HIGH USERS OF MULTIPLE SYSTEMS (HUMS)

HUMS scale is 2 dimensional based on data review conducted by Maria X Martinez, SF Department of Public Health.

Dimension 1: Level of urgent/emergent service use

HUMS patients are in the Top 1% of all users over an annual time frame. Typically this is approximately 500 individuals out of approximately 50,000 who have used an urgent/emergent service. In San Francisco, the urgent/emergent spectrum of services includes:

Medical
EMS
Emergency Department
Inpatient
Medical Respite
Outpatient Urgent Care

Psychiatric
Mobile Crisis
Psychiatric Emergency Services
Inpatient
Acute Diversion Unit
Outpatient Crisis (e.g., Dore Urgent Care Center)

Substance Use
Sobering Center
Residential Medical Detox
Residential Social Detox

Dimension 2: Care fragmentation

Persons receiving services in multiple areas - medical, mental health, substance use - are more likely to become extremely high cost and have high escalating costs, low engagement, and worsening care prognosis. HUMS people appear in at least two of the three care areas. The ones most worrisome show tri-morbidity of chronic conditions and get care in three systems. They are likely to be high ambulance users and poorly engaged in ongoing care. The number averages about 300 annually.
SFDPH Urgent/Emergent Care System and HUMS Methodology for identifying high risk patients

Updated June, 2015
Kelly Hiramoto, Transitions

Urgent/Emergent Care in SFDPH

Medical System
- EMS transports
- ED medical
- Inpatient – 24hr
- Medical Respite (hospital offset)
- Urgent care clinics at TWHC, hospital

*Programs in red are the only ones studied in other communities.

Psychiatric System
- PES, Dore St (PES offset)
- Psy Inpatient – 24hr
- Adult Diversion Units (hospital offset) – 24hr
- Crisis clinics at WSC, Mobile Crisis

Substance Abuse System
- Sobering Center
- Res Medical Detox – 24hr
- Res Social Detox – 24hr
Urgent/Emergent Care in SFDPH

**Medical System**
- EMS transports
- ED medical
- Inpatient – 24hr
- Medical Respite (hospital offset)
- Urgent care clinics at TWHC, hospital

**Psychiatric System**
- PES, Dore St (PES offset)
- Psychiatric Inpatient – 24hr
- Adult Diversion Units (hospital offset) – 24hr
- Crisis clinics at WSC, Mobile Crisis

**Substance Abuse System**
- Sobering Center
- Res Medical Detox – 24hr
- Res Social Detox – 24hr

*Programs in red are the only ones studied in other communities.*

---

**SFDPH Urgent/Emergent Care**

- **$2.0 billion**: The annual SFDPH budget
- **$200 million**: The total U/E costs which remain fairly steady annually. These are estimated actual costs in constant dollars.
- **50,000**: The total number of unique individuals served annually in UE which may be trending down to 45K.
- **50%**: The percentage of total costs used by the top 5% of individuals (counts UE service use, then associated costs).
- **20,000**: The approximate number of individuals per year who are seen only once for U/E care.
### Identifying high risk patients by examining high utilizers of services

<table>
<thead>
<tr>
<th>Summary of FY 14-15 (11mo)</th>
<th># Patients</th>
<th>Total Costs</th>
<th>% Total Costs</th>
<th>Ave Cost/Pt</th>
<th>Ave # Svcs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Top 1%</td>
<td>405</td>
<td>$31,294,889</td>
<td>18%</td>
<td>$77,271</td>
<td>95</td>
</tr>
<tr>
<td>Next 2 - 5%</td>
<td>1,620</td>
<td>$50,661,102</td>
<td>28%</td>
<td>$31,272</td>
<td>35</td>
</tr>
<tr>
<td>Remaining 95%</td>
<td>38,452</td>
<td>$96,463,215</td>
<td>54%</td>
<td>$2,509</td>
<td>3.3</td>
</tr>
<tr>
<td>Totals</td>
<td>40,477</td>
<td>$196,508,475</td>
<td>100%</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### The original presentation of high utilizers, FY 10-11

<table>
<thead>
<tr>
<th>Summary of FY 10-11</th>
<th># Patients</th>
<th>Total Costs</th>
<th>% Total Costs</th>
<th>Ave Cost/Pt</th>
<th>Ave # Svcs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Top 1%</td>
<td>511</td>
<td>$49,793,566</td>
<td>25%</td>
<td>$97,443</td>
<td>89</td>
</tr>
<tr>
<td>Next 2 - 5%</td>
<td>2,078</td>
<td>$58,527,401</td>
<td>30%</td>
<td>$28,165</td>
<td>30</td>
</tr>
<tr>
<td>Remaining 95%</td>
<td>49,207</td>
<td>$88,187,508</td>
<td>45%</td>
<td>$1,792</td>
<td>2.5</td>
</tr>
<tr>
<td>Totals</td>
<td>51,796</td>
<td>$196,508,475</td>
<td>100%</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Identifying risk by measuring systems used – a proxy for needing care coordination, FY14-15, 11 months

<table>
<thead>
<tr>
<th>HU Single Sys. top 10</th>
<th>Variable</th>
<th>HU Multiple Sys. top 10</th>
</tr>
</thead>
<tbody>
<tr>
<td>$1,187,200</td>
<td>Total Costs</td>
<td>$2,343,337</td>
</tr>
<tr>
<td>$118,720</td>
<td>Average Cost</td>
<td>$234,334</td>
</tr>
<tr>
<td>213</td>
<td>Average # Services</td>
<td>208</td>
</tr>
<tr>
<td>9 Med only,</td>
<td>Systems Used</td>
<td>5 Med-Psy,</td>
</tr>
<tr>
<td>1 Psy only</td>
<td></td>
<td>4 Med-SA,</td>
</tr>
<tr>
<td>0</td>
<td>Deceased?</td>
<td>1 Tri-morb</td>
</tr>
<tr>
<td>8M, 2F</td>
<td>Gender</td>
<td>1</td>
</tr>
<tr>
<td>2W, 7B, 1L</td>
<td>Ethnicity</td>
<td>8M, 2F</td>
</tr>
<tr>
<td>57</td>
<td>Average age</td>
<td>6W, 4B</td>
</tr>
<tr>
<td>90%</td>
<td>History of Homelessness</td>
<td>61</td>
</tr>
<tr>
<td>3 perm hsd</td>
<td>Current Housing</td>
<td>100%</td>
</tr>
<tr>
<td>1 temp hsd</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1 institutional</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3 homeless</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2 unknown</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Is HUMS identification and care coordination working?

- Total U/E costs have remained unchanged at approximately $200 million annually (estimated actual costs in constant dollars).
- Total unique individuals served annually in U/E is also about the same at 45,000-50,000.
- The high risk top 1% of individuals now account for 18% of costs – a reduction from 25%.
- The high risk top 5% of individuals now comprise 46% of costs – a reduction from 55%.
- Costs savings are being transferred to lower risk patients.
Conclusions

• HUMS method is useful way to identify and monitor urgent care patients.
• HUMS method helps plan care coordination to reduce costs and improve health outcomes.
• Shining spotlight on HUMS patients may be reducing their costs already.
• Further interventions and grant funding are planned.
For the most frequently hospitalized patients in primary care, we aim to:

1) Reduce hospitalizations and ED visits

2) Improve patient satisfaction

3) Improve provider and staff satisfaction

Using interprofessional teams to improve health and health care
Programmatic Oversight/Responsibility

- Primary Care Complex Care Management
- Nurse Advice Line
- New Patient Appointment Unit
- Telephone Provider Visits Program
Patient Identification

- Patients with 3 or more hospitalizations in the last year
  - SFGH
  - SFHP

- Providers review list of patients and refer those who are appropriate for CCM
Where does “Care Coordination" happen?

