

TIPPING POINT
COMMUNITY

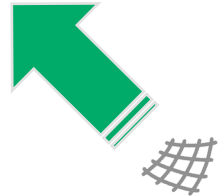
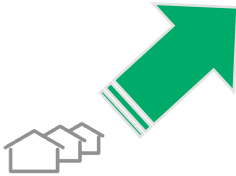
Tipping Point Community

Chronic Homelessness Initiative
Behavioral Health Update

Tipping Point's support of San Francisco goal



**REDUCE CHRONIC HOMELESSNESS
BY 50% BY 2022**



Create More Housing

Create 2,200 permanent supportive housing placements for chronically homeless

800 PSH units in city pipeline	1,400 PSH units from Moving On Initiative and Flexible Subsidy Strategy
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Prevent Homelessness

Reduce inflow into chronic homelessness

Individual interventions	System interventions
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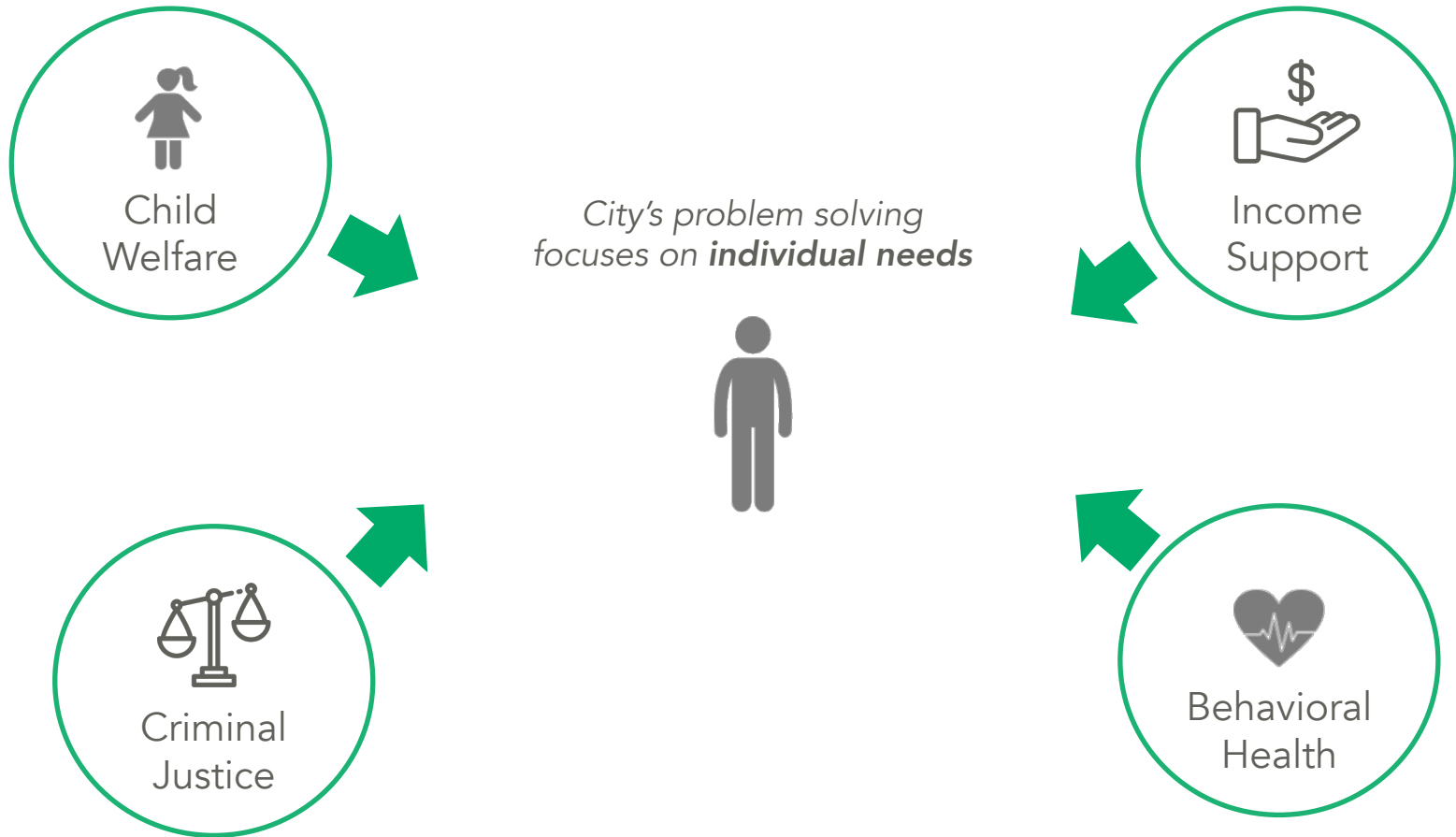


Optimize Public Sector

Collaborate with the public sector to support systemic changes by leveraging outside funding sources, increasing accountability to the populations they serve, and improving data collection and sharing.

