San Francisco Department of Public Health

Behavioral Health Services Director's Update

March 19, 2024

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Director of Behavioral Health Services and Mental Health SF
San Francisco Department of Public Health

Outline

- System of Care Overview
- Highlights of specific system elements
  - Outpatient Care
  - Residential Care and Treatment Sites
  - Care Coordination
  - Street Care
  - Intensive Outpatient Treatment
  - Coordinated City Response
- Data and Measuring Outcomes
  - Overdose Response Activities
  - Evaluating Health Outcomes

Our Vision, Mission, and Key Strategies

Vision

For all San Franciscans to experience mental and emotional well-being and participate meaningfully in the community across lifespans and generations.

Mission

To provide equitable, effective substance use and mental health care and promote behavioral health and wellness among all San Franciscans.

Behavioral Health Services at a Glance

BHS is both a Medi-Cal (insurance) plan and provider and must adhere to state and federal regulations. Primarily serves SF residents with low incomes through, Medi-Cal, which provides coverage for mild, moderate, and serious mental health and substance use disorders.

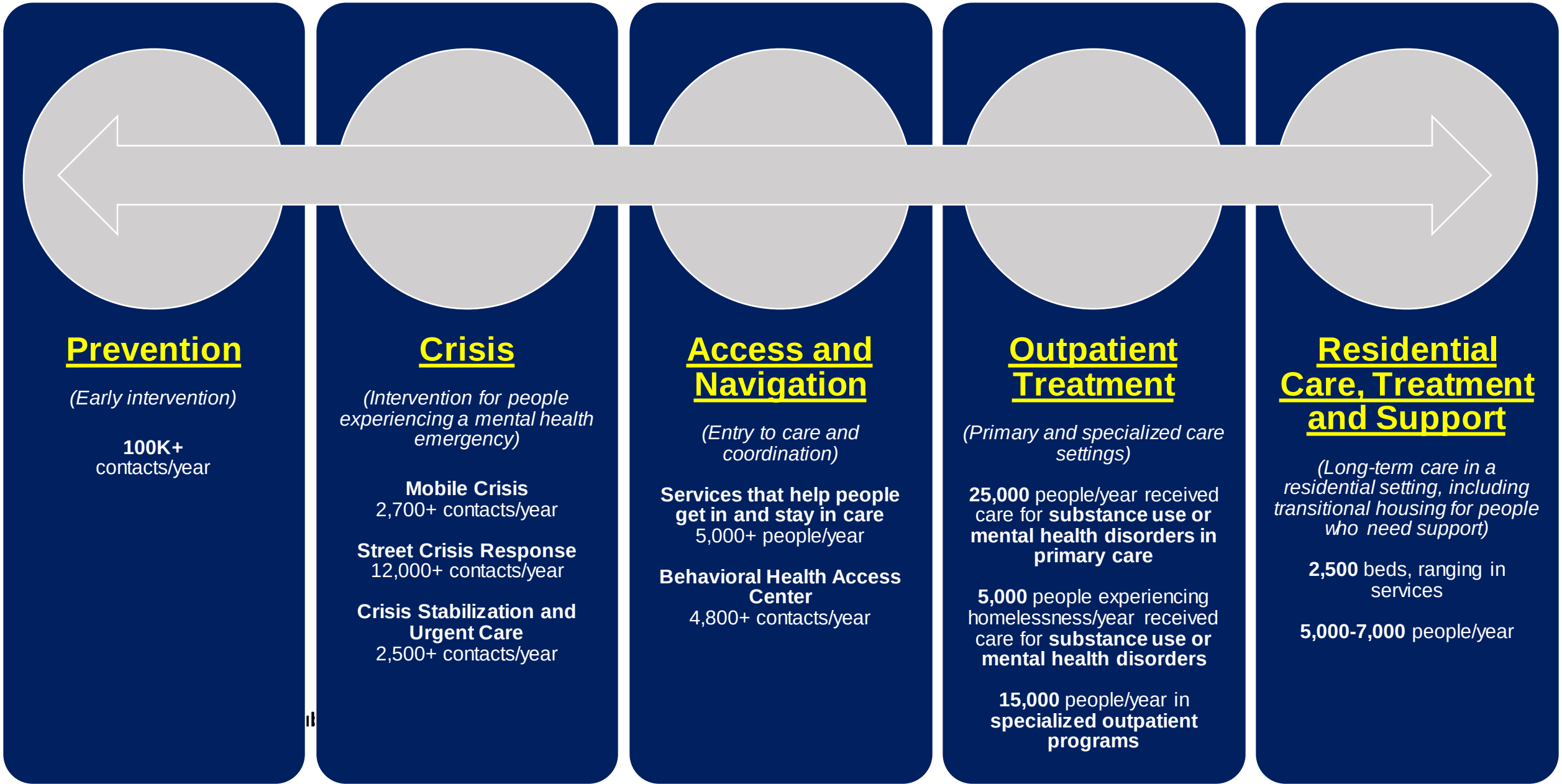
100,000+ connections to prevention, care, and treatment

~21,000 people using Behavioral Health Services in FY 22-23 (Mental Health & Substance Use Disorder)

Top 5 Most Frequent Primary Diagnoses

- Depressive/Mood Disorders
- Substance Use Related Disorders
- Schizophrenic/Psychotic Disorders
- PTSD/“Severe” Stress Reaction
- Anxiety Disorders

Range of Behavioral Health Care Services



Prevention

(Early intervention)

100K+
contacts/year

Crisis

(Intervention for people experiencing a mental health emergency)

Mobile Crisis
2,700+ contacts/year

Street Crisis Response
12,000+ contacts/year

Crisis Stabilization and Urgent Care
2,500+ contacts/year

Access and Navigation

(Entry to care and coordination)

Services that help people get in and stay in care
5,000+ people/year

Behavioral Health Access Center
4,800+ contacts/year

Outpatient Treatment

(Primary and specialized care settings)

25,000 people/year received care for **substance use or mental health disorders in primary care**

5,000 people experiencing homelessness/year received care for **substance use or mental health disorders**