<table>
<thead>
<tr>
<th>Low Risk Patients</th>
<th>In Flux</th>
<th>High Risk Patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Primary Care</td>
<td>- Pathways</td>
<td>- Complex Care Management</td>
</tr>
<tr>
<td>- Medical Home</td>
<td>- Bridge</td>
<td>- Transitions Team</td>
</tr>
<tr>
<td>- Routine Care</td>
<td>- Jail</td>
<td>(Kelly’s team)</td>
</tr>
<tr>
<td>- RNs</td>
<td>- Hospitalized</td>
<td>- Mental Health Homes</td>
</tr>
<tr>
<td>- MDs</td>
<td></td>
<td>- Respite</td>
</tr>
<tr>
<td>- BAs</td>
<td></td>
<td>- Hotels/SROs</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Home Health Nurses</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- ED Case Management</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- San Francisco Health Plan</td>
</tr>
</tbody>
</table>
Average utilization before and after enrollment in GMC Care Management

- ED visits before Enrollment
- ED visits after Enrollment
- Hospital days before Enrollment
- Hospital days after Enrollment

31% decrease in ED visits  57% decrease in hosp. days
### PRIMARY CARE
- Primary Care Physician
- NP/RN
- Pharmacist
- Behaviorist
- Behaviorist Asst.
- RN Care Coordinator
- Care Coordinator
- Support Staff
  - MEA
  - Health Workers
  - Clerk(s)
  - Reception

### BEHAVIORAL HEALTH
- Psychiatrist
- Psychologist
- NP/RN
- Pharmacist
- Care Coordinator
- Clinical CM
- SATS
- Health & Wellness
- Peer Specialist
- Support Staff
  - Health Worker
  - Clerk(s)
  - MEA
  - Reception

### HIV
- Primary Care Physician
- NP/RN
- Pharmacist
- Care Coordinator/Care Manager
- Support Staff
  - MEA
  - Clerk(s)
  - Reception

### HOMELESS/TRANSIENT
- Primary Care Physician
- Psychiatrist
- NP/RN
- Pharmacist
- Care Coordinator
- Care Manager
- Support Staff
  - MEA
  - Clerk(s)
  - Reception

### JAIL
- Medical Physician
- Psychiatrist
- NP/RN/LVN
- HIV Services
- Pharmacist
- Care Coordinator
- Care Managers
- MH Clinicians
- Discharge Planners
- MH Workers
- Support Staff
  - MEA
  - Clerk(s)

### LAGUNA HONDA
- Primary Care Physician
- CNS/RN/LVN
- Pharmacist
- Social Worker
- Activities
- Rehab Staff
- CNA/HHA
- Dietician
- SATS (Substance Tx)
- Support Staff
  - MEA
  - Clerk(s)

### SPECIALITY CARE
**CHRONIC DISEASE**
- RESPIRATORY  
  (ex: COPD, ASTHMA, TB)
- CARDIAC (ex: CHF)
- RENAL
- ONCOLOGY
**SUBSTANCE ABUSE**
**HEALTH at HOME**
**INFECTIOUS DISEASE**

### **COLLABORATIVE COURTS**
- Care Managers (CBO & Civil)
- SATS (CVC and Drug)
- Psychiatrist (CVC)

### **REGIONAL CENTERS**
- Care Managers

---

* Until assigned or returned to a Health Home/Medical Home
** Role to be determined but their impact needs to be included
CCMS - SFDPH Coordinated Care Management System Patient Summary

Health Home:
First Known Health Svc Date: 03/04/2016, Bismark
Last Known Health Svc Date: 12/15/2012, Antelope
Last Known Svc: 04-15-2013 (40) SSSH/SP - Disabled (Avatar)
Last Community Care Plan: 08-16-2014

Care Team Members (Active)

<table>
<thead>
<tr>
<th>Role</th>
<th>Name</th>
<th>License</th>
<th>Program</th>
<th>Beginning Date</th>
<th>Last Visit Date</th>
<th>Phone</th>
<th>Email</th>
</tr>
</thead>
<tbody>
<tr>
<td>CC</td>
<td>Lisa Callahan</td>
<td></td>
<td>Transition Care Coordination</td>
<td>08-15-2014</td>
<td>05-15-2014</td>
<td>(415)705-2156</td>
<td><a href="mailto:lisa.callahan@sfph.org">lisa.callahan@sfph.org</a></td>
</tr>
<tr>
<td></td>
<td>Montgomery, Frances</td>
<td>M-212532</td>
<td>SFHP Care Support Team</td>
<td>05-04-2013</td>
<td>05-15-2014</td>
<td>415-409-5165</td>
<td><a href="mailto:f.montgomery@sfph.org">f.montgomery@sfph.org</a></td>
</tr>
<tr>
<td></td>
<td>Hart</td>
<td></td>
<td>City College of San Francisco (MMNY)</td>
<td>06-03-2011</td>
<td>10-30-2012</td>
<td>415-230-3370</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>FMP Screening</td>
<td>07-01-2010</td>
<td></td>
<td>415-206-7000</td>
<td></td>
</tr>
</tbody>
</table>

Future Medical Appointments (LCR)

Note

Risk Factors

If you have questions about the Patient Summary, please contact Spencer Williams at 415-503-4757 or Spencer.Williams@sfph.org.

We also welcome any feedback or suggestions about the content or design of the Patient Summary.

- UOE & Urgent/Emergent
- Per 42 CFR, SA-related information was pulled from records OTHER THAN substance abuse treatment program records.

Urgent/Emergent Health Service Summary

Ten Most Recent Health Services

Your session will timeout after 40 minutes of inactivity.

WILLIAMS

10/28/2014
INDIVIDUALIZED SERVICE LINKAGE / DISCHARGE PLAN

Name: TESTING, ONLY
Admission
DOB: 4/07/1945
SSN: XXX-XX-1111
MRN: 01035335
Unit:

Note:

**CAP: Behavior**

<table>
<thead>
<tr>
<th>Start Date</th>
<th>Need</th>
<th>Interventions/Services</th>
<th>Linkages/Discipline/Resources</th>
<th>Status/Outcome</th>
<th>Target Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>7/23/2012</td>
<td>Wandering/Elopement Risk</td>
<td>Evaluate need for secured egress.</td>
<td></td>
<td>Active</td>
<td></td>
</tr>
</tbody>
</table>

**GOAL:** Resident/client will reside in structured environment that provides appropriate level of safety and supervision.

**CAP: Finances**

<table>
<thead>
<tr>
<th>Start Date</th>
<th>Need</th>
<th>Interventions/Services</th>
<th>Linkages/Discipline/Resources</th>
<th>Status/Outcome</th>
<th>Target Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>7/23/2012</td>
<td>Inability to manage financial affairs</td>
<td>Acquire appropriate Rep Payee/Money Manager. 1&amp;2</td>
<td></td>
<td>Active</td>
<td></td>
</tr>
</tbody>
</table>

**GOAL:** Resident/client will have safe and secure money management system that can maximize household resources.

**CAP: Health**

<table>
<thead>
<tr>
<th>Start Date</th>
<th>Need</th>
<th>Interventions/Services</th>
<th>Linkages/Discipline/Resources</th>
<th>Status/Outcome</th>
<th>Target Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>7/23/2012</td>
<td>Health Practices: Frequency and adequacy of health care</td>
<td>Refer to appropriate PCP, nurse or other medical specialist. Referral to Adult Day Health Center site., Coordinate delivered medications/supplies with local pharmacy., Assist in securing needed transportation to get to medical appointments including referral to Paratransit., Assist in coordination of referral to medical</td>
<td></td>
<td>Active</td>
<td></td>
</tr>
</tbody>
</table>

**GOAL:** Resident/client will maintain medical care compliance.
INDIVIDUALIZED SERVICE LINKAGE / DISCHARGE PLAN

Name: TESTING, ONLY
Admission
DOB: 4/07/1945
SSN: XXX-XX-1111
MRN: 01035335
Unit:

services

CAP: Transportation

GOAL: Resident/client will have access to transportation services depending on the level of the resident/client's physical disability and need.

