



MEMORANDUM

November 2, 2004

To: Honorable Edward A. Chow, MD, President and
Members of the Health Commission

Through: Mitchell H. Katz, M.D., Director of Health

From: Anne Kronenberg, Director, Office of Policy and Planning
Marc Trotz, Director, Housing and Urban Health

Re: Annual Homeless and Housing Services Report

Attached is the Annual Homeless and Housing Services Report being presented to the Health Commission on November 9, 2004. We are pleased to provide you for the second consecutive year with a combined report on homeless and housing services in the Department, providing a comprehensive examination of services provided to the homeless and at-risk populations in San Francisco.

We look forward to presenting this report to you on November 9, 2004. If you have questions in the meantime, please call Anne Kronenberg at 554-2898 or Marc Trotz at 554-2565.

2003-04 Housing & Homeless Services Annual Report
San Francisco Health Department

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Introduction

Ending homelessness continues to be one of the Department of Public Health's top priorities. The Department's efforts are greatly enhanced by Mayor Newsom's strong interest and leadership on this issue and his clear desire to move toward innovative and results oriented approaches. Within his first year in office, the Mayor developed a Ten Year Plan to End Chronic Homelessness in San Francisco, established a Homeless Cabinet comprised of key City Department heads, implemented Care Not Cash, and revitalized the city's homeless outreach efforts to focus on "housing first" solutions. The Department of Public Health (DPH) has been, and will continue to be, a key player in these initiatives and on-going citywide policy discussions. DPH remains committed to partnering with any and all parties in developing and implementing constructive solutions to end widespread homelessness in San Francisco.

In addition to participating in the policy discussions surrounding homelessness, DPH is among the largest providers of services to the homeless in San Francisco. Annually, DPH spends approximately \$55 million on homeless-related services. As discussed in more detail below, DPH is increasingly adopting the strategy articulated by the National Alliance to End Homelessness that includes a focus on prevention services ("closing the front door"), effective intervention services, and innovative housing services ("opening the back door")

While a key player in San Francisco's homeless response, DPH does not do all this on its own. Rather, DPH relies on an array of community partners, from individuals and community groups, to policymakers and policy bodies that determine the direction of the City's homeless response, to contractors who deliver services. San Francisco has led by example the importance of a humane, community-driven response to homelessness. DPH has been at the heart of that response.

This report provides a comprehensive overview of homeless services in DPH over the past year (FY 03-04), including major policy changes, particularly as they affect DPH, accomplishments of DPH sections in serving homeless clients, and a discussion of the collaborations that make this possible. It concludes with a discussion of the emerging issues for the near future as well as several recommendations to guide DPH's work on this issue.

Homelessness as a Health Issue

Homelessness is a complex social phenomenon comprised of many contributing factors such as poverty, inadequate education, the loss of low-skill jobs, domestic violence, and lack of affordable housing. However, health-related issues such as mental illness, substance abuse, and chronic disease often play a significant role. While it is difficult to determine the "cause or effect" nature of these factors, it is clear from studies both nationally and locally that homeless people are less

healthy and are higher utilizers of health care services than are non-homeless people:

- A November 2003 survey of 1,361 homeless and marginally housed people in Alameda County found that among the “chronically homeless” (homeless for more than a year or homeless three or more times over three years) 61 percent were chemically dependent, 30 percent had a mental illness, and 21% had received care at a psychiatric hospital within the past year.¹
- Seventy-four percent of homeless or marginally housed people in San Francisco with HIV are co-infected with hepatitis C. Only four percent of those with hepatitis C receive treatment.²
- Prior to the opening of the McMillan Stabilization Center, nearly one-third of ambulances arriving at hospitals in the City were transporting homeless alcoholics who used the ED to “sober up.”³
- A 2002 survey found that eight percent of homeless and marginally housed people in San Francisco used EDs for medical treatment four or more times in the past year. Another 32 percent used an ED between one and three times in the same period.⁴
- In a November 2002 report on mental health in California, the Little Hoover Commission noted that 57 percent of all homeless adults suffer from a mental illness.⁵

Ten Year Plan to Abolish Chronic Homelessness

In March 2004, Mayor Newsom announced the formation of a 33-member Council designed to write a Ten Year Plan to end homelessness in San Francisco. Headed by former Board of Supervisors President Angela Alioto, the Council was charged with writing San Francisco’s Ten Year Plan, in accordance with U.S. Interagency Council on Homelessness (ICH) guidelines, by the end of June 2004.

Ten Year Plans, advocated by the ICH, are intended to re-energize and re-commit a community’s effort toward the goal of ending homelessness. San Francisco, as well as other plans nationally, draws upon the expertise of

¹ P. Hoge, “New Plan Focuses on Worst-Case Homeless. Data Verify Link Between Housing and Their Health,” *San Francisco Chronicle*, May 14, 2004, p. B-1. <http://sfgate.com/cgi-bin/article.cgi?file=/chronicle/archive/2004/05/14/BAGFK6LK7N1.DTL>

² C. Hall, “S.F.’s Homeless with HIV Plagued by Hepatitis C Virus – Few Treated,” *San Francisco Chronicle*, April 2, 2004, p. A-1. <http://sfgate.com/cgi-bin/article.cgi?file=/chronicle/archive/2004/04/02/MNG405VM181.DTL>

³ R. Gordon, “S.F. Starts Detoxification Center for Public Alcoholics,” *San Francisco Chronicle*, July 30, 2003, p. A-18. <http://sfgate.com/cgi-bin/article.cgi?file=/chronicle/archive/2003/07/30/BA214899.DTL>

⁴ “Eight Percent of San Francisco Homeless Used ERs for Medical Care Four or More Times in Past Year, Study Finds,” *California Healthline*, April 30, 2002. <http://www.californiahealthline.org/index.cfm?Action=dspItem&itemID=91725>