15,000 people/year in **specialized outpatient programs**

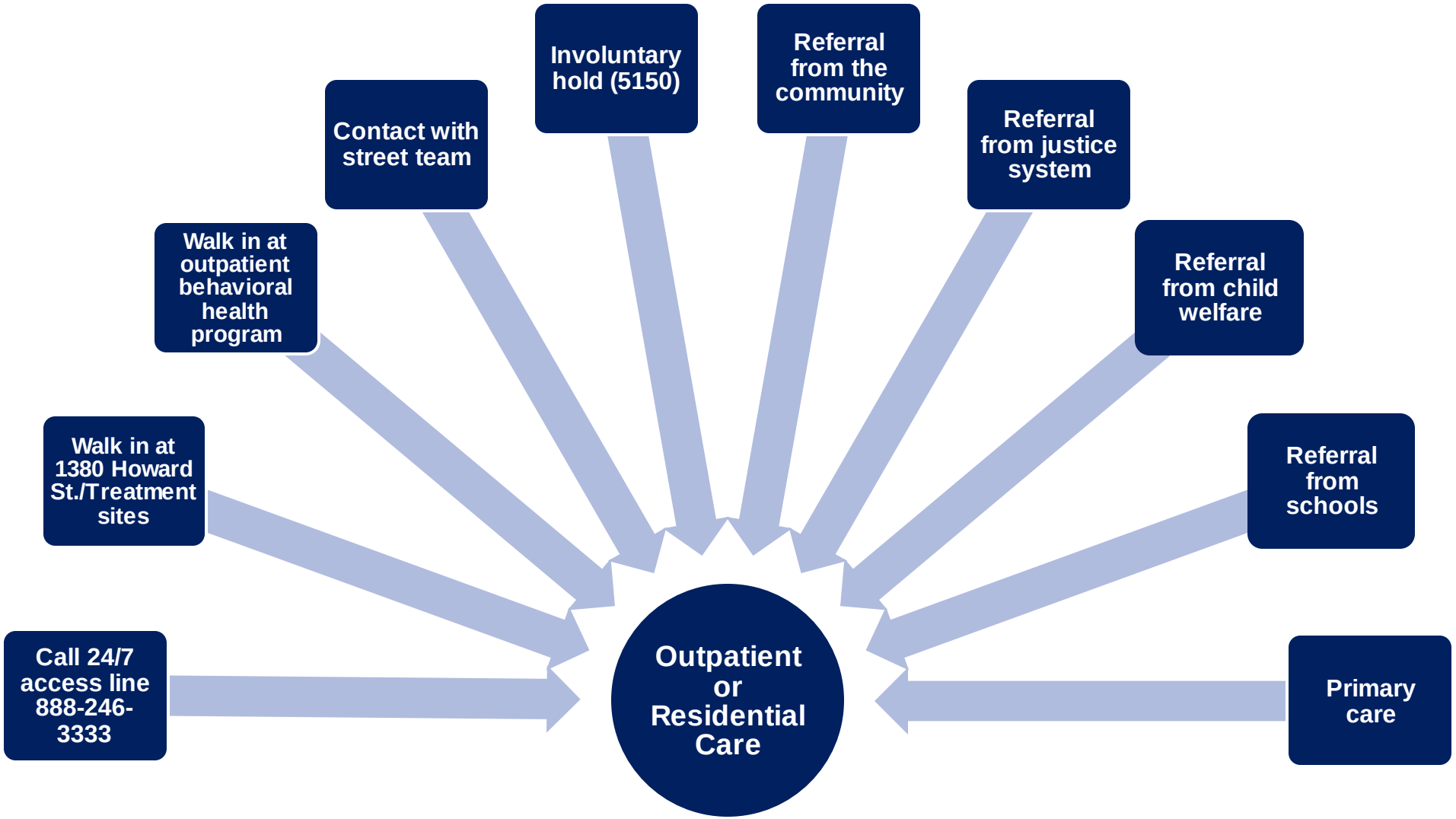
Residential Care, Treatment and Support

(Long-term care in a residential setting, including transitional housing for people who need support)

2,500 beds, ranging in services

5,000-7,000 people/year

How People Can Get Into Behavioral Health Care



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DPH Primary Care Clinics with Behavioral Health Services

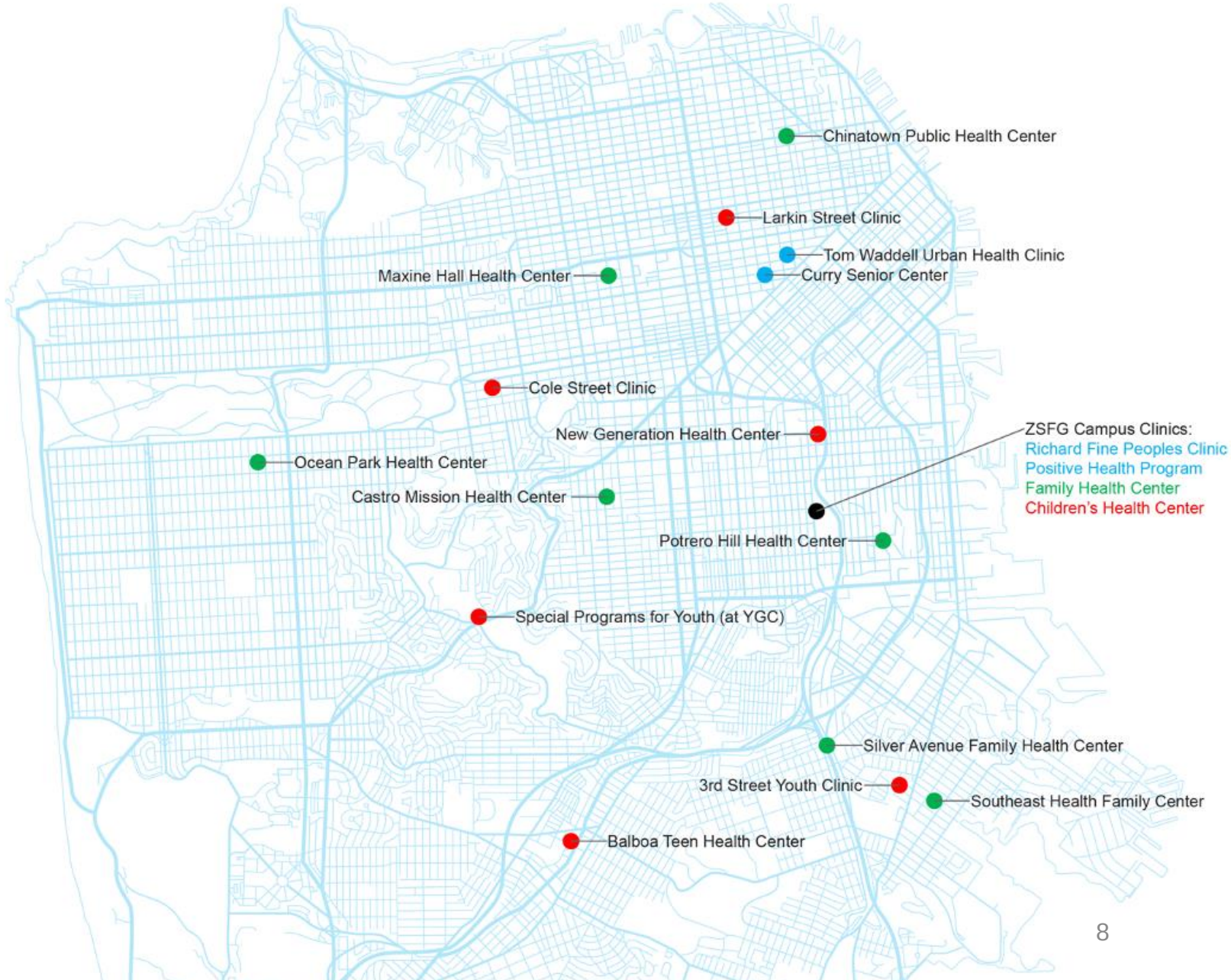
Of all people served in primary care approximately half receive care for behavioral health conditions.

Served FY21-22

25,000 people treated in DPH primary care clinics for mental health and substance use issues.

Operating Hours

Generally 8am-5pm, Monday-Friday, with extended weekend and evening hours at some locations.



- Primary Care for adults only
- Primary Care for adults, children, families
- Community Health Programs for Youth

55 Specialized Outpatient Mental Health and Substance Use Treatment Sites

Most people accessing specialty services are treated in outpatient settings.

