: Jail Health Services; the San Francisco Sheriff's Department; the San Francisco District Attorney's Office; and Goodwill Industries. Each referring entity selects clients based on their participation in specified agency programs and their ability to succeed in a structured, community-based setting. Referring case managers and other representatives provide client support and individualized treatment plans.

#### **STEPS Case Study**

"Betty" is an African American woman who grew up in San Francisco's Fillmore district. Revolving through cycles of homelessness since the age of 16, the San Francisco Sheriff's Department referred Betty to the STEPS program in July 2006 after she served time for distributing narcotics. STEPS' structure—along with living on an all-women's floor while in the program—afforded Betty a feeling of safety she had never before experienced. The program also gave her the opportunity to face persistent anger management issues and to participate in a vocational program through Goodwill Industries. Betty graduated from STEPS in January 2007. While in the program, she managed to secure a private apartment in which she now lives independently. Though she has completed the STEPS program, Betty continues to utilize program resources (e.g., computers) and staff support as she refines her resume to find more permanent employment.

Throughout their program participation, STEPS clients live in a designated Single Room Occupancy hotel in San Francisco's Tenderloin neighborhood. Tenderloin Health, a local non-profit, provides an on-site case manager to support program clients during their stay.

### Stabilization Housing

Stabilization housing allows DPH to provide clients with immediate, short-term housing connected to intensive case management services. Usually one week to three months in duration, case managers utilize stabilization housing to afford clients a transition to permanent housing or a more appropriate level of care (e.g., residential substance abuse program). DPH-HUH brokers stabilization housing while service partners provide intensive case management to referred clients. DPH-HUH has expanded existing partnerships and created new alliances with the following programs to provide 351 emergency stabilization units to the City's homeless:

- AIDS Emergency Housing Program
- McMillan Intensive Case Management Team
- Project Homeless Connect
- Proposition 36 (*Substance Abuse Crime Prevention Act*) Program
- Proposition 63 (*Mental Health Services Act*) Program
- San Francisco General Hospital
- San Francisco General Hospital / University of California San Francisco Intensive Case Management Programs, including Citywide, Emergency Department Case Management, Crisis Resolution Team, and Community Focus
- San Francisco Homeless Outreach Team, including Golden Gate Outreach

### Dolores Hotel

Scheduled to open in 2008, the Dolores Hotel will provide a combination of emergency stabilization and long-term housing in San Francisco's Mission district. A partnership between Dolores Street Community Services, DPH-HUH, the Human Services Agency (HSA), the Mayor's Office of Housing, and the San Francisco Homeless Outreach Team, the Dolores Hotel will offer much needed housing and services to homeless Mission residents who typically cycle in and out of the shelter system—particularly undocumented persons who lack stable housing and income.

Services provided at the site will be voluntary and will include but not be limited to:

- Case management
- Housing support
- Education geared toward English as a Second Language learners
- Money management
- Legal aid

Program collaborators continue to meet regularly to formalize the program's structure and to finalize the Dolores Hotel's rehabilitation. Collaborators anticipate that the Dolores Hotel will be ready for occupancy by Spring / Summer 2008.

## PRIMARY CARE AND HEALTH SERVICES



*DPH's network of primary care clinics, medical providers, and health services combine to create a medical safety net designed to improve the health outcomes of San Francisco's homeless and at-risk of homelessness populations. Innovation and collaboration define DPH's primary care and health service programs, and all initiatives are geared toward patient-centered treatment and improved health outcomes.*

## DPH Health Clinics

### Tom Waddell Health Center

In Fiscal Year 05/06, Tom Waddell Health Center (TWHC) received nearly 58,600 visits for its urgent care, primary care, wound clinic, telephone advice, social services, mental health, substance abuse, dental, community health, and community outreach services. Over 13,600 individuals are served at TWHC each year, most of them homeless. In Fiscal Year 05/06, TWHC:

- Served more than 3,100 patients (18,000 total visits) at its 50 Ivy primary care clinic.
- Served more than 600 HIV+ patients.
- Conducted 1,400 dental visits.
- Performed 19,200 urgent care visits.
- Opened a new podiatry clinic in June 2006.

In Fiscal Year 05/06, TWHC also received a grant to redesign primary care services for homeless patients who often encounter barriers to care. The grant served to improve patient cycle time, reducing the time between patient arrival and medical appointment end from 97 to 66 minutes.

#### Examples of TWHC Specialty Clinics

##### *HIV+/AIDS Care*

TWHC is one of the largest HIV primary care providers within DPH. Serving more than 600 HIV+ individuals each year, TWHC has developed treatment models that have gained national attention by improving health outcomes in HIV+ homeless patients who are multiply diagnosed. TWHC provides HIV-integrated services at the TWHC site and also in collaboration with Tenderloin Health and the Asian and Pacific Islander Wellness Center. In 2007, TWHC will again collaborate with Tenderloin Health to initiate a new five-year dental SPNS (Special Project of National Significance) program funded by the Health Resources and Services Administration; the grant will allow clients with HIV/AIDS to receive much needed dental care.

##### *Transgender Clinic*

TWHC provides a range of services to address the unique needs of transgender patients, such as a weekly drop-in harm reduction support group facilitated by Walden House staff. TWHC's doctors, nurses and social workers provide consultation and education nationwide to professionals serving the transgender population; TWHC has also trained providers in Canada and Mexico.

### *Hepatitis C Care*

TWHC remains at the forefront of Hepatitis C treatment among homeless persons. Clinical staff have developed an on-site specialist model at TWHC which has centralized clinic management and reduced the use of expensive, unnecessary viral load testing.

Though ongoing substance abuse and mental health issues typically preclude homeless patients from Hepatitis C treatment, TWHC treated an increasing number of homeless persons in Fiscal Year 06/07. Between October 2006 and March 2007, for example, TWHC treated 23 homeless primary care patients with peginterferon / ribavirin therapy. Eighteen additional patients are being evaluated for possible treatment currently. TWHC anticipates that the demand for Hepatitis C services will increase in the future, as the homeless suffer disproportionately from the disease.

### *Urgent Care*

TWHC provided urgent care services to more than 8,300 patients in Fiscal Year 05/06, translating to an average 62 visits per day. Urgent care is an access point to housing and primary care for the homeless, and staff encourage patients to access social and substance abuse services and primary medical care. TWHC's urgent care also acts as a post-hospital point-of-care for homeless persons discharged from private and public hospitals across the city. By acting in this capacity, TWHC prevents "bounce backs" to the discharging hospital.

### *Office-Based Opiate Treatment*

TWHC is one of two primary care sites to participate in a national pilot program of office-based opiate treatment (OBOT). Staffed by one physician, two substance abuse counselors, and a program coordinator, the OBOT treats substance abusers with long-term Methadone or Buprenorphine, counseling, and case management. Currently, TWHC has 17 clients enrolled in the OBOT methadone program and 25 in the Buprenorphine program.

#### **TWHC CASE STUDY**

Mr. X is a 50-year-old homeless man who had been chronically homeless and living on the street for more than 10 years. Suffering from debilitating hip and knee pain, Mr. X recently began receiving primary care services at TWHC. He was treated in urgent care and was referred to primary care and case management through the South of Market Multi-Service Center. At his TWHC appointment, the client stated that it was the first time that he had not been forced to push his belongings in a shopping cart in nearly six years. Mr. X is currently applying for housing, awaiting SSI, and awaiting a hip replacement.

### *Addiction Medicine Clinic*

In 2007, TWHC opened its addiction medicine clinic in collaboration with the Central City Hospitality House Self-Help Center and Tenderloin Health. The physician-run program is designed to address substance abuse and chronic pain.

### *Shelter Health Program*

The newly created Shelter Health Program will draft standards of care guidelines and develop a long-range plan to improve the health and safety of shelter residents and staff. Specifically, the new Shelter Health Program strives to:

- Improve the health of shelter staff and residents.
- Impact the health of all San Franciscans. People living in close proximity have a high rate of disease transmission, which can easily spread to the general population.
- Draft standards and systems of care to better prepare shelters for times of disaster.

A collaboration of TWHC, HSA, the Shelter Monitoring Committee, and shelter staff, the Shelter Health Program strives to improve coordination between agencies to maximize impact and minimize duplication of resources.

### **Housing and Urban Health Clinic**

The DPH Housing and Urban Health Clinic (HUHC) received Federally Qualified Health Center (FQHC) status in 2006, which allows HUHC to bill Medi-Cal for eligible services. As one of 14 clinics comprising DPH's Community-Oriented Primary Care health centers, HUHC clinicians currently log approximately 1,000 encounters each month, 75% of which generate Medi-Cal revenue for the City and County.

HUHC continues to provide primary medical and psychiatric care to persons living in one of 38 supportive housing sites in San Francisco. Ten percent (10%) of total encounters are bedside home visits at the supportive housing site, while all other appointments take place at HUHC. HUHC also provides building-based services to the Empress and Windsor Hotels and the Plaza Apartments; HUHC's provision of medication management services to these hotels has proven pivotal in the stabilization of the sites' most challenging tenants. In addition to preventive, medical, and psychiatric care, HUHC offers on-site acupuncture, medication management, diabetes education, and ophthalmology services via the UCSF eye van. HUHC will expand its list of available services in mid-2007 to include podiatric services.

