Street Care Services

San Francisco Department of Public Health

April 16, 2024

Dara Papo
Director of Whole Person Integrated Care
San Francisco Department of Public Health

Kathleen Johnson-Silk
Program Manager of BEST Neighborhoods
San Francisco Department of Public Health

City & County of San Francisco
Department of Public Health

Agenda

- Coordinated City Street Response Overview
- SFDPH Street Teams Overview
- Recommendations and Improvements

Citywide Coordinated Street Response

Citywide network of crisis and rapid response as well as planned outreach efforts that aim to increase stability and connections to care through daily and weekly coordination. Multi-department effort includes:

- **Department of Public Health (DPH):** Behavioral and physical health care and case management.
- **Department of Emergency Management (DEM):** Coordination, Healthy Streets Operations Center (HSOC), Tenderloin Joint Field Operations, Ambassador Programs, Homeless Engagement Assistance Response Team (HEART).
- **San Francisco Fire Department (SFFD):** Behavioral health crisis and non-acute physical and wellness services.
- **Department of Homelessness and Supportive Housing (HSH):** Outreach, shelter, and housing.

SF Coordinated Street Response Teams

1. SCRT
Street Crisis Response Team

2. SORT
Street Overdose Response Team

3. HEART
Homeless Engagement Assistance Response Team

4. HSOC
Healthy Street Operation Center

5. HOT
Homeless Outreach Team

6. Street Medicine

7. POET
Post Overdose Engagement Team

8. OCC Triage
Office of Coordinated Care

9. OCC/Best Neighborhoods
Bridge and Engagement Services Team: Neighborhoods

- DPH Street Teams
- Non-DPH Street Teams (DEM, HSH)
- Street Teams in Partnership with DEM and SFFD

All Street Teams – Services Delivery

Crisis Response	Rapid Response	Planned Outreach
911	311/Non-Emergency #	Hotspot/Zone/Neighborhood

• Emergency - BH/Medical, Overdose response
  • Crisis; fastest response, ~ 15 mins)
  • De-escalate, assess, transport, service linkage
	• Immediate – PEH, Blocked Sidewalks
	  • Non-crisis; rapid response (1-hour: 1-day)
	  • Triage/assess; transport, service linkage
		• Persistent Homelessness/BH/Medical
		  • Planned/routine operations; planned follow up
		  • Triage/assess; transport, service linkage

SCRT SORT	HEART	HSOC, HOT, Street Medicine, POET, OCC Triage, OCC/BN

SF Coordinated Response Program

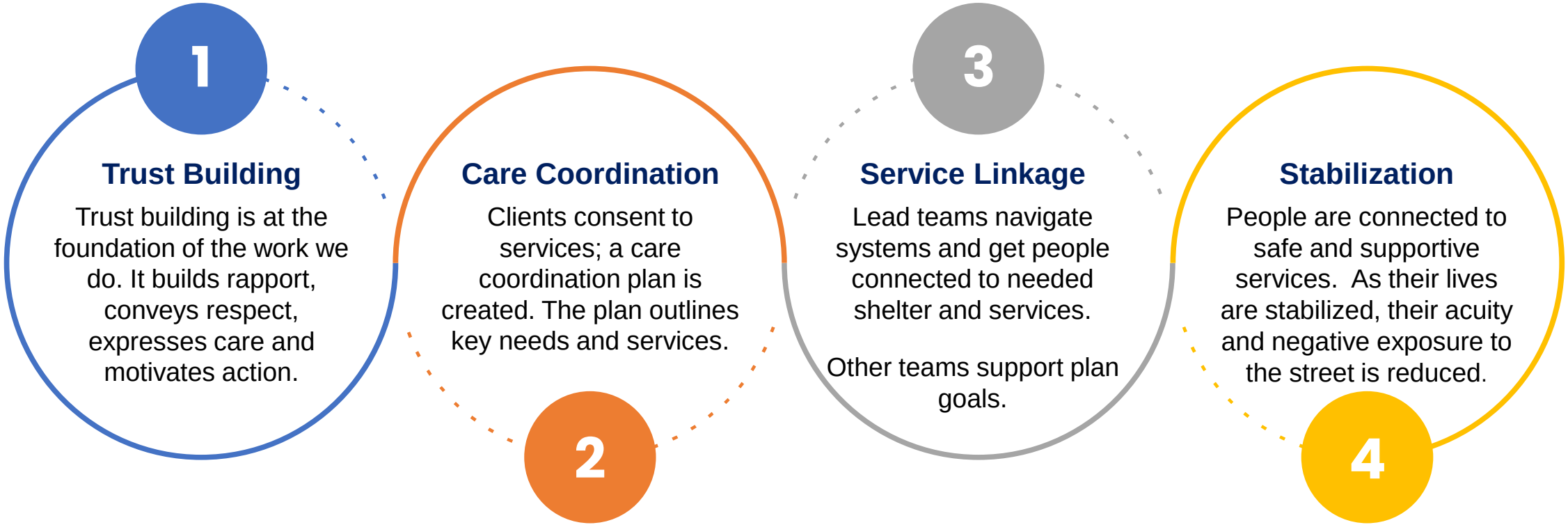
DPH Street Team Contracted Partners

Additionally, the following community-based organizations are contracted to support DPH street care services:

- Richmond Area Multiservices, Inc. (RAMS)
- Harm Reduction Therapy Center (HRTC)

Street Care Process Overview

SF coordinated street response teams follow a consistent process of engagement.



About SFDPH Street Teams

To ensure that clients receive care that meets their specific needs, SFDPH street care teams offer a wide range of care and treatments for physical health care, substance use and mental health disorders, and overdose prevention.

SFDPH has various street care teams that managed **23,000+** encounters in 2023, including:

- BEST Neighborhoods (Bridge and Engagement Services Team: Neighborhoods)
- Street Overdose Response Team (SORT), in partnership with SFFD
- Street Crisis Response Team (SCRT), in partnership with DEM and SFFD
- Street Medicine
- Post Overdose Engagement Team (POET)

DPH Street Team Composition

- Multidisciplinary, diverse and highly dedicated teams that deliver compassionate and results-focused care.
- Focus is on short- and long-term linkages.
- Provide basic need supplies, food, transportation, other immediate resources.

BEST Neighborhoods
(Bridge and Engagement Services Team: Neighborhoods)

Launched in March 2023 as a part of the Behavioral Health Services Office of Coordinated Care and provides trauma-informed behavioral health assessment and care linkages to people living on the streets with complex behavioral health needs who are facing significant barriers to engage with much-needed care. Teams are 'place-based,' work in assigned neighborhoods and provide time-limited, focused, and phased interventions to support clients in transitioning to ongoing care and supports.

- Collaborates with DEM, HSOC, Street Medicine, SFHOT.
- Clients are:
  - Referred for follow up from SCRT encounters, other OCC Triage referrals.
  - Shared priority clients who regularly exhibit street behaviors that result in concern from providers, community, or other people familiar with client.

BEST Neighborhoods Data (Mar 23-Mar 24)

- 8,448 total engagements
- 1100+ linkages to mental health and substance use services, medical care, and shelter

Budget
$6.2 million

Staffing
13 FTE DPH staff
Vacancies: 5 FTE (3 FTE Behavioral Health Clinicians, 2 FTE Behavioral Health Clinical Supervisors)

Street Crisis Response Team (SCRT)

Led by the Department of Emergency Management (DEM) and San Francisco Fire Department (SFFD) in partnership with DPH, SCRT responds to people experiencing behavioral health crises. Supportive follow-up services are provided by DPH via POET and OCC.

Budget
$8.2 million

Staffing
DPH contracts RAMS Peers to support staffing

Street Overdose Response Team (SORT)

Led by SFFD in partnership with DPH, SORT responds to 911 calls to assist people experiencing a drug overdose.

Budget
$2.6 million

Staffing
DPH contracts RAMS Peers to support staffing

Street Medicine

In the community six days per week, providing essential medical, mental health and substance use treatment in streets, parks and encampments. The team serves clients who are hard to reach—people experiencing homelessness who are disconnected from health care.

Encounters

- 11,641 encounters across 3,075 unique patients
- Weekly outreach at 16+ off-site clinics and 15+ distinct neighborhood outreach events

Budget

$5 million

Staffing

18.5 FTE budgeted (Health Workers, Nurses, Behavioral Health, Medical Providers)
Vacancies: 0.5 FTE Nurse Practitioner, 1.0 FTE Health Worker

Post-Overdose Engagement Team (POET)

POET follows up with survivors of overdose to engage them and offer care such as connections for medication for opioid use disorder (MOUD) and counseling to prevent future overdoses.

Encounters

1,558 follow up encounters for 617 unduplicated clients.
783 referrals to treatment.

Follow up Engagement Activities in FY22-23

- Counseled on overdose prevention and treatment services – 49%
- Assisted client connecting with services – 40%
- Provided Narcan – 37%
- Prescribed Buprenorphine – 14%
- Referred to withdrawal management – 4%

Budget

$4.5 million

Staffing

9.5 FTE DPH staff (Health Workers, Nurse, Medical Staff) + CBO contracts for peers and behavioral health)
Vacancies: 2.0 FTE Health Workers

DPH Street Team Data Improvements

Recommendation: Increase reporting on metrics and goals

- Capturing data across all DPH street teams.
  - Tracking engagements and linkages for BEST Neighborhoods team since launch.
- Street Medicine quality improvement goals include:
  - Monitoring and increasing the number of clients screened for alcohol, tobacco, and drug use;
  - Telehealth services;
  - HIV and Hepatitis C metrics (e.g. connection to treatment, undetectable viral load);
  - CalAIM Enhanced Care Management reporting.
- As part of Coordinated Street Response, collaborating in use of ASTRID to identify and track progress of highest utilizers of Citywide street teams and 'Shared Priority' individuals

DPH Street Team Service Improvements

Recommendation: Modify the service model of the POET and SCRT-OCC follow-up teams to improve the success rate and cumulative follow-up rate for clients who are referred for services.

SCRT-OCC

- Follow up rate was 64% at the time of BLA audit but increased to 80% during 2022 and beyond.
- Follow up for SCRT is now fully integrated into the Office of Coordinated Care (OCC) Triage team, which provides care coordination and follow up for people who have multiple points of contact across systems.

POET

- High percentage of non-fatal overdose survivors did not express immediate readiness for connection to services at SORT intervention.
- Hard to locate people next day.

Moving Forward

- Pivoted POET to focus on who can be located and is at high vulnerability, including shared priority individuals
- DPH, SFFD, UCSF and DEM to evaluate SORT, POET, and HOPE model with Civic Bridge (Mayor's Office of Innovation)

Client Scenario: Mary

- Female
- 43-years-old
- Bipolar disorder
- Uses methamphetamine and fentanyl
- Currently unengaged in treatment
- Unsheltered
- Encountered by SCRT and referred to OCC: BEST Neighborhoods

Client Scenario: BEST Neighborhoods Follow Up

Mary is a highly visible person staying on the street, experiences crises. She exhibits disorganized thought process, manic features, and co-occurring substance use. She is encountered by the Street Crisis Response Team (SCRT) and referred to the Office of Coordinated Care (OCC) for follow up.

The BEST Neighborhoods team outreaches to Mary, and when they find her, she expresses that she is uninterested in shelter, behavioral health care, or physical health care, though it is clear that she is in need of all three. She does agree to have the team come back to meet with her again.

Client Scenario: BEST Neighborhoods & Street Medicine Coordination

BEST Neighborhoods provides another engagement the following day, accompanied by a nurse from Street Medicine. Mary allows the nurse to tend to a wound on her leg and says that she is open to another visit. BEST Neighborhoods and Street Medicine staff follow up at least three times a week to get to know Mary and build trust. After several weeks, Mary opens up to the team about her mental health challenges.

The team offers and she agrees to a visit with a street-based psychiatrist. The psychiatrist assesses Mary's mental health and recommends psychiatric medications. Mary expresses openness to medications but is also concerned about being on the streets and taking medications that could make her less alert and compromise her safety.

The team revisits the idea of shelter, which she agrees to, and the team helps her move into a shelter placement.

Client Scenario: Connection to Care and Housing

The psychiatrist starts Mary on medication and provides medication support. Mary also connects with the Shelter Health nursing team for follow up on her medical needs. Mary continues to decline treatment for her substance use disorder, and the BEST Neighborhoods team and Shelter Health continues working on building motivation to make changes in her substance use.

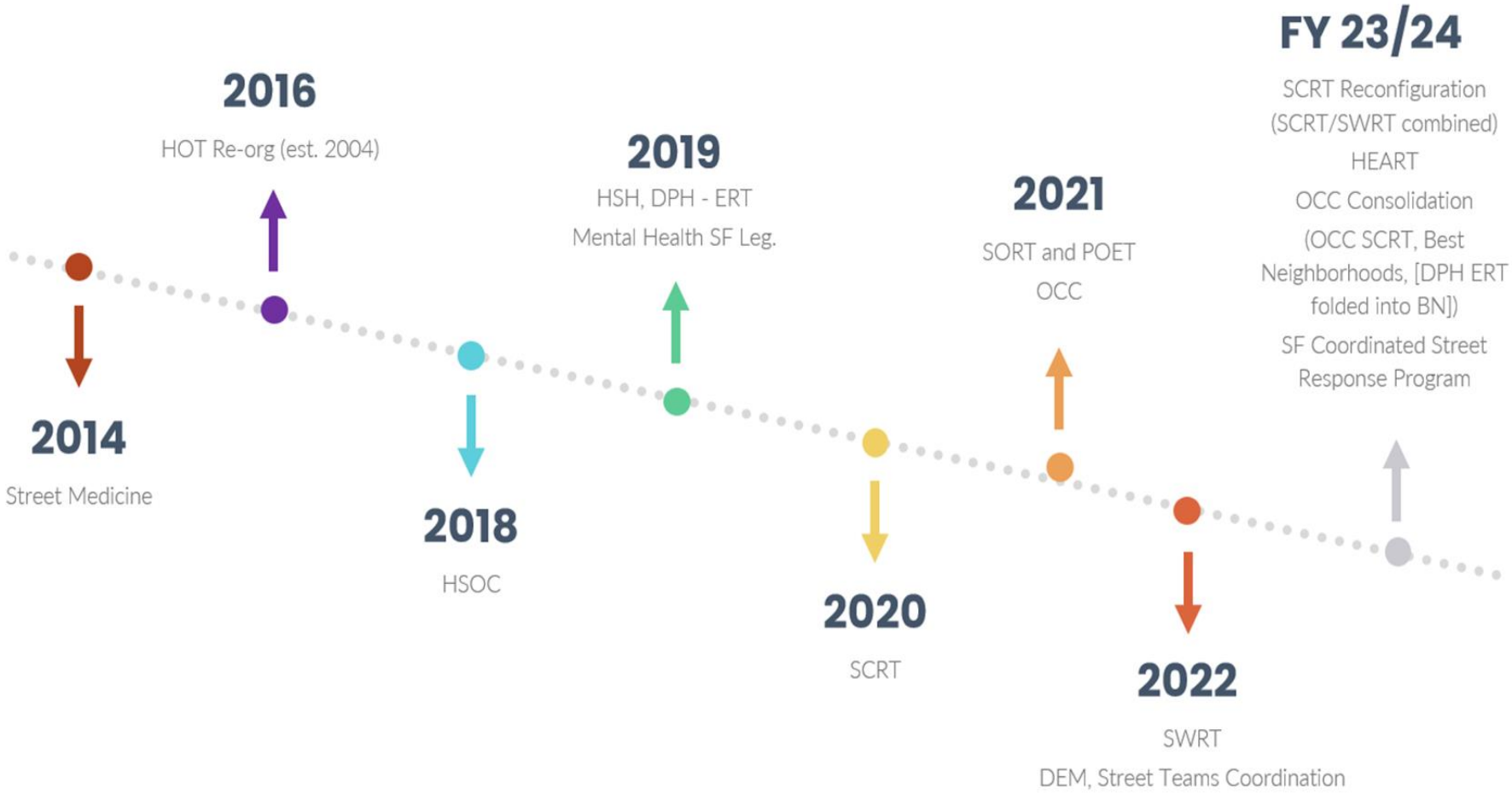
The team also begins working to obtain permanent supportive housing for Mary by facilitating a housing assessment by SFHOT. As Mary becomes more stable in her shelter and on medications, BEST Neighborhoods also works to transition her care to a BHS Intensive Outpatient Program (also known as Intensive Case Management or ICM).

The Intensive Outpatient Program takes over her care plan, mental health treatment, and supports Mary in maintaining her shelter placement and housing plan. Mary is now adherent with her medications and has reduced her distressing street behaviors, with a pathway to housing.

Thank you

Additional Information

SF Coordinated Street Response Program Evolution



BHS Office of Coordinated Care

Central Access Services

Information, screening, referral and direct connection to behavioral health care

Behavioral Health Access Line (BHAL): 24/7 state-mandated call center providing connection to behavioral health services

Behavioral Health Access Center (BHAC): Walk-in center, open 7 days/week, for access to behavioral health services

Eligibility Services: Centralized eligibility support to ensure individuals are enrolled in MediCal or other appropriate benefits

Care Coordination Services

Focused services for priority populations needing engagement and connections to care

Triage: Central hub managing referrals, ensuring connections to care after 5150 or SCRT contact, deploying OCC field-based follow-up teams

BEST Care Management: Field-based team focused on individuals leaving hospital, jail or post-crisis contact

BEST Neighborhoods: Teams providing outreach, engagement, coordination for unhoused people with acute behavioral health needs

Shelter Behavioral Health Team: Teams providing behavioral health care coordination and linkage for individuals in shelters and navigation centers

PHACS: Collaboration between BHS-OCC and WPIC providing care coordination and linkage for individuals in permanent supportive housing sites

How People Can Get Into Behavioral Health Care