⁵ “Being There: Making a Commitment to Mental Health,” Little Hoover Commission, November 2000, p. 11. <http://www.lhc.ca.gov/lhcdir/157/report157.pdf>

government, business, service providers, philanthropy, and homeless people to develop and implement plans that end homelessness. An important shift in the focus of these plans includes: 1) an emphasis on proven strategies that remove people from homelessness rather than manage or ameliorate their condition on the street; and 2) a honing in on a subset of the population known as “chronically homeless” because of the dire health conditions of this population and the expensive over-utilization of emergency services which further erodes a communities ability to provide safety net services. The ICH defines this subset as those who have been homeless for a year or more, or have had multiple episodes of homelessness over a several year period. Typically, they are single adults in their early 40s, disabled by addiction, mental illness, or a chronic physical or developmental disability, and have frequent histories of hospitalization, unstable employment, and incarceration. ICH notes that while this subset typically comprises about ten percent of a community’s overall homeless population, it consumes 50 percent of the resources devoted to homelessness, including emergency medical services, psychiatric treatment, detox facilities, shelters, and criminal justice.⁶ Solving homelessness for this population through a “housing first” model that includes efforts to “close the front door” (prevention) and to “open the back door” (housing placement) begins to chip away at a seemingly intractable problem and focuses energy on a highly visible and costly segment of the homeless population. ICH has also indicated that additional federal resources will be made available to communities that develop ten year plans to end homelessness for the chronically homeless.

San Francisco’s plan, “The San Francisco Plan to Abolish Chronic Homelessness,” released in late June 2004, places a heavy emphasis on the “housing first” approach, which emphasizes immediate placement into permanent supportive housing and providing the necessary services on-site to stabilize individuals and keep them housed. In the past, the goal had been to stabilize individuals with a variety of services provided on the street, in shelters, and in transitional housing prior to placing them in permanent housing. The recommended goal of the Ten Year Council is to create 3,000 units of new, permanent supportive housing by 2010. DPH’s Direct Access to Housing program is expected to play a large part under this plan. In-depth discussion of the DAH program is contained in the section “Closing the Back Door,” later in the report.

Additional steps called for in San Francisco’s Ten Year Plan include:

- Phasing down shelters and transitional housing as new, permanent supportive housing units are brought on line.
- Developing a new service model that moves resources away from homeless services that are not linked to housing.
- Providing nutritional support.

⁶ Martha R. Burt, Laudan Y. Aron and Edgar Lee, “Helping America’s Homeless: Emergency Shelter or Affordable Housing? Urban Institute Press, Washington, DC, 2001.

- Developing prevention and intervention innovations, especially improving case management and housing placement linked to discharges from the criminal justice and health care system.
- Coordinating City resources and expanding the role of the San Francisco Housing Authority.
- Providing employment and training opportunities specifically addressing the needs of the chronically homeless.

The Council recommends that implementation and oversight of the plan be accomplished through a seven-member Planning & Implementation Council appointed by the Mayor. A full copy of “The San Francisco Plan to Abolish Chronic Homelessness” is attached as Appendix A.

San Francisco’s Council included 33 mayoral appointees including representatives from City government, business, labor, philanthropy, health care, community-based service providers, activists, the faith community, and policy makers. Anne Kronenberg, DPH Deputy Director was one of the Council Members as representative of the Local Homeless Coordinating Board. Marc Trotz, Director of DPH’s Housing and Urban Health Program and Dariush Kayhan, Director of DHS’ Housing and Homeless Services provided staff support to the Council.

Over the 15 weeks that San Francisco’s Council worked, the Council and its five committees (Finance; Prevention and Discharge Planning; Mainstream Health and Employment; Outreach, Assessment and Behavioral Health; and Permanent Supportive Housing) met 85 times. More than 348 individuals representing 126 organizations participated in at least one of the 85 meetings. Public hearings were held on May 26 and May 27, 2004.

Relationship of Homeless and Housing Services to the DPH Strategic Plan

During 2004, DPH has been updating and revising the Strategic Plan it developed in 2000. Many of the goals and objectives will remain from the 2000 document: homeless people will remain a DPH target population and the plan will continue to emphasize supportive housing, particularly in light of the Ten Year Plan Council recommendations. In addition, DPH specifically incorporates the following principles, taken from the revised Strategic Plan into its housing and homeless services planning:

1. Harm Reduction

Homeless people face many competing life challenges. Chemical dependency or other unhealthy behaviors may not be their most pressing concern. Therefore, it is crucial that programs work to engage clients in addressing their most important need and assist them over time in making life changes and choices that reduce their physical, mental, and/or social harm. This is consistent with the

Harm Reduction Policy officially adopted by the Health Commission in September 2000. All services are voluntary and respect clients' rights.

2. Partnerships with Local, Regional and National Organizations

Many organizations are working to solve homelessness in San Francisco. Clearly no one agency can solve the problem on its own. In 1996, the Board of Supervisors and the Mayor established the Local Homeless Coordinating Board in to ensure the development and implementation of a unified citywide homeless strategy. DPH continues to play an active leadership role on the Local Board. DPH also continues to work collaboratively with our sister city agencies including the Department of Human Services, Mayor's Office of Community Development, Department of Children, Youth and Their Families, Mayor's Office of Housing, San Francisco Redevelopment Agency, and the Mayor's Office of Criminal Justice. In addition, DPH continues to collaborate with local and national organizations. Discussion of specific collaborations is contained in the section "Collaborations," below.