#### **HUHC Case Study**

Mr. K is a 34-year-old gay man who moved to San Francisco to leave behind an abusive home life. Since then, he has contracted HIV, Hepatitis B, Hepatitis C, various STDs, engaged in survival sex work, suffered from chronic soft tissue skin infections, had multiple psychiatric hospitalizations, endured years of being marginally housed, and struggled with profound methamphetamine and crack habits. Mr. K has also struggled with bipolar disease, depression, and developmental delay.

About a year ago, Mr. K's case manager placed him at the Windsor Hotel, one of DPH-HUH's Direct Access to Housing sites. At the Windsor, Mr. K. has a social worker, nurse, and case manager to support him in basic life skills, medical, substance abuse, and psychiatric issues. If Mr. K fails to make his medical appointments, staff go to his room and escort him next door to the HUHC where he can see his primary care provider, get his labs, and have continuity of care—vital given his medical history. Having the clinic next door is a key component to providing low-threshold care and mitigating barriers to medical care.

In the last year, Mr. K has started to make his appointments without being reminded by his case manager. He has been practicing safer sex as evidenced by his being STD free for nearly a year. Most importantly, he has created a home at the Windsor that includes support staff and other residents.

## Respite Services

### DPH-HUH Medical Respite

In March 2007, DPH-HUH opened a respite facility at Next Door, one of two planned medical respite sites to provide 60 beds of short-term housing to medically frail homeless persons exiting the hospital system; DPH-HUH opened a second respite facility at 39 Fell Street in July 2007. Mid-level health care providers (e.g., nurse practitioners, physicians' assistants) staff each site and provide medically-oriented support services for homeless persons who are too medically frail to return to the street but who do not require hospitalization. Respite sites operate 24/7, though admission to respite beds must be scheduled. DPH-HUH anticipates that length of stay will depend on need and range from one week to three months.



*Respite beds at DPH-HUH's 39 Fell facility*

In addition to basic medical care, clients will receive transportation to medical appointments, case management, benefits counseling, referral to substance abuse treatment, referral to health care treatment, and housing placement services. Clients will receive three meals daily and laundry service for bedding while at respite. The sobering center will continue to operate out of 39 Fell Street along with the new Medical Respite Program.

## Medical Screening

### Tuberculosis Control

In March 2005, the Tuberculosis (TB) Control Section began using the Quanti-FERON<sup>®</sup> TB-Gold blood test, which coincided with the mandatory TB screening policy for shelter clients. Use of the test has facilitated TB screening among the homeless by increasing the number of valid results. Community providers reported a 50% return rate for TB skin testing prior to use of the TB blood test; in 2006, 2,807 persons were screened for and cleared of TB.

Through this process of active case finding, shelter cases of TB have declined significantly, with only three TB cases reported among shelter residents in 2006. All of these cases were diagnosed as a result of mandatory shelter screening.

Although shelter-related cases are down, large outbreaks in private single-room occupancy (SRO) hotels increased among marginally housed individuals in 2006. For the first time, a TB strain resistant to three drugs was introduced to the Tenderloin in 2005 and resulted in six cases to date. This strain likely originated in the former Soviet Union, where drug-resistant rates are exceptionally high. This demonstrates the tinderbox effect of dangerous strains in poorly ventilated and crowded conditions.

In addition to its shelter efforts, San Francisco reconvened the TB Task Force on July 26, 2007. The Task Force strives to combine all community resources to prevent and control TB among San Francisco's homeless and marginally housed populations. The Task Force brings together community providers working with homeless and clients within private and supportive SROs and those residents at highest risk for TB. The Task Force will meet bi-monthly.

## INTEGRATED SUPPORT SERVICES



*Integrated support services provide an important means of connecting clients to care, allowing them to stabilize their health, gain income, access medical and psychiatric treatment, and secure housing. DPH works tirelessly to tailor services to each individual, coordinating effort between sections and outside service providers to ensure that San Francisco's most vulnerable do not fall through system "cracks."*

## Outreach, Engagement, and Linkage

### Project Homeless Connect

Project Homeless Connect (PHC) began in September 2004. An example of what the community can accomplish by working together, PHC started when a small group of committed City employees reached out to the Tenderloin neighborhood to provide San Francisco's homeless with easy access to needed services.

Since then, the event has grown tremendously. Based on a one-stop-shop model, PHC events occur every other month at Bill Graham Civic Auditorium. More than 2,000 homeless persons / persons at-risk of homelessness come to PHC seeking the 100+ offered services including medical care, drug treatment, shelter and stabilization housing, SSI, GA, food stamps, legal aid, employment services, eyeglasses, wheelchair repair, DMV IDs, haircuts, and more. At one PHC event, people can accomplish what would otherwise take up to eight months to achieve.

Truly a public/private/non-profit partnership, more than 250 non-profit and government agencies and 300 corporations have donated their time to PHC; 95% of the costs for each event are paid through private donations and in-kind support.

Community members are the foundation of PHC, and more than 15,000 persons have volunteered at a PHC event since the program's inception. More than 1,000 volunteers provide support at each event—40% of whom have participated in four or more PHC events. According to one long-time volunteer, "Project Homeless Connect has provided a venue for me to give back to my community and to help others. Every other month you help do something to change what seemed hopeless...but in fact is not hopeless at all."

PHC has been acknowledged as a best practice model for addressing homelessness, and PHC events now occur in more 100 cities in the U.S. and in other countries including Puerto Rico, Canada, and Australia.

PHC has been the recipient of several awards including: The Full Circle Fund Full Impact Award, which is presented to organizations who achieve meaningful social impact; the Volunteer Center Nonprofit Excellence Award; the Deloitte Annual Appreciation Award; the Jefferson Award honoring community service; and the National Association of Counties Acts of Caring Legacy Award. PHC volunteers were the first in the country to receive the Presidential Service Award.



*On April 27, 2007, Project Homeless Connect received the National Association of Counties (NACo) 2007 Acts of Caring Legacy Award for Excellence and Innovation, presented in Washington, DC. Pictured L to R: Preston V. Lee, Jr., Director of Industry Relations; Judith Klain, Director, Project Homeless Connect; Barbara A. Garcia, Director, SFDPH Community Health Programs; Colleen Landkamer, NACo.*

Since its inception PHC has provided services to almost 19,000 people experiencing homelessness. Of those<sup>5</sup>:

- 4,362 have received benefits assistance (SSI, food stamps, GA)
- 3,944 have received medical care
- 3,613 have received eye exams and free eyeglasses
- 2,397 have received screening for employment opportunities
- 2,333 have received legal assistance
- 1,836 have received dental assessments
- 1,413 have received mental health and substance abuse services
- 1,348 have received methadone treatment
- 2,000 have received given shelter and stabilization housing

### PHC Case Study

Born in San Francisco, Giovanni Epinoza is a formerly homeless man who is now off the street. When he was only seven years old, Giovanni's parents were murdered, and he became a homeless child struggling to survive in the Mission. A local gang took him in, and Giovanni eventually became an active gang member himself.

Giovanni came to PHC for employment, glasses, and benefit services. "Knowing that people are out there to help you, and they won't give up on you and they will be there for you. It means so much to me. This is a great place to come for help."

Giovanni is now working to put his life together. He has a girlfriend, and they are trying to take care of each other. Giovanni hopes to go to college soon.



### Homeless Outreach and Medical Evaluation Team

The Homeless Outreach and Medical Evaluation (HOME) Team is a cross-departmental initiative lead by the San Francisco Fire Department (SFFD); DPH and HSA are co-collaborators. Started in October 2004, HOME is designed to reduce high emergency medical service (EMS) and emergency department (ED) use.

Since its creation, HOME's mission has expanded to include helping other agencies better address the needs of extremely entrenched homeless individuals and encampments. As a result, HOME now provides EMS coverage during Project Homeless Connect events and also provides emergency response for Adult Protective Services.

The HOME Team targets its field outreach by:

- Identifying high users, analyzing their pick-up sites and reasons for pickup by using data gathered from 911 calls.
- Responding to EMS field unit requests and calls from hospital ED staff.