<table>
<thead>
<tr>
<th>Start Date</th>
<th>Need</th>
<th>Interventions/Services</th>
<th>Linkages/Discipline/Resources</th>
<th>Status/Outcome</th>
<th>Target Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>7/23/2012</td>
<td>Lack of safe, affordable</td>
<td>Complete necessary applications for Paratransit services.</td>
<td></td>
<td>Active/</td>
<td></td>
</tr>
<tr>
<td></td>
<td>transportation</td>
<td>Acquire and/or provide escort transport.</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

MR 714 (i)
Rev 10/15/06
Signature: __________________________ Date: 7/23/2012

Printed: July 23, 2012
Community Placement
San Francisco Health Network

Presented by: Kelly Hiramoto, LCSW, Acting Director of Transitions
July 29, 2015

Not the Bed Committee!
Goal of Placement

The goal of the Placement division is to ensure clients are stabilized in the most appropriate, least restrictive setting in the most cost effective manner.
How It Works

The Lingo

- ADU: Acute Diversion Unit
- LSAT: Locked Sub Acute Treatment
- "L": Locked setting
- IMD: Institute for Mental Disease
- MHRC: Mental Health Rehabilitation Center
- RCF/E: Residential Care Facility/for Elderly
  (also referred to as "Board and Care")
- TCM: Targeted Case Management
- LTC: Long Term Care = IMD/MHRC, RCF/E, SNF
- SNF: Skilled Nursing Facility
Identifying Appropriate Referrals

- SF Residency
- Low/No income
- Treatment Ready & Willing if not Conserved
- Conserved clients who are Low/No income
- In need of subsidized placement to leave the hospital
- Complex discharges

Where We Do It

- Acute Psychiatric and Medical Units at SFGH and Community Hospitals
- Acute Diversion Units, Residential Treatment (Mental Health, Substance Use and Dual Diagnoses), Transitional Residential
- Residential Care Facilities (Board & Care)
- Locked settings: IMD/MHRC/Neurobehavioral SNF
- Laguna Honda Hospital
- Community Settings
- Jail
- Emergency Departments: Psychiatric & Medical
- State Hospitals
Collaborations

- Baker, Conard, Progress Foundation, HealthRight360
- Canyon Manor
- Crestwood Behavioral Health Services: converted beds in 2 facilities from IMD level of care to Residential Care; established Dialectical Behavioral Therapy in every facility
- Community Behavioral Health Services to link to Care Management and Primary/Behavioral Health Care
- Behavioral Health Access Center: Treatment Access Program
- Jail Re-Entry Services
- Direct Access to Housing

Levels of Care

- Treatment
- Shelter
- Hotel aka SRO, Stabilization Room
- Support Service Hotels
- Co-operative Housing
- Direct Access to Housing and Shelter + Care
- Residential Care aka "Board & Care"
  - RCF/ARF: 18 y.o. – 59 y.o.
  - RCFE: 60 y.o. and older
- MHRC/IMD/LSAT
- Neuro-Behavioral SNF
  - Chronic Inebriate Program
- Medical SNF
- State Hospital
Placement Authorization
Referral

What We Do

- Assessment, Authorization and Utilization Management and Utilization Review at every level of care for placement in the most appropriate, least restrictive level of care to support client flow

- Assist with discharges

- Bridge Care Management to provide transitional care management coverage to facilitate client stability and movement

- Medi-Cal and Short Doyle Authorization for acute hospital payments throughout California
Assessment, Utilization Management & Review

- LOCUS: Level of Care Utilization System
  Deerfield Behavioral Health
  - Risk of Harm
  - Functional Status
  - Medical, Addictive and Psychiatric Co-Morbidity
  - Recovery Environment
    - Sub-scale: A - Stressors
    - B - Supports
  - Treatment and Recovery History
  - Engagement

- Chart Review
- BioPsychosocial Assessment: EMRD90 Form

Factors Considered

- Current state of behavioral health issues
- Recent history
- What has changed
- Treatment readiness
- Recovery & Wellness path
- If unwilling to agree to the Treatment Plan, what is the impact to move them against their will
Residential Care

- 2 types of Facilities:
  - Adult Residential
  - Elderly

- In order to receive DPH subsidy, individuals must have a Representative or Third Party Payee

- Very few non-ambulatory facilities in SF

- Very few delayed egress facilities in SF

- Limiting factors: diabetes management, wound care, oxygen, active substance use, behaviors: aggressive, agitated, intrusive, non-compliance

RCF/E Packet
**Locked/Secure Placement**

**LOCKED**
- Able to participate in treatment but not demonstrating good insight or judgment regarding safe behaviors in an open setting
- Level of cognitive impairment puts the person at high risk for victimization
- Limiting factors: behaviors: aggressive, agitated, intrusive, non-compliance; 1:1

**SECURE**
- Wandering
- Level of cognitive impairment puts the person at high risk for victimization
- Limiting factors: behaviors: aggressive, agitated, intrusive, non-compliance; 1:1

---

**LSAT Checklist**

<table>
<thead>
<tr>
<th>Item</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Client Information (see PSIS)</td>
</tr>
<tr>
<td>2.</td>
<td>Physical Health Status: Mental Health Assessment: Mild to Severe</td>
</tr>
<tr>
<td>3.</td>
<td>Physical Health Status: Physical Health Assessment: None to Severe</td>
</tr>
<tr>
<td>4.</td>
<td>Social History: None to Severe</td>
</tr>
<tr>
<td>5.</td>
<td>Family History: None to Severe</td>
</tr>
<tr>
<td>6.</td>
<td>Past Medical History: None to Severe</td>
</tr>
<tr>
<td>7.</td>
<td>Current Medications: None to Severe</td>
</tr>
<tr>
<td>8.</td>
<td>Allergies: None to Severe</td>
</tr>
<tr>
<td>9.</td>
<td>Mental Health: None to Severe</td>
</tr>
<tr>
<td>10.</td>
<td>Behavioral: None to Severe</td>
</tr>
</tbody>
</table>

---

**Notes:**
- Client Information (see PSIS)
- Physical Health Status: Mental Health Assessment: Mild to Severe
- Physical Health Status: Physical Health Assessment: None to Severe
- Social History: None to Severe
- Family History: None to Severe
- Past Medical History: None to Severe
- Current Medications: None to Severe
- Allergies: None to Severe
- Mental Health: None to Severe
- Behavioral: None to Severe
Conservatorship: LPS

- LPS: Lanterman Petris Short Act
- Governed by California Welfare and Institutions Code
- Designed for persons with serious mental disorders, or who are impaired by chronic alcoholism
- Initiated by a 5150 hold that continues as a 5250 hold
- Individuals receive a 5 day notice to contest the application for LPS Conservatorship during the 5250
- After the 5 days, a Temporary Conservatorship (T-Con) can be issued by the court that lasts approximately 30 days
- A Permanent Conservator (P-Con) hearing is then held in court. If issued, the P-Con lasts for 1 year
- Clients have the right to contest the P-Con every 30 days