3. Collaboration Across the Department

As with the importance of collaboration with outside agencies, internal collaboration and coordination of sections within DPH are critical to providing the most effective response to homeless people with the most efficient use of resources. Given the structure of DPH service delivery by section, homeless clients are consuming services across all sections of the Department (e.g., Behavioral Health, Primary Care, San Francisco General Hospital (SFGH), Laguna Honda Hospital (LHH), Housing and Urban Health, etc.). By coordinating services, DPH can eliminate duplication of efforts, develop more thorough assessments, and provide more appropriate care for clients. One of the primary ways by which this coordination occurs is through the Homeless Coordinating Committee, which meets quarterly, consists of all sections of DPH providing services to the homeless, and is chaired and staffed by the Office of Policy and Planning. Additionally, there are several important "client level" coordination efforts occurring including weekly case conferences to assist the Homeless Outreach Team in placing clients and daily patient flow meeting at SFGH and LHH.

4. Services Are Outcomes Based

Over the last 20 years, San Francisco and other urban centers have gained important data and experience in our efforts to "solve" homelessness. With the momentum of the Ten Year Plan, and what seems to be a renewed sense of determination on this issue, now is the time to apply these lessons to DPH's policies and programs to ensure that our efforts are outcome driven and geared toward moving homeless people from the streets to stable living environments.

All sections within the Department are being encouraged to question and reevaluate policies and program in light of this goal.

“Closing the Front Door”

DPH has begun to orient its programming into the Ten Year Plan paradigm. “Closing the Front Door” encompasses homeless prevention programs designed to reduce the number of people who become chronically homeless. Efforts to “close the front door” include:

Community Health Promotion and Prevention Services

Client directed prevention services such as:

- The Health Education Resource Center home visiting program for asthma,
- Black Infant Health outreach, education and care management (a joint program with Maternal Child Health),
- SevenPrinciples Project also providing health education and community organizing,
- Pedestrian Safety, and
- Violence Prevention community action projects

are targeted at people in neighborhoods for whom homelessness is just a step away.

The Prevention section’s efforts are on building capacity and skills among community members. Prevention works to address root causes of crime and violence in the community, and to improve environmental and social conditions, which lead to unemployment, lack of education and the potential for homelessness.

Examples of how prevention programs work to maintain healthy people in health communities include:

- The Community Empowerment Center is based in one of the Housing Authority sites in the Bayview-Hunter’s Point area. The purpose of the center is to provide intervention and counseling services to young men at risk of violence, substance abuse, and related problems. This relates to housing on a deep level as it prevents an unsafe environment around low-income households and addresses root causes of poverty.
- The Black Infant Health Improvement Program works with pregnant and post-partum women with limited financial, educational, and employment prospects who are raising young children and infants. Many of these women find themselves near homeless when domestic violence occurs early in pregnancy or when they have “fallen out of favor” with close family members. The project staff assists clients obtain basic survival essentials including referrals to housing assistance, emergency food or payment of

outstanding utilities in order to maintain a stable roof over the heads of a vulnerable population.

- With community-based agencies, the Tobacco Free Project provides funding for organizing of residents in single-room occupancy (SRO) hotels or Housing Authority-managed apartments to address indoor air quality, secondhand smoke exposure, and fire prevention due to unattended cigarettes. Some groups have established smoke-free zones, and provided education and smoke detectors for residents.

SRO Task Force and SRO Collaboratives

SRO Task Force

The mission of the Single Room Occupancy Hotel Safety and Stabilization Task Force (SRO Task Force) is to monitor, develop, and present recommendations to the Mayor and Board of Supervisors regarding policies and procedures concerning fire prevention and mitigation, investigation and prosecution of SRO violators, and stabilization of SRO tenants and residents. Comprised of advocates, SRO owners and residents, service providers, community-based organizations, and relevant City departments, the SRO Task Force has been meeting monthly since early 2000. Anne Kronenberg, Deputy Director of the Department serves as the Chair of the Task Force.

Per the implementing legislation (868-99), the Task Force is assigned five major areas of concern:

1. Emergency Response and Follow-up;
2. Fire Mitigation Programs;
3. Structural Rehabilitation of Fire Damaged SRO Hotels;
4. Long-term Tenant Stabilization; and
5. Investigation and Prosecution of Tenant Rights Abuses, Building Code, and Fire Safety Violations.

During the past year, the SRO Task Force has seen a number of successes including monitoring of the Sprinkler Ordinance and Visitor Policy, continuing outreach and education on fire prevention for SRO residents, improvements in coordinating inspections, prosecution of “musical rooms” and other code violations, tracking of fire survivors and off-line hotels, improving efforts to reach and serve families living in SRO hotels, and working with the independent hotel owners and operators. In addition, the SRO Task force made two very successful presentations to the Board of Supervisors in March 2004, which served to secure ongoing funding for the SRO Collaboratives and for housing vouchers when tenants are displaced due to fires.

SRO Collaboratives

This SRO Collaboratives provide comprehensive community outreach and education regarding fire prevention and community stabilization in Single Room Occupancy (SRO) hotels. These services are provided in the Chinatown/North Beach, Mission, Tenderloin and South of Market neighborhoods in San Francisco. In providing these services, the Collaboratives seek to empower and improve the conditions and safety in the SRO hotels. The Fire Prevention Workshops are done in collaboration with San Francisco Fire Department, with the target population being very low-income SRO tenants, who are at risk of homelessness because of the unsafe and unhealthy conditions in the SRO hotels.

The fire prevention outreach and education program has three components: (1) Fire Prevention and Community Stabilization through direct outreach to SRO building residential, commercial occupants and owners about hazards and preventive measures; (2) Emergency Response through coordination with the Fire Emergency Response Network; and (3) one-on-one housing counseling assistance for fire victims and residents of SRO buildings. The SRO Collaboratives have an established working relationship with the Department of Building Inspections for code enforcement violations. Referrals are provided to tenants when a code violation is discovered in the buildings they live in. The SRO Collaboratives also have Memorandums of Understanding (MOUs) with other community agencies such as Chinese Progressive Association (CPA), Mental Health Association St. Peter's Housing Committee and Mission Agenda. It is estimated that 55 to 75 percent of the SRO Collaboratives work involves code enforcement.