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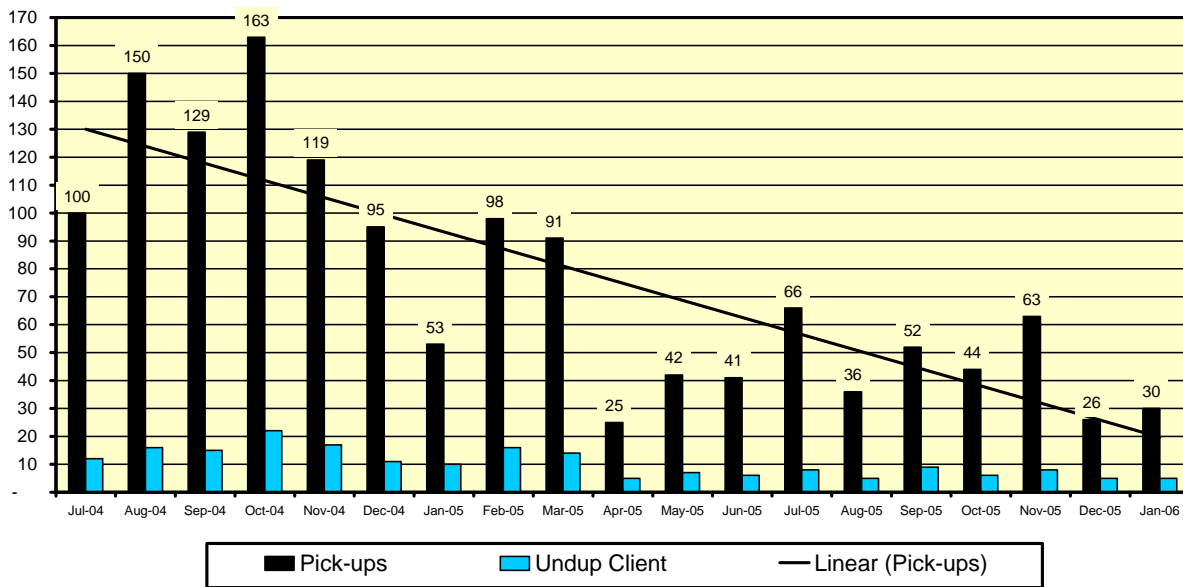
<sup>5</sup> Data through July 2007. Data from the 24<sup>th</sup> PHC event (August 2007) does not appear in this report.

- Deploying in areas with a high concentration of street-homeless people. HOME specifically targets individuals lying on the ground in the Tenderloin, Market Street, South of Market, the area between the Main Branch of the San Francisco Public Library and City Hall, in underground encampments, and on freeway on-ramps and off-ramps.

The SFFD, DPH, and HSA partnership is essential in serving the HOME Team’s target population effectively; staff representatives from each collaborating agency provide distinct—yet vital—functions pivotal to the HOME Team’s success. For example, the SFFD EMS captain can provide clients with emergency medical and referral services; however, it is the DPH social workers who provide ongoing wraparound services and intensive case management to clients.

The top 35 users of EMS who received case management during the project’s pilot phase have significantly decreased their usage of EMS. (Please see Chart 1 below.) Long-term benefits of HOME Team intervention include reduction in inpatient stays and better health outcomes for the target population. NOTE: The November 2005 spike is due primarily to one high user who had 26 of the 63 pickups that month.

**Chart 1: Top 35 High Users, 18-Month Period**



With assistance from the HOME Team, San Francisco has reduced the number of EMS high users by 18% and the number of pickups by 24%. As a result, EMS response time to other medical emergency calls has improved and ED wait-times reduced.

**Table 3: Reductions in EMS Usage, July 2004 – June 2006**

EMS High Users	FY 04-05	FY 05-06	DIFF	% Change
Total High Users	266	219	- 47	18% Decrease
Total EMS Pick-ups	2,632	1,990	- 642	24% Decrease

## San Francisco Homeless Outreach Team

In May 2004, DPH, HSA, and Community Awareness and Treatment Services jointly implemented the multidisciplinary San Francisco Homeless Outreach Team (SFHOT). Designed to mobilize housing and other client resources, SFHOT's primary focus is to house and stabilize the chronically homeless based on a harm reduction approach to housing and integrated care.

The team initially consisted of 10 street outreach workers, one psychiatrist and two clinicians – all of whom did street outreach in Central City.<sup>6</sup> The team also took referrals from the larger

### SFHOT Case Study

Mr. C is a 54-year-old Caucasian man who had lived in Golden Gate Park for 15 years before encountering SFHOT during an outreach visit. At the time of initial contact he lacked financial benefits other than food stamps; he reported receiving CAAP benefits in the past, but these stopped after he was unable to make monthly appointments with his eligibility worker. He denied any significant medical, psychiatric or substance abuse illnesses.

Mr. C said he became homeless after losing a carpentry job, allegedly due to unfair treatment by his boss. He said he consequently lost his contracting permit and could not return to work as a carpenter. He reported working odd jobs, fixing things in the Haight-Ashbury neighborhood to earn enough money to get by. When asked how he ended up in Golden Gate Park, he said he had given up on society after he “unfairly” lost his job.

Mr. C accepted an SFHOT stabilization unit in the Tenderloin, despite his discomfort in that neighborhood. He met regularly with his SFHOT case manager and successfully applied for CAAP benefits. He also started the process of re-acquiring his contracting permit.

Three and a half months after leaving Golden Gate Park—and more than 15 years after he first became homeless—Mr. C moved to permanent housing at a case management-rich hotel. He thanked SFHOT for its assistance and said he would pursue a return to work, so he would no longer need public assistance.

San Francisco community on a case-by-case basis. As a result, SFHOT is now expanding in size and scope to serve other neighborhoods including the Mission, Castro, and South of Market; SFHOT also serves the City's parks.

SFHOT started with “boots on the ground” outreach services, developing street-to-home plans with clients that incorporated housing placement, short-term intensive case management services, psychiatric services, and advocacy for financial and medical benefits. The team has since added additional services such as access to methadone and alcohol treatment, access to primary care treatment and low-demand stabilization rooms, and SSI advocacy and other legal services.

The team's interagency composition and deepening perspective has led to an expanding advocacy role within City government. SFHOT representatives, for example, serve in an advisory capacity to various planning committees regarding necessary services and systems-change. SFHOT also works with staff at Project Homeless Connect, the SFFD's HOME Team, the San Francisco Police Department's Operation Outreach Team, and the McMillan Intensive Case Management Team. SFHOT coordinates closely with existing outreach and homeless programs to support their efforts, leverage their resources, and fill critical gaps.

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<sup>6</sup> At the time, Central City had the highest density of chronically homeless persons in San Francisco.

SFHOT's other recent collaborations include:

- In August 2006, SFHOT began working with the Main Branch of the San Francisco Public Library to provide outreach, intensive case management, and consultation services for homeless patrons. SFHOT also assisted library staff who expressed a desire to help homeless individuals using the library.
- In Fall 2006, SFHOT outreach case managers persuaded 94 individuals (and eight dogs) to accept placement in SFHOT stabilization rooms as part of a multi-department coordinated outreach effort in Golden Gate Park.
- From July 2005 to December 2006, SFHOT provided case management services to more than 500 chronically homeless individuals. Of these:
  - Approximately 90% accepted stabilization placement.
  - One hundred eighty-three (183) secured permanent supportive housing.
  - One hundred fifty-five (155) accessed primary care treatment for the first time.
  - One hundred sixty-five (165) were newly engaged in psychiatric and/or substance abuse treatment (including methadone maintenance).
  - Two hundred eighty-one (281) secured financial benefits.

SFHOT has been a key member of the design team for the Coordinated Case Management Services (CCMS) System, a comprehensive Web-based tool for communication, charting, and reporting. Consequently, SFHOT dispensed with paper charts and uses the electronic CCMS to look up client information, enter progress notes in the field, communicate with other case managers, and measure outcomes.

In Fiscal Year 07/08, SFHOT will expand staffing—growing from 12.5 FTE in 2004 to 47.0—to provide services to other City neighborhoods; SFHOT will also strengthen its relationships with collaborating agencies. SFHOT members believe that their optimism, dedication, and hard-work will contribute significantly toward San Francisco's commitment to ending chronic homelessness.

## **Drop-In Services**

### The 13<sup>th</sup> Street Drop-in Center, "Buster's Place"

On March 19, 2007, DPH collaborated with Haight Ashbury Free Clinic, Inc. to open "Buster's Place," a new homeless drop-in center. Buster's Place is a 24-hour, 7-day per week site, offering drop-in and early intervention services to homeless individuals. The center offers showers, laundry facilities, and activities for clients. Center staff provide drop-ins with short-term case management and assistance accessing shelter services. Center staff also refer clients to Haight Ashbury's Integrated Health Services Center, the San Francisco Homeless Outreach Team, and other DPH services as needed. Linkages include a range of behavioral health and primary care services and some emergency housing options. Intended to replace the closure of the McMillan Drop-In Center (39 Fell Street), Buster's Place is located at 211 13<sup>th</sup> St.

## 6<sup>th</sup> Street Self-Help Center



*The 6<sup>th</sup> St. Self-Help Center before rehab.  
The Center site is located at 169 and 181  
6<sup>th</sup> Street.*

DPH will collaborate with Central City Hospitality House to open the 6<sup>th</sup> Street Self-Help Center in October 2007. Undergoing renovation currently, the community drop-in center will provide a range of socialization and wellness services for housed and homeless persons in the neighborhood. Founded on a peer-based, self-help, harm reduction model, the 6<sup>th</sup> Street Self-Help Center will allow people to access services when they are ready and able to do so.

The Center will be modeled after the Tenderloin Self-Help Center, which Hospitality House has operated for 20 years through partnerships with DPH and the Tenderloin community.