Conservatorship: Probate

- 2 types
  - Person only; can also include Dementia Powers
  - Estate only
- Governed by the California Probate code
- Designed for people who are gravely disabled and/or unable to appropriately manage their finances
- Individuals receive notice at least 15 days before the Court Hearing
- If a Temporary Conservatorship is being pursued, the individual must receive notice 5 days before the Court date
- Temporary Conservatorship lasts 30 days
- A Court Investigator interviews the individual prior to the Court Hearing
- Probate Conservatorships are very difficult to remove
Medical Probate

- Governed by the California Probate Code Section 3200
- Allows a "Health Care Institution" to make health care decisions for a client who lacks capacity but is not yet conserved
- Completed by the Doctor and the City Attorney

Conservatorship Information

- San Francisco Department of Aging and Adult Services 355-3555
**Substance Abuse Treatment**

- Residential
- Outpatient
- Referrals are processed through the Behavioral Health Access Center
- Use the same Placement Authorization Referral Form
- FAX to: 255-3629

---

**Placement Quick Reference**

<table>
<thead>
<tr>
<th>LEVEL OF CARE</th>
<th>Disposition Options</th>
</tr>
</thead>
<tbody>
<tr>
<td>24h Supervision Locked/Secure</td>
<td>[Involuntary] LSAT: LPS only, Aids/Chronic</td>
</tr>
<tr>
<td></td>
<td>[Involuntary] Secure SNAP: LPS or Probate</td>
</tr>
<tr>
<td></td>
<td>Medically frail, retractable TBI</td>
</tr>
<tr>
<td>24h Supervision Open Unit Shf</td>
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*not required for LOC: if checked, it can impact the number of options; lack of entitlements limit placement to within SF and very unlikely to receive pending probable/limited placement to within SF few facilities in SF take wholebody/armchair

(IDOA) client must be able to self-inject for unsecured LOC
LTC Looking Forward

- Approach client flow with a long range view to maximize opportunity for stability

- Promote Recovery and Wellness to encourage maximum independence

- Continue to develop relationships with community partners to streamline process and contain costs

CONCLUSION

The Placement Team
thanks you
for your continued support!
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Total Dollars spent*    $1,779,614.64      $1,772,278.32     $1,721,028.46      $1,738,778.19      $1,664,327.45     $1,708,712.23     $1,681,694.84     $1,541,339.44     $1,664,767.54     $1,653,423.86     $1,643,392.58     $1,613,857.41     $29,264,971.78     $8,964,795.06     $11,210,156.00     $9,348,749.06     $11,210,156.00     $2,002,411.00

*Actual payment for Chestnut, NeuroBehavioral, all RCF homes and annual average of Canyon Manor contract award, not include State Hospital

Prepared by Valerie Lai

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**Note:** The table provides financial data for various facilities and departments, including the total dollars spent, total employees, and other financial metrics. The data is organized by month and includes various facilities such as Plymouth, Peabody, Attlester, States Hospital Total, Cape Cod Island Hospital, Chequesset Bay Hospital, Chestnut Health Plan, Chestnut Health System, Chestnut Health Plan CA, Chestnut Merchant, Chestnut University Health System, Chestnut Valley SNF, Chestnut Valley Total, Chestnut Hosp, Our House, American River Hospital, Subtotal, Out of county total, UHMC, SNF, Subtotal, RCF & LFH total, RCF, Total, CLS total, Grand total, and Total Dollars spent. The table covers different locations such as Plymouth, Peabody, Attlester, States Hospital Total, Cape Cod Island Hospital, Chequesset Bay Hospital, Chestnut Health Plan, Chestnut Health System, Chestnut Health Plan CA, Chestnut Merchant, Chestnut University Health System, Chestnut Valley SNF, Chestnut Valley Total, Chestnut Hosp, Our House, American River Hospital, and includes a subcategory for RCF & LFH total, with subcategories for RCF and Total. The financial metrics include total dollars spent from $1,779,614.64 to $29,264,971.78, with specific details for each month and location.
San Francisco Behavioral Health Center
September, 2015

PRIOR STATE

THIRD FLOOR: Mental Health Rehabilitation Center
SECOND FLOOR: Neurobehavioral Skilled Nursing Facility
FIRST FLOOR: Adult Residential Facility (ARF)
[Seneca Group Home occupied part of the floor until giving up their lease in May, 2012]

CURRENT STATE

THIRD FLOOR: Mental Health Rehabilitation Center
- Recent influx of returns from State Hospital and a high number of Misdemeanor Incompetent to Stand Trial referrals from Jail.

SECOND FLOOR: Residential Care Facility for the Elderly (60+ years old)
- Opened December 8, 2014

FIRST FLOOR: Adult Residential Facility (18-59 years old)
- Hummingbird Place, a Psychiatric Respite
  - Unlicensed program
  - Hybrid staffing of Peers and CNAs; Peers paid through MHSA
  - Staff trained in Intentional Peer Support, SMART and WRAP
  - See Brochure and Program Calendar
There is a gap service area for people who are not yet accepting of the need to manage their mental health symptoms/ issues in a more productive and healthy manner and people who would benefit from a supervised setting to monitor medication changes after an inpatient stay. SFHN Transitions in collaboration with CBHS and MHSA is developing the program and launch of a hybrid Peer + Clinical Staff Model Psychiatric Respite that can provide a safe place for these identified individuals to rest and re-group before returning home. Referrals will be a closed system open only to SFGH Psychiatry, Community Mental Health Treatment Programs (Progress and Baker), SF HOT and Intensive Case Management programs. At Respite, they can have 1:1 Peer support, access to Recovery and Wellness conversation, activities and programs in a home-like environment. The programs will not be mandatory. Average length of stay is anticipated to be 3-5 days with a maximum stay of 14 days. Medications will be kept in a centralized area for safekeeping. CNAs will be able to provide reminders, education and support to maintain medication compliance.

- Peers to staff the program are trained in a variety of mental health and substance counseling techniques
- CNAs formerly with the BHC SNF will be returning as clinical staff
- Open Houses for Hummingbird Place will take place April 13-15
- Soft Opening April 20: will trial with 5-8 actual clients
- Identifying Participants for the Pilot
  - We are initially targeting people who are appropriate to ADU but decline to do the programming. We will ask Stephanie Twu, Progress Foundation Evaluator, to refer people from PES in addition to people she assesses on the inpatient unit.
  - We will identify PES High Users who rarely meet eligibility for admit and could use the Respite model appropriately
  - Those recommended by Intensive Care Managers who can appropriately use Hummingbird Place as part of their Treatment Plan
- Will expand the number of day participants and begin overnights through summer
  - Maximum 4 overnight guests and 10-15 participants for day use, depending on Peer staff levels

CURRENT STATUS

- Telephones are installed and working. Main number assigned: 415-206-2855
- Access to computer network established. Working on establishing wifi
- First Open House went successfully with visitors from SFHOT and SFGH UM and others

PARTICIPATING STAFF

Marlo Simmons, MHSA Director
- MHSA provided a Facilitator to lead the Peers in the program development
- MHSA provided funds for furnishings, appliances and supplies

Charlie Mayer, CBHS Director of Consumer Employment
Tracey Helton, CBHS Consumer Employment Manager
- Lead on Program Development and Peer Supervision

Jennie Hua, CBHS Director of Vocational Rehab Services
- Lead on the Program Facility Design

Sharon McCole-Wicher, Director of SF Behavioral Health Center
Kelly Hiramoto, Director of Transitions
- Program Directors
Staff Bios:

**Talon Dempo** is a certified Wellness Recovery Action Plan trainer, and group facilitator. He is a 2014 graduate of the Peer Specialist Mental Health Certificate Program and he has been working with the recovery community at 1380 Howard St. as a Peer Navigator for two years. He loves art, music, yoga and surfing. He also likes to practice spirituality, exercise and eat healthy food.