Served FY21-22
15,000 people

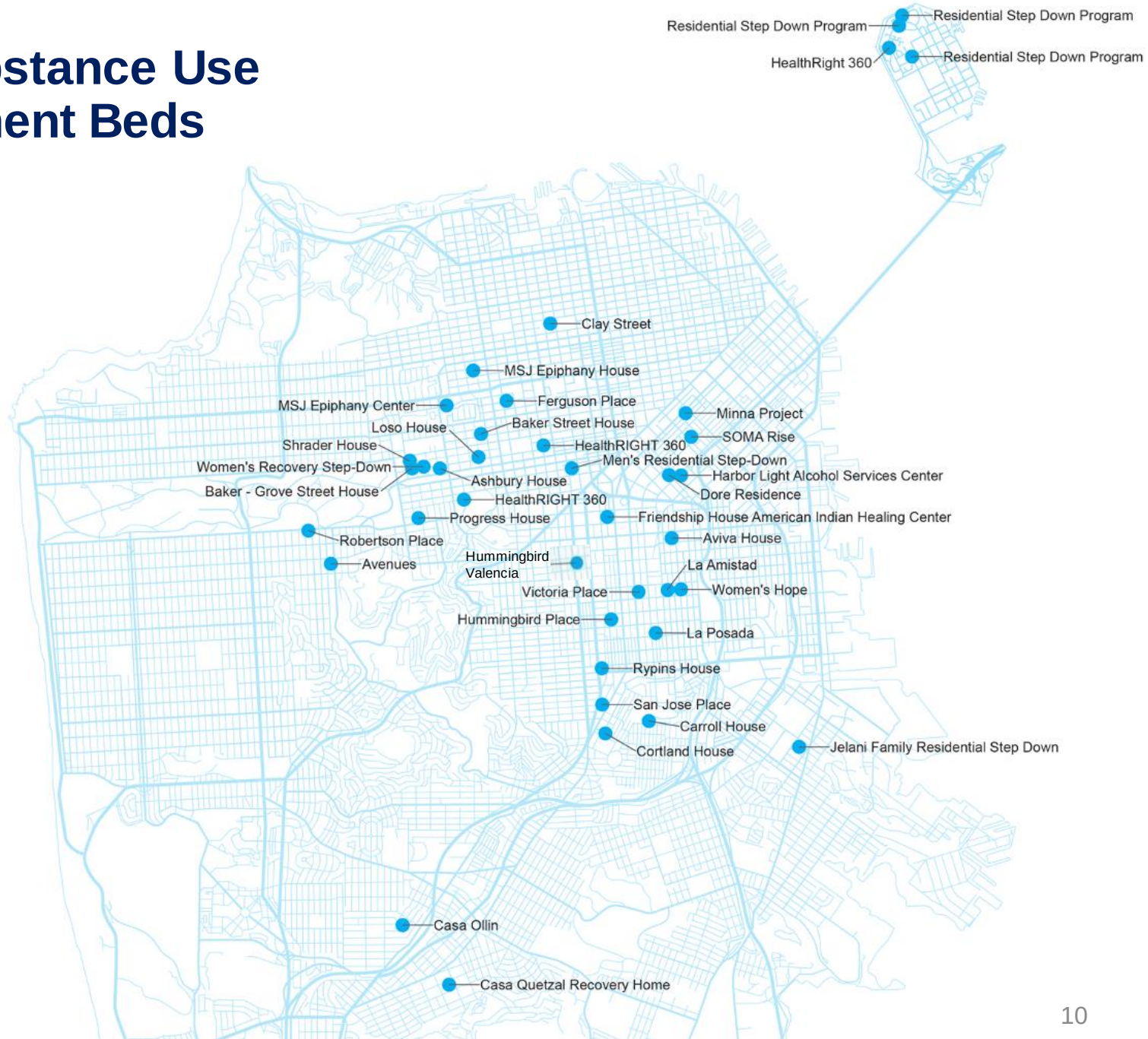
Operating Hours
9am-5pm
Monday-Friday

Open evenings and/or weekends:

- Buprenorphine Induction Clinic
- Behavioral Health Access Center
- BAART Programs.

2,500 Mental Health and Substance Use Residential Care and Treatment Beds

Out of County
~450 beds



Beds Dashboard

DPH Behavioral Health Residential Treatment Expansion

The San Francisco Department of Public Health (DPH) is increasing residential treatment and care services by approximately 400 overnight treatment spaces, or beds. The expansion effort is guided by the 2020 DPH Behavioral Health Bed Optimization Report, Mental Health SF legislation, and with input from stakeholders. The goal is to offer high quality, timely, easily accessible, coordinated, and recovery-oriented care delivered in the least restrictive setting.

KEY

Feb12, 2024

Project Phases and Status

Δ MHSF legislation

1 Program design
2 Regulatory assessment
3 Facility selection
4 Out for bid/contracting
5 Community outreach & City approvals
6 Permit & construction

Complete
In process
Planned

Goal **30**	Open 2021 **Hummingbird - Valencia** **Status** Serving clients Open *28 beds currently available*	Psychiatric respite facility to serve people experiencing homelessness from the Mission and Castro
Goal **20** Est. Beds	Open 2020 **Managed Alcohol Program** **Status** Permanent location and additional funding will expand the program from 10 beds to 20 beds Open *13 beds currently available*	Pilot | Medical supervision for people with chronic alcohol dependency
Goal **31** Est. Beds	Open 2021 **Mental Health Rehabilitation Beds** **(aka LSAT)** **Status** Serving clients Open *Client placement varies*	Out-of-county psychosocial rehabilitation for people who are conserved in a locked setting
Goal **13** Est. Beds	Open 2022 **Psychiatric Skilled Nursing Facilities** **(aka PSNF)** **Status** Serving clients Open *Client placement varies*	Out-of-county secure 24-hour medical care for people with chronic mental health conditions
Goal **75** Est. Beds	Open 2022 **Dual Diagnosis Transitional Care for People With Justice Involvement** **(aka Minna Project)** **Status** Serving clients Open *Client placement varies*	Transitional care for people in contact with the criminal justice system with a dual diagnosis of mental health and/or substance use issues
Goal **99** Est. Beds	Open 2022 **Residential Care Facility**Δ **(aka Board and Care)** **Status** Serving clients Open *Client placement varies*	Residential Care Facility: Supervised residential program for individuals with mental health issues who require assistance with daily living activities
Goal **20** Est. Beds	Open 2022 **SOMA RISE** Δ **(aka Drug Sobering Center)** **Status** Serving Clients Open *Client placement varies*	Pilot | 24-7 program for people experiencing homelessness with drug intoxication, providing short term stays and linkage to services
Goal **6** Est. Beds	Open 2022 **Cooperative Living for Mental Health** Δ **Status** Serving Clients Open *Client placement varies*	Communal living for people with chronic mental health and/or substance use Additional $11M to stabilize leased properties available through MOHCD
Goal **70** Est. Beds	Open 2023 **Residential Step-down - SUD** Δ **Status** Serving clients Open *Client placement varies*	Long-term sober living environment for clients coming out of residential care programs
Goal **30** Est. Beds	Open 2024 **Enhanced Dual Diagnosis** Δ **Status** Serving clients Open *12 beds currently available*	Transitional medically enhanced care for people with a dual diagnosis of mental health and substance use issues
Goal **10** Est. Beds	Opening 2024 **Transitional Age Youth (TAY) Residential Treatment** Δ **Status** Program design in development 1 2 3 4 ~~5~~ ~~6~~	Supervised treatment for young adults with serious mental health and/or substance use issues
Goal **16** Est. Beds	Opening 2024 **Crisis Diversion Facility** Δ **Status** Contracting and construction in process 1 2 3 4 ~~5~~ ~~6~~	Short-term, urgent care intervention as an alternative to hospital care

350+ of 400 total beds opened

Improving Access and Care Coordination for San Franciscans

The Office of Coordinated Care (OCC) manages behavioral health central access points, provides case management, care oversight, and care planning.

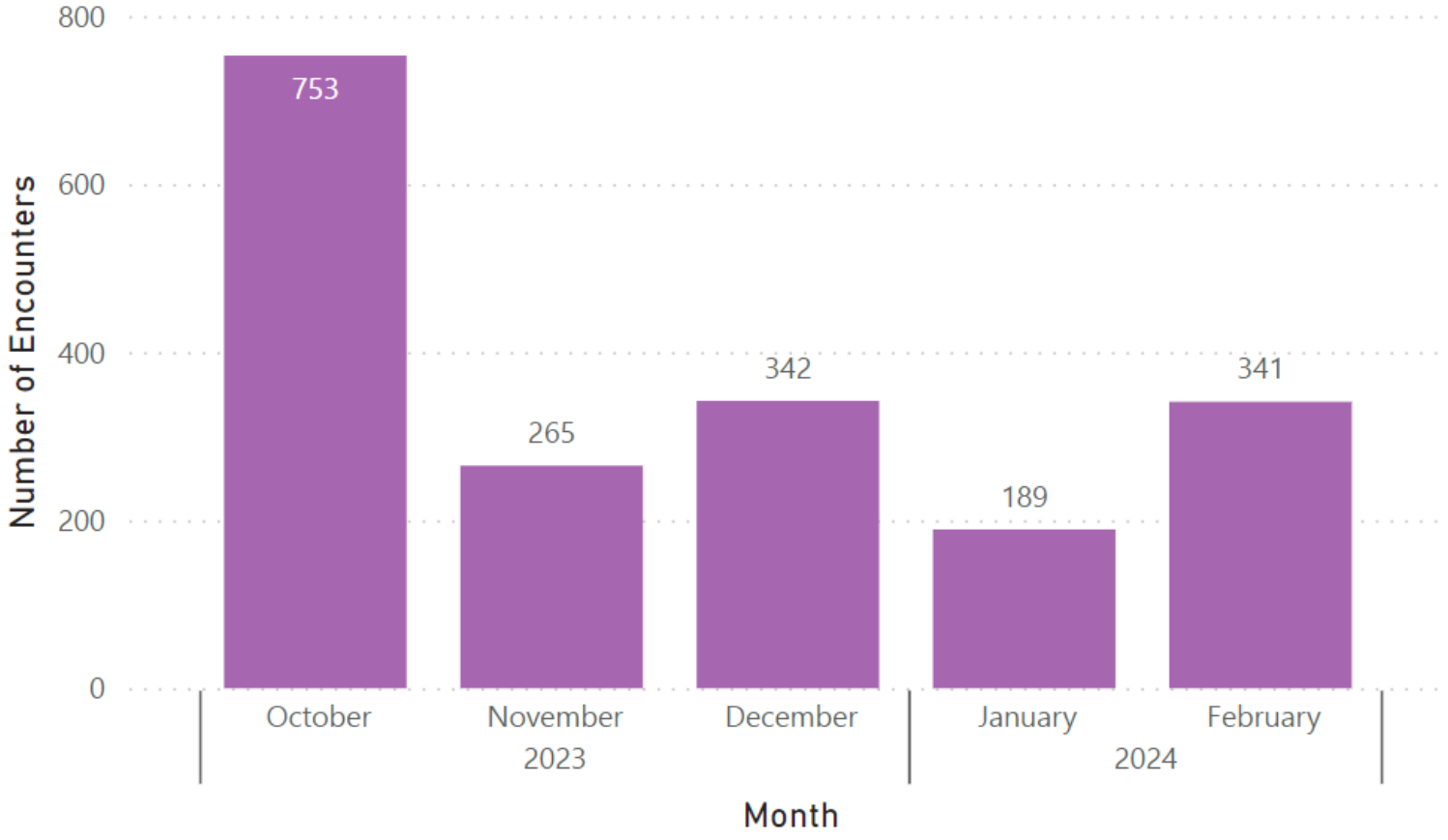
Access & Navigation – Information, screening, referral and direct connection to behavioral health care