### **Intensive Case Management**

#### **McMillan Intensive Case Management Team**

The McMillan Intensive Case Management (ICM) Team is an interdisciplinary body created to serve and treat public chronic inebriates. Often facing concurrent medical and mental health issues, McMillan clients are typically high users of emergency medical services (EMS) who benefit from the provision of wraparound services such as:

- Psychiatric care
- Medical detoxification
- Emergency stabilization and access to permanent housing
- Benefit advocacy
- Money management
- Assistance with immigration issues

In keeping with DPH's emphasis on the provision of culturally competent services, the McMillan ICM Team has the capacity to provide services in English, Spanish, Tagalog, and Chinese.

Created in July 2003, the McMillan ICM Team has long held collaboration as a key component to its success. For example, the Team works closely with EMS and the Tom Waddell Health Center to identify clients most in need of ICM services. Most recently, the McMillan ICM Team has partnered with:

- DPH-HUH and the U.S. Department of Housing and Urban Development to connect chronically homeless alcoholics to ICM services coupled with permanent housing via the Direct Access to Housing Program for Chronic Alcoholics. (Please see page 5 for more information.)
- The DPH Placement Team and several long-term care (LTC) facilities that work with chronic alcoholics suffering from concurrent, debilitating mental health issues. For

example, one partnering LTC provides services such as substance abuse treatment and dual diagnosis groups for McMillan ICM Team clients in LTC.

With 60 clients in its caseload currently, the McMillan ICM Team continues to seek out new partnerships to better serve and stabilize the City's chronic inebriate population.

## Emergency Department Case Management Program

Developed in 1994, Emergency Department Case Management (EDCM) is a proven, nationally recognized program that provides long-term comprehensive psychiatric, psychosocial, and medical care for underserved individuals. Those served are often homeless, medically fragile persons who frequently rely on medical emergency services at San Francisco General Hospital (SFGH). EDCM's interdisciplinary team—consisting of social workers, a nurse practitioner, a primary care physician, and a psychiatrist—employs an innovative, nonjudgmental approach to maximize clients' quality of life while reducing overall health care costs.

EDCM services help clients address needs such as establishing a regular medical care provider, securing entitlements, addressing legal issues, and obtaining housing. Program staff also work with clients to address concurrent mental health and substance abuse issues.

The majority of EDCM clients are homeless at the time of case opening, and program staff work to help clients obtain and maintain housing. For example, 82% (75/92) of clients working with EDCM between March 2, 2006 and March 1, 2007 were homeless.

Through their work with the EDCM team:

- 67% (50/75) became permanently housed.
- 8% (6/75) entered alternate treatment programs (e.g., Laguna Honda).
- 7% (5/75) were working actively to obtain permanent housing.
- 19% (14/75) remained homeless.

EDCM's success in addressing clients' housing needs relies on close collaboration with such programs as DPH-HUH's DAH program, HSA's Shelter Plus Care program, and other community

### EDCM Case Study

"Lily" is a bi-racial African American / Native American woman who formerly made more than 30 visits annually to SFGH's emergency department. Presenting with paranoid delusions, Lily was homeless and addicted to crack at the time of initial contact, and she repeatedly declined EDCM assistance.

After several months, Lily requested help accessing benefits, allowing EDCM staff to build her trust over time. Staff connected her to GA and SSI and placed Lily in emergency housing. Though delusions led her to destroy several emergency housing units, EDCM staff worked with Lily to help her stabilize her health and housing.

After one year of EDCM services, Lily went from 41 to nine SFGH emergency department visits.

Within three years, Lily:

- Secured SSI.
- Completed residential drug treatment.
- Obtained permanent, subsidized housing.

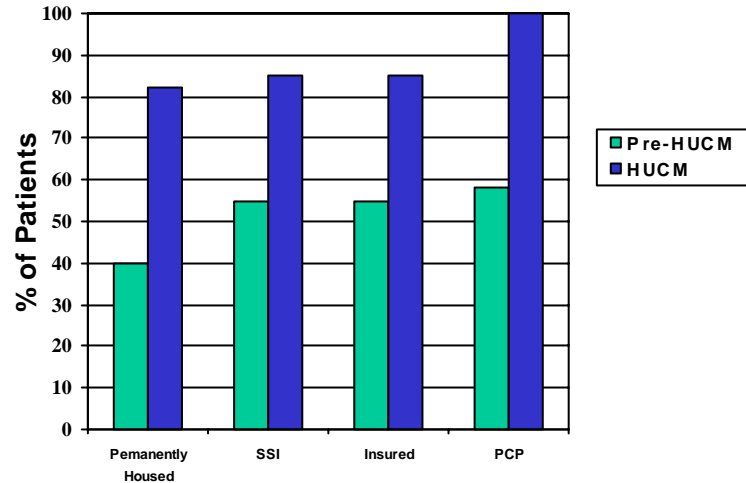
Now graduated from EDCM for more than six years, Lily is still housed, taking literacy classes, and serving as a deacon in her church.

programs that provide affordable housing connected to services. EDCM coordinates care through DPH-Community Behavioral Health Services and other DPH sections.

## High User Case Management Program

The High User Case Management (HUCM) program is a collaborative effort between UCSF and DPH designed to provide intensive case management services to frequently admitted patients. These patients have multiple chronic illnesses often complicated by homelessness, substance abuse, and psychiatric co-morbidities. HUCM links patients to social work services, psychiatry, nursing, and medical consultation. The goal is to help coordinate, streamline, and improve patients' use of ambulatory services and provide them with appropriate psychosocial support for entitlements and housing.

**Chart 2: Benefits and Primary Care Linkage Resulting from HUCM Interventions**



To be eligible for HUCM services, a patient must:

- Have inpatient status at SFGH and be receiving medicine, family practice or cardiology services.
- Have had three prior admissions to the above services in the past 12 months, including the present admission.
- Have a primary care physician who is part of the San Francisco safety net (i.e., a clinician part of any Community Health Network clinic or San Francisco Community Consortium clinic).

Once a patient is enrolled in the program, HUCM works as an adjunct to primary care and collaborates closely with the inpatient medical teams, primary care providers, and SFGH's specialty clinics.

Recent successes of the HUCM include:

- Recently shepherding a patient through a heart transplant.
- Markedly decreasing patient hospitalizations from a mean of five hospitalizations in the year prior to enrollment to a mean of 2.5 hospitalizations post-enrollment.
- Generating revenue for the program through Medi-Cal reimbursement for Targeted Case Management at a rate of \$216 per claimable encounter.
- Training primary care providers to serve "high users" effectively.

Despite these successes, HUCM continues to face system barriers such as lack of appropriate housing for patients and lengthy waits for entitlements. Given complex histories of concurrent mental, medical, and substance issues, HUCM patients have a high death rate. For example, 43% of the program's total discharges have been due to death. Despite such challenges, HUCM continues to serve as a national model, recognized for its innovative and effective approach to serving the medical high-user population.

### **AB2034 Mobile Support and Treatment Program**

The Mobile Support and Treatment (MOST) program is a homeless integrated service project of the South of Market Mental Health Services Clinic. Funded through State legislation (AB2034), the program serves 120 homeless clients exhibiting severe psychiatric symptoms; clients have had repeated hospitalizations or incarcerations but have not been linked to outpatient services. Many MOST clients also have co-occurring substance abuse issues and/or serious medical conditions.

Outcome data indicate that MOST has improved clients' lives by helping them secure entitlements and employment and by decreasing episodes of hospitalization and incarceration. The MOST Team also helps clients secure housing. For example, MOST has housed 66 clients, 85% (57/66) of whom were still enrolled in the program as of March 21, 2007. Of those, 91% (52/57) remain stably housed.<sup>7</sup>

MOST's success may be attributed to unique funding stipulations that mandate:

- Housing first
- Funding flexibility to assist with consumer needs
- 24/7 service availability
- Client access to vocational services
- Low caseloads with a single point of responsibility

### **Prop. 63 – *Mental Health Services Act* Full Service Partnerships**

In November 2004, California voters passed Prop. 63 to provide dedicated funding for the expansion of county mental health services and programs that serve severely mentally ill persons and their families. Despite San Francisco's high density of homeless / indigent persons with mental health needs, the City received one of the lowest funding allocations in the State due to a funding formula based on total population rather than need. Following State approval, San Francisco selected several *Mental Health Services Act* (MHSA) service providers via a competitive process, and MHSA programming is now underway in San Francisco.<sup>8</sup>

MHSA funds several initiatives designed to serve persons with severe mental illness or serious emotional disturbances. For example, MHSA's Full Service Partnerships (FSPs) and Community

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<sup>7</sup> Of the five who are no longer housed, four are now in residential treatment; one has been incarcerated.

<sup>8</sup> San Francisco submitted a required three-year plan to the State outlining its proposed use of MHSA funds. Developed by an extensive community planning process, San Francisco's plan received State approval in March 2006.

Services and Support programs target persons who are homeless or at-risk of becoming homeless and who are underserved / not served by current services.<sup>9</sup> MHSAs also require that a focused effort be made to outreach to clients who are:

- High utilizers of emergency rooms and other crisis services.
- Discharged from psychiatric units.
- Incarcerated.