**Mark Ostergard** is a San Francisco native with two grown kids and a colorful past giving him experience that he can share with others. He is a 2014 graduate of the Peer Specialist Mental Health Certificate Program and he has been working with the Dual Recovery community for the past four years.

**Melanie Brandt** is a 2013 graduate of the Peer Specialist Mental Health Certificate Program. She has been working at Sunset Mental Health as a Peer Counselor for the past year and a half. Prior to that she facilitated groups with the Dual Recovery Program throughout San Francisco. She draws from her experiences and help peers to realize they are not alone.

**Seth Watkins** graduated The Peer Mental Health Specialist Certificate course in 2010. In the past five years Seth has worked as a Peer Counselor for BHS's Dual Recovery Program, UCSF Citywide Case Management and RAMS, PAES Program. In 2014 BHS hired him as a Peer Counselor for the Peer Respite Program. Helping others is his passion as a Peer Counselor.

**Kristina Wallace** is a native who grew up in Potrero Hill. She graduated from Walden House Recovery Program in 2008 and she went on to work at their Dual Diagnosis program for three years. She began to work at 1380 Howard St. as a System Navigator in 2014 and was promoted to a Peer Counselor position at The Peer Respite. Her passion is working with the hard to serve and homeless populations.

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Hummingbird
Place
Peer Respite

887 Potrero Ave
San Francisco, CA
94110
1 415 206-2855
Hummingbird Place

The Peer Respite is a peer-led safe space that offers connection and breathing room to those in need of a healing space and support with their path towards wellness.

This respite space operates under the Wellness and Recovery model and primarily serves individuals that may be in a pre-contemplative stage or may need help using alternative support to urgent/emergent care.

Objective

To provide services at the most appropriate and least restrictive level of care that promotes wellness and healthy activities.

Non-judgmental

We aim to be a safe haven from the stigma, shame, judgment, and fear surrounding mental illness and substance use that our guests may experience from the world outside our doors on a daily basis.

We believe everyone has the right to make mistakes—and learn from them—without being criticized, shamed and bullied. We work to meet individuals where they are at!

Holistic and Individualized

Our approach expands the standard view of wellness into an integrated approach that focuses on the whole individual, rather than on a collection of symptoms.

Peer-led wellness activities

Will include daily support:
- Art
- Gardening
- Recreation
- Wellness Recovery Action Plan (WRAP) groups

The Peer Respite leaves room in the day for guests to simply relax in a quiet space.

Eligibility

ICM & FSP Case Management
Referred
- Individuals who may be in a pre-contemplative stage
- Individuals with anxiety
- Individuals who rely on hospital resources for a safe space
- Individuals who have a place to go after the respite
- People must have place to live at end of day.