Coordinated Entry	Accountability, sustainability + data
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Our prevention strategy focuses on system-level interventions





Partnership

UCSF Department of Psychiatry

Tipping Point Community

John Snow, Inc. (JSI)



Methodology

1. Process

2. Data Sources

- Key Informant Interviews
- DPH Leadership
- Advisory Committee
- National Best Practices
- Client Focus Group



Process





Data Sources

1. Review of Existing Data Reports
2. Key Informant Interviews
3. Scan of National Best Practices
4. Monthly Meetings with DPH Leadership
5. Monthly Meetings with Advisory Committee
6. Client Focus Group



Key Informant Interviews

- Jason Albertson, HSH
- Angelica Almeida, Jail Health
- Scott Arai and John Fostel, PRC Baker Places
- Ayanna Bennett, DPH
- Anton Bland and Mark Leary, PES ZSFG
- Jack Chase, ZFSG Care Coordination
- Kelly Eagen and Alice Moughamian, Medical Respite and Sobering Center
- Susan Ehrlich, ZSFGH CEO
- Steve Field, Progress Foundation
- Jennifer Friedenbach, Coalition on Homelessness
- Lisa Golden, DPH
- Hemal Kanzaria, Maria Martinez, Dara Papo, Maria Raven and Amber Reed, Whole Person Care
- Jeff Kositsky, HSH
- Captain David Lazar, HSOC/SFPD
- David Serrano Sewell, Hospital Council
- Eileen Loughran and Tracey Packer, DPH
- Judy Martin, BHS
- Tanya Mera, Jail Health
- Fumi Mitsuishi, Citywide
- Captain Simon Pang, EMS6
- Sneha Patil, DPH
- Beth Romley, LA ACT program
- Melida Solorzano, Hummingbird Psychiatric Respite
- Barry Zevin, Homeless Outreach Team (HOT)



DPH Leadership Meetings

Greg Wagner

Naveena Bobba

Alice Chen

Sneha Patil

Roland Pickens



Advisory Committee

Brett Andrews, PRC/Baker Place, CEO

Alice Chen, Department of Public Health, Chief Medical Officer and Deputy Director for the SFHN

Kavoos Ghane Bassiri, Department of Public Health, Director of Behavioral Health Services

Kelly Hiramoto, Department of Public Health, Director of SFHN Transitions

Hemal Kanzaria, Associate Professor of Emergency Medicine at UCSF

Margot Kushel, Director of the UCSF Center for Vulnerable Populations (CVP)

Mark Leary, UCSF Department of Psychiatry, Director of Division of Acute Emergency Services

Dara Papo, Department of Homelessness and Supportive Housing, Care Coordination Services Manager

David Serrano Sewell, Hospital Council of Northern and Central California, Regional Vice President

Ana Valdes, HealthRight 360, Chief Healthcare Officer



National Review

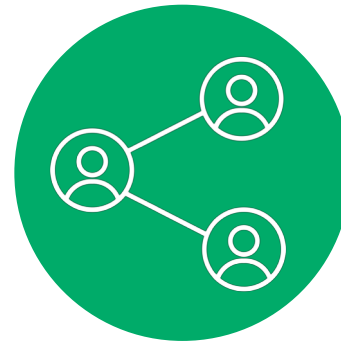
Lessons from National Best Practice Review



**Address racial
disparities**



**Provide trauma-
informed care**



**Utilize peer
support models**



**Facilitate change
through
motivational
interviewing (MI)**



Vision

San Francisco's system of care should know the **names and needs of everyone** who is homeless with a behavioral health care need (regardless of how they come into the system and whether they are currently using it);

provide wrap-around services that promote stabilization and a path to permanent housing;

and ensure that systems and services **proactively address and reduce disparities** impacting African Americans and LGBTQ individuals experiencing homelessness.



Findings

- 1. Identified Goals, Strategies & Priority Solutions**
- 2. Next Steps & Discussion**



GOAL 1: IMPROVE COORDINATION, ACCOUNTABILITY, AND OUTCOME ALIGNMENT

1. Improve data on clients and existing resources

- DEVELOP A REAL-TIME BEHAVIORAL HEALTH BED INVENTORY
- SUPPORT FOR BEHAVIORAL HEALTH EPIC IMPLEMENTATION

2. Establish shared client-centered outcome goals

- CROSS-AGENCY ALIGNMENT AROUND PRIORITIZATION OF CLIENTS
- ESTABLISH SHARED OUTCOME GOALS ACROSS DEPARTMENTS

3. Improve system-wide coordination and accountability for continuous quality improvement

- LEGAL SUPPORT FOR DATA SHARING
- SUPPORT THE WHOLE PERSON CARE PLATFORM IMPLEMENTATION
- IMPROVE STAFF RETENTION



GOAL 2: IMPROVE STABILIZATION AND TREATMENT

1. Improve access to short- and long-term housing for all levels of care

- ADDITIONAL AFFORDABLE AND SUPPORTIVE HOUSING
- INCREASE THE NUMBER OF RESIDENTIAL CARE FACILITIES
- ADDITIONAL RESOURCES FOR CLIENTS WITH DEMENTIA OR INCONTINENCE

2. Increase availability of appropriate, accessible treatment

- INTERVENTIONS FOR TREATMENT OF METHAMPHETAMINE USE AND CHRONIC ALCOHOLISM
- ADDITIONAL TREATMENT BEDS ACROSS THE CONTINUUM OF CARE

3. Increase support for care transitions and maintenance

- EXPAND AVAILABILITY OF INTENSIVE CASE MANAGEMENT SERVICES



GOAL 3: INCREASE SYSTEM ENGAGEMENT

1. Expand field-based services

2. Create additional safe spaces to build trust

- DEVELOP AND IMPLEMENT A MANAGED ALCOHOL PROGRAM
- ADD ADDITIONAL DAY PROGRAMS

3. Implement client-centered, responsive services

- NON-EMERGENCY TRANSPORTATION
- LINKAGE COORDINATORS
- EXPAND SERVICE AND REFERRAL HOURS



Next Steps & Discussion

- **Mayoral announcement**
- **New investments**
- **Opportunity for collaboration**
 - Director of Mental Health Reform
 - Whole Person Care
 - Methamphetamine task force
 - Justice reform efforts