“Opening the Back Door”

“Opening the Back Door,” the second part of the Ten Year Plan paradigm includes interventions designed to increase placement into supportive housing of people who are currently experiencing homelessness. DPH efforts to “close the back door” include:

Housing and Urban Health (HUH)

Housing and Urban Health (HUH) is the division within DPH responsible for creating housing options for homeless and disabled residents. DPH, through its many services, is deeply involved in caring for persons who are living in poverty, many of whom lack adequate housing. Throughout DPH's system of care, this pervasive lack of a stable living environment has emerged as a key stumbling block to achieving lasting improvements in the health status of the population that DPH is most committed to assisting. Because of this reality, DPH has embarked

upon an aggressive strategy to develop housing sites tailored to the needs of clients utilizing the public health system. While we recognize that DPH cannot solve the City’s overall housing shortage, we do believe we can reduce healthcare costs and provide stability and dignity to a population that is struggling with multiple issues related to mental health, drug addiction, physical health, violence, and lack of financial resources.

HUH’s main goal is to provide community-based housing combined with innovative healthcare services for people who have been living on the streets, in shelters, and/or rotating through our institutional settings. Creating alternatives to institutional care to facilitate discharge and prevent unnecessary hospitalization is also a key goal of our work.

The Direct Access to Housing program (DAH), a ‘low-threshold’ housing model, has become a major emphasis for HUH and a cornerstone of DPH’s overall strategy to stabilize and house San Francisco’s chronically homeless population. DAH has been recognized by the U.S. Interagency Council on Homelessness, National Alliance to End Homelessness, and the Corporation for Supportive Housing, as a “best practice” model.

Currently, there are nine sites connected to DAH. Seven of the sites are privately owned master-leased buildings and two are a partnership with a non-profit developer. The following table summarizes those sites:

Site (Date Opened)	No. Units
Pacific Bay Inn (1999)	75
Windsor Hotel (1999)	92
LeNain Hotel (2000)	86
Broderick Street RCF (2001)	33
Star Hotel (2003)	54
Camelot Hotel (2003)	53
Civic Center Residence (2004)	60
Empress Hotel (2004)	90
West Hotel (2004)	40
Total	583

The new sites for 2004 represent exciting new housing opportunities for chronically homeless people. The Civic Center Residence is an existing 204 unit affordable housing develop owned and operated by Tenderloin Neighborhood Development Corporation (TNDC). In this case, DPH contracted with TNDC to secure a block of 60 units targeted to homeless seniors. DPH funding reduces the rent to a level affordable to homeless seniors and funds on-site services. Curry Center is providing on-site medical services as needed. Similarly, the West Hotel, also owned by TNDC, will house 40 homeless seniors within the newly renovated 105-unit building.

The Empress Hotel is a result of an Interagency Council on Homelessness (ICH) grant that HUH received in fall of 2003. This grant was a national competition with eleven awardees. HUH's \$4 million award was the largest in the country. With combined funding from HRSA, SAMHSA, HUD, and VA, the Empress Hotel, located at 144 Eddy St., will house 90 people who have long histories of homelessness and who have been struggling with complex medical and behavior health issues. Additionally, the funding from HRSA has facilitated the opening of the Housing and Urban Health Clinic, an integrated medical and behavioral health clinic for persons housed in supportive housing and further described in the Primary Care section of this report.

In FY 2004-05, HUH is continuing to explore new ways to fund and open additional community based housing options. The Ten Year Plan to End Homelessness calls for the development of 3,000 additional supportive housing units – 1,500 to be developed by non-profit housing providers and 1500 units to be master leased. HUH staff, working in collaboration with the Mayor's Office of Housing, the San Francisco Redevelopment Agency, the Department of Human Services, are working to ensure that those units are developed so we can significantly reduce the number of people living on the streets of San Francisco.

Additional information about HUH contracts and the DAH Program is included in Appendices B and C.

Placement and Discharge Planning

In February 2004 the Department initiated a project with a goal to improve the patient flow from SFGH and LHH, significantly reducing staff time spent on transfers and the number of days spent by patients at SFGH awaiting transfer at a "lower level of care." A group of individuals from SFGH, LHH and central administration representing a variety of disciplines began meeting on a regular basis, both in the large group and in numerous subgroups to work together toward this common goal.

Removing barriers that impede patient flow allows patients to be cared for at the proper level of care, and allows the public health care system to free beds at the acute care hospital thereby reducing crowding in the Emergency Room. In 2004 (January through May), 78 percent of LHH's patients were admitted to LHH from SFGH, 13 percent were admitted from other facilities and nine percent from home. In this same time period in 2003 (January through May), 54 percent of LHH's admissions came from SFGH, 34 percent from other facilities and 12 percent from home.

Services for the Currently Homeless

Although DPH is actively working toward the Ten Year Plan paradigm of prevention and housing placement, and is actively taking a "housing first"

approach to its homeless services, a number of services are targeted to the homeless who are currently on the streets, in shelters, and in transitional housing. Accomplishments in FY 2003-04 in those programs include:

Community Behavioral Health Services

Homeless Outreach Team

In the spring of 2004, DPH and the Department of Human Services (DHS), under the direction of Mayor Newsom's Office, developed a Homeless Outreach Team whose goal is to reduce the number of, and improve the health outcomes for, chronically homeless people who live on San Francisco streets.

In May 2004, the multidisciplinary team – dressed in green CCSF jackets – began walking the Tenderloin District to assess needs, develop “Street to Home” plans, and transport people safely to the resources they need to get off the streets. During the first three months of operation, the team had 3,000 encounters, moved 69 clients into temporary or permanent housing, and have 67 clients in active case management as they work on their Street-to-Home Plans. The Team continues to reach out to individuals until positive contact is made and Street-to-Home plans are developed and implemented.