Hummingbird Place, Peer Respite
887 Potrero Ave, San Francisco CA
1 415 206-2855

Day Program available

11 AM—7 PM
Option to stay overnight starting in late spring
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<td>Private Owner</td>
<td>730 Eddy Street</td>
<td>94102</td>
<td>86</td>
<td>86</td>
<td></td>
<td></td>
<td></td>
<td>DPH-HUH</td>
<td>DISH</td>
<td>Homeless seniors 55+ with special needs</td>
<td>Master-leased SRO Bldg.</td>
</tr>
<tr>
<td>1</td>
<td>Feb-01</td>
<td>Brodenick Street Residential Care Facility</td>
<td>Private Owner</td>
<td>1421 Broderick St.</td>
<td>94115</td>
<td>33</td>
<td>33</td>
<td></td>
<td></td>
<td></td>
<td>RAMS</td>
<td>RAMS</td>
<td>Homeless patients leaving institutions with mental and/or physical health needs</td>
<td>Licensed Residential Care Facility; Master-leased by HUH.</td>
</tr>
<tr>
<td>1</td>
<td>Oct-02</td>
<td>Camelot</td>
<td>Private Owner</td>
<td>124 Turk St.</td>
<td>94102</td>
<td>55</td>
<td>55</td>
<td></td>
<td></td>
<td></td>
<td>DPH-HUH</td>
<td>DISH</td>
<td>Homeless adults w/special needs</td>
<td>Master-leased SRO Bldg.</td>
</tr>
<tr>
<td>1</td>
<td>Jan-03</td>
<td>Star</td>
<td>Private Owner</td>
<td>2176 Mission St.</td>
<td>94110</td>
<td>54</td>
<td>54</td>
<td></td>
<td></td>
<td></td>
<td>DPH-HUH</td>
<td>DISH</td>
<td>Homeless adults w/special needs</td>
<td>Master-leased SRO Bldg.</td>
</tr>
<tr>
<td>1</td>
<td>Apr-04</td>
<td>Civic Center Residence</td>
<td>TNDC</td>
<td>44 McAllister</td>
<td>94102</td>
<td>204</td>
<td>60</td>
<td></td>
<td></td>
<td></td>
<td>TNDC</td>
<td>TNDC</td>
<td>Homeless seniors 55+ with special needs</td>
<td>Affordable housing site; Remodeled efficiency units.</td>
</tr>
<tr>
<td>1</td>
<td>Jul-04</td>
<td>Empress</td>
<td>Private Owner</td>
<td>144 Eddy St.</td>
<td>94102</td>
<td>89</td>
<td>89</td>
<td>75</td>
<td></td>
<td></td>
<td>DPH-HUH</td>
<td>DISH</td>
<td>Chronically Homeless* w/special needs</td>
<td>Master-leased SRO Bldg; HUH med. services on site.</td>
</tr>
<tr>
<td>1</td>
<td>Oct-04</td>
<td>West</td>
<td>TNDC</td>
<td>141 Eddy St.</td>
<td>94102</td>
<td>104</td>
<td>40</td>
<td></td>
<td></td>
<td></td>
<td>TNDC</td>
<td>TNDC</td>
<td>Homeless seniors 55+ with special needs</td>
<td>Affordable housing site; Mod. SRO rehab.</td>
</tr>
<tr>
<td>1</td>
<td>Mar-05</td>
<td>Folsom/Dore</td>
<td>TNDC</td>
<td>75 Dore Alley</td>
<td>94102</td>
<td>98</td>
<td>40</td>
<td></td>
<td></td>
<td>33</td>
<td>LSS</td>
<td>TNDC</td>
<td>Chronically Homeless* w/special needs; 13 HUD funded units</td>
<td>New construction, Affordable housing site; LSS is contracted to serve 40 units (20 DAH plus 20 S/C).</td>
</tr>
<tr>
<td>1</td>
<td>Dec-05</td>
<td>Plaza</td>
<td>PAA</td>
<td>988 Howard St.</td>
<td>94102</td>
<td>106</td>
<td>106</td>
<td></td>
<td></td>
<td></td>
<td>Conard House</td>
<td>JSCo</td>
<td>Homeless adults w/special needs</td>
<td>New construction (developed by PIDC, subsidiary of SFRA); highly staffed with support services team and HUH medical services on site.</td>
</tr>
<tr>
<td>1</td>
<td>Feb-06</td>
<td>Mission Creek Senior Community</td>
<td>Mercy Housing California</td>
<td>225 Berry St.</td>
<td>94158</td>
<td>139</td>
<td>51</td>
<td></td>
<td></td>
<td></td>
<td>Mercy Services</td>
<td>Mercy</td>
<td>Frail homeless seniors 62+ with special needs</td>
<td>New construction, 1 BR units. Stepping Stone Adult Day Health Center on site DAH clients prioritized if eligible.</td>
</tr>
<tr>
<td>1</td>
<td>Jul-06</td>
<td>Arlington Residence</td>
<td>Mercy Housing California</td>
<td>480 Ellis St.</td>
<td>94102</td>
<td>153</td>
<td>103</td>
<td></td>
<td></td>
<td></td>
<td>Mercy</td>
<td>Mercy</td>
<td>Homeless Adults w/special needs; 24 Homeless Chronic Alcoholics*</td>
<td>SRO Mod. Rehab. Mini-Efficiency Units w/private baths and kitchenettes. A turn-over of 5 units/per FY will bring the total DAH units to 153 by 2026.</td>
</tr>
<tr>
<td>1</td>
<td>Jul-06</td>
<td>Bayanihan House</td>
<td>TODCO</td>
<td>88 6th St.</td>
<td>94103</td>
<td>152</td>
<td>10</td>
<td>10</td>
<td></td>
<td></td>
<td>TODCO</td>
<td>JSCo</td>
<td>Homeless Chronic Alcoholics*</td>
<td>Affordable housing provider; remodeled SRO building.</td>
</tr>
<tr>
<td>1</td>
<td>Aug-06</td>
<td>Eddy Street Apartments</td>
<td>CATS</td>
<td>425 Eddy St.</td>
<td>94109</td>
<td>25</td>
<td>15</td>
<td></td>
<td></td>
<td></td>
<td>CATS</td>
<td>CATS</td>
<td>Homeless Chronic Alcoholics*</td>
<td>Studios and 1 BR units.</td>
</tr>
<tr>
<td>1</td>
<td>Aug-06</td>
<td>Hotel Isabel</td>
<td>TODCO</td>
<td>1095 Mission St.</td>
<td>94103</td>
<td>72</td>
<td>4</td>
<td></td>
<td></td>
<td></td>
<td>TODCO</td>
<td>JSCo</td>
<td>Homeless Chronic Alcoholics*</td>
<td>Affordable housing provider; remodeled SRO building.</td>
</tr>
<tr>
<td>1</td>
<td>Aug-06</td>
<td>Knox Apartments</td>
<td>TODCO</td>
<td>241 6th St.</td>
<td>94103</td>
<td>140</td>
<td>15</td>
<td></td>
<td></td>
<td></td>
<td>TODCO</td>
<td>JSCo</td>
<td>Homeless Chronic Alcoholics*</td>
<td>Affordable housing provider; remodeled SRO building.</td>
</tr>
<tr>
<td># of Blgs</td>
<td>Opening Date</td>
<td>Building Name</td>
<td>Owner</td>
<td>Street Address</td>
<td>Zip Code</td>
<td>DAH Total Units</td>
<td>DAH Unit Count</td>
<td>HUD Unit Count</td>
<td>Unit Count*</td>
<td>Support Services</td>
<td>Property Management</td>
<td>DAH Population</td>
<td>Special Features</td>
<td></td>
</tr>
<tr>
<td>----------</td>
<td>--------------</td>
<td>--------------------------------</td>
<td>--------------</td>
<td>-----------------------------------------</td>
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<td>---------------</td>
<td>-------------------</td>
<td>---------------------</td>
<td>-------------------------------</td>
<td>--------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>1</td>
<td>Aug-06</td>
<td>William Penn Hotel</td>
<td>CCDC</td>
<td>160 Eddy St.</td>
<td>94102</td>
<td>94</td>
<td>10</td>
<td>10</td>
<td>CCDC</td>
<td>CCDC</td>
<td>Homeless Chronic Alcoholics*</td>
<td>Affordable housing provider; remodeled SRO building.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>May-07</td>
<td>Dalt, Ritz, and Ambassador**</td>
<td>TNDC</td>
<td>Dalt: 34 Turk St. Ritz: 216 Eddy St. Ambassador: 55 Mason St.</td>
<td>94102</td>
<td>399</td>
<td>21</td>
<td>21</td>
<td>TNDC</td>
<td>TNDC</td>
<td>Homeless MHSA 63 clients</td>
<td>Affordable housing provider; remodeled SRO building.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>Mar-08</td>
<td>Cambridge</td>
<td>CHP</td>
<td>473 Ellis St.</td>
<td>94102</td>
<td>59</td>
<td>5</td>
<td>5</td>
<td>CCDC</td>
<td>CCDC</td>
<td>Homeless seniors (50y+)</td>
<td>Affordable housing provider; remodeled SRO building.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>Mar-08</td>
<td>Parkview Terrace Apartments</td>
<td>AF Evans/CCDC</td>
<td>871 Turk St.</td>
<td>94102</td>
<td>101</td>
<td>20</td>
<td>20</td>
<td>NCPHS</td>
<td>A.F. Evans</td>
<td>Chronically homeless* Seniors 55+ with special needs; 10 S+C</td>
<td>New construction; 1 BR and studio units. All 20 units have S+C subsidy. 10 HSA referred to DART and 10 DART reviewed for S+C eligibility by HSA.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>Jul-08</td>
<td>Mosaica</td>
<td>TNDC</td>
<td>680 Florida St.</td>
<td>94110</td>
<td>151</td>
<td>11</td>
<td>11</td>
<td>LSS</td>
<td>TNDC</td>
<td>Homeless seniors 62+ with special needs</td>
<td>New construction; studios and 1 BR units. HUH medi. services on site. The 10 HSA units have LOSP.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>Nov-08</td>
<td>990 Polk Street</td>
<td>TNDC</td>
<td>990 Polk St.</td>
<td>94109</td>
<td>110</td>
<td>50</td>
<td>50</td>
<td>LSS</td>
<td>TNDC</td>
<td>Homeless seniors 55+; 10 MHSA Prop 63</td>
<td>New construction. Referrals will come from Glide and DPH. Medical services provided by Glide Comm. Clinic.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>Mar-10</td>
<td>149 Mason Street</td>
<td>GEDC</td>
<td>149 Mason St.</td>
<td>94102</td>
<td>56</td>
<td>55</td>
<td>55</td>
<td>GHC</td>
<td>EPMI</td>
<td>Homeless adults w/special needs</td>
<td>New construction. 11 LOSP and 16 PRAC units; all DAH/HUD unit applicants need to be documented. All pay third of income in rent.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>Aug-10</td>
<td>Edith Witt Senior Community</td>
<td>Mercy Housing California</td>
<td>66 - 9th Street</td>
<td>94103</td>
<td>107</td>
<td>27</td>
<td>11</td>
<td>CCCYO</td>
<td>Mercy</td>
<td>Homeless seniors 62+ with special needs;</td>
<td>New construction. 11 LOSP and 16 PRAC units; all DAH/HUD unit applicants need to be documented. All pay third of income in rent.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>Mar-11</td>
<td>Armstrong Place Senior Housing</td>
<td>Bridge/Providence</td>
<td>5600 - Third Street</td>
<td>94124</td>
<td>116</td>
<td>23</td>
<td>23</td>
<td>Providence Foundation</td>
<td>Bridge</td>
<td>Homeless seniors 62+ with special needs</td>
<td>New construction. First DAH site in the Bayview. Non-smoking building. One block from SEHC.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>Mar-11</td>
<td>Coronet Senior Housing</td>
<td>Bridge</td>
<td>3575 Geary St.</td>
<td>94118</td>
<td>150</td>
<td>25</td>
<td>25</td>
<td>IOA</td>
<td>Bridge</td>
<td>Homeless seniors 55+ with severe disabilities; must be PACE eligible</td>
<td>New construction. IOA w/ADHC and PACE Center in commercial space. Building has 50 PACE units, 25 of which are set-aside for DAH.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>Aug-11</td>
<td>Dolores Hotel/Casa Quezada</td>
<td>Dolores Street Community Services (DSCS)</td>
<td>35 Woodward St.</td>
<td>94103</td>
<td>53</td>
<td>53</td>
<td>53</td>
<td>DSCS/MNRC</td>
<td>DSCS</td>
<td>Homeless Adults w/special needs</td>
<td>Mod. Rehab of Dolores Hotel. 50% referred by DSCS and MNRC.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>Sept-11</td>
<td>JJ Richardson Apartments</td>
<td>Community Housing Partnership/Mercy Housing California</td>
<td>365 Fulton Street</td>
<td>94102</td>
<td>120</td>
<td>120</td>
<td>108</td>
<td>UCSF - Citywide Case Mgmt.</td>
<td>Bridge</td>
<td>Homeless Adults w/special needs;</td>
<td>New construction. The 12 MHSA units have MHSA subsidy.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
# of Blgs | Opening Date | Building Name | Owner | Street Address | Zip Code | Total Units Count | DAH Unit Count | Unit Count a | HUH Unit Count | Unit Count b | Support Services | Property Management | DAH Population | Special Features |
---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
1 | Nov-12 | Veterans Common | CSCC/Swords to Plowshares | 150 Otis Street | 94103 | 76 | 8 | 8 | Swords to Plowshares | Swords to Plowshares | Homeless Vets; 8 MHSA Prop 63 | HSA building. The 8 MHSA units have S+C subsidies; referred directly by HSA. |
1 | Jan-13 | Kelly Cullen Community | TNDC | 220 Golden Gate Ave. | 94102 | 172 | 172 | 155 | TNDC/ HUHC | TNDC | Homeless Adults w/special needs; 17 MHSA Prop 63 | TWUH Clinic & Wellness Center in Commercial space. Mod. Rehab. 17 MHA units have MHSA subsidy. |
1 | Jan-13 | Mary Helen Rogers Community | CCDC/URBAN CORE, LLC | 701 Golden Gate Ave. | 94102 | 100 | 20 | 20 | NCPHS | CCDC | Chronically homeless; Seniors 55+ with special needs; all S+C | New construction; 1 BR and studio units. All 20 units have S+C subsidy. 10 HSA referred to DART and 10 DART reviewed for S+C eligibility by HSA. |
1 | Dec-13 | Rene Cazenave Apartments (formerly Transbay Block 11A) | Bridge/CHP | 25 Essex Street | 94105 | 120 | 120 | 110 | UCSF - Citywide | CHP | Homeless Adults w/special needs; 9 HOPWA requirements & 10 MHSA requirements. | New construction at Folsom and Essex; 9 HOPWA units; 10 MHSA units with MHSA subsidies. |
1 | Sept-14 | Vera Haile aka 121 Golden Gate Senior Community | Mercy Housing California | 121 Golden Gate | 94102 | 90 | 18 | 3 | Mercy | Mercy | Homeless Seniors 62+ with special needs | Project has enough HUD 202 project subsidies for 15 DAH units; only 3 LOSP subsidies are needed. Also has 8 HOPWA units. Smoke-free property. All DAH/HUD unit applicants need to be documented. |
| **36 BUILDINGS** | | | | | | **3750** | **1685** | **611** | **253** | **83** | **83** | **83** | **83** | **83** | **450** | **1235** | **1685** |
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**Portfolio Key**
* Chronically homeless according to HUD definition. Chron A Units are for chronic inebriates. Case Management provided by SF FIRST ICM and other ICM teams.
^ LOSP = Local Operating Subsidy Program. Funded via SF request from DPH; LOSP agreement between developer and MOH.
**MHSA = Mental Health Services Act funded units. Intensive Case Management provided by Full Service Partnership.
***The allocation of contracted units between buildings is not defined. In terms of total building units, the Ritz has 88, the Dalt 177, and the Ambassador 134. All DAH units are also supported by tenant rent contribution. For more information on the DAH program, please go to www.sfdph.org."Our Programs" & "Direct Access to Housing."
<table>
<thead>
<tr>
<th># of Blgs</th>
<th>Projected Rent-Up Start Date</th>
<th>Name of Building</th>
<th>Owner</th>
<th>Street Address</th>
<th>Zip Code</th>
<th>Total # of Units</th>
<th># of DAH Units</th>
<th>Support Services</th>
<th>Property Management</th>
<th>DAH Population</th>
<th>Special Features</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Sept 2015</td>
<td>Carroll Avenue Senior Housing (5800 Third Street)</td>
<td>Bayview Supportive Housing LLC</td>
<td>1751 Carroll Avenue</td>
<td>94124</td>
<td>121</td>
<td>23</td>
<td>Bayview Hunter's Point Multipurpose Senior Center</td>
<td>TBD (an affiliate of McCormack Baron Salazar)</td>
<td>Homeless Seniors 62+ with special needs</td>
<td>New construction; mostly one bedroom and a few two bedroom units; enough HUD project based section eight subsidies for all units; i.e., all DAH unit applicants need to be documented.</td>
</tr>
<tr>
<td>1</td>
<td>Feb 2016</td>
<td>Rosa Parks II</td>
<td>TNDC</td>
<td>1251 Turk</td>
<td>94115</td>
<td>98</td>
<td>20</td>
<td>TNDC</td>
<td>TNDC</td>
<td>Homeless Seniors 62+ with special needs</td>
<td>New construction in front of Rosa Parks Housing Authority site; enough HUD 202 project subsidies for all units; i.e., all DAH unit applicants need to be documented.</td>
</tr>
</tbody>
</table>