San Francisco selected five FSPs to serve youth, transitional aged youth, adults, and older adults. Integrated service teams modeled after the AB2034 program, San Francisco's FSPs include: the Family Service Agency, HSA - Seneca, the Family Mosaic Project, Hyde Street Community Services, and UCSF - Citywide Case Management Forensics.

Other MHSAs service providers include:

- Housing Support Services: Larkin Street Youth Services, Central City Hospitality House, and Curry Senior Center
- Peer Based Centers: Larkin Street Youth Services, the San Francisco Study Center, and the Family Service Agency
- Residential Treatment Services: Walden House
- Vocational Rehabilitation Services: RAMS Hire-Ability and Community Vocational Enterprise

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<sup>9</sup> Twenty percent of MHSAs funding is used to provide stabilization rooms, transitional, and permanent housing for the various age populations.

## OTHER IMPORTANT INITIATIVES



*DPH's success in eradicating homelessness depends on its ability to respond to the changing needs of San Francisco's homeless / at-risk populations. Success also relies on the Department's capacity to address changes in federal and state legislation, which promise to impact funding streams for homeless housing and related services. The following pages outline DPH's response to these emerging issues at the local, state, and federal level.*

## Homeless Families

### Homeless Families Services Redesign

In January 2006, DPH representatives participated in an HSA-directed community planning process to develop recommendations reorienting the current Homeless Families Services System into a housing first model. This planning process concluded in June 2006 with more than 140 individuals participating and representing a variety of community organizations, advocacy groups, homeless families, City departments and constituents. As part of the planning process a number of surveys, questionnaires and focus groups were conducted to explore the needs of homeless families and community partners.

### SRO Families United Collaborative

The SRO Families United Collaborative provides outreach and support to very low-income families with children who live in SRO hotels located in the Chinatown, Mission, South of Market, and Tenderloin neighborhoods. The collaborative relies on two bilingual, bicultural Project Coordinators<sup>10</sup> and a network of Peer Outreach Workers to provide:

- Outreach and referrals.
- Community programming such as community events, support groups, and meetings of SRO families. Past meeting topics include tenant rights, housing, health care, tax credits, and more.
- Peer Outreach Worker trainings.

Peer Outreach Workers are typically low-income residents of targeted neighborhoods who demonstrate a commitment to issues facing SRO families.

The Collaborative, lead by the Chinatown Community Development Center (CCDC), is also comprised of:

- Chinese Progressive Association
- Coalition of Homelessness
- SOMA Families (formerly known as Mission /6<sup>th</sup> Street Agenda)
- St. Peter's Housing Committee

#### SRO Families United Collaborative: Testimonial

"I lived in an SRO in the Mission for eight years. Living in the hotel, my poor daughter and I witnessed so many outrageous things: Racist attacks by the owner of the property; rats and cockroaches that were practically part of our family; the rooms without a kitchen, bathroom or space where my daughter could play. We saw horrible things that I don't even want to talk about.

In the past year, I have had the opportunity to receive affordable housing. I've realized the difference between being homeless and having a dignified home. My daughter has changed and is more focused in her studies and is very happy.

As for me, I feel satisfaction from my work as a leader of the families. I would like to see all mothers in dignified housing. From my own experience, I know that, through struggling, we can achieve results."



- Clara Luz García

<sup>10</sup> The Project Coordinators are Cantonese and Spanish speaking respectively.

Providing services for more than six years, the Collaborative provides culturally competent services to hundreds of SRO families each year. At the time of its Fiscal Year 06/07 program monitoring, the Collaborative had resolved 92% of its family housing counseling cases, resulting in improvements to families' living conditions. Most cases involved code violations such as utility shutoffs and lack of proper ventilation.

The greatest challenge faced by the Collaborative is the continued influx of new families with children into SROs. CCDC estimates that for every one family that exits SRO-living for more appropriate permanent housing, three to four new families enter SROs.

### **Tom Waddell Health Center Homeless Family Team**

The Tom Waddell Health Center (TWHC) Homeless Family Team provides care to more than 1,000 homeless persons in families each year. Additionally, the Team, links many families to primary care at SFGH's Family Health Center. TWHC's collaboration with the Family Health Center has been an undeniable success.

In Summer 2007, the Team will conduct a needs assessment to inform its expansion of services to families in the Tenderloin, many of whom are marginally housed or "doubled-up" in SROs. Results from the assessment will inform the development of programs to address issues related to families' health access and utilization.

TWHC works closely with a number of community providers to better serve homeless families. For example, TWHC works with UCSF, Family and Community Medicine to provide primary care services at Connecting Point, Saint Joseph's Village, Compass Family Center, Hamilton Family Residence, and the Hamilton Family emergency shelter.

### **Early Childhood Mental Health Consultation Initiative**

The San Francisco Early Childhood Mental Health Consultation Initiative (ECMHCI) strives to prevent, identify, treat, and reduce the impact of mental health challenges among children aged 0-5 and their families. Based on a prevention model, the Initiative funds 13 community based organizations that serve over 150 child care centers and family child care homes. ECMHCI also funds consultation services to 11 homeless and domestic violence shelters throughout San Francisco.

The presence of mental health professionals in child care and shelter settings provides staff and parents the opportunity to identify and address mental health issues or delays before children enter school. Further, ECMHCI evaluation efforts indicate that children who receive consultation services show significant improvement in social skills, decreasing the incidence of problem behaviors. Child care staff also experience increased confidence in working with parents and children through consultation.

The Initiative's work in homeless and domestic violence shelters has resulted in service to 11 shelters. Within those shelters, 290 children and their families have benefited from mental

health services. The most common service provided in shelter settings is one-on-one therapeutic intervention to children and/or their parents.

**Table 4: ECMHCI Billed Services, January – June 2007**

<b>Modality</b>	<b>Hours Billed</b>	<b>% of Total Hours Billed</b>
Direct Service Individual	1458	32%
Outreach/Linkage	1073	23%
Consultation Group	770	17%
Direct Service Group	610	13%
Consultation Individual	298	6%
Evaluation	203	4%
Training	183	4%
Observation	0	0%

Surveys of ECMHCI site staff suggest that staff members are very pleased with the work of the mental health consultants. Results also indicate that assistance from ECMHCI consultants helped improve the quality of child care in child care centers and homeless sites.

## **Data and Systems**

### **Homeless Death Registry**

In response to legislation passed by the Board of Supervisors in June 2005, DPH developed a homeless death count form, which the Health Commission reviewed and approved. The form—to be completed by the institution registering the death (e.g., Medical Examiner, funeral home, hospital)—has streamlined the homeless death count process and has helped overcome barriers resulting from legal confidentiality constraints. The homeless death count form resulted from a resolution introduced by Supervisor Bevan Dufty.

### **Emergency Department Action Plans**

Emergency Department Action Plans (ED Action Plans) help emergency and crisis service providers improve coordination and quality of care for shared patients. ED Action Plans outline recommended interventions for select high-risk clients and also track data related to ambulance pick-ups, sobering encounters and ED notes. ED Action Plans are posted to DPH's secure, HIPAA-compliant Website and are accessible only by authorized clinicians based in acute, emergency, and crisis services sites where high-risk / high-user clients most commonly present.

DPH uses ED Action Plans to:

- Identify high-use / high-risk clients in the acute systems of care—especially those who are not connected to ongoing services.
- Improve the coordination and provision of care across systems. This includes developing treatment plans and linkages to reduce the client's use of restrictive, high-cost, institutional services and facilitating their linkage to more appropriate levels of care.
- Evaluate systems of care and policies affecting this population.

A client will present in the ED Action Plan database if s/he:

- Has an existing ED Action Plan, and/or
- Is a high EMS user as defined by having four or more pick ups by ambulance in one month, and/or
- Is an active client of the San Francisco Homeless Outreach team, and/or
- Is an active client of the High User Case Management Program.

Current users of the ED Action Plan system include: the San Francisco Fire Department Homeless Outreach and Medical Evaluation Team, DPH clinicians, and St. Francis Memorial Hospital. Future users will include the eight San Francisco emergency departments, and those hospitals which serve as partial receiving facilities. Other DPH programs that will be added in the future include urgent care facilities, acute diversions units, intensive case management teams, mental health crisis clinics and services, and primary care clinics.

### **Coordinated Case Management System**

The Coordinated Case Management System (CCMS) is the first database of unique homeless clients in San Francisco. A Web-based database designed to function as an electronic charting, reporting, and communication tool for teams working with homeless clients served across multiple systems of care, CCMS immediately impacts patient care utility. CCMS will also:

- Improve case management services and Emergency Department Coordination, informing clinicians of a patient's care history.
- Improve charting (electronic versus paper).
- Improve evaluation and planning, helping DPH understand the epidemiology of the City's most disabled, fragile residents.
- Improve cost-effectiveness, helping policy makers prioritize limited resources.

CCMS permits members of various site- / street-based case management teams to communicate clinical alerts, histories, placements, status changes, progress notes, ambulance pick-ups, and other pertinent client data while in the field.<sup>11</sup> CCMS is populated via direct data entry and information from existing databases associated with various health and social service programs in San Francisco.<sup>12</sup>

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<sup>11</sup> Please see Appendix C for a complete list of CCMS-authorized providers.

