Street Crisis Response Team Pilot: **Information Requests from MHSF Implementation Working Group Members**			
ID	**MHSF IWG Question**	**Member Name**	**SCRT Response**
1	Please describe the evaluative framework.	M. LeSarre	Dr. Almeida will present on this topic on 3/23 meeting.
2	I am trying to understand the staffing of the CRT. Not sure why the "Behavioral Health Clinician" position is not drawn solely from DPH as per ordinance 300-19, page 11, lines 3-4. Rather the title and position is granted to Health Right 360. The Behavioral Health Clinician is an official position within the City and as such, the classification ensures that those under that classification have the knowledge skills, and abilities to perform the job, including issuing 5150**.** *Context* The whole purpose of this board is to streamline and reorganize access to care within the DPH. What changed? DPH be needs to communicate swiftly and effectively and not have different entities that do not interface with each other. We need to clear and stabilize the DPH resources before contracting out to different entities which can be disruptive to the continuity of care. Contracting out could increase difficulty in creating a cohesive network. Despite the 1st CRT has begun, we want to make sure the next five teams will be given priority to city workers. To reiterate, in planning stages of the MHSF, it was agreed that the jobs created will be part of DPH to maintain the continuity of care.	A. Wong	Hiring civil service staff for SCRT is not a requirement of the legislation. . We appreciate and value creating new pathways to city employment both through MHSF, as well as other opportunities. The Office of Coordinated Care staff dedicated to SCRT (including behavioral health clinicians and peer health workers) are civil service staff. Specifically for the team that is responding to crises, we are partnering with HealthRigth360 (through an RFP process) to staff the behavioral health clinician and peer team members respectively. As a community program this decision was made to ensure that staffing was provided by partners who have strong ties to the community and that team members are reflective of the communities we are serving. This team is overseen by civil service staff (currently Dr. Almeida) to ensure coordination and effective communication across partners. Thus far, this has been incredibly successful.
3	As the SCRT teams go live, particularly when they are at full capacity, what will be the downstream effect across the spectrum of care, particularly for urgent/crisis care services? This is particularly pertinent as we have seen decreased bed capacity due to COVID, coupled with threats of projected budget shortfalls that may impact capacity across the system of care.	A. Salinas	The evaluation plan will be presented in more detail on 3/23 meeting. This will be considered closely by the RWJ research project. The impact of COVID on capacity will be a constant as a reality since the start of the pilot program. Our hope is to reduce overall contact with crisis services (when clinically appropriate) to ensure access to those with the highest need.
4	Has there been any impacts to bed utilization across the system of care since SCRT has been in effect? Has there been a change in the number of days PES has been on red/divert? If it is easier to capture, Per every 100 clients seen by SCRT what is the projected increase in utilization across the spectrum of care: PES, DUCC, inpatient, LSAT, Hummingbird, ADU, ddx rtx, Sobering center,	A. Salinas	The evaluation plan will be presented in more detail on 3/23 meeting. This will be considered closely by the RWJ research project. The goal for the team is to reduce unnecessary urgent/emergent service utilization and support individuals in less restrictive treatment option. We will be monitoring immediate service utilization for individuals served by the team, as well as long term linkage and engagement in services.

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	medical respite, Joe Healy, SUD residential, transitional residential, wait list for OP, ICM, FSP, caseload for Public Guardian/Conservator?		
5	What are the projected number of new referrals to OP, ICM, FSP? What is the projected number of clients that will be seen monthly when SCRT is at full capacity?	A. Salinas	It is too early to reliably make the projection related to referrals to outpatient behavioral health programs. The estimated volume of clients to be seen monthly when SCRT is at full capacity is 11,000-18,000 per year, or roughly 800-1,500 per month. This is based on a 5-8 calls per team per 12 hour shift estimate. The OCC team will be tracking linkage to care for individuals served by the program.
6	Can BHS create an ongoing live dashboard or other monitoring system to track the number of available beds across the system of care to see how BHS resources/services are being impacted by the new SCRT program including: PES, DUCC, inpatient, LSAT, Hummingbird, ADU, ddx rtx, Sobering center, medical respite, Joe Healy, SUD residential, transitional residential, wait list for OP, ICM, FSP, caseload for Public Guardian/Conservator.	A. Salinas	This is an additional component legislated by MHSF. FindtreatmentSF.org is live and currently displays voluntary mental health and substance use residential treatment beds funded by DPH in San Francisco. We are not anticipating a negative impact on the system, rather, this will allow for more appropriate and streamlined linkages into care with a goal of reducing unnecessary emergent/urgent service utilization both at the time of the crisis and by appropriately supporting the individual long term.
7	When SCRT encounters clients on the streets, how often are they referring to police? What is the race/ethnic background of clients referred to police?	A. Salinas	SCRT does not refer clients to police. SCRT would only engage the Police Department in scenarios in which public safety is threatened, for example, the client has a weapon or becomes violent beyond the capacity of the SCRT team members.
8	Where is funding for SCRT coming from?	A. Salinas	Prop C

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9	For the "clients engaged and remained safely in the community", what specific services were provided?	A. Salinas	Individuals are deescalated in that moment and are offered transport to an appropriate placement (e.g., Dore Urgent Care Center, Sobering Center, shelter). Individuals may be referred back to an existing provider, connected to outpatient case management services, or linked to other follow up care. Once OCC staff are operational, they will provide follow up to these cases to develop rapport, offer services, and support linkages to care.
10	How many calls were for clients already known to the system? What percentage of overall clients seen by SCRT is this? What are the needs/reasons these persons are needing this type of crisis intervention?	A. Salinas	This will be closely tracked through the pilot evaluation and data will be shared once available.