|          | **TOTALS**                  |                  |           |            |        | 219             | 43            |                  |                  |                |                 |

**Portfolio Key**

* Chronically homeless according to HUD definition.

^ LOSP = Local Operating Subsidy Program. Funded via GF request from DPH; LOSP agreement between developer and MOH.

**MHSA = Mental Health Services Act funded units.

All DAH units are also supported by tenant rent contribution.

For more information on the DAH program, please go to www.sfdph.org→"Our Programs"→"Direct Access to Housing."
Section Report for the
San Francisco Health Commission
June 16, 2015

Margot Antonetty, Acting Director
1. Overview of Housing and Urban Health

Housing and Urban Health (HUH) is a section within the Transitions Division of the Department of Public Health’s SF Health Network. The goal of the section is to develop community-based residential options for people who have experienced homelessness as well as people who have had intermittent or extended hospitalizations. For this population, access to housing with on-site services (supportive housing) is an essential element to regaining and maintaining stability and improved health status. Conversely, without access to supportive housing, homeless persons dealing with complex medical and behavioral health issues will more often than not, find themselves in a costly and destructive cycle of living on the streets, in shelter, residential treatment, hospitalization and long-term care facilities. Since 1999, HUH has been partnering with other city agencies, non-profits, and private property owners to deliver a range of housing settings geared toward residential stabilization, improved health status, and reintegration into various San Francisco neighborhoods.

HUH has developed many different types of housing typologies to meet the varying needs of homeless clients with special needs as well as the discharge demands of other sections within the Health Department. For example, the Department’s homeless outreach team, SFHOT, has the need for immediate placement options for people coming off the street. For that purpose, HUH, has secured several hundred “stabilization rooms”. On the other end of the spectrum, the section has developed the Direct Access to Housing (DAH) program, which provides almost 1,700 units of permanent supportive housing (PSH) that provide long-term stable housing for persons who are currently homeless and/or moving from a different level of care, including Laguna Honda Hospital or the SFHOT stabilization program, discussed above. The chart below summarizes the different housing types that HUH has developed and currently operates:

<table>
<thead>
<tr>
<th>Housing Type</th>
<th>Total Units/Beds</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stabilization Housing</td>
<td>~350 max.</td>
<td>Blocks of rooms in private SROs for short-term stays to gain basic stability with the support of intensive case management teams, incl. SFHOT</td>
</tr>
<tr>
<td>Transitional Housing</td>
<td>104</td>
<td>Medium stay housing, population specific, intensive on-site services</td>
</tr>
<tr>
<td>HIV Housing Subsidies</td>
<td>690</td>
<td>Tenant based rental subsidies that allow persons with HIV/AIDS to rent units in the private market</td>
</tr>
<tr>
<td>Permanent Supportive Housing</td>
<td>1,685</td>
<td>Multi-unit buildings that include on-site health and support services; the Direct Access to Housing program</td>
</tr>
<tr>
<td>Scattered-Site LHHRSP</td>
<td>150</td>
<td>Scattered-site housing with wrap around services for people discharged from LHH (another 150 clients live in DAH sites)</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>2,979</strong></td>
<td></td>
</tr>
</tbody>
</table>
The remainder of this report will highlight two HUH programs that deliver permanent housing to clients of the Health Department in very different ways but achieve the same objective of providing healthy, safe housing with access to services to promote stability and improved health and well-being.