<sup>12</sup> Please see Appendix C for a complete list of CCMS-populating databases.

DPH information technology staff have developed a secure electronic environment that assures that only authorized staff have access to the DPH wireless network and protected health information contained in the CCMS; the degree to which personnel have information access is based on a determination of each user's "need to know." Only service providers will have access to identifiable health information—all other data reporting will be aggregated and/or de-identified prior to export.

CCMS is embraced by clinicians, analysts, and leadership throughout DPH, the Department of Adult and Aging Services, HSA, and other counties. The Mayor and HSA have committed to provide DPH with the additional resources necessary to enhance and maintain CCMS.

## Quality Improvement Efforts

### Comprehensive HIV/AIDS Housing Work Group

In response to San Francisco Board of Supervisors' (BOS) Resolution 0308-06, DPH-HUH first convened the Comprehensive HIV/AIDS Housing Work Group in September 2006. Charged with developing a new Comprehensive HIV/AIDS Housing Plan for San Francisco—the third in the City's history—the Work Group met monthly for a total of six months (through February 2007) to draft recommendations; DPH-HUH presented the recommendations before the BOS in May 2007. The Work Group's recommendations reflect the current realities and housing needs of low-income San Franciscans living with HIV/AIDS and highlight the need for future change.

Cuts in federal funding associated with the Ryan White CARE Act prompted the City and County of San Francisco to backfill large amounts of HIV/AIDS program funding for Fiscal Year 07/08. As a result, only the first of the Tier 1 recommendations could be implemented. DPH will, in future years, advocate for the implementation of other Work Group recommendations, and DPH-HUH commits to revise the policies and procedures associated with the AIDS Housing Waitlist to make the list a more effective placement tool.

To view a list of the Work Group's membership, past meeting agendas/minutes, background materials, and other information, please go to [www.sfdph.org/Meetings/otherMeetings.htm#HIVAIDSHousingGrp](http://www.sfdph.org/Meetings/otherMeetings.htm#HIVAIDSHousingGrp).

### Shelter Monitoring Committee

The 13-member Shelter Monitoring Committee was created on November 16, 2004 through the San Francisco Administrative Code, Article 20, Article XII. The committee strives to provide the Mayor, Board of Supervisors, Local Homeless Coordinating Board, public, and any other appropriate agency with comprehensive information about the conditions and operations of San Francisco's homeless shelters. Through announced and unannounced site inspections, monthly meetings, a hot-line, walk-in hours, and community outreach, the Committee offers multiple access points through which shelter clients and staff may bring complaints, concerns, and suggestions for improving the shelter system.

Through a volunteer base model, the Committee:

- Inspected the majority of San Francisco's shelters and resource centers.
- Has established a formal meeting structure.
- Drafts and presents quarterly findings before the Rules Committee. In 2006, for example, the Committee highlighted the lack of defibrillators in shelters and resource centers. As a result, shelters must be equipped with an Automatic External Defibrillator.

The Committee's work, through outreach and inspections, gives the City a better understanding of what consumers feel is missing from the shelter system. For more information about the Committee's work, please visit [http://www.sfgov.org/site/sheltermonitoring\\_index.asp](http://www.sfgov.org/site/sheltermonitoring_index.asp).

### **Placement Task Force**

DPH's Integrated Steering Committee created the Placement Task Force to improve placement activities throughout the DPH system of care. The Placement Task Force Committee consists of Community Programs, SFGH, Laguna Honda Hospital, Jail Services, and Long Term Care.

In its first year, the Placement Task Force:

- Analyzed the top reasons for non-acute days for psychiatric patients versus medical / surgical patients. (Please see Appendix D.)
- Developed a Level of Care document.
- Performed a chart review of top the 25 users of non-acute services.
- Convened a conservatorship workgroup to explore ways to assist the most difficult-to-place patients suffering from severe, morbid conditions.

## **Innovation and Advocacy**

### **Community Justice Center**

Tentatively scheduled to open in January 2008, the Community Justice Center is a collaboration of DPH, the Mayor's Office, the Police Department, the Office of the Public Defender, the Office of the District Attorney, the Sherriff's Department, the San Francisco Pre-Trial Diversion Project, the Superior Court of California, and the Adult Probation Department. A proposed alternative to traditional criminal courts, the Community Justice Center will help restore the Tenderloin and South of Market neighborhoods through community service projects and will assist rehabilitated defendants through social service programs including detoxification, substance abuse treatment, vocational services, and stabilization/transitional housing.

The Community Justice Center is part of a larger movement to shift the focus of the criminal justice system, particularly its handling of infractions and misdemeanors (e.g., minor drug possession, prostitution, shoplifting, and disorderly conduct), from traditional criminal court to community-based restoration.<sup>13</sup>

While specific design elements vary by program, certain guiding principles remain constant:

- Traditional courts focus resources on serious crime and devote insufficient attention to quality-of-life offenses.
- Quality-of-life offenses may lead to more serious crimes, which causes social and economic problems in neighborhoods where crime occurs; therefore, sentences should include community service.
- Offenders should have access to rehabilitation opportunities.
- Community members have a stake in the production of effective justice; therefore, community members have a role to play in shaping the justice system.

### **Supplemental Security Income Advocacy**

Over the past three years, DPH has made great strides in securing Supplemental Security Income (SSI) benefits for disabled clients. Specifically, more than 2,000 clients have been awarded SSI through clinical documentation and advocacy services provided by the Positive Resource Center, the Homeless Advocacy Project, and DPH's Disability Evaluation and Advocacy Project.

Based upon a two-year analysis of awardees,<sup>14</sup> for each dollar the City and County of San Francisco (CCSF) invests in SSI advocacy, CCSF generates approximately five dollars of revenue in the first year post-award; CCSF obtains this income through a combination of Medi-Cal reimbursements and reimbursements for cash benefits received by HSA. While the long-term benefits to clients of SSI advocacy have been well documented in the literature, knowing CCSF's high rate of return on such advocacy helps justify an initial investment in the service.

Summary findings from the Fiscal Year 03/04 – Fiscal Year 04/05 SSI advocacy research appear below:

- Eighty-six percent (227/263=86%) of those who applied for SSI benefits received them (compared to the national 40% average).
- Given their ability to bill retroactively to the application date, DPH and HSA recouped an average of more than \$15,000 in lost revenues per award.
- Advocacy services averaged a cost of \$2,834 per award, resulting in the 5:1 return on investment. In Fiscal Year 06/07, however, DPH began to leverage State block grants through HSA to recoup 50% of SSI advocacy costs, nearly doubling DPH's return on investment.

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<sup>13</sup> Community-based restoration refers to sentencing offenders to community service—preferably to compensate the neighborhood where the crime occurred—and offering defendants help through social services. This movement began in the 1980s with community policing, followed by community courts, community prosecution, and other such initiatives in the 1990s.

<sup>14</sup> Analysis spanned Fiscal Years 03/04 and 04/05.

## Legislation

### **AB2745: Hospital Discharge of Homeless Patients**

The State passed Assembly Bill 2745 (AB2745) in response to allegations that hospitals in other parts of California had “dumped” discharged homeless patients to the streets.<sup>15</sup> The state mandate took effect on January 1, 2007 and required hospitals to expand their patient discharge and continuing care policies to include homeless patients.

As a result of this legislation, regional hospital associations are required convene regional planning meetings with key stakeholders to improve post-hospital transition for homeless patients. This legislation defines categories of stakeholders who must be invited to participate in these regional planning meetings such as the Board of Supervisors, law enforcement, county social service agencies and healthcare providers, continuum of care providers, homeless advocates, and emergency medical service leaders.

Meetings must result in a summary document with recommendations for action by January 1, 2008. The report must address best practices for post-hospital transition, systems for improved communication, and identification of resources to serve the target population. Hospitals are also prohibited from discharging homeless patients to another county for the purpose of receiving support services without prior notification to and authorization from the provider. DPH will participate in the AB2745 planning process to facilitate better coordination of patient discharge between public and private hospitals.

### **AB2968: Medi-Cal Coverage for Community-Based Living Services**

Signed by Governor Schwarzenegger in 2006, Assembly Bill 2968 (AB2968) will create a designated Medi-Cal reimbursement rate structure for support services in community based housing. The measure will also assist beneficiaries who would otherwise be homeless, living in shelters, or institutionalized.<sup>16</sup> The City, through the California Department of Health Services, will seek a San Francisco-specific waiver that would provide community based care targeted to:

- Individuals wishing to leave Laguna Honda Hospital (LHH), or
- Persons at risk of entering LHH absent such services.<sup>17</sup>

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<sup>15</sup> AB2745 defines a homeless patient as an “individual who lacks a fixed or regular nighttime residence, or has a primary nighttime residence that is a supervised publicly or privately operated shelter designated to provide temporary living accommodations, or who is residing in a public or private place that was not designated to provide temporary living accommodations or to be used as a sleeping accommodation for human beings.”