- **Behavioral Health Access Line (BHAL):** 24/7 state-mandated/regulated call center
- **Behavioral Health Access Center (BHAC):** Walk-in center, open 7 days/week, for access to behavioral health services

CARE Coordination – Systematic and focused services for priority populations needing engagement and connections to care.

- **Triage:** Central hub managing referrals; systematically tracking and ensuring connections to care after 5150 or SCRT contact; deploying OCC follow-up teams
- **BEST Care Management:** Field-based follow up team focused on individuals leaving hospital of jail or post-crisis contact (provide follow-up for other pops as needed)
- **BEST Neighborhoods: T**eams providing outreach, engagement, coordination for unhoused people with behavioral health needs using a neighborhood-based approach

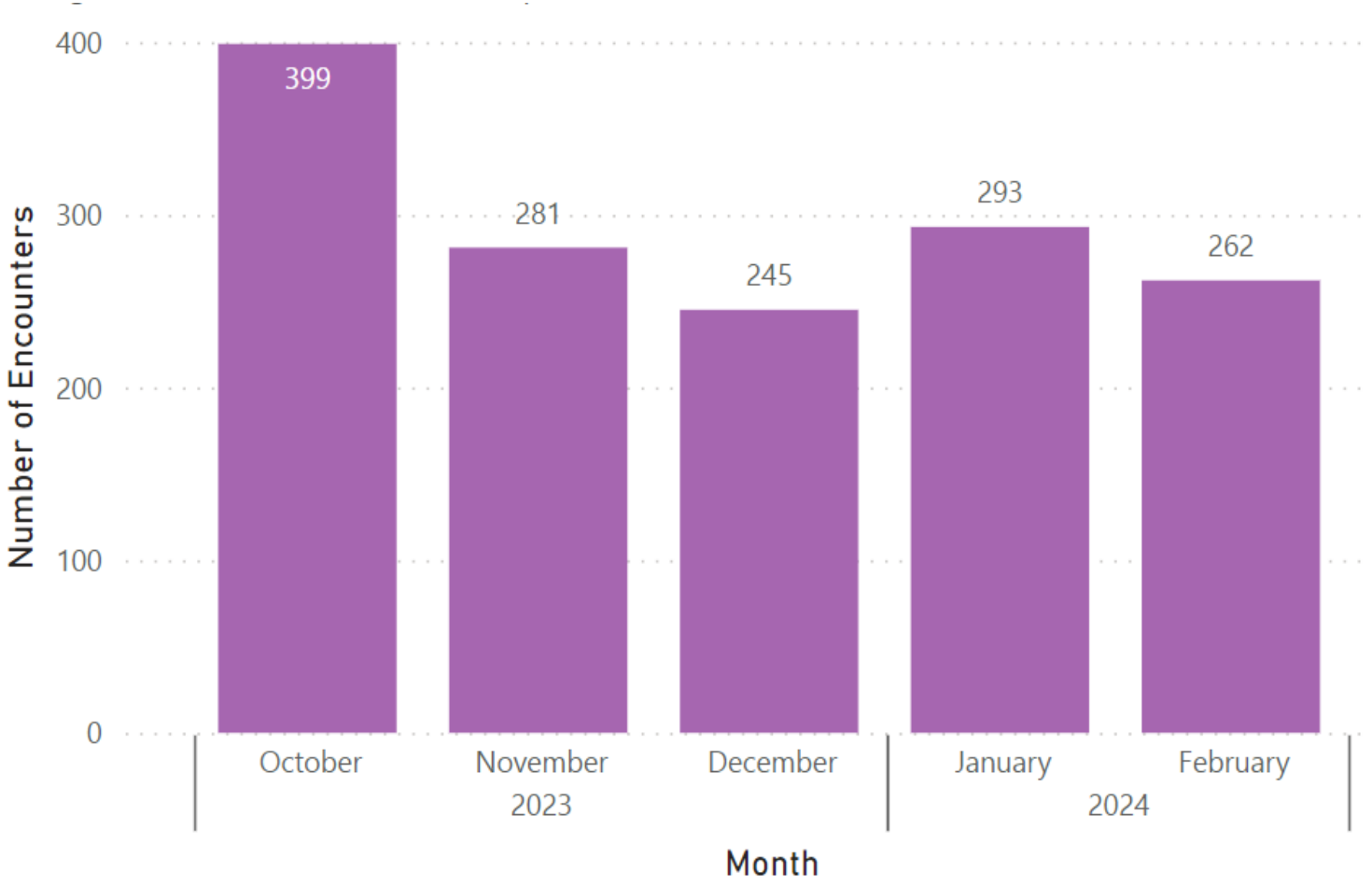
Behavioral Health Access Center Drop-Ins



Resolution Groupings	January	February	October	November	December
⊞ Info Disseminated	123	239	296	162	149
⊞ Other	1	1	1		
⊞ Referrals/Administrative	64	92	436	92	190
⊞ Referrals/Clinical				1	
⊞ Transfers	1	9	20	10	3
Total	189	341	753	265	342

This includes all services and information received when people dropped-in but did not engage enough to create a registration and patient record in Epic. October-February 2023

Behavioral Health Access Line Contacts



Resolution Groupings	January	February	October	November	December
⊞ Info Disseminated	209	179	294	206	175
⊞ Not Categorized	6	7			1
⊞ Other	33	40	44	46	35
⊞ Referrals/Administrative	6	6	19	8	6
⊞ Referrals/Clinical	4	7	12	5	6
⊞ Transfers	35	23	30	16	22
Total	293	262	399	281	245

This includes all services and information received when people dropped-in but did not engage enough to create a registration and patient record in Epic. October-February 2023

