City and County of San Francisco

SFDPH Health Services in Permanent Supportive Housing

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Overview

- Permanent Housing Advanced Clinical Services (PHACS)
- Permanent Supportive Housing (PSH) Site-Based Nursing
- Supportive Housing Services funded by SFDPH Behavioral Health Services (BHS)
- Additional SFDPH programs in Permanent Supportive Housing

Permanent Housing Advanced Clinical Services (PHACS)

PHACS is an interdisciplinary team of DPH medical and behavioral health care providers which launched and started seeing clients in March 2022:

- Program was created to meet the complex needs of tenants in PSH in support of their wellness, quality of life, and housing retention and to provide clinical partnership to City-contracted PSH providers.
- Supported as a new initiative in 2022 with Proposition C funding.

Population served:

- PSH population with chronic homelessness and medical vulnerabilities (physical/mental health).
- 650 clients were seen or referred to PHACS in the first year of operation.

Services:

- Recently expanded to 69 buildings, which are home to more than 5,300 residents.
- Offers on-site medical and behavioral health services, linkage to ongoing care, and help with getting benefits and other social services.
- Also provides support to on-site staff from HSH-funded PSH providers, including training, technical assistance, and onsite consultation.

Staffing:

- Fully staffed, PHACS will include 22 staff including NPs, RNs, health workers, behavioral health clinicians, a physician consultant, pharmacist partners, and a training/capacity building coordinator.
- Plan to add more staff as program grows to meet demand.

PHACS Client Story #1

Man in his mid-30's with uncontrolled diabetes, which led to loss of vision in one eye, concern about his sight in his other eye, a partially amputated foot, and severe nerve damage in both feet. Diabetes puts him at high risk for more vision issues, amputations (and further disability), and heart disease. Hadn't seen primary care provider or Ophthalmologist for over a year.
Unable to administer insulin shots and had fired his assigned caregiver.

Referred to PHACS: due to self-neglect stemming from mental health issues, substance use, physical disability, and failed monthly habitability inspections, which was putting him at risk for eviction.

PHACS staff:

- Helped him obtain a culturally congruent caregiver
- Reconnected him with his PC clinic and Ophthalmology clinic – arranged escort and provided bus tokens for transportation to appointments
- Worked with his PCP to change his medication to once a week injection; PHACS administered the shot until his caregiver was trained
- Worked with housing staff and caregiver around expected habitability standards

Outcome: Diabetes is controlled, room passes inspections, case is now closed.

PHACS Client Story #2

Woman in her late 70's with chronic lung disease, memory issues, high blood pressure and cholesterol, degenerative joint disease (ie arthritis), history of bladder cancer, unintentional weight loss

Referred to PHACS: concerns about her cognitive abilities and frailty, owes thousands of dollars in rent (hasn't paid for 3+ years), and habitability concerns.

PHACS staff:

- Referred for neuropsychology evaluation and coordinated escort to appointments
- Coordinated follow up screening for bladder cancer (had missed previous one)
- Connected to in-home support and helped navigate initial conflict with provider
- Coordinated de-lousing, getting laundry done and getting a new mattress
- Connected to a day program (attends two days/week)
- Connected to payee
- Referred to meals on wheels

Outcome: Has payment plan for back rent, passes room passes inspections, stable food, habitable room, continuing to monitor

PHACS Service Provider Connections

Background:

The physical and behavioral health needs of PSH tenants have increased under Coordinated Entry

Resident service providers at PSH sites:

- Feel unsure how to access the health care system
- Do not have access to health information

PHACS staff:

- Identify when tenants already have connections to care
- Identify potentially available resources
- Walk staff through the process of making connections to care

PHACS Service Provider Consultation Story

PSH housing services provider made a PHACS referral for a tenant who reported *"being out of important medicine, doesn't know the names of their medication, and doesn't think they have a medical provider."*

PHACS Health Worker:

- Identified the primary care provider from the electronic health record
- Met with the housing case manager to provide coaching around how to schedule an appointment
- Worked with the housing case manager to identify questions to ask at the appointment
- Provided coaching on ways that the housing case manager could support the tenant around medication management
- Checked in after the appointment

"PHACS helped me know how to connect my tenants to services, they helped me identify questions to ask at the appointment that I wouldn't have thought of, it's like a huge burden has been lifted off my shoulders because I had no idea on who to call to help my tenants obtain medical care."