Members of the Homeless Outreach Team, key housing and service providers, and management staff from the Mayor's Office, DHS, and DPH meet routinely to case conference, place clients, and remove system barriers.

AB2034 Permanent Housing Program

The Mobile Support and Treatment (MOST) Team is a homeless integrated service project of South of Market Mental Health Services funded through State legislation (AB2034). The MOST Team's AB2034 Project is funded to serve 120 homeless individuals with severe psychiatric symptoms who have repeated hospitalizations and/or incarcerations and have not utilized community-based services. The mission is to create opportunities for people with severe psychiatric symptoms to begin the process of recovery and to have ordinary lives. Consumer involvement and participation is welcome and utilized at all levels of programming, including representation on the AB2034 Consumer Advisory Board.

Eighty-seven (73%) of the 120 currently enrolled clients are living independently in supportive housing, receiving a subsidy from the AB2034 Program in a private-market SRO unit/studio apartment, living in “low-income” or “mixed income” housing managed by non-profit agencies, receiving either a Shelter Plus Care or Section 8 subsidy, or paying rent on the private market. Fifteen clients have transitioned to paying 100 percent of their own rent and live in permanent housing on the private market. A number of clients are currently on active

waitlists for permanent housing with seven different agencies with pending move-ins in process.

The AB2034 Housing Coordinator and case managers stay involved with property management and landlords to advocate for housing retention, provide support, and problem-solve client/landlord conflicts. PATH McKinney grant funding as well as AB2034 Emergency Housing funds are used to pay for damages repair, unit cleaning, and to provide loans for back rent to prevent eviction. The Housing Coordinator will also consult with local housing rights, eviction prevention, and legal service offices as well as provide referrals to these offices to clients facing eviction.

Primary Care

Housing and Urban Health (HUH) Clinic

The new Housing and Urban Health (HUH) Clinic opened on September 13, 2004 serving residents of the City's supportive housing programs. The HUH clinic will serve all residents of DPH's Direct Access to Housing sites as well as the DHS Master Lease hotels and the Housing, Health and Integrated Service Network hotels. All told, more than 2,000 formerly homeless, now housed individuals will be able to access primary care services at the clinic.

The new clinic is open five days a week and is staffed by mental health and medical providers. Clinical staff includes two psychiatric nurse practitioners, three adult nurse practitioners, a physician's assistant, a physician and a psychiatrist as well as an LCSW from the U.S. Department of Veterans Affairs. Funding for the new clinic comes predominantly from a grant from the federal Interagency Council on Homelessness. The medical team will work with the on-site staff of the supportive housing programs to improve housing stability and greater access to care.

In addition to the integrated mental health and medical services, the HUH clinic will also establish a paperless medical records system where all medical records are entered in DPH's Lifetime Clinical Record and other electronic storage systems. By investing in mental health and medical services and by coordinating services across disciplines, the clinic will continue the goals of reducing utilization of downstream medical services by homeless people, improve housing stability for people living in supportive housing and continue to work toward ending homelessness in San Francisco.

Tom Waddell Health Center

Nearly 13,000 individuals are served at Tom Waddell Health Center (TWHC) each year, most of who are homeless and 600 of whom are new patients to primary care. Designed to address the distinct health needs of San Francisco's homeless population, TWHC receives nearly 60,000 visits a year at its facility on

Ivy Street for its urgent care, primary care, wound clinic, respite, telephone advice, social services, mental health, dental, community health, and community outreach services.

The population served consists primarily of white, African-American, and Latino patients in the range of 25 to 54 years of age. Major diagnoses and needs of patients include lack of housing, poly-substance use, mental health disorders, cellulites and abscesses, upper respiratory infections, asthma/COPD/lung disease, hypertension, HIV/AIDS, bronchitis, chronic viral hepatitis, and dermatological conditions.

In addition to general primary care services, blocks of clinic time at TWHC and “satellite” community clinics have been developed to serve special populations. They are staffed with professionals who are clinically, culturally and linguistically competent to serve the special needs of these low-income, primarily homeless patients. “Specialty” primary care services include:

- Homeless shelters. TWHC works with community providers at the following sites: Next Door Transitional Shelter, Episcopal Sanctuary, South of Market Multi-service Center, A Woman’s Place, A Man’s Place, Hamilton Family Shelter, and Santa Marta Shelter. TWHC staff provides a full range of services, including medical assessment, urgent and episodic care, comprehensive engagement, and linkage to continuity primary care. Public health prevention services such as immunization campaigns, TB screening and education, and attention to keeping the environment healthy are services also provided.
- Homeless Families. TWHC works closely with community providers of services for homeless families, including 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.
- Latinos and Latin American Indigenous Patients. This past year saw the initiation of a very successful program of group visits for diabetics at TWHC for this population. Primary care services are also provided at TWHC and at CARECEN, San Francisco Day Laborer Program, and Santa Marta Shelter. TWHC also does outreach with the staff of the San Francisco Clinic Consortium’s Street Outreach Services Van in the Mission District.
- HIV+/AIDS Patients. TWHC is the second largest provider of HIV primary care in DPH, serving over 1,000 individuals each year. TWHC has developed and participated in models that have gained national attention for improving health outcomes in homeless HIV positive multiply diagnosed people. In addition to the TWHC site, HIV+ integrated services are provided in collaboration with the Tenderloin AIDS Resource Center and the Asian and Pacific Islander Wellness Center.

The Respite Program of TWHC is a 30-bed shelter-based unit at the Next Door Shelter at 1001 Polk St. designed to serve homeless and marginally-housed patients not sick enough to require acute hospitalization, but too ill to be left homeless on the streets. The Respite Program provides the opportunity for patients to recuperate from illness or injury in a safe setting where they receive hot meals, a clean bed, medical care, social outreach services and short-term case management. The work of the TWHC Respite Team spans over 12 years, and the Team has worked with thousands of patients to identify their immediate medical needs, and to facilitate access to necessary follow-up medical care. Staff also assists patients with social work services including applications for housing benefits, mental health services, and substance abuse treatment.