Intensive Outpatient Programs Provide Integrated Treatment and Case Management

~1300* adults were served in Intensive Outpatient Programs

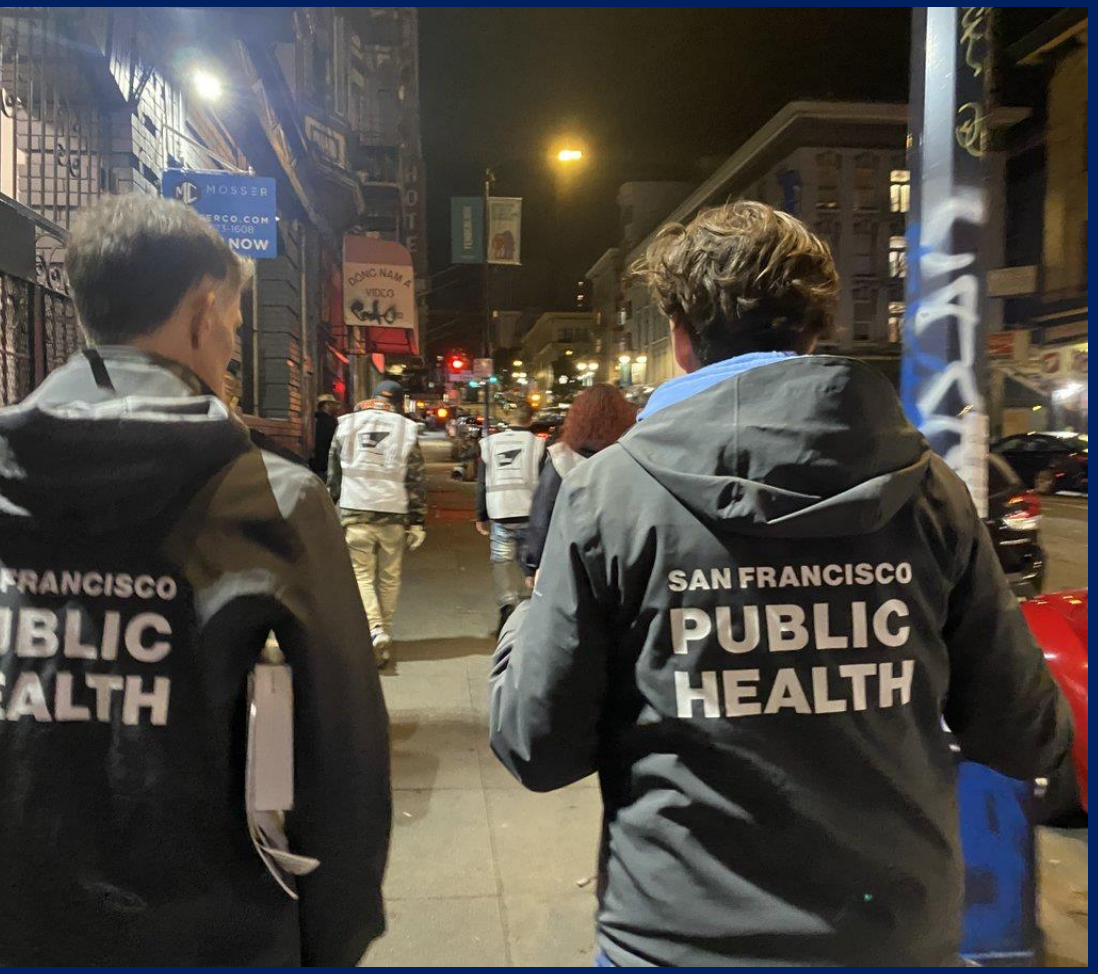
An **Intensive Outpatient Program** (also known as Intensive Case Management) consists of a **multidisciplinary treatment team** (social worker, psychiatrist, health worker, nurse.) that **provides team-based care** for people with **complex mental health and substance use needs**.

Intensive Outpatient teams aim to stabilize people, improve their health outcomes, and equip them with the tools necessary to move them from a crisis to stability and routine care.

- Provide mental health and substance use treatment.
- Support people to access and maintain benefits (health care, food, housing, etc.),
- Case managers meet with people weekly, or as often as is needed. If someone is in acute distress, they may be seen daily.

*FY22-23

Coordinated Response with City Agencies and Community Organizations



Aims to **increase stability** and **connections** to **care**. DPH takes lead on providing behavioral and physical health care and case management.

- Daily and weekly coordination with **SFPD**, **DEM**, **SFFD, HSA**, and **HSH** on street engagement and response, including case management for high-priority individuals.

- Collaborate with **SFFD** on follow up for people seen by **SCRT** and **POET** teams and linkage to care.

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Overdose Deaths Increased in San Francisco in 2023 Compared to 2022

813 preliminary overdose deaths in 2023, **166 (26%)** above 2022

Strengthening the Continuum of Evidence-based Services will Save Lives

Center for Substance Abuse Treatment. Brief Interventions and Brief Therapies for Substance Abuse. Rockville (MD): Substance Abuse and Mental Health Services Administration (US); 1999. (Treatment Improvement Protocol (TIP) Series, No. 34.)

Strengthening Efforts to Lower Fatal and Non-fatal Overdoses and Reduce Overdose Disparities

- Aligning, coordinating, and leveraging existing and new approaches to maximize the impact of medications for opioid use disorder, naloxone, contingency management and community engagement
- Centering equity in all strategies and addressing gaps in existing interventions
- Deepening partnerships in the community
- Advancing local, state, and federal policy
- Strengthening data tracking and reporting to maximize and demonstrate impact

Key Overdose Reduction Objectives

Expanding and strengthening substance use services continuum of services

- Key Objective: Improve access and retention of methadone in jail, at ZSFGH, and mobile site in the Bayview
- Key Objective: Increase number of programs offering contingency management

Community engagement for priority populations

- Key Objective: Build the capacity of Black/African American-led organizations to address overdose in their communities
- Key Objective: Increase naloxone access and overdose prevention trainings in PSH

Public awareness

- Key Objective: Launch media campaigns aimed at increasing awareness about the availability of services and reducing stigma

Increased Access to the Continuum of Substance Use Services in SF

~5,000 people treated for substance use disorders in DPH programs

2,500
people receive buprenorphine for opioid use disorder annually

2,300
people receive methadone for opioid use disorder annually

~575
residential treatment admissions annually

~1,100
people use withdrawal management services annually

Educated and Trained Community Members in Overdose Recognition and Naloxone use

120,000+ naloxone doses
distributed by DPH and the DOPE Project in 2023

5,000+ completions
of DPH's online Overdose Recognition and Response training between October 2022-December 2023

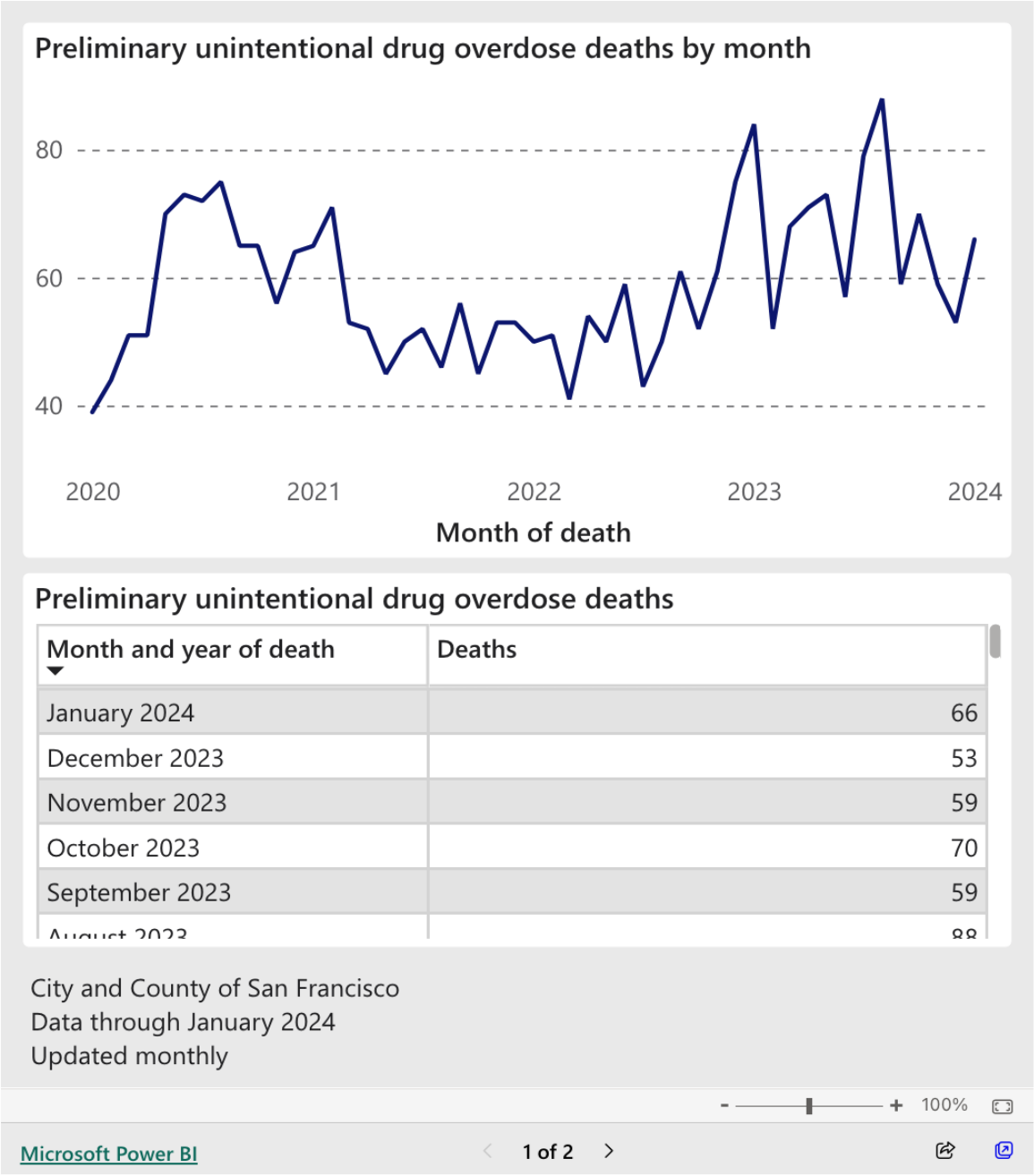
1,000+ members of the public
received DPH's Overdose Recognition and Response training in-person in 2023