<sup>16</sup> Medi-Cal currently provides a single reimbursement rate for the range of services beneficiaries need when they are in an inpatient institutional setting. However, no such designated reimbursement rates exist for community-based living services in San Francisco.

<sup>17</sup> According to a review of residents conducted by the Laguna Honda Office of Social Services in September 2005, approximately one-quarter (more than 250 residents) could instead be cared for in a community-based setting.

DPH anticipates that AB2968 will:

- Increase options for lower income individuals in need of long-term care. For example, the waiver initiated by AB2968 would support alternatives to institutionalization at LHH such as the permanent supportive housing provided through DPH-HUH's Direct Access to Housing Program.
- Expand access to services at no additional cost to the State. AB2968 does not increase Medi-Cal eligibility nor does it create a new category of service in the State's Medi-Cal program; rather, AB2968 bundles together medical and support services already allowable under Medi-Cal. The waiver will permit provision of such services in a variety of community-based settings.
- Simplify currently uncoordinated, complex reimbursement mechanisms.
- Reduce inappropriate inpatient care.

DPH supports AB2968 and is currently working with the State to develop the waiver.

### **Reauthorization of the Ryan White CARE Act**

The Ryan White Comprehensive AIDS Resources Emergency (CARE) Act is federal legislation that addresses the unmet health needs of PLWHA by funding primary health care and support services. First passed in 1990, the CARE Act delivers medical care, medications, and support services to approximately 50,000 uninsured/underinsured PLWHA each year, acting as a "payer of last resort." Through February 28, 2007, Title I of the CARE Act also funded certain housing services (i.e., emergency and transitional housing, rental subsidies, and residential case management) for PLWHA.

On December 19, 2006, President Bush reauthorized the CARE Act for three years, which redefines how eligible metropolitan areas (EMAs) may allocate CARE awards. The most significant change resulted in an overall reduction of the San Francisco EMA's funding amount from \$26.5 million to \$17.48 million—approximately \$9.1 million less overall, potentially translating into \$7.1 million in service cuts for San Francisco. In addition, the reauthorized CARE Act dictates which services may be funded with CARE dollars. Specifically:

- 75% of funding must be applied toward "core medical services," defined as medical/health care expenses only.
- No more than 25% of funding may be applied to "other support services."
- Services not included in "other support services" (e.g., housing and complimentary therapy) can no longer be funded through CARE.<sup>18</sup>

Reauthorization had a dramatic effect on funding levels for all HIV/AIDS services not included in the "core medical" medical category; CARE-funded housing would have been eliminated entirely. However DPH, in partnership with the Board of Supervisors, worked to backfill service cuts not already addressed in the Fiscal Year 07/08 Mayor's Budget. Altogether, the City's Fiscal

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<sup>18</sup> Residential substance abuse services, including detoxification, were to have been eliminated from the "other support services" category; however, advocacy on the part of providers, consumers, and City representatives led to the inclusion of substance abuse services in CARE's "other support services" category for Fiscal Year 07/08.

Year 07/08 budget includes enough funding to maintain all HIV services at Fiscal Year 06/07 levels—including housing and “other support services”. In preparation for Fiscal Year 08/09, the HIV Health Services CARE Council must be mindful of new CARE funding patterns during its prioritization and allocation process.

# RECOMMENDATIONS



## Building Health Communities in the Future

DPH has demonstrated many innovations and improvements in those services affecting homeless persons / persons at-risk of homelessness. While important to recognize these successes, DPH must anticipate future challenges if it is to end homelessness and improve the health of all San Franciscans. Mindful of future opportunities to improve, DPH must:

- Expand community-based housing options.
- Continue to integrate services.
- Enhance primary care services for homeless people.
- Improve discharge and placement.
- Develop and implement key legislation.

### Expand Community-Based Housing Options

DPH must continue to expand the development and operation of a broad range of community housing options located throughout San Francisco's neighborhoods. While these housing options may differ in size, style, and location, they should all stress independence, health and comfort, access to wrap-around services, and community integration.

#### Health Commission Action Steps

- Utilize community connections to foster acceptance and understanding of the need for increased housing options for homeless persons and persons at-risk of homelessness. Such education will lay the groundwork needed to expand housing options in and beyond the Tenderloin neighborhood.
- Help DPH and the City secure funding for an additional 2,500 permanent supportive housing units designated for San Francisco's homeless and frail populations; the City must go beyond the 3,000 unit goal laid out in its *10-Year Plan to End Chronic Homelessness* if it is to continue to move persons off the street and into housing.

### Continue to Integrate Services

DPH must continue to provide integrated, client-centered services to help people move beyond homelessness and isolation. DPH should emphasize those services that recognize the complete individual, addressing physical health, behavioral health, socialization, employment, family connection, and other elements important to improved health and wellbeing.

#### Health Commission Action Steps

- Support the full integration of the AIDS Office into Community Programs to ensure that persons living with HIV/AIDS have access to the full spectrum of care they need to stabilize their health and improve their wellbeing.
- Back the continued integration of behavioral health services into primary care, so all persons receive the highest quality care possible.

- Continue to foster leadership and vision throughout DPH, supporting innovative approaches to seamless, fully integrated service provision.

### **Enhance Primary Care Services for Homeless People**

With the opportunity and challenge afforded by Healthy San Francisco, DPH must continue to enhance community-oriented primary care. DPH should place an emphasis on reducing barriers to care while increasing efficiency in primary care services.

#### Health Commission Action Steps

- Support the ability of all primary care sites to accommodate the health needs of homeless persons in the most integrated fashion possible to ensure that all clients have an identifiable "medical home" in their community.
- Continue to support Primary Care's Quality Improvement Program which tracks a variety of health and quality indicators that are important to the improved health of frail and homeless people. This includes continuing to participate in the monitoring carried out by the Clinic Consortium that tracks quality of care issues specific to homeless people.

### **Improve Discharge and Placement**

DPH encounters thousands of homeless persons / persons at-risk of homelessness each year—many of whom cycle between hospital placement and the streets. While DPH has worked diligently to break this cycle—especially among identified “high users”—DPH must further improve its discharge planning and placement efforts. Areas of concentration should include improved access to data and client information within the safety net, real time information regarding bed availability, and improved utilization review throughout the system.

#### Health Commission Action Steps

- Set policy to ensure that all patients receive thorough clinical and psychosocial assessments that support accurate treatment plans and timely discharge.
- Continue to provide leadership and support to DPH as it further develops data and tracking systems that allow for more effective information sharing among and between service providers.
- Develop policy that assists in the streamlining and expansion of intensive case management functions to ensure continuity of patient care post-discharge. These services are key to breaking the avoidable cycles of hospitalization and discharge to the streets.

## **Develop and Implement Key Legislation**

DPH must work toward implementing legislation at the local, State, and Federal level that increases funding and capacity for homeless services.

### Health Commission Action Steps

- Support DPH in the development and timely submission of a San Francisco-specific waiver under AB2968 that would allow the City to facilitate Medi-Cal billing in supportive housing.
- Ensure that San Francisco actively engages in the planning process required by AB7545 to address discharge planning for homeless persons exiting the hospital system.
- Continue to pursue earmarks instrumental in funding housing and services for persons living with HIV/AIDS.
- Help DPH identify best practices in health care nationally and help advocate for legislative change at the appropriate level of government.

## APPENDICES



**Appendix A: City and County of San Francisco Homeless Definitions**

Poverty is the major cause of homelessness. To reach a definition of homelessness, this root cause must be addressed. These definitions are not meant to supersede or replace definitions of homelessness and chronic homelessness that have been set forth by funding sources, contractual agreements, or existing data collection systems.

<b>HOMELESSNESS<sup>19</sup></b>	
The term “homeless” includes individuals or families who lack a fixed, regular, and adequate nighttime residence and who have a primary nighttime residence in one or more of the following categories:	
Shelter	<ul style="list-style-type: none"> <li>▪ Anyone staying in a mission or homeless or domestic violence shelter, i.e., a supervised public or private facility that provides temporary living accommodations.</li> <li>▪ Anyone displaced from housing due to a disaster situation.</li> </ul>
Street	Anyone staying outdoors; for example, street, sidewalk, doorway, park, freeway underpass.
Vehicle	Anyone staying in a car, van, bus, truck, RV, or similar vehicle.
Make-Shift	Anyone staying in an enclosure or structure that is not authorized or fit for human habitation by building or housing codes, including abandoned buildings (“squats”) or sub-standard apartments and dwellings.
Doubled-Up	<ul style="list-style-type: none"> <li>▪ Anyone staying with friends and/or extended family members (<u>excluding</u> parents and children), because they are otherwise unable to obtain housing, or</li> <li>▪ Any family with children staying in a Single Room Occupancy (SRO) hotel room – whether or not they have tenancy rights, or</li> <li>▪ Anyone staying in temporary housing for less than 6 months, and the accommodations provided the person are substandard or inadequate, for example, garage, small room, overly crowded space.</li> </ul>
Transitional	<ul style="list-style-type: none"> <li>▪ Anyone staying in a Single Room Occupancy (SRO) hotel room <u>without</u> tenancy rights, or</li> <li>▪ Anyone formerly homeless (formerly in one of the above categories) who is now incarcerated, hospitalized, or living in a treatment program, half-way house, transitional housing or</li> <li>▪ Anyone formerly homeless (formerly in one of the above categories) who has obtained supportive housing or permanent housing for less than 30 days. While we recognize that the issues that brought people to homelessness may take a lifetime to overcome, we believe that at a minimum, 90 days of wraparound aftercare services should be provided for individuals exiting homelessness into permanent housing.</li> </ul>

<b>CHRONIC HOMELESSNESS<sup>20</sup></b>
An individual or family who has been continuously homeless for at least one year, or has been homeless on at least 4 separate occasions in the last 3 years.