TWHC is one of two primary care sites to participate in a nationally significant pilot of office-based opiate treatment. Thirty patients, 75 percent of whom are homeless, have been enrolled to receive methadone or buprenorphine. Evaluation has been very favorable.

Finally, many of the multi-disciplinary staff at TWHC are asked to provide their expertise on best practices for caring for the homeless at national, state, and local levels, including the National Health Care for the Homeless Council, Healthcare for the Homeless Clinicians Network, National Harm Reduction Coalition, San Francisco Tenderloin Collaborative Workgroup, and the San Francisco Homeless Providers Network to name a few.

McMillan Stabilization Center

The McMillan Stabilization Pilot Project, a medically supported sobering center for homeless alcohol-dependent persons implemented in July 2003, had nearly 5,000 admissions during its first year, serving over 2,000 unduplicated clients. Designed to divert patients from unnecessary emergency department and ambulance usage to a safe, more effective, and less costly level of care, the program operates seven days-a-week, 24 hours-a-day, and provides transportation, 20 beds of medically-supported sobering services, intensive case management and linkages to detox, housing, and other services. The program is situated in the CATS McMillan Drop-in Center at 43 Fell Street.

McMillan's "high ambulance user" clients averaged 12 visits during the year, as compared to non-high users' two visits per year. The 57 "high ambulance users" were served a total of 690 times – encounters that, without the Stabilization Project, would have otherwise resulted in an ambulance pick-up and emergency department drop-off. Transports to the larger McMillan Drop-in Center have increased by 50 percent since the pilot project began. Clinicians report that for the majority of clients health status improved (64%) or was maintained (34%) during the McMillan Stabilization stay.

The City and County of San Francisco and the Hospital Council of Northern and Central California, a nonprofit hospital and health system trade association

representing more than 200 hospitals, provided the funds necessary to implement the public/private pilot project and have committed to continued funding for FY 2004-05.

During the next fiscal year, DPH leadership will strive to increase the number of referrals to the Stabilization Project from SFGH Emergency Department staff and Emergency Medical Service (ambulance) drivers, as well as formally evaluate the program.

Acute Care/Hospitalization

San Francisco General Hospital

As San Francisco's leading acute care safety net hospital, San Francisco General Hospital (SFGH) provides hospital services to the City's homeless population. In FY 2003-04, a total of 7,724 (7.8%) of SFGH patients were identified as homeless. This number is an underestimate of homeless patients treated at SFGH because only those patients who self identify as homeless are coded as homeless. In addition to treating homeless individuals as part of its regular patient population, SFGH offers a number of programs that treat populations that are exclusively or primarily homeless:

- Two of SFGH's homeless programs, the Emergency Department Psychiatric Case Management (EDPCM) and Inpatient High User Case Management (IHUCM) programs began linking services with the Homeless Outreach Team (HOT) in 2004. Now, when a HOT client is admitted to SFGH, EDPCM and IHUC program staff work with HOT to link the client to housing upon discharge. EDPCM is designed to decrease hospitalization and emergency department visits; decrease homelessness, substance abuse and alcohol use; improve quality of life; and get eligible patients into entitlements including Medi-Cal and SSI. IHUC addresses the needs of frequently admitted patients (three admissions in the prior year), who have multiple chronic illnesses complicated by homelessness, substance abuse, and/or mental illness.
- Homeless/IVDU Case Management Follow Up provides case management services to approximately 300 IV drug-using clients annually after discharge from the SFGH inpatient care or the ISIS clinic.
- Tenderloin Outreach and Prevention Services (TOPS) is a satellite of the tuberculosis (TB) clinic at SFGH designed to provide early detection and timely treatment of active TB, and preventive therapy for those with latent TB infection in the Tenderloin/South of Market areas.
- The ISIS Clinic treats patient with soft tissue infections (abscesses or cellulitis) and includes patient education, access to methadone treatment, referral and linkage to other substance abuse treatment resources, on-site counseling, and social services.

- The Trauma Recovery Program assists victims of violent crime find safe housing and mental health services to decrease post-traumatic stress disorders. One-third of the clients are homeless.

Laguna Honda Hospital (LHH)

Laguna Honda Hospital (LHH) continues to be the safety net provider for homeless San Franciscans in need of nursing facility care. A total of 225 (13.2%) LHH residents in FY 2003-04 were homeless. In addition to providing direct care to homeless residents, LHH supplies up to 250 clean sheets per day, 150 pillow cases per day and 1400 blankets per day to homeless people in shelters throughout the City. The soiled linens and blankets are delivered to LHH each morning, sent out to be laundered the same day and picked up for delivery on the following day. The linens and blankets are not commingled with Laguna Honda residents' laundry. The volume of laundry serviced in this way varies according to the weather and the daily shelter population in the City.

In addition to serving homeless clients in its general patient population, LHH's Substance Abuse Treatment Services (SATS) program monitors approximately 160 residents at any given time, 85 percent are homeless. SATS participants live in a stable, safe, and structured environment where alcohol and drug use is prohibited and where medical, psychiatric, and substance abuse services are available. At discharge, SATS staff places willing and motivated residents into community programs for ongoing treatment.

Collaborations

To accomplish its goals, DPH necessarily partners with a wide variety of organizations, including all levels of government, advocacy groups, service providers and others interested in solving the homeless crisis in San Francisco.

Federal Agencies

DPH has developed partnerships with the following federal funding agencies to support housing and homeless services:

Substance Abuse and Mental Health Services Administration (SAMHSA)

SAMHSA is the federal agency charged with improving the quality and availability of prevention, treatment, and rehabilitative substance abuse and mental health services. SAMHSA funding has supported the Treatment on Demand Planning Council, Homeless Addict Vocational and Educational Network (HAVEN), Methadone Van, integration of behavioral health services into supportive housing, Action Point, and several other projects.