Other activities include:

- Developing new relationships with Black-led and Black-serving organizations
- Collaborated with the Entertainment Commission
- Launched a Request-by-Mail naloxone program
- Expanded naloxone access at DPH pharmacy, community events, lobby of county jail
- Supported legislation requiring retail pharmacies stock naloxone

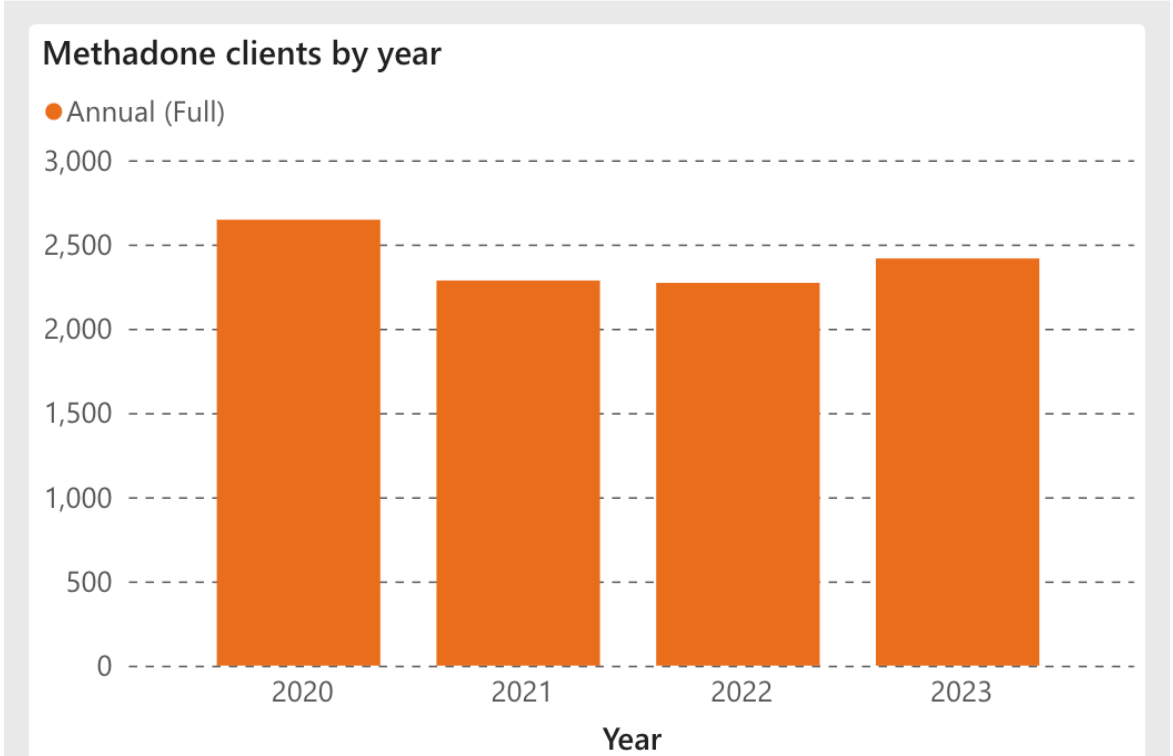
Preliminary Unintentional Drug Overdose Deaths By Month

- Goal: Measure success and inform program development and change
- Centralize data collection on drug-related metrics, including fatal and non-fatal overdose
- **Launched a publicly-available dashboard on overdose and treatment trends**
- Bi-weekly meetings with community members and frontline staff of service organizations to review data and discuss findings



Unintentional_Overdose_Deaths

Total Number Of People Treated With Methadone By Year

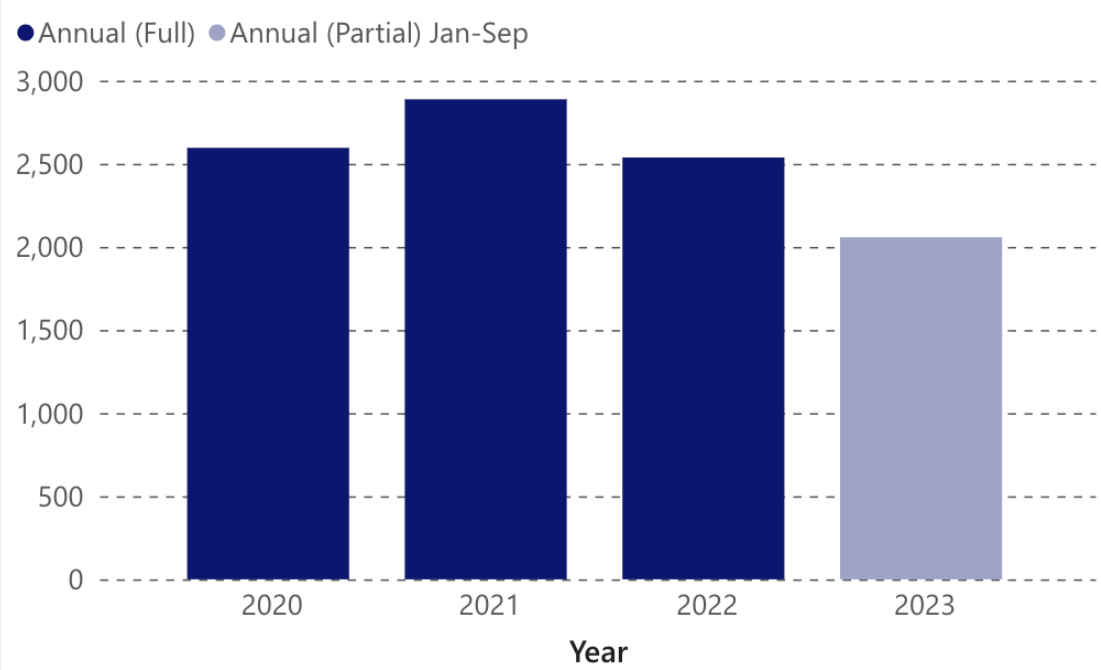


Methadone clients

Year	Reporting period	Methadone clients
2023	Annual (Full)	2,417
2022	Annual (Full)	2,272
2021	Annual (Full)	2,286
2020	Annual (Full)	2,647

City and County of San Francisco
Data through December 2023

Total Number Of People Who Received Buprenorphine By Year



Buprenorphine clients

Year	Reporting period	Buprenorphine clients
2023	Annual (Partial) Jan-Sep	2,058
2022	Annual (Full)	2,538
2021	Annual (Full)	2,888
2020	Annual (Full)	2,596

City and County of San Francisco
Data through September 2023

How BHS Evaluates Health Outcomes

Current State

Across our system of care, BHS utilizes the following assessment tools:

- **Child and Adolescent Needs and Strengths (CANS):** multi-purpose tool developed for children's services to support decision making, including level of care and service planning, to facilitate quality improvement initiatives, and to allow for the monitoring of outcomes of services.
- **Adult Needs and Strengths Assessment (ANSA):** multi-purpose tool developed for adult behavioral health services to support decision making, including level of care and service planning, to facilitate quality improvement initiatives, and to allow for the monitoring of outcomes of services.
- **Adult Level of Care (LOC):** tool developed to identify the appropriate level of care that a person needs within the continuum of care.
- **Program Utilization Review Quality Committee (PURQC):** BHS utilization review program.