PHACS referrals

Top 3 reasons for PHACS referrals:

- 38% medical needs
- 30% behavioral needs
- 19% co-occurring medical, mental health, and substance use needs

Referrals received to date in 2023: 106

- 34 (32%) were successfully resolved through consultations/coaching to CBO staff
- 72 (69%) were assigned to PHACS team for assessment/direct services

PHACS workflows:

- Look up historical health information about the tenant, screens for Cal AIM Enhanced Care Management eligibility if not already enrolled
- Connects with CBO staff to obtain background information, helps make an introduction to tenant
- Meets with tenant for engagement and identification of goals
- Creates care plan
- Provides care coordination/direct care
- When goals are met, monitors for ongoing stabilization before closing the case

PHACS Outcomes/metrics planned

- Connection to routine primary care services
- Connection to routine behavioral health services
- Connection to non-medical services (IHSS, etc.)
- Initiation of buprenorphine/connections to methadone or other substance use treatment
- 90% of clients eligible for ECM services are enrolled in ECM
- 90% of eligible clients enrolled in health insurance
- Management of chronic health conditions (eg diabetes, hypertension, HIV)

PSH Site-Based Nursing

Population served:

- Previously chronically homeless individuals housed in HSH-funded PSH
- Population in PSH with highest medical vulnerability (physical/mental health)
- In 2022, served 516 tenants out of 739 total living in 7 buildings served by DPH

Services:

- Now provided in 11 PSH sites (8 DPH, 3 UCSF)
- Onsite nursing services including chronic care management, linkages, medication adherence support, direct nursing care, triage, clinical consultations
- Higher intensity and longer term nursing support than is possible in PHACS model

Staffing:

- Nurse services in 11 PSH buildings (8 DPH, 3 UCSF) ranging from 0.4 FTE to 1.0 FTE per building
- Partner closely with on-site support services

PSH Site-Based Nursing Client Story

Man in his late 50's. Resident of PSH for 2 years, not engaged with onsite services. Behavioral changes noted by property management including wandering hallways and stairwells at night, reports of entering other tenants' units, urinating in shared spaces. Behavior causing risk of eviction.

RN engagement: RN engaged the client, chart review/physical assessment identified the client was unconnected to care and had a history of hepatitis C, end stage liver disease.

Onsite RN intervention:

- RN assessed the concerning behavior to be possibly due to encephalopathy, a symptom of his liver disease
- Linkage to primary care and specialty liver and GI clinic, provided medication adherence support
- Advocacy with property management to pause legal process while linking client to needed medical

Outcome: Hepatitis C treated, stabilized on meds to help manage chronic symptoms, maintained housing, supported by onsite staff and home hospice honoring his wish to die at home

PSH Site-Based Nursing Ongoing goals and Outcomes

- Linkage to, engagement, and ongoing partnership with primary care
- Partnership with onsite support services, and non-medical services (IHSS etc.)
- Harm reduction, overdose prevention, linkage to and support with medication for addiction treatment (buprenorphine)
- Management of chronic health conditions (eg diabetes, hypertension, HIV) through ongoing assessment, education, medication adherence support.
- Support with mental health stabilization through onsite medication adherence support (eg long acting injectables)
- Reduction in unnecessary inpatient hospitalizations and ED visits
- Supporting end-of-life care

Supportive Housing & SFDPH-BHS

	Supportive Housing Program	Mental Health Services Act (MHSA) Supportive Housing Services
Program	Contracted multidisciplinary teams offer mental health services, crisis intervention, and case management.	DPH-funded CBOs provide supportive services, most of which are for adults with serious mental illness (Full-Service Partnership)
Services	• On-site case management • Crisis intervention services	• Supportive behavioral health services • Intensive Case Management through FSP providers • On-site CBO case management
Staffing	SFDPH-BHS contracts with CBOs to provide supportive housing services, which include multidisciplinary teams with case managers, social workers or psychologists, nurses, and psychiatrists/or nurse practitioners	

Additional SFDPH programs in PSH

- **Citywide Roving**
  - Provides behavioral health case management and primary medical and psychiatric care, in collaboration with HSH, for formerly homeless individuals in 28 PSH sites

- **Overdose Prevention**
  - Medications for addiction treatment (MAT) home delivery
  - Post-overdose follow-up
  - Overdose prevention training for staff in PSH
  - Naloxone distribution at housing sites

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Questions?

Thank you.