2. Direct Access to Housing linked to Affordable Housing (Pipeline Housing)

During the last ten years, HUH has been focusing on the housing production method often referred to as “Pipeline Housing”. This approach involves partnering with the city’s affordable housing production agencies (the Mayor’s Office of Housing and Community Development and SF Housing Authority) and non-profit affordable housing developers. In doing so, DPH benefits greatly from the financial and development expertise these partners bring to the table and at the same time secures high quality housing in beautiful new developments that include high levels of disabled access and other amenities critical to housing persons transitioning from higher levels of care and homeless persons with complex medical issues. These pipeline projects are generated by Requests for Proposals (RFPs) put out by the housing agencies with DPH as a collaborating partner. The projects are mostly new construction sites but also include acquisition and major rehabilitation of existing buildings. Some projects are designated as 100% supportive housing while others are a mix of supportive housing and traditional affordable housing for low-income San Franciscans. The “deal” that is struck between DPH and the housing developers is that in exchange for access to the units (meaning DPH refers the tenants) the Department provides the project with an operating subsidy and services funding. The main barrier developers have in providing supportive housing is that the project cannot support basic operational costs based on the rent that indigent or very low income clients pay, and therefore, the project needs an operating subsidy; generally, in the range of $400-$800 per unit per month. Additionally, since DPH is generally placing clients with long histories of homelessness, substance use, mental illness, and other chronic health issues, the development requires some level of on-site services to help maintain the stability of clients which DPH provides, either through a contract with a support service provider or directly with DPH civil services staff. The total monthly funding for a DAH unit averages $1,500 per month, including all support services and property management/operating costs. This is about the same amount as two SFGH ED visits, one SFGH inpatient day, or four days in a Mental Health or Substance Use treatment program.

Outcomes
The impact of supportive housing on medically disabled homeless individuals in terms of housing stability, medical care use and associated cost is highlighted in pre-post test evaluations.

- At the Plaza (rent-up in December 2005), the overall cost for 106 formerly homeless residents decrease from over $3.1 million the year before moving into PSH to over $900,000 the year after moving into PSH. This is a savings of approximately $2.3 million
in healthcare costs. After reducing the annual cost of operations and on-site services of this building, the total savings are about $1.1 million in public funds.\(^1\)

- A study at Mission Creek Senior Community, a mixed building for seniors 62< with 51 (~34%) of the units earmarked for frail homeless seniors referred by DAH, the total reduction in healthcare cost from the year before and the year after moving into the Mission Creek Senior Community (MCSC), was $2.25 million (82%). A majority of those savings occurred at SNFs, since DPH prioritized patients “stuck” on that level of care for housing at MCSC. SNF use for all 51 residents went from 3,842 days the year before to 533 days the year after moving into PSH. Additionally, ED visits, inpatient days and psych inpatient days all decreased by at least 30%.

Newer research looks at comparison groups, made possible with the implementation of the ACA. The total Cost Offsets for Housing First participants relative to controls averaged $2,449 per person per month after accounting for housing program costs. This is compatible to the before and after cost study at the Plaza where the average savings per person was $21,698. Preliminary results in a local comparison study shows a reduction of about 70% between the group housed in a new DAH PSH site as compared with the control group that was not housed in DAH. It will be interesting to see how those numbers adjust as the study continues.

Examples of pipeline projects include 990 Polk Street in which 50 of the 110 senior units are referred by DAH as well as Dr. Julian and Raye Richardson Apartment, where all 100 units house residents referred by DAH. Here are some projects in teh last seven (7) years.

\(^1\) These numbers only include services inside of the DPH safety net. Information for non-DPH services and costs were not available.
**990 Polk Senior Housing**

- Opened November 2008
- New construction
- Serves homeless seniors (ages 55+)
- 110 total units
- 50 DAH units, 10 of them reserved for persons with severe mental health issues (MHSA)

**Armstrong Place**

- Opened May 2011
- New construction
- Serves homeless seniors (ages 62+)
- 116 total units
- 23 DAH units
The Coronet

- Opened March 2011
- New construction
- Serves homeless seniors (ages 55+), must be PACE eligible
- 150 total units
- 25 DAH units

J.J. Richardson Apartments

- Opened September 2011
- New construction
- Serves homeless adults with special needs
- 120 total units, 12 reserved for persons with severe mental health issues (MHSA)
- 100% DAH

Kelly Cullen Community

- Opened January 2013
- Rehabilitation
- Serves homeless adults with special needs
- 172 total units, 17 reserved for persons with severe mental health issues (MHSA)
- 100% DAH

Rene Cazenave Apartments

- Opened December 2013
- New construction
- Serves homeless adults with special needs
- 120 total units, 10 reserved for persons with severe mental health issues (MHSA)
- 100% DAH
3. Laguna Honda Hospital Rental Subsidy Program (LHHRSP)

The Department has been an innovative leader in producing site based housing through Direct Access to Housing program for many years. Nonetheless, the demand for community placements continues to outstrip the availability of units in our network of supportive housing. Given that reality and our continued desire to provide housing at the least restrictive level of care, the Department began an ambitious project to place up to 500 persons in scattered site housing over five years. The target population of this project includes persons able to be discharged from Laguna Honda Hospital and those persons who meet a skilled nursing level of care but can be diverted to community housing with wrap around services. The project is a joint effort between the Health Department and the Department of Aging and Adult Services with the Health Department responsible for locating and maintaining a network of housing and assisting in identifying and providing appropriate services. As distinct from a DAH-like site based model, this project relies on market rate housing and the deployment of services tailored to individual client necessary to maintain community based housing.

The project got its start in 2008 and has reached its goals this fiscal year. As a result of an RFP, the Department contracted with Brilliant Corners (formerly Brilliant Corners), an innovative non-profit housing agency. Their primary role is to secure (blocks of) units in the private market that are suitable for the target population of this project. In many cases, Brilliant Corners is able to negotiate with owners to allow significant accessibility improvements in units, including the replacement of standard shower/tubs with roll-in showers. Brilliant Corners also plays the important role of liaison between the building owner and tenants. If and when tenant caused difficulties arise at a site, Brilliant Corners is there to problem solve and assure the owner that all necessary measures are being taken. At this point in time, Brilliant Corners has leased approximately 150 units in buildings ranging from Fox Plaza, the Avalon Apartments, and the Fillmore Center. All apartments are self contained units with bath and kitchen. Depending on client need, the units range from studio to two bedroom. On average, the current monthly housing subsidy for the scattered site model is $1,500 per unit per month. Before the housing boom. The average subsidy used to be around $1,000. The photos below provide an example of a few of the housing sites utilized by this project.
Sample Unit Modifications

Before

After

4. Housing and Urban Health Budget Summary

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<th>Personnel (Admin; Support Services and RN Team)</th>
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