Future State

BHS continues to improve client outcome measures by:

- Strengthening tools that ensure all providers are addressing all assessment requirements.
- Revamping utilization review process to ensure timely review of level of care for clients.
- Revamping performance objectives to focus on client outcomes in place of contractual requirements.
- Developing data dashboards that allow for review of client outcomes by program.

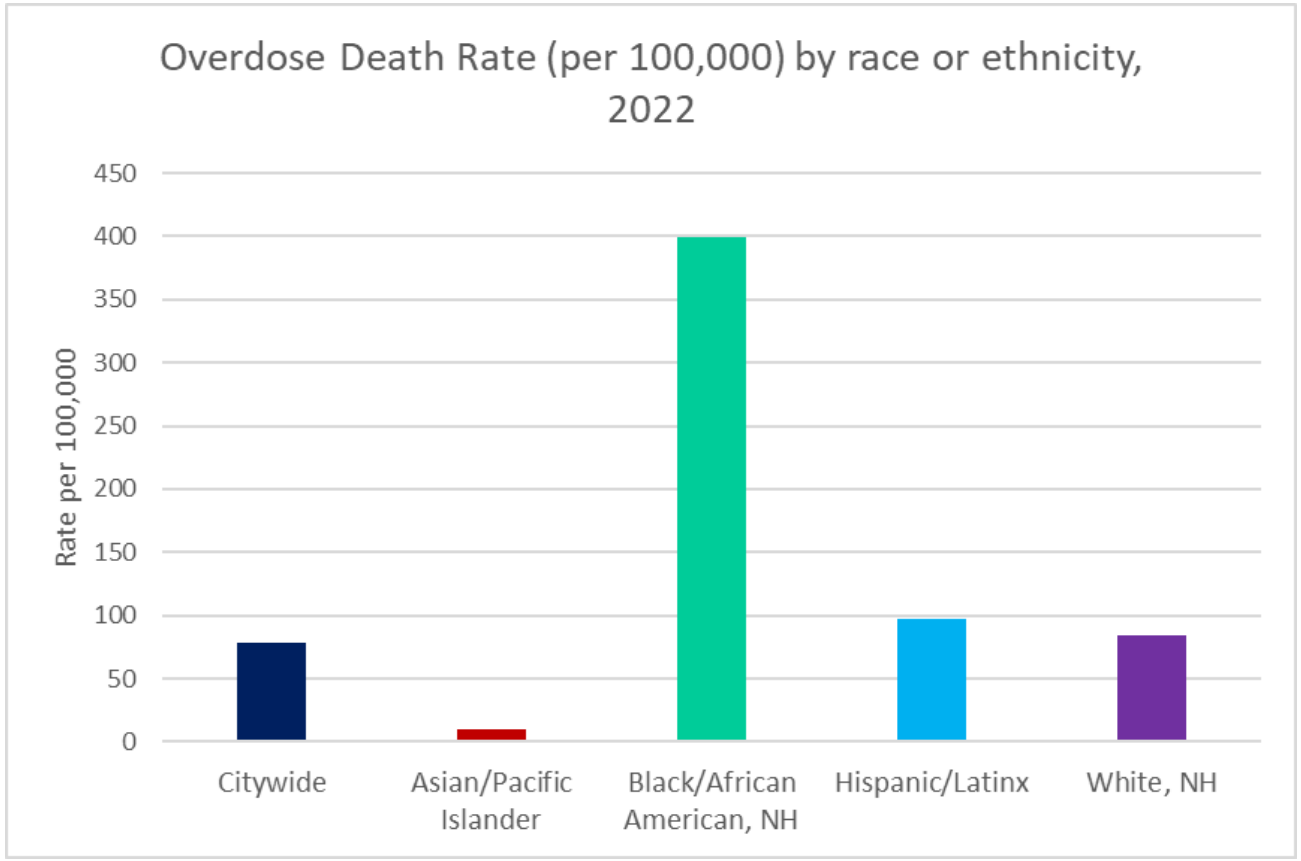
Thank you

Additional Information

Where DPH is Delivering Behavioral Health Care

Substance Use Disorder and Overdose Data

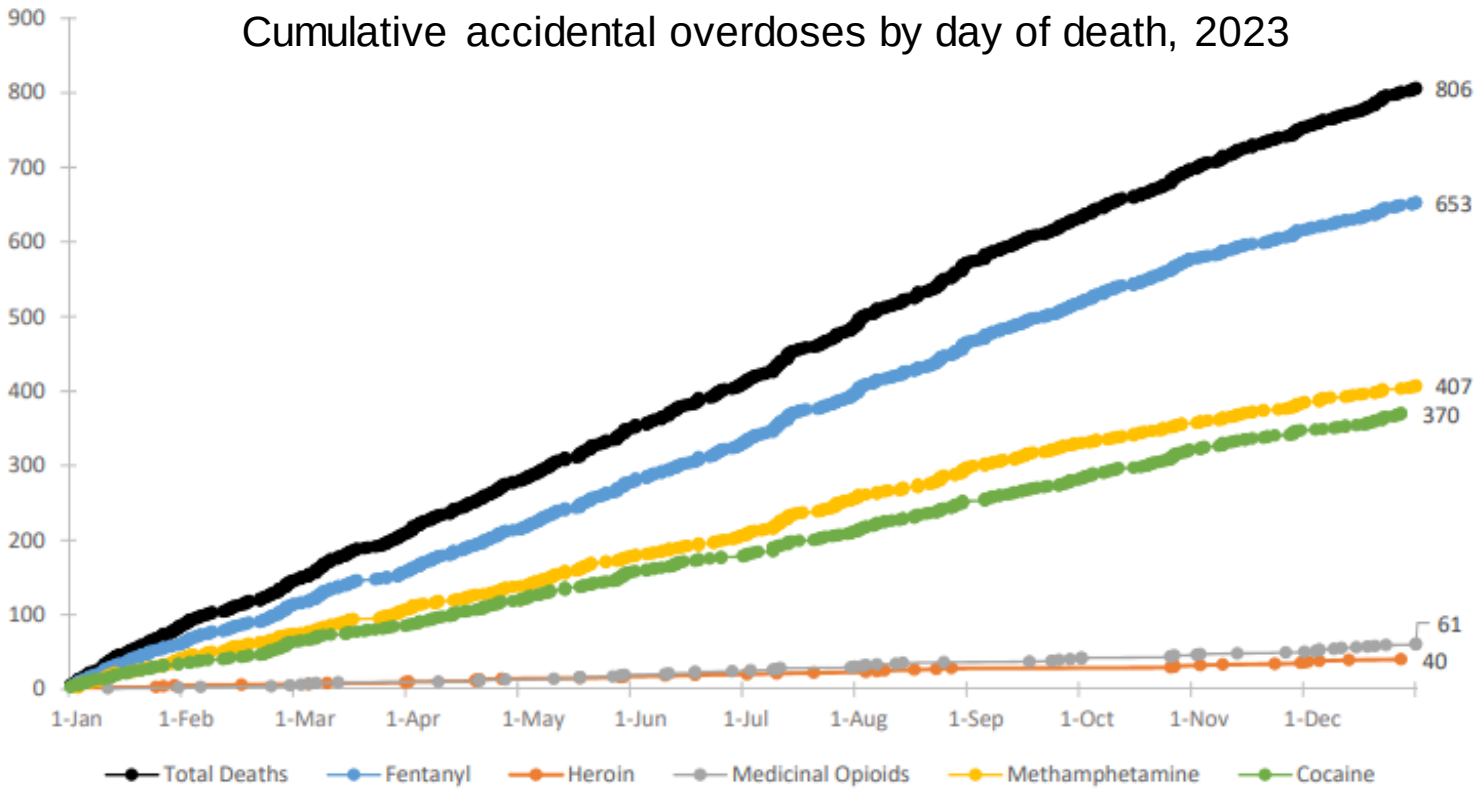
Profound racial disparities exist among overdose decedents in SF



- Black/African Americans represent just **6%** of the **population in SF**, but **31%** of **preliminary overdose deaths** in 2023
- The overdose death rate among Black/African Americans is **5X higher** than the citywide rate

San Francisco Office of the Chief Medical Examiner, 2023; Center on Substance Use and Health, 2023

Fentanyl is the most common drug involved in overdose deaths



Over 80% of preliminary overdose deaths in 2023 involved fentanyl, up from 12% in 2016.