<sup>19</sup> Homeless definition adopted by the San Francisco Board of Supervisors on December 12, 2001 and approved by Mayor Willie L. Brown on December 28, 2001. File No. 012191, Gloria L. Young, Clerk of the Board.

<sup>20</sup> Chronically homeless definition adopted by DPH on January 11, 2005 and approved by Homeless Cluster Group of the *10 Year Plan to End Chronic Homelessness* on January 26, 2005.

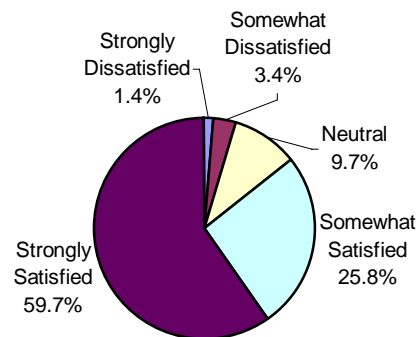
## Appendix B: Early Childhood Mental Health Consultation Initiative

The work of the Early Childhood Mental Health Consultation Initiative (ECMHCI) is rooted in the following guiding principles:

- Positive, trusting relationships are key to all human development.
- Healthy adults are an essential to the healthy development of children.
- Mental health services are based on the unique goals and needs of the caretakers, parents, and children with whom they work.
- Prevention and early identification of developmental challenges are key to a child's success in school.
- Families are essential in every aspect of consultation.
- Consultation services are culturally competent and sensitive to the clients' life circumstances.

To assess program effectiveness, ECMHCI analyzed nearly 450 surveys collected from child care and homeless shelter site staff.

**Chart 3: Distribution of Degree of Satisfaction of Mental Health Consultant Services**



**Table 5: Responses to ECMHCI Staff Survey, Percent "Somewhat" or "Strongly Agreed"**

Consultation Performance Objectives	Child Care Centers	Overall	Homeless Shelters
The mental health consultant helped increase my understanding of children's emotional needs.	85%	<b>85%</b>	87%
The mental health consultant helped add to my understanding of children's development.	83%	<b>83%</b>	80%
Working with the mental health consultant helped me respond more effectively to children's behavior.	84%	<b>84%</b>	82%
The mental health consultant helped me communicate more effectively with parents of children who have challenging behaviors.	81%	<b>81%</b>	80%
How satisfied are you overall with the services of the mental health consultant?	85%	<b>86%</b>	92%

## Appendix C: Coordinated Case Management System

CCMS users include:

- Current Users
  - San Francisco Homeless Outreach Team serving chronic homeless clients
  - McMillan Intensive Case Management Team serving the Sobering Center and EMS high users
  - SFFD EMS Homeless Outreach and Medical Emergency Team serving EMS high users
  - DPH Emergency Department Intensive Case Management Team serving SFGH ED high users and EMS high users
  - DPH High User Case Management Team serving SFGH medical high users
  - St. Francis Emergency Department social worker staff
  - Department of Aging and Adult Services Case Management Connect Pilot serving people with disabilities of all ages and frail low income elders (60+)\*
  - Health at Home (view only and progress notes)
  - Jail Health Services (same)
  - Community Placement Services (same)
  
- Planned Users
  - SFGH Psychiatric Emergency Services
  - All DPH Case Management Teams
  - All DPH Primary Care Providers
  - All DPH Mental Health Clinicians
  - DHS Homeless Case Managers serving homeless clients placed into DHS housing<sup>21</sup>
  - All EDs in San Francisco<sup>22</sup>
  - Social Worker staff in Psychiatric Units in San Francisco hospitals<sup>23</sup>

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<sup>21</sup> This agency holds a Memorandum of Understanding with DPH, which allows it to provide and share protected health information for health purposes. Part of the DPH Safety Net, the agency agrees to abide by all DPH privacy policies.

<sup>22</sup> This agency holds a Memorandum of Understanding with DPH, which allows it to provide and share protected health information for health purposes. Part of the DPH Safety Net, the agency agrees to abide by all DPH privacy policies.

<sup>23</sup> This agency holds a Memorandum of Understanding with DPH, which allows it to provide and share protected health information for health purposes. Part of the DPH Safety Net, the agency agrees to abide by all DPH privacy policies.

The following sources populate CCMS data fields:

- Current Data Sources
  - Case Manager data entry
  - DPH Sobering Records
  - DPH 13th St Drop-in Records
  - SFFD EMS High User Pickups Records
  - DAAS Case Manager Rolodex Records
  - DPH Project Homeless Connect Records
  - DPH Direct Access to Housing Records
  - SFFD Public Intoxication Citations Records
  - DPH 13th St Drop-in Records
  - SFFD EMS High User Pickups
  - DAAS Case Manager Rolodex
  
- Planned Data Sources
  - DPH Project Homeless Connect
  - DPH Medical Records (LCR)
  - DPH Bed Placement Records (RTZ)
  - DPH MH Records (BIS)
  - DHS Housing Placement Records
  - DPH MH Progress Notes (GATEWAY)
  - DHS Shelter Records (CHANGES)
  - SFFD HOME Team Progress Notes
  - UCSF Psych Emergency Records
  - DPH SA Records (BIS)<sup>24</sup>
  - DPH AIDS Records (REGGIE)
  - DPH Jail Health Records
  - SFFD EMS Pickups (LEMSIS)
  - CCSF Death Registry

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<sup>24</sup> Requires client authorization; process for electronic authority pending.

## Appendix D: Placement Task Force Data, Lifetime Clinical Record and Chart Review

### Fiscal Year 05/06 Non-Acute Days at SFGH

The top 4 reasons for the **13,184 Psych Non-Acute Days** (1,026 patients) were due to:

1. 40% (5,337 days, 219 patients): Awaiting locked sub-acute / L facilities (no beds)
2. 35% (4,578 days, 519 patients): Awaiting unlocked board and care, ADUs, residential treatment (no beds)
3. 11% (1,508 days, 375 patients): Being stabilized for shelter/hotel or preparing home to be able to support
4. 8% (1,110 days, 49 patients): Discharge diagnosis not being covered by M/C (e.g., alcohol dependence or dementia) and/or behavioral issues that need to be stabilized

The top 4 reasons for the **10,127 Med-Surg Non-Acute Days** (1,684 patients) were due to:

1. 31% (3,107 days, 850 patients): Awaiting 4A (no bed)
2. 9% (961 days, 148 patients): Awaiting hotel, respite, B&C, Psych (no bed)
3. 8% (780 days, 126 patients): Accepted at LHH (no bed)
4. 4% (385 days, 62 patients): Awaiting LHH ADL - need long term placement

### Chart Review of Top 50 Users of Fiscal Year 05/06 Non-Acute Days for Psych

- All Agreed – Appropriate Therapeutic Setting Existed, But There Were No Beds  
Half (47%) of the 3,480 non-acute days and placements for 24 of the 50 patients were due to capacity issues; i.e., current programs were appropriate clinical settings for these patients, but they did not have beds available. Although there was consensus that these 24 patients were appropriate for the treatment system, behavioral issues, cognitive impairments, medication compliance, medical conditions and substance use were rated as significant for this cohort.
- All Agreed – No Appropriate Therapeutic Setting Existed  
Quarter (27%) of the 3,480 non-acute days and placements for 11 of the 50 patients were due to not currently having an appropriate treatment facility/program to accommodate the patients' conditions. Placement Team, clinical team, and chart reviewers agreed that the factors present proved independently, or combined, as significant enough to be barriers to community placement:
  - 73% of the 11 patients in this category had significant behavioral issues, including being physically assaultive, a sexually predator, etc.
  - 45% had significant co-occurring medical conditions
  - 36% had significant cognitive impairments
  - 27% had significant mobility issues
  - 27% had significant substance issues

- Other Reasons

Another Quarter (22%) of the 3,480 non-acute days and placements of 12 of the 50 patients were due to “other” reasons, including need for medication and health stabilization and negotiation time for community placements who were refusing placement. Barriers to placement for the patients in this category showed a:

- Higher percentage cognitive impairments and homelessness
- Lower percentage of behavioral issues and substance use

Chart reviewers were unable to classify the remaining 5% of patients, as they were not known by the reviewers and the charting was not indicative enough.

For only 3 of the 50 patients was there no consensus between the Utilization Review Team, Placement Team, and SFGH Clinical Team about the patients being appropriate or inappropriate for to be placed in the current community treatment system.