Bureau of Primary Care

The Bureau of Primary Care provides Healthcare for the Homeless funding to DPH. This funding supports primary health care, substance abuse services, emergency care, mental health services, and outreach services to access difficult to reach homeless persons. Funding is also used for aid in establishing eligibility for entitlement programs and housing.

Interagency Council on Homelessness (ICH)

The ICH is responsible for providing Federal leadership for activities to assist homeless families and individuals. It is composed of representatives from SAMHSA, HRSA, VA and HUD. The ICH has spearheaded efforts to urge communities, including San Francisco to develop ten-year plans to end homelessness. On October 4, 2004, the ICH announced that San Francisco is receiving a \$4.6 million grant to go to three agencies: \$2 million to Mount St. Joseph's-St. Elizabeth's Epiphany residential center for mothers and children, \$2 million to the Friendship House for Native Americans, and \$600,000 to Swords to Plowshares for a residential program on Treasure Island for veterans. The grant was awarded largely on the basis of the City having enacted its ten-year plan.

Department of Veterans Affairs (VA)

DPH works with the VA to offer a wide array of special programs designed to help homeless veterans live as self-sufficiently and independently as possible. For example, the Swords to Plowshares program provides homeless veterans emergency shelter, mental health services, housing, job training and referrals, and free attorney representation.

Local Agencies

DPH works with the following local organizations to solve the homeless crisis:

Local Homeless Coordinating Board

San Francisco's Local Homeless Coordinating Board (Local Board) is a 34-member body with membership of homeless advocates, formerly homeless persons, service providers, non-profit housing organizations, neighborhood residents, education and training, labor, business, foundations, and key City departments. DPH has a seat on the Local Board, filled by Anne Kronenberg, Deputy Director, who is serving as Local Board Co-Chair and as Co-Chair of the Steering Committee. The Local Board was formed in 1997 to oversee the integrated health, housing, employment, and social service system contained in the City's Continuum of Care plan. The Local Board meets monthly and is responsible for coordinating the City's homeless policy, McKinney (HUD) funding, and Continuum of Care implementation.

Department of Human Services (DHS)

The Department of Human Services (DHS) officially began its implementation of the *Care Not Cash* initiative on May 3rd, 2004. The voters of San Francisco adopted *Care Not Cash* as Proposition N in the November 2002 election. *Care Not Cash* implementation was delayed due to court challenges, but the State Supreme Court eventually ruled that the plan could remain intact as passed by voters.

Homeless persons receiving cash assistance from the City's County Adult Assistance Program (CAAP) are being phased-into *Care Not Cash* over a seven-month period (from May through November 2004). Under *Care Not Cash*, homeless CAAP clients are offered housing and meals as a portion of their benefit package. Funding that otherwise would have been used for cash aid is being used to expand housing and services for this population. During the first four months of implementation, roughly 1,600 homeless CAAP clients have been granted benefits under or had their pre-existing benefits converted to *Care Not Cash*. During this same period the homeless CAAP caseload has decreased by an unprecedented 34 percent (down from around 2,500 clients before *Care Not Cash* was implemented in April).

Homeless CAAP clients are being given up-front direct access to permanent supportive housing whenever possible. Emergency shelter is used as a back up when housing is not available or refused. Housing referrals have been targeted to clients on pre-existing housing waiting lists, and those with the longest stays in San Francisco's shelter system. Available housing statistics for the first four months of *Care Not Cash* reveal the following:

- 462 homeless CAAP clients have been offered a housing referral.
- 245 homeless CAAP clients have already moved into housing, with an additional 22 clients approved for housing and awaiting move-in.

By the end of the current fiscal year, DHS projects that its SRO Housing Program will consist of almost 2,000 units (1,000 of which will be funded through *Care Not Cash* and serve as an exclusive referral source for homeless CAAP clients).

In an exciting new collaboration with DPH, *Care Not Cash* funding has allowed for the creation of a Behavioral Health Roving Team. The goal of the Behavioral Health Roving Team is to provide medical and behavioral health services to tenants living in the SRO Housing Program in order to stabilize them in housing and avoid future episodes of homelessness. The case management part of the team is supervised by UCSF/City-Wide Case Management and consists of a Clinical Supervisor, a social worker and a substance abuse specialist. The medical portion of the team is comprised of two nurse practitioners who are employed and supervised by DPH's Housing and Urban Health section. The

case management team reaches out to and engages clients who are referred by on-site staff at the hotels. The team employs a range of interventions to help stabilize residents, including mental health and substance abuse services, vocational and entitlements assistance, and skills groups. DPH staff provides medical and psychiatric assessments on-site in the hotels and collaborates closely with the case management team in the development and implementation of treatment plans to best serve the needs of the hotel population and enhance stability in housing. The Behavioral Health Roving Team is also beginning to make referrals to the new DPH Housing and Urban Health Clinic.

Through another important partnership with DPH, DHS is using *Care Not Cash* funds to expand substance abuse treatment for homeless CAAP clients, including the following:

- 32 residential treatment beds
- Two medically supported detoxification/dual diagnosis stabilization beds
- 30 methadone maintenance slots
- One Treatment Access Program (TAP) case manager

DHS states that implementation of *Care Not Cash* is going smoothly. There is evidence that the initiative is promoting its goal to reduce homelessness and improve the health and welfare of homeless indigent adults receiving cash assistance through permanent housing opportunities and enhanced services.

Emerging Issues

Changes to Section 8 Housing

Historically, Congress has maintained or increased the HUD Section 8 budget, which continues to be a critical source of housing subsidies for low-income people. Recently the administration had proposed cuts to the Section 8 budget that would have resulted in the loss of thousands of Section 8 vouchers throughout the country including an estimated 700 in San Francisco. Ultimately this cut was abandoned due to the pressure from localities. This is an issue San Francisco must continue to monitor closely. Reductions in mainstream housing resources such as Section 8 will undermine our effort to “close the front door” of homelessness as low income households lose their subsidy and fall into homelessness.

Samaritan Act

Both houses of Congress have introduced legislation (Samaritan Act) designed to establish a grant program administered under an agreement among the Secretaries of Housing and Urban Development, Health and Human Services, and Veterans Affairs, in consultation with the U.S. Interagency Council on

Homelessness, to address the goal of ending chronic homelessness through coordinated provision of housing, health care, mental health and substance abuse treatment, supportive and other services, including assistance in accessing non-homeless specific benefits and services, and for other purposes. Authorizing legislation (S. 2829/H.R. 4057) has been introduced, and while the Senate included a \$10 million appropriation, the House did not include any funding. The passage and funding of this legislation is important to the City. The ICH grant (discussed above) that funded the Empress Hotel was a pilot of the Samaritan Act concept. Having completed a Ten Year Plan, the City will be very competitive for this important funding source.

Implementation of the Ten Year Plan

The next step for The San Francisco Plan to Abolish Chronic Homelessness is implementation. The Homeless Cluster, which includes both DPH and DHS, will work to develop a formal implementation plan. Nonetheless, many of the key recommendations of the Plan are already being implemented. DPH, DHS, Mayors' Office of Housing, and the Redevelopment Agency are meeting regularly to plan for the creation of the 3,000 new units of supportive housing called for in the plan. Key stakeholders are meeting on a regular basis to improve discharge planning to significantly reduce discharge of homeless people back to the street. The San Francisco Homeless Outreach Team is engaging homeless people seven days per week and having much success in placing people in housing.

Recommendations

Outcomes from Last Year's Recommendations

The 2002-03 Housing & Homeless Report contained seven recommendations for DPH activities in FY 2003-04. DPH has made excellent progress toward meeting those recommendations including:

1. Expand housing options as a health care intervention for all people living with homelessness. In 2004, DPH's DAH program opened 190 new units at the Civic Center Residence, Empress Hotel, and West Hotel, bringing the total number of DAH units to 583. In addition DHS has opened 768 units of supportive housing through its Master Lease program as a result of the Care Not Cash implementation.
2. Expand services tailored for people living with homelessness, substance abuse, mental illness, and chronic medical conditions. In addition, tailor services to assist in moving people from institutionalized to community settings. The Patient Flow project, begun in February 2004, has as a goal to place clients in the most appropriate level of care. When fully implemented, this project will result in the flow of clients through the continuum of care from acute care settings at SFGH, to skilled care at

- LHH, to community-based settings through DAH and DPH community partners.
3. Work with DHS to assist in expanding health care to formerly homeless people housed in DHS master-lease programs and to homeless people living on the streets and in shelters. Working together, DPH's HUH program and DHS's Division of Housing and Homeless Programs have arranged to provide DPH-sponsored primary and behavioral care services in DHS master lease sites through the newly opened HUH clinic.
 4. Expand primary care for homeless people so that all people living with homelessness have access to primary care and behavioral health services. On September 13, 2004, HUH opened a clinic at the Windsor Hotel at 234 Eddy St., which is staffed by medical and mental health providers. Open five days per week, the new clinic will provide services to 2,000 formerly homeless individuals now housed in DPH DAH and DHS Master Lease sites. In addition, TWHC continues to see 13,000 patients annually, most of whom are homeless.
 5. Continue to research and generate revenue from mainstream revenue sources and aggressively go after grant opportunities. Completion of San Francisco's Ten Year Plan in June 2004 has opened and will continue to open opportunities for funding. For example, the recent \$4.6 million grant from ICH is a direct result of San Francisco's Ten Year Plan.
 6. Continue to integrate and connect sections within DPH to more effectively marshal our resources. The Patient Flow project and DPH's Behavioral Health integration are both designed to make more efficient and more effective use of resources.
 7. Maintain and expand connections to state and federal advocacy organizations. One of the primary federal organizations with which San Francisco has been able to collaborate more closely is the ICH. This expanded connection has come about largely as a result of the City's Ten Year Plan.

Medical Respite

The City continues to need a large scale Medical Respite program. While there are several small respite programs in operation, none has sufficient space or adequate staffing. Ideally, a new respite would include 75 to 100 beds of semi-private sleeping spaces along with comprehensive on-site medical and behavioral health services. The main purpose of this facility would be a place where frail homeless people could come off the street, receive treatment, be assessed and placed in an appropriate residential setting. The length of stay would be a maximum of six months with an average length of approximately three months.

Expansion of the Homeless Outreach Team

As described above, the new Homeless Outreach Team began its work in spring 2004 and has been successful in engaging and housing homeless people.

However, it is clear that the team needs additional outreach workers to establish an effective citywide presence. Currently the 12 team members are focusing on the central city area and are stretched thin covering this relatively small area. In order to expand its work to South of Market, Mission, Haight, Bayview, and other neighborhoods as needed, this team must expand. Given the 20-hour per day, seven day per week staffing pattern, there are currently only three to five people on the street per shift.

Expansion of Permanent Housing Placement

In order to continue the momentum toward ending chronic homelessness in San Francisco, there needs to be a steady flow of housing units targeted to this population. The Ten Year Plan calls for the creation of 3,000 units targeted to chronically homeless people by 2010. It is proposed that this goal be met by a combination of master leasing and non-profit development. The Health Department is in a position to support both types of efforts. Master leasing sites can be accomplished through the Direct Access to Housing program and the Department can support non-profit owned building by funding/providing the on-site medical and behavioral health services. Regardless of the method, a key to success is to continue our “housing first” efforts.

Appendices

- A: SF Ten Year Plan
- B: HUH Contracts
- C: DAH Description