In 2022, **>80% of overdose deaths** involving fentanyl also had at least one other drug present (heroin, cocaine or methamphetamine)

City & County of San Francisco
Department of Public Health

Office of the Chief Medical Examiner, 2023; Center on Substance Use and Health 2022

BHS Residential Care and Treatment Needs and Recommendations

Estimating Current Behavioral Health Residential Needs

In 2023, DPH updated its 2020 behavioral health bed modeling to develop **preliminary recommendations** for the number of beds needed for 95% of clients to experience zero wait time.

- Project Goals:
  - Update 2020 analysis, using quantitative modeling, input from subject matter experts, and supplemental wait-time data and RAND analysis (2022)
  - Develop infrastructure to regularly track bed utilization and bed needs, optimize flow, and evaluate the impact of bed expansion investments on client wait times.

Residential Expansion: Preliminary Recommendations

Residential Type	Additional Beds Needed	Considerations
Mental Health Residential Treatment	~50	• Includes different lengths of stay • Includes need for clients with specific needs (e.g., both severe mental health and substance use diagnoses; seniors; and perinatal clients)
Mental Health Rehabilitation Centers (MHRC) / LSAT	Estimated 55-95	• Given current wait times • Potential for increase in demand under SB 43
Behaviorally Complex Therapeutic (Enhanced Residential Care / Residential Care for the Elderly	Estimated 20-40	• Highly specialized level of care for complex, high-need clients difficult to place in care.

Residential Expansion: Preliminary Recommendations

Residential Type	Additional Beds Needed	Considerations
SUD Residential Withdrawal Management	~8-10	• Includes high-complexity withdrawal management for people with both severe withdrawal medical needs and other health needs
SUD Residential Step-Down	~20-30	• The number of clients served in RSD has increased as SFDPH has added capacity.
State Hospital Beds	Admission data needed to make a recommendation.	• These beds are managed by the State. • 2022 RAND analysis showed that access to these beds significantly contributes to the supply other beds types

Mental Health SF Successes & Challenges

Mental Health San Francisco Successes

- Established Office of Coordinated Care services to **ensure successful transitions** through care and treatment as well as keeping **people with complex needs** connected to care.
- Launched BEST Neighborhoods behavioral health care team to regularly engage with **high-priority unhoused people** with **serious behavioral health conditions**.
- Increased residential care and treatment by more than **350 beds**.
- **Expanded assessment** and **treatment** including hours of operation for the walk-in treatment center, pharmacy, OBIC, and Opioid Treatment Programs.
- **$1.8M** added to existing **intensive outpatient** and **stabilization providers** to support filling critical vacancies, ensure competitive salaries, and increasing staffing.

Key Challenges and Impacts to Service Delivery

- Acquisition of **new services** to **meet changing demand**
- Workforce **recruitment** and **retention**
- Nationwide **shortage of behavioral health clinicians**
- Acquiring **new beds** and **facilities** for care and treatment
- **Data infrastructure** and **workforce**

BHS Client Scenario

Scenario 1: About Gerald

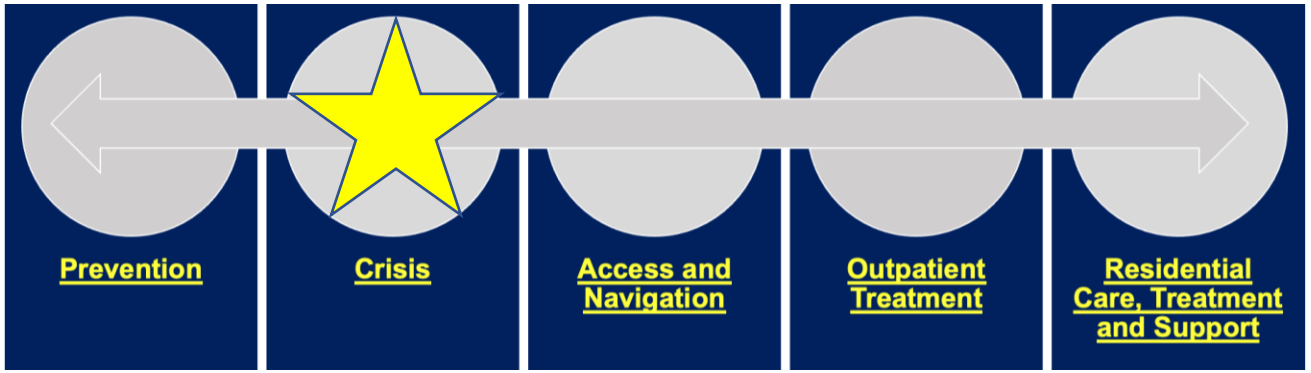
- Male
- 57-year-old
- Bipolar disorder
- Uses methamphetamine
- Currently unengaged in treatment
- Unhoused or marginally housed for the last 15 years
- Previously engaged in mental health treatment but only for a short period of time
- History of emergency department visits
- Has cancer but is not regularly receiving physical health care

Scenario: Crisis Encounter to Care Coordination

SCRT encounters Gerald after he is observed in distress on the street. SCRT assesses and transports Gerald to Dore Urgent Care and makes a referral to Office of Coordinated Care (OCC) for follow up.

Upon receiving the referral, an OCC case manager meets with him at Dore Urgent Care. The case manager reviews Gerald's health history to better understand his behavioral health needs and learns that Gerald stopped using his psychiatric medication because he didn't like how it made him feel.

Gerald informs the case manager that a close family member recently passed away, which is contributing to his distress. He declines behavioral health care but agrees to receive help to find a navigation bed.



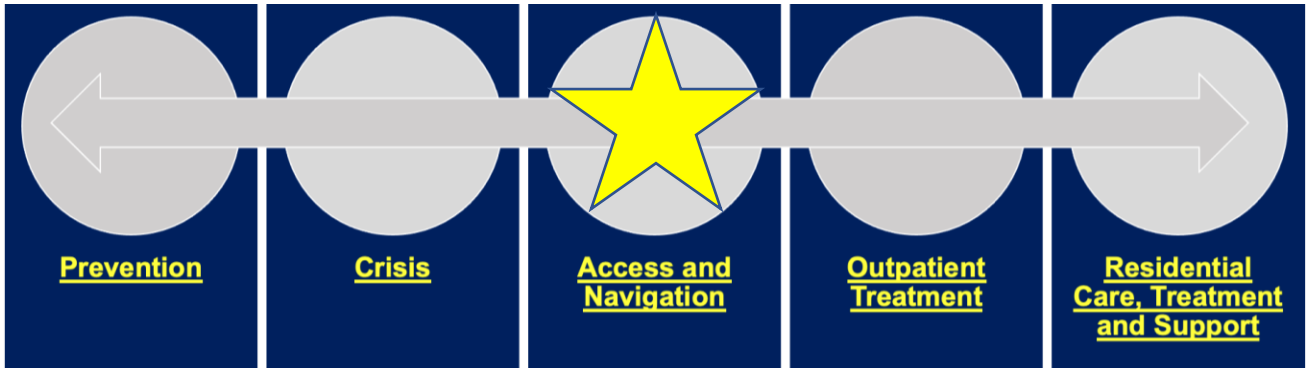
Scenario: Care Plan and Coordination

After visiting the navigation center with Gerald, the case manager offers to meet with him daily. Gerald agrees to meet twice a week and declines mental health care.

Finally, he agrees to develop a care plan with the case manager. He expresses that securing housing is his first priority, and that he is interested in receiving physical health care.

Although, he declines mental health care and says he's not ready to make a change in his drug use, which he says makes him feel better. He does agree to continue discussing mental health and substance use as a part of his care plan.

The case manager accompanies Gerald to a Coordinated Entry access point so he can be assessed for permanent supportive housing. The case manager also works with him to re-engage with his physical health providers.



Scenario: Progress and Outcome

Throughout the seven months that the case manager engages with Gerald, progress is slowed when Gerald disappears for days or expresses a lack of willingness to engage. However, the case manager's persistent, regular engagement supports Gerald's continued interest in obtaining supportive housing, and increased interest in receiving cancer treatment.

Gerald is successfully placed in permanent supportive housing and begins treatment for cancer. Once housed, Gerald tells the case manager that he would like to enter a mental health treatment program.

The case manager connects Gerald to an Intensive Outpatient Program where a multi-disciplinary team reviews his care plan, communicates with OCC, and implements the plan. An Intensive Outpatient Program case manager takes over and begins to meet with Gerald